ILLINOIS HEALTH FACILITIES PLANNING BOARD 08-075

APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION (IDEN)

RECEIVED
SEP 29 2008
HEALTH FACILITIES PLANNING BOARD

This section must be completed for all projects.

A. **Facility/Project Identification**

Facility Name Palos Community Hospital
Street Address 12251 S. 80th Avenue City Palos Heights
County Cook Zip 60463 Illinois State Representative District 27th House District

B. **Applicant Identification** (provide for each co-applicant [refer to Part 1130.220] and insert after this page)

Exact Legal Name Palos Community Hospital
Address 12251 S. 80th Avenue
Palos Heights, IL. 60463 Name of Registered Agent Sr. Margaret Wright
Name of Chief Executive Officer Sr. Margaret Wright Title President
CEO Address 12251 S. 80th Avenue, Palos Heights, IL. 60463 Telephone No. (708) 923-5000
Type of Ownership: ☑ Non-profit Corporation ☐ For-profit Corporation ☐ Limited Liability Company
☐ Partnership ☐ Governmental ☐ Sole Proprietorship ☐ Other (specify)

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

APPEND DOCUMENTATION AS ATTACHMENT IDEN-1 AFTER THE LAST PAGE OF THIS SECTION.

C. **Primary Contact Person** (person who is to receive correspondence or inquiries during the review period)

Name Margie Zeglen Title Director of Planning
Company Name Palos Community Hospital
Address 12251 S. 80th Avenue
Palos Heights, IL.60463 Telephone No. (708) 923-4744
E-mail Address MZeglen@PalosComm.org Fax Number (708) 923-4169

D. **Additional Contact Person** (person such as consultant, attorney, financial representative, registered agent, etc. who also is authorized to discuss application and act on behalf of applicant)

Name Delia Wozniak Title President
Company Name DMW and Associates, Inc.
Address 3716 N. Bernard Street
Chicago, Illinois 60618 Telephone No. (773) 279-0458
E-mail Address deliawoz@comcast.net Fax Number (773) 279-0473

E. Post Permit Contact Person (person to whom all correspondence and inquiries pertaining to the project subsequent to permit issuance are to be directed)

Name Margie Zeglen Title Director of Planning
Company Name Palos Community Hospital
Address 12251 S. 80th Avenue
Palos Heights, IL.60463 Telephone No. (708) 923-4744
E-mail Address MZeglen@PalosComm.org Fax Number (708) 923-4169

F. Site Ownership (complete this information for each applicable site and insert after this page)

Exact Legal Name of Person Who Owns Site Palos Community Hospital
Address of Site Owner 12251 S. 80th Avenue, Palos Heights, IL. 60463
Street Address or Legal Description of Site 12251 S. 80th Avenue, Palos Heights, IL. 60463

G. Operating Entity/Licensee (complete this information for each applicable facility and insert after this page)

Exact Legal Name Palos Community Hospital
Address 12251 S. 80th Avenue, Palos Heights, IL. 60463

Type of Ownership: ☑ Non-profit Corporation ☐ For-profit Corporation ☐ Limited Liability Company ☐ Partnership ☐ Governmental ☐ Sole Proprietorship ☐ Other (specify)

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

APPEND DOCUMENTATION AS ATTACHMENT IDEN-2 AFTER THE LAST PAGE OF THIS SECTION.

H. Organizational Relationships **NOT APPLICABLE**

Provide (for each co-applicant) an organization chart containing the name and relationship of any person who is related (related person is defined in Part 1130.140). If the related person 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 IDEN-3 AFTER THE LAST PAGE OF THIS SECTION.

I. Status of Previous Certificate of Need Projects

Provide the project number for any of the applicant's projects that have received permits but are not yet complete (completion is defined in Part 1130.140) and provide the current status of the project. If all projects are complete, indicate NONE: **NONE**

J. Flood Plain Requirements (refer to instructions for completion of this application)

Provide documentation regarding compliance with the Flood Plain requirements of Executive Order #4, 1979.

APPEND DOCUMENTATION AS ATTACHMENT IDEN-4 AFTER THE LAST PAGE OF THIS SECTION.

See Attachment IDEN-4.

K. Historic Resources Preservation Act Requirements (refer to instructions for completion of this application)

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

APPEND DOCUMENTATION AS ATTACHMENT IDEN-5 AFTER THE LAST PAGE OF THIS SECTION.

See Attachment IDEN-5.

L. Project Classification (check those applicable, refer to Part 1110.40 and Part 1120.20.b)

1. Part 1110 Classification
   - ☑ Substantive
   - ☐ Non-substantive

2. Part 1120 Applicability or Classification: (check one only)
   - ☐ Part 1120 Not Applicable
   - ☐ DHS or DVA Project
   - ☐ Category A Project
   - ☑ Category B Project

M. Narrative Description

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

NARRATIVE DESCRIPTION

Palos Community Hospital, located at 12251 S. 80th Ave. in Palos Heights, Illinois (60463), proposes a major modernization of Medical/Surgical (M/S) Services and expansion of Intensive Care (ICU), Surgery, Recovery, Emergency and other clinical and non-clinical services. The project provides for complete conversion to private patient rooms in its M/S services. Upon project completion the Hospital would have 36 ICU beds and 306 M/S beds, an addition of 12 ICU beds and a net reduction of 9 M/S beds.

The Hospital proposes to build an East Wing with eight levels which would be adjacent and connected to the existing hospital at the northeast corner (see the following pages for existing and proposed schematics.) The East Wing would contain a total of 399,669 new gross square feet (gsf) including 223,462 gsf for clinical services, as follows (further details follow schematics):

EAST WING Clinical Services	Building GSF*	Location
Medical/Surgical (156 beds)		
Four 36-bed M/S units	83,120 gsf	Floors 2- 5
One 12-bed telemetry M/S unit	8,670 gsf	Floor 6
	91,790 gsf	
Intensive Care (36 beds)		
One 24-bed ICU	16,980 gsf	Floor 7
One 12-bed ICU	8,670 gsf	Floor 6
	25,650 gsf	

Integrated Procedure Services	**42,826 gsf**	**Floor 1**
Surgery	**(37,354 gsf)**	
GI/Endo	**(3,468 gsf)**	
Special Procedures	**(2,004 gsf)**	
Recovery/Minor Outpatient Tx	**26,690 gsf**	**Floor 1**
PACU (Stage 1)	**(3,750 gsf)**	
Center for Short Stay Care (Stage 2 and minor procedures)	**(22,940 gsf)**	
Respiratory Therapy		
Satellites for each ICU	**1,060 gsf**	**Floors 6 & 7**
Outpatient & Pre-admission Testing	**4,730 gsf**	**Floor 1**
Pharmacy		
Central Pharmacy	**7,779 gsf**	**Basement**
Satellite Pharmacy for OR	**450 gsf**	**Floor 1**
	8,229 gsf	
Laboratory	**22,487 gsf**	**Basement**
TOTAL	**223,462 BGSF***	

* **The above gross square feet (gsf) refer to building gsf (BGSF) and include both internal departmental circulation space and a portion of the building's circulation.**

The following non-clinical services would occupy 176,207 gsf in the East Wing: Sterile Supply Processing; General Stores; Medical Staff Facilities, Staff Lockers/Lounge; Conference and Education; Nursing Administration/Education; Admitting/Registration; Purchasing; Maintenance/Engineering; Mechanical/Electrical/Stairs; and Lobby/Public Space.

The project modernizes 187,879 total gross square feet (gsf), including 131,247 gsf for clinical services. Almost 60% of the remodeled clinical space (77,330 gsf) is for the conversion of all current, semi-private M/S patient rooms to private rooms. A total of 165 M/S beds in semi-private rooms will be discontinued. As the East Wing contains only 156 replacement M/S beds, the Hospital proposes to discontinue 9 M/S beds, for a total of 306 M/S beds.

Another 53,917 gsf of vacated space will be remodeled to expand the following clinical services: on the 1st Floor - Emergency Department (ED); Admissions Unit adjacent to the ED; Cardiology; and Radiology and Nuclear Medicine, with satellite ED imaging for each service; and on the 3rd Floor - Respiratory Therapy and Inpatient Dialysis.

Non-clinical services would be remodeled to occupy the remaining vacated space, as follows: Medical Records (Transcription, Quality Assurance, Risk Management and Case Management); Health Information; Conference/Education; Purchasing; Pastoral Care; and Transport Services on the 1st Floor; Nursing Administration/Education; Dining; and Housekeeping/Linen Services in the Basement; and Medical Staff Facilities on the 3rd Floor.

Modernization also includes the total replacement of plumbing supply and waste risers estimated at about $17.5 million and several air handling units estimated at another $2.3 million.

The Hospital estimates that demolition, construction and modernization will take approximately 6 ¼ years to complete, starting August 1, 2010 and ending November 1, 2016.

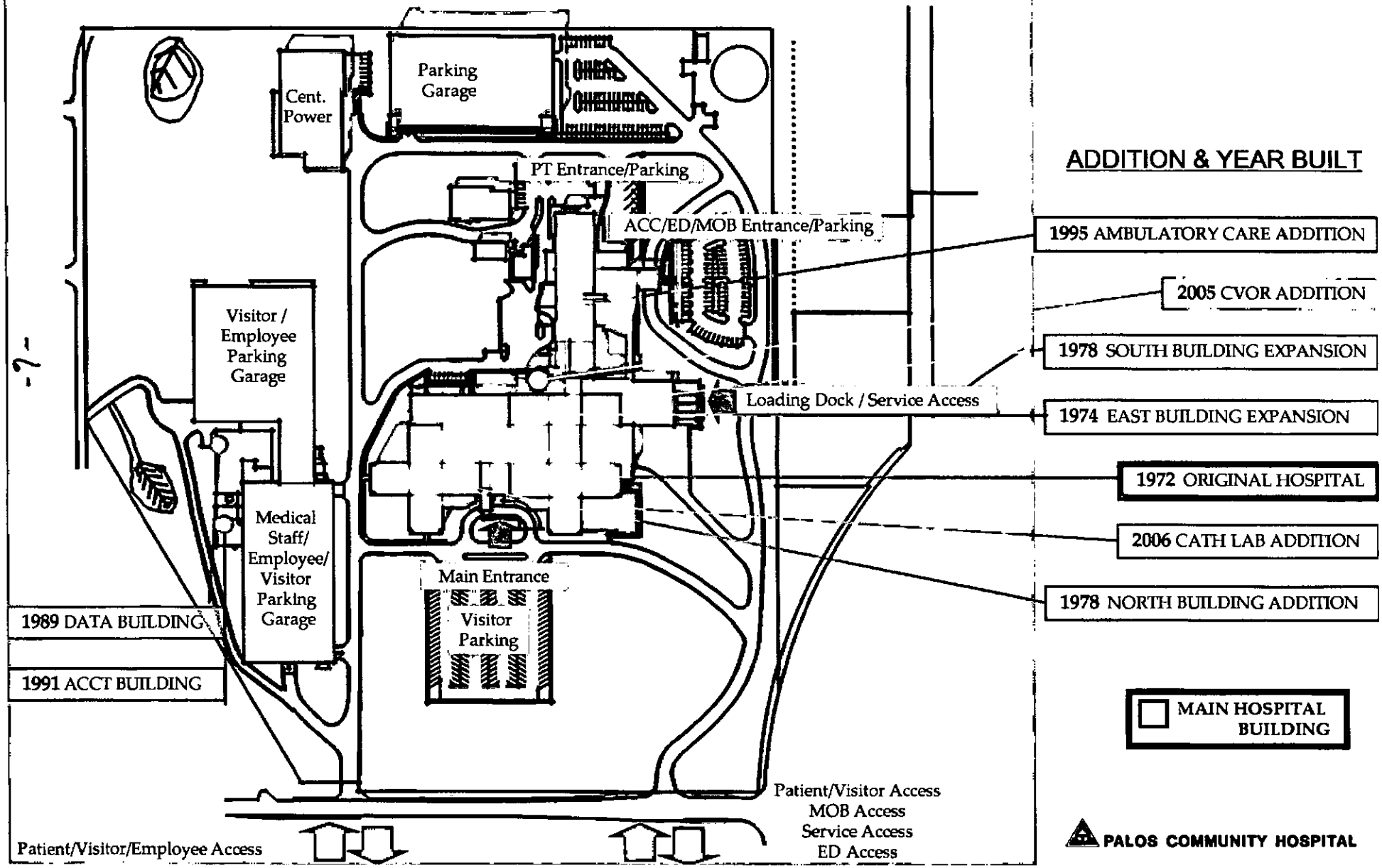
Project completion is expected by March 31, 2018. Please see "Project Timeline" which follows the schematics and the detailed project summary of new construction and modernization, by department and by floor.

The estimated total project cost is $420,438,329 of which $250,350,575 is for clinical services and $170,087,754 is for non-clinical services. The project would be funded by cash and a $300 million tax-exempt, FHA-guaranteed, fixed-rate bond issue with a term of thirty years.

The project is considered substantive due to the project cost.

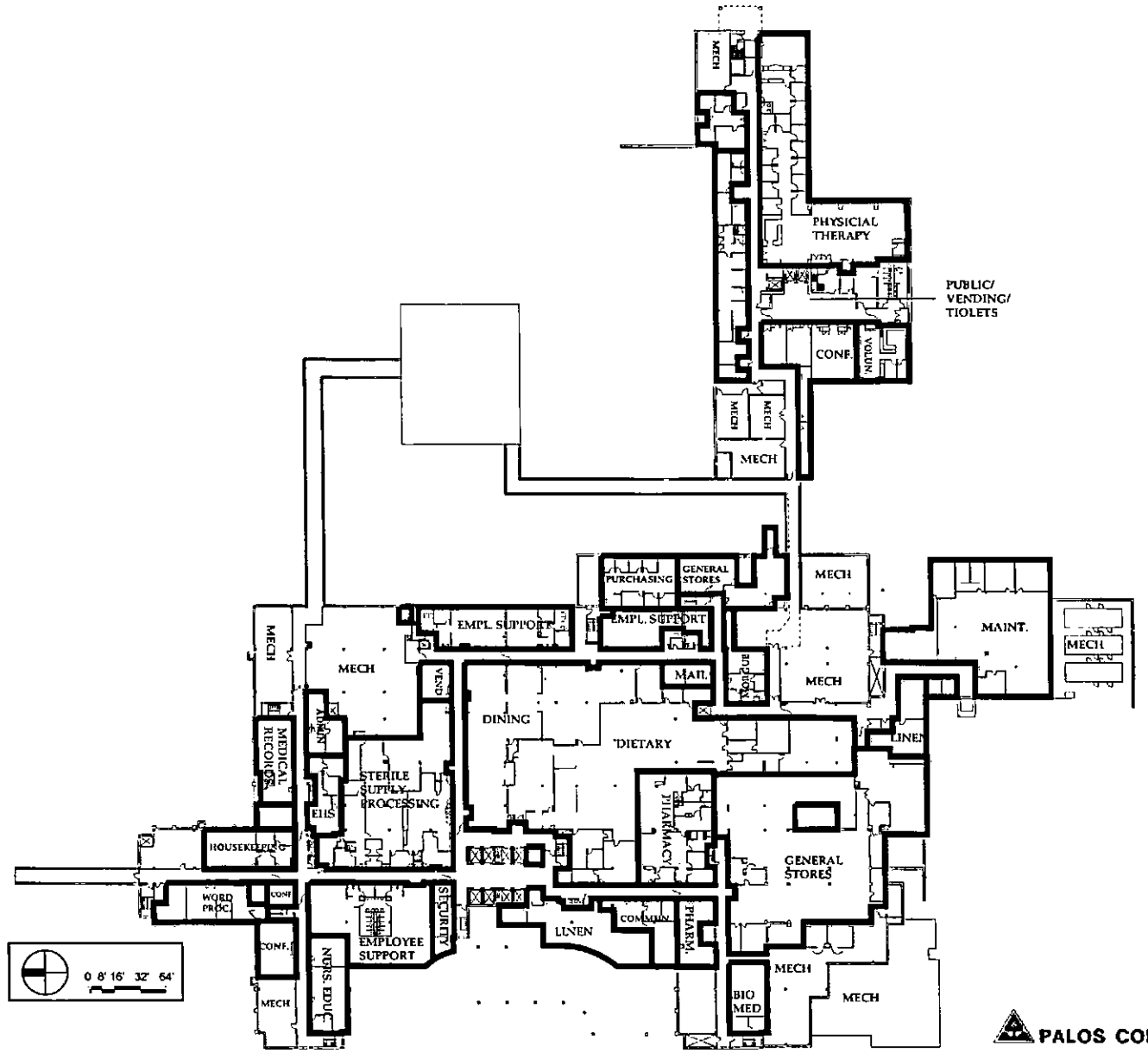
Palos Community Hospital

Existing Campus – Facilities / Site Plan



Palos Community Hospital

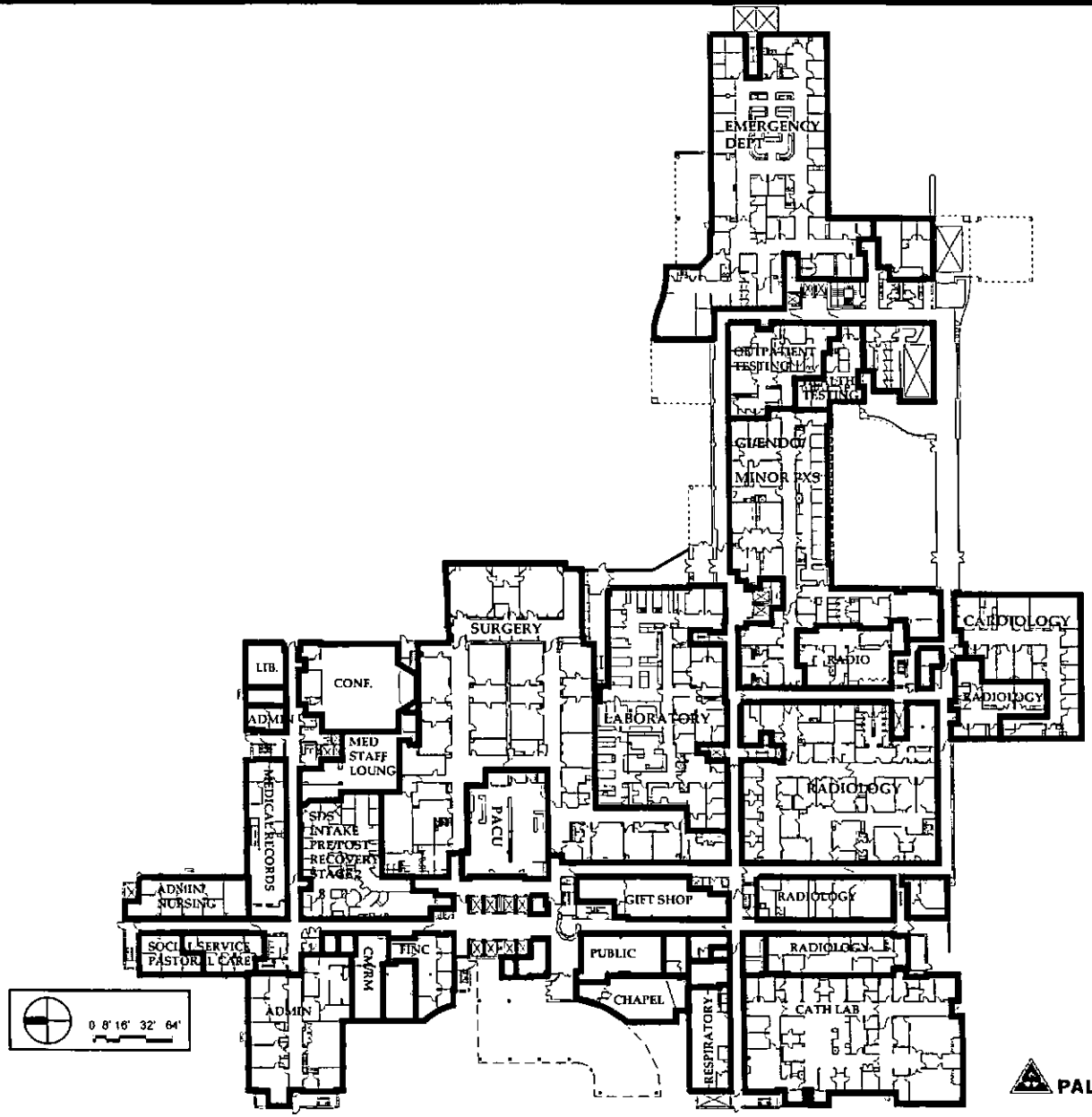
Existing – Ground Level



PALOS COMMUNITY HOSPITAL

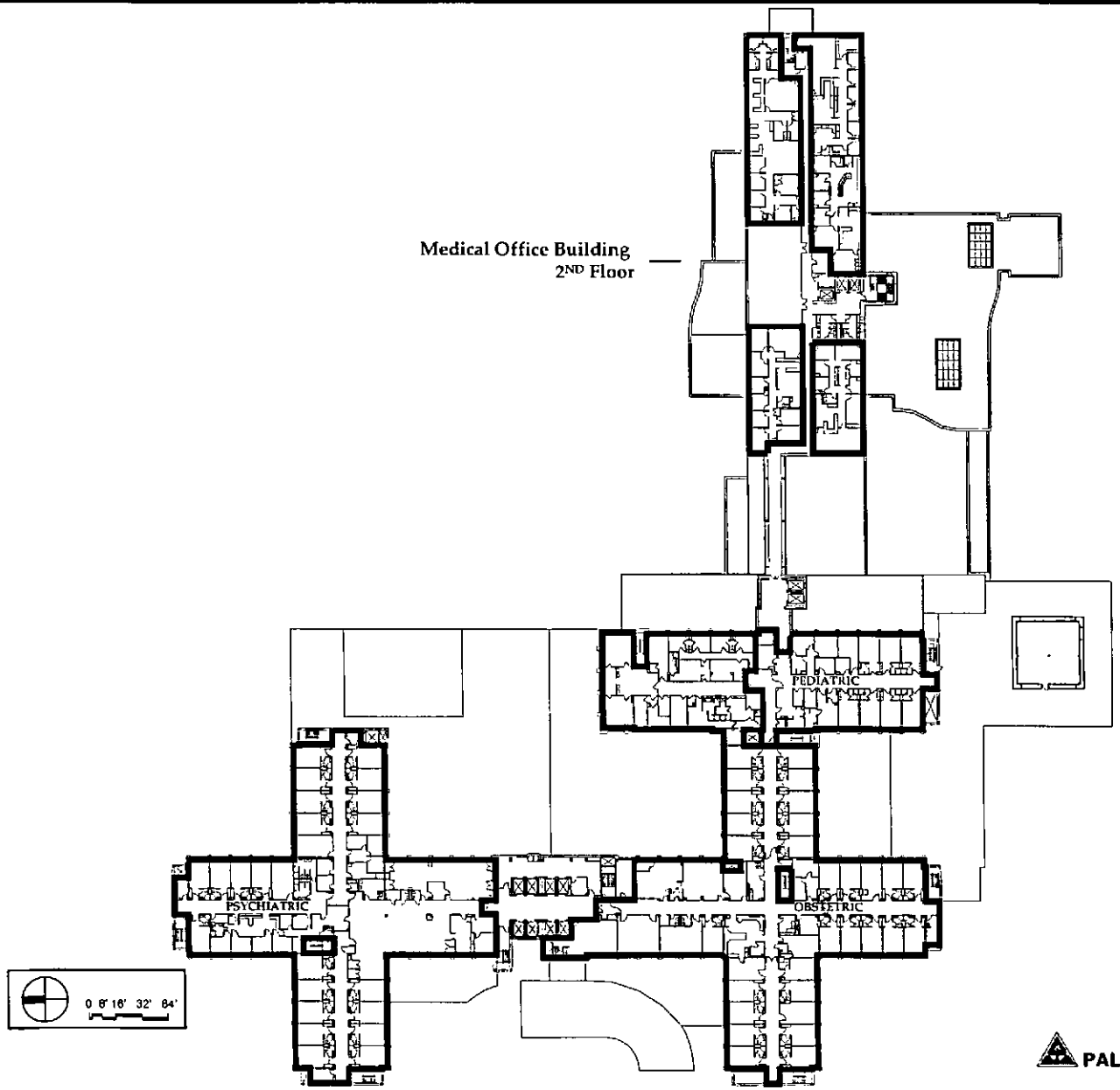
Palos Community Hospital

Existing – Level 1



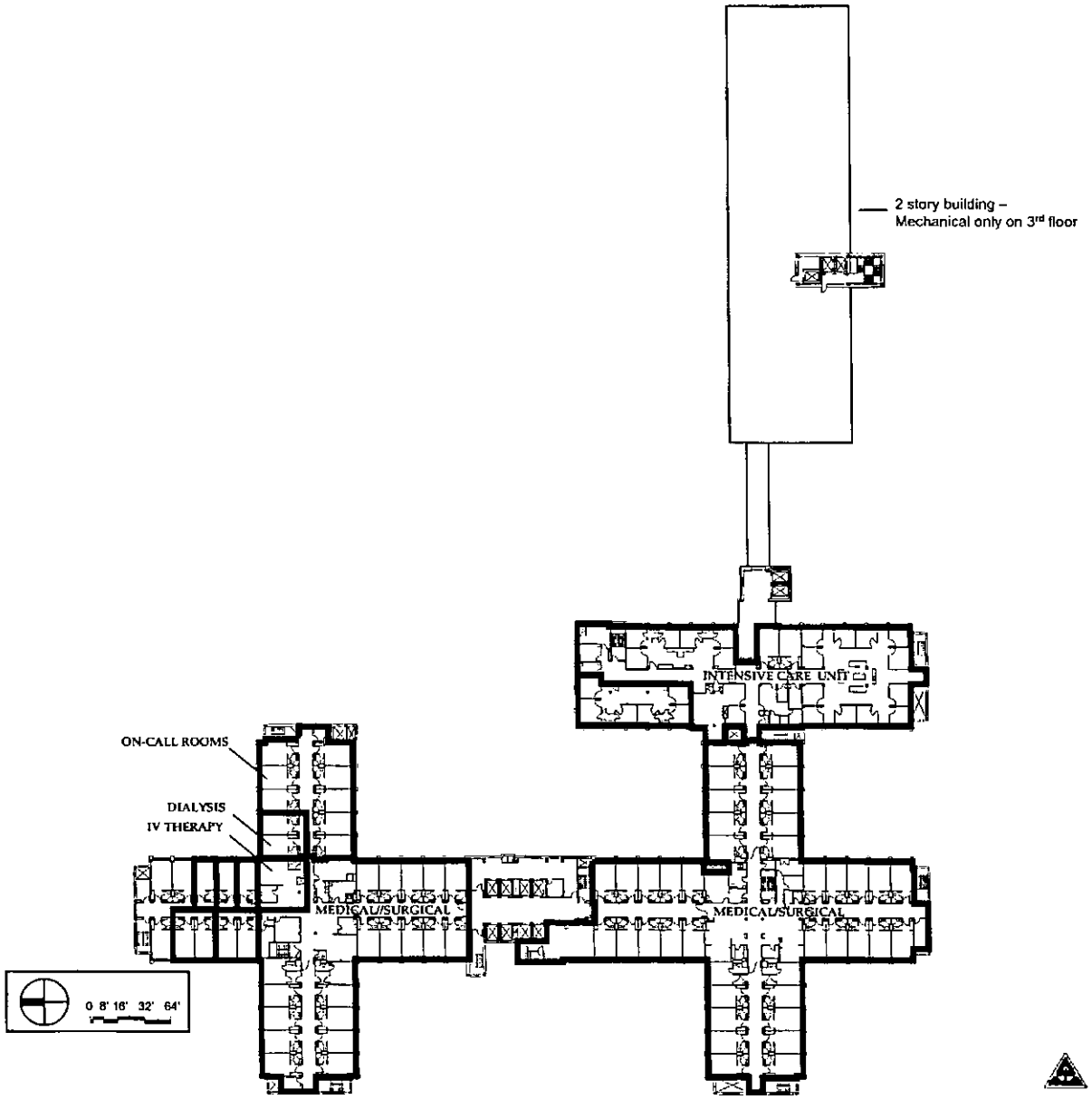
PALOS COMMUNITY HOSPITAL

Palos Community Hospital
Existing –Level 2



PALOS COMMUNITY HOSPITAL

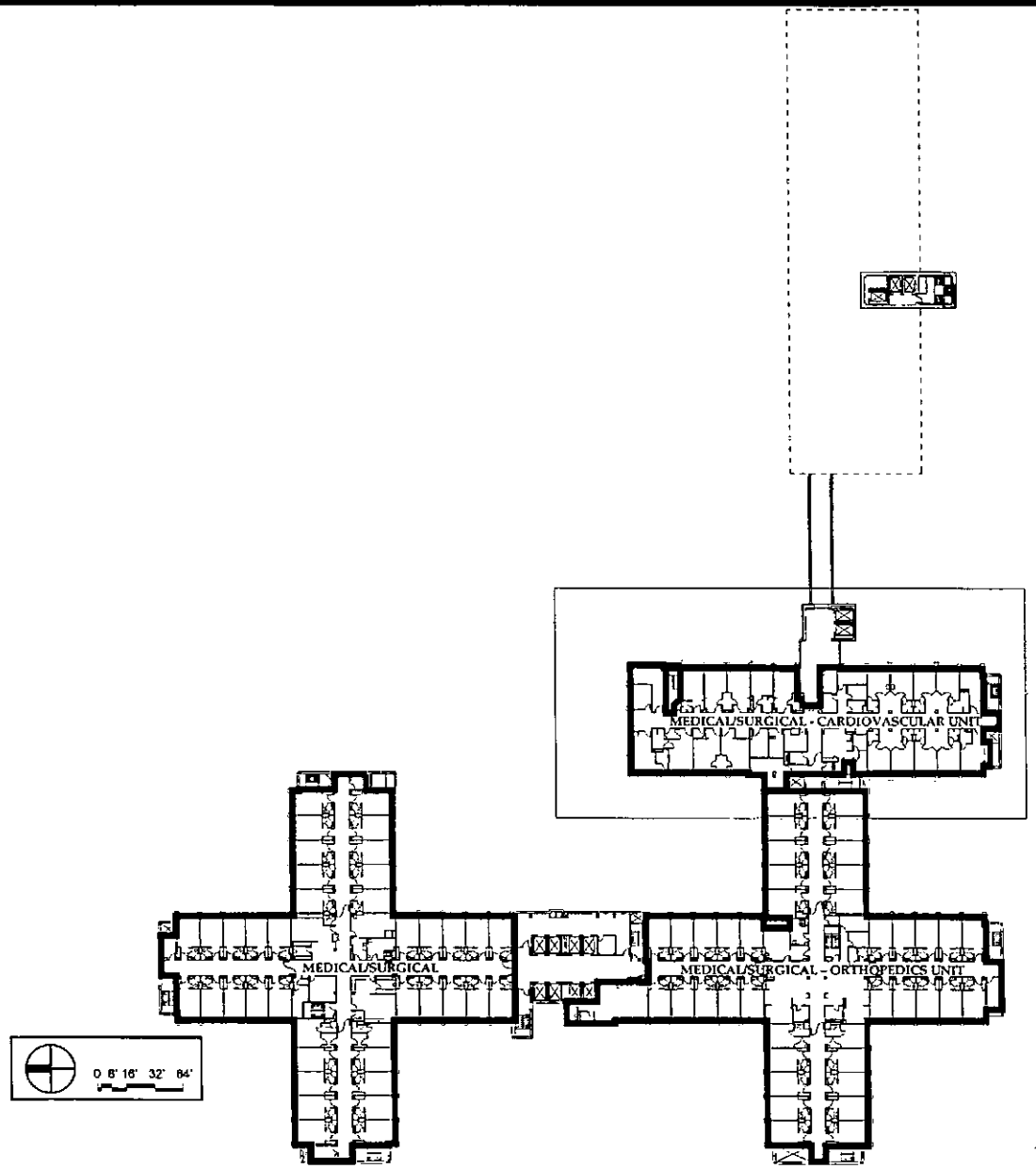
Palos Community Hospital
Existing –Level 3



PALOS COMMUNITY HOSPITAL

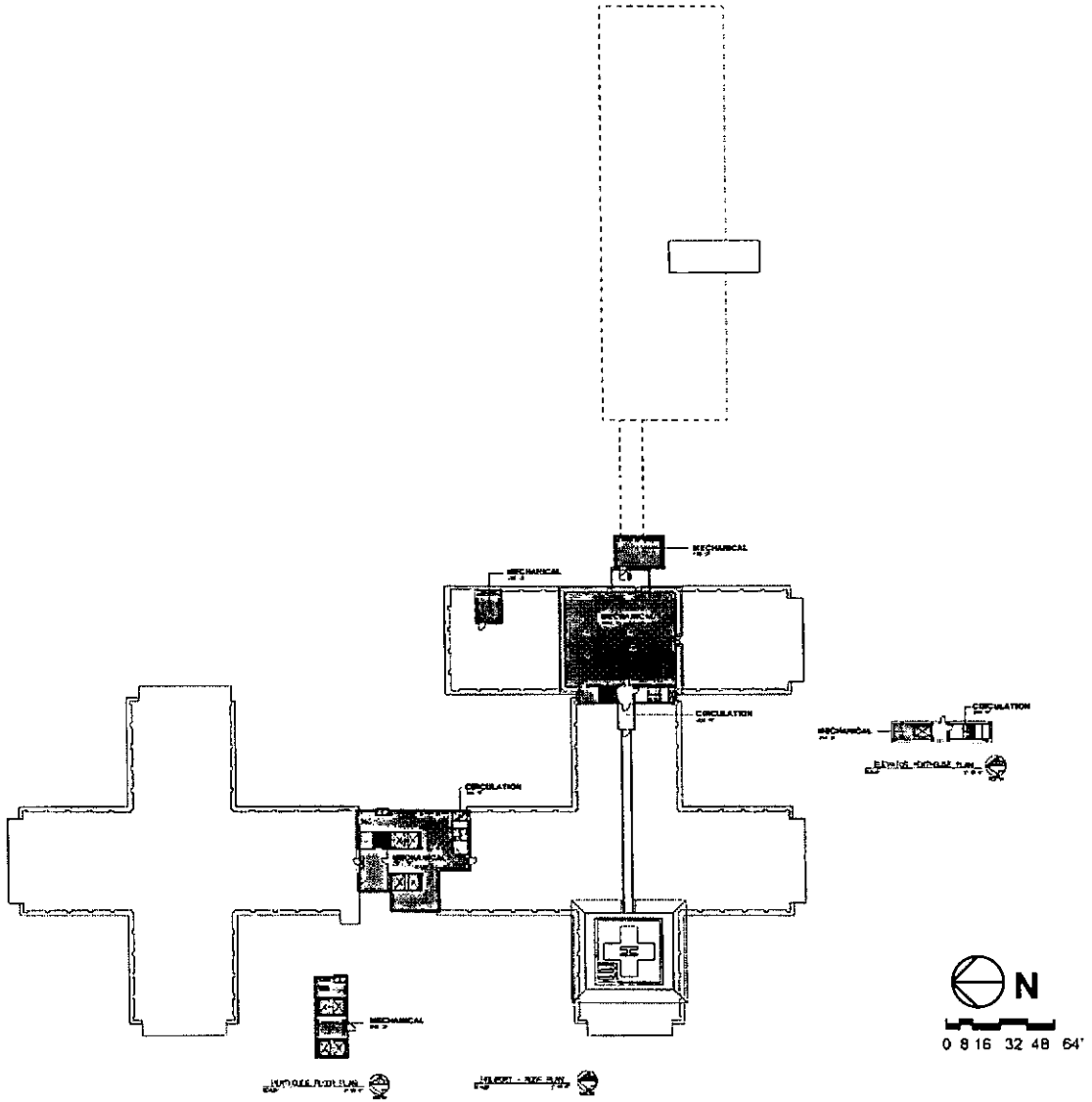
Palos Community Hospital

Existing –Level 4



PALOS COMMUNITY HOSPITAL

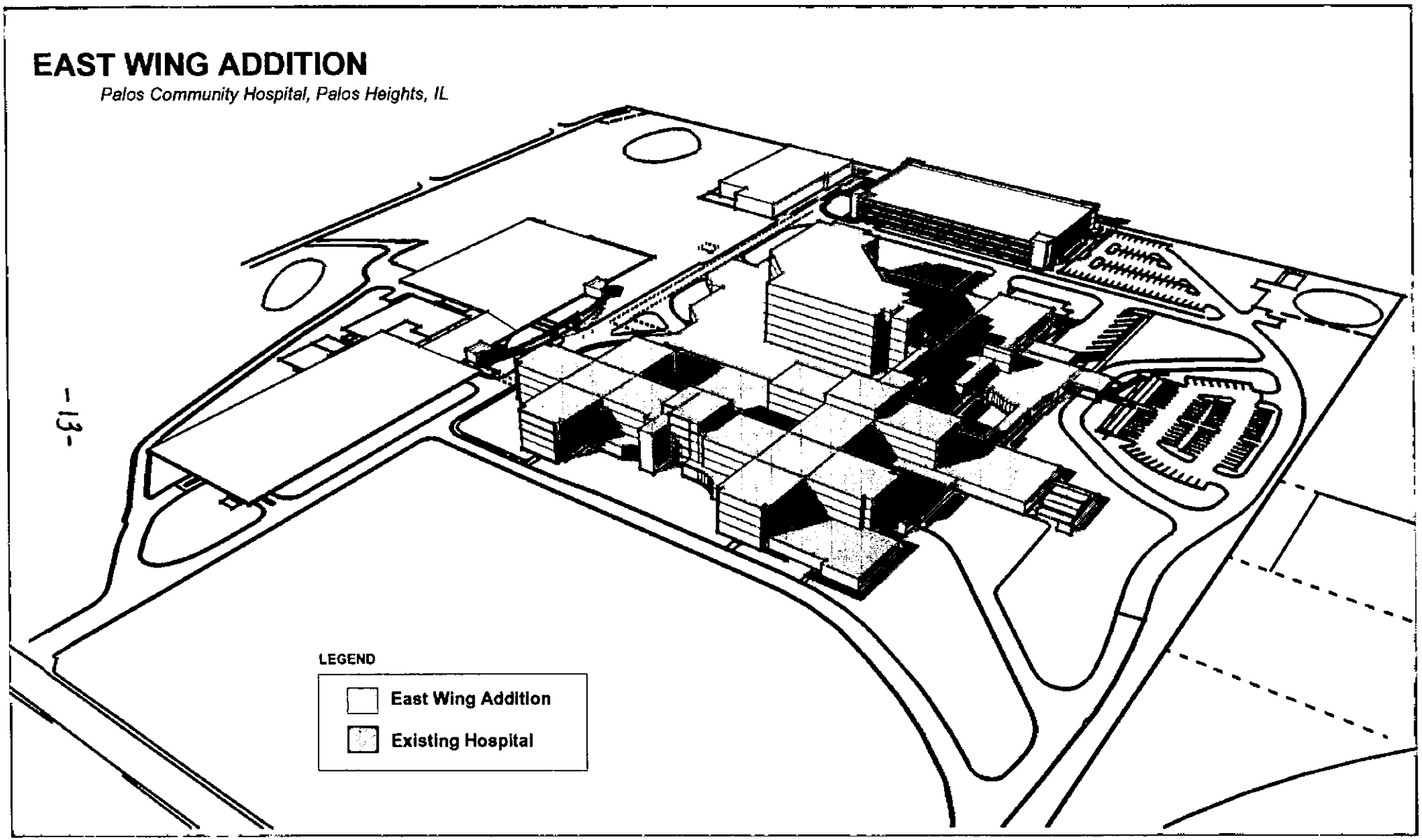
Palos Community Hospital
Existing –Level 5



PALOS COMMUNITY HOSPITAL

EAST WING ADDITION

Palos Community Hospital, Palos Heights, IL



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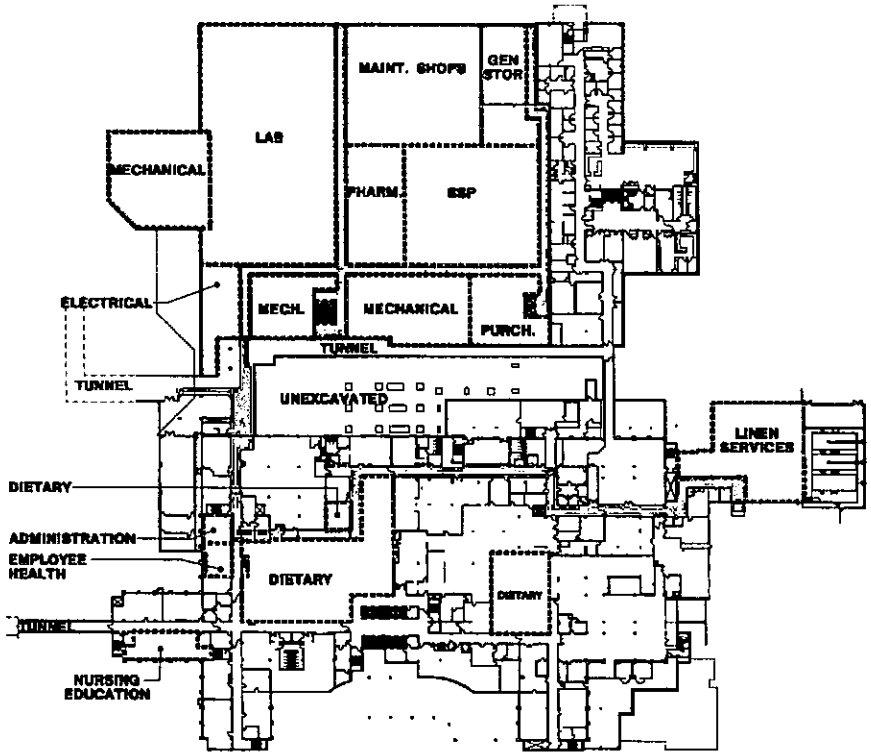
PALOS COMMUNITY HOSPITAL

NAVIGANT CONSULTING

Proposed Facility Plan
Lower Level

Palos Community Hospital
East Wing Addition



LEGEND

- *East Wing Addition*
- *Modernization*
- *As-Is*

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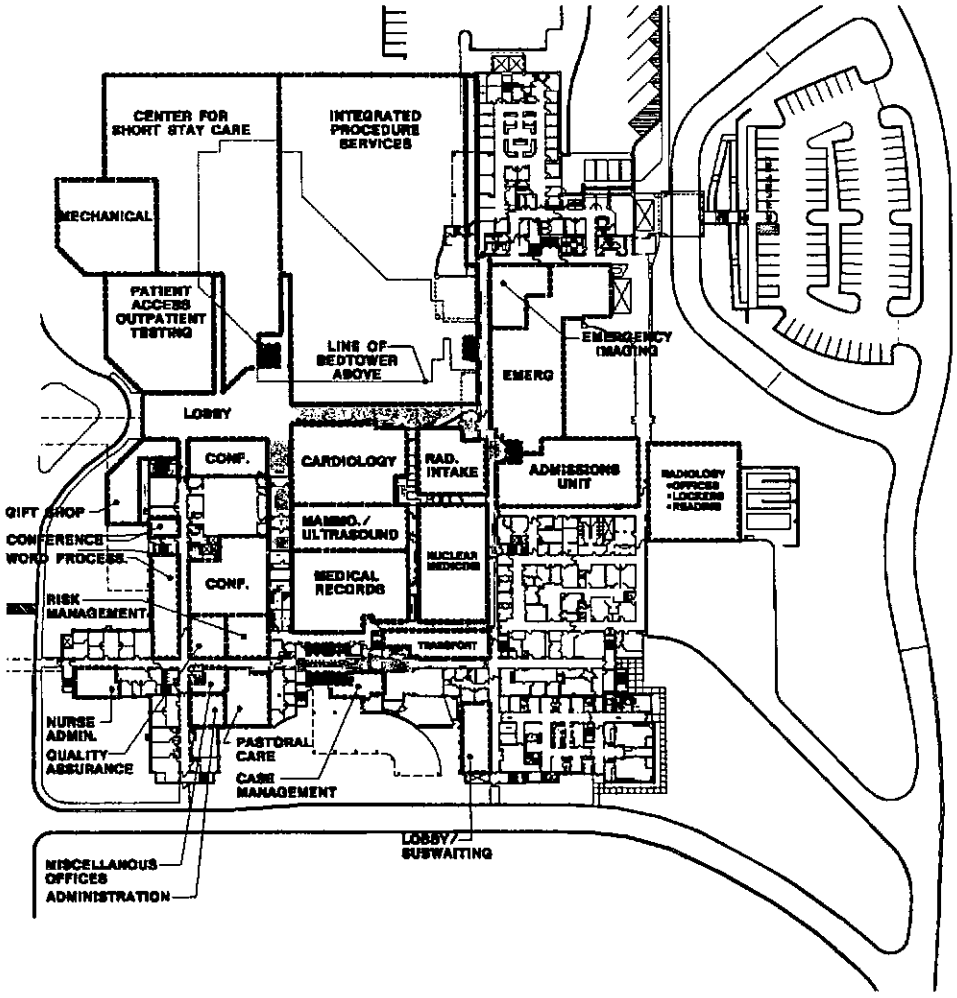
GROUND FLOOR PLAN
OPTION 2 1.22.08

PALOS COMMUNITY HOSPITAL

Proposed Facility Plan
First Floor

Palos Community Hospital
East Wing Addition



LEGEND

- *East Wing Addition*
- *Modernization*
- *As-Is*

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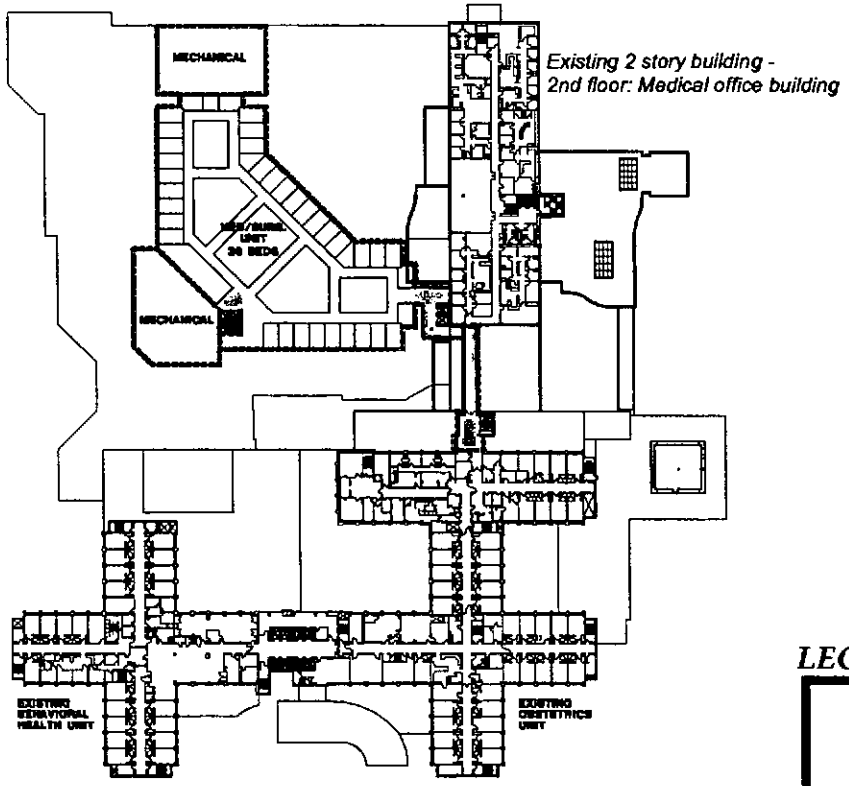
FIRST FLOOR PLAN
OPT 2 - 1.22.08

PALOS COMMUNITY HOSPITAL

Proposed Facility Plan
Second Floor

Palos Community Hospital
East Wing Addition



LEGEND

- *East Wing Addition*
- *Modernization*
- *As-Is*

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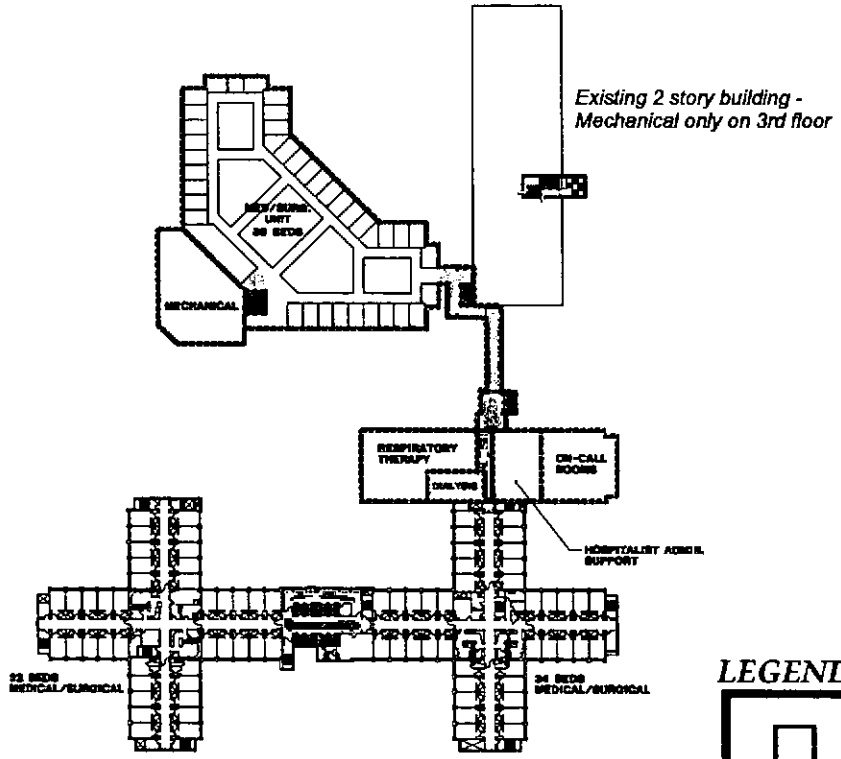
SECOND FLOOR
OPTION 2 1.22.08

PALOS COMMUNITY HOSPITAL

Proposed Facility Plan
Third Floor

Palos Community Hospital
East Wing Addition



LEGEND

- *East Wing Addition*
- *Modernization*
- *As-Is*

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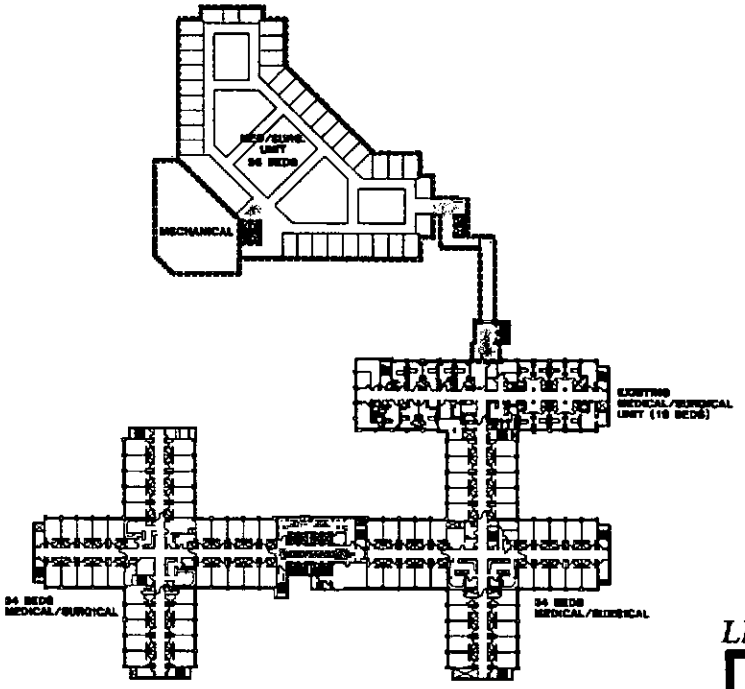
THIRD FLOOR
OPTION 2 1.22.08

PALOS COMMUNITY HOSPITAL

Proposed Facility Plan
Fourth Floor

Palos Community Hospital
East Wing Addition



LEGEND

- *East Wing Addition*
- *Modernization*
- *As-Is*

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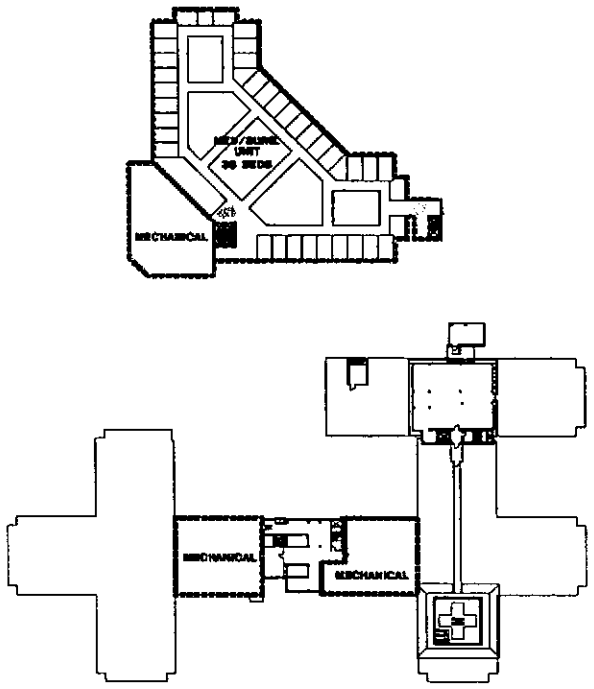
FOURTH FLOOR
OPTION 2 1.22.08

PALOS COMMUNITY HOSPITAL

Proposed Facility Plan
Fifth Floor

Palos Community Hospital
East Wing Addition



LEGEND

- *East Wing Addition*
- *Modernization*
- *As-Is*

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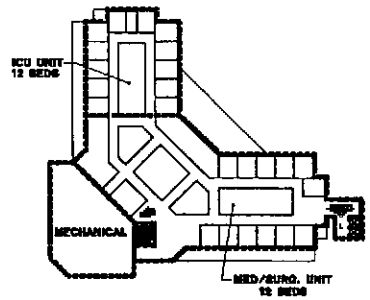
M&CA

FIFTH FLOOR
OPTION 2 1.22.08

PALOS COMMUNITY HOSPITAL

Proposed Facility Plan
Sixth Floor

Palos Community Hospital
East Wing Addition



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LEGEND

- *East Wing Addition*
- *Modernization*
- *As-Is*

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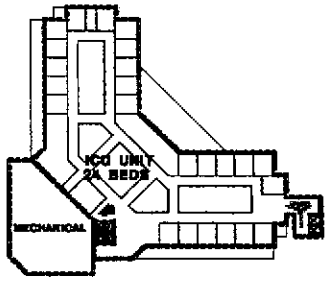
SIXTH FLOOR
OPTION 2 1.22.08

PALOS COMMUNITY HOSPITAL

Proposed Facility Plan
Seventh Floor

Palos Community Hospital
East Wing Addition



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LEGEND

- *East Wing Addition*
- *Modernization*
- *As-Is*

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SEVENTH FLOOR
OPTION 2 1.22.08

PALOS COMMUNITY HOSPITAL

Palos Community Hospital

New Construction Area										
Department	Basement	1st Floor	2nd Floor	3rd Floor	4th Floor	5th Floor	6th Floor	7th Floor	Penthouse	Total
CLINICAL										
Medical/Surgical Bed Units			21,147	21,147	21,147	19,679	8,670			91,790
Intensive Care							8,670	16,980		25,650
INTEGRATED PROCEDURE SERVICES		42,826								42,826
A) Surgery		37,354								
B) Endoscopy		3,468								
C) Special Procedures		2,004								
RECOVERY		26,690								
A) PACU (Stage I)		3,750								3,750
B) Center for Short Stay Care (Stage II)		22,940								22,940
Respiratory Therapy							530	530		1,060
Laboratory	22,487									22,487
Pharmacy	7,779	450								8,229
Outpatient & Pre-Admission Testing		4,730								4,730
Subtotal Clinical New	30,266	74,696	21,147	21,147	21,147	19,679	17,870	17,510	0	223,462

New Construction Area										
Department	Basement	1st Floor	2nd Floor	3rd Floor	4th Floor	5th Floor	6th Floor	7th Floor	Penthouse	Total
NON-CLINICAL										
Purchasing	3,380									3,380
Sterile Supply Processing	13,721									13,721
Maintenance/Engineering	17,235									17,235
General Stores	5,953									5,953
Admitting / Registration		3,370								3,370
Nursing Administration/Education		1,600	810	810	810	810	685	685		6,210
Medical Staff Facilities/Support		2,514								2,514
Conference/Education		4,020						360		4,380
Staff Lockers, Lounge & Support	2,795	1,367	710	710	710	710	1,050	1,050		9,102
Lobby / Public Spaces / Gift Shop		12,422	3,540	3,540	3,540	1,940	3,420	3,420		31,822
Mechanical/Elec/IT/Shafts	12,500	5,200	10,420	5,420	5,420	13,920	5,420	5,420		63,720
Stairs / Elevators	2,250	2,000	1,425	1,425	1,425	1,425	1,425	1,425		12,800
Parking	1,000	1,000								2,000
Subtotal Non-Clinical New	58,834	33,493	16,905	11,905	11,905	18,805	12,000	12,360	0	176,207
TOTAL NEW CONSTRUCTION	89,100	108,189	38,052	33,052	33,052	38,484	29,870	29,870	0	399,669

	Modernization									
	Basement	1st Floor	2nd Floor	3rd Floor	4th Floor	5th Floor	6th Floor	7th Floor	Penthouse	Total
CLINICAL										
Medical/Surgical Bed Units				38,665	38,665					77,330
Respiratory Therapy				4,365						4,365
Inpatient Dialysis				1,105						1,105
Emergency Department		11,435								11,435
Admissions Unit		6,696								6,696
Cardiology		6,661								6,661
Nuclear Medicine		6,766								6,766
Radiology		16,889								16,889
Subtotal Clinical Modernization	0	48,447	0	44,135	38,665	0	0	0	0	131,247

	Modernization									
Department	Basement	1st Floor	2nd Floor	3rd Floor	4th Floor	5th Floor	6th Floor	7th Floor	Penthouse	Total
NON-CLINICAL										
Quality (QA, CM, RM)		4,179								4,179
Transport Services		2,132								2,132
Health Information Management		9,083								9,083
Pastoral Care & Other Patient Support Services		1,997								1,997
Conference/Education		5,832								5,832
Dietary- Cafeteria/Kitchen	14,480									14,480
Housekeeping/Linen Services	6,140									6,140
Nursing Administration/Education	1,475	949								2,424
Administration	567	1,528								2,095
Staff Lockers, Lounge & Support	675									675
Medical Staff Facilities/Support				5,470						5,470
Lobby / Public Spaces		1,485								1,485
Plumbing										
Air Handling										
Parking	640									640
Corridors/Circulation										0
										0
Subtotal Non-Clinical Modernization	23,977	27,185	0	5,470	0	0	0	0	0	56,632
TOTAL MODERNIZATION	23,977	75,632	0	49,605	38,665	0	0	0	0	187,879
TOTAL CLINICAL (New & Mod)	30,266	123,143	21,147	65,282	59,812	19,679	17,870	17,510	0	354,709
TOTAL NON-CLINICAL (New & Mod)	82,811	60,678	16,905	17,375	11,905	18,805	12,000	12,360	0	232,839
GRAND TOTAL NEW & MOD	113,077	183,821	38,052	82,657	71,717	38,484	29,870	29,870	0	587,548

N. Project Costs and Sources of Funds - $

Description	TOTAL	CLINICAL	NON-CLINICAL
Pre-Planning Costs	$ 2,600,610	$ 1,560,366	$ 1,040,244
Survey and Soils	$ 265,000	$ 159,000	$ 106,000
Site Prep & Demolition	$ 9,169,254	$ 5,501,552	$ 3,667,702
Off-Site Improvements	$ 5,674,036	$ 3,404,422	$ 2,269,614
New Construction Costs	$ 166,663,879	$ 99,301,441	$ 67,362,438
New Construction Owner Contingencies	$ 16,666,388	$ 9,930,144	$ 6,736,244
Modernization Costs	$ 77,386,038	$ 45,435,235	$ 31,950,804
Modernization Owner Contingencies	$ 11,607,906	$ 6,815,285	$ 4,792,621
Architectural / Engineering	$ 13,794,804	$ 8,276,883	$ 5,517,922
Consulting & Other Fees	$ 9,667,171	$ 5,800,303	$ 3,866,868
Moveable Capital Equipment	$ 77,962,168	$ 46,777,301	$ 31,184,867
Bond Issuance Expense	$ 6,000,000	$ 3,600,000	$ 2,400,000
Net Interest Expense During Construction	$ 21,000,000	$ 12,600,000	$ 8,400,000
Fair Market Value of Leased Equipment	$ -	$ -	$ -
Other Costs to be Capitalized	$ 1,981,074	$ 1,188,644	$ 792,430
Acquisition of Buildings & Property	$ -		
Total Project Cost	**$ 420,438,329**	**$ 250,350,575**	**$ 170,087,754**

Cash & Securities	$ 120,438,329	$ 70,350,575	$ 50,087,754
Bond Issues (project related)	$ 300,000,000	$ 180,000,000	$ 120,000,000
Total Funds	**$ 420,438,329**	**$ 250,350,575**	**$ 170,087,754**

Note:

1) $488.82 per GSF for clinical new construction costs & contingencies

2) $398.11 per GSF for clinical modernization construction costs & contingencies

3) Construction costs are based on 7% escalation per year

Clinical portion of the cost:	$250,350,575	60%
Non-clinical portion of the cost:	$170,087,754	40%
NEW Clinical portion of the GSF:	223,462	63%
MOD Clinical portion of the GSF:	131,247	37%
Clinical portion of the GSF:	354,709	60%
Non-clinical portion of the GSF:	232,839	40%
	587,548	
Total Cost:	$420,438,329	
Total GSF:	587,548	

Palos Community Hospital

Palos Heights, Illinois

East Wing Addition

Project Timeline	Start	Complete	Duration	
Architectural/Engineering				
Planning and Programming	**July 1, 2008**	August 1, 2008	1 month	
Schematic Design	February 1, 2009	May 1, 2009	3 months	
Design Development	April 1, 2009	October 1, 2009	6 months	15
Construction Documents	August 1, 2009	May 1, 2010	9 months	months
Public Approvals				
Certificate of Need	September 1, 2008	May 1, 2009	8 months	
Zoning and Planning	April 1, 2009	October 1, 2009	6 months	
Construction				
Contract	May 1, 2010	August 1, 2010	3 months	
New				
Start / Complete	August 1, 2010	September 1, 2012	26 months	
Inspections / Approvals	September 1, 2012	October 15, 2012	6 weeks	
Modernization (Backfill)				
Start / Complete	November 1, 2012	November 1, 2013	12 months	
Inspections / Approvals	November 1, 2013	December 15, 2013	6 weeks	
Modernization (Existing Inpatient Units)				
Start / Complete	November 1, 2012	November 1, 2016	48 months	
Inspections / Approvals	November 1, 2016	December 15, 2016	6 weeks	
Construction Midpoint		September 15, 2013		
CON Project Completion Date		**March 31, 2018**		

O. Related Project Costs

1. 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:

   √ No land acquisition is related to project;

   Purchase Price $_____; Fair Market Value $_____

2. Does the project involve 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 $ _____.

P. Project Status and Completion Schedules

1. Indicate the stage of the project's architectural drawings:

   __None or not applicable √ Schematics __ Preliminary __Final Working

2. Provide the following dates (indicate N/A for any item that is not applicable):

25% of project costs expended	3/1/2011	50% of project costs expended	4/1/2012
75% of project costs expended	12/1/2013	95% of project costs expended	2/1/2016
100% of project costs expended	6/1/2017	Midpoint of construction date	9/15/2013

   Anticipated project completion date (refer to Part 1130.140) 3/31/2018

3. 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 INFO-6 AFTER THE LAST PAGE OF T SECTION.

Q. Cost/Space Requirements

Provide in the format of the following example the gross square footage (GSF) and the attributable portion of total project cost for each department/area. Identify each piece of major medical equipment. 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 measurement plus the department or area's portion of the surrounding circulation space. Indicate the proposed use of any vacated space.

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	Cost	Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
Dietary	1,150,000	3,000	6,000	3,000	1,000	2,000	
Radiation Therapy	3,250,000	4,000	5,500	5,500			
Medical Records	300,000	2,500	6,500		4,000	2,500	
TOTALS	4,700,000	9,500	18,000	8,500	5,000	4,500	

APPEND DOCUMENTATION AS ATTACHMENT INFO-7 AFTER THE LAST PAGE OF THIS SECTION.

R. Facility Bed Capacity and Utilization

1. Complete the following chart as applicable. Complete a separate chart for each facility that is part of the project and insert following this page. Provide the existing bed capacity and utilization data for the latest 12 month period for which data is available. Any bed capacity discrepancy from the Inventory will result with the application being deemed incomplete.

FACILITY NAME **PALOS COMMUNITY HOSPITAL** CITY **PALOS HEIGHTS**

REPORTING PERIOD DATES: From **April 1, 2007** to **March 31, 2008**

Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	315	15,910	76,721	-9	306
Pediatrics	15	448	871	0	15
Obstetrics	28	1,641	4,108	0	28
Intensive Care	24	1,753	5,983	+12	36
Neonatal ICU	-	-	-	-	-
Acute Mental Illness	48	1,233	6,137	0	48
Rehabilitation	-	-	-	-	-
Nursing Care	-	-	-	-	-
Sheltered Care	-	-	-	-	-
Other (identify)	-	-	-	-	-
Other (identify)	-	-	-	-	-
Other (identify)	-	-	-	-	-
TOTALS	430	20,985	93,820	+3	433

2. Is the facility certified for participation in the Medicare "swing bed" (i.e. acute care beds certified for extended care) program? ____ Yes **X** No

3. For the following categories of service, indicate the number of existing beds that are Medicare certified and the number of existing beds that are Medicaid certified (if none, so indicate):

Service	# Medicare Beds	#Medicaid Beds
Nursing Care	0	0
ICF/DD Adult	0	0
Children DD	0	0

S. Certification

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are in the case of a corporation, any two of its officers or members of its board of directors; in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist); in the case of a partnership, two of its general partners (or the sole general partner when two or more general partners do not exist); in the case of estates and trusts, two of its beneficiaries(or the sole beneficiary when two or more beneficiaries do not exist); and in the case of a sole proprietor, the individual that is the proprietor. The signature(s) must be notarized. If the application has co-applicants, a separate certification page must be completed for each co-applicant and inserted following this page. One copy of the application must have the ORIGINAL signatures for all persons that sign for the applicant and for each of the co-applicants.

This Application for Permit is filed on behalf of Palos Community Hospital * **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.**

Sister Margaret Wright
Signature

Printed Name Sister Margaret Wright

Printed Title President

Notarization:
Subscribed and sworn to before me
this 24th day of September, 2008

Nancy K. Navarro
Signature of Notary

Seal

"OFFICIAL SEAL"
NANCY K. NAVARRO
Notary Public, State of Illinois
My Commission Expires 06-10-2010

Signature

Printed Name Hugh Rose

Printed Title Treasurer

Notarization:
Subscribed and sworn to before me
this 24th day of September, 2008

Nancy K. Navarro
Signature of Notary

Seal

"OFFICIAL SEAL"
NANCY K. NAVARRO
Notary Public, State of Illinois
My Commission Expires 06-10-2010

*Insert EXACT legal name of the applicant

File Number 2564-757-2

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

PALOS COMMUNITY HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON MAY 02, 1938, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 10TH *day of* APRIL *A.D.* 2008 .

Jesse White

SECRETARY OF STATE

Authentication #: 0810101550

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

ATTACHMENT IDEN-1

File Number 2564-757-2

STATE OF ILLINOIS
OFFICE OF
THE SECRETARY OF STATE

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Jesse White

SECRETARY OF STATE

Authentication #: 0810101550

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

ATTACHMENT IDEN-2

ILLINOIS DEPARTMENT OF NATURAL RESOURCES

Illinois State Water Survey

Main Office • 2204 Griffith Drive • Champaign, IL 61820-7495 • Tel (217) 333-2210 • Fax (217) 333-6540
Peoria Office • P.O. Box 697 • Peoria, IL 61652-0697 • Tel (309) 671-3196 • Fax (309) 671-3106

SWS

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

Requester: Margie Zeglen, RHIA
Address: Palos Community Hospital, 12251 S. 80th Ave.
City, state, zip: Palos Heights, IL 60463 Telephone: (708) 923-4744

Site description of determination:
Site address: Palos Community Hospital, 12251 S. 80th Ave.
City, state, zip: Palos Heights, IL 60463
County: Cook Sec¼: SW 1/4 of NW 1/4 Section: 25 T. 37 N. R. 12 E. PM: 3rd
Subject area: Parcels 23-25-106-18-0000 through 23-25-106-21-0000; which are within the area bounded by 121st St on the north, 123rd St./McCarthy Road on the south, 80th Ave. on the west, and the transmission line ROW on the east).

The property described above IS NOT located in a Special Flood Hazard Area or a shaded Zone X floodzone.
Floodway mapped: N/A Floodway on property: No
Source used: FEMA Flood Insurance Rate Map (FIRM). An annotated copy is attached.
Community name: City of Palos Heights, IL Community number: 170142
Panel/map number: 17031C0612 F & 17031C0616 F Effective Date: November 6, 2000
Flood zone: X [unshaded] Base flood elevation: N/A ft NGVD 1929

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

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

Note: This determination is based on the current Federal Emergency Management Agency (FEMA) flood hazard map for the community. This letter does not imply that the referenced property will or will not be free from flooding or damage. A property or structure not in a Special Flood Hazard Area may be damaged by a flood greater than that predicted on the FEMA map or by local drainage problems not mapped. This letter does not create liability on the part of the Illinois State Water Survey, or employee thereof for any damage that results from reliance on this determination. This letter does not exempt the project from local stormwater management regulations.

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

William Saylor, CFM IL-02-00107, Illinois State Water Survey Title: ISWS Surface Water & Floodplain Information Date: 3/11/2008

Intentionally

Left

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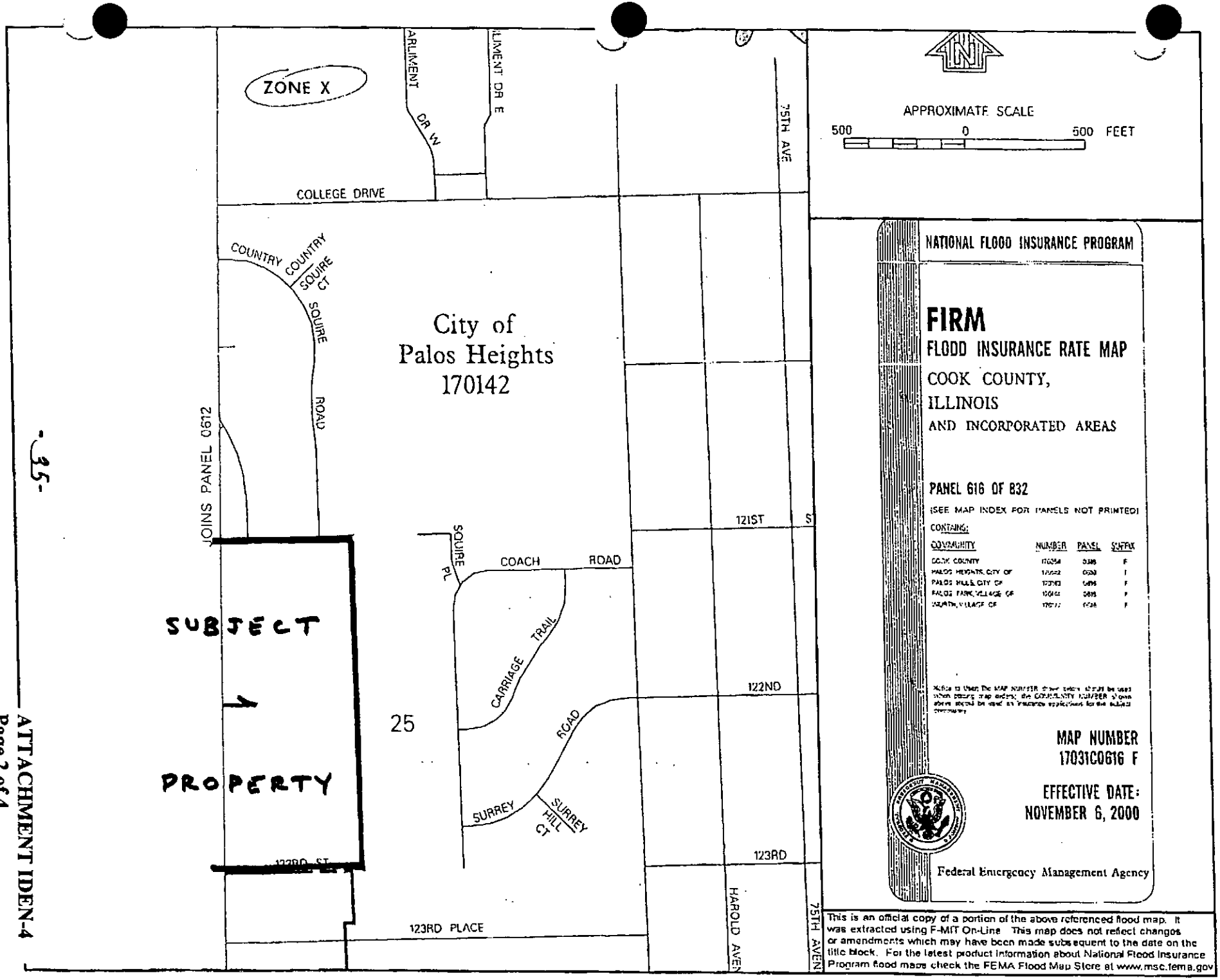
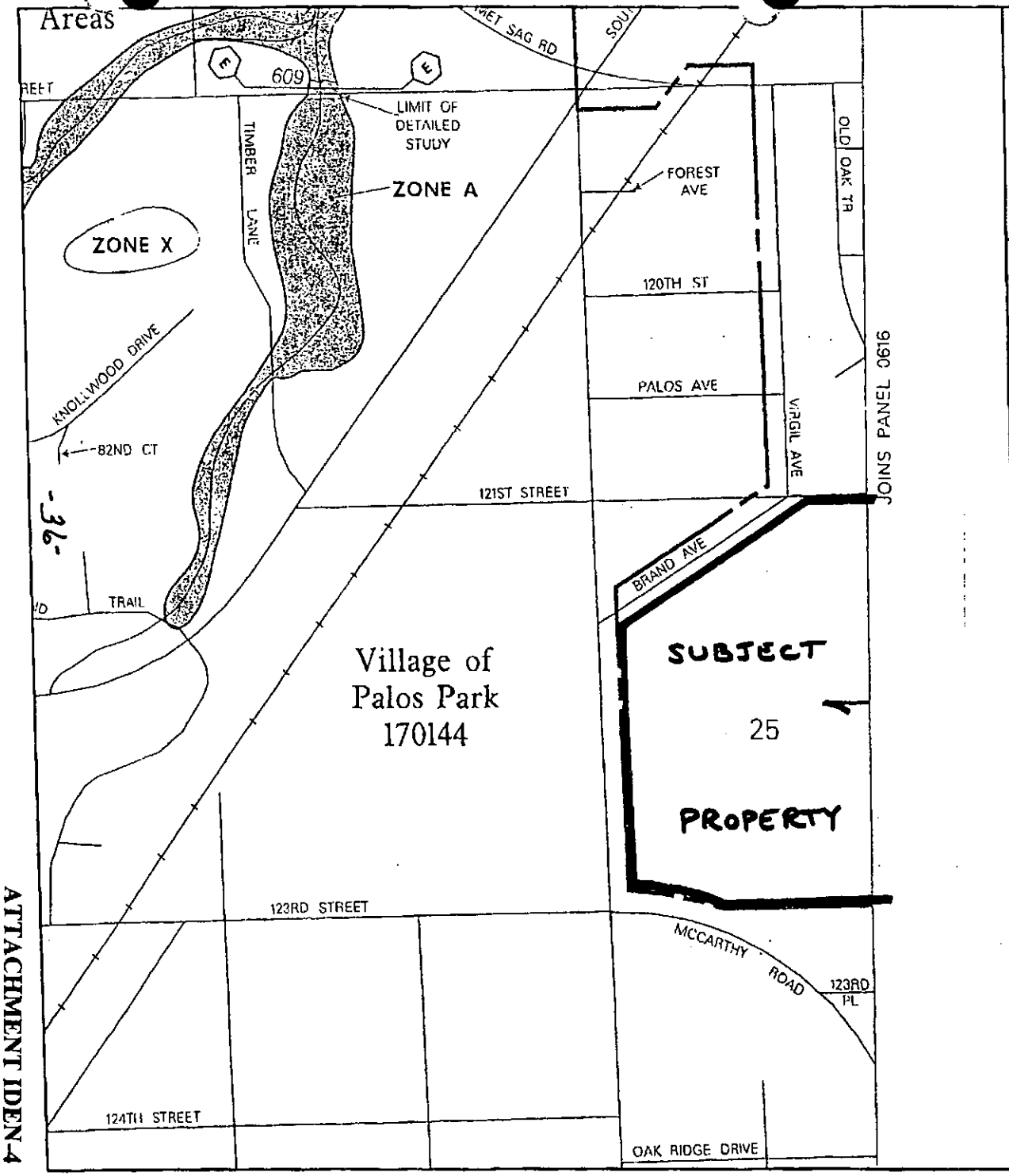


ATTACHMENT IDEN-4
Page 2 of 4



APPROXIMATE SCALE

500 0 500 FEET

NATIONAL FLOOD INSURANCE PROGRAM

FIRM

FLOOD INSURANCE RATE MAP

COOK COUNTY,
ILLINOIS
AND INCORPORATED AREAS

PANEL 612 OF 832

(SEE MAP INDEX FOR PANELS NOT PRINTED)

CONTAINS:

COMMUNITY	NUMBER	PANEL	SUFFIX
COOK COUNTY	170054	0612	F
PALOS HEIGHTS, CITY OF	170467	0612	F
PALOS HILLS, CITY OF	170463	0612	F
PALOS PARK, VILLAGE OF	170141	0612	F

Notice to User: The Map Number shown below should be used when placing map orders; the Community Number shown above should be used on insurance applications for the subject community.

MAP NUMBER
17031C0612 F

EFFECTIVE DATE:
NOVEMBER 6, 2000

Federal Emergency Management Agency

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

ATTACHMENT IDEN-4
Page 3 of 4

LEGEND

SPECIAL FLOOD HAZARD AREAS INUNDATED BY 100-YEAR FLOOD

ZONE A No base flood elevations determined.

ZONE AE Base flood elevations determined.

ZONE AH Flood depths of 1 to 3 feet (usually areas of ponding); base flood elevations determined.

ZONE AO Flood depths of 1 to 3 feet (usually sheet flow on sloping terrain); average depths determined. For areas of alluvial fan flooding, velocities also determined.

ZONE A99 To be protected from 100-year flood by Federal flood protection system under construction; no base flood elevations determined.

ZONE V Coastal flood with velocity hazard (wave action); no base flood elevations determined.

ZONE VE Coastal flood with velocity hazard (wave action); base flood elevations determined.

FLOODWAY AREAS IN ZONE AE

OTHER FLOOD AREAS

ZONE X Areas of 500-year flood; areas of 100-year flood with average depths of less than 1 foot or with drainage areas less than 1 square mile; and areas protected by levees from 100-year flood.

OTHER AREAS

ZONE X Areas determined to be outside 500-year floodplain.

ZONE D Areas in which flood hazards are undetermined, but possible.

UNDEVELOPED COASTAL BARRIERS*

Identified 1983

Identified 1990 or Later

Otherwise Protected Areas Identified 1991 or Later

Floodway Boundary

Zone D Boundary

Boundary Dividing Special Flood Hazard Zones, and Boundary Dividing Areas of Different Coastal Base Flood Elevations Within Special Flood Hazard Zones.

513 Base Flood Elevation Line; Elevation in Feet*

A — A Cross Section Line

23 - - - - - 23 Transect Line

(EL 987) Base Flood Elevation in Feet Where Uniform Within Zone**

RM7 X Elevation Reference Mark

M1.5 River Mile

**Referenced to the National Geodetic Vertical Datum of 1929

MAP REPOSITORY

Refer to Repository Listing on Map Index

EFFECTIVE DATE OF COUNTYWIDE FLOOD INSURANCE RATE MAP

NOVEMBER 6, 2000

EFFECTIVE DATE(S) OF REVISION(S) TO THIS PANEL

Please refer to the Listing of Communities table on the FIRM Index for NFIP Initial Identification and Post-FIRM dates for all jurisdictions shown on this map.

To determine if flood insurance is available in this community, contact your insurance agent or call the National Flood Insurance Program at (800) 638-6620.

APPROXIMATE SCALE

500 0 500 FEET

Illinois Historic
Preservation Agency

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

Cook County PLEASE REFER TO: IHPA LOG #001091807
Palos Heights
12251 South 80th Avenue, Section: 25-Township: 37N-Range: 12E
Emergency Department Parking Improvements

September 21, 2007

Thomas Petermann
Graef, Anhalt, Schloemer & Associates, Inc.
332 South Michigan Avenue, Suite 1400
Chicago, Illinois 60604-4367

Dear Mr. Petermann:

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

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

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

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

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

Sincerely,

Anne E. Haaker

Anne E. Haaker
Deputy State Historic
Preservation Officer

AEH

Q. Cost/Space Requirements

Cost / Space Requirements

	Project Cost	BGSF*		Amount of Proposed Total GSF That is:				
		Existing	Proposed	New	Remodeled	As Is	Vacated	Notes regarding vacated space:
CLINICAL								
Medical Surgical	$91,231,579	93,260	180,065	91,790	77,330	10,945		
Intensive Care	$19,625,470	10,846	25,650	25,650			10,846	(1) Resp. therapy, dialysis and medical staff admin/support space
INTEGRATED PROCEDURE SERVICES								
A) Surgery	$26,964,356	19,166	37,354	37,354			19,166	(2) HIM, Quality Services and Conference/Education facilities
B) Endoscopy	$3,390,472	2,961	3,468	3,468			2,961	(3) Emergency Department expansion
C) Special Procedures	$2,087,087	946	2,004	2,004			946	(4) Radiology modernization/expansion
RECOVERY								
A) PACU	$3,906,650	2,092	3,750	3,750			2,092	(2) HIM, Quality Services and Conference/Education facilities
B) Center for Short Stay Care	$13,392,633	14,572	22,940	22,940			14,572	(3) Emergency Department expansion
Respiratory Therapy	$2,650,416	1,485	5,425	1,060	4,365		1,485	(5) Lobby / Public Spaces
Laboratory	$4,518,483	9,362	22,487	22,487			9,362	(4) Radiology modernization/expansion
Pharmacy	$2,673,294	4,135	8,229	8,229			4,135	(6) Dietary expansion
Outpatient & Pre-Admission Testing	$14,163,019	1,265	4,730	4,730			1,265	(3) Emergency Department expansion
Inpatient Dialysis	$7,034,718	717	1,105		1,105		717	(7) Space returned to inpatient medical surgical unit - on 3rd floor
Emergency Department	$7,711,443	12,361	22,814		11,435	11,379		
Admissions Unit	$3,576,110	0	6,696		6,696			
Cardiology	$4,382,685	4,299	6,661		6,661		4,299	(4) Radiology modernization/expansion
Nuclear Medicine	$5,426,154	1,652	6,766		6,766		1,652	(4) Radiology modernization/expansion
Radiology	$20,870,579	20,068	31,732		16,889	14,843	2,421	(8) Admissions Unit
Sub Total Clinical	**$233,605,146**	**199,187**	**391,876**	**223,462**	**131,247**	**37,167**	**75,919**	
Plus Clinical Contingencies	$16,745,429							
Total Clinical	**$250,350,575**							

***New construction is BGSF (building gross square feet) and includes external circulation.**

	Project Cost	BGSF*		Amount of Proposed Total GSF That is:				
		Existing	Proposed	New	Remodeled	As is	Vacated	Notes
NON-CLINICAL								
Purchasing	$2,075,978	1,316	3,380	3,380			1,316	(9) Vacated space for linen services
Sterile Supply Processing	$9,658,942	6,698	13,721	13,721			6,698	(6) Dietary expansion
Maintenance/Engineering	$10,064,977	7,973	17,235	17,235			7,973	(10) 1,833 GSF of carpentry shop part of site prep - demolition
General Stores	$3,531,997	19,635	25,588	5,953		19,635		
Admitting & Registration	$2,114,401	2,804	3,370	3,370			2,804	(3) Emergency Department expansion
Nursing Administration/Education	$2,858,877	3,964	11,296	6,210	2,424	2662	1,302	(11) Administrative offices
Medical Staff Facilities/Support	$4,541,445	2,643	7,984	2,514	5,470		2,643	(12) Conf./Community Education , conversion back to patient rooms
Quality Management (QA/RM/CM)	$2,147,205	890	4,179		4,179		890	(13) Pastoral care & other misc. offices
Transport Services	$1,094,994	0	2,132		2,132			
Health Information Management	$4,660,190	5,177	9,083		9,083		5,177	(14) Word processing 1st floor; Admin offices lower level
Pastoral Care, Chapel & Other Support	$1,026,018	2,170	3,372		1,997	1,375	795	(15) Expansion for Nursing Administration
Dietary - Kitchen & Dining	$8,171,648	19,871	31,750		14,480	17,270		
Housekeeping/Linen Services	$2,928,987	4,579	10,719		6,140	4,579		
Conference & Education	$5,977,761	8,142	18,354	4,380	5,832	8,142		
Staff Lockers & Lounge & Support	$6,554,006	8,954	18,064	9,102	675	8,287	667	(16) Dietary Dinging and corridor
Lobby / Public Spaces / Gift Shop	$22,342,486	71,775	103,306	31,822	1,485	69,999	2103	(17) Transport service plus lobby / public space
Administrative & Other Offices	$1,074,876	5,743	5,978		2,095	3,883	775	(12) Conf./Community Education , conversion back to patient rooms
Mechanical/Electrical/IT/Shafts	$34,264,971	68,104	131,824	63,720		68,104		
Stairs/Elevators	$8,146,089		12,800	12,800				
Plumbing	$21,518,982		0					(18) Structural/equipment change as opposed to remodeling
Air Handling	$2,287,924		0					(18) Structural/equipment change as opposed to remodeling
Parking	$1,516,135		2,640	2,000	640			
Sub Total Non-Clinical	$158,558,889	**240,438**	**436,775**	**176,207**	**56,632**	**203,936**	**33,143**	
Plus Non-Clinical Contingencies	$11,528,864							
Total Non-Clinical	**$170,087,753**							
TOTAL PROJECT	**$420,438,328**	439,625	828,651	**399,669**	**187,879**			

***New construction is BGSF (building gross square feet) and includes external circulation.**

SECTION III. GENERAL REVIEW CRITERIA

This section is applicable to all projects EXCEPT those projects that are solely for discontinuation with no project costs and those projects that are non-substantive and subject only to a Part 1120 review. Refer to Part 1110.40 for the requirement for non-substantive projects.

A. **Criterion 1110.230(a), Location** **NOT APPLICABLE**

Check if the project will result in any of the following: 9 establishment of a health care facility: 9 establishment of a category of service; 9 acquisition of major medical equipment (for treating inpatients) that is not or will not be located in a health care facility and is not being acquired by or on behalf of a health care facility. If NO boxes are checked, this criterion is not applicable. If any box is checked, read the criterion and submit the following:

1. A map (8 ½" x 11") of the area showing:
   a. the location of the applicant's facility or project;
   b. the name and location of all the other facilities providing the same service within the planning area and surrounding planning areas within 30 minutes travel time of the proposed facility;
   c. the distance (in miles) and the travel time (under normal driving conditions) from the applicant's facility to each of the facilities identified in b. above;
   d. an outline of the proposed target population area.
2. For existing facilities, provide patient origin data for all admissions for the last 12 months presented by zip code. Note this information must be based upon the patient's legal residence other than a health care facility for the last 6 months immediately prior to admission. For all other projects for which referrals are required patient origin data for the referrals must be provided.
3. The ratio of beds to population (population will be based upon the latest census data by zip code) within 30 minutes travel time of the proposed project.
4. The status of the project in the zoning process. Provide letter(s) from the appropriate local officials.
5. Evidence of legal site ownership, possession, or option to purchase or lease.

APPEND DOCUMENTATION AS ATTACHMENT GRC-1 AFTER THE LAST PAGE OF THIS SECTION.

B. **Criterion 1110.230(b), Background of Applicant**

Read the criterion and submit the following information:

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

2. Proof of current licensing and, if applicable, certification and accreditation of all health care facilities owned or operated by the applicant.

3. A certification from the applicant listing any adverse action taken against any facility owned or operated by the applicant during the three (3) years prior to the filing of the application.

4. Authorization(s) permitting the State Board and Agency access to information in order to verify any documentation or information submitted in response to the requirements of this subsection or to obtain any documentation or information that the State Board or Agency finds pertinent to this subsection. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any action by the State Board.**

APPEND DOCUMENTATION AS ATTACHMENT GRC-2 AFTER THE LAST PAGE OF THIS SECTION.

C. **Criterion 1110.230(c), Alternatives to the Proposed Project**

Read the criterion and provide the following information:

1. Provide a comparison of all of the alternatives considered including the alternative of doing nothing. The comparison must address cost benefit analyses, patient access, quality, and short and long-term financial benefits.

2. Discuss why the alternative of using other area facilities or resources to meet the needs identified in your project is not feasible.

3. Discuss why the alternative of utilizing underutilized bed or other space in the facility is not feasible.

4. If the alternative selected is based solely or in part on improved quality of care, provide empirical evidence (including quantified outcome data) that verifies improved quality of care.

APPEND DOCUMENTATION AS ATTACHMENT GRC-3 AFTER THE LAST PAGE OF THIS SECTION.

D. Criterion 1110.230(d), Need for the Project

Is the need for the project based upon need assessment per Part 1100 or a variance?
☐ Yes ☑ Some services are based on IHFPB need assessment
If no is indicated, read the criterion and submit the following as applicable:

1. Copies of area market studies including explanations regarding how and when these studies were performed.

2. Calculation of the need for the beds or services including the models used to estimate the need (all assumptions used in the model and the mathematical calculations must be included).

3. Identification of the individuals likely to use the proposed beds or service by:

   Provide letters from physicians or hospitals which document how many patients were referred for this service in the past 12 months, where the patients were referred and how many patients will be referred annually to the proposed project.

4. If the project is for the acquisition of major medical equipment that does NOT result in the establishment of a category of service, provide documentation that the equipment will achieve or exceed the applicable target utilization levels specified in Appendix B of Part 1110 within 12 months after acquisition.

APPEND DOCUMENTATION AS ATTACHMENT GRC-4 AFTER THE LAST PAGE OF THIS SECTION.

E. Criterion 1110.230(e), Size of Project

Read the criterion and provide the following:

1. For any department involved in this project that has a square footage which exceeds the State Norm found in Appendix B of Part 1110 or if no State Norm is shown in Appendix B, provide:

   a. a rationale explaining how the proposed square footage was determined;

   b. copies of any standards used to determine appropriate square footage;

   c. architectural drawings showing any design impediments in the existing facility; and

   d. if the project is for the conversion of beds from one category of service to another an explanation as to why the excess space within the facility cannot be more appropriately used for other purposes.

APPEND DOCUMENTATION AS ATTACHMENT GRC-5 AFTER THE LAST PAGE OF THIS SECTION.

2. If the project involves a category of service for which the State Board has established utilization targets, provide the following:

   a. projected utilization for the first two years of operation after project completion;

   b. an explanation regarding how these projections were developed;

   c. copies of any contracts with new physicians or professional staff;

   d. a list of any new procedures which will affect the workload of the facility.

APPEND DOCUMENTATION AS ATTACHMENT GRC-6 AFTER THE LAST PAGE OF THIS SECTION.

BACKGROUND OF APPLICANT

1-2. **Palos Community Hospital is fit, willing and able and has the qualifications, background and character to adequately provide a proper standard of care.**

Below is a listing of the facilities owned and operated by Palos Community Hospital:

Palos Community Hospital
12251 S. 80th Avenue
Palos Heights, IL 60463

Palos Community Hospital Primary Care Center
15300 West Avenue
Orland Park, IL 60462

Palos Family Health Center
15327 W. 143rd Street
Lockport, IL 60441

Palos Immediate Care Center
7340 W. College Drive
Palos Heights, IL 60463

Palos Community Hospital Home Health Care
15295 E. 127th Street
Lemont, IL 60439

See Attachment GRC-2(1) for Medicare and Medicaid provider numbers of Palos Community Hospital. See Attachment GRC-2(2) for proof of licensure, certification, and accreditation for Palos Community Hospital.

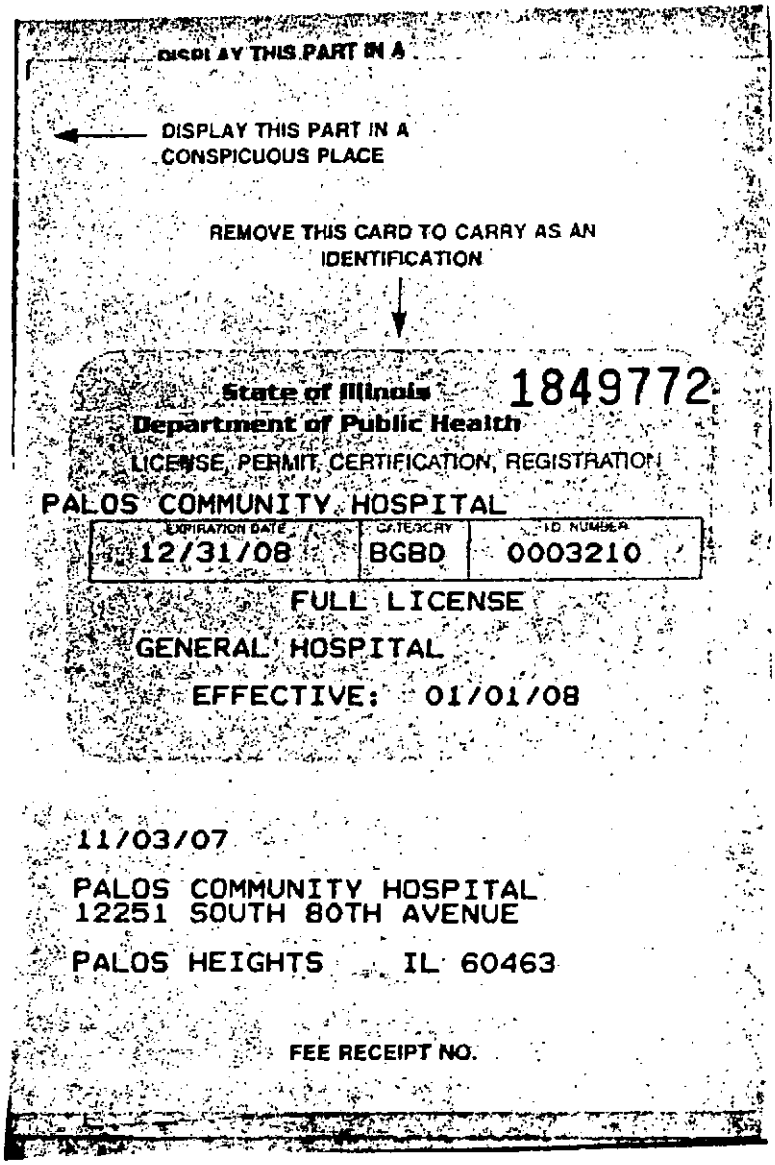
3. **No adverse action has been taken against the applicant within three years preceding the filing of this Certificate of Need. See Attachment GRC-2(3).**

4. **Palos Community Hospital authorizes the State Board and its Agencies access to information in order to verify any documentation of information necessary and pertinent to this subsection. See Attachment GRC-2(3).**

ATTACHMENT GRC-2

PALOS COMMUNITY HOSPITAL

NPI Numbers:	
PCH Hospital:	1851386692
PCH Home Care:	1790750016
Provider #s:	
	Medicare
Hospital	140062
Home Health:	147470
Hospice:	141591
	Medicaid
Hospital:	362169179001
Home Health:	362169179004
Hospice:	362169179003



DISPLAY THIS PART IN A

DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

State of Illinois 1849772

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

PALOS COMMUNITY HOSPITAL

EXPIRATION DATE	CATEGORY	ID NUMBER
12/31/08	BGBD	0003210

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/08

11/03/07

PALOS COMMUNITY HOSPITAL
12251 SOUTH 80TH AVENUE

PALOS HEIGHTS IL 60463

FEE RECEIPT NO.

State of Illinois 1806313
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

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

ERIC E. WHITAKER, M.D.
DIRECTOR

EXPIRATION DATE	CATEGORY	I.D. NUMBER
04/30/08	072	2001888

FULL HOSPICE
PROGRAM

BUSINESS ADDRESS

PALOS COMMUNITY HOSPITAL HOSPICE
15295 E. 127TH STREET
LEMONT IL 60439

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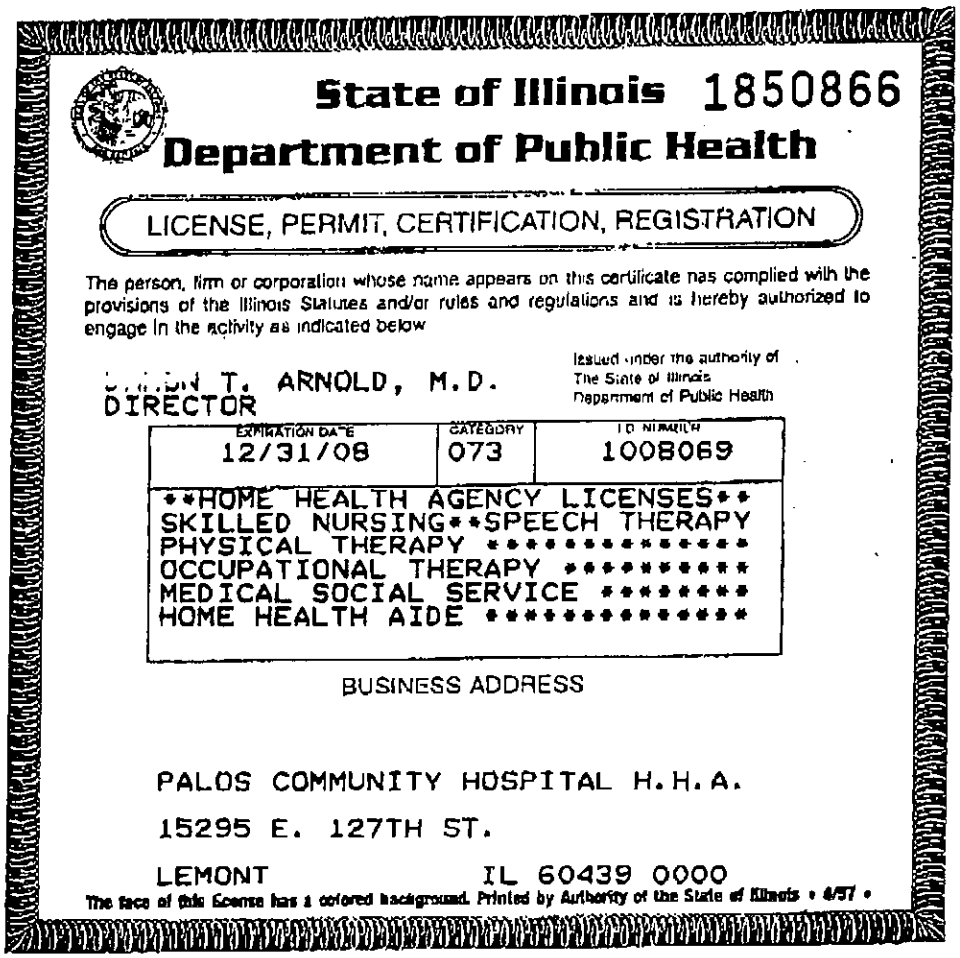

State of Illinois 1850866

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

[illegible] T. ARNOLD, M.D.
DIRECTOR

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

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/08	073	1008069

HOME HEALTH AGENCY LICENSES
SKILLED NURSING**SPEECH THERAPY
PHYSICAL THERAPY **********
OCCUPATIONAL THERAPY **********
MEDICAL SOCIAL SERVICE ********
HOME HEALTH AIDE **********

BUSINESS ADDRESS

PALOS COMMUNITY HOSPITAL H.H.A.
15295 E. 127TH ST.
LEMONT IL 60439 0000

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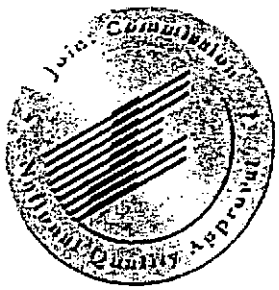
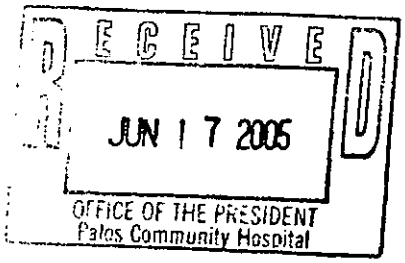




June 13, 2005

Margaret Wright
President
Palos Community Hospital
12251 South 80th Avenue
Palos Heights, IL 60463

Joint Commission ID #: 7306
Accreditation Activity Completed: 6/8/2005
Accreditation Activity: Evidence of Standards Compliance

Dear Sister Wright:

The Joint Commission would like to thank your organization for participating in the Joint Commission's accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Home Care
- Comprehensive Accreditation Manual for Hospitals.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

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

Please visit Quality Check® on the Joint Commission web site for updated information related to your accreditation decision.

Sincerely,

Russell P. Massaro

Russell P. Massaro, MD, FACPE
Executive Vice President
Division of Accreditation Operations

Palos Community Hospita

Palos Heights, IL

has been Accredited by the

Joint Commission

on Accreditation of Healthcare Organizations

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

2005-2008

Palos Community Hospital

12251 S. 80th Avenue Palos Heights, Illinois 60463 (708) 923-4000

September 24, 2008

Mr. Jeffrey S. Mark
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Mr. Mark:

RE: CON FOR MAJOR MODERNIZATION & EAST WING EXPANSION

With regard to the above, this is to affirm that no "adverse action" has been taken against the applicant, Palos Community Hospital, within three (3) years preceding the filing of this Certificate of Need (CON).

I also wish to indicate that the applicant, Palos Community Hospital, is fit, willing, and able and has the qualifications, background and character to adequately provide a proper standard of health care service for the community. Further, this letter authorizes the State Board and Agency access to information in order to verify any documentation or information submitted with respect to the above Certificate of Need.

Sincerely,

Sister Margaret Wright

Sister Margaret Wright
President

ATTACHMENT GRC-2(3)

ALTERNATIVES

Palos Community Hospital (Palos) proposes a major modernization and expansion of Medical/Surgical (M/S), Intensive Care (ICU), Surgery, Recovery, Emergency and other clinical and non-clinical services. The project provides a complete conversion to private patient rooms in its M/S services. Upon project completion the Hospital would have 36 ICU beds and 306 M/S beds, an addition of 12 ICU beds and a net reduction of 9 M/S beds.

The Hospital proposes to build an East Wing with eight levels, adjacent and connected to the existing hospital at the northeast corner, containing 399,669 new gross square feet (gsf) including 223,462 gsf for clinical services, as follows:

EAST WING Clinical Services	Gross Square Feet*	Location
Medical/Surgical (156 beds)		
Four 36-bed M/S units	83,120 gsf	Floors 2- 5
One 12-bed telemetry M/S unit	8,670 gsf	Floor 6
	91,790 gsf	
Intensive Care (36 beds)		
One 24-bed ICU	16,980 gsf	Floor 7
One 12-bed ICU	8,670 gsf	Floor 6
	25,650 gsf	
Integrated Procedure Services	42,826 gsf	Floor 1
Surgery	(37,354 gsf)	
GI/Endo	(3,468 gsf)	
Special Procedures	(2,004 gsf)	
Recovery/Minor Outpatient Tx	26,690 gsf	Floor 1
PACU (Stage 1)	(3,750 gsf)	
Center for Short Stay Care (Stage 2 and minor procedures)	(22,940 gsf)	
Respiratory Therapy		
Satellites for each ICU	1,060 gsf	Floors 6 & 7
Outpatient & Pre-admission Testing	4,730 gsf	Floor 1
Pharmacy		
Central Pharmacy	7,779 gsf	Basement
Satellite Pharmacy for OR	450 gsf	Floor 1
	8,229 gsf	
Laboratory	22,487 gsf	Basement
TOTAL	223,462 gsf *	

* The above gross square feet (gsf) refer to building gsf (BGSF) and include both internal departmental circulation space and a portion of the building's circulation.

The following non-clinical services would occupy 176,207 gsf in the East Wing: Sterile Supply Processing; General Stores; Medical Staff Facilities, Staff Lockers/Lounge; Conference and Education; Nursing Administration/Education; Admitting/Registration; Purchasing; Maintenance/Engineering; Mechanical/Electrical/Stairs; and Lobby/Public Spacc.

The project modernizes 187,879 total gross square feet (gsf), including 131,247 gsf for clinical services. Almost 60% of the remodeled clinical space (77,330 gsf) is for the conversion of all current, semi-private M/S patient rooms to private rooms. A total of 165 M/S beds in semi-private rooms will be discontinued. As thc East Wing contains only 156 replacement M/S beds, the Hospital proposes to discontinue 9 M/S beds, for a total of 306 M/S beds.

Another 53,917 gsf of vacated space will be remodeled to expand the following clinical services: on the 1st Floor - Emergency Department (ED); Admissions Unit adjacent to the ED; Cardiology; and Radiology and Nuclear Medicine, with satellite ED imaging for each service; and on the 3rd Floor - Respiratory Therapy and Inpatient Dialysis.

Alternatives for Meeting the Identified Need

The Hospital considered four general alternatives to the project, as follows:

(1) Do nothing and continue to manage excessive occupancies with inefficiencies;
(2) Modernize existing space for additional beds;
(3) Build an addition to the existing hospital; and
(4) Build another hospital.

Alternative 1: Do Nothing

This alternative was not chosen as it does not respect the community need for modern, appropriate inpatient and ancillary services. Current facilities are over 35 years old and are deteriorating and obsolete (See Attachments MOD-2A and 3A for discussion of these conditions.) Nursing units are small and lack adequate patient and support space (See the Attachments in MOD-3.) Semi-private rooms would need to be maintained indefinitely, limiting the ability to control infection, provide patient privacy, facilitate patient comfort, and fully occupy the facility. Modern facilities improve access to inpatient care by reducing unnecessary waiting times for services.

Estimated Cost of Alternative 1

The discussion above indicates that "doing nothing" has hidden costs even though the capital cost appears to be minimal.

Alternative 2: Modernize Existing Space

Converting existing inpatient space to expand ICU is infeasible. Excluding the new 16-bed cardiovascular unit (CVU) modernized in 2005, the Hospital's nursing units were built by 1978, and are at least 30 years old. The nursing units are very small by modern standards, with small, semi-private rooms and severely undersized staff and support areas. Excluding the new 16-bed cardiovascular unit (CVU), the remaining 299 M/S bcds contain only 275 gsf per bed. These units will be modernized for continued M/S Services.

Other inpatient services have similar space constraints. Pediatrics and AMI Services contain only 5,872 gsf and 18,438 gsf, respectively. The modern ICU requires 653 department gsf (dgsf) per bed

or 23,490 dgsf (see rationale in Attachment GRC-5.) In addition, all existing units are configured as disconnected, narrow units which are operationally obsolete for a modern ICU requiring patient visualization. Therefore, while other acute care services operate below IHFPB target occupancies, it is not feasible to convert such small units which are at least 30 years old, to modern ICUs. The Hospital has no available space anywhere in its current facilities for expanding ICU.

Upon construction of the proposed East Wing addition with 156 replacement M/S beds, the Hospital can modernize 134 existing M/S beds. Without the proposed East Wing, the Hospital does not have sufficient space anywhere in its current facilities for expanding the Hospital to provide modern M/S patient rooms and nursing units.

Without the proposed East Wing, the Hospital does not have sufficient space anywhere in its current facilities for expanding other necessary ancillary services i.e. Surgery, Recovery, Emergency Services etc.

Estimated Cost of Modernizing:
IHFPB standards indicate that modernizing is approximately 70% of new construction. The project modernizes clinical services. See construction costs identified in Section XXVI.

Alternative 3: Build an Addition
Due to space constraints on the site the Hospital considered one other option. This option built two additions, a bed tower expansion in the front of the Hospital and the ancillary service expansion in the back. This option had the benefit of phasing in costs, but cost $55 million dollars more. Due to the additional costs, the project was rejected.

Alternative 4: Build Another Hospital
This option represents an expensive, unnecessary duplication of existing services. A new hospital would need to duplicate all existing clinical services such as operating suites, recovery areas, imaging modalities, clinical laboratory, emergency services, and rehabilitation services (PT, OT, Speech, Respiratory Therapy, and Pulmonary Function.) A new hospital would also duplicate all existing non-clinical services such as food service, housekeeping, storage, administration, telecommunications, loading dock, boiler plant, and mechanical/electrical/heating systems.

Estimated Cost of Alternative 4
Building a new hospital to provide additional medical/surgical services is the most expensive option. Based on CON applications filed in the last few years, the estimated cost of a new hospital of comparable size would be upwards of $700 million, almost twice the cost of the current project.

This option was rejected as unnecessarily expensive and wasteful. The current facility has significant useful life and is able to accommodate growth. The site is adequately sized and well situated for meeting the community needs for medical care in the foreseeable future.

NEED FOR THE PROJECT

MARKET STUDY

Palos Community Hospital, located in Palos Heights, is a major provider of hospital services in south metropolitan Chicago. The Hospital is located in Planning Area A – 4. In 2007 the Hospital admitted 20,939 inpatients, and almost 80% were residents of the IHFPB Planning Area (see map and table in Attachment GRC-4(1A).) The Hospital's primary service area (PSA) consists of a 25 zip-code area stretching from Bridgeview in the north to Frankfort in the south, and from Lockport in the west to Chicago Ridge in the east (see map in Attachment GRC-4(1).) In 2007 the Hospital served 18,528 inpatients from its PSA, which was 89% of its inpatients (see patient origin in Attachment GRC-4(2).)

The Hospital served about one of every four (23.5%) inpatients in its PSA in 2007, representing the second highest market share in 2007. The Hospital served half of all inpatients who live in the Core and North quadrants of its PSA (see Attachments GRC-4(3) and GRC-4(4).) These areas include Orland Park, Palos Park, Palos Heights, Palos Hills, Worth, Alsip, Chicago Ridge, Mount Greenwood, Evergreen Park, Oak Lawn, Burbank, Hickory Hills, Justice and Bridgeview. The Hospital serves an especially high percentage of the area's elderly, 30% of all females and 27% of all males 65 years or older.

The PSA contains an estimated 624,400 people, an increase of over 15% from the 2000 U.S. Census population of 580,608. The increase represents an average annual increase of 1.1% between 2000 and 2007. See Attachment GRC-4(5) which projects this growth to continue through 2020 when the PSA population is projected to reach 719,100. The elderly population is projected to grow at a much higher rate of 2.5% per year through 2012, increasing from 80,200 to 90,600 between 2007 and 2012 (see Attachment GRC-4(6).)

Most notably, utilization growth does not assume increase in market share. Rather, the project assumes continued growth and aging of the area's population. The high number of elderly in the service area, 12.8% of population, is higher than Illinois or the U.S, and will continue to use more resources. Given the medical needs of this population, combined with their chronic disease conditions, these patients tend to be sicker. See Attachment GRC-4(7) for documentation of this ratio and the substantially higher inpatient use rates in the service area for this population.

To keep pace with growing utilization, the Hospital has hired additional staff, recruited more physicians, and increased shifts. But the Hospital has simply outgrown the current Hospital, and needs to expand. Medical/Surgical (M/S) and ICU beds are obsolete, and related ancillary and support services are functioning in inadequate space, using existing areas for multiple purposes. Many important functions have no dedicated support space!

Projected utilization for each clinical service is based primarily on the department's historical utilization rates. Other key assumptions in developing the utilization projections include the continued growth and aging of the service area population and continuing increases in severely ill patients. Projected utilization also assumes continued growth and development of the Medical Staff and establishment of a new Hospitalist program.

Growth in the Medical Staff

To continue to meet the needs of its growing population, the Hospital's medical staff has grown almost 9% in the last eight (8) years, from 474 physicians to 515 physicians. Ninety-nine percent (99%) of the medical staff is Board certified. The Hospital has adopted a medical staff development plan to ensure continued recruitment of physicians to replace physicians who retire. The plan includes formation of Palos Medical Group, an integrated (employed) physician practice group and establishment of a Hospitalist program (see Attachment GRC-4(8) for additional information.)

PALOS COMMUNITY HOSPITAL
Comparison of Historical and Projected Utilization, 2005 - 2020
Average Annual Rates of Change

Clinical Service	Historical Utilization Average Increase 2005 - 2007	Projected Utilization Average Increase 2008 - 2020
Medical Surgical*		
Patient Days	5.8%	2.5%
Intensive Care		
Admissions	9.5%	3.0%
Patient Days	5.4%	3.0%
Surgery		
Number of Hours	4.0%	2.8%
Endoscopy		
Number of Hours	6.9%	2.8%
Special/ Minor Procedures	slight decline	held constant
Infusion/ Other Outpatient treatments	13.3%	1.8%
Respiratory Therapy procedures **	0.5%	0.5%
Laboratory		
Visits	4.5%	2.5%
FTE	101	held constant
Pharmacy		
Doses	4.5%	3.0%
Orders	6.9%	3.0%
Outpatient & Pre-Admission Testing	held constant	held constant
Inpatient Dialysis***		
Patients	20.9%	2.0%
Treatment	11.3%	2.0%
Emergency Department		
Visits	1.9%	1.9%
Admissions Unit		
Admissions	7.8%	2.3%
Cardiology		
ECG/ EKG	8.8%	2.0%
All Other Procedures	3.7%	2.0%
Nuclear Medicine**		
Visits	6.3%	4.1%
Procedures	4.3%	4.1%
Radiology		
General Procedures	2.4%	2.2%
CT Procedures	1.6%	1.5%
Ultrasound Procedures	4.4%	3.5%
Mammography Procedures	2.5%	2.0%

* Includes M-S Observation Days
** Historical Data spans from 2006 thru June 2008
*** Historical Data spans from 2005 thru May 2008

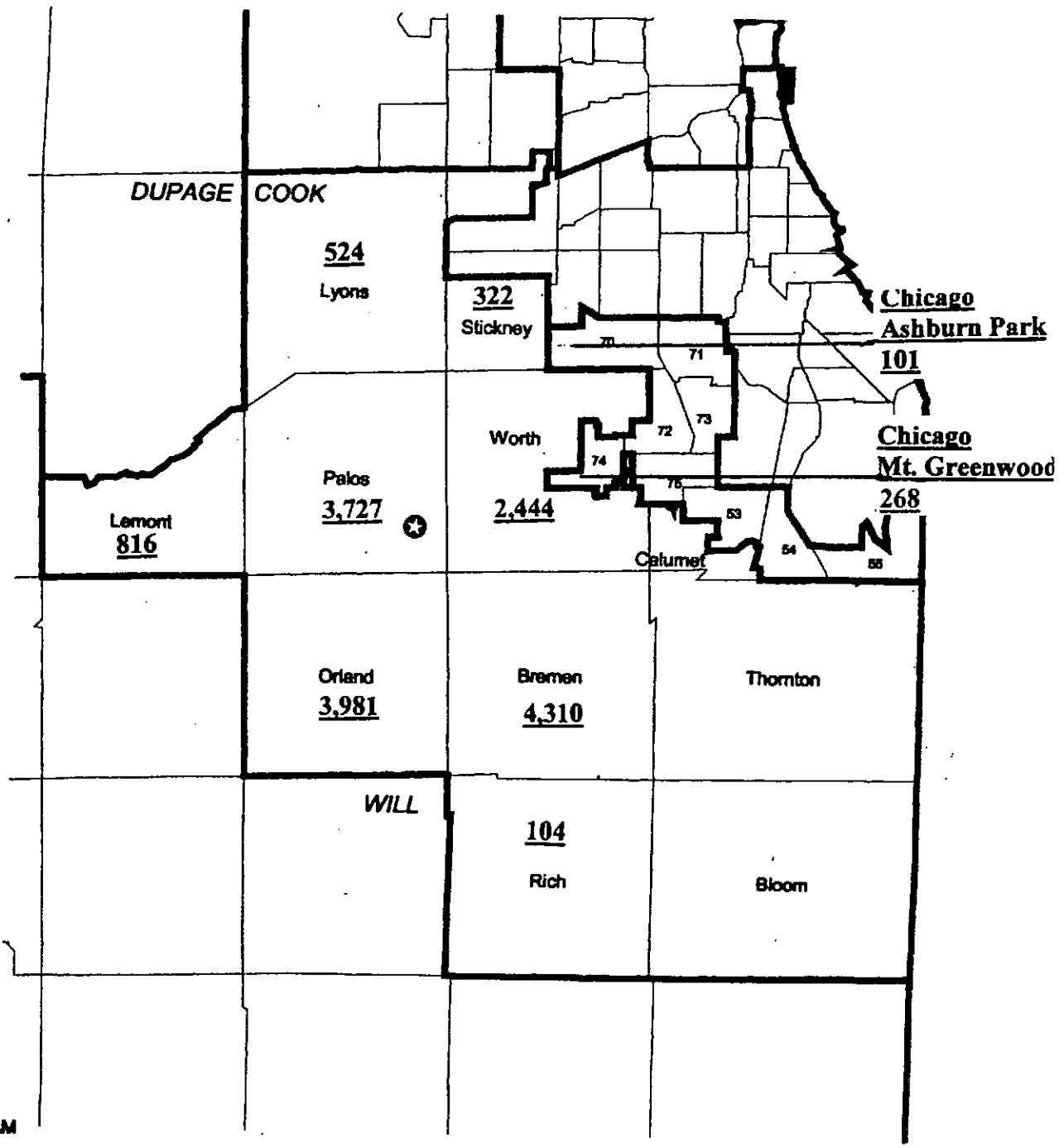
-58-

Attachment GRC-4
Page 3 of 3

PALOS COMMUNITY HOSPITAL

PATIENT ORIGIN – 2007 INPATIENT ADMISSIONS

IHPB PLANNING AREA A4



A-04
SUBURBAN
COOK
SOUTH

COOK COUNTY
TOWNSHIPS

BLOOM
BREMEN
CALUMET
LEMONT
LYONS
ORLAND
PALOS
RICH
STICKNEY
THORNTON
WORTH

CHICAGO
COMMUNITY AREAS

53 WEST PULLMAN
54 RIVERDALE
55 HEGEWISCH
70 ASHBURN
71 AUBURN GRESHAM
72 BEVERLY
73 WASHINGTON HEIGHTS
74 MOUNT GREENWOOD
75 MORGAN PARK

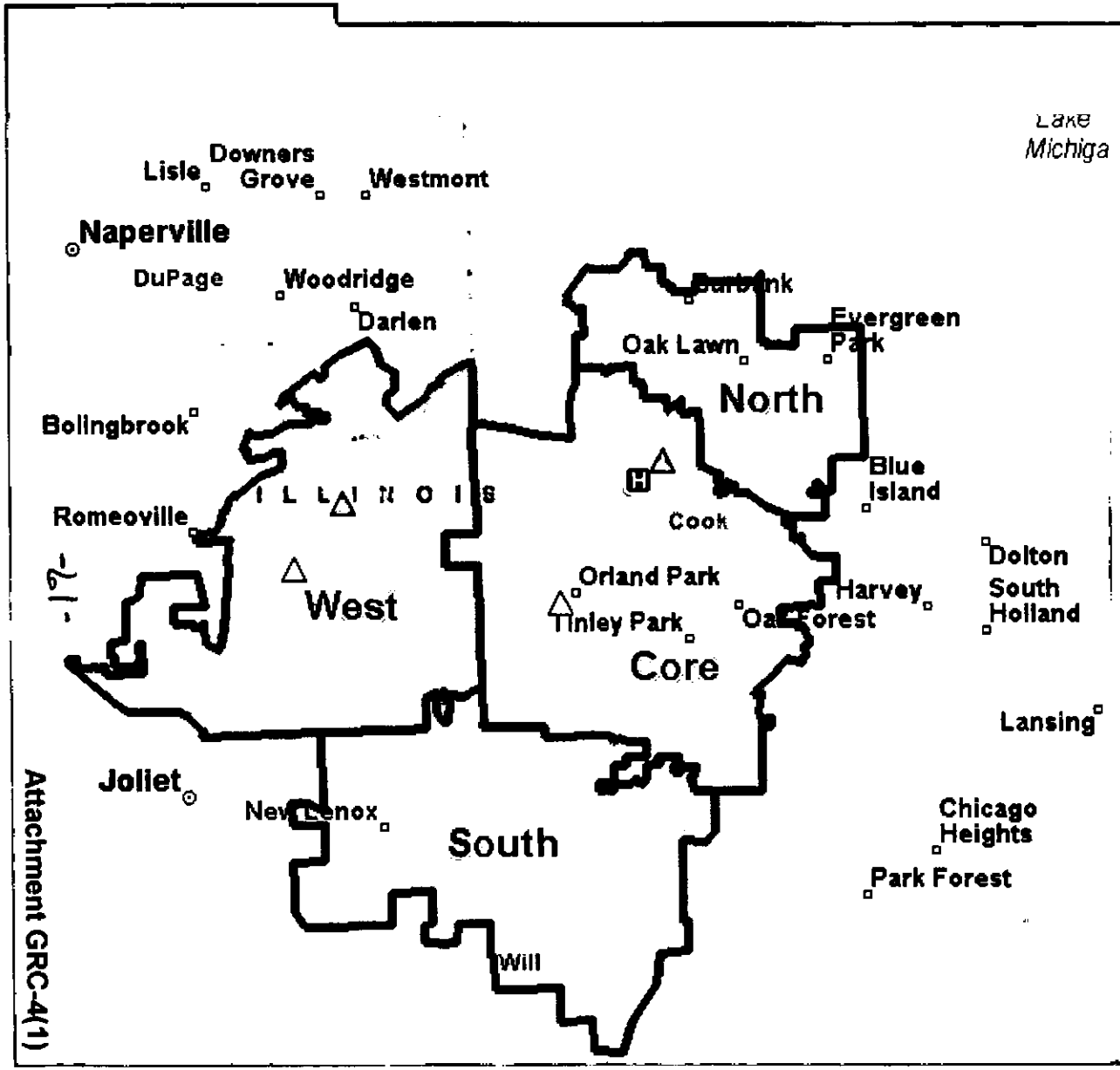
Patient Origin:
In 2007, 79.2 % of admissions were Planning Area A-4 admits; 16, 592 of 20,939.
See following page.

PALOS COMMUNITY HOSPITAL
Patient Origin - 2007 Inpatient Admisisons

Zip Code	Town	2007 Admissions	% Total Admissions
Zip Codes In Planning Area A-4			
60462	Orland Park-core	2639	13%
60477	Tinley Pk-CC Hills	1871	9%
60463	Palos Heights	1621	8%
60467	Orland Park-SW	1338	6%
60465	Palos Hills	1046	5%
60445	Midlothian-Crestwood	929	4%
60452	Oak Forest	845	4%
60439	Lemont	833	4%
60453	Oak Lawn	782	4%
60464	Palos Park	736	4%
60487	Tinley Park (south)	571	3%
60482	Worth	591	3%
60415	Chicago Ridge	475	2%
60457	Hickory Hills	397	2%
60803	Alsip	393	2%
60459	Burbank	324	2%
60455	Bridgeview	308	1%
60655	Mt. Greenwood	268	1%
60458	Justice	212	1%
60805	Evergreen Park	127	1%
60443	Matteson	104	0.5%
60652	Chicago - Ashburn Park	101	0.5%
60406	Blue Island	81	0.4%
	Subtotal	16592	79.2%
Zip Codes Outside Planning Area A-4			
60491	Homer Glen	820	3.9%
60423	Frankfort	463	2.2%
60448	Mokena	407	1.9%
60441	Lockport	309	1.5%
60451	New Lenox	252	1.2%
60638	Chicago - Bedford Park/ Stickney	177	0.8%
60629	Chicago - Bedford Park	92	0.4%
60449	Monee	92	0.4%
	Subtotal	2612	12.5%
	Total	19204	91.7%
Admissions from Zip Codes with Fewer than 80 Admits		1,735	8.3%
	Total Inpatient Admissions	**20,939**	**100.0%**

Source: Palos Community Hospital

Palos Community Hospital Service Area



SERVICE AREA ZIP CODES

CORE	
60462	Orland Park-core
60467	Orland Park-SW
60463	Palos Heights
60464	Palos Park
60465	Palos Hills
60482	Worth
60445	Midlothian-Crestwood
60452	Oak Forest
60477	Tinley Pk-CC Hills
60487	Tinley Park (south)
NORTH	
60453	Oak Lawn
60455	Bridgeview
60457	Hickory Hills
60458	Justice
60459	Burbank
60415	Chicago Ridge
60805	Evergreen Park
60655	Mt. Greenwood
60803	Alsip
WEST	
60439	Lemont
60441	Lockport
60491	Homer Glen
SOUTH	
60423	Frankfort
60448	Mokena
60451	New Lenox

PALOS COMMUNITY HOSPITAL
PRIMARY SERVICE AREA
Patient Origin - 2007

Zip Code	Town	2007 Admissions	Cumulative % Admissions
CORE			
60462	Orland Park-core	2,639	13%
60467	Orland Park-SW	1,338	6%
60463	Palos Heights	1,621	8%
60464	Palos Park	736	4%
60465	Palos Hills	1,046	5%
60482	Worth	591	3%
60445	Midlothian-Crestwood	929	4%
60452	Oak Forest	845	4%
60477	Tinley Pk-CC Hills	1,871	9%
60487	Tinley Park (south)	571	3%
			58%
NORTH			
60453	Oak Lawn	782	4%
60455	Bridgeview	308	1%
60457	Hickory Hills	397	2%
60458	Justice	212	1%
60459	Burbank	324	2%
60415	Chicago Ridge	475	2%
60805	Evergreen Park	127	1%
60655	Mt. Greenwood	268	1%
60803	Alsip	393	2%
			17%
WEST			
60439	Lemont	833	4%
60441	Lockport	309	1%
60491	Homer Glen	790	4%
			9%
SOUTH			
60423	Frankfort	463	2%
60448	Mokena	407	2%
60451	New Lenox	253	1%
			5%
Admissions from Primary Service Area		18,528	**89%**
Admisisons from Other Zips		2,411	12%
Total Inpatient Admissions		20,939	101%

Source: Palos Community Hospital

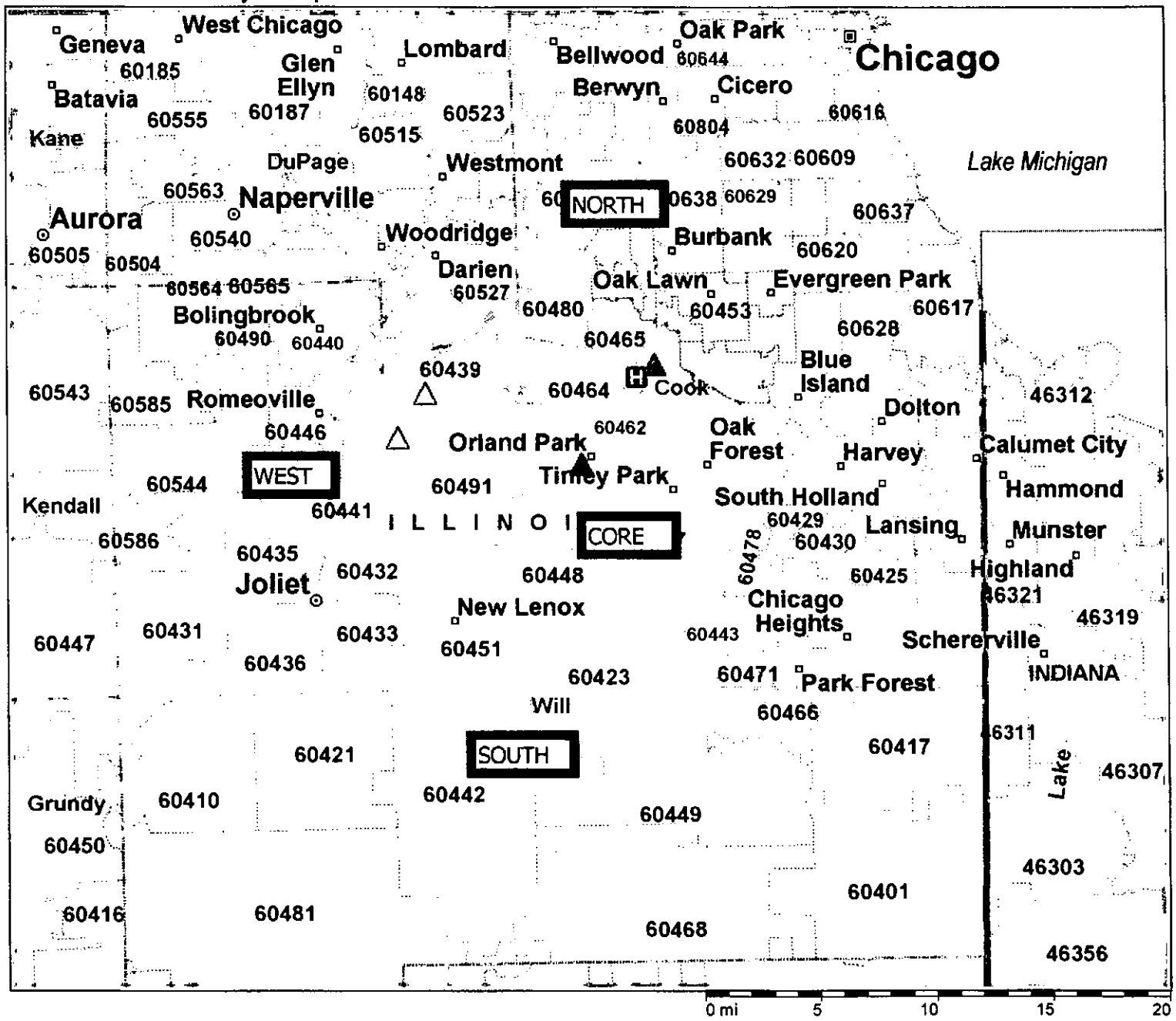
Palos Community Hospital Service Area Quadrants-IP Totals

PCH Service Area Quad IP Admission Totals

- 12,207-Core
- 3,295-North
- 1,945-West
- 1,122-South

Location by Street Address

- Immediate Care Center-Palos
- Palos Community Hospital
- PCH Family Health Center-Homer
- PCH Home Health Center
- Primary Care Center-Orland



Market Share 2007

Age Cohort	Cases	LOS	Market Share	Rank
Hospital				
Advocate Christ	21,503	4.77	27.2%	1
Palos Community Hospital	**18,528**	**4.44**	**23.5%**	**2**
Silver Cross Hospital	5,799	3.82	7.3%	3
Little Company of Mary	3,807	4.33	4.8%	4
St. Francis Hospital	3,175	4.22	4.0%	5
Subtotal (5)	52,812		67%	
Total Market	**78,958**		**100%**	

Palos Community Hospital has the 2nd highest market share in its service area.

* *Excluding newborns*

ENUFF
Market Advisor

Kaufman Hall

Market Analysis By Hospital

User Filter: None
Date Generated: 22-Sep-2008
Report Filter: ZIPCode.GeoCluster = FarSouth
Comparison FY: 2007
Minimum Cases: 0

Hospital	2007 Cases	2007 Days	Statistic Comparison LOS	Statistic Comparison Mrkt Share	Rank Cases	Rank Days
ADVO CHRIST H&MC - OAKL (172413)	21,503	102,514	4.77	27.2%	1	1
PALOS COMM - PALO (171060)	**18,528**	**82,342**	**4.44**	**23.5%**	**2**	**2**
SILVER CROSS - JOLI (172000)	5,799	22,154	3.82	7.3%	3	3
LITTLE COMPANY MARY - EVE (171690)	3,807	16,497	4.33	4.8%	4	4
ST FRANCIS H&HC - BLUE (170270)	3,175	13,385	4.22	4.0%	5	5
ADV SOUTH SUBURBAN - HAZE (171865)	2,682	12,326	4.60	3.4%	6	6
INGALLS - HARV (171860)	1,991	9,235	4.64	2.5%	7	8
LOYOLA UNIV MC - MAYW (170841)	1,953	8,895	4.55	2.5%	8	9
ST JAMES OLY FLDS - OLYM (170811)	1,931	8,350	4.32	2.4%	9	10
RUSH UNIVERSITY MC - CHG (170985)	1,900	10,125	5.33	2.4%	10	7
PROVENA ST JOSEPH MC - JO (171990)	1,802	7,997	4.44	2.3%	11	12
NORTHWESTRN MEM H - CHGO (170545)	1,660	8,109	4.88	2.1%	12	11
UNIVERSITY OF CHGO - CHIC (171210)	1,262	7,571	6.00	1.6%	13	13
ADVENTIST HINSDALE - HINS (171920)	906	3,735	4.12	1.1%	14	17
ADVENTIST LAGRANGE - LAGR (172055)	840	3,946	4.70	1.1%	15	16
MACNEAL - BERW (170240)	832	3,434	4.13	1.1%	16	18
ADV GOOD SAMARITAN - DOWN (171475)	721	2,673	3.71	0.9%	17	21
UNIVERSITY OF ILL - CHGO (170553)	623	3,262	5.24	0.8%	18	19
JOHN H STROGER JR - CHGO (170600)	481	2,413	5.02	0.6%	19	24
ST JAMES CH HTS - CHGH (171300)	441	2,397	5.44	0.6%	20	25
HOLY CROSS - CHGO (170700)	423	2,469	5.84	0.5%	21	23
EDWARD - NAPE (172350)	385	1,352	3.51	0.5%	22	31
OAK FOREST COOK CNTY - CH (172410)	369	1,903	5.16	0.5%	23	26
CHILDREN'S MEM - CHGO (170560)	273	1,755	6.43	0.3%	24	28
SAINT MARY NAZ-DIV (171090)	248	1,093	4.41	0.3%	25	33
ST JOSEPH - CHGO (171070)	241	1,007	4.18	0.3%	26	34
RIVEREDGE - FORE (171713)	240	2,997	12.49	0.3%	27	20
LINDEN OAK AT EDW - NAPE (175000)	236	1,847	7.83	0.3%	28	27
MOUNT SINAI - CHGO (170930)	201	906	4.51	0.3%	29	36
All other	3,505	30,087	8.58			
Total	**78,958**	**376,776**	**4.77**	**100.0%**		

ENUFF
Market Advisor

Market Share By GeoCluster

User Filter: None

Report Filter: ZIPCode.GeoCluster = FarSouth

Dimension:	Grouping:
Zipcode	GeoCluster

Sort Criteria:	GeoCluster
Sort Order:	Ascending
Inmigration:	Exclude
Newborns:	Exclude
Service Area:	Total
Base Year:	2007

GeoCluster	Market Cases			Palos Community Hospital			Market Share			05-07 Change	
	2005	2006	2007	2005	2006	2007	2005	2006	2007	Cases	Share
Core	31,366	31,038	31,488	11,860	11,870	12,187	37.8%	38.2%	38.7%	327	0.89%
North	31,183	30,744	30,085	3,462	3,176	3,286	11.1%	10.3%	10.9%	(176)	-0.18%
South	8,178	8,436	8,486	1,155	1,117	1,123	14.1%	13.2%	13.2%	(32)	-0.89%
West	8,787	8,892	8,899	1,931	1,896	1,932	22.0%	21.3%	21.7%	1	-0.27%
Total	**79,514**	**79,110**	**78,958**	**18,408**	**18,059**	**18,528**	**23.2%**	**22.8%**	**23.5%**	**120**	**0.31%**

Market Share By Age/Gender/LOS

Age Cohort	Market Cases	Market LOS	Palos Community Hospital Cases	Palos Community Hospital LOS	Palos Community Hospital Market Share
FEMALE					
0-17 Years	1,992	4.23	199	2.20	10.0%
18-44 Years	13,493	3.09	2,661	2.68	19.7%
45-64 Years	10,257	4.64	2,083	3.93	20.3%
Over 65 Years	**20,922**	**5.48**	**6,277**	**5.31**	**30.0%**
MALE					
0-17 Years	2,243	4.08	208	2.10	9.3%
18-44 Years	5,001	4.13	1,081	2.93	21.6%
45-64 Years	10,564	4.80	2,118	3.97	20.0%
Over 65 Years	**14,486**	**5.79**	**3,901**	**5.45**	**26.9%**
Total	**78,958**	**4.77**	**18,528**	**4.44**	**23.5%**
				(0.33)	

Palos Community Hospital has a higher market share of patients over 65 years - 28.7% compared to overall market share of 23.5%.

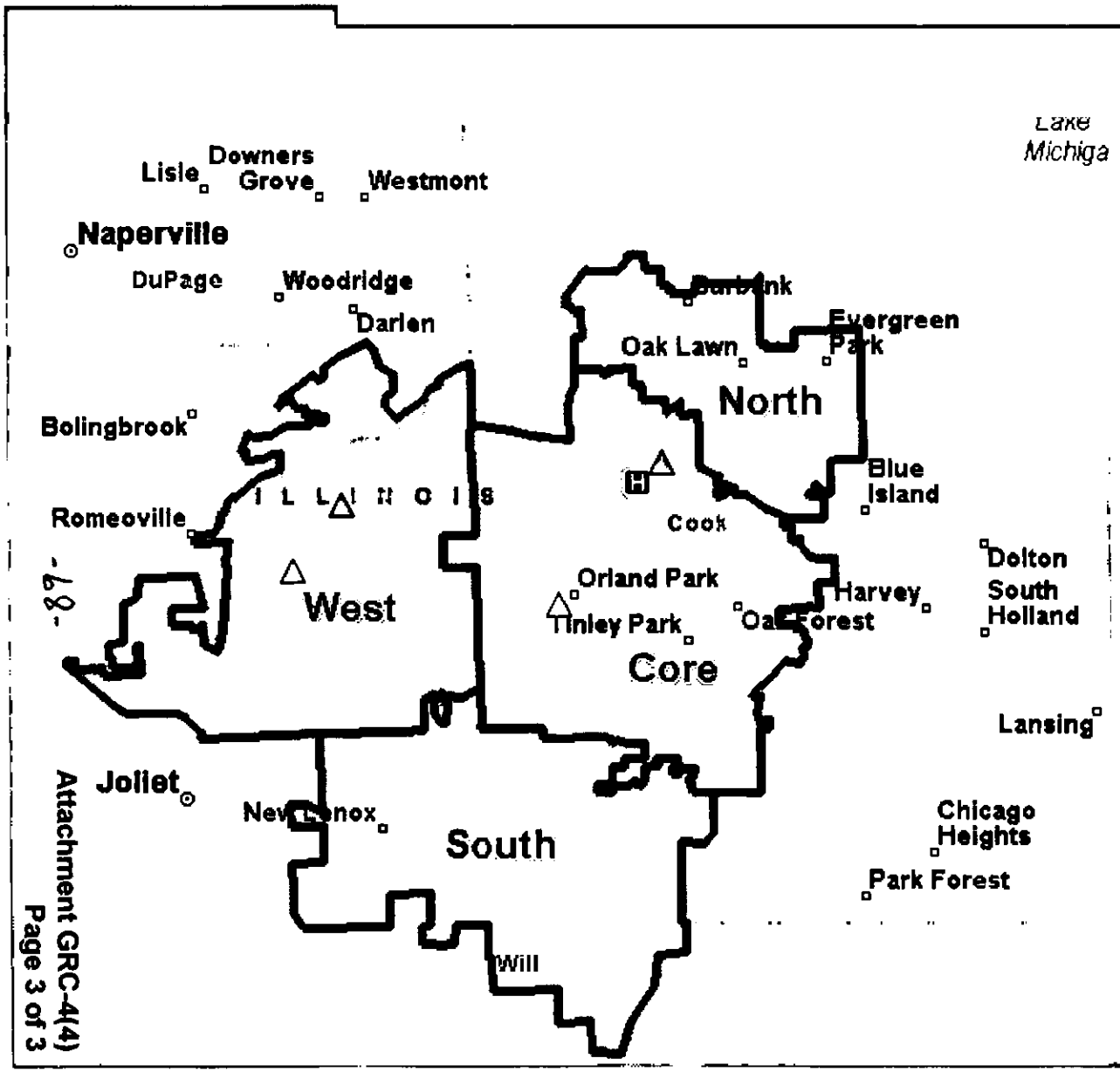
Patients over age 65 have a higher healthcare utilization rate and a higher LOS than other patients - nearly one day longer than average LOS.

Calculations:

PCH over age 65	*Market over age 65*	*PCH Market Share over 65*
10,178	*35,408*	*28.7%*

Source: Planning: Market Advisor 2007 Market Comparison by Age Cohort

Palos Community Hospital Service Area



SERVICE AREA ZIP CODES

CORE	
60462	Orland Park-core
60467	Orland Park-SW
60463	Palos Heights
60464	Palos Park
60465	Palos Hills
60482	Worth
60445	Midlothian-Crestwood
60452	Oak Forest
60477	Tinley Pk-CC Hills
60487	Tinley Park (south)
NORTH	
60453	Oak Lawn
60455	Bridgeview
60457	Hickory Hills
60458	Justice
60459	Burbank
60415	Chicago Ridge
60805	Evergreen Park
60655	Mt. Greenwood
60803	Alsip
WEST	
60439	Lemont
60441	Lockport
60481	Homer Glen
SOUTH	
60423	Frankfort
60448	Mokena
60451	New Lenox

HISTORICAL AND PROJECTED POPULATION
Primary Service Area
Palos Community Hospital

		1990 Census	2000 Census	% change 1990-2000	Estimated 2007	% change 2000-2007	Projected 2010	% change 2000-2010	Projected 2020	% change 2010-2020
CORE										
60462	Orland Park	34,905	37,952	8.7%	39,429	13.0%	39,778	4.8%	40,963	3.0%
60467	Orland Park	9,020	21,053	133.4%	27,063	200.0%	29,147	38.4%	37,322	28.0%
60463	Palos Heights	16,248	19,918	22.6%	14,269	-12.2%	14,690	-26.2%	16,186	10.2%
60464	Palos Park	9,852	10,226	3.8%	10,165	3.2%	10,248	0.2%	10,528	2.7%
60465	Palos Hills	18,505	18,133	-2.0%	17,668	-4.5%	17,320	-4.5%	16,207	-6.4%
60482	Worth	12,134	12,112	-0.2%	10,564	-12.9%	10,360	-14.5%	9,708	-6.3%
60453	Oak Lawn	57,545	55,297	-3.9%	53,586	-6.9%	52,730	-4.6%	49,974	-5.2%
60455	Bridgeview	12,773	14,946	17.0%	15,195	19.0%	15,006	0.4%	14,392	-4.1%
60457	Hickory Hills	10,684	13,476	26.1%	12,560	17.6%	12,374	-8.2%	11,772	-4.9%
60458	Justice	15,932	14,124	-11.3%	14,407	-9.6%	14,552	3.0%	15,047	3.4%
60459	Burbank	26,439	28,208	6.7%	27,323	3.3%	27,046	-4.1%	26,143	-3.3%
60415	Chicago Ridge	12,166	14,086	15.8%	13,658	12.3%	13,451	-4.5%	12,782	-5.0%
60805	Evergreen Park	20,874	20,911	0.2%	19,687	-5.7%	19,117	-8.6%	17,333	-9.3%
60655	Mt. Greenwood	29,296	29,185	-0.4%	26,854	-8.3%	25,856	-11.4%	22,791	-11.9%
60803	Alsip	19,818	22,148	11.8%	22,528	13.7%	22,123	-0.1%	20,825	-5.9%
60445	Midlothian-Cres	24,304	25,900	6.6%	25,286	4.0%	25,212	-2.7%	24,639	-2.3%
60452	Oak Forest	27,524	28,038	1.9%	28,224	2.5%	28,283	0.9%	28,480	0.7%
60477	Tinley Pk-CC Hi	45,173	55,215	22.2%	42,738	-5.4%	44,444	-19.5%	50,638	13.9%
60487	Tinley Pk- new				22,337		23,459		27,622	17.7%
60423	Frankfort	17,949	24,825	38.3%	31,658	76.4%	35,167	41.7%	49,921	42.0%
60448	Mokena	11,242	19,224	71.0%	25,176	123.9%	27,461	42.8%	36,683	33.6%
60451	New Lenox	18,099	27,040	49.4%	35,900	98.4%	39,459	45.9%	54,075	37.0%
60439	Lemont	13,023	19,852	52.4%	22,669	74.1%	23,627	19.0%	27,122	14.8%
60441	Lockport	39,959	48,739	22.0%	39,811	-0.4%	44,301	-9.1%	63,257	42.8%
60491	Homer Glen- new				25,623		27,476		34,679	26.2%
TOTAL PCH SERVICE AREA		**503,464**	**580,608**	77,144	**624,378**	43,770	**642,687**	62,079	**719,089**	76402
Percent Change				15.3%		7.5%		10.7%		11.9%
Average Annual Percent Change				1.5%		1.1%		1.1%		1.2%

Sources: Historical and estimated data from U.S. Census
Projected data from Claritas, prepared by Navigant Consulting, Inc. and Palos Community Hospital.

Source: Claritas, Navigant Consulting, Inc.

PCH Service Area Demographics

Source: Claritas, NCI Analysis.

ZipCode	City	Service Area	Total Population (2007)	Total Population (2008)	Total Population (2009)	Total Population (2010)	Total Population (2011)	Total Population (2012)	Total Population (2013)
60462	Orland Park-core	Core	39,429	39,545	39,661	39,778	39,895	40,012	40,130
60467	Orland Park-SW	Core	27,063	27,740	28,435	29,147	29,876	30,624	31,391
60463	Palos Heights	Core	14,269	14,408	14,548	14,690	14,833	14,978	15,124
60464	Palos Park	Core	10,165	10,192	10,220	10,248	10,275	10,303	10,331
60465	Palos Hills	Core	17,668	17,551	17,435	17,320	17,205	17,091	16,978
60482	Worth	Core	10,564	10,496	10,427	10,360	10,293	10,226	10,160
60453	Oak Lawn	North	53,586	53,299	53,014	52,730	52,448	52,167	51,888
60455	Bridgeview	North	15,195	15,132	15,069	15,006	14,943	14,881	14,819
60457	Hickory Hills	North	12,560	12,498	12,435	12,374	12,312	12,251	12,190
60458	Justice	North	14,407	14,455	14,504	14,552	14,601	14,650	14,699
60459	Burbank	North	27,323	27,230	27,138	27,046	26,954	26,863	26,772
60415	Chicago Ridge	North	13,658	13,588	13,519	13,451	13,382	13,314	13,246
60805	Evergreen Park	North	19,687	19,495	19,305	19,117	18,931	18,746	18,563
60655	Mt. Greenwood	North	26,854	26,517	26,185	25,856	25,532	25,212	24,896
60803	Alsip	North	22,528	22,392	22,257	22,123	21,990	21,857	21,725
60445	Midlothian-Crestwood	East	25,386	25,328	25,270	25,212	25,154	25,096	25,038
60452	Oak Forest	East	28,224	28,244	28,263	28,283	28,302	28,322	28,342
60477	Tinley Pk-CC Hills	East	42,738	43,299	43,868	44,444	45,028	45,619	46,218
60423	Frankfort	South	31,658	32,787	33,956	35,167	36,420	37,719	39,064
60448	Mokena	South	25,176	25,916	26,677	27,461	28,268	29,098	29,953
60451	New Lenox	South	35,900	37,049	38,235	39,459	40,722	42,026	43,371
60439	Lemont	West	22,669	22,984	23,303	23,627	23,955	24,288	24,625
60441	Lockport	West	39,811	41,255	42,751	44,301	45,907	47,572	49,297
60491	Homer Glen	West	25,623	26,226	26,844	27,476	28,124	28,786	29,464
60487	Tinley Park (new)	East	22,337	22,705	23,079	23,459	23,845	24,238	24,637
	Total	**Total**	**624,478**	**630,332**	**636,398**	**642,684**	**649,196**	**655,939**	**662,921**

Source: Claritas.

City	ZipCode	Service Area	Total Population (2014)	Total Population (2015)	Total Population (2016)	Total Population (2017)	Total Population (2018)	Total Population (2019)	Total Population (2020)	Projected Annual Population Growth
Orland Park-core	60462	Core	40,248	40,366	40,485	40,604	40,723	40,843	40,963	0.29%
Orland Park-SW	60467	Core	32,176	32,982	33,807	34,654	35,521	36,410	37,322	2.50%
Palos Heights	60463	Core	15,271	15,420	15,570	15,722	15,875	16,030	16,186	0.97%
Palos Park	60464	Core	10,359	10,387	10,415	10,443	10,471	10,499	10,528	0.27%
Palos Hills	60465	Core	16,866	16,754	16,643	16,533	16,423	16,315	16,207	(0.66%)
Worth	60482	Core	10,094	10,028	9,963	9,899	9,835	9,771	9,708	(0.65%)
Oak Lawn	60453	North	51,610	51,334	51,059	50,786	50,514	50,243	49,974	(0.54%)
Bridgeview	60455	North	14,757	14,696	14,634	14,573	14,513	14,452	14,392	(0.42%)
Hickory Hills	60457	North	12,130	12,069	12,009	11,950	11,890	11,831	11,772	(0.50%)
Justice	60458	North	14,748	14,798	14,847	14,897	14,947	14,997	15,047	0.34%
Burbank	60459	North	26,681	26,591	26,501	26,411	26,321	26,232	26,143	(0.34%)
Chicago Ridge	60415	North	13,179	13,112	13,045	12,979	12,913	12,847	12,782	(0.51%)
Evergreen Park	60805	North	18,382	18,203	18,026	17,850	17,676	17,504	17,333	(0.97%)
Mt. Greenwood	60655	North	24,584	24,275	23,971	23,670	23,374	23,080	22,791	(1.25%)
Alsip	60803	North	21,594	21,464	21,335	21,206	21,078	20,951	20,825	(0.60%)
Midlothian-Crestwood	60445	East	24,981	24,924	24,866	24,809	24,752	24,696	24,639	(0.23%)
Oak Forest	60452	East	28,361	28,381	28,401	28,420	28,440	28,460	28,480	0.07%
Tinley Pk-CC Hills	60477	East	46,825	47,440	48,063	48,694	49,334	49,982	50,638	1.31%
Frankfort	60423	South	40,457	41,899	43,393	44,940	46,543	48,202	49,921	3.57%
Mokena	60448	South	30,833	31,739	32,671	33,631	34,619	35,636	36,683	2.94%
New Lenox	60451	South	44,760	46,193	47,671	49,197	50,772	52,398	54,075	3.20%
Lemont	60439	West	24,968	25,314	25,666	26,023	26,384	26,751	27,122	1.39%
Lockport	60441	West	51,085	52,937	54,857	56,846	58,907	61,043	63,257	3.63%
Homer Glen	60491	West	30,158	30,868	31,595	32,339	33,101	33,881	34,679	2.36%
Tinley Park (new)	60487	East	25,043	25,455	25,875	26,301	26,734	27,174	27,622	1.65%
Total		**Total**	**670,148**	**677,629**	**685,369**	**693,377**	**701,681**	**710,228**	**719,087**	**0.99%**

Source: Claritas.

PCH Service Area Demographics

Source: Claritas, NCI Analysis.

ZipCode	City	2007 TOTAL POP	2007 Pop 00-17	2007 Pop 18-44	2007 Pop 45-64	2007 Pop 65+	2012 TOTAL POP	2012 Pop 00-17	2012 Pop 18-44	2012 Pop 45-64	2012 Pop 65+
60462	Orland Park-core	39,429	8,356	12,184	12,303	6,586	40,012	8,075	12,468	12,202	7,267
60467	Orland Park-SW	27,063	7,151	7,913	8,207	3,792	30,624	7,804	8,816	9,335	4,669
60463	Palos Heights	14,269	2,768	3,683	4,215	3,603	14,978	2,850	3,956	4,243	3,929
60464	Palos Park	10,165	2,092	2,595	3,553	1,925	10,303	1,935	2,849	3,403	2,116
60465	Palos Hills	17,668	3,276	6,030	5,285	3,097	17,091	3,160	5,585	5,088	3,278
60482	Worth	10,564	2,490	3,979	2,721	1,374	10,226	2,403	3,606	2,818	1,399
60453	Oak Lawn	53,586	11,313	18,867	13,876	11,530	52,167	10,905	15,857	13,858	11,547
60455	Bridgeview	15,195	3,858	5,282	3,822	2,233	14,881	3,824	4,900	3,878	2,279
60457	Hickory Hills	12,560	3,024	4,478	3,426	1,632	12,251	2,969	4,175	3,345	1,762
60458	Justice	14,407	4,100	5,673	3,433	1,201	14,650	4,159	5,409	3,702	1,380
60459	Burbank	27,323	6,376	9,887	7,175	3,885	26,883	6,117	9,510	7,212	4,024
60415	Chicago Ridge	13,658	3,572	5,538	2,875	1,673	13,314	3,635	4,854	3,133	1,692
60805	Evergreen Park	19,687	5,231	6,500	4,894	3,062	18,746	4,863	6,003	5,090	2,790
60655	Mt. Greenwood	26,854	6,990	9,465	7,036	3,363	25,212	6,513	8,488	6,986	3,225
60803	Alsip	22,528	5,814	8,449	5,619	2,646	21,857	5,566	7,698	5,928	2,665
60445	Midlothian-Crestwood	25,386	6,237	9,136	6,386	3,627	25,096	6,102	8,410	6,768	3,818
60452	Oak Forest	28,224	7,038	10,352	8,009	2,825	28,322	6,952	9,797	8,249	3,324
60477	Tinley Pk-CC Hills	42,738	10,342	15,181	12,045	5,170	45,619	10,914	15,199	13,424	6,082
60423	Frankfort	31,658	8,722	11,324	8,890	2,722	37,719	9,527	12,911	11,255	4,026
60448	Mokena	25,176	7,015	9,697	6,648	1,816	29,098	7,499	10,519	8,471	2,609
60451	New Lenox	35,900	10,287	13,832	9,142	2,639	42,026	11,246	15,135	11,861	3,784
60439	Lemont	22,669	5,943	6,879	6,775	3,072	24,288	6,091	7,074	7,416	3,707
60441	Lockport	39,811	9,624	18,317	8,435	3,435	47,572	11,373	20,051	11,884	4,464
60491	Homer Glen	25,623	6,743	9,211	7,743	1,926	28,786	6,828	9,947	9,137	2,874
60487	Tinley Park (new)	22,337	6,438	8,171	6,347	1,381	24,238	6,434	8,516	7,405	1,883
	Total	**624,478**	**154,800**	**220,623**	**168,840**	**80,216**	**655,939**	**157,744**	**221,713**	**186,889**	**90,593**

CAGR Average Annual Increases, 2007-2012

ZipCode	City	Total Population	Pop 00-17	Pop 18-44	Pop 45-64	Pop 65+
60462	Orland Park-core	0.3%	(0.7%)	0.5%	(0.2%)	2.0%
60467	Orland Park-SW	2.5%	1.8%	2.2%	2.6%	4.2%
60463	Palos Heights	1.0%	0.6%	1.4%	0.1%	1.7%
60464	Palos Park	0.3%	(1.5%)	1.9%	(0.9%)	1.9%
60465	Palos Hills	(0.7%)	(0.7%)	(1.6%)	(0.7%)	1.1%
60482	Worth	(0.6%)	(0.7%)	(1.9%)	0.7%	0.4%
60453	Oak Lawn	(0.5%)	(0.7%)	(1.2%)	(0.0%)	0.0%
60455	Bridgeview	(0.4%)	(0.2%)	(1.5%)	0.3%	0.4%
60457	Hickory Hills	(0.5%)	(0.4%)	(1.4%)	(0.5%)	1.5%
60458	Justice	0.3%	0.3%	(0.9%)	1.5%	2.8%
60459	Burbank	(0.3%)	(0.8%)	(0.8%)	0.1%	0.7%
60415	Chicago Ridge	(0.5%)	0.4%	(2.6%)	1.7%	0.2%
60805	Evergreen Park	(1.0%)	(1.4%)	(1.6%)	0.6%	(1.8%)
60655	Mt. Greenwood	(1.3%)	(1.4%)	(2.2%)	(0.1%)	(0.8%)
60803	Alsip	(0.6%)	(0.9%)	(1.8%)	1.1%	0.1%
60445	Midlothian-Crestwood	(0.2%)	(0.4%)	(1.6%)	1.2%	1.0%
60452	Oak Forest	0.1%	(0.2%)	(1.1%)	0.6%	3.3%
60477	Tinley Pk-CC Hills	1.3%	1.1%	0.0%	2.2%	3.3%
60423	Frankfort	3.6%	1.8%	2.7%	4.8%	8.1%
60448	Mokena	2.9%	1.3%	1.6%	5.0%	7.5%
60451	New Lenox	3.2%	1.8%	1.8%	5.3%	7.5%
60439	Lemont	1.4%	0.5%	0.6%	1.8%	3.8%
60441	Lockport	3.6%	3.4%	1.8%	6.7%	5.4%
60491	Homer Glen	2.4%	0.3%	1.5%	3.4%	8.3%
60487	Tinley Park (new)	1.6%	(0.0%)	0.8%	3.1%	6.4%
	Total	**1.0%**	**0.4%**	**0.1%**	**1.9%**	**2.5%**

CAGR Projected Population, By Zip, By Gender

Total Population (2007)	Male Total Pop (2007)	Female Total Pop (2007)	Total Population (2012)	Male Total Pop (2012)	Female Total Pop (2012)
39,429	18,836	20,593	40,012	19,125	20,887
27,063	13,150	13,913	30,624	14,870	15,754
14,269	6,705	7,564	14,978	7,046	7,932
10,165	4,833	5,332	10,303	4,916	5,387
17,668	8,311	9,357	17,091	8,057	9,034
10,564	5,218	5,346	10,226	5,074	5,152
53,586	25,261	28,325	52,167	24,663	27,504
15,195	7,513	7,682	14,881	7,363	7,518
12,560	6,244	6,316	12,251	6,097	6,154
14,407	7,064	7,343	14,650	7,200	7,450
27,323	13,389	13,934	26,863	13,190	13,673
13,658	6,662	6,996	13,314	6,514	6,800
19,687	9,406	10,281	18,746	9,005	9,741
26,854	13,183	13,671	25,212	12,405	12,807
22,528	10,925	11,603	21,857	10,661	11,196
25,386	12,143	13,243	25,096	12,055	13,041
28,224	14,036	14,188	28,322	14,090	14,232
42,738	20,723	22,015	45,619	22,197	23,422
31,658	15,550	16,108	37,719	18,486	19,233
25,176	12,647	12,529	29,098	14,589	14,509
35,900	17,641	18,259	42,026	20,632	21,394
22,669	10,942	11,727	24,288	11,733	12,555
39,811	21,189	18,622	47,572	24,977	22,595
25,623	12,865	12,758	28,786	14,393	14,393
22,337	10,961	11,376	24,238	11,873	12,365
624,478	**305,397**	**319,081**	**655,939**	**321,211**	**334,728**

Inpatient Utilization - PCH Service Area (2004 - 2007)

	2004	2005	2006	2007*	2007 (9 mos)
Total Inpatient Admissions Age 0-17, PCH Service Area	5,698	6,254	5,906	3,103	2,327
Total Inpatient Admissions Age 18-44, PCH Service Area	18,316	19,448	18,458	19,460	14,595
Total Inpatient Admissions Age 45-64, PCH Service Area	18,234	20,211	20,247	21,528	16,146
Total Inpatient Admissions Age 65+, PCH Service Area	32,161	35,580	35,126	36,496	27,372
PCH Service Area Population Age 0-17	152,869	153,585	154,191	154,800	
PCH Service Area Population Age 18-44	219,684	219,968	220,295	220,623	
PCH Service Area Population Age 45-64	156,508	160,826	164,784	168,840	
PCH Service Area Population Age 65+	76,514	78,388	79,296	80,215	
Inpatient Utilization Per 1,000 Pop. Age 0-17, PCH Service Area	37.27	40.72	38.30	20.04	
Inpatient Utilization Per 1,000 Pop. Age 18-44, PCH Service Area	83.37	88.41	83.79	88.20	
Inpatient Utilization Per 1,000 Pop. Age 45-64, PCH Service Area	116.50	125.67	122.87	127.51	
Inpatient Utilization Per 1,000 Pop. Age 65+, PCH Service Area	420.33	453.90	442.97	454.98	
Age 65+ Utilization Growth Rate		*8.0%*	*-2.4%*	*2.7%*	
Total Inpatient Admissions (Source: COMPdata)	**74,409**	**81,493**	**79,737**	**80,587**	60,440
Total Service Area Population (Source: Claritas)	**605,575**	**612,767**	**618,567**	**624,478**	
Inpatient Utilization (Admits per 1,000 Population)	**122.87**	**132.99**	**128.91**	**129.05**	

*2007 COMPdata figures annualized based on 9 months of actual data (Jan-Sept).

Note: Analysis does not include normal newborns (DRG 391).

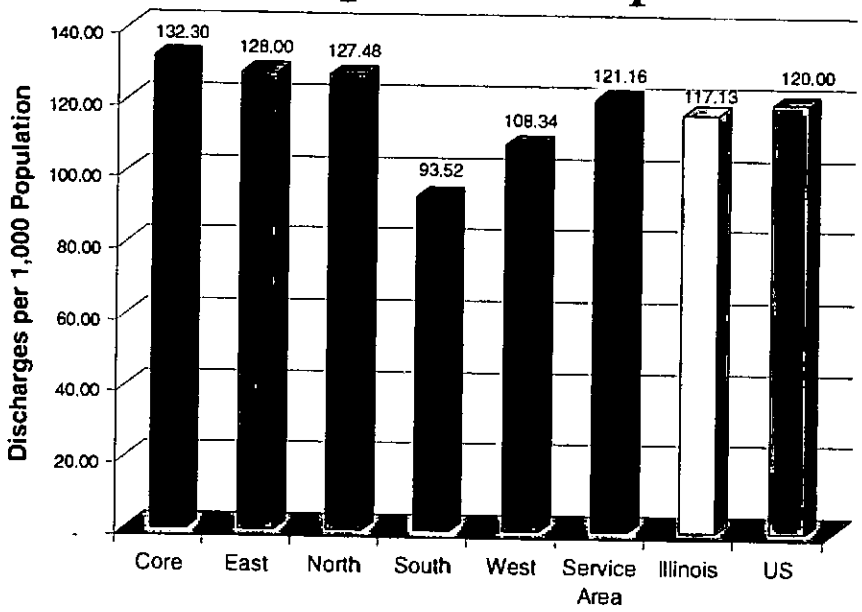
PCH Service Area Projected Population Growth (Source: Claritas)

	Claritas Projected Population CAGR (2005-2010)	(2007-2013)
PCH Service Area Population Age 0-17	0.5%	0.4%
PCH Service Area Population Age 18-44	0.1%	0.1%
PCH Service Area Population Age 45-64	2.8%	1.9%
PCH Service Area Population Age 65+	2.4%	2.5%
PCH Service Area Population (All Ages)	**1.2%**	**1.0%**

The age 65 and older cohort, by far, utilizes the most inpatient services and is also the fastest growing segment of the population within PCH's service area.

Inpatient Utilization by Service Area

Inpatient Utilization, 2005
Use Rate per 1,000 Population



Percent of Population by Age Cohort, 2005

Region	% of Population	
	Age 45-64	Age 65+
Core	29.8%	17.0%
East	26.5%	10.7%
North	24.4%	15.2%
South	26.2%	7.4%
West	25.6%	9.4%
Total Service Area	26.2%	12.8%
Illinois	21.5%	12.1%
United States	22.0%	12.4%

Source: Claritas, US Census Data, IL COMPdata, PCH Internal Discharge Data, Navigant Analysis.

Observations

- With almost half the population age 45 or older, the Core Service Area's utilization rate is about 10% higher than the state-wide and U.S. rates
- But, the percent of age 45-64 and age 65+ population is, respectively, almost 10% and 5% higher than the state and U.S. percentages, which partially explains the above average use rates in the Core market
- As expected due to the younger population, the South and West Service Areas currently have substantially lower utilization rates
- Additionally, the average length of stay for patients originating from the South/West are lower at 4.3 days versus almost 5.0 days for patients from the Core/North/East areas

Medical Staff

Key statistical information regarding the Hospital's medical staff is summarized below.

Total Medical Staff	**515**
Percentage of Total Medical Staff that is Board Certified	**99%**

Source: Hospital Medical Staff Records, 2008

The Hospital has a large and stable active medical staff. The loyalty of the medical staff is reflected through its less than typical splitting behavior. The average age of the active medical staff is slightly less than 50 years old. The average age of the physicians recently added to the medical staff was 40 years old while those that resigned/retired were older. Departures from the medical staff were related to increasing malpractice insurance costs, physician re-locations, medical/health issues and retirement.

The number of Palos physicians expected to retire in the next 5 years is 6%, where a total of 27% will have retired within 10 years, and a total of 47% will have retired in 15 years. By 2021, only 53% of the current staff will be less than the age of 65. Nearly 50% of both current and projected total physician supply is within primary care.

To maintain an appropriate number and complement of physicians, the Hospital has adopted a medical staff development plan that identifies physician needs by specialty on an annual basis. This plan also addresses the accessibility and practice patterns of current and new physicians. Components of plan include:

1) **Recruitment of new physicians to PCH Medical Staff**
2) **The formation of Palos Medical Group – an integrated (employed) physician practice group consisting of the following specialties: family practice, internal medicine, general surgery and OB/Gyne.**
3) **Implementation of a Hospitalist program.**

Net Gain in Physicians:

Since 2006, over 70 new physicians were appointed to PCH's medical staff; 33 retired or resigned for a net gain of 33 physicians since 2006.

	2006	2007	2008 YTD	**Total**
Internal Medicine/Family Practice	4	6	-	**10**
OB/Gyne	2	-	-	**2**
Pediatrics	4	7	-	**11**
General Surgery	1	2	-	**3**
Cardiology	1	4	4	**9**
All Other	15	11	10	**36**
Total Added to Medical Staff:	**27**	**30**	**14**	**71**
Net Gain*	**9**	**18**	**6**	**33**

Source: New Medical Staff Appointments, Medical Staff Office memorandums

**Net gain is after subtracting physicians that retired/resigned from the medical staff.*

Sources: NCI Consulting, PCH Medical Staff Rosters, AMI, BCBS website.

Hospitalist Program

It is the Mission of PCH that all of its services – preventive, curative or palliative—shall be delivered with quality of the highest caliber and that PCH shall be committed to continually responding to the health care needs of the community with services that are readily available in a form that enhances their efficient use by physicians and patients.

Acting on its mission and values, PCH is implementing a Hospitalist program that consists of physicians who dedicate all their time to in-hospital care of patients. PCH will employ several board-certified internists, several whose focus is to care for patients in critical care units of the hospital. Hospitalists will assess patients in the Emergency Department, admit patients, arrange for specialty consultants and arrange post-hospital care. They will then refer the patients back to their regular physician for outpatient care.

In addition, hospitalists are available to care for patients who have out-of-town physicians, or patients who do not have an established primary care physician. Patients are able to retain their primary care physician or internist and can be seen by a hospitalist as a complement to their care at Palos Hospital. For example, if a patient comes into the emergency room and their primary care physician is unavailable, the hospitalist can be called to evaluate and treat the patient. For continuity of care, the hospitalist will then notify the primary care physician and work together on treatment.

The Hospitalist facilitates a continuity of care by being able to focus solely on patients in the hospital. When the patient needs to be seen by a doctor, the Hospitalist is there and doesn't have to be called over from his office where he may be with a patient. The Hospitalist is able to review test results quickly and begin treatments in a timely manner, thereby moving the patient closer to discharge. Hospitalists are also at the hospital for a full shift so they are available to review test results sooner and to order follow-up tests immediately if needed, which may reduce the length of hospital stays.

In addition to taking care of patients, Hospitalists are partners with the hospital in improving processes and outcomes. They participate on multidisciplinary patient care teams, ethics teams and a variety of quality improvement teams.

There are many benefits to be realized with this program, for both the patient and the patient's family: greater continuity of care, more in-person coordination of care; reduced length of stay. Patients who present to the emergency department and require admission are seen in a more timely manner, which expedites transfer out of the emergency department to the inpatient unit. A hospitalist cares for patients only in the hospital and has no outside medical practice. This allows hospitalists to devote their full attention to care for and treat patients in the hospital. Discharges should occur earlier in the day so you can start recovering sooner in the comfort of your own home.

Source: http://www.todayshospitalist.com; Source: Wachter RM, Goldman L. The Hospitalist Movement 5 Years Later. JAMA. 2002;287:487–9; Health Care Market Trends and the Evolution of Hospitalist Use and Roles; Hoangmai H Pham, MD, MPH,1 Kelly J Devers, PhD,2 Sylvia Kuo, PhD,3 and Robert Berenson, MD4 (http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1490059)

NEED FOR THE PROJECT
Community Support & Additional Community Benefits

Palos Community Hospital provided over $4.1 million in Charity Care in 2007, a 33.9% increase over 2006 (see Attachment GRC-4A(1).)

Community Support

The following public officials and elected representatives lend their support to the project. Please see Attachment GRC-4A(2) for these important community testimonials from the following persons:

Robert S. Straz, Mayor of the City of Palos Heights
Jack E. Nagle, Chief, Palos Heights Fire Protection District
Steven J. Carr, Fire Chief, Palos Park Fire Protection District
Gerald Burns, Vice President, Trace Ambulance Service, Inc.
B. Ramakrishna, M.D., Infectious Disease Practitioner
Lawrence J. Putz, Administrator, Lexington Health Care of Orland Park
Leslie G. Ohm, Regional Director of Operations, Manor Care Palos Heights West
Nancy McDonald, Administrator, Lexington Health Care of Chicago Ridge
Dr. James M. Gay, Superintendent, Consolidated High School District 230
Donald E. Chapman, Executive Director, PLOWS Council on Aging

Additional Community Benefits

The project is also needed to allow the Hospital to continue providing substantial community benefits to patients in its service area. Please see Attachment GRC-4A(3) which summarizes and defines the community benefits Palos Community Hospital provided in 2006 and 2007. In 2007 the Hospital provided over $60.7 million in community benefits! These benefits consist of the following:

Government sponsored indigent health care, which is the un-reimbursed *cost* of Medicare, Medicaid, and other federal, State, or local indigent health care programs, eligibility for which is based on financial need ($45.4 million);

Charity care ($4.1 million);

Subsidized health services including community health education and wellness programs ($0.8 million);

Education, including uncompensated costs of providing medical residencies, internships, nursing and other technician programs ($0.5 million);

Bad debt ($9.3million); and

Other benefits, such as volunteers, government-sponsored program services, donations, and language assistant services ($0.6 million.)

For a comparison to other area hospitals' Community Benefit Reports, see Attachment GRC-4A(4).

Please see Attachment GRC-4A(5) for the Hospital's charity care policy. The charity care policy has been in place since 1991, and provides guidance to staff to ensure that patients are fully aware of the Hospital's benefit policies. The Hospital's 2007 inpatient payer mix is displayed below.

Payer	Percent of Net Inpatient Revenues	Percent of InPatients Served
Medicare	56.7%	53.4%
Medicaid	-0.6%	2.2%
Private Pay	3.6%	0.5%
Charity Care	1.5%	3.4%
Private Insurance	40.3%	40.5%
Other Public	0.0%	0.0%
TOTAL	100.0%	100.0%

SOURCE: Annual Hospital Questionnaire, 2007.

The Hospital's mission as a non-for profit health care organization is to provide community benefits. The proposed project enables the Hospital to continue to serve its community.

Form AG-CBP-I
2/05

LISA MADIGAN
ATTORNEY GENERAL

Annual Non-Profit Hospital Community Benefits Plan Report

Hospital or Hospital System: Palos Community Hospital

Mailing Address: 12251 S. 80th Avenue, Palos Heights, IL 60463
(Street Address/P.O. Box) (City, State, Zip)

Physical Address (if different than mailing address):

(Street Address/P.O. Box) (City, State, Zip)

Reporting Period: 1 (Month) / 1 (Day) / 2007 (Year) **through** 12 (Month) / 31 (Day) / 2007 (Year) **Taxpayer Number:** 36-2169179

If filing a consolidated financial report for a health system, list below the Illinois hospitals included in the consolidated report.

Hospital Name	Address	FEIN #

1. **ATTACH Mission Statement:**
The reporting entity must provide an organizational mission statement that identifies the hospital's commitment to serving the health care needs of the community and specify the date it was adopted.

2. **ATTACH Community Benefits Plan:**
The reporting entity must provide its most recent Community Benefits Plan and specify the date it was adopted. The plan should be an operational plan for serving health care needs of the community. The plan must:
   1. Set out goals and objectives for providing community benefits including charity care and government-sponsored indigent health care.
   2. Identify the populations and communities served by the hospital.
   3. Disclose health care needs that were considered in developing the plan.

3. **REPORT Charity Care:**
Charity care is care for which the provider does not expect to receive payment from the patient or a third-party payer. Charity care does not include bad debt or the unreimbursed cost of Medicare, Medicaid, and other federal, State, or local indigent health care programs, eligibility for which is based on financial need. In reporting charity care, the reporting entity must report the actual cost of services provided, based on the total cost to charge ratio derived from the hospital's Medicare cost report (CMS 2552-96 Worksheet C, Part 1, PPS Inpatient Ratios), and not the actual charges for the services.

Charity Care..... $ 4,115,000

ATTACH Charity Care Policy:
Reporting entity must attach a copy of its current charity care policy and specify the date it was adopted.

4. **REPORT Community Benefits** actually provided other than charity care:
See instructions for completing Section 4 of the Annual Non Profit Hospital Community Benefits Plan Report.

Community Benefit Type

Language Assistant Services		$ 5,678
Government Sponsored Indigent Health Care		$45,400,026
Donations		$ 82,591
Volunteer Services		
a) Employee Volunteer Services	$ 2,625	
b) Non-Employee Volunteer Services	$ 428,435	
c) Total (add lines a and b)		$ 431,060
Education		$ 454,258
Government-sponsored program services		$
Research		$
Subsidized health services		$ 847,001
Bad debts		$ 9,264,000
Other Community Benefits		$ 63,945

Attach a schedule for any additional community benefits not detailed above.

5. **ATTACH Audited Financial Statements for the reporting period.**

Under penalty of perjury, I the undersigned declare and certify that I have examined this Annual Non Profit Hospital Community Benefits Plan Report and the documents attached thereto. I further declare and certify that the Plan and the Annual Non Profit Hospital Community Benefits Plan Report and the documents attached thereto are true and complete.

Timothy J. Brosnan,VP Planning & Community Rel. — Name / Title (Please Print)

708-923-5006 — Phone: Area Code / Telephone No.

Signature

June 30, 2008 — Date

Timothy J. Brosnan — Name of Person Completing Form

708-923-5006 — Phone: Area Code / Telephone No.

tbrosnan@paloscomm.org — Electronic / Internet Mail Address

708-923-4620 — FAX: Area Code / FAX No.

Gov't Sponsored Indigent Care - Hospitals
FYE: 12/31/07

	Medicare	Medicaid	Total
Total charges	[redacted]	[redacted]	454,275,683
Contractual allowances	[redacted]	[redacted]	(348,600,410)
Effect of Medicaid Tax Assessment to C/As	[redacted]	[redacted]	(392,055)
Net revenue	105,290,354	(7,136)	105,283,218
Cost to Charge Ratio	33.17%	33.17%	
Estimate of costs	141,848,555	8,834,689	150,683,244
Unreimbursed costs - BHH	(36,558,201)	(8,841,825)	(45,400,026)

Palos Community Hospital
2007 Community Benefit Plan
June 30, 2008

Introduction

In keeping with its mission, philosophy and organizational values, the Leadership of Palos Community Hospital (PCH) has established a Community Benefit Plan. This plan outlines the processes by which PCH will identify and document those aspects of the operations which provide for community benefit. Incorporated within the context of this plan are an identification of populations and communities served by the plan and the health care needs considered in developing the plan and the corresponding goals and objectives.

Community Need

In planning for community benefit, PCH takes seriously its role in responding to identified health care needs and will provide services and assistance within the scope of its competence and physical, financial and human resources.

The goals of community benefit plan are designed in direct response to the specific needs of the local community. Demographic information and data gathered through a community needs assessment provide an understanding of these needs.

Palos Community Hospital serves growing communities that expect to experience further growth in the coming years. Communities within the hospital's service area have seen an overall growth in population of approximately 7% from 2000 to 2006 with a current estimated population of 672,438. Continued growth is anticipated. From 2007 to 2012, the population is expected to reach 708,963.

Community	Zip	2007 Estimate	2012 Projected
Chicago Ridge	60415	13658	13314
Frankfort	60423	31658	37719
Lemont	60439	22669	24288
Lockport	60441	65434	76358
Midlothian-Crestwood	60445	25386	25096
Mokena	60448	25176	29098
New Lenox	60451	35900	42026
Oak Forest	60452	28224	28322
Oak Lawn	60453	53586	52167
Bridgeview	60455	15195	14881
Hickory Hills	60457	12569	12251
Justice	60458	14407	14650
Burbank	60459	27323	26863
Orland Park – core	60462	39423	40012
Palos Heights	60463	14269	14978
Palos Park	60464	10165	10303
Palos Hills	60465	17668	17091
Orland Park – SW	60467	27063	30624
Tinley Park – CC Hills	60477	65075	69857
Worth	60482	10564	10226
Homer Glen	60491	25623	28786
Mt. Greenwood	60655	26854	25212
Tinley Park (south)	60487	22337	24238
Evergreen Park	60642/60805	19687	18746
Alsip	60658/60803	22528	21857
Total		672,413	708,963

Of those living within the service area of Palos Community Hospital:

- 51.1% are female
- 89.5% are white
- 86.56% are English speaking
- the median age is 38 years
- 32% are high school graduates
- 31.2% have had some college, and
- 21.8% have earned a bachelor's degree or beyond.

From community needs assessment data, we also understand that the health status of the local population is better than national and state comparisons. The utilization of healthcare services among those living in the PCH service varies.

- PCH Emergency Department utilization is lower than national and state rates. This may be due to the availability of several immediate care centers located within the hospital's primary and secondary service area and the lower mean age of the population.
- Inpatient utilization rates are higher than comparative groups. This is likely due to the saturation of nursing homes in PCH's service area.
- Utilization of outpatient testing is higher than national and state norms. This is likely due to the general compliance of the community with recommended health behaviors/screenings.

In understanding the needs of the community it is useful to know the prevalence of chronic diseases in the community. Those that rank higher than the state benchmark for the PCH service area include:

- allergies
- arthritis
- high blood pressure
- high cholesterol
- osteoporosis
- indigestion/irritable bowel
- sciatica/chronic back pain
- sinus problems and
- skin cancer.

Those in the PCH service area are well educated about their healthcare needs and take an active role in maintaining their health. The community has a higher than state compliance with several recommended preventative health behaviors including:

- cardiovascular stress testing
- cholesterol testing
- colon screening
- eye and dental exams
- flu shots
- osteoporosis testing
- pap smear
- prostate screening, and
- routine physical exams.

Opportunities to increase preventative behavior present themselves in Child immunization, mammography and weight loss programs. PCH's community trust and confidence in health care is higher than state and national benchmarks.

Goals of the Community Benefit Plan

In response to those topics identified through the community needs assessment, the following goals have been established for the PCH Community Benefit Plan.

- Palos Community Hospital will assure the availability of quality inpatient, outpatient, emergency and home care services to the community at all times. Access to these services will be determined by clinical presentation and medical needs of the patient without consideration of the patient's ability to pay.

- Palos Community Hospital will be a resource for health education and wellness initiatives for residents of the service area.

- Palos Community Hospital will monitor the health care needs of its service area to assure the need for the services it offers and evaluate the opportunity to develop new programs and services as necessary.

- Palos Community Hospital will work together with and in support of other not-for-profit, educational, governmental, civic or community organizations, as appropriate, to promote health and wellness through awareness, education, research, access or support.

- Palos Community Hospital will have policies and procedures in place to provide for charity care for patients without financial resources, including the unreimbursed costs of government sponsored indigent health care.

- Palos Community Hospital will provide language assistance services as necessary to assure effective communication in the delivery of patient care.

2007 Community Benefits Summary

Charity Care.....$4,115,000
Care for which PCH does not expect to receive payment from the patient or a third-party payer. This does not include bad debt or the unreimbursed cost of Medicare, Medicaid, and other federal, State or local indigent health care programs, eligibility for which is based on financial need.

Language Assistant Services.....$5,678
While 86.43% of those living in the PCH service area are English speaking, the hospital does provide language assistant services for those in need. This includes the unreimbursed actual costs for providing such services including salaries and benefits of translators.

Government Sponsored Indigent Health Care.....$45,400,026
This is the total of unreimbursed cost of Medicare, Medicaid, and other federal, State, or local indigent heath care programs, eligibility for which is based on financial needs.

Donations.....$82,591
Cash and in-kind donations such as the value of meeting space, equipment, and personnel to assist other health care providers, social service agencies and organizations. Examples include the use of hospital facilities for college/university nursing education, donations to Y-Me and the American Heart Association.

Volunteer Services **$431,060**
Palos Community Hospital provides extensive volunteer services as a result of a formal hospital initiative amounting to more than 60,000 hours.

Education **$454,258**
This includes costs incurred for hospital based educational programs such as diabetes education, nursing education, pharmacy education, radiology education and physical therapy seminars.

Subsidized Health Services **$847,001**
Health services provided in response to community need for which the hospital must subsidize from other revenue sources. This includes the costs of community health screenings, informational materials, health education, immunization programs, hospice, physician referral services, poison control, etc.

Bad Debts **$9,264,000**
The expense resulting from the extension of credit for services the hospital provided for which payment was expected but not received.

Other Community Benefit **$63,945**
Other benefits not listed above such as the cost of Meals on Wheels programs.

Commitment to the Community
Each year Palos Community Hospital takes steps to understand the ongoing needs of its community and prepare a response based upon those needs. In 2007, the total amount of community benefit provide by PCH was **$60,663,559.**

SUPPORT LETTERS

CITY OF PALOS HEIGHTS

September 16, 2008

Jeffrey S. Mark
Executive Secretary
Illinois Department of Public Health
Health Facilities Planning Board
525 W. Jefferson Street, 2nd Floor
Springfield, IL 62761

Dear Mr. Mark:

Palos Community Hospital is the largest employer in our city and has been a valued and well-respected health care provider for over 35 years. Their role in the community is significant and includes emergency, surgical and other medical services, home care and hospice, immediate care, outpatient testing, plus many community programs like psychiatric care, asthma education workshops, health screenings, and immunization programs. They also support the educational institutions in the area by providing clinical education to train nurses, radiology technicians, physical therapists and a host of other highly skilled health care professionals. Additionally, I would consider them the economic driver in our city with many medical offices and ancillary services located in Palos Heights because of the proximity to the hospital.

The senior population of our community is the fastest growing segment and one which typically has a higher demand for health care and hospitalization. With population growth and aging, the demand for additional hospital beds and operating rooms will continue to increase. Therefore, expansion is necessary for Palos Hospital to meet the future demands for medical services in our community. Our community deserves an upgraded facility to attract and keep quality health care providers and to continue to meet the health care needs of our community. I am pleased to support this project that will bring substantial future benefit to the southwest suburbs.

Sincerely,

Robert S. Straz, Mayor
City of Palos Heights

cc: Margie Zeglen, Director, Planning, Palos Community Hospital ✓

Tim Brosnan, Palos Community Hospital

-88-

7607 W. College Drive, Palos Heights, IL 60463 • Phone 708-361-1800 • Fax 708-361-9711
www.palosheights.org

Palos Heights Fire Protection District

September 15, 2008

Jeffery Mark, Executive Secretary
Illinois Department of Public Health
The Health Facilities Planning Board
525 W. Jefferson St. Second Floor
Springfield, IL. 62761

Dear Mr. Mark,

I have been with the Palos Heights Fire Protection District for 26 years. I also reside in the community of Palos Heights. Palos Community Hospital has been a healthcare provider for the southwest suburbs for over 35 years. This is why I was pleased to learn about and to support these plans for further expansion.

The Palos Heights Fire Protection District relies on Palos Community Hospital for most of our residential transports. Palos Hospital accepts many ambulance transfers daily-one in three of which results in an admission to the hospital.

Furthermore, the age and acuity of the patients is increasing. The volumes and higher acuity of patients being treated substantiates the need for Emergency Department expansion, more ICU beds and the conversion of patient rooms to all privates patient rooms.

We support Palos Community Hospital's efforts to continue to provide high quality patient care to an aging and growing community through facility expansion and modernization.

Sincerely,
Jack E Nagle
Chief Jack Nagle
Palos Heights Fire Protection District

12300 South Harlem Avenue, Palos Heights, IL 60463-1425
708/448-4272

FIRE PROTECTION DISTRICT
8815 WEST 123rd STREET
PALOS PARK, ILLINOIS 60464

STEVEN J. CARR
Chief

ROBERT S. KNEZ
Assistant Chief

Jeffrey Mark
Executive Secretary
IDPH, Health Facilities Planning Board
525 W. Jefferson Street, Second Floor
Springfield, IL 62761

18 September 2008

Dear Mr. Mark,

Palos Fire Protection District was pleased to learn about and to support plans for further expansion at Palos Community Hospital. Our community has relied on Palos Community Hospital as a healthcare provider for the southwest suburbs for over 35 years.

- It is our understanding that one out of every three patients seen in the emergency department at Palos Hospital is admitted. This supports the hospital's efforts to expand the emergency department, critical care areas and create an admissions area adjacent to the emergency department.
- The increased volume of patients transported to Palos Hospital via ambulance regularly taxes the current emergency room, admissions, and intensive care areas.
- Furthermore the age and degree of infirmity of the patients is increasing. The increased volumes and higher severity of patients being treated substantiates the need for expansion in the Emergency Department, and other critical care areas.

Palos Fire Protection District supports Palos Community Hospital's efforts to continue to provide high quality patient care to an aging and growing community through facility expansion and modernization.

Should there be any questions specific to this issue that you would like to discuss with me or other area fire/EMS administrators, please do not hesitate to contact me at the number listed below.

Respectfully,

Steven J. Carr
Fire Chief

FIRE PROTECTION IS YOUR JOB, TOO
• BUSINESS PHONE (708) 448-0369 • FAX (708) 448-0849

Trace
Ambulance Service, Inc.
8400 West 183rd Place
Tinley Park, IL 60487
Phone
(708) 532-0088
Fax
(708) 633-1622
Patient Account Information
(708) 614-1343

September 16, 2008

Jeffrey S. Mark, Executive Secretary
Illinois Department of Public Health
Health Facilities Planning Board
525 W. Jefferson Street, Second Floor
Springfield, IL. 62761

Dear Mr. Mark,

As a provider of Emergency Medical Services in the south suburbs of Chicago, I was very pleased to learn of Palos Community Hospital's plans for modernization and expansion.

I applaud the administration for their dedication and foresight in their ongoing effort to ensure the continuation of high quality patient care to an aging and growing community. With the addition of an expanded emergency department and adjacent admissions unit and the addition of intensive care beds, this expansion is critical for the continuation of quality healthcare in the area.

I respectfully urge you to approve this plan as it is part of the future of healthcare in the South Suburbs.

Respectfully Submitted,

Gerald Burns

Gerald Burns
Vice President
Trace Ambulance, Inc.

Cc:Margie Zeglen, Director, Planning, Palos Community Hospital

Zeglen, Margie

From: bhagavatula ramakrishna [rpssks@gmail.com]
Sent: Thursday, September 18, 2008 1:22 PM
To: Zeglen, Margie
Subject: Fwd: CON for Private Rooms

---------- Forwarded message ----------
From: **bhagavatula ramakrishna** <rpssks@gmail.com>
Date: Wed, Sep 17, 2008 at 10:41 PM
Subject: CON for Private Rooms
To: MZeglen@ppaloscomm.org

Dear Mr. Jeffrey S. Mark
Illinois Dept. of Public Health HFP Board
525 W. Jefferson Street, 2nd Floor
Springfield, IL 62761

Dear Mr. Mark,
I am writing this letter in support of private rooms for all hospitalized patients. I strongly believe that this will be the trend in the future at all hospitals.

It is well known now that the common pathogens such as Staph. aureus and Streptococci have reemerged with more virulence. Drug resistance of bacteria is another problem with many organisms such as MRSA. Also known is the relatively new menace of C. diff. colitis that has become a significant cause of morbidity and mortality of tens and thousands of patients especially the frail elderly, the nursing home and hospitalized patients. Nosocomial transfer of this pathogen is well documented.

In this regard it becomes imperative that these pathogens are not transmitted from patient to patient in the health care centers. At present the semi private rooms defeat that purpose as we do not isolate patients unless we know that they carry such organisms as MRSA , C. diff, and ESBL . It takes 48-72 hours before we get cultures back during which time the patients are not in isolation exposing roommates and visitors.

There's another important issue with private rooms. There's no privacy when we interview a patient about sexual behavior , drug use and psychiatric issues. Simply we do not know when another patient and their visitors are in the room, who knows who. Sometimes it's a small world.

I truly believe that in the future all hospitals will have private rooms. You can be a leader in helping to further this cause and approval of the CON for Palos Comm. Hospital and lead Illinois in this important safety and comfort issue for all patients.

Sincerely
B. Ramakrishna,MD
Infectious Disease Practitioner

LEXINGTON
Health Care

9/15/2008

Jeffery S. Mark, Executive Secretary
Illinois Department of Public Health
Health Facilities Planning Board
525 W. Jefferson Street, 2nd Floor
Springfield, IL. 62761

Lexington
of
Orland Park

Dear Mr. Mark:

RE: PALOS COMMUNITY HOSPITAL

I am pleased to hear of Palos Community Hospital's plan to expand and modernize the hospital. As a sub-acute rehab and nursing center located near the hospital, we are aware of the increased need for quality medical services for the residents of the community. The community served by Palos Hospital and the Lexington Care Health Facility has a high concentration of elderly residents. Elderly nursing home patients have chronic disease conditions that often require emergency department visits and hospitalization. Access to more ICU beds and a larger emergency department will benefit the rapidly growing elderly population in our community.

Palos Community Hospital is an essential healthcare provider in our community. Lexington Health Care supports the hospital's plan to expand the emergency department, modernize and expand the intensive care units and create private patient rooms.

Sincerely,

Lawrence J. Putz (mf)
Lawrence J. Putz
Administrator

14601 South John Humphrey Drive
Orland Park, Illinois 60462
tel 708 349 8300
fax 708 349 4093

Manor Care Palos Heights West
11860 Southwest Highway
Palos Heights, IL 60463
708-361-4555
708-361-3777 Fax

ManorCare

September 17, 2008

Jeffrey S. Mark, Executive Secretary
Illinois Department of Public Health
Health Facilities Planning Board
525 W. Jefferson Street, 2nd Floor
Springfield, IL 62761

Dear Mr. Mark:

RE: PALOS COMMUNITY HOSPITAL

I am pleased to hear of Palos Community Hospital's plans to expand and modernize the hospital. As a sub-acute rehabilitation and skilled nursing center located near the hospital, we are aware of the increased need for quality medical services for the residents of the community. The community served by Palos Hospital and the ManorCare Health Services' facilities has a high concentration of elderly patients and residents. Elderly nursing home patients have chronic disease conditions that often require emergency department visits and hospitalization. Access to more ICU beds and a larger emergency department will benefit the rapidly growing elderly population in our community.

Palos Community Hospital is an essential healthcare provider in our community. ManorCare supports the hospital's plans to expand the emergency department, modernize and expand the intensive care units and create private patient rooms.

Respectfully,

Leslie G. Ohm
Regional Director of Operations

LEXINGTON
Health Care

9-15-08

Jeffrey S. Mark, Executive Secretary
Illinois Department of Public Health
Health Facilities Planning Board
525 W. Jefferson Street, 2nd Floor
Springfield, Il 62761

Lexington
of
Chicago Ridge

Dear Mr. Mark

RE: PALOS COMMUNITY HOSPITAL

I am pleased to hear of Palos Community Hospital's plans to expand and modernize the hospital. As a sub-acute rehab and Long Term Care nursing facility located near Palos Hospital, we are aware of the increased need for quality medical services for the residents of the community. The community served by Palos Hospital and Lexington Health Care Center has a high concentration of elderly residents. Elderly nursing home residents have chronic conditions that often require emergency department visits and hospitalizations. Access to more ICU beds and a larger emergency department will benefit the rapidly growing elderly population in our community.

Palos Hospital is an essential health care provider in our community. Lexington Health Care supports the hospitals plans to expand the emergency department modernize and expand the intensive care units and create private patient rooms.

Nancy McDonald
Administrator

10300 Southwest Highway
Chicago Ridge, Illinois 60415
tel 708 425 1100
fax 708 425 0779

CONSOLIDATED HIGH SCHOOL DISTRICT 230

15100 South 94th Avenue Orland Park, IL 60462 Phone: 708-745-5203 Fax: 708-349-2105 www.d230.org

Dr. James M. Gay
SUPERINTENDENT

September 10, 2008

Jeffrey S. Mark
Executive Secretary
Illinois Department of Public Health
Health Facilities Planning Board
525 W. Jefferson Street, Second Floor
Springfield, IL 62761

Dear Mr. Mark:

Palos Community Hospital has provided quality health care services to our community for more than 35 years. This summer I learned about the details of the hospital's plans for expansion and am supportive of what the project promises for our area.

Our schools have partnered with Palos Community Hospital for many years to assist students in completing various community service experiences. This mutually beneficial relationship has offered hundreds of students a valuable introduction to potential careers in health care. Some of our students have continued their volunteerism at the hospital far beyond their initial project, which is another sign of the positive influence the hospital has had on our community.

Palos Community Hospital is a valuable member of our community and I believe that the proposed project will further enhance the health care services available in the southwest suburbs.

Dr. James M. Gay
Superintendent

cc: Margie Zeglen, Director, Planning, Palos Community Hospital

PLOWS COUNCIL ON AGING
7808 WEST COLLEGE DRIVE - SUITE 5E • PALOS HEIGHTS, IL 60463
Phone: 708-361-0219

September 18, 2008

Jeffrey S. Mark
Executive Secretary
Illinois Department of Public Health
Health Facilities Planning Board
525 W. Jefferson Street, Second Floor
Springfield, IL 62761

Dear Mr. Mark:

I am pleased to hear of Palos Community Hospital's plans to expand and modernize the hospital.

- Palos Hospital is a major provider of health care services for elderly patients living in the community, and especially for those that arrive via ambulance from nursing or assisted living facilities.

- An expanded emergency department, new intensive care units and private patient rooms will ease patient flow from the emergency department to admission and provide space for family involvement.

Palos Community Hospital is an essential healthcare provider in our community. The PLOWS Council on Aging is enthusiastic about the hospital's plans for expansion and fully supports their growth and development.

Donald E. Chapman
Executive Director

cc: Margie Zeglen, Director, Planning, Palos Community Hospital

Charity Care:

- PCH provided over $4.1 million dollars in Charity Care in 2007, a 33.9% increase compared to 2006. Total community benefit provide in 2007 was $60,663,559.

- PCH charity care and community benefit compared to other community hospitals is reflected in the table below. PCH ranked second in total amount of community benefit provided compared to similar community hospitals.

	Reporting Year	Charity Care	% change 2006-2007	Total Community Benefit
Palos Community Hospital	2007	$4,115,000	33.9%	$60,663,559
	2006	$3,073,000		$64,368,209
Northwest Community Hospital	2007	$7,579,000		$78,293,000
	2006	$1,634,000		$41,065,000
Edward Hospital	2007	$6,084,482		$54,398,133
	2006	$5,439,173		$52,979,936
Silver Cross Hospital	2007	$2,743,000		$17,461,000
	2006	$2,170,000		$31,280,000
Elmhurst Hospital	2007	$2,048,992		$89,252,975
	2006	$1,789,527		$71,468,805
Delnor Community Hospital	2007	*Not available*		
	2006	$2,063,344		$35,084,189

* *Source: Individual hospital websites*

Other information related to community:

PCH's commitment to the provision of accessible quality health care has resulted in PCH consistently rating as a first choice hospital in Healthcare Market Guide consumer survey for Best Overall Quality, Best Doctors, Best Nurses, Highest Patient Safety, Inpatient Stays, Hospital Emergency Room Services, Maternity/OB Services, Women's Health Services, Outpatient Testing/X-rays, Orthopedic Surgery, Outpatient Same Day Surgery, Physical Therapy, Home Health Care Services, Most Preferred for All Health Needs and Best Community Health Programs.

Throughout its 35-year history, PCH has proactively responded to the health care needs of the community through the development of innovative clinical services offered with uncompromised quality, efficiency and competence.

Most recently, identifying the need for additional growth and recognizing the problems associated with an aging physical plant and infrastructure, PCH undertook a Facilities Planning Process in 2006 that will result in the expansion and major reconfiguration of most clinical and support areas.

This process incorporated the expertise of outside consultants including Navigant Consulting, Matthei and Colin Architects and KJWW Engineering. The focus of the planning process was to evaluate existing facilities and infrastructure and identify any current capacity constraints or opportunities for growth in order to develop and evaluate any facility alternatives. Utilizing use rates, market share and demographic information, Navigant projected significant volume increases for the Hospital and service area over the next 20 to 15 years.

As a consequence of this facility assessment and volume projections, the Hospital has recognized significant current and future facility constraints and the needs of expansion and major reconfiguration of most clinical and supports areas.

COMMUNITY OUTREACH AND COMMUNITY BENEFIT

Along with traditional health services, the Hospital makes its resources available to support many community health initiatives and programs responsive to the needs of the community. Examples of community services provided by the Hospital include: Asthma Education Program, Chemical Dependency Services, Diabetes Fair & Diabetes Self-Management Program, Home Delivered Meals, *Lifeline* (crisis line), Osteoporosis Program, Parent-Child Health Education, Physician Referral Service, Psychiatric Services (inpatient & outpatient), Speakers Bureau, and a number of different Support Groups.

In addition, the Hospital provides annual health screenings for skin, prostate & colorectal cancer. The Hospital regularly offers programs on smoking cessation, depression/emotional health, prenatal care/childbirth preparation, caregiving, heart disease, and diabetes. Through its numerous outreach activities, the Hospital is recognized as the area leader in community education services. The Hospital also participates in and sponsors a variety of annual community events including a 5K run (benefits Y-ME), Women's Day, Heart Month & a Heart Walk (benefits American Heart Association). Its Speakers Bureau & Health Fair participation reaches thousands in community. The Hospital's home delivered meals program provides over 30,000 home delivered meals annually to home-bound seniors in our community. The Hospital's Senior Resource department provides assistance to seniors with Medicare and hospital paperwork. In addition, a variety of community publications including Perspective magazine and Community Calendar are mailed to residents, reaching over 150,000 homes.

Working together with other area hospitals, the Hospital is a member of the Southland Healthcare Forum and the Southland Health Alliance. The Southland Healthcare Forum is a coalition of area hospital providers from the south suburbs of Chicago whose purpose is to develop positive solutions to health care issues and to increase health care related employment opportunities for residents of the region. The Southland Health Alliance is a consortium of south suburban Chicago health care providers, striving to improve the health of residents through meaningful health communication efforts with a focus on collective health status change through disease prevention, early disease detection, collaboration and advocacy.

2007

Hospital Location No. of Beds Year	Palos Palos Hts. 438 2007	 2006	Silver Cross Joliet 304 2007	 2006	Edward Naperville 348 2007	 2006	NW Comm Arlington Hts. 488 2007	 2006	Elmhurst Elmhurst 427 2007	 2006	Delnor Geneva 118 2007	 2006
Charity Care	$ 4,115,000	$ 3,073,000	$ 2,743,000	$ 2,170,000	$ 6,084,482	$ 5,439,173	$ 7,579,000	$ 1,634,000	$ 2,048,992	$ 1,789,527	not available	$ 2,063,344
Language Assistance Services	$ 5,678	$ 12,512	$ 83,000	$ 590,000			$ 384,000	$ 225,000	$ 52,157	$ 93,773	not available	$ 37,575
Govt. Sponsored Indigent Health Care	$ 45,400,026	$ 47,349,000	$ 4,202,000	$ 5,730,000	$ 35,559,000	$ 33,376,900	$ 64,593,000	$ 34,389,000	$ 40,840,652	$ 39,985,548	not available	$ 24,305,249
Donations	$ 82,591	$ 82,994	$ 265,000	$ 960,000			$ 522,000	$ 1,425,000	$ 15,365,258	$ 1,050,150	not available	$ 378,211
Volunteer Services	$ 431,060	$ 390,336	$ 205,000	$ 290,000			$ 1,027,000	$ 973,000	$ 395,848	$ 414,623	not available	$ 299,902
Education	$ 454,258	$ 449,856	$ 412,000				$ 921,000		$ 98,228	$ 154,100	not available	$ 602,250
Govt. Sponsored Programs	-	$ -	$ 2,937,000	$ 2,470,000					$ 111,720	$ 175,485	not available	
Research	-	$ -	-	$ 410,000			$ 28,000		$ 81,116	$ 30,969	not available	$ 101,194
Subsidized Health Services	$ 847,001	$ 856,604	$ 1,169,000	$ 500,000			$ 2,021,000	$ 1,551,000	$ 8,605,000	$ 8,883,649	not available	$ 4,092,405
Bad Debts	$ 9,264,000	$ 12,093,000	$ 5,445,000	$ 18,160,000	$ 6,612,651	$ 7,188,284			$ 14,969,572	$ 18,890,981	not available	$ 2,526,881
Other Community Benefits	$ 63,945	$ 60,907			$ 6,142,000	$ 6,975,579	$ 1,218,000	$ 868,000	$ 6,684,432		not available	$ 677,178
Total	$ 60,663,559	$ 64,368,209	$ 17,461,000	$ 31,280,000	$ 54,398,133	$ 52,979,936	$ 78,293,000	$ 41,065,000	$ 89,252,975	$ 71,468,805		$ 35,084,189

* Source: Hospital web sites.

2-2-1

PALOS COMMUNITY HOSPITAL
POLICIES AND PROCEDURES MANUAL

TITLE: Financial Assistance for Uninsured/Underinsured Patients

EFFECTIVE DATE: November 15, 1991 REVISION DATE: May 13, 2005

POLICY: It is the policy of Palos Community Hospital to provide quality medical health care to all persons regardless of race, creed, sex, national origin, handicap, age or ability to pay. The Hospital recognizes that not all individuals possess the ability or means to purchase essential medical services, and, further, that our mission is to serve the community with respect to providing health care services and health care education. Therefore, in keeping with the Hospital's commitment to serve all members of the community, charity and/or subsidized care will be considered where the need and/or an inability to pay are identified.

Charity and/or subsidized care includes medical services provided to uninsured non-governmental patients, indigent government program patients and/or other low income, underinsured patients. Palos Community Hospital will also consider cases of medical need in catastrophic cases where income or assets would otherwise be considered too high to qualify for governmental assistance. Each patient will be reviewed based upon the standards set forth within this policy.

Charity and/or subsidized care are granted solely for the benefit of the patient and his/her family for services rendered by Palos Community Hospital and do not relieve the patient of liability for payment to other third parties, e.g. physicians. Eligibility for charity and/or subsidized care is contingent upon approval and on the cooperation of the patient/guarantor during the charity process.

PROCEDURES: I Self-Pay Uninsured Discounts

A. All patients registered as "Self Pay" will be eligible for a 40% uninsured discount. Under this policy, the Hospital will first send the patient correspondence to verify that they are not insured.

B. The Hospital will investigate if the patient is eligible for Public Aid or any other Federal or State assistance.

C. If the Hospital does not receive notification of insurance from the patient, and if the patient does not qualify for any Federal or State assistance program, the Hospital will issue a letter granting the patient a 40% uninsured discount.

D. The patient's remaining balance may still be eligible for charity care consideration.

ATTACHMENT GRC-4A(5)
PAGE 1 OF 4

II Charity Care Assistance

A. If, during the pre-admission or admission procedure, or at any time during or following treatment at the Hospital, it is determined that a patient may be unable to pay, the patient will be referred to the Financial Counselor or the Business Office Collection Staff. It is at this point of contact that the process of determining financial need begins.

B. The Financial Counselor or Collection Staff will obtain appropriate financial and demographic information to assist in the determination of eligibility. The information will include a signed completed "Request for Financial Assistance" form.

1. Financial/demographic information may include but is not limited to the following:
   a. Income including wages, payments from unemployment and pension plans.
   b. Liquid assets.
   c. Living expenses.
   d. Family size, including all dependent children aged 18 and under residing in the home.
   e. Credit report.

2. The Hospital does not include the following into the computation of income:
   a. Social Security Disability.
   b. Child support.

3. The Hospital will accept the following documentation as proof of income:
   a. three (3) recent pay check stubs, or
   b. a copy of the most recent Federal Income Tax filing.

4. A brief written statement from the patient or family member is requested explaining the circumstances surrounding the request for financial assistance. In the event this documentation is unavailable, the Hospital will process the application utilizing the information that can be received during a teleconference with the patient/guarantor. This information will be documented on the Charity Application-Telephone short form.

5. The Hospital will have the patient assessed for medical assistance through the Illinois Department of Public Aid (IDPA) if it is determined that the patient may qualify. If it is determined that the patient will qualify for assistance through the State, the Hospital will utilize MedAssist, Inc., to complete the proper monetary assistance (non-grant) or MANG application.

C. The Hospital Financial Counselor or Collector will run a credit report on the patient/guarantor and attach it to the signed, completed form. The Charity Care Approval form is affixed to the compiled data and forwarded to the Director of Patient Financial Services for review.

D. If the patient is determined to be ineligible for assistance through the State and after reimbursement of any insurance, if applicable, the financial/demographic information will be evaluated by employing the Hospital's sliding scale matrix which is structured utilizing a general guideline of 200% of the poverty level as published annually in the Federal Register by the Department of Health and Human Services (DHHS). This document is available for review in the Business Office. The Director of Patient Financial Services will annotate the Charity Care Approval form with pertinent data which was utilized to make a final determination.

E. The Hospital utilizes signage, the Hospital's Website and the *Patient Financial Responsibilities* brochure to notify all patients of the financial assistance program. This brochure is available at all entry points and is included in the admissions packet and all outpatient registration areas.

F. The Hospital will review accounts that are presently with a collection agency for charity if the financial circumstances warrant a review or if the collection agency contacts the Hospital after speaking with the patient/guarantor. Collection agencies are not at liberty to sue, file a lien, issue a wage garnishment or body attachments against any patient.

G. Once a final determination has been made, the Director of Patient Financial Services will take the following action:

1. If charity is approved,
   a. the Charity Care Approval form shall be signed and dated. In the event the account(s) total $50,000 or more, the signature of the President will also be required prior to processing a charity adjustment to the account.
   b. the Director of Patient Financial Services will apply the appropriate charity adjustment against the patient account, thereby reducing the balance to zero or to the determined discounted amount. The account will also be documented in reference to the outcome of the charity review.
   c. the Director of Patient Financial Services will forward the approved form to the designated Collector. The Collector will prepare the appropriate "Gift of Care" letter to the patient/guarantor. If the patient/guarantor will have a balance after the application of [illegible] adjustment, the Collector will contact the patient/guarantor by phone in order to arrange a

mutually agreeable payment plan for the remaining balance. All payment plans are interest free.

d. the "Gift of Care" allowance will always be in addition to the 40% Uninsured Discount for those applicable patients.

2. If charity is denied,
   a. the application is annotated with pertinent data utilized to make the final determination and is signed by the Director of Patient Financial Services.
   b. the denied application is returned to the designated Collector. The Collector will contact the patient/guarantor to explain the outcome of the charity review and to arrange for a mutually agreeable payment plan. All payment plans are interest free.

3. All completed applications are filed by the month/day of the adjustment date. Each day is filed in alphabetical order for ease of reference.

RESPONSIBILITY: It is the responsibility of the Director of Patient Financial Services, in consultation with the Vice President of Fiscal Management, to interpret all aspects of this policy subject to the ultimate authority of the President.

Sister Margaret Wright
Sister Margaret Wright
President

REFERENCES:

- Office of the Inspector General of the United States (OIG): 68 Federal Register 53939 (9/15/2003)
- Office of the Inspector General of the United States (OIG): 65 Federal Register 24400, 24409 (4/26/2000)
- House Committee for Ways and Means, Public Testimony (3/9/2004)
- Report of the Task Force on Charity Care and Collection Practices for the Uninsured of the Illinois Hospital Association (IHA) and the Metropolitan Chicago Healthcare Council (MCHC), adopted on 9/11/03
- Hospital Billing & Collection Practices, Statement of Principles & Guidelines, as adopted by the American Hospital Association (AHA)
- Fact sheet on HHS Guidance on Hospital Discounting for Uninsured Patients
  http://www.cms.hhs.gov/providers/FAQ_Uninsured_Additional.pdf
- Hospital Discounts Offered to Patients Who Cannot Afford to Pay Their Own Hospital Bills (Open letter from Department of Health & Human Services (DHHS), 2/02/2004
  http://oig.hhs.gov/

SIZE OF PROJECT

The Project

The Hospital proposes to build an East Wing with eight levels adjacent and connected to the existing hospital at the northeast corner. The East Wing would contain a total of 399,669 new gross square feet (gsf), including 223,462 gsf (56%) for clinical services as follows:

Clinical Services	EAST WING Building GSF*	Location
Medical/Surgical (156 beds)		
Four 36-bed M/S units	83,120 gsf	Floors 2- 5
One 12-bed telemetry M/S unit	8,670 gsf	Floor 6
	91,790 gsf	
Intensive Care (36 beds)		
One 24-bed ICU	16,980 gsf	Floor 7
One 12-bed ICU	8,670 gsf	Floor 6
	25,650 gsf	
Integrated Procedure Services		Floor 1
Surgery	37,354 gsf	
GI/Endo	3,468 gsf	
Special Procedures	2,004 gsf	
	42,826 gsf	
Recovery/Minor Procedures		Floor 1
PACU (Stage 1)	3,750 gsf	
Center for Short Stay Care	22,940 gsf	
(Stage 2 and Minor Procedures)	26,690 gsf	
Respiratory Therapy Satellites for each ICU	1,060 gsf	Floors 6 & 7
Outpatient & Pre-admission Testing	4,730 gsf	Floor 1
Pharmacy		
Central Pharmacy	7,779 gsf	Basement
Satellite Pharmacy for OR	450 gsf	Floor 1
	8,229 gsf	
Laboratory	22,487 gsf	Basement
TOTAL	223,462 BGSF	

* The above gross square feet (gsf) refer to building gsf (BGSF) and include both internal departmental circulation space and a portion of the building's circulation.

The project modernizes 187,879 gross square feet (gsf), including 131,247 gsf for clinical services. Almost 60% of the remodeled clinical space (77,330 gsf) is for the conversion of semi-private M/S rooms to private rooms. This modernization results in the loss of 165 M/S beds as only 156 M/S will be replaced. Upon project completion the Hospital will have 306 M/S beds and 36 ICU beds, representing an addition of 12 ICU beds and net reduction of 9 M/S beds.

Another 53,917 gsf of vacated space will be remodeled to expand the following clinical services: on the 1st Floor - Emergency Department (ED); Admissions Unit adjacent to the ED; Cardiology; and Radiology/Nuclear Medicine, with satellite imaging for each service in the ED; and on the 3rd Floor - Respiratory Therapy and Inpatient Dialysis.

Space Plan, Methodology and Goals

The Hospital conducted a lengthy, thorough planning process involving Hospital Administration, Medical Staff, Governing Board, and Key department personnel in determining each department's size, scope and location. In 2006 the Hospital commissioned Navigant Consulting and Matthei & Colin Associates (M&CA) to develop a Strategic Facility Plan and Functional Space Plan to enable the Hospital to meet the needs of service area residents through the year 2020. This project is the culmination of those efforts. See Attachment GRC-5(1) for existing and proposed gross square feet (gsf) for each clinical department affected by the project. The proposed gsf are based on detailed, departmental assessments addressing the space needed for increased utilization, and related increases in physicians, staff, equipment and necessary ancillary/support areas (see Attachment GRC-5(2) for the Space Program.) Alternative solutions are presented in Attachment GRC-3.

Comparison of Department GSF with IHFPB Space Guidelines

All departments conform to IHFPB space guidelines, except M/S, ICU, Recovery, and Pharmacy (see Attachment GRC-5(3) for comparison of departments to current IHFPB space guidelines. Please note that while gross square feet (gsf) are *building* gross square feet (bgsf,) and include external circulation (stairs/corridors,) this comparison with IHFPB standards is based on department gsf, and excludes external building circulation. The Space Plan in Attachment GRC-5(2) reconciles these spaces.

MEDICAL/SURGICAL (M/S) SERVICES

The IHFPB standard is 401gsf/bed, allowing 122,706 gsf for 306 beds. Palos will have 180,065 gsf, 588 gsf per bed upon project completion. The 156 replacement beds contain 84,825 department gsf, 544 dgsf per bed, exceeding the standard by 22,269 gsf (156 beds X 401 gsf per bed = 62,556 dgsf.) See the M/S Space Plan in Attachment GRC-5(2) for the department gross square feet (dgsf.)

Please refer to the line drawings of the new and modernized units in Attachments GRC-5(4) and 5(4A).) The drawings, together with the detailed, room-by-room space program for M/S in Attachment GRC-5(2), document the appropriate use of space within the M/S units. The apparent excess space in the new units is due entirely to the use of private rooms, each with a bathroom and a small family zone. A prototypical private M/S room contains 255 net square feet (nsf): 165 nsf in usable bedroom space; 50 nsf in bathroom/door swing area; and 40 nsf in the family zone (see Attachment GRC-5(5).) This private model adds 32,760 dgsf to the new M/S units over the standard semi-private room configuration, as follows:

Additional Space for Private Rooms			
Private rooms - Attachment GRC-5(5)	=	165	net usable square feet
Private room X 2 need	=	330	"
Semi-private - Attachment GRC-5(5A)	=	- 180	"
Difference	=	150	nsf added/bedroom
78 semi-private rooms (156 beds)	=	11,700	nsf for 78 more rooms
Additional Space for Private Bathrooms			
Private bathroom/door swings	=	50	nsf
Private bathrooms X 78 rooms	=	3,900	nsf added/bathroom
Additional Space for Family/Visitor Zone			
Family/visitor area	=	40	nsf
For each 156 rooms	=	6,240	gsf
Subtotal (Bedroom/Bath/Family Zone)	=	21,840	nsf
Departmental circulation space (1.5)	=	32,760	departmental gsf

The apparent excess M/S space is due to the private rooms, bathrooms and small family areas.

INTENSIVE CARE SERVICES (ICUs)

The IHFPB standard is 603 gsf per bed, allowing 21,708 gsf for the 36 ICU beds. Palos proposes 23,490 dgsf, 653 dgsf per bed, exceeding the standard by only 1,782 dgsf. See the ICU Space Plan in Attachment GRC-5(2) for the dgsf.

Please refer to the line drawings of the two ICUs in Attachment GRC-5(6.) The drawings, together with the detailed, room-by-room space program in Attachment GRC-5(2), document the appropriate use of space within the ICUs. The apparent excess space is due entirely to the use of private rooms each with a bath and a small family zone. The prototypical ICU private room contains 260 net square feet (nsf): 174 nsf in usable bedroom space; 65 nsf in bathroom/door swing area; and 21 nsf in the family zone (see Attachment GRC-5(7).) The rooms add 4,954 gsf over the standard ICU configuration of curtained ICU cubicles, as follows:

Additional Space for Private Bathrooms			
Private bathroom/door swings	=	65	nsf
Private bathrooms X 36	=	2,340	nsf added/bathroom
Additional Space for Family/Visitor Zone			
Family/visitor area	=	21	nsf
For each 156 rooms	=	756	gsf
Subtotal (/Bath/Family Zone)	=	3,096	nsf
Departmental circulation space (1.6)	=	4,954	departmental gsf

The apparent excess ICU space is due to the configuration of the private rooms which offer a bathroom and small family area.

RECOVERY

The IHFPB standard allows 4 stations per procedure room, or 92 recovery stations for the allowable 23 procedure rooms. The IHFPB standard is 180 gsf per recovery station, or 16,560 gsf. Palos proposes 22,380 dgsf, and appears to exceed the IHFPB standard by 5,820 gsf.

Please refer to the line drawings of the two recovery areas in Attachment GRC-5(8.) The Post Anesthesia Care Unit (PACU) for Stage 1 Recovery is located adjacent to Integrated Procedure Services (Surgery, GI/Endo, Interventional Imaging, & Minor Procedures) and contains 3,350 gsf. The drawings, together with the detailed, room-by-room space program for the PACU in Attachment GRC-5(2), document the appropriate use of space within the PACU.

PACU has 15 recovery positions which occupy 1,920 dgsf, over 57% of dgsf. Thirteen (13) of the 15 stations are stretcher bays separated by curtains each with only 80 nsf. Two recovery positions are isolation rooms of 120 nsf each. Any apparent excess PACU space is in necessary support functions which contain only 1,430 dgsf (see to Attachment GRC-5(2) for room-by-room detail.) These support functions include control/team station and areas for physician dictation, clean/soiled utility, linen cart & equipment storage, staff hand-washing, a pneumatic tube, and housekeeping.

The Center for Short Stay Care (CSSC) integrates recovery for all procedures, including Surgery, GI/Endo, Interventional Imaging and Minor Procedures. This integration eliminates the need to build and staff separate recovery areas for each service, and increases staff efficiencies. The CSSC is adjacent to the PACU and contains 19,030 dgsf. The apparent excess gsf in Recovery is due to three factors affecting the CSSC: (1) CSSC accommodates outpatient treatment; (2) CSSC's 55 recovery positions offer privacy; and (3) CSSC decentralizes staff and support space for visualization (see Attachment GRC-5(8) for line drawing and GRC-5(8A) for concept diagrams.)

The CSSC accommodates three distinct functions: preparation and staging for all IPS procedures; Stage 2 recovery for inpatients and outpatients; and direct treatment, observation and recovery for various outpatients. Outpatient procedures performed in the CSSC include infusion therapy, epidural blocks, Rhogam injections, blood patches, bone marrow aspirations, and PEG replacements. The CSSC will function in a unique, decentralized unit with 55 private positions arranged in eleven pods of five positions each (see line drawing and concept diagram again in Attachments GRC-5(8) and 5(8A).) The eleven 5-position clusters are interchangeable with one 5-position cluster designed for isolation. The Hospital anticipates that at any given time five of the 55 positions (9.1%) will be used for the above outpatient treatments.

Therefore, approximately 1,732 dgsf (19,030 dgsf X 9.1%) will be for outpatient treatment.

Each private recovery position is 130 nsf (see Attachment GRC-5(9) for the prototypical private recovery position.) The rooms are three-sided with sliding glass fronts to optimize patient visualization. The rooms add 4,098 dgsf over the standard 80 nsf cubicle, as follows:

Additional Space for Private Stations			
Private station - Attachment GRC-5(9)	=	130	net usable square feet
Standard curtained cubicle (see PACU)	=	-80	"
Difference	=	50	nsf added/station
55 private recovery stations	=	X 55	
Total nsf added	=	2,750	nsf added for 55 stations
Departmental circulation space (1.49)	=	4,098	departmental gsf

Therefore, 4,098 dgsf in recovery is due to the private nature of the 55 stations.

The cluster configuration optimizes patient visualization in the CSSC, bringing the caregiver closer to the patient. This decentralization requires that each cluster contain selective staff and support areas. Each of the ten, non-isolation pods has a total of 155 nsf for a caregiver workstation sized for two staff, hand washing sink, patient toilet, and two supply carts for linen and patient supplies. The 10 pods serving 50 recovery positions have a 1,550 nsf for these staff/support areas, 2,325 dgsf adding an internal circulation factor of 1.5 (see CSSC Space Program in Attachment GRC-5(2).)

Additional support space is shared between the clusters, including crash cart/equipment alcove, soiled holding rooms, nourishment station, and clean/soiled utility rooms. The CSSC has a centralized IV therapy station with two workstations and space to store an IV cart.

In summary, the CSSC integrates Stage 2 recovery for all procedures, including Surgery, GI/Endo, Interventional Imaging and Minor Procedures and provides outpatient treatment space for various infusion/outpatient procedures. This integration eliminates the need to build and staff separate recovery and treatment areas for each service, and significantly increases efficiencies.

The apparent excess space within Recovery is most probably due to the following three factors: (1) outpatient treatment space which adds 1,782 dgsf; (2) the 55 private recovery positions which add 4,098 dgsf; and (3) decentralized staff support space which adds at least 2,325 dgsf. These important functional design components add 8,205 dgsf to Recovery.

PHARMACY

The IHFPB standard is 12 gsf per bed, allowing 5,196 gsf for the 433 beds. Palos proposes 7,360 dgsf, and exceeds the IHFPB standard by 2,164 gsf. Please refer to a concept drawing for the Pharmacy in Attachment GRC-5(10.) The drawing, together with the detailed, room-by-room space program for the Pharmacy in Attachment GRC-5(2), document the appropriate use of space for Pharmacy Services.

The apparent excess space is due to four factors: (1) increasing utilization of Pharmacy Services i.e. more doses, orders, IVs etc. requires more order entry and dispensing staff; (2) new practice guidelines in management and compounding processes requiring added equipment, supplies and workstations; (3) eventual transition to a new automated medication dispensing system; and (4) a new, satellite pharmacy of 450 gsf will be located adjacent to the IPS/CSSC area.

The Pharmacy was designed over 30 years ago, and even though the distribution model, the cart system, has not dramatically changed, the number of orders, doses, IVs, interventions, pre-packed doses, narcotics dispensed, cart-fill doses etc. has increased on a yearly basis. Increases in the last three years averaged 6.9% for orders and 4.5% for doses. Pharmacy utilization is projected to increase at an average 3.0% and 4.5% per year for orders and doses, respectively, through 2020.

As a result of this growth, clinical and dispensing staff has grown. The Pharmacy is open 24/7 and employs 67 team members. Since Pharmacy clinical support space outside the department is very limited, more support space is required within the department. Work stations now cover all work surfaces with the Pharmacy. Pharmacy recently added two new positions, Pharmacy Buyer and a Data Information Pharmacist, and their work stations needed to be placed in the only conference room. Another two work stations were recently added for pharmacists to perform order entry. Their work stations needed to be located in the staff break area which provides for a non-conducive work environment for those at workstations in this area.

Recently, the Pharmacy Department changed work flow and storage areas for IV medications and preparation to comply with the new USP 797 guidelines (see Attachment GRC-5(11).) Pharmacy began bar coding medications which are pre-packed by Pharmacy. These increases and changes in workloads have increased the stock in the Pbarmacy and the need for more terminals in the Pharmacy for order entry and calls. More drug storage takes up every inch of current space. Pharmacy added storage shelves to the unit dose section so that more drugs could be stored in the designated areas (standardization) to minimize exceptions and the potential for medication errors. The current dispensing area is within the order entry area. This location distracts pharmacists during the order entry process which requires total concentration due to the increased complexity of orders, acuity of the patients and numbers of medication orders.

The IV room requirements by USP 797 change workflow storage in the IV room. All pre-made IVs have been moved out of the IV room and are now dispensed from the Pharmacy. A new printer was added to the Pharmacy to accommodate these pre-made IVs and the printing of the labels. Also, a refrigerator was removed from the IV room to assist with compliance with USP 797. These changes crowd an already undersized Pharmacy. Fortunately, Pharmacy cabinetry was rearranged and reconfigured to allow for some changes that need to be implemented.

Automation is being introduced into the pharmacy workflow to help assure medication safety. In the future, all doses which are dispensed in the pharmacy will require bar coding. Bar code labeling of unit doses and prepared doses will require new equipment which is not currently available in the Pharmacy. This equipment requires dedicated terminals and space which is currently not available in the Pharmacy.

The hospital will eventually adopt automatic dispensing machines in the nursing care areas to assist with first doses, decrease order turn around time and assist with narcotic control. This technology will require work space and workstations within the pharmacy for dose preparation accompanied with carts for delivery of these doses. The new system will be phased in over a ten-year period, requiring flexible space to operate both systems. All of these functions will require more space not available today. Please refer to Detailed Functional Space Programming discussion in Attachment GRC-5(12.)

The Pharmacy also lacks a private area to counsel employees with questions. The Clinical office is a galley office for 5 individuals. When the Clinical Coordinator has a meeting with nursing, a physician or sales person, the clinical pharmacists are all in the same office. Lack of privacy impedes a productive work environment.

In conclusion, Pharmacy requires additional space to increase productivity and decrease the potential of medication errors by providing an environment that is less disruptive to the registered pharmacists and certified technicians within the pharmacy, more automated, and compliant with new management/compounding practice guidelines and distribution systems.

SIZE AND SCOPE

CLINICAL SERVICE	GSF* Existing	GSF* Proposed	Amount of Proposed Total GSF That is: New	Remodeled	As Is	Vacated	Department GSF **
Medical Surgical	93,260	180,065	91,790	77,330	10,945		84, 825
Intensive Care	10,846	25,650	25,650			10,846	23,490
INTEGRATED PROCEDURE SERVICES							37,590
A) Surgery	19,166	37,354	37,354			19,166	
B) Endoscopy	2,961	3,468	3,468			2,961	
C) Special Procedures	946	2,004	2,004			946	
RECOVERY							22,380
A) PACU	2,092	3,750	3,750			2,092	3,350
B) Center for Short Stay Care	14,572	22,940	22,940			14,572	19,030
Respiratory Therapy	1,485	5,425	1,060	4,365		1,485	1,060
Laboratory	9,362	22,487	22,487			9,362	18,880
Pharmacy	4,135	8,229	8,229			4,135	7,360
Outpatient & Pre-Admission Testing	1,265	4,730	4,730			1,265	4,180
Inpatient Dialysis	717	1,105		1,105		717	1,105
Emergency Department	12,361	22,814		11,435	11,379		22,818
Admissions Unit	0	6,696		6,696			6,696
Cardiology	4,299	6,661		6,661		4,299	6,661
Nuclear Medicine	1,652	6,766		6,766		1,652	6,766
Radiology	20,068	31,732		16,889	14,843	2,421	31,732
Sub Total Clinical	**199,187**	**391,876**	**223,462**	**131,247**	**37,167**	**75,919**	

* GSF for new construction areas include external circultion i.e. BGSF. Modernized areas are DGSF,

* * Department GSF include internal circulation with 1/2 adjacent corridor space and exclude external circulation. See Attachment GRC-5(2) for department gsf.

PALOS COMMUNITY HOSPITAL

EAST WING EXPANSION

Preliminary Space Plans
For
Clinical Services

Medical Surgical Unit

156 Medical Surgical Beds

Functions	Proposed Program Total NSF	Circ. Factor	Total DGSF	Remarks
Summary NSF				
A. (4) 6 Bed Clusters	6,420	1.50	9,640	144 private rooms comprised of (4) 36 bed Med/Surg units (including 2 isolation rooms per uinit). Rooms include care/equipment alcoves, caregiver workstations alcoves
B. (2) 6 Bed Isolation Clusters	3,330	1.50	5,000	same as above plus isolation anterooms
C. (2) 18 Bed Support Zones	2,500	1.50	3,760	Team workstation, crash cart alcoves, MD workroom, automatic medication dispensing, nuurishment, clean/soiled linen, patient supply storage, family sub-family, staff toilets, etc.
D. Shared Clinical Support - 36 Bed Unit	615	1.35	830	Unit secretary workstation, non-unit caregiver workarea, equipment & wheelchair storage, etc.
Total Med/ Surg Unit - 2nd Floor	12,865	1.49	19,230	534 SF per bed
Total Med/ Surg Unit - 3rd Floor	12,865	1.49	19,230	Same as 2nd Floor
Total Med/ Surg Unit - 4th Floor	12,865	1.49	19,230	Same as 2nd Floor
Total Med/ Surg Unit - 5th Floor	12,865	1.49	19,230	Same as 2nd Floor
F. (2) Six Bed Clusters	3,550	1.60	5,680	12 private patient rooms, 1 isolation with anteroom, caregiver workstation alcoves, crash cart/equipment alcove automatic medication dispensing, linen cart alcove.
G. Shared Clinical & Support Zone	1,100	1.60	1,760	Team workstation, MD workroom, non-unit caregiver workarea, nourishment station, conference/report room, clean/soiled utility, strecher storage, staff toilet, housekeeping closet, PACS reading room, blood/gas POCT satellite lab, equipment storage
H. Shared Clinical & Admin Zone - 6th Floor*	290	1.60	465	PACS reading room, blood/gas POCT satellite lab, equipment storage
Total Med/ Surg Unit - 6th Floor (Step-Down Unit)	4,940	1.60	7,905	659 SF Per Bed
TOTAL MEDICAL SURGICAL	56,400	1.50	84,825	
			1.08	Circulation
			91,790	**TOTAL GSF**
			588	GSF per Medical Surgical Bed

Note: 1. *NSF - net square feet, DGSF - department gross square feet.*
2. *Circulation Factor - NSF to DGSF: allowance for interior circulation, total partition/column area, etc.*
** Shared Clinical & Staff Support on Floor 6 reflects shared support with 12 bed Med/Surg Step-Down unit.*

CODE	FUNCTIONAL ELEMENT	PROPOSED # OF RMS	PROPOSED NSF/ RM	PROPOSED TTL NSF / RM TYPE	REMARKS
	Medical Surgical Units	**156**	**Inpatient Beds**		
	A. 6 Bed Clusters				
	1. Medical/ Surgical Private Room	6	255	1,530	Private room sound-attenuated for privacy; patient bed, cubicle curtain & IV track; overbed table, reading lamp, television, radio, two visitor chairs; nurse call/communication system; visualization from caregiver workstation; couch or futton for overnight family accommodation; includes toilet/shower/lavatory; charting space provided within room, monitor; direct & indirect lighting w/ dimmer switches; hand-free sink in cabinet with hand-free paper towel dispenser; digital clock, patient supplies storage cart
	2. Cart/Equipment Alcove	3	15	45	parking spot crash, procedure, isolation cart
	3. Caregiver Workstation Alcove	1	30	30	One per 6 Bed Cluster; computer; storage for supplies, forms, reference material; seating for two staff; glucose monitor; phone
	SUBTOTAL-NSF			**1,605**	
	Circulation Factor			1.50	Corridor circulation inside dept.
	TOTAL FOR 6 BED CLUSTER-DGSF			**2,410**	
	Number of 6 Bed Clusters			4	
	(4) 6 Bed Clusters			**9,640**	
	B. 6 Bed Cluster w/ Isolation				
	1. Medical/ Surgical Private Room	5	255	1,275	Private room sound-attenuated for privacy; patient bed, cubicle curtain & IV track; overbed table, reading lamp, television, radio, two visitor chairs; nurse call/communication system; visualization from caregiver workstation; couch or futton for overnight family accommodation; includes toilet/shower/lavatory; charting space provided within room; monitor; direct & indirect lighting w/ dimmer switches; hand-free sink in cabinet with hand-free paper towel dispenser; digital clock; patient supplies storage cart
	2. Isolation Anteroom	1	60	60	Work counter, sink, soiled linen cart
	3. Medical/ Surgical Isolation Room	1	255	255	Private room sound-attenuated for privacy; patient bed, cubicle curtain & IV track; equipped for dialysis; overbed table, reading lamp, television, radio, two visitor chairs; nurse call/communication system; visualization from caregiver workstation; couch or futton for overnight family accommodation; includes toilet/shower/lavatory, charting space provided within room; monitor; direct & indirect lighting w/ dimmer switches; hand-free sink in cabinet with hand-free paper towel dispenser; digital clock; patient supplies storage cart
	4. Cart/Equipment Alcove	3	15	45	parking spot crash, procedure, isolation cart
	5. Caregiver Workstation Alcove	1	30	30	One per 6 Bed Cluster; computer; storage for supplies, forms, reference material; seating for two staff; glucose monitor; phone
	SUBTOTAL-NSF			**1,665**	
	Circulation Factor			1.50	Corridor circulation inside dept
	TOTAL FOR 6 BED CLUSTER-DGSF			**2,500**	
	Number of 6 Bed Isolation Clusters			2	
	(2) 6 Bed Isolation Clusters			**5,000**	
	C. Shared Clinical Support - 18 Bed Cluster				
	1. Team Workstation	1	190	190	Seating for 4 staff, central monitoring station, storage for forms & reference materials, printers; copiers, fax
	2. Crash Cart Alcove	1	15	15	Parking spot near Team Workstation for crash cart or transfer equipment; electrical outlet, possible storage for supplies above
	3. MD Workroom	1	140	140	Accommodates up to 4 MD's at modular workstations with computers and phones; separate PACS Viewing station.
	4. Automated Medication Dispensing	1	30	30	
	5. Nourishment Station	1	90	90	Space to accommodate one closed dietary cart; work counter w/ sink; wall and base storage cabinets; undercounter refrigerator; undercounter freezer; microwave oven; countertop ice maker; toaster; hot water tap at sink to make instant coffee and tea; appropriate ventilation
	6. Conference Room	1	270	270	Table & chairs to seat up to 15; marker board, computer workstation for clinical education
	7. Clean Linen Cart Alcove	1	30	30	Exchange cart alcove
	8. Clean Patient Supply Storage	1	180	180	Centralized location, accessible from two sides; work counter w/ base & wall storage cabinets; sink w/ soap & paper towel dispenser, supply carts; shelving; blanket warmer
	9. Soiled Utility	1	100	100	Centralized location, accessible from two sides; stainless steel double sink; soap & paper towel dispensers; countertop w/ wall & base storage cabinets, linen hamper; trash containers; hazardous waste disposal; clinical service sink;
	10. Family Sub-wait	1	80	80	Small seating area for families
	11. Staff Toilet	1	65	65	ADA compliant; toilet, lavatory, mirror & accessories
	12. Housekeeping Closet	1	60	60	Storage of housekeeping supplies to be used by Environmental Services staff; mop sink; shelves
	SUBTOTAL-NSF			**1,250**	
	Circulation Factor			1.50	Corridor circulation inside dept.
	TOTAL-DGSF			**1,880**	
	Number of 18 Bed Support Zones			2	
	(2) 18 Bed Support Zones			**3,760**	

CODE	FUNCTIONAL ELEMENT	PROPOSED # OF RMS	NSF/ RM	TTL NSF / RM TYPE	REMARKS
D. Shared Clinical Support - 36 Bed Unit					
	1. Unit Secretary/Clerk	1	150	150	Unit Secretary/Clerk primary location; control point to unit/ visualization of waiting area, storage for forms & reference materials, printers; copiers, fax; seating for 2
	3. Non-unit Caregiver Workarea	1	120	120	3 workstations with PCs, phone, forms/reference material storage; shared printer
	4. Pneumatic Tube Station	1	15	15	Locate adjacent to Unit Sec/Clerk
	5. Stretcher/Wheelchair Storage	1	80	80	assumes central transport model is developed
	6. Equipment Storage	1	250	250	Scales, specialty carts, ultrasound machine
SUBTOTAL-NSF				615	
	Circulation Factor			1.35	Corridor circulation inside dept.
TOTAL-DGSF				830	
E1. Sixth Floor - Bed Cluster 1		**6**	**Inpatient Beds**		
	1. Medical Surgical Step-Down Private Room	5	260	1,300	Private room; min dimensions 15'w x 18'd'- includes enclosed toilet room; Nurse server accessed from corridor & room;Double-wide opening (break-away doors entry into rooms); visualization from caregiver workstation; monitors; sound-attenuated for privacy; electric bed; direct & indirect lighting w/ dimmer switches; overbed table; TV; hand-free sink in cabinet with hand-free paper towel dispenser; cubicle curtain & IV track; digital clock; nurse call/communication system; patient supplies storage cart; family seating area with ability to convert to sleeping position.
	2. Isolation Anteroom	1	60	60	Work counter, sink, soiled linen cart
	3. Inpatient Isolation Room	1	260	260	Private room; min dimensions 15'w x 18'd'- includes enclosed toilet room; Nurse server accessed from corridor & room; Double-wide opening (break-away doors entry into rooms); one door directly to patient room and one door from ante room, visualization from caregiver workstation; monitors; sound-attenuated for privacy; electric bed; direct & indirect lighting w/ dimmer switches; overbed table; TV; hand-free sink in cabinet with hand-free paper towel dispenser; cubicle curtain & IV track; digital clock; nurse call/communication system; patient supplies storage cart; family seating area with ability to convert to sleeping position.
	4. Caregiver Workstation Alcove	3	30	90	Visualization into two patient rooms; computers (2); storage for supplies, forms, reference material; seating for two staff; glucose monitor; phone
	5. Crash Cart/Equipment Alcove	1	15	15	parking spot for crash cart or transfer equipment; electrical outlet; possible storage for supplies above
	6. Automated Medication Dispensing	1	30	30	
	7. Linen Exchange Cart Alcove	1	20	20	1 cart
SUBTOTAL-NSF				**1,775**	
	Circulation Factor			1.6	Corridor circulation inside dept.
TOTAL-DGSF				**2,840**	
E2. Sixth Floor - Bed Cluster 2		**6**	**Inpatient Beds**		
	1. Medical Surgical Step-Down Private Room	5	260	1,300	Private room; min dimensions 15'w x 18'd'- includes enclosed toilet room; Nurse server accessed from corridor & room;Double-wide opening (break-away doors entry into rooms); visualization from caregiver workstation; monitors, sound-attenuated for privacy; electric bed; direct & indirect lighting w/ dimmer switches; overbed table, TV; hand-free sink in cabinet with hand-free paper towel dispenser, cubicle curtain & IV track; digital clock, nurse call/communication system; patient supplies storage cart; family seating area with ability to convert to sleeping position.
	2. Isolation Anteroom	1	60	60	Work counter, sink, soiled linen cart
	3. Inpatient Isolation Room	1	260	260	Private room; min dimensions 15'w x 18'd'- includes enclosed toilet room; Nurse server accessed from corridor & room; Double-wide opening (break-away doors entry into rooms); one door directly to patient room and one door from ante room, visualization from caregiver workstation; monitors; sound-attenuated for privacy; electric bed; direct & indirect lighting w/ dimmer switches; overbed table; TV; hand-free sink in cabinet with hand-free paper towel dispenser; cubicle curtain & IV track; digital clock; nurse call/communication system; patient supplies storage cart; family seating area with ability to convert to sleeping position
	4. Caregiver Workstation Alcove	3	30	90	Visualization into two patient rooms; computers (2); storage for supplies, forms, reference material; seating for two staff; glucose monitor; phone
	5. Crash Cart/Equipment Alcove	1	15	15	parking spot for crash cart or transfer equipment; electrical outlet; possible storage for supplies above
	6. Automated Medication Dispensing	1	30	30	
	7. Linen Exchange Cart Alcove	1	20	20	1 cart
SUBTOTAL-NSF				**1,775**	
	Circulation Factor			1.6	Corridor circulation inside dept.
TOTAL-DGSF				**2,840**	
TOTAL-DGSF				**5,680**	**(2) Six Bed Clusters**

CODE	FUNCTIONAL ELEMENT	PROPOSED # OF RMS	PROPOSED NSF/RM	PROPOSED TTL NSF / RM TYPE	REMARKS
F. Shared Clinical & Administrative Support - 12 Bed Pod					
1	Team Workstation	1	180	180	Unit Secretary/Clerk primary location; central monitoring station, storage for forms & reference materials, printers; copiers, fax; seating for 4
2.	Pneumatic Tube Station	1	15	15	Locate at Team Workstation
3.	MD Workroom	1	150	150	4 charting/dictation stations;PACS Reading station; located adjacent/behind team workstation with visualization into room
4.	Non-unit Caregiver Workarea	1	120	120	3 workstations with PCs, phone, forms/reference material storage; shared printer
5	Nourishment Station	1	70	70	Space to accommodate one closed dietary cart, work counter w/ sink; wall and base storage cabinets; undercounter refrigerator; undercounter freezer; microwave oven; countertop ice maker; toaster; Hot water tap at sink to make instant coffee and tea; appropriate ventilation
6.	Conference/Report Room	1	160	160	Table & chairs to seat 8; marker board; computer workstation for clinical education: consider locating back-to-back with Pod CD conference room if possible
7.	Clean Utility	1	180	180	Centralized location; accessible from two sides, work counter w/ base & wall storage cabinets; sink w/ soap & paper towel dispenser; supply carts; shelving; blanket warmer; includes area for IV Prep and storage of IV Supplies
8.	Soiled Utility	1	100	100	Centralized location; accessible from two sides; stainless steel double sink; soap & paper towel dispensers; countertop w/ wall & base storage cabinets; linen hamper; trash containers; hazardous waste disposal; clinical service sink;
9.	Stretcher/Wheelchair Storage	0	80	0	asumes central transport model is developed
11.	Staff Toilet	1	65	65	ADA compliant; toilet, lavatory, mirror & accessories
12.	Housekeeping Closet	1	60	60	Storage of housekeeping supplies to be used by Environmental Services staff; mop sink; shelves
SUBTOTAL-NSF				1,100	
	Circulation Factor			1.6	Corridor circulation inside dept.
TOTAL-DGSF				1,760	
G. Shared Clinical & Admin Support					
2.	PACS Reading Room	1	90	90	Digital reading station, monitors, viewboxs
3.	Blood Gas/POCT Satellite Lab	1	200	200	Work counter, sink, label printer, computer; POCT equipment; POCT supply storage; refrigerator; should be located accessible from each pod
SUBTOTAL-NSF				290	
	Circulation Factor			1.60	Corridor circulation inside dept.
TOTAL-DGSF				465	
TOTAL-DGSF				7,905	**12 Bed Medical Surgical Step Down**

19,230 Each 36 Bed Unit - Floors 2, 3, 4 & 5
76,920 Subtotal
7,905 Plus Step Down Unit - 6th Floor
84,825 Total DGSF
1.08 Circulation
91,790 Total BGSF Med/Surg Units (156 Beds)

Intensive Care

Functions	Proposed Program Total NSF	Circ. Factor	Total DGSF	Remarks
Summary NSF				
A. Bed Cluster A	1,775	1.60	2,840	6 critical private patient rooms, 1 isolation with anteroom, caregiver workstation alcoves, crash cart/equipment alcove automatic medication dispensing, linen cart alcove.
B. Bed Cluster B	1,775	1.60	2,840	Same as Bed Cluster A
C. Shared Clinical & Administrative Support - 12 Bed Pod AB	1,100	1.60	1,760	Team workstation, MD workroom, non-unit caregiver workarea, nourishment station, conference/report room, clean/soiled utility, strecher storage, staff toilet, housekeeping closet
D. Bed Cluster C	1,775	1.60	2,840	Same as Bed Cluster A
E. Bed Cluster D	1,775	1.60	2,840	Same as Bed Cluster A
F. Shared Clinical & Administrative Support - 12 Bed Pod CD	1,100	1.60	1,760	Same as C. above.
G. Shared Clinical & Admin Support - 7th Floor	490	1.60	780	PACS reading room, blood/gas POCT satellite lab, equipment storage
Total ICU Floor 7	9,790	1.60	15,660	(4) 6 Bed ICU Pods = 24 ICU Beds
A. Bed Cluster E	1,775	1.60	2,840	6 critical private patient rooms, 1 isolation with anteroom, caregiver workstation alcoves, crash cart/equipment alcove automatic medication dispensing, linen cart alcove.
B. Bed Cluster F	1,775	1.60	2,840	Same as Bed Cluster A
C. Shared Clinical & Administrative Support - 12 Bed Pod EF	1,100	1.60	1,760	Team workstation, MD workroom, non-unit caregiver workarea, nourishment station, conference/report room, clean/soiled utility, strecher storage, staff toilet, housekeeping closet
G. Shared Clinical & Admin Support - 6th Floor*	245	1.59	390	PACS reading room, blood/gas POCT satellite lab, equipment storage
Total ICU Floor 6	4,895	1.60	7,830	(2) 6 Bed ICU Pods = 12 ICU Beds
Total ICU Program	14,685	1.60	23,490	**(6) 6 Bed ICU Pods = Total 36 ICU Beds**
			1.09	Circulation
			25,650	**TOTAL GSF**
			713	GSF per ICU Bed

Note: 1. NSF - net square feet, DGSF - department gross square feet.
2. Circulation Factor - NSF to DGSF: allowance for interior circulation, total partition/column area, etc.
** Shared Clinical & Admin Support on Floor 6 reflects shared support with 12 bed Med/Surg Step-Down unit.*

CODE	FUNCTIONAL ELEMENT	PROPOSED # OF RMS	PROPOSED NSF/ RM	PROPOSED TTL NSF / RM TYPE	REMARKS
	Intensive Care Unit	**36**	**Total ICU Patient Beds**		
	A. Bed Cluster A	**6**	**Inpatient Beds**		
	1. Critical Care Private Room	5	260	1,300	Private room; min dimensions 15'w x 18'd'- includes enclosed toilet room; Nurse server accessed from corridor & room;Double-wide opening (break-away doors entry into rooms); visualization from caregiver workstation; monitors; sound-attenuated for privacy; electric bed; direct & indirect lighting w/ dimmer switches; overbed table; TV; hand-free sink in cabinet with hand-free paper towel dispenser; cubicle curtain & IV track; digital clock; nurse call/communication system; patient supplies storage cart; family seating area with ability to convert to sleeping position.
	2. Isolation Anteroom	1	60	60	Work counter, sink, soiled linen cart
	3. Inpatient Isolation Room	1	260	260	Private room; min dimensions 15'w x 18'd'- includes enclosed toilet room; Nurse server accessed from corridor & room; Double-wide opening (break-away doors entry into rooms); one door directly to patient room and one door from ante room; visualization from caregiver workstation; monitors; sound-attenuated for privacy; electric bed; direct & indirect lighting w/ dimmer switches; overbed table; TV; hand-free sink in cabinet with hand-free paper towel dispenser; cubicle curtain & IV track; digital clock; nurse call/communication system; patient supplies storage cart; family seating area with ability to convert to sleeping position.
	4. Caregiver Workstation Alcove	3	30	90	Visualization into two patient rooms; computers (2); storage for supplies, forms, reference material; seating for two staff; glucose monitor; phone
	5. Crash Cart/Equipment Alcove	1	15	15	parking spot for crash cart or transfer equipment; electrical outlet; possible storage for supplies above
	6. Automated Medication Dispensing	1	30	30	
	7. Linen Exchange Cart Alcove	1	20	20	1 cart
	SUBTOTAL-NSF			**1,775**	
	Circulation Factor			1.6	Corridor circulation inside dept.
	TOTAL-DGSF			**2,840**	
	B. Bed Cluster B	**6**	**Inpatient Beds**		
	1. Critical Care Private Room	5	260	1,300	Private room; min dimensions 15'w x 18'd'- includes enclosed toilet room; Nurse server accessed from corridor & room;Double-wide opening (break-away doors entry into rooms); visualization from caregiver workstation; monitors; sound-attenuated for privacy; electric bed; direct & indirect lighting w/ dimmer switches; overbed table; TV; hand-free sink in cabinet with hand-free paper towel dispenser; cubicle curtain & IV track; digital clock; nurse call/communication system; patient supplies storage cart; family seating area with ability to convert to sleeping position.
	2. Isolation Anteroom	1	60	60	Work counter, sink, soiled linen cart
	3. Inpatient Isolation Room	1	260	260	Private room; min dimensions 15'w x 18'd'- includes enclosed toilet room; Nurse server accessed from corridor & room; Double-wide opening (break-away doors entry into rooms); one door directly to patient room and one door from ante room; visualization from caregiver workstation; monitors; sound-attenuated for privacy; electric bed; direct & indirect lighting w/ dimmer switches; overbed table; TV; hand-free sink in cabinet with hand-free paper towel dispenser; cubicle curtain & IV track; digital clock; nurse call/communication system; patient supplies storage cart; family seating area with ability to convert to sleeping position.
	4. Caregiver Workstation Alcove	3	30	90	Visualization into two patient rooms; computers (2); storage for supplies, forms, reference material; seating for two staff; glucose monitor; phone
	5. Crash Cart/Equipment Alcove	1	15	15	parking spot for crash cart or transfer equipment; electrical outlet; possible storage for supplies above
	6. Automated Medication Dispensing	1	30	30	
	7. Linen Exchange Cart Alcove	1	20	20	1 cart
	SUBTOTAL-NSF			**1,775**	
	Circulation Factor			1.6	Corridor circulation inside dept.
	TOTAL-DGSF			**2,840**	

CODE	FUNCTIONAL ELEMENT	PROPOSED # OF RMS	PROPOSED NSF/ RM	PROPOSED TTL NSF / RM TYPE	REMARKS

Intensive Care Unit **36 Total ICU Patient Beds**

C. Shared Clinical & Administrative Support - 12 Bed Pod AB

1. Team Workstation	1	180	180	Unit Secretary/Clerk primary location; central monitoring station, storage for forms & reference materials, printers; copiers, fax; seating for 4
2. Pneumatic Tube Station	1	15	15	Locate at Team Workstation
3. MD Workroom	1	150	150	4 charting/dictation stations;PACS Reading station; located adjacent/behind team workstation with visualization into room
4. Non-unit Caregiver Workarea	1	120	120	3 workstations with PCs, phone, forms/reference material storage; shared printer
5. Nourishment Station	1	70	70	Space to accommodate one closed dietary cart; work counter w/ sink; wall and base storage cabinets; undercounter refrigerator; undercounter freezer, microwave oven; countertop ice maker; toaster; Hot water tap at sink to make instant coffee and tea; appropriate ventilation
6. Conference/Report Room	1	160	160	Table & chairs to seat 8; marker board; computer workstation for clinical education; consider locating back-to-back with Pod CD conference room if possible
7. Clean Utility	1	180	180	Centralized location; accessible from two sides; work counter w/ base & wall storage cabinets; sink w/ soap & paper towel dispenser; supply carts; shelving; blanket warmer; includes area for IV Prep and storage of IV Supplies
8. Soiled Utility	1	100	100	Centralized location; accessible from two sides; stainless steel double sink; soap & paper towel dispensers; countertop w/ wall & base storage cabinets; linen hamper; trash containers; hazardous waste disposal; clinical service sink;
9. Stretcher/Wheelchair Storage	0	80	0	asumes central transport model is developed
11. Staff Toilet	1	65	65	ADA compliant; toilet, lavatory, mirror & accessories
12. Housekeeping Closet	1	60	60	Storage of housekeeping supplies to be used by Environmental Services staff; mop sink; shelves
SUBTOTAL-NSF			1,100	
Circulation Factor			1.6	Corridor circulation inside dept.
TOTAL-DGSF			1,760	

D. Bed Cluster C **6 Inpatient Beds**

1. Critical Care Private Room	5	260	1,300	Private room; min dimensions 15'w x 18'd'- includes enclosed toilet room; Nurse server accessed from corridor & room;Double-wide opening (break-away doors entry into rooms); visualization from caregiver workstation; monitors; sound-attenuated for privacy; electric bed; direct & indirect lighting w/ dimmer switches, overbed table; TV; hand-free sink in cabinet with hand-free paper towel dispenser; cubicle curtain & IV track; digital clock; nurse call/communication system; patient supplies storage cart; family seating area with ability to convert to sleeping position.
2. Isolation Anteroom	1	60	60	Work counter, sink, soiled linen cart
3. Inpatient Isolation Room	1	260	260	Private room; min dimensions 15'w x 18'd'- includes enclosed toilet room; Nurse server accessed from corridor & room; Double-wide opening (break-away doors entry into rooms); one door directly to patient room and one door from ante room, visualization from caregiver workstation; monitors; sound-attenuated for privacy; electric bed; direct & indirect lighting w/ dimmer switches; overbed table; TV; hand-free sink in cabinet with hand-free paper towel dispenser; cubicle curtain & IV track; digital clock; nurse call/communication system; patient supplies storage cart; family seating area with ability to convert to sleeping position.
4. Caregiver Workstation Alcove	3	30	90	Visualization into two patient rooms; computers (2); storage for supplies, forms, reference material; seating for two staff; glucose monitor; phone
5. Crash Cart/Equipment Alcove	1	15	15	parking spot for crash cart or transfer equipment; electrical outlet; possible storage for supplies above
6. Automated Medication Dispensing	1	30	30	
7. Linen Exchange Cart Alcove	1	20	20	1 cart
SUBTOTAL-NSF			1,775	
Circulation Factor			1.6	Corridor circulation inside dept.
TOTAL-DGSF			2,840	

CODE	FUNCTIONAL ELEMENT	PROPOSED # OF RMS	PROPOSED NSF/ RM	PROPOSED TTL NSF / RM TYPE	REMARKS
Intensive Care Unit		**36**	**Total ICU Patient Beds**		
E.	**Bed Cluster D**	**6**	**Inpatient Beds**		
	1. Critical Care Private Room	5	260	1,300	Private room; min dimensions 15'w x 18'd'- includes enclosed toilet room; Nurse server accessed from corridor & room;Double-wide opening (break-away doors entry into rooms); visualization from caregiver workstation; monitors: sound-attenuated for privacy; electric bed; direct & indirect lighting w/ dimmer switches; overbed table; TV; hand-free sink in cabinet with hand-free paper towel dispenser; cubicle curtain & IV track; digital clock; nurse call/communication system; patient supplies storage cart; family seating area with ability to convert to sleeping position.
	2. Isolation Anteroom	1	60	60	Work counter, sink, soiled linen cart
	3. Inpatient Isolation Room	1	260	260	Private room; min dimensions 15'w x 18'd'- includes enclosed toilet room; Nurse server accessed from corridor & room; Double-wide opening (break-away doors entry into rooms); one door directly to patient room and one door from ante room; visualization from caregiver workstation; monitors; sound-attenuated for privacy; electric bed; direct & indirect lighting w/ dimmer switches; overbed table; TV; hand-free sink in cabinet with hand-free paper towel dispenser; cubicle curtain & IV track; digital clock; nurse call/communication system, patient supplies storage cart; family seating area with ability to convert to sleeping position.
	4. Caregiver Workstation Alcove	3	30	90	Visualization into two patient rooms; computers (2); storage for supplies, forms, reference material; seating for two staff; glucose monitor; phone
	5. Crash Cart/Equipment Alcove	1	15	15	parking spot for crash cart or transfer equipment; electrical outlet; possible storage for supplies above
	6. Automated Medication Dispensing	1	30	30	
	7. Linen Exchange Cart Alcove	1	20	20	1 cart
SUBTOTAL-NSF				**1,775**	
	Circulation Factor			1.6	Corridor circulation inside dept.
TOTAL-DGSF				**2,840**	
F.	**Shared Clinical & Administrative Support - 12 Bed Pod CD**				
	1. Team Workstation	1	180	180	Unit Secretary/Clerk primary location; central monitoring station, storage for forms & reference materials, printers; copiers, fax; seating for 4
	2. Pneumatic Tube Station	1	15	15	Locate at Team Workstation
	3. MD Workroom	1	150	150	4 charting/dictation stations,PACS Reading station; located adjacent/behind team workstation with visualization into room
	4. Non-unit Caregiver Workarea	1	120	120	3 workstations with PCs, phone, forms/reference material storage; shared printer
	5. Nourishment Station	1	70	70	Space to accommodate one closed dietary cart; work counter w/ sink; wall and base storage cabinets; undercounter refrigerator; undercounter freezer; microwave oven; countertop ice maker; toaster; Hot water tap at sink to make instant coffee and tea; appropriate ventilation
	6. Conference/Report Room	1	160	160	Table & chairs to seat 8; marker board; computer workstation for clinical education; consider locating back-to-back with Pod CD conference room if possible
	7. Clean Utility	1	180	180	Centralized location; accessible from two sides; work counter w/ base & wall storage cabinets; sink w/ soap & paper towel dispenser; supply carts; shelving; blanket warmer; includes area for IV Prep and storage of IV Supplies
	8. Soiled Utility	1	100	100	Centralized location; accessible from two sides, stainless steel double sink; soap & paper towel dispensers; countertop w/ wall & base storage cabinets; linen hamper; trash containers; hazardous waste disposal; clinical service sink;
	9. Stretcher/Wheelchair Storage	0	80	0	Assumes central transport model is developed
	11. Staff Toilet	1	65	65	ADA compliant; toilet, lavatory, mirror & accessories
	12. Housekeeping Closet	1	60	60	Storage of housekeeping supplies to be used by Environmental Services staff; mop sink; shelves
SUBTOTAL-NSF				**1,100**	
	Circulation Factor			1.6	Corridor circulation inside dept.
TOTAL-DGSF				**1,760**	

CODE	FUNCTIONAL ELEMENT	PROPOSED # OF RMS	PROPOSED NSF/ RM	PROPOSED TTL NSF / RM TYPE	REMARKS
	Intensive Care Unit	**36**	**Total ICU Patient Beds**		
	G. Shared Clinical Support - 24 Bed Unit				
	1. PACS Reading Room	1	90	90	Digital reading station, monitors, viewboxs
	2. Blood Gas/POCT Satellite Lab	1	200	200	Work counter, sink, label printer, computer; POCT equipment; POCT supply storage; refrigerator; should be located accessible from each pod
	3. Equipment Storage	1	200	200	Scales, specialty carts, ultrasound machine
	SUBTOTAL-NSF			**490**	
	Circulation Factor			1.60	Corridor circulation inside dept.
	TOTAL-DGSF			**780**	
	B. Bed Cluster E	**6**	**Inpatient Beds**		
	1. Critical Care Private Room	5	260	1,300	Private room; min dimensions 15'w x 18'd'- includes enclosed toilet room; Nurse server accessed from corridor & room;Double-wide opening (break-away doors entry into rooms); visualization from caregiver workstation; monitors; sound-attenuated for privacy; electric bed; direct & indirect lighting w/ dimmer switches; overbed table; TV; hand-free sink in cabinet with hand-free paper towel dispenser; cubicle curtain & IV track; digital clock; nurse call/communication system; patient supplies storage cart; family seating area with ability to convert to sleeping position.
	2. Isolation Anteroom	1	60	60	Work counter, sink, soiled linen cart
	3. Inpatient Isolation Room	1	260	260	Private room; min dimensions 15'w x 18'd'- includes enclosed toilet room; Nurse server accessed from corridor & room; Double-wide opening (break-away doors entry into rooms); one door directly to patient room and one door from ante room; visualization from caregiver workstation; monitors; sound-attenuated for privacy; electric bed; direct & indirect lighting w/ dimmer switches; overbed table; TV; hand-free sink in cabinet with hand-free paper towel dispenser; cubicle curtain & IV track; digital clock; nurse call/communication system; patient supplies storage cart; family seating area with ability to convert to sleeping position.
	4. Caregiver Workstation Alcove	3	30	90	Visualization into two patient rooms; computers (2); storage for supplies, forms, reference material; seating for two staff; glucose monitor; phone
	5. Crash Cart/Equipment Alcove	1	15	15	parking spot for crash cart or transfer equipment; electrical outlet; possible storage for supplies above
	6. Automated Medication Dispensing	1	30	30	
	7. Linen Exchange Cart Alcove	1	20	20	1 cart
	SUBTOTAL-NSF			**1,775**	
	Circulation Factor			1.6	Corridor circulation inside dept.
	TOTAL-DGSF			**2,840**	
	B. Bed Cluster F	**6**	**Inpatient Beds**		
	1. Critical Care Private Room	5	260	1,300	Private room; min dimensions 15'w x 18'd'- includes enclosed toilet room; Nurse server accessed from corridor & room;Double-wide opening (break-away doors entry into rooms); visualization from caregiver workstation; monitors; sound-attenuated for privacy; electric bed; direct & indirect lighting w/ dimmer switches; overbed table; TV; hand-free sink in cabinet with hand-free paper towel dispenser; cubicle curtain & IV track; digital clock; nurse call/communication system; patient supplies storage cart; family seating area with ability to convert to sleeping position.
	2. Isolation Anteroom	1	60	60	Work counter, sink, soiled linen cart
	3. Inpatient Isolation Room	1	260	260	Private room; min dimensions 15'w x 18'd'- includes enclosed toilet room; Nurse server accessed from corridor & room; Double-wide opening (break-away doors entry into rooms); one door directly to patient room and one door from ante room; visualization from caregiver workstation; monitors; sound-attenuated for privacy; electric bed; direct & indirect lighting w/ dimmer switches; overbed table; TV; hand-free sink in cabinet with hand-free paper towel dispenser; cubicle curtain & IV track; digital clock; nurse call/communication system; patient supplies storage cart; family seating area with ability to convert to sleeping position.
	4. Caregiver Workstation Alcove	3	30	90	Visualization into two patient rooms; computers (2); storage for supplies, forms, reference material; seating for two staff; glucose monitor; phone
	5. Crash Cart/Equipment Alcove	1	15	15	parking spot for crash cart or transfer equipment; electrical outlet; possible storage for supplies above
	6. Automated Medication Dispensing	1	30	30	
	7. Linen Exchange Cart Alcove	1	20	20	1 cart
	SUBTOTAL-NSF			**1,775**	
	Circulation Factor			1.6	Corridor circulation inside dept.
	TOTAL-DGSF			**2,840**	

CODE	FUNCTIONAL ELEMENT	PROPOSED # OF RMS	NSF/ RM	TTL NSF / RM TYPE	REMARKS
Intensive Care Unit		**36**	**Total ICU Patient Beds**		
J.	**Shared Clinical & Administrative Support - 12 Bed Pod EF**				
	1. Team Workstation	1	180	180	Unit Secretary/Clerk primary location; central monitoring station; storage for forms & reference materials; printers, copiers, fax; seating for 4
	2. Pneumatic Tube Station	1	15	15	Locate at Team Workstation
	3. MD Workroom	1	150	150	4 charting/dictation stations;PACS Reading station; located adjacent/behind team workstation with visualization into room
	4. Non-unit Caregiver Workarea	1	120	120	3 workstations with PCs, phone, forms/reference material storage; shared printer
	5. Nourishment Station	1	70	70	Space to accommodate one closed dietary cart; work counter w/ sink, wall and base storage cabinets; undercounter refrigerator; undercounter freezer, microwave oven; countertop ice maker; toaster; Hot water tap at sink to make instant coffee and tea; appropriate ventilation
	6. Conference/Report Room	1	160	160	Table & chairs to seat 8; marker board; computer workstation for clinical education; consider locating back-to-back with Pod CD conference room if possible
	7. Clean Utility	1	160	180	Centralized location; accessible from two sides; work counter w/ base & wall storage cabinets; sink w/ soap & paper towel dispenser; supply carts, shelving; blanket warmer; includes area for IV Prep and storage of IV Supplies
	8. Soiled Utility	1	100	100	Centralized location; accessible from two sides; stainless steel double sink; soap & paper towel dispensers; countertop w/ wall & base storage cabinets, linen hamper; trash containers, hazardous waste disposal; clinical service sink;
	9. Stretcher/Wheelchair Storage	0	80	0	Assumes central transport model is developed
	11. Staff Toilet	1	65	65	ADA compliant; toilet, lavatory, mirror & accessories
	12. Housekeeping Closet	1	60	60	Storage of housekeeping supplies to be used by Environmental Services staff; mop sink; shelves
SUBTOTAL-NSF				**1,100**	
	Circulation Factor			1.6	Corridor circulation inside dept.
TOTAL-DGSF				**1,760**	
K.	**Shared Clinical Support***				
	2. PACS Reading Room	1	90	90	Digital reading station, monitors, viewboxs
	3. Blood Gas/POCT Satellite Lab	1	200	200	Work counter, sink, label printer, computer; POCT equipment; POCT supply storage; refrigerator; should be located accessible from each pod
	4. Equipment Storage	1	200	200	Scales, specialty carts, ultrasound machine
SUBTOTAL-NSF				**490**	
	Circulation Factor			1.60	Corridor circulation inside dept.
TOTAL-DGSF				**780**	
				390	**Shared with Step-Down Med/Surg Unit - Reflects half of total GSF*
				23,490	TOTAL
				1.09	Circulation
				25,650	Total BGSF

Integrated Procedure Services

See Integrated Procedure Services block diagram

Functions		Total NSF	Proposed Program Circ. Factor	Total DGSF	Remarks
Summary NSF					
A.	OR Procedure Zone	9,190	1.60	14,700	12 ORs, 4 endoscopy rooms, 1 special procedure room and one minor procedure room - supported by 15 bed PACU
B.	Endoscopy Zone	2,050	1.50	3,080	
C.	Special & Minor Procedures	1,205	1.50	1,810	
D.	Clinical Support - Clean Core	1,050	1.60	1,680	
E.	Clinical Support - Soiled Processing	810	1.50	1,220	
F.	Clinical Support - Transitional Zone	6,310	1.50	9,470	
G.	Clinical Support - Anesthesia Satellite	1,130	1.50	1,700	
H.	Shared Physician & Staff Support	2,910	1.35	3,930	
Total Square Footages		24,655	1.52	37,590	
				1.14 Circulation	
				42,826	TOTAL BGSF

Note: *1. NSF - net square feet, DGSF - department gross square feet.*
2. Circulation Factor - NSF to DGSF: allowance for intradepartmental circulation, interior partitions, etc.

		PROPOSED			
?E	FUNCTIONAL ELEMENT	# OF RMS	NSF/ RM	TTL NSF / RM TYPE	REMARKS
	OR Procedure Zone	(14 Total Procedure Rooms)			
	Procedure Zone				
	1. Operating Room - General	8	650	5,200	ORs to be designed as universal rooms - 6' door opening; rooms to include - piped in gases with individual room shut offs; patient monitoring equipment, consider ceiling mounted; viewboxes, recessed storage cabinets; charting area with computer access; video/audio; emergency communications to OR control desk
	2. Operating Room - Robotic	2	800	1,600	ORs to be designed as universal rooms - 6' door opening; rooms to include - piped in gases with individual
	3. Operating Room - CV	2	720	1,440	
	4. Heart Lung Pump Room	1	200	200	Adjacent to CV OR; access from both ORs and from corridor; strip electric outlets; computer
	5. Minor Procedure Room	1	300	300	Set-up for various procedures requiring partial anesthesia or conscious sedation; fully equipped OR; piped in gases with individual room shut off; patient monitoring equipment, consider ceiling mounted; viewboxes, recessed storage cabinets; charting area with computer access; video/audio
	6. Cystoscopy Procedure Room	1	450	450	Space includes control area- 6' door opening; flushing rim floor drain; specialty urological table; piped in gases with individual room shut off; patient monitoring equipment, consider ceiling mounted; viewboxes, recessed storage cabinets; charting area with computer access; video/audio
	Sub-Total, NSF			9,190	
	Circulation Factor			1.60	Corridor circulation inside dept.
	Sub-Total, DGSF			14,700	
B.	**Endoscopy Zone**	(4 Total Procedure Rooms)			
	Procedure Zone				
	1. Endoscopy Procedure Room	2	250	500	Medical gases required; anesthesia cart; equipment/monitors mounted on boom; patient monitoring equipment; 2 negature pressures with ante room (one fluoro, one non-fluoro); enclosed storage cabinets; charting area with computer access; video/audio; 5' doors
	2. Endoscopy Procedure Room w/ Fluoroscopy	2	300	600	One room with fluoroscopy capabilities; one room "fluoro ready"; includes control alcove
	3. Patient Toilet	1	65	65	ADA compliant; toilet, lavatory, mirror & accessories
	4. Caregiver Workstation	1	80	80	Control point to GI Lab area; handwashing sink; writing surface, computer; storage cabinets; workarea for 2 staff; pneumatic tube station
	Scope Zone				
	5. Scope Processing Area	1	320	320	Immediately adjacent to procedure rooms; work counter, storage cabinets; special exhaust; set up for negative or positive pressure; 4 AER sterilizers; 2 separate sink stations (clean/dirty)
	6. Scope Storage	1	120	120	Enclosed room accessible from scope processing area and corridor; vertical storage of scopes
	GI Transitional Zone				
	7. GI Equipment Storage	1	200	200	Storage for laser; ERCP cart; specialty equipment; 4 video carts
	8. Clean Supply Storage	1	150	150	Includes linen cart(1); blanket warmer; supply carts (2); automated medication dispenser
	9. Crash Cart Alcove	1	15	15	Easily accessible
	otal, NSF			2,050	
	Circulation Factor			1.60	Corridor circulation inside dept.
	ub-Total, DGSF			3,280	
C.	**Special & Minor Procedures Zone**	(1 Total Procedure Rooms)			
	Procedure Zone				
	1. Interventional Procedure Room	1	600	600	Adjacent to OR clean core; HVAC, power, lighting, & finishes to meet OR standards; medical gas column; 1 negature pressure with ante room; patient monitors; viewbox; apron rack; handwashing sink w/paper towel & soap dispenser; work counter w/ base & wall storage cabinets; linen hamper; indirect & direct lighting w/ dimming switches; clock; crash cart; medication dispensing unit or cart
	2. Control Room	1	240	240	Control console; maximize visualization into scan room; direct access to scan room from control area and from access corridor; intercom to scan room; viewbox; workarea for 5 staff.
	3. Equipment Storage	1	80	80	Storage for back-up supplies; lead aprons in horizontal storage drawers
	Specials Transitional Zone				
	1. Clean Supply Storage	1	150	150	Includes linen cart(1); blanket warmer; supply carts (2);
	2. Crash Cart Alcove	1	15	15	Easily accessible
	3. Staff Workroom	1	120	120	Enclosed room located near procedure zone; 4 staff workareas with PC, phone; pneumatic tube station
	Sub-Total, NSF			1,205	
	Circulation Factor			1.50	Corridor circulation inside dept.
	Sub-Total, DGSF			1,810	
D.	**Clinical Support - Clean Core**				
	1. Staff Workstations	1	100	100	Workarea for 2 staff; computer, phone, printers
	2. On-Dock Case Cart Staging	12	30	360	Located near access to each OR for next case
	3. Equipment / Exchange Cart Storage	14	10	140	Specialty carts & linens; includes 6 emergency carts
	4. Anesthesia Supply Carts	4	10	40	Anesthesia back-up storage
	5. Pneumatic Tube Station	1	15	15	
	6. Clean Supply Storage	1	255	255	Area to store clean supplies; assumes 14 5' shelving units; full-size ice maker
	7. Case Cart Staging	0	10	0	Primary staging in SSP below; on deck case accommodated in D2
	8. Medication Dispensing Unit Alcove	2	30	60	Centrally located
	9. CV OR Case Cart Storage	8	10	80	CV OR case carts to be held separate from main OR
	Sub-Total, NSF			1,050	
	Circulation Factor			1.60	Corridor circulation inside dept.
	ub-Total, DGSF			1,680	

E. Clinical Support - Soiled Processing

1. Sub-Decontamination	1	120	120	Case cart holding area for carts awaiting transfer to SSP, case carts are moved from holding areas adjacent to ORs and Waste is segregated as to type
2. Soiled Hold / Housekeeping	10	45	450	1 room per 2 ORs/procedure rooms includes GI & IVR rooms; intended to hold waste generated during cases in adjoining ORs. This is a temporary hold area to facilitate room turnover; needs to accommodate case carts and bagged waste; should also contain mop & buckets, slop sink
3. Housekeeping Equipment	1	120	120	Area dedicated to the equipment used to clean surgery, includes capability of charging battery operated floor scrubbers as well as other special cleaning equipment
4. Soiled Elevator Staging Area	1	120	120	Area outside soiled elevator; accessible from Sub-decontamination area; two-sided elevator with access to SSP decontam & egress path to main hospital dock
Sub-Total, NSF			810	
Circulation Factor			1.50	Corridor circulation inside dept.
Sub-Total, DGSF			1,220	

F. Clinical Support - Transitional Zone

1. Scrub Station Alcove	8	60	480	One for every 2 ORs/cysto, minor & IVR rooms- double scrub sinks with window to each OR, no scrub sink required for GI rooms
2. Sub-Sterile	8	160	1,280	One module shared between 2 ORs, access from OR and Transitional Zone; flash sterilizers; blanket & fluid warmers; supply cabinets; linen cart; handwashing sink, ice maker; pneumatic tube station; blood refrigerator
3. Satellite Instrument Processing Rooms	2	240	480	Processing rooms for sterilization of instrumentation during case; access from both transitional zone & pass-thru to clean core; workcounter; 2 separate sink work areas (clean/dirty); supply storage - 4 shelving units; AER & sterilizer
4. Equipment Storage	4	350	1,400	Dispersed equipment storage areas; important that equipment storage is proximal to all ORs; shelving, but most equipment will be on wheels; consider specially designed wall mounted storage for OR table accessories; strip electric outlets
5. Equipment Storage - Clean	1	600	600	Equipment Storage room located off clean core
6. CV OR Equipment/Supply Storage	1	200	200	Space for 6 carts; wheeled equipment
7. Dictation/Computer Work Area	4	40	160	Small work areas geographically dispersed to serve the entire OR suite evenly
8. C-arm/Equipment Alcoves	7	30	210	In clean corridor; electrical outlets
9 Stretcher Storage Alcove	15	25	375	3' x 8' alcove adjacent to each OR & IVR
10. Central Control Station	1	220	220	Central control point monitoring all traffic into OR Suites - staff & patients; central location for patient tracking display board; seating for up to 6 staff; 3 computers, phone, printers, copier; pneumatic tube station
11. Scheduling Workstation	1	120	120	Located adjacent/behind control station; workstations w/ PC, phone & storage for 2 staff
12. Frozen Section Room	0	175	0	conveyance of sample to Anatomical Pathology section of the Clinical Lab completed thru dedicated dumbwaiter
14. Staff Toilet	5	65	325	ADA compliant; toilet, lavatory, mirror & accessories; one in GI Zone; one in IVR Zone
15. Imaging PACS Workroom	2	80	160	Room with PACS reading stations, located adjacent to IVR Zone
Sub-Total, NSF			6,010	
Circulation Factor			1.50	Corridor circulation inside dept.
Sub-Total, DGSF			9,020	

G. Clinical Support - Anesthesia Satellite

1. Soiled Hold	1	60	60	Clinical sink; trash
2. Equipment Storage	1	150	150	Area to store anesthesia equipment
3. Drug Storage	0	50	0	Not required; anesthesia utilizes satellite pharmacy
4. Supply Storage	1	180	180	Area to store clean supplies; shelving or carts; sink with small workcounter
5. Staff Workroom	1	640	640	Enclosed room with 20 workstations; bookcase/file storage
6 Gas Tank Storage (Portable)	1	100	100	Provision for reserve gas cylinders necessary to complete at least one day's procedures
Sub-Total, NSF			1,130	
Circulation Factor			1.50	Corridor circulation inside dept.
Sub-Total, DGSF			1,700	

H. Shared Physician & Staff Support

Locker areas support IPS functions (CSSC Separate)

1. Staff Locker - Female	1	740	740	195 lockers; "Z" type lockers; coat closet; drying area for wet boots/shoes includes space for scrubs storage & linen hampers; lockers to have keypad code locks
2. Staff Toilet/Shower - Female	1	225	225	
3. Staff Locker - Male	1	650	650	170 "Z" type lockers; coat closet; drying area for wet shoes/boots; includes space for scrubs storage & linen hampers; lockers to have keypad code locks
4. Staff Toilet/Shower - Male	1	225	225	
5. Staff Lounge	1	550	550	Pantry area w/ refrigerator, sink, coffee, microwave, seat 25 table & chairs, tackboard, television
6. On-Call Rooms	4	130	520	Utilize locker area for shower/toilet access; each has sleep space for two
Sub-Total, NSF			2,910	
Circulation Factor			1.35	Corridor circulation inside dept.
Sub-Total, DGSF			3,930	

37,590 Total DGSF
1.14 Circulation
42,826 Total BGSF
19 Total Procedure Rooms

Post-Anesthesia Recovery Care Unit (PACU)

Functions	Total NSF	Proposed Program Circ. Factor	Total DGSF	See Integrated Procedure Services block diagram Remarks
Summary NSF				
A. **Post Anesthesia Recovery Unit - Primary Functions**	1,280	1.50	1,920	
B. **Post Anesthesia Recovery Unit - Support Functions**	950	1.50	1,430	15 Bed PACU supports Integrated Procedure Services (IPS)
Total Square Footages	2,230	1.50	3,350	
			1.12 Circulation	
			3,750	**TOTAL GSF**

Note: *1. NSF - net square feet, DGSF - department gross square feet.*
2. Circulation Factor - NSF to DGSF: allowance for intradepartmental circulation, interior partitions, etc.

Palos Community Hospital
Palos Heights, IL

Post-Anesthesia Recovery Care Unit (PACU)

A. Post Anesthesia Recovery Unit - Primary Functions

1. Post Anesthesia Recovery Position	13	80	1,040	Individual stretcher bays separated by cubicle curtains; monitors; headwall unit w/ medical gases; writing surface; hazmat/trash receptacles, stool
2. Post Anesthesia Recovery Isolation / Private Position	2	120	240	Configuration similar to bays; enclosed room for utilized for isolation & pediatric patients
Sub-Total, NSF			1,280	
Circulation Factor			1.50	Corridor circulation inside dept
Sub-Total, DGSF			1,920	

B. Post Anesthesia Recovery Unit - Support Functions

1. Control/Team Station	1	280	280	Control point to PACU area; central monitor station; handwashing sink; writing surface, computer; storage cabinets; workarea for 8 staff
2. Staff Handwashing alcoves	4	15	60	Small hands-free operating sink, soap & paper towel dispensers, antiseptic hand rub
3. Crash Cart/Equipment Alcove	2	20	40	Easily accessible
4. Physician Dictation Room	1	120	120	Workstations for 3; each with computer, telephone, paper supplies; 1 shared printer; locate adjacent to Team Station
5. Clean Utility/Supplies	1	140	140	Work counter w/ base & wall storage cabinets; sink w/ soap & paper towel dispenser; supply carts, shelving; medication refrigerator
6. Soiled Utility Room	1	80	80	Stainless steel double sink; soap & paper towel dispensers, countertop w/ wall & base storage cabinets; linen hamper; trash containers; hazardous waste disposal; clinical service sink; hopper
7. Linen Cart Alcove	2	20	40	30" x 60" carts
8. Equipment Storage	1	80	80	Specialty Emergency carts
9. Staff Toilet	1	65	65	ADA compliant; toilet, lavatory, mirror & accessories
10. Pneumatic Tube Station	1	15	15	Locate at Control/Team Station
11. Housekeeping Closet	1	30	30	Mop sink, supply storage, bucket, hooks, near soiled utility room
SUBTOTAL-NSF			950	
Circulation Factor			1.50	Corridor circulation inside dept.
Sub-Total, DGSF			1,430	

3,350 Total DGSF
1.12 Circulation
3,750 Total BGSF

Center for Short Stay Care

Functions	Proposed Program Total NSF	Circ. Factor	Total DGSF	Remarks
Summary NSF				
A. 5 Bed Cluster (5 x 10 = 50)	8,200	1.50	12,300	**50 private Stage 2 recovery positons to accommodate all Outpatient and Same Day Surgery volumes from IPS plus 5 additional private positions to accommodate infusion therapy patients.**
B. 5 Bed Isolation Cluster (5 x 1 = 5)	850	1.50	1,280	
C. Shared Clinical Support	2,610	1.50	3,920	
D. Shared Staff & Administrative Support	378	1.35	510	
E. IV Therapy Admin Support	758	1.35	1,020	
Total Square Footages	**12,796**	1.49	**19,030**	*Total of 55 privaate positions*
		1.21	3,910	Circulation
			22,940	*TOTAL BGSF*

See Center for Short Stay Care block diagram

Note: 1. NSF - net square feet, DGSF - department gross square feet.
2. Circulation Factor - NSF to DGSF; allowance for intradepartmental circulation, interior partitions, etc.

CODE	FUNCTIONAL ELEMENT	PROPOSED # OF RMS	PROPOSED NSF/ RM	PROPOSED TTL NSF / RM TYPE	REMARKS
	Center for Short Stay Care	**55**	**Total Recovery Positions**		
	A. 5 Bed Cluster				
	1. Private Holding/ Recovery Position	5	130	650	Private room; min dimensions 10'w x 13'd'; glass sliding door + curtain; visualization from caregiver workstation; sound-attenuated for privacy; wired for portable monitoring; monitor; stretcher; recliner; direct & indirect lighting w/ dimmer switches; wall-mounted TV; cabinet for supplies; digital clock; gloves dispenser; antiseptic hand rub; headwall w/ nurse call/communication system, electric outlet, oxygen vacuum air, medical air, telephone outlet, pressure-gauge, thermometer, lamp; one guest chair.
	2. Staff Handwashing Alcove	1	15	15	Small hands-free operating sink; soap & paper towel dispensers, antiseptic hand rub.
	3. Clean Linen Storage/Patient Supplies Storage	1	30	30	2 carts @ 30"x42"
	4. Toilet	1	65	65	ADA compliant; toilet, lavatory, mirror & accessories.
	5. Caregiver Workstation	1	60	60	Work counter for charting; storage of paper/form supplies; computer (2); seating for 2 staff
	SUBTOTAL-NSF			**820**	
	Circulation Factor			1.50	Corridor circulation inside dept.
	TOTAL-DGSF			**1,230**	
	Number of 5 Bed Clusters			**10**	
	Total Patient Care Zone - DGSF			**12,300**	
	B. 5 Bed Isolation Cluster				
	1. Private Holding/ Recovery Position/ Isolation Room	5	130	650	Same as A above but isolation
	2. Isolation Support Alcove	1	30	30	Work counter, sink, soiled linen cart; isolation supply cart
	3. Staff Handwashing Alcove	1	15	15	small hands-free operating sink; soap & paper towel dispensers, antiseptic hand rub.
	4. Clean Linen Storage/Patient Supplies Storage	1	30	30	2 carts @ 30"x42"
	5. Toilet	1	65	65	ADA compliant; toilet, lavatory, mirror & accessories.
	6. Caregiver Workstation	1	60	60	Work counter for charting; storage of paper/form supplies; computer (2); seating for 2 staff
	SUBTOTAL-NSF			**850**	
	Circulation Factor			1.50	Corridor circulation inside dept.
	TOTAL-DGSF			**1,280**	
	C. Shared Clinical Support				
	1. Unit Coordinator / Monitoring Station	1	240	240	Control Point to unit; centrally located to the bed zones; seating/workarea for 5 includes computers, monitoring, storage, printers, fax, copier.
	2. Pneumatic Tube Station	1	10	10	Locate within Unit Secretary Clerk Workstation
	3. Patient Belongings Storage	1	300	300	Storage area for patient belongings centrally located; can be open storage area with secured locked room; area to store DME to be accommodated within room
	4. MD Charting/Dictation	2	120	240	workstations for 4; each with computer, telephone, paper supplies; one shared printer; locate adjacent to Unit Secretary Desk
	5. IV Therapy Workarea	1	70	70	Shared workspace for 2 staff; computers; printer; storage for 2 IV supply carts
	6. Soiled Holding Room	6	30	180	Closed room with one linen hamper; trash receptacles (regular and red bag); one for every 10 stations
	7. Crash Cart/Equipment Alcove	6	15	90	parking spot for crash cart/other wheeled equipment; electrical outlet; possible storage for supplies above; one for every 10 stations
	8. Nourishment Station (Dietary/ Pantry)	2	120	240	Space to accommodate one dietary cart; work counter w/ sink; wall and base storage cabinets; full size refrigerator/freezer; microwave oven; toaster; coffee maker; countertop ice maker; ventilation.
	9. Clean Utility/Patient Supplies	2	200	400	Centralized location to serve 25 positions; work counter w/ base & wall storage cabinets; sink w/ soap & paper towel dispenser; exchange carts; shelving; includes space for Medication distribution system (refrigerated)
	10. Soiled Utility	2	80	160	Centralized location to serve 25 positions; stainless steel double sink; soap & paper towel dispensers; countertop w/ wall & base storage cabinets; linen hamper; trash containers; hazardous waste disposal; clinical service sink; hazardous waste disposal; hopper
	11. Equipment Storage	2	150	300	Wheelchairs, stretchers, crib; if central transport service initiated storage can be reduced
	12. Staff Toilet	4	65	260	ADA compliant; toilet, lavatory, mirror & accessories.
	13. Housekeeping Closet	2	60	120	Storage of housekeeping supplies to be used by Environmental Services staff; mop sink, supply storage; bucket, hooks, shelves; near soiled utility room.
	SUBTOTAL-NSF			**2,510**	
	Circulation Factor			1.50	Corridor circulation inside dept.
	TOTAL-DGSF			**3,920**	
	D. Shared Staff & Administrative Support				
	1. Clinical Nurse Manager	1	90	90	Private Office; modular work counter with files, shelves, visitor chair, files
	2. On-Call Room/Toilet & Shower	0	130	0	Shared with IPS
	3. Conference/Multipurpose Room	1	288	288	Table & chairs to seat 16; marker board; tackboard; clock; TV/VCR; computer ports; computer workstation for clinical education; work area for students
	SUBTOTAL-NSF			**378**	
	Circulation Factor			1.35	Corridor circulation inside dept.
	TOTAL-DGSF			**510**	
	E. IV Therapy Support				
	1. IV Therapy Supply Storage	1	150	150	Centralized location; work counter w/ base & wall storage cabinets; sink w/ soap & paper towel dispenser; exchange carts; shelving;
	2. IV Therapy Cart Docking	1	150	150	Space to park IV Therapy cart when not in use; space to accommodate 10 carts
	3. IV Therapy Charge RN Office	1	90	90	Private Office; modular work counter with files, shelves, visitor chair, files; locate adjacent to IV Therapy Staff workroom
	4. IV Therapy Staff Workroom	1	368	368	Table & chairs to seat 12; marker board; tackboard; clock; TV/VCR; computer ports; two computer workstations
	SUBTOTAL-NSF			**758**	
	Circulation Factor			1.35	Corridor circulation inside dept.
	TOTAL-DGSF			**1,020**	

19,030 Total DGSF
1.21 Circulation
22,940 Total BGSF
55 Total Positions (50 Stage II recovery; 5 infusion therapy)

CODE	FUNCTIONAL ELEMENT	PROPOSED # OF RMS	PROPOSED NSF/ RM	PROPOSED TTL NSF / RM TYPE	REMARKS
	A. Respiratory Therapy Satellites				**one located adjacent to each ICU floor**
	1. Respiratory Therapy Supply Storage	2	250	500	Storage for supplies to be used by RT staff; storage for 8 ventilators; small enclosed decontam area supporting some clean processing of ventillators; separate clean processing counter w/ O2
	2. Respiratory Therapy office / workroom	2	80	160	Small workroom adjacent to RT supply storage, 2 workstations
	SUBTOTAL-NSF			**660**	
	Circulation Factor			1.60	Corridor circulation inside dept.
	TOTAL-DGSF			**1,060**	
					Circulation
					TOTAL GSF

Note: *1. NSF - net square feet, DGSF - department gross square feet.*
2. Circulation Factor - NSF to DGSF: allowance for interior circulation, total partition/column area, etc.

CODE	FUNCTIONAL ELEMENT	PROPOSED # OF RMS	PROPOSED NSF/ RM	PROPOSED TTL NSF / RM TYPE	REMARKS
A.	**Respiratory Therapy Satellites**				**one located adjacent to each ICU floor**
	1. Respiratory Therapy Supply Storage	2	250	500	Storage for supplies to be used by RT staff; storage for 8 ventilators; small enclosed decontam area supporting some clean processing of ventillators; separate clean processing counter w/ O2
	2. Respiratory Therapy office / workroom	2	80	160	Small workroom adjacent to RT supply storage, 2 workstations
SUBTOTAL-NSF				**660**	
	Circulation Factor			1.60	Corridor circulation inside dept.
.OTAL-DGSF				**1,060**	
				0	Circulation
				1,060	***TOTAL GSF***

Note: 1. NSF - net square feet, DGSF - department gross square feet.
2. Circulation Factor - NSF to DGSF: allowance for interior circulation, total partition/column area, etc.

Laboratory

Functions	Proposed Program Total NSF	Circ. Factor	Total DGSF	SEE CLINICAL LABORATORY BLOCK DIAGRAM Remarks
Summary				
A. **Central Receiving**	**1,225**	1.35	**1,650**	Reception, phlebotomy dispatch, phlebotomy cart storage, workstations, printer room, coordinator offices, etc.
B. **Primary Lab Functions**	**8,495**	1.35	**11,470**	Core lab, microbiology, molecular lab, histology, cytology, blood bank, point of care and referral
C. **Shared Lab Support**	**1,170**	1.35	**1,580**	Includes staff support plus refrigerator, centralized clean supply, soiled utility, reagent storage, etc.
D. **Administrative Support**	**2,090**	1.30	**2,720**	Includes administrative offices, conference room, lab IT server room and workroom, central file
F. **Pathology Offices**	**1,120**	1.30	**1,460**	Pathology medical staff physician offices and support
TOTAL	**14,100**	1.34	**18,880**	*
			1.19	Circulation
			22,487	**Total BGSF**
			21,027	*Without Pathology Administrative Office (1,460 GSF)*
				1,289 GSF over benchmark

Note: *1. NSF - net square feet, DGSF - department gross square feet.*
2. Circulation Factor - NSF to DGSF: allowance for intradepartmental circulation, interior partitions, etc.
** Benchmark - Clinical & Laboratory Standards Institute (19,738 GSF)*

FUNCTIONAL ELEMENT	PROPOSED # OF RMS	NSF/ RM	TTL NSF / RM TYPE	REMARKS
A. Central Receiving				
1. Reception/Receiving	1	180	180	Includes a small waiting/reception area; window/space for centralized specimen receiving; direct but secured access from exterior required
2. Accessioning Work Area/ Phlebotomy Dispatch	1	575	575	Shared area with 7 workstations at 50 sq ft/station, small work counter, under/over counter file storage; specimen receipt, labeling, tracking, and limited processing; client service workstations; 3 pneumatic tube stations; specimen storage/refrigerator
3. Phlebotomy/Support Coordinators	2	100	200	2 Offices - shared by 4 coordinators - modular work counter with files, shelves, visitor chair
4. Printer Room	1	90	90	Enclosed room for 5 printers; full sized floor copier, countertop area with storage for paper and office supplies; scanner
5. Phlebotomy Cart Storage	1	180	180	Area to stage 15 portable carts; area to dock handheld devices(electrical/data access ports); 2 supply carts for restocking of supplies
Sub-Total, NSF			1,225	
Circulation Factor			1.35	Corridor circulation inside dept.
Sub-Total, DGSF			1,650	
B. Primary Lab Functions				
1. Core Lab	1	4,000	4,000	Configured based on an "open lab" concept; includes 2 fully automated testing lines (Stream lab 1,329 sq. ft. and hematology 244 sq. ft.); *Urinalysis workstation - 200 sq.ft, Serology workstation- 150 sq. ft., Manual Chemistry - 2 workstations - 300 sq. ft.; Manual differentials and hematology workstations 470 sq. ft.; blood gas analyzers - 2 workstations 200 sq.ft.;* undercounter storage; adjacent to walk-in refrigerator and centralized reagent storage; chemical hood, 2 double door freezers, 1 Chemical Hood; Flammable Storage cabinets ; eye wash, emergency shower, hand washing stations as specified by code; includes 200 sq ft open storage space; Note: Sq ft. for Streamlab and hematology lines have been increased by 20% so that the space can be adapted to potential selection of alternative vendors
2. Microbiology	1	850	850	Configured for automated Sensitivies/Id and blood culture analyzers, hood(s); includes dark room for AFB; includes 2 workstations for culture set up, 2 workstations for plate reading
3. Molecular Lab	1	300	300	Adjacent to Microbiology, includes area for "clean" processing for PCR
4. Histology				
a. Grossing Room	1	275	275	Separated from main open lab areas; eye wash, emergency shower, hand washing stations as specified by code; two grossing stations with shared central cassette marker and PC; storage of surgical specimens (3) cabinets; down-waiter, 2 crayo stats.
b. Histology	1	780	780	Separated from main open lab areas; eye wash, emergency shower, hand washing stations as specified by code; storage space for blocks, slides and specimens assumes 16 block cabinets and two slide storage cabinets; frozen section area is included at 100 sq ft; four workstations for microtomes, cutting, slide labeling, at 150 sq ft each; fridge with small freezer, 1/2 freezable cabinet (under counter).
c. Remote Storage	1	570	570	Storage relocated from morgue to be internal to lab but not required to be within the histology work area; assumes 30 linear feet of slide storage cabinets and 60 linear feet for block storage
5. Cytology	1	520	520	Separated from main open lab areas; includes 3 private work areas for screening; 1 hood, other areas for prep work.
6. Blood Bank	1	750	750	Configured for emergency monitoring of refrigerators and freezers; access to pneumatic tube for blood product transport; includes 4 workstations, 2 double door refrigerator, 2 single freezers, additional down-waiter.
7. Point of Care/Referral Testing	1	450	450	Configured with 1 refrigerator and 1 freezer specimen storage; 3 workstations, close to Accessioning/ Receiving Work Area.
Sub-Total, NSF			8,495	
Circulation Factor			1.35	Corridor circulation inside dept.
Sub-Total, DGSF			11,470	
C. Shared Lab Support				
1. Walk-in Refrigerator	1	270	270	Centralized refrigerator storage positioned between Core Lab and Microbiology
2. Centralized Clean Supply	1	270	270	Centralized refrigerator storage positioned between Core Lab and Microbiology
3. Reagent Storage	1	200	200	Supplies that are scattered throughout to be store here for a week; month long storage supplies are held in stores; 2 freezable cabinets.
4. Soiled Utility	1	100	100	Holding area for soiled/trash; to include a utility sink
5. Autoclave/Glasswash	0	100	0	Limited glassware cleaning to be done by SSP
6. Housekeeping Closet	2	60	120	Evenly distributed to support primary lab functions
7. DI Water System Support	1	80	80	
8. UPS Closet	1	80	80	
9. Air Compressor Room	1	50	50	
Total, NSF			1,170	
Circulation Factor			1.35	Corridor circulation inside dept.
Total, DGSF			1,580	

F	IONAL ELEMENT	PROPOSED # OF RMS	NSF/ RM	TTL NSF / RM TYPE	REMARKS
D.	**Administrative Support**				
	1. Director Office	1	140	140	Private office - desk with credenza or modular work counter with files, shelves, visitor chair, files, small side table with 2 visitor chairs
	2. Administrative Assistant Workstation	1	80	80	Located adjacent to Director - 8'x8' cubicle - modular components with extended corner worksurface for computer; lockable upper storage bins, pedestals provide secured filing and personal storage; task lighting
	3. Section Leader Offices	6	100	600	Based on current 6 section leaders, private office; modular work counter with files, shelves, visitor chair, files
	4. Coordinator Office	0	0	0	Included in central receiving area
	5. Shift Supervisor Office	1	150	150	Semi-private office with two modular workdesk area with files, shelves, visitor chair, files
	6. Conference Room	1	360	360	Contains 4 IT training workstations along wall; seating for 12 conference style; marker board; tackboard; clock; TV/VCR; computer ports
	7. Lab IT Server Room	1	150	150	Server area to be adjacent to Lab IT staff workroom
	8. Lab IT Staff Workroom	1	150	150	Semi-private office with two modular workdesk area with files, shelves, visitor chair, files
	9. Office Support	1	80	80	Central area for storage of office equipment & supplies- copier, fax, etc.
	10. Central File Storage	1	300	300	Assume 14 lateral files to accommodate file retention needs related to QC.
	11. Waiting/Administrative Reception	1	80	80	Small waiting area adjacent to administrative assistant workstation
Sub-Total, NSF				**2,090**	
Circulation Factor				**1.30**	Corridor circulation inside dept.
Sub-Total, DGSF				**2,720**	
F.	**Pathology Offices**				
	1. Pathologist Office	6	140	840	Private office; modular work counter with files, shelves, visitor chair, files
	2. Clerical Workstation	1	60	60	
	3. Conference Room	1	150	150	Seating for 6 conference style; marker board; tackboard; clock; TV/VCR; computer ports
	4. Reference Area/Microscope	1	70	70	
Sub-Total, NSF				**1,120**	
Circulation Factor				**1.30**	Corridor circulation inside dept.
-Total, DGSF				**1,460**	

18,880 Total DGSF
1.19 Circulation
22,487 Total BGSF

Pharmacy

Functions	Proposed Program Total NSF	Circ. Factor	Total DGSF	See Pharmacy Block Diagram Remarks
Summary				
A. Receiving/Bulk Stores	866	1.30	1,130	
B. Manufacturing/Pre-Packaging	350	1.31	460	
C. IV/Admixture	915	1.30	1,190	
D. Distribution	1,123	1.30	1,460	
E. Staff OP Pharmacy	218	1.30	280	
F. Administrative/Staff Zone	1,840	1.30	2,390	
G. Satellite Pharmacy (Surgery/IPS)	450		450	
TOTAL BGSF	**5,762**	**1.28**	**7,360**	
			1.12	Circulation
			8,229	**TOTAL BGSF**

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Note: 1. NSF - net square feet, DGSF - department gross square feet.
2. Circulation Factor - NSF to DGSF: allowance for interior circulation, total partition/column area, etc.

	Proposed Program #Of Rm.	NSF /Rm.	Ttl.NSF /Room	Remarks
Receiving/Bulk Stores				
1. Receiving	1	120	120	Used for receiving medications and other supplies; storage for vendor supplies; cart holding
2. Trash/Recycling area	1	50	50	
3. Secured Pharmacy Stock	1	420	420	assumes high density open moveable shelving, table for returns, IV shelf for product stockup
4. Remote Supplies Storage	1	150	150	Includes TPN Supplies; assumes rolling storage unit
5. Freezer	2	18	36	One included in Bulk Supply Storage; one in Controlled Substance Storage
6. Receiving Workstation	1	60	60	computer terminal, phone; adjacent receiving & secured stock area
7. Outdated Drug Storage	1	30	30	
b-Total, NSF			**866**	
culation Factor			**1.30**	Corridor circulation inside dept.
b-Total, DGSF			**1,130**	
Manufacturing/Pre-Packaging				
1. Compounding workstation	1	80	80	includes work counter, PC, storage, sink
2. Pre-Pack Workstations	1	60	60	includes sink
3. Pre-Pack Automation	2	60	120	Assumes tabletop automation
4. Distribution Cart Staging	2	30	60	
5. Supply Cart	1	30	30	
b-Total, NSF			**350**	
culation Factor			**1.30**	Corridor circulation inside dept.
b-Total, DGSF			**460**	
IV/Admixture				
1. IV Gowning/ Ante Room	1	150	150	Includes handwashing sink, one cart for IV supplies, shelving for gowning supplies; computer workstation w/ overhead shelves, shelving for storing bins, counter with undercounter drawers for chemo record storage and supplies; two refrigerators for storing meds and chemo meds
2. Tube Station Alcove	1	15	15	Located inside the IV Clean Work Room
3. IV Work Room	1	150	150	Accessible off IVAnte Room; clinical sink, workcounter with two computer workstations; three supply carts
4. IV Prep Room	1	200	200	2 Laminar Flow Hoods; counter for pass through to ante area and labeling IV's, garbage can, used syringe disposal, space for two supply carts; accessible off IV Clean Work Room only
5. Chemo Prep Room	1	120	120	1 Laminar Flow Hood; seven 2-foot shelves for drug storage and supplies; counter for pass through to ante room and labeling IV's, garbage can, chemo waste containter, one additional waste container, space for two supply carts; accessible off IV Clean Work Room only; adjacent to IV Prep Room
6. Refrigerator	1	30	30	Pass thru
7. IV Solutions Storage	1	250	250	
b-Total, NSF			**915**	
culation Factor			**1.30**	Corridor circulation inside dept.
b-Total, DGSF			**1,190**	
Distribution				
1. Order Processing Workstations	4	48	192	computer; overhead storage for forms, supplies, and reference materials
2. Unit Dose Picking Stations	2	120	240	Space for pharmaceuticals, work counter with bins and shelves, includes space for mobile cart
3. Patient Unit Support Workstation	1	60	60	workstation for inventory control of unit ADM
4. Distribution Cart Staging	1	120	120	
6 Controlled Substance Storage	1	100	100	Adjacent to Distribution; controlled substance vault includes workstation & refrigerator
7. Pick-up window/Clerk workstation	1	60	60	Clerk primary location; pick up/drop off window; one designated for employees
8. COD Patient Unit Support Station	1	60	60	
9. Refrigerator	2	18	36	For Narcotics
10. Pre-Made IV Workstation	1	60	60	Workstation with PC, label printer
11. IV Solution Cart	1	60	60	Space for IV Solution Cart; supplies
12. Supply Cart	2	30	60	
13. Tube Station Alcove	1	15	15	
14. Medication Cart	2	30	60	
b-Total, NSF			**1,123**	
culation Factor			**1.30**	Corridor circulation inside dept.
b-Total, DGSF			**1,460**	

Functions - Detailed Space List	Proposed Program #Of Rm.	NSF /Rm.	Tl.NSF /Room	Remarks
E. Staff OP Pharmacy				
1. Order Processing Workstations	1	48	48	computer; overhead storage for forms, supplies, and reference materials
2. OP Pharmacy Stock (bulk tablets)	1	80	80	open fixed shelving
3. Pick-up window/Clerk workstation	1	60	60	Clerk primary location, pick up/drop off window; one designated for employees
4. Supply Cart	1	30	30	
Sub-Total, NSF			**218**	
Circulation Factor			**1.30**	Corridor circulation inside dept.
Sub-Total, DGSF			**280**	
F. Administrative/Staff Zone				
1. Director Office	1	120	120	Private Office - desk with credenza or modular work counter with files, shelves, visitor chair, files, small side table with 2 visitor chairs
2. Director Assistance		100	100	Private Office - desk with credenza or modular work counter with files, shelves, 2 visitor chairs, files
3. Supervisor - Shift Manager	1	80	80	Private Office - desk with credenza or modular work counter with files, shelves, visitor chair, files; shared by first and second shift managers
4. Clinical Pharm Workroom	1	420	420	Shared Office with 6 modular workstations with files, shelves, visitor chair, files;
5. Data Information Specialist	1	80	80	Private Office - desk with credenza or modular work counter with files, shelves, visitor chair, files
6. Clinical Coordinator	1	100	100	Private Office - desk with credenza or modular work counter with files, shelves, visitor chair, files
7. Secretary	1	80	80	Private Office - desk with credenza or modular work counter with files, shelves, visitor chair, files
8. Stock Ordering Workstations	1	100	100	computer terminal, phone; adjacent Receiving
10. Education/ Conference Room	1	180	180	to be verified; conference room for up to 10 people
9. Staff Lockers	1	70	70	Confirm number of lockers
11. Staff Lounge w/ Pantry Alcove	1	170	170	Includes pantry area with microwave, toaster, uc refrig; countertop sink w/ base & wall cabinets; table and chairs to seat 8; markerboard; tackboard; clock; TV/DVD; computer ports; mail boxes
12. Office Support	1	150	150	workcounter, supply cabinets, fax machine, copier; central to zone; includes 4 lateral file storage shelves, 2 cabinets for paper goods, bookshelves for old PDR's
13. Housekeeping Closet	1	60	60	Storage of housekeeping supplies to be used by Environmental Services staff; mop sink; shelves
14. Staff Toilet	2	65	130	ADA; Adjacent to Clinical Work areas
Sub-Total, NSF			**1,840**	
Circulation Factor			**1.30**	Corridor circulation inside dept.
Sub-Total, DGSF			**2,390**	
G. Satellite Pharmacy				
1. Satellite Pharmacy (Surgery/IPS)	1	300	300	Located near PACU & ORs; secured; pneumatic tube station; 3 picking workstation; 8 fixed shelving units; 2 anesthesia med cart tray holders; Pick-up station with window or half-door; 2 computer workstations; full sized refrigerator; blood refrigerator
Sub-Total, NSF			**300**	
Circulation Factor			**1.50**	Corridor circulation inside dept.
Sub-Total, DGSF			**450**	

7,360 Total DGSF
1.12 Circulation
8,229 Total BGSF

Outpatient Testing

Functions	Proposed Program Total NSF	Circ. Factor	Total DGSF	Remarks
Summary NSF				
A. **Phlebotomy/Diagnostics**	**1,040**	1.35	**1,400**	6 phlebotomy draw stations, 2 therapeutic draw stations, 2 EKG rooms, staff workarea, public toilets, etc.
B. **Pre-Admission Testing**	**590**	1.35	**800**	Patient consultation/exam rooms, staff workroom
C. **Shared Clinical & Admin. Support**	**500**	1.35	**680**	Manager's office, clinical support, clean utility, patient supplies, soiled utility, equipment storage, staff toilets, housekeeping closet
D. **Shared Family/ Patient/ Public Support**	**1,050**	1.25	**1,300**	Directly adjacent to reception area and OP Testing; Assumes 40 seats @ 15 sf per; handicapped waiting for 4 people @ 20sf; child play area @ 50 sf; divide area into separate seating groups.
Total	**3,180**	1.31	**4,180**	
			1.13 Circulation	
			4,730	***TOTAL BGSF***

Note: 1. NSF - net square feet, DGSF - department gross square feet.
2. Circulation Factor - NSF to DGSF: allowance for intradepartmental circulation, interior partitions, etc.

CODE	FUNCTIONAL ELEMENT	PROPOSED # OF RMS	PROPOSED NSF/ RM	PROPOSED TTL NSF / RM TYPE	REMARKS
	Outpatient Testing				
	A. Phlebotomy/Diagnostics				
	1. Phlebotomy Draw Stations	6	50	300	Private area/bay with three hard walls and front curtain; visualization from staff workstation; draw chair; computer; appropriate lighting; cart for supplies, digital clock; gloves dispenser, antiseptic hand rub; nurse call/communication system
	2. Therapeutic Draw Stations	2	80	160	Private room; min dimensions 8'w x 10'd'; glass sliding door + curtain; visualization from staff workstation; sound-attenuated for privacy; computer; sized to allow for recliner, one room to be configured for neonatal draws; direct & indirect lighting w/
	3. EKG/Exam Room	2	120	240	Sound attenuated for privacy; exam table; exam light; BP cuff; two side chairs, stool, clothes hook, mirror, sink w/ paper towel & soap dispensers, counter w/ base & wall storage cabinets; writing surface (30") w/ data outlet; cubicle curtain & track; nur
	4. Staff Handwashing Alcove	2	15	30	small hands-free operating sink; soap & paper towel dispensers, antiseptic hand rub.
	5. Patient Toilet	2	65	130	ADA compliant; toilet, lavatory, mirror & accessories; each with pass-thru to staff work area; nurse call
	6. Staff Work area/Specimen Prep	1	170	170	Adjacent to draw stations; work counter for order verification and specimen prep; labeling; undercounter refrigerator for storage of specimens; paper/form supplies; printers, fax, work space for 3 staff with PC's; undercounter refrigerator for nutrition
	7. Pneumatic Tube Station	1	10	10	Locate within Staff Work area; high volume of use to transport specimens to lab
	SUBTOTAL-NSF			**1,040**	
	Circulation Factor			1.35	Corridor circulation inside dept.
	TOTAL-DGSF			**1,400**	
	B. Health Testing				
	1. Consultation Room	2	140	280	Round table, chairs; set-up to accommodate 4 people for consultations; quiet and private; storage cabinets for patient literature;
	2. Exam Room	0	120	0	Utilize EKG/Exam Room when required
	3. Staff Workroom	1	300	300	workstations for 6; each with computer, telephone, paper supplies; one shared printer/fax
	4. Pneumatic Tube Station	1	10	10	Locate within Staff Work area; high volume of use to transport specimens to lab
	SUBTOTAL-NSF			**590**	
	Circulation Factor			1.35	Corridor circulation inside dept.
	TOTAL-DGSF			**800**	
	C. Shared Clinical & Admin. Support				
	1. Manager Office	1	90	90	Private Office; modular work counter with files, shelves, visitor chair, files
	2. Clean Utility/Patient Supplies	1	100	100	Centralized location; work counter w/ base & wall storage cabinets; sink w/ soap & paper towel dispenser; exchange carts; shelving; Clean linen cart
	3. Soiled Utility	1	70	70	Centralized location; stainless steel double sink; soap & paper towel dispensers; countertop w/ wall & base storage cabinets; linen hamper; trash conlainers; hazardous waste disposal; hazardous waste disposal;
	4. Equipment Storage	1	50	50	
	5. Staff Toilet	2	65	130	ADA compliant; toilet, lavatory, mirror & accessories.
	6. Housekeeping Closet	1	60	60	Storage of housekeeping supplies to be used by Environmental Services staff; mop sink, supply storage; bucket, hooks, shelves; near soiled utility room.
	SUBTOTAL-NSF			**500**	
	Circulation Factor			1.35	Corridor circulation inside dept.
	TOTAL-DGSF			**680**	
	E. Shared Family/ Patient/ Public Support				
	1. Reception/ Intake	1	190	190	ADA compliant; sized for two staff each with computer terminal & telephone
	2. Family Waiting Room	1	730	730	Directly adjacent to reception area and OP Testing; Assumes 40 seats @ 15 sf per; handicapped waiting for 4 people @ 20sf; child play area @ 50 sf; divide area into separate seating groups; Include TV viewing area
	3. Public Toilet	2	65	130	Male / female; ADA compliant.
	SUBTOTAL-NSF			**1,050**	
	Circulation Factor			1.25	Corridor circulation inside dept.
	TOTAL-DGSF			**1,300**	

4,180 Total DGSF
1.13 Circulation
4,730 Total BGSF

PALOS COMMUNITY HOSPITAL: EAST WING EXPANSION AND MAJOR MODERNIZATION

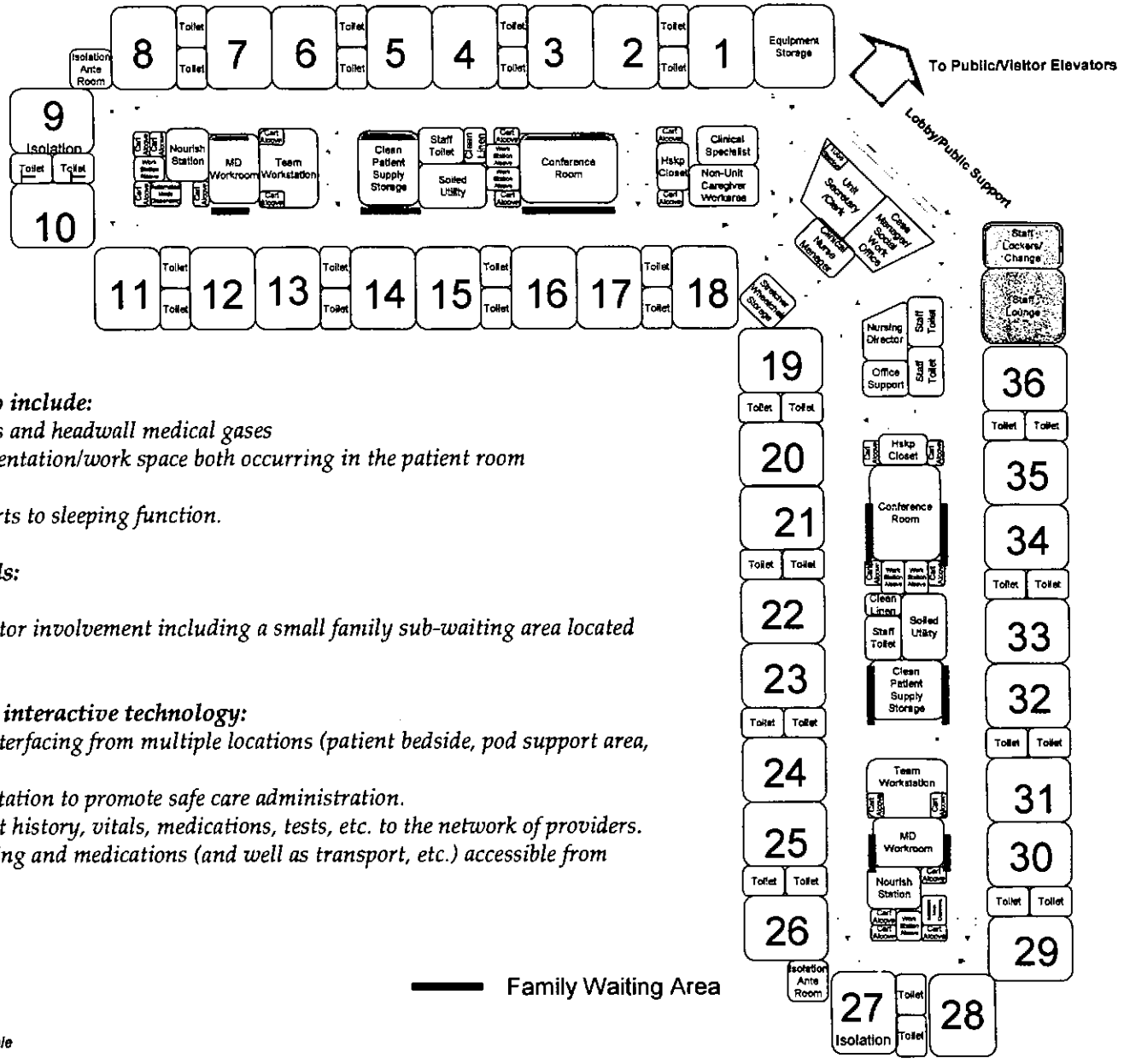
CLINICAL SERVICE	IHFPB GUIDELINE	UNIT OF SERVICE Year 2020	SPACE (GSF) ALLOWED Year 2020	PROPOSED DGSF	COMPARISON (+/-)
MEDICAL/ SURGICAL	401 gsf/bed	306 beds 156 Replacement beds	122,706 gsf 62,556 gsf	180,065 gsf 588 gsf/bed 84,825 dgsf 544 gsf/bed	Total Beds: +57,359 gsf Replacement Beds: +22,269 dgsf Additional space due to private rooms, bathrooms, family zones = 32,760 dgsf
INTENSIVE CARE SERVICES (ICUs)	603 gsf/bed	36 beds	21,708 gsf allowed	23,490 dgsf 653 gsf/bed	+1,782 dgsf Additional space due to private bathrooms & family zones = 4,954 dgsf
INTEGRATED PROCEDURE SERVICES: SURGERY GI/ENDO/CYSTO SPECIAL/MINOR PROCEDURES	 1500 hours/room 2,078 gsf/room 2000 visits/room 1,386 gsf/room	Total 19 Rooms 31,394 hours 17 rooms 5,005 visits 2 rooms	Total 38,098 gsf allowed for 19 rooms 23 rooms allowed 35,326 gsf allowed for 17 ORs 21 rooms allowed 2,772 gsf 2 rooms allowed	Total 37,590 dgsf	-508 dgsf Economies of space due to shared staff/support services: Surgery; GI/ENDO; Interventional Imaging & Minor Procedures
RECOVERY: PACU CSSC (INCLUDES INFUSION)	180 gsf/station 4 stations per OR/procedure room	Total 70 stations 15 50 5	Total 16,560 gsf allowed 23 IPS rooms @ 4 stations = 92 stations allowed	22,380 dgsf 3,350 dgsf 19,030 dgsf	+5,820 dgsf Additional Space for outpatient treatment = 1,732 dgsf private recovery positions = 4, 098 dgsf decentralized support = 2,325 dgsf Total = 8,205 dgsf

RESPIRATORY/ THERAPY	20.5 procedures/gsf	176,048 procedures	8,587 gsf allowed	5,425 dgsf	-3,162 dgsf
LABORATORY	225 gsf/FTE	101 FTEs	22,725 gsf allowed	18,880 dgsf	- 3,845 dgsf
PHARMACY	12 gsf/bed	433 beds	5,196 gsf allowed	7,360 dgsf	+2,164 dgsf Additional space due to increasing demand & more staff, automated practices & more equipment, transition to new distribution system & a new satellite pharmacy near IPS/CSSC
OUTPATIENT & PRE-ADMISSION TESTING	No Standard	89,324 visits	No Standard	4,180 dgsf	
INPATIENT DIALYSIS	No Standard Outpatient Standard is 470 gsf/station	4 stations	1,880 gsf allowed	1,105 gsf	-775 gsf
EMERGENCY DEPARTMENT	2,000 visits/room 744.6 gsf/room	60,810 visits 31 stations	23,083 gsf allowed 31 stations allowed	22, 814gsf	-269 gsf
ADMISSIONS UNIT	No Standard ER Standard applied 2,000 visits/room 744.6 gsf/room	30,397 visits 14 stations	10,424 gsf allowed (14) 15 stations allowed	6,696 gsf	-3,728 gsf Unit will share support space with the Emergency Department
CARDIOLOGY ECG/EKG	No Standard	129,915 procedures	No Standard	6,661 gsf	

CLINICAL SERVICE	IHFPB GUIDELINE	UNIT OF SERVICE Year 2020	SPACE (GSF) ALLOWED Year 2020	PROPOSED DGSF	COMPARISON (+/-)
NUCLEAR MEDICINE	2.9 procedures/gsf	20,386 procedures	7,030 gsf allowed (procedures)	6,766 gsf	-264 gsf
DIAGNOSTIC RADIOLOGY	5.5 proc/gsf 1,386 gsf/room		33,675 gsf allowed (procedures) 47,124 gsf allowed (rooms)	31,732	- 1,943 gsf based on 5.5 procedures/gsf -15,392 gsf based on 1,386 gsf/room
GENERAL RADIOLOGY	6,500 proc/room	General Radiology 93,707 procedures	15 general rooms allowed	12 rooms	- 3 rooms
SPECIAL RADIOLOGY:	2,000 visits/room				
Visits		Special Radiology			
Ultrasound		15,029	8 rooms allowed	8 rooms	
CT Scanning		7,623	4 rooms allowed	4 rooms	
Mammography		15,212	8 rooms allowed	4 rooms	
Bone Density*				1 room	
Breast Biopsy*				1 room	
Special Procedures				1 room **	
Total		37,864	20 rooms allowed	19 rooms	- 1 rooms
Procedures			Total 35 rooms allowed	31 rooms	-4 rooms
Ultrasound		31,088			
CT Scanning		43,614	(Only 34 rooms allowed		
Mammography		16,803	As one rooms for		
Bone Density*		*	Special Procedures is in		
Breast Biopsy*		*	Integrated Procedure Services)		
Special Procedures		**			
Total		91,505			
TOTAL PROCEDURES		185,212 procedures			

CLINICAL SERVICE	IHFPB GUIDELINE	UNIT OF SERVICE Year 2020	SPACE (GSF) ALLOWED Year 2020	PROPOSED DGSF	COMPARISON (+/-)
*Dexa procedures in general radiology. *Sterotactic Breast Biopsies in Mammo. ** Special Procedures in Integrated Procedure Services (IPS)					

EAST WING ADDITION
Prototypical Med/Surg Unit



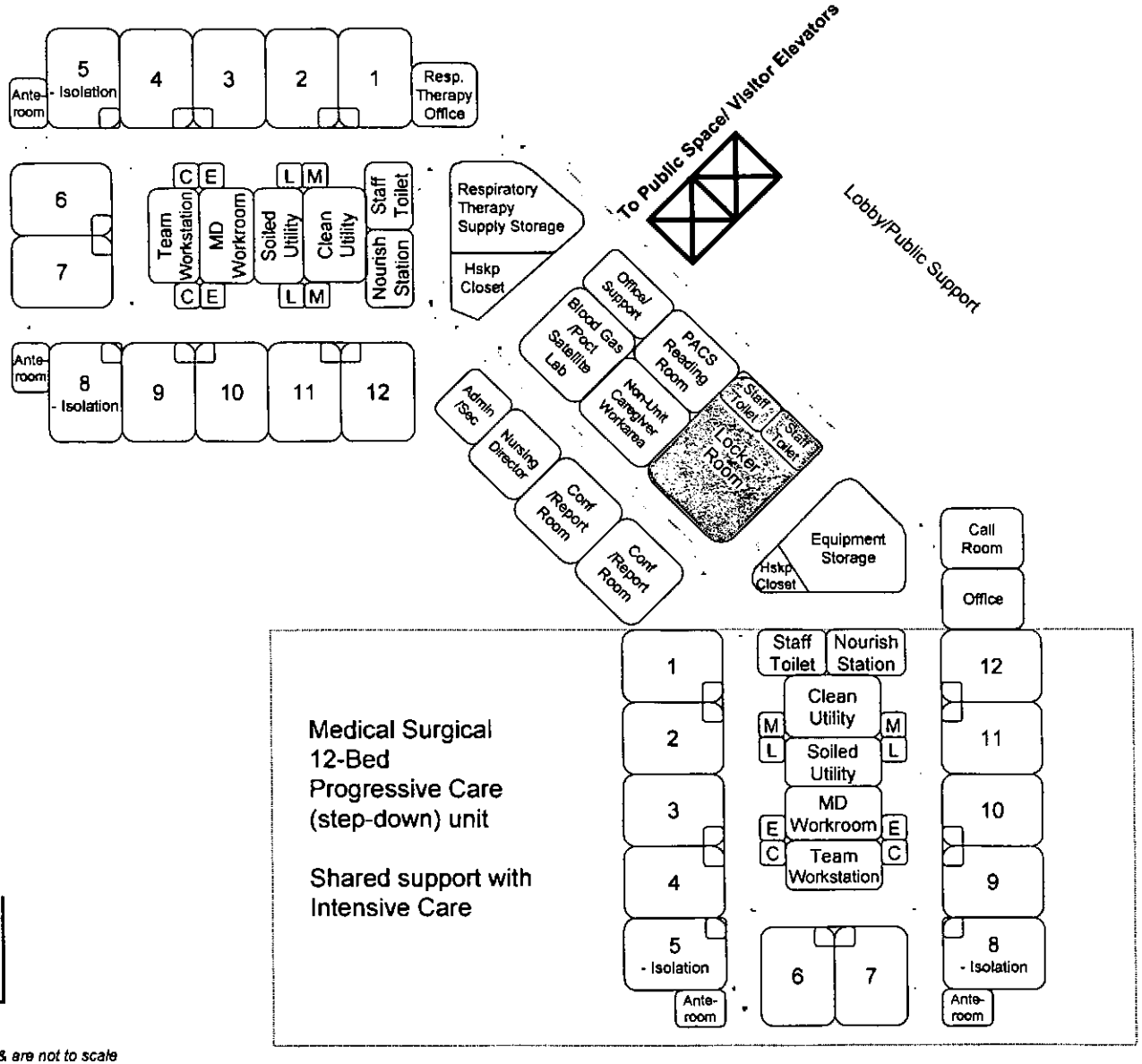
All rooms are private and configured to include:
- *Patient zone with monitoring capabilities and headwall medical gases*
- *Staff zone with hand washing and documentation/work space both occurring in the patient room*
- *Full patient toilet and shower*
- *Family zone with seating area that converts to sleeping function.*

Units are configured into "pods" of beds:
- *Each pod consists of 18 beds.*
- *Units configuration supports family/visitor involvement including a small family sub-waiting area located within the unit itself.*

Units are planned to employ advanced interactive technology:
- *Patient monitoring system that allows interfacing from multiple locations (patient bedside, pod support area, team area, off-site).*
- *Bedside scanning and real-time documentation to promote safe care administration.*
- *Electronic Medical Record linking patient history, vitals, medications, tests, etc. to the network of providers.*
- *Secure online order entry system for testing and medications (and well as transport, etc.) accessible from multiple locations.*

Note: Not all program elements shown.
Diagrams illustrate adjacencies and flow & are not to scale

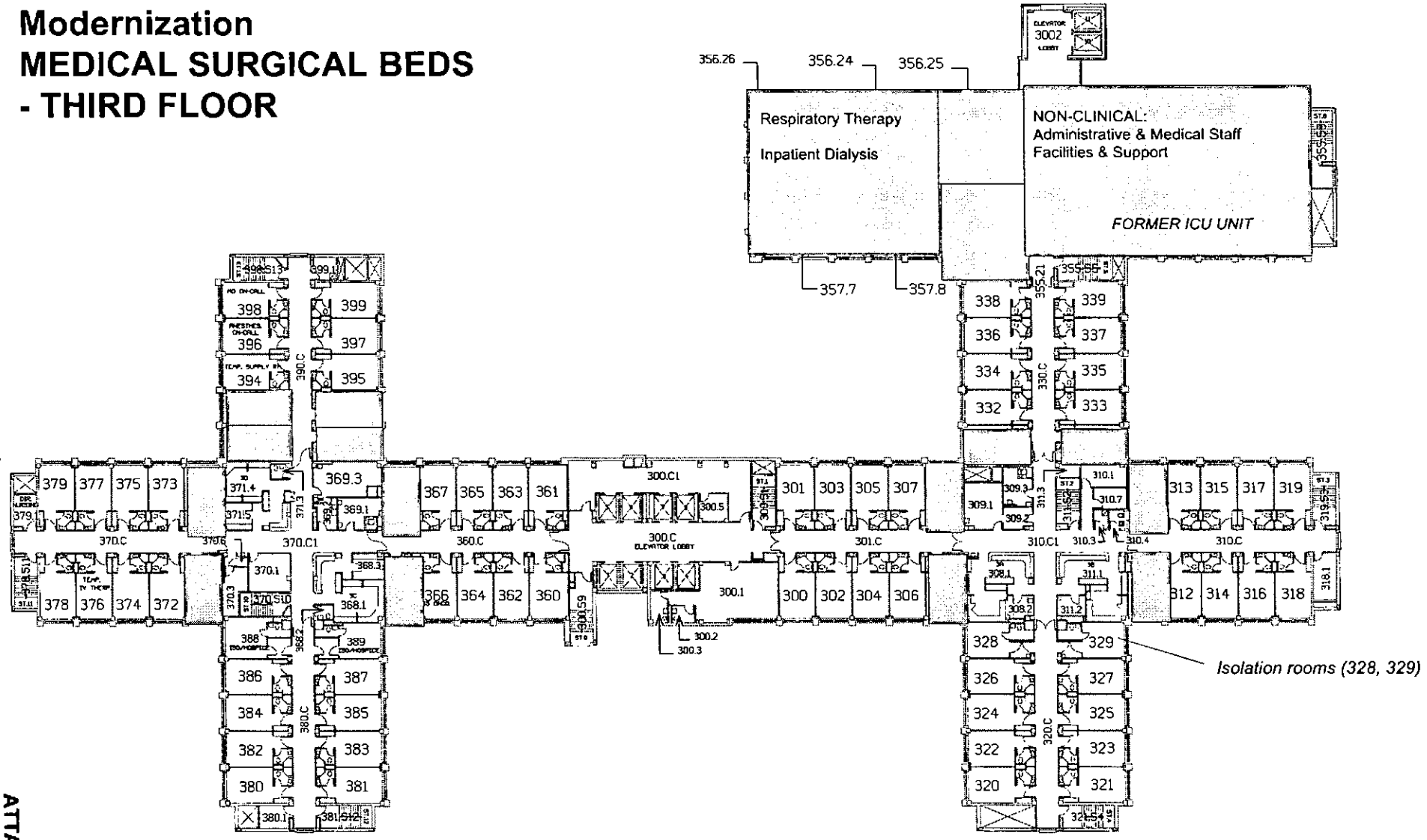
EAST WING ADDITION
Intensive Care Unit &
Progressive Care Units – Floor 6



Abbreviation Key:
C – Crash Cart
E – Equipment Alcove
M – Automated Medication Dispensing
L – Linen Exchange Cart Alcove

Note: Not all program elements shown.
Diagrams illustrate adjacencies and flow & are not to scale

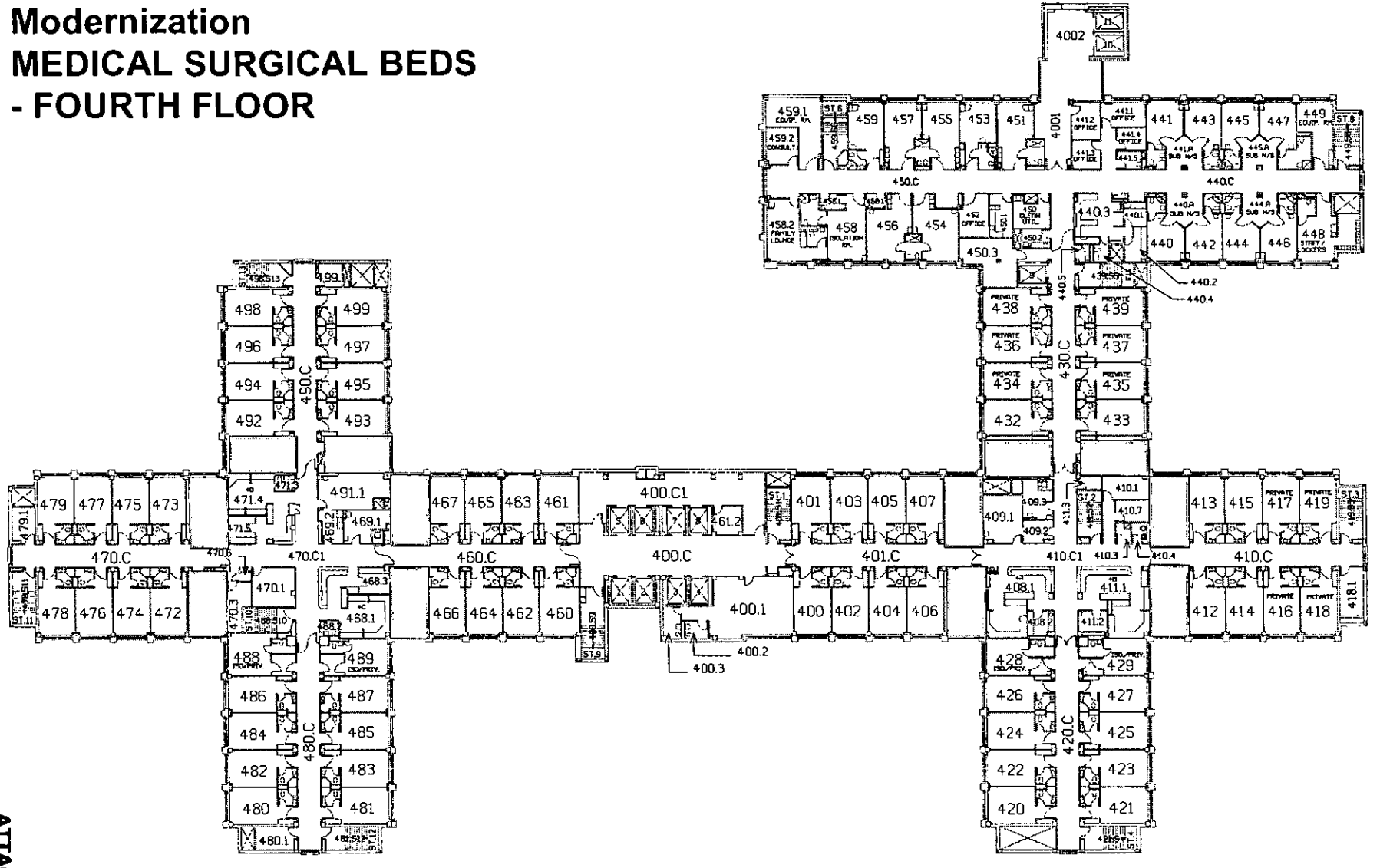
Modernization
MEDICAL SURGICAL BEDS
- THIRD FLOOR



Indicates conversion to ancillary/staff/unit support.

THIRD FLOOR:
66 MEDICAL/SURGICAL BEDS

Modernization
MEDICAL SURGICAL BEDS
- FOURTH FLOOR



PALOS COMMUNITY HOSPITAL
PALOS HEIGHTS, ILLINOIS

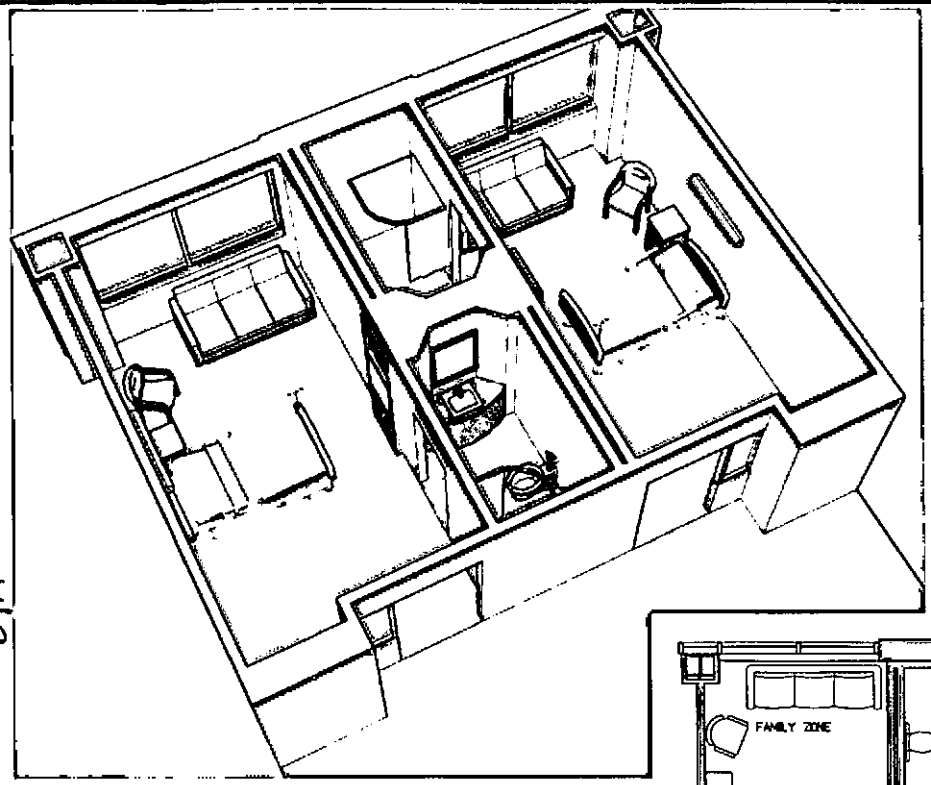
FOURTH FLOOR PLAN

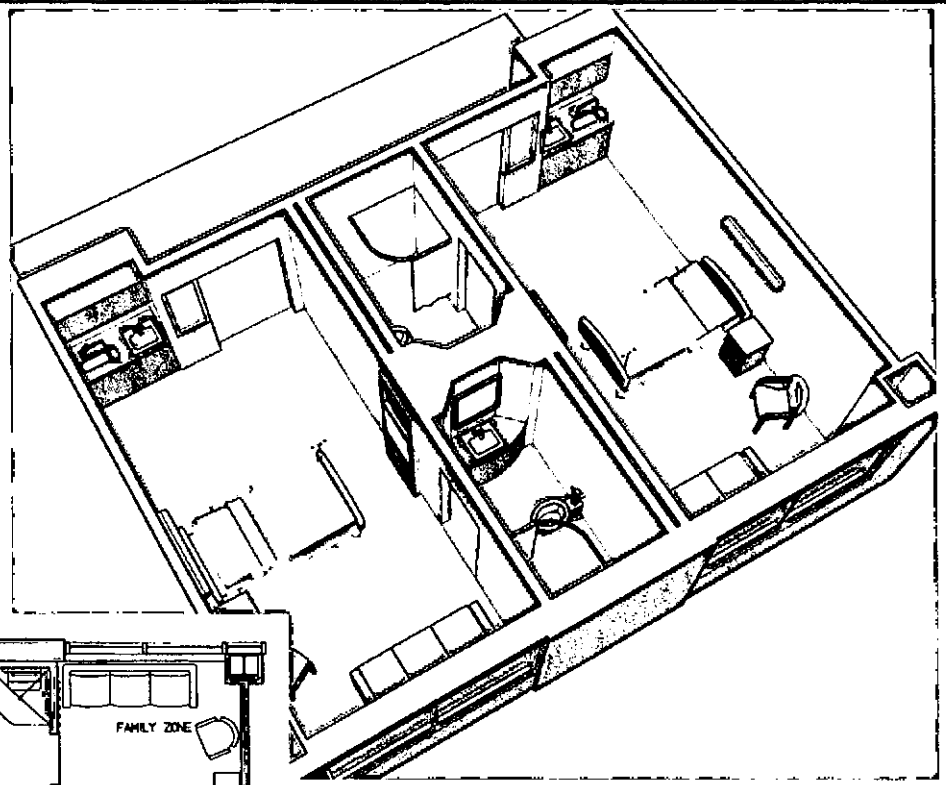
NORTH

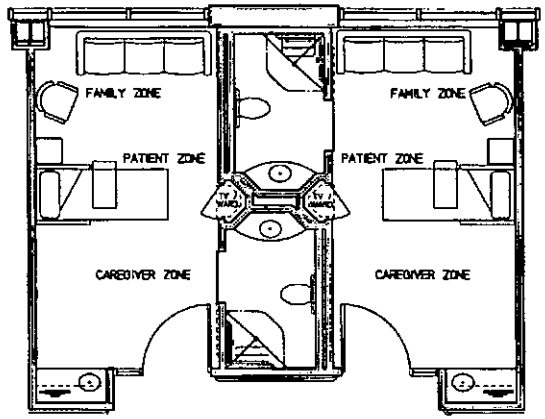
Indicates conversion to ancillary/staff/unit support.

FOURTH FLOOR:
84 MEDICAL/SURGICAL BEDS

Palos Community Hospital
Med/Surg Prototype







MIDBOARD PLAN

255 SF

165 Net Usable SF

M&CA

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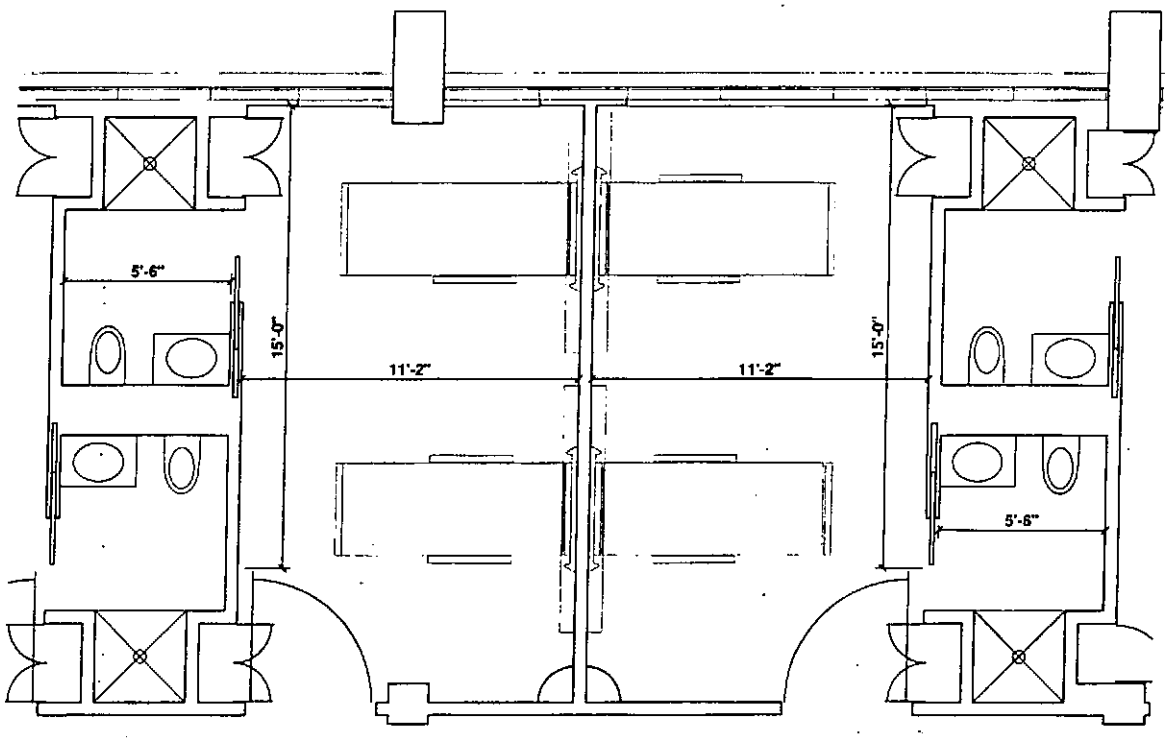
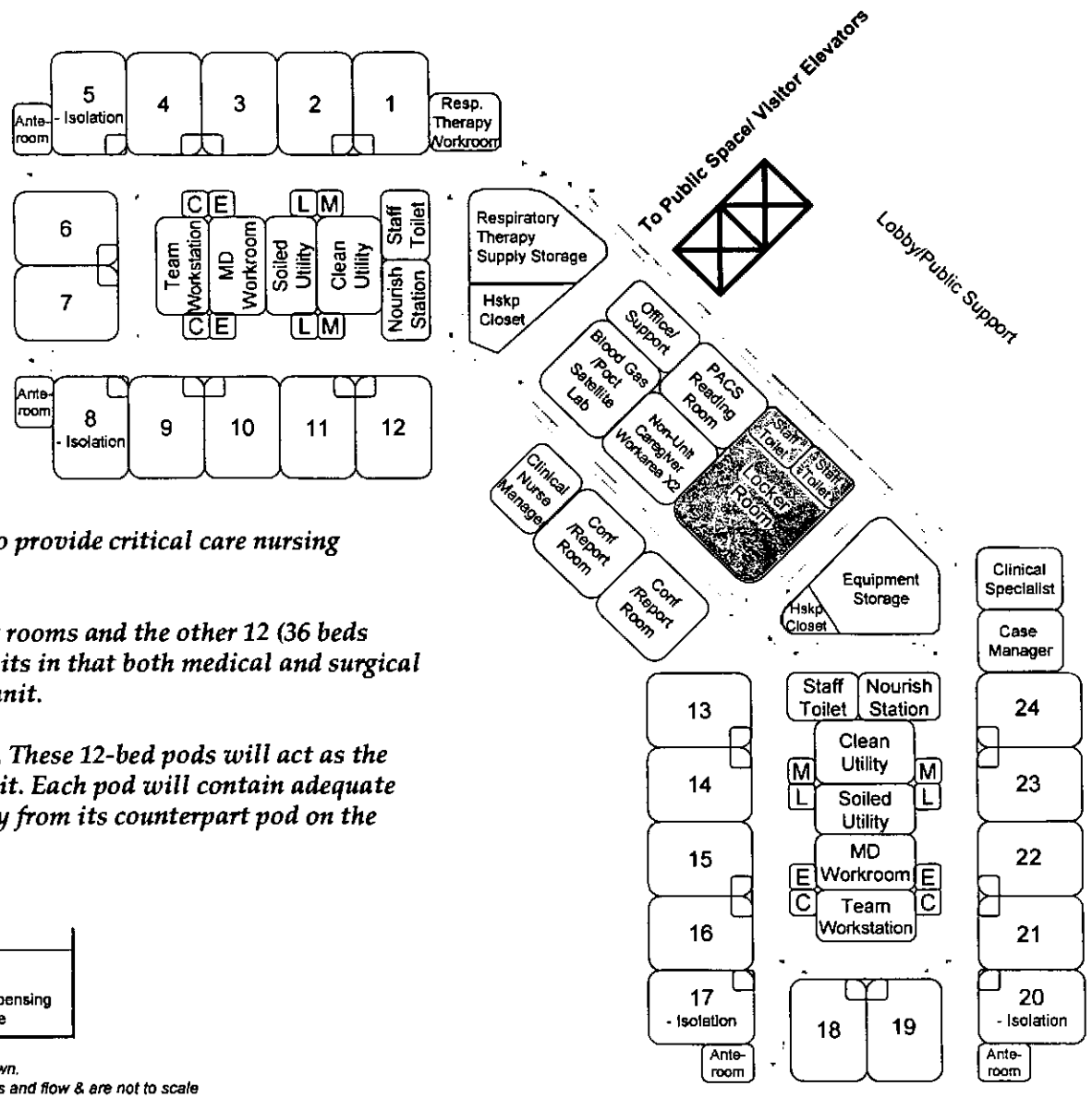
ATTACHMENT GRC-5(5)



Typical Semi-Private Patient Rooms

EAST WING ADDITION
Prototypical ICU



The two new proposed ICUs are planned to provide critical care nursing capacity through 2020.

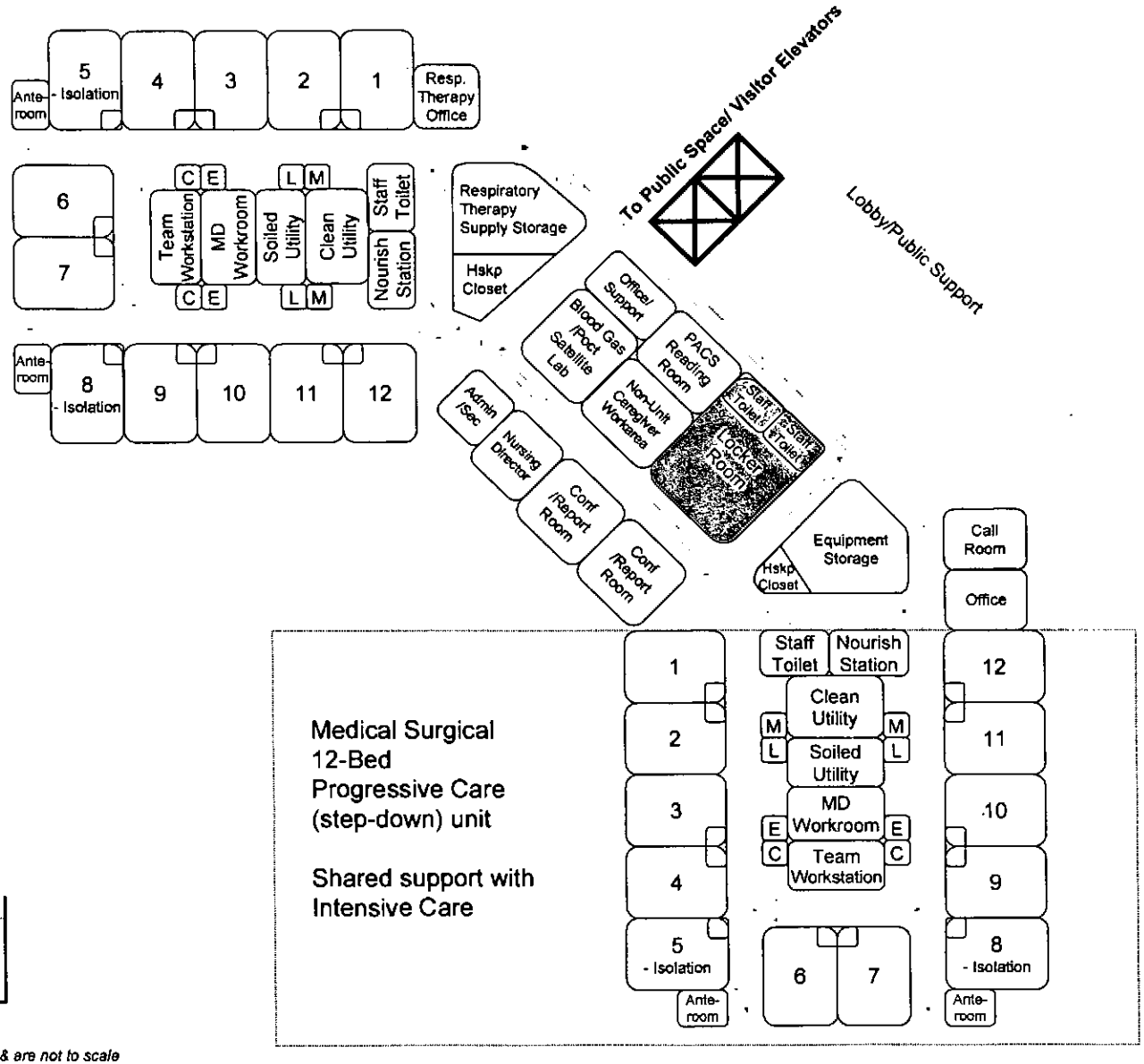
One ICU is two contain 24 private patient rooms and the other 12 (36 beds total). They are planned to be universal units in that both medical and surgical patients will be accommodated on either unit.

ICUs are organized into "pods" of 12 beds. These 12-bed pods will act as the primary organizational element for the unit. Each pod will contain adequate support functions to operate independently from its counterpart pod on the floor.

Abbreviation Key:
C – Crash Cart
E – Equipment Alcove
M – Automated Medication Dispensing
L – Linen Exchange Cart Alcove

Note: Not all program elements shown.
Diagrams illustrate adjacencies and flow & are not to scale

EAST WING ADDITION
Intensive Care Unit &
Progressive Care Units – Floor 6



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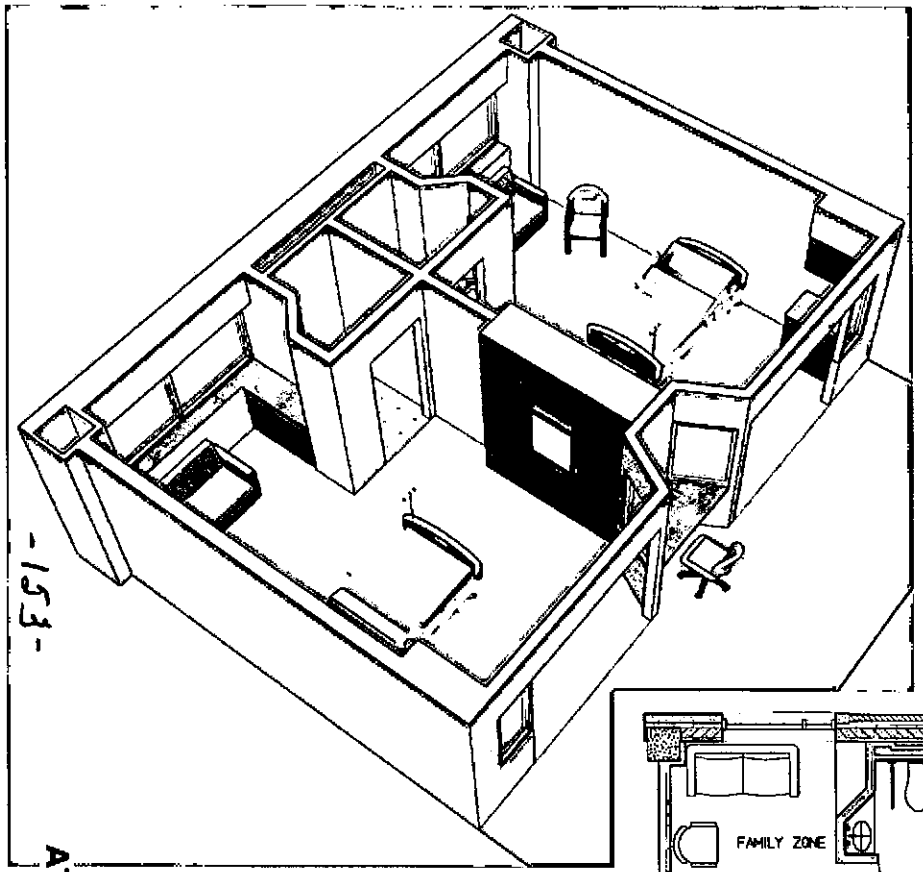
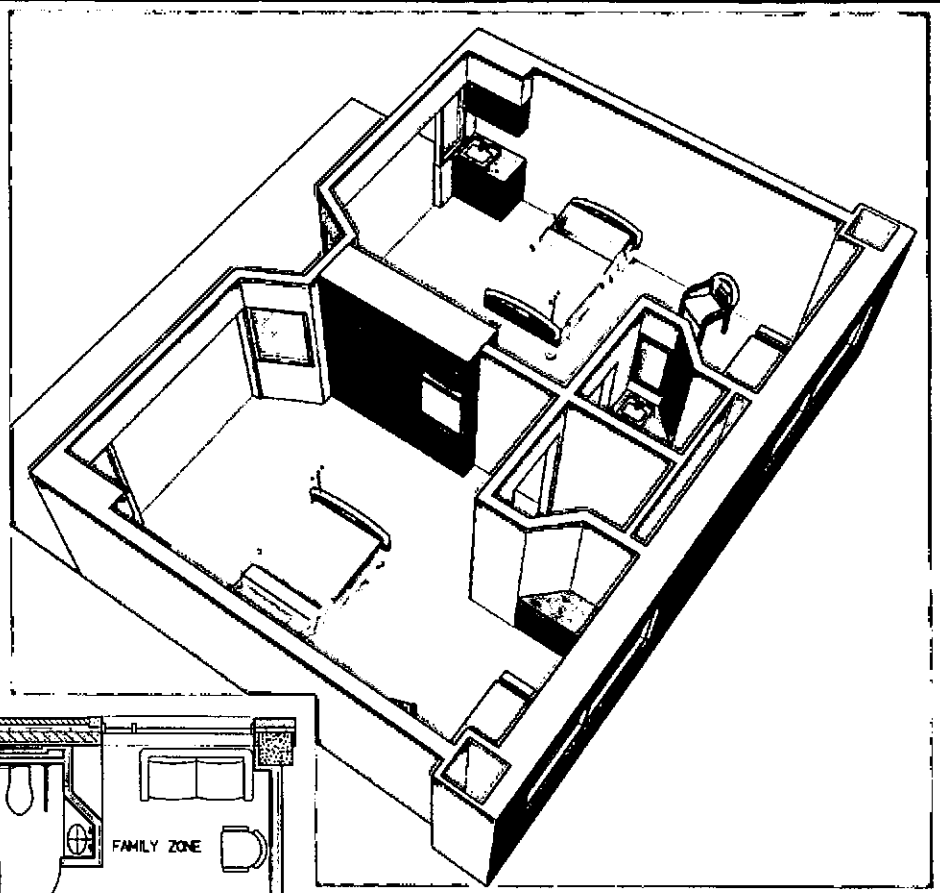
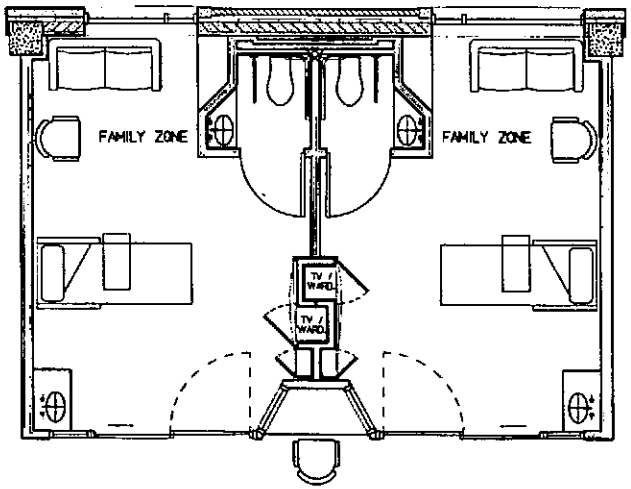
Note: Not all program elements shown.
Diagrams illustrate adjacencies and flow & are not to scale

Palos Community Hospital

ICU Prototype







260 SF

174 Net Usable SF

M&CA

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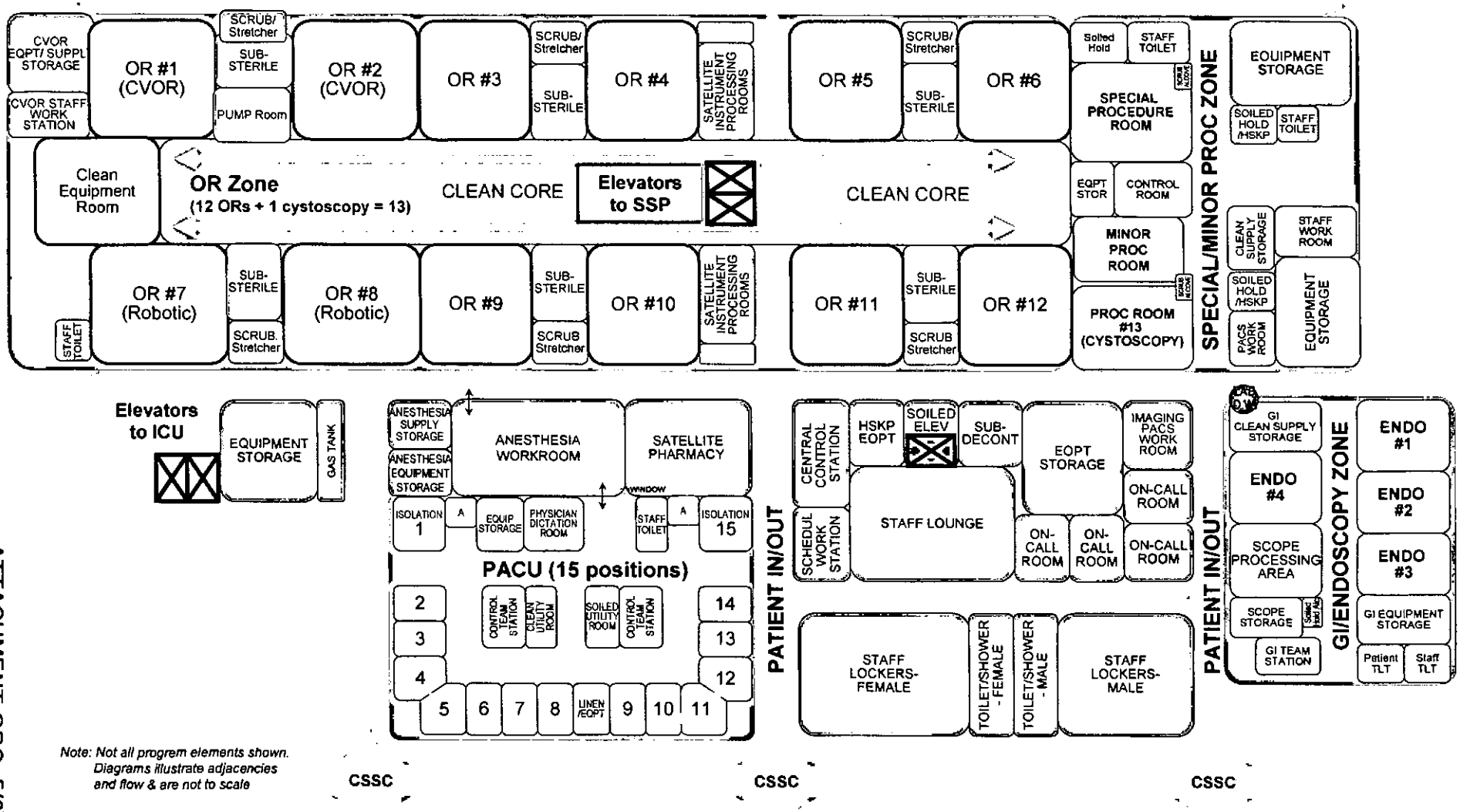
ATTACHMENT GRC-5(7)

Integrated Procedure Services / PACU

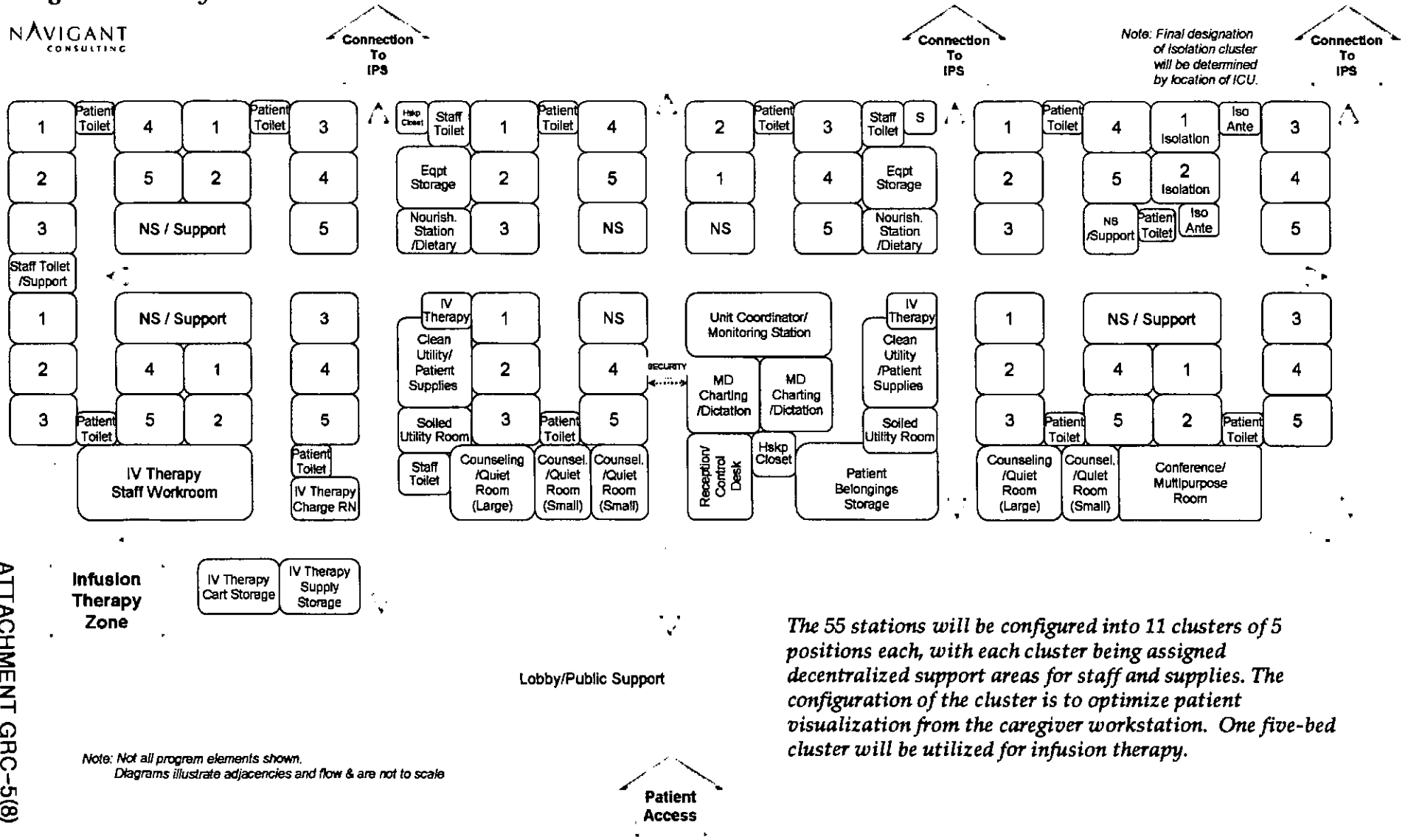
The planned Integrated Procedure Services (IPS) will combine Surgery, Interventional Imaging (special procedures), and GI/Endo services into a single functionally and physically integrated space. The combination of these three procedures services will facilitate immediate realizable efficiencies in sharing of resources and staff as well as long term flexibility in care delivery.



Note: Not all progrem elements shown. Diagrams illustrate adjacencies and flow & are not to scale

Center for Short Stay Care w/ Infusion Therapy
Stage II Recovery

NAVIGANT CONSULTING



Note: Not all program elements shown.
Diagrams illustrate adjacencies and flow & are not to scale

The 55 stations will be configured into 11 clusters of 5 positions each, with each cluster being assigned decentralized support areas for staff and supplies. The configuration of the cluster is to optimize patient visualization from the caregiver workstation. One five-bed cluster will be utilized for infusion therapy.

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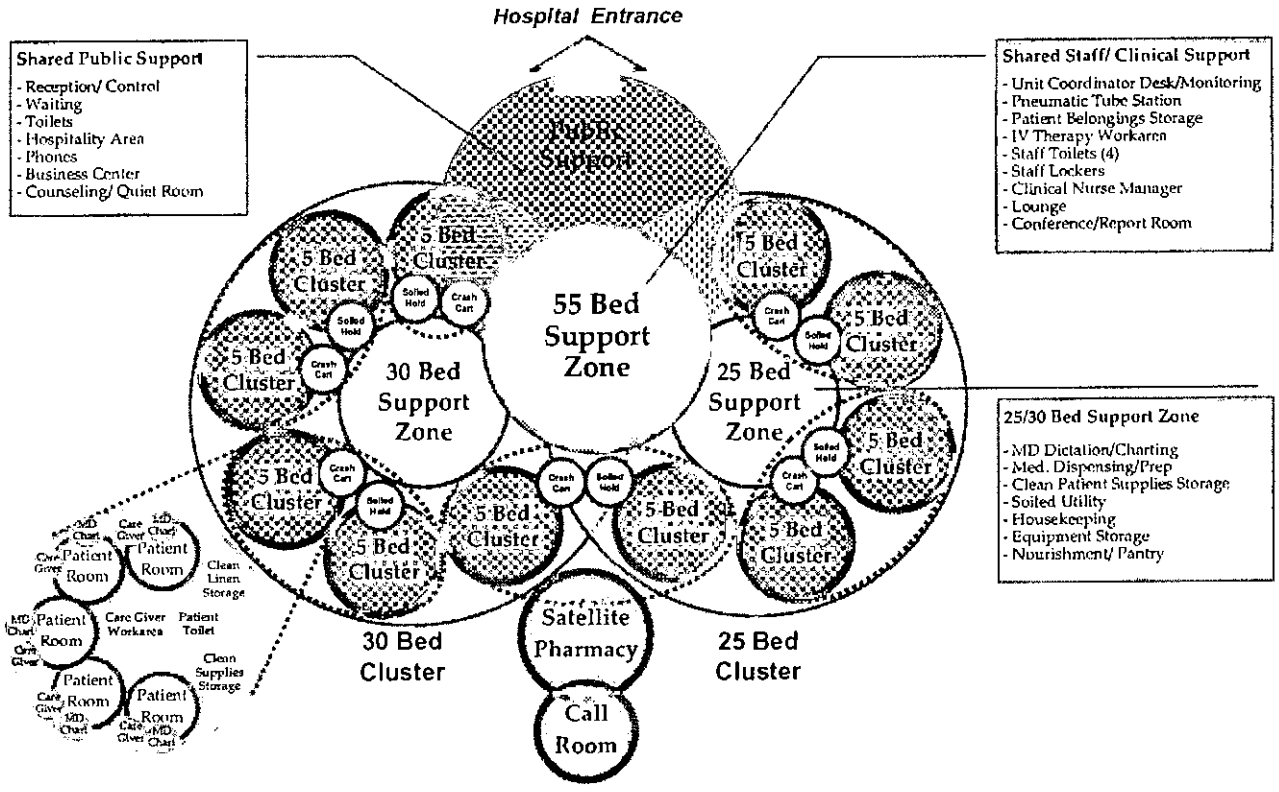
ATTACHMENT GRC-5(8)

CSSC - Functional Capacity/Zoning

The 55 CSSC positions will be configured into eleven clusters of five positions each, with each cluster being assigned decentralized support areas for staff and supplies. The configuration of the cluster is to optimize patient visualization from the caregiver workstation. Additional shared clinical support areas will be dispersed through the CSSC serving 25 to 30 beds in order to provide both convenient access for staff as well as to optimize operational/supply efficiency.

The CSSC will have a central administrative and staff support area. The Public/Family support functions will be the access point for all outpatient and same day admit patients having a procedure in the IPS.



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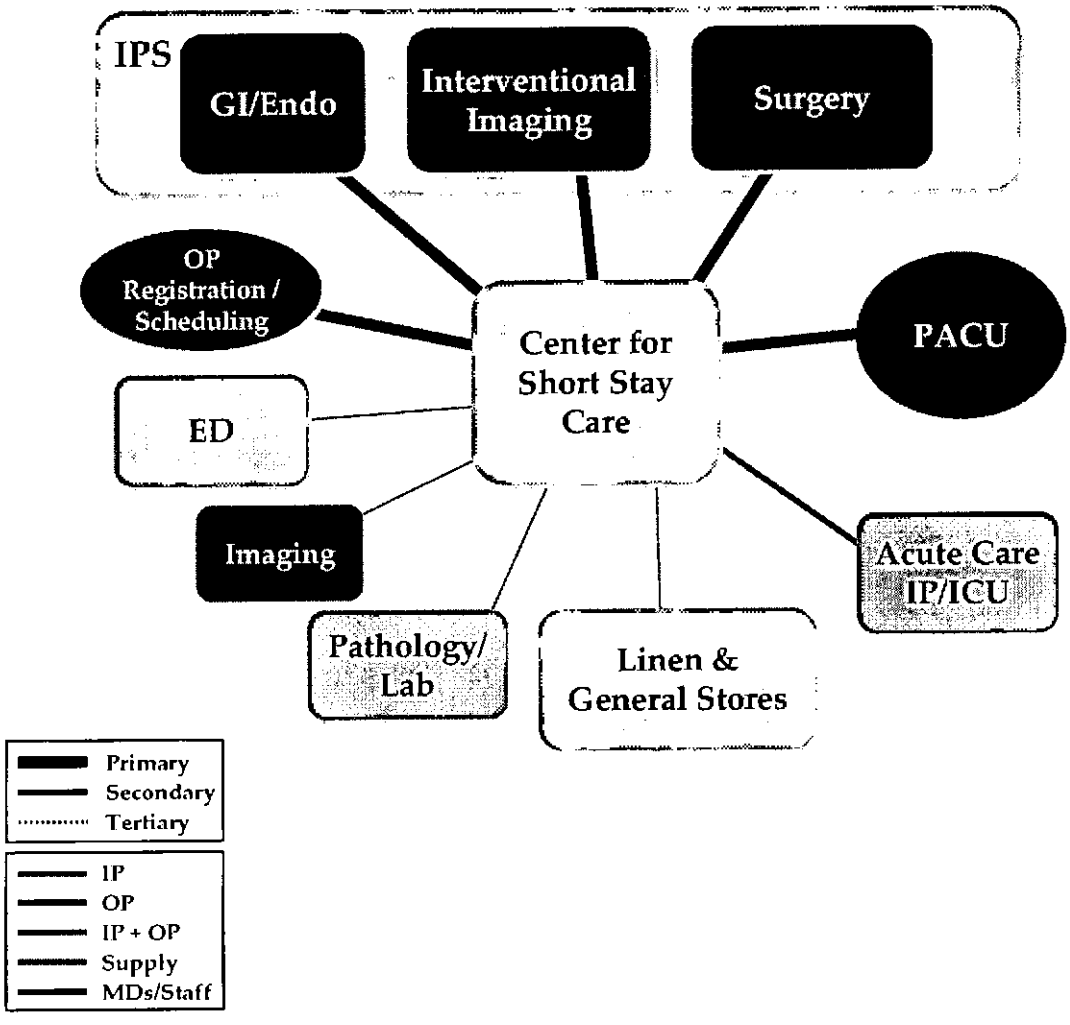
ATTACHMENT GRC-5(8A)

Page 1 of 2

CSSC - Staffing, Hours of Operation, Key Relationships

Key Adjacencies / Relationships

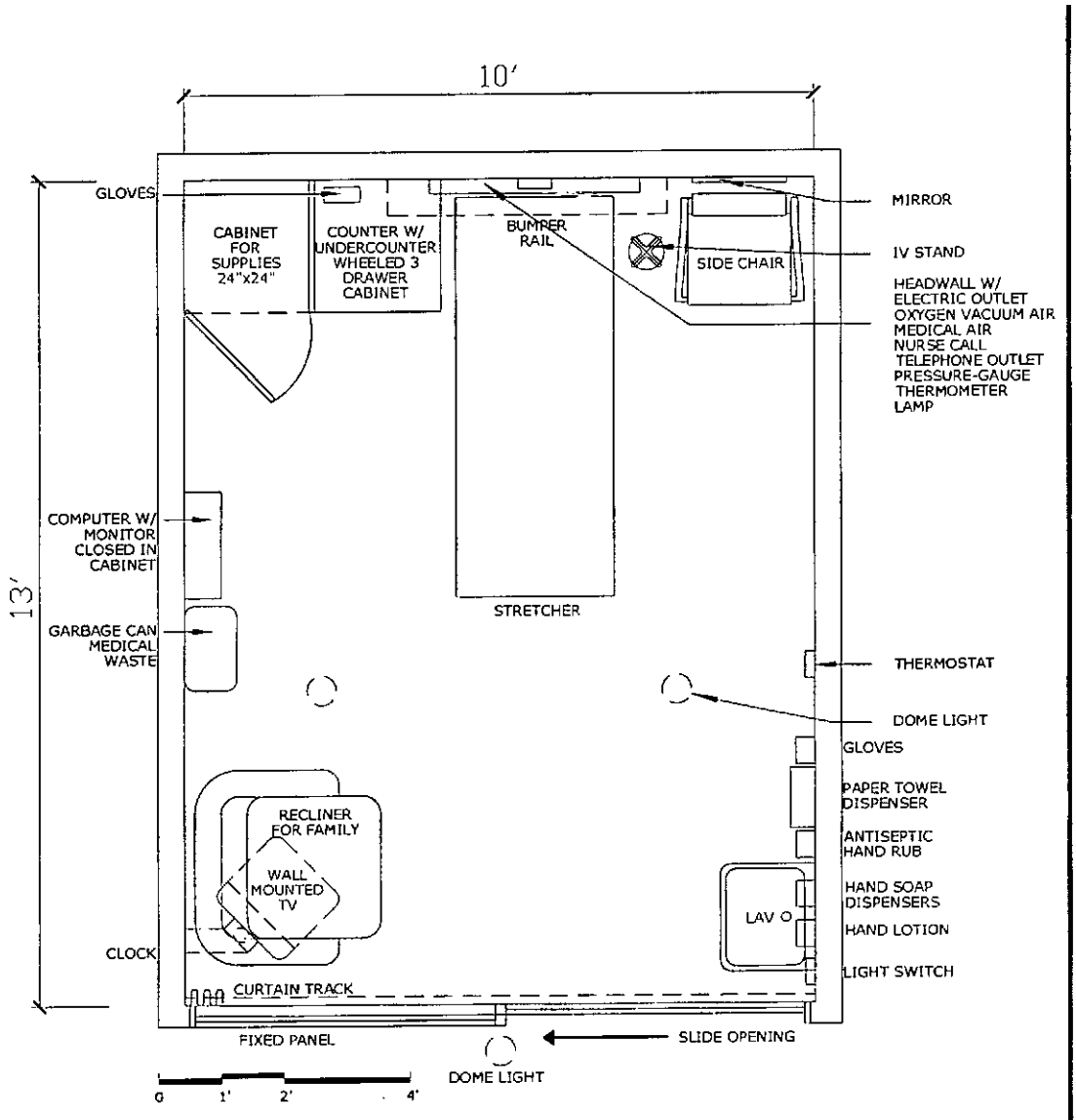
CSSC must be located directly adjacent to Integrated Procedure Services & PACU in order to facilitate the patient flow related to preparation and Stage 2 recovery. In a sense, CSSC is the public "front door" for the IPS. Since inpatients will be staged in the CSSC prior to their procedure, the paths of travel between CSSC and the inpatient units must be configured in such a way as to limit travel time and cross traffic with public.



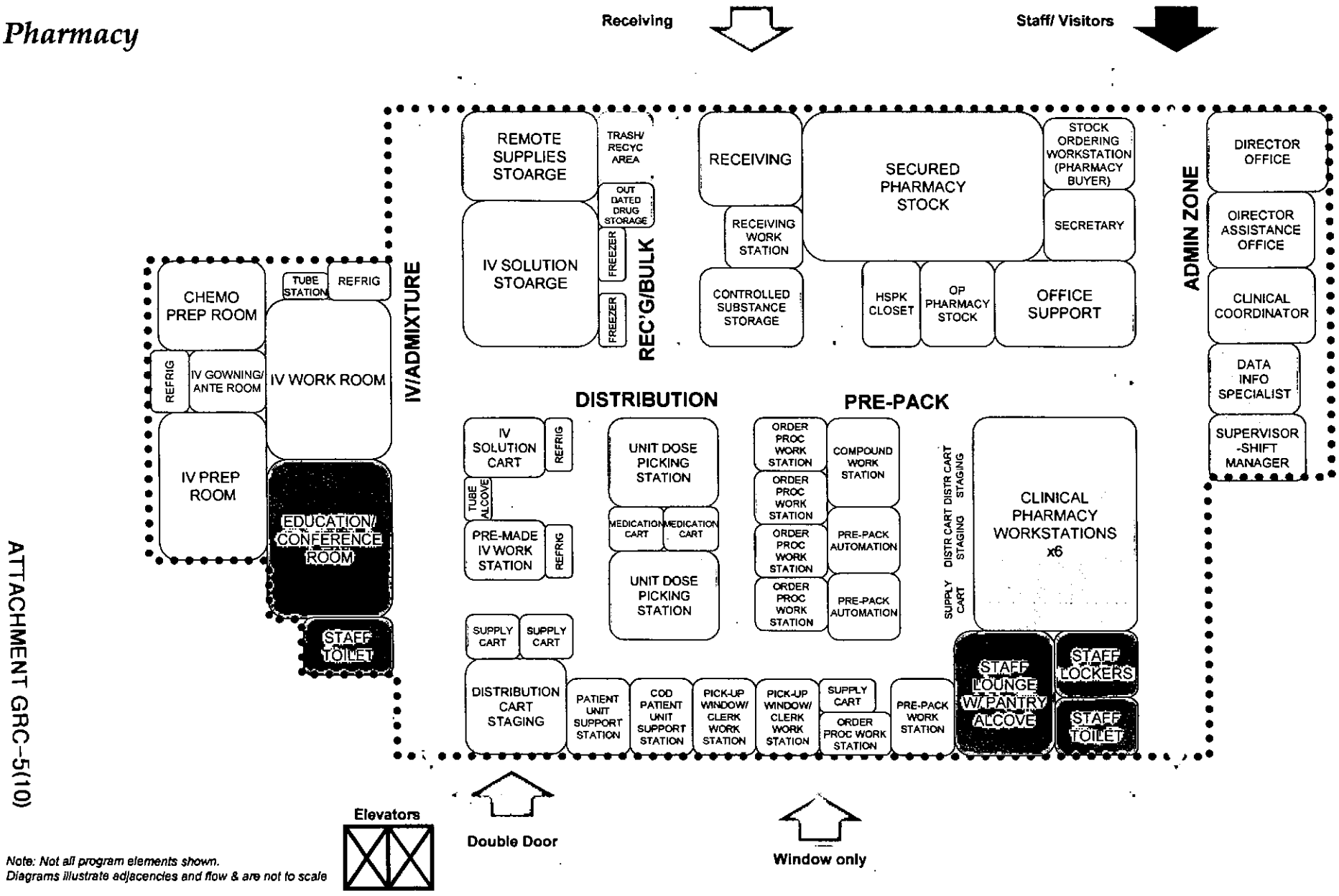
CSSC - Room Prototypes

Prototypical Private Prep/Recovery Position

For the purpose of sizing the overall center, a prototypical private patient position was developed at **130 net SF**. The room is to be enclosed with sliding glass door and will include patient monitor capabilities, medical gases, space for a stretcher, recliner, one side chair, and a hand-washing sink. Five of the 55 total positions to be contained within the CSSC will be configured as isolation positions.



Pharmacy



Note: Not all program elements shown.
Diagrams illustrate adjacencies and flow & are not to scale

ATTACHMENT GRC-5(10)

From: "Zeglen, Margie" <MZeglen@paloscomm.org>
To: <deliawoz@comcast.net>
Subject: USP 797 Overview
Date: Monday, August 25, 2008 2:01:26 PM

THE US PHARMACOPOEIA (USP):
USP Chapter 797(1), enacted January 1, 2004, presents the first enforceable standards for sterile compounding. Following years of patient safety recommendations and professional guidelines, the intent of USP 797 is to set forth the procedural and practical requirements for safe compounding of sterile preparations. The Chapter's requirements are applicable in all practice settings where sterile preparations are compounded.

USP 797 was written to improve the compounding of sterile products. And for the most part, USP 797 contains many procedural, training and quality assurance requirements that are not unreasonable for a quality IV operation. In time, USP 797 will be implemented as the US standard for sterile compounding, with ASHP and other industry guidelines following its lead. The standards developed by USP are important for several reasons:

1. The Food, Drug and Cosmetic Act (and thus the FDA) recognizes the USP/NF (National Formulary) as the official compendia of US drug standards. There are hundreds of USP drug standards and all standards numbered less than 1,000 are enforceable by either individual State Boards of Pharmacy, or the FDA. The FDA does not routinely inspect individual pharmacies but may intervene in the case of injuries, a death, or a complaint.

2. USP/NF standards are often used as evidence of national standards in lawsuits.

3. The JCAHO (Joint Commission for Accreditation of Healthcare Organizations) has adopted these standards for use after July 1, 2004. JCAHO accreditation is the most universally recognized standard of US healthcare system quality. JCAHO accreditation is required for reimbursement through the national Medicare program and almost all state Medicaid (welfare) programs.

4. Many State Boards of Pharmacy are adopting USP 797 for their pharmacy inspections.

Compliance with USP 797 will be achieved through the completion of steps on a timeline that stretches out through 2008. The requirements allow pharmacies to plan appropriately for compliance, understanding that changes of this magnitude will not be accomplished overnight.

USP 797 represents a profound change for the profession of pharmacy. The key is using aseptic technique with the right equipment in an environment that's appropriate.

The USP (US Pharmacopoeia) is a private organization formed in 1820. Current members include many members of accredited schools of medicine and pharmacy, state medical and pharmacy associations, government agencies, consumer organizations and other prestigious health organizations. For more information, see the ASHP Discussion Guide on USP Chapter 797.

Source: Baxa, Understanding USP 797 - Technical Paper: An overview of USP General Chapter 797 Pharmaceutical Compounding - Sterile Preparations; http://publicrelationsnewsroom.com/wsn page4.html

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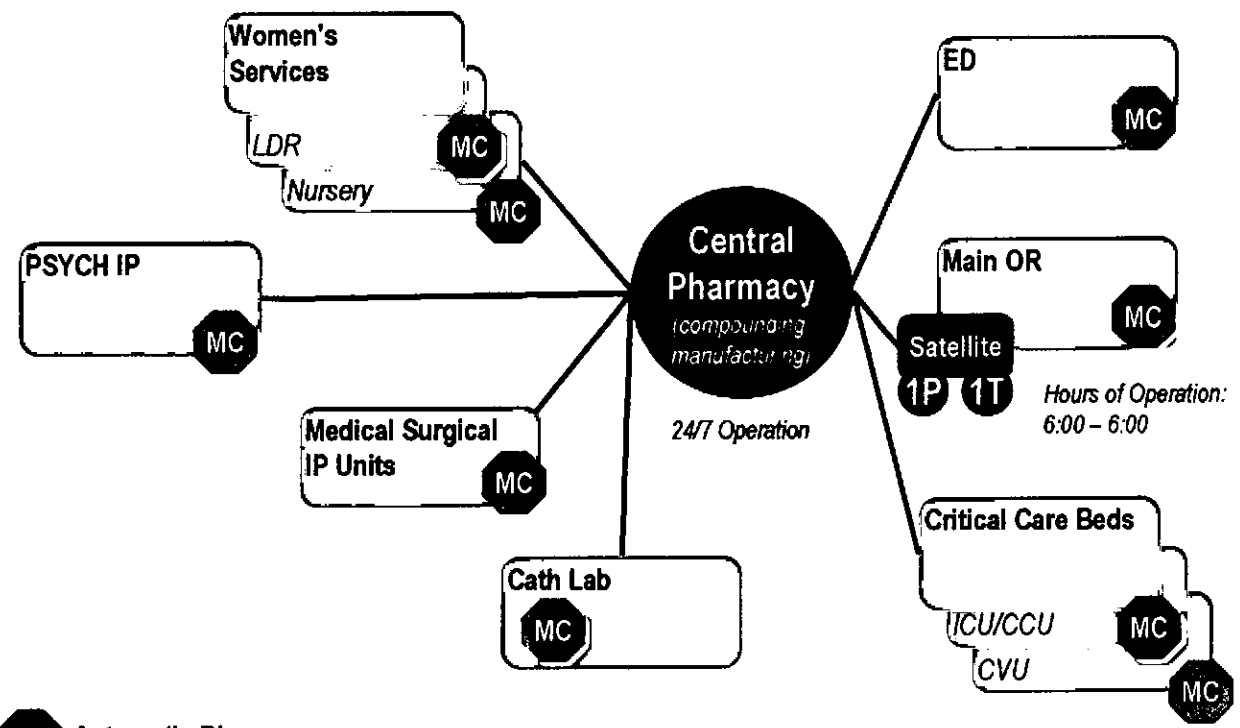
Margie Zeglen
Director, Planning
Palos Community Hospital
12251 S. 80th Ave.
Palos Heights, IL 60463
708-923-4744 phone
708-923-4169 fax
mzeglen@paloscomm.org <mailto:mzeglen@paloscomm.org>

ATTACHMENT GRC-5(11)

Pharmacy - General Description

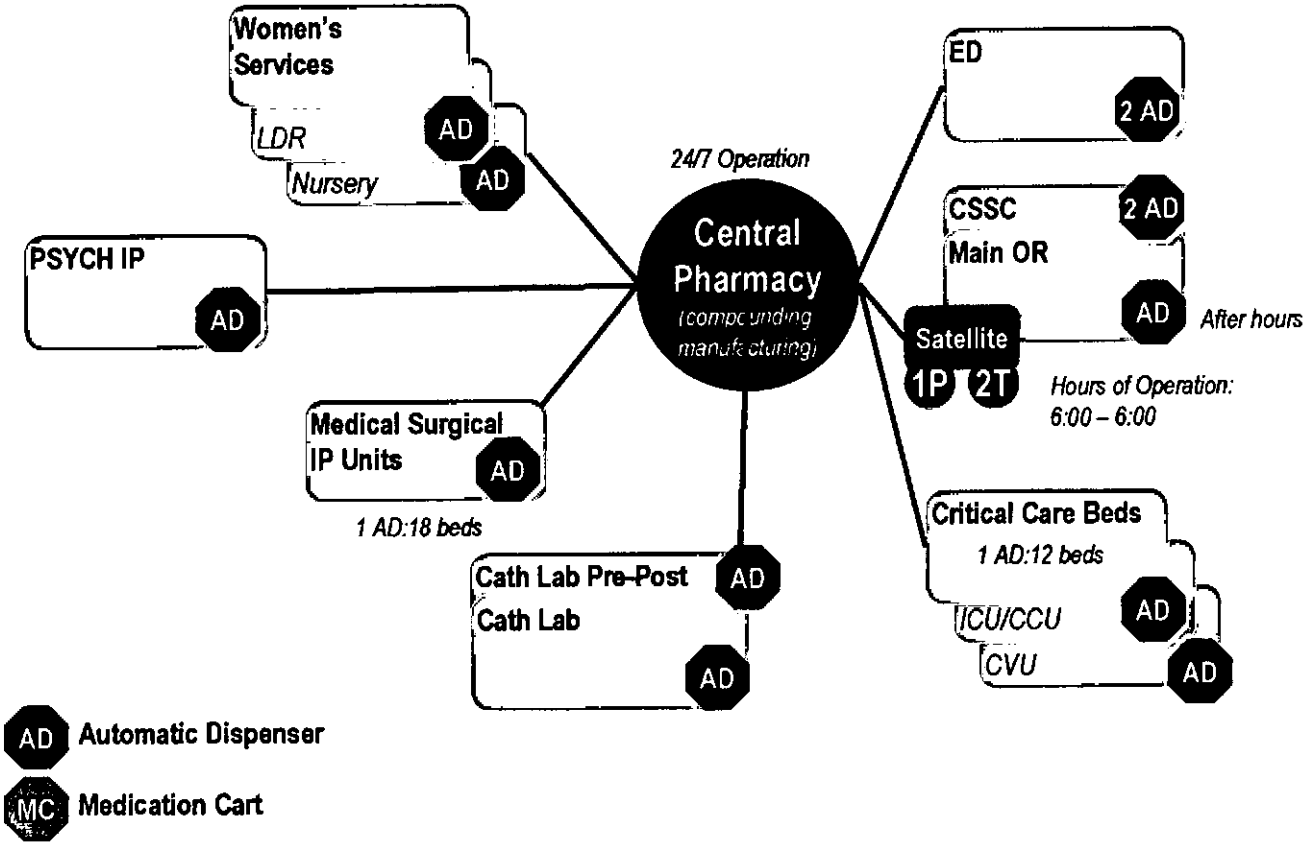
The Pharmacy provides purchasing and management of all medications dispensed to inpatients at PCH, as well as, filling prescription orders for PCH staff. All IV medications and necessary compounding, including chemotherapy, will done within the main pharmacy. A satellite pharmacy located with the IPS will support the direct needs of the operating and procedure rooms and their associated recovery beds. All other medications will be distributed from the Main Pharmacy that will be located on the lower level of the new addition.

Currently the pharmacy utilizing a medication cart distribution system as illustrated in the diagram below. An distribution model utilizing automated medication dispensing units (AD) is under development and will be phased in over the next several years. Given the limited amount of support space on the existing IP units, it is anticipated that the complete roll out of automated dispensing on these units will not occur until after the completion of the new bed tower and the reconfiguration of the current IP units. As such the new pharmacy space must be flexible in its design and configuration to accommodate both medication cart fill processes as well as automated dispensing units. To the degree possible the design of the pharmacy should be executed in an open environment with the utilization of reconfigurable systems product rather than fixed casework to provide the ability to adjust the work flow over time.



Pharmacy - General Description

The proposed automated dispensing model is planned to be implemented with as illustrated below with 80% of medications stocked in the dispensing units. All first-dose and STAT meds will either be sent via pneumatic tube or delivery by pharmacy technicians to the floor. Pneumatic tube connection to all key pharmacy customers including the satellite pharmacy is critical and the system needs to empty into a secure area on the inpatient units and clinical departments. Given this distribution strategy and the current and project volume, the pharmacy does not plan on acquiring any robotics to assist in the prescription fill process.

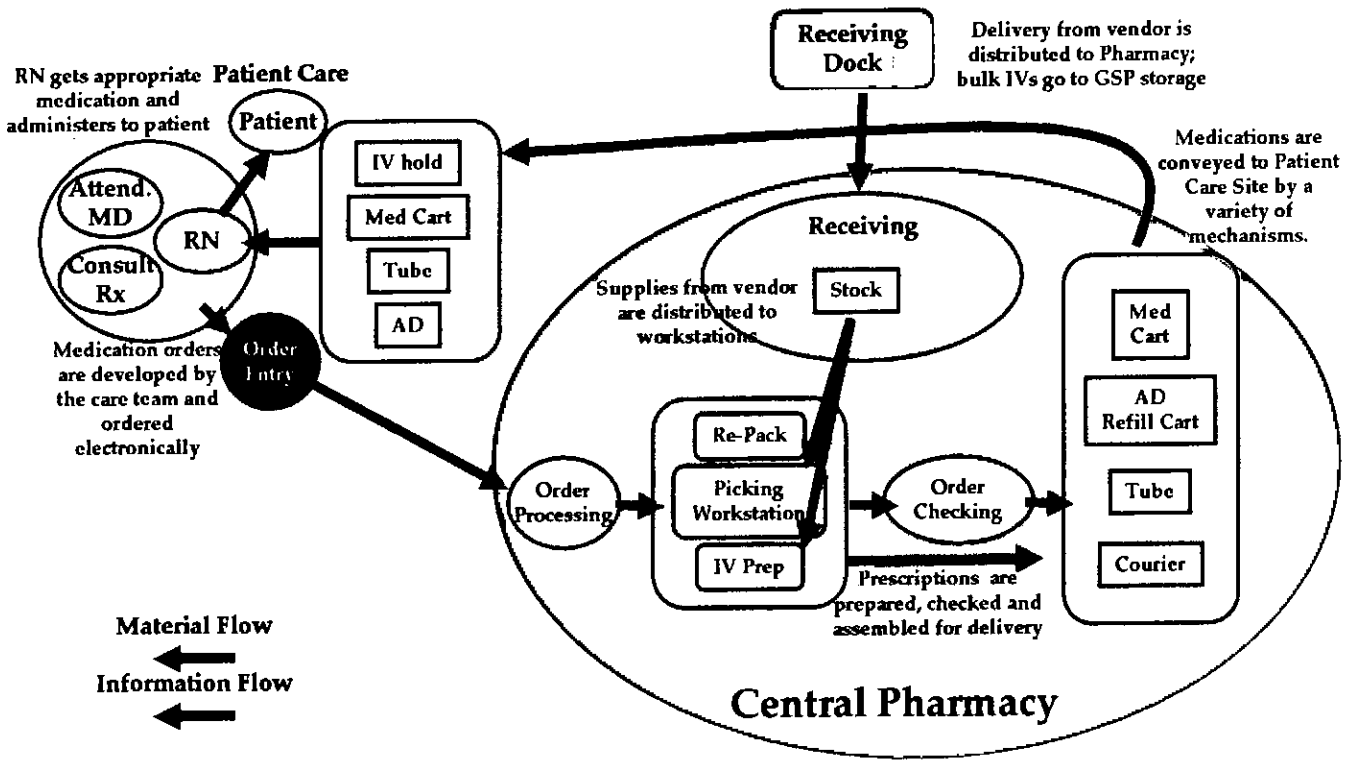


In addition to the implementation of an automated distribution model , PCH also plans to implement Bedside Barcode Scanning and physician order entry. It is not anticipated at this time that either of these initiatives will be in place prior to the completion of the addition which further impacts the need for flexibility in the design of the main pharmacy as changes to the order entry process will impact the work flow within the department.

With additional support space planned to be provided on the patient floors, PCH will also disperse the Clinical Pharmacists to the inpatient units. Support space for pharmacy within each key clinical area has been included as part of the planning with direct involvement and input by pharmacy representatives.

Pharmacy – Operational Overview

The Pharmacy is configured around the work flow for the filling of orders and stocking of medication carts and automated dispensing units. This work flow will adjust over time as various medication safety and operational initiatives are put into place. The area is to be designed as a predominately open work environment within the secured area.



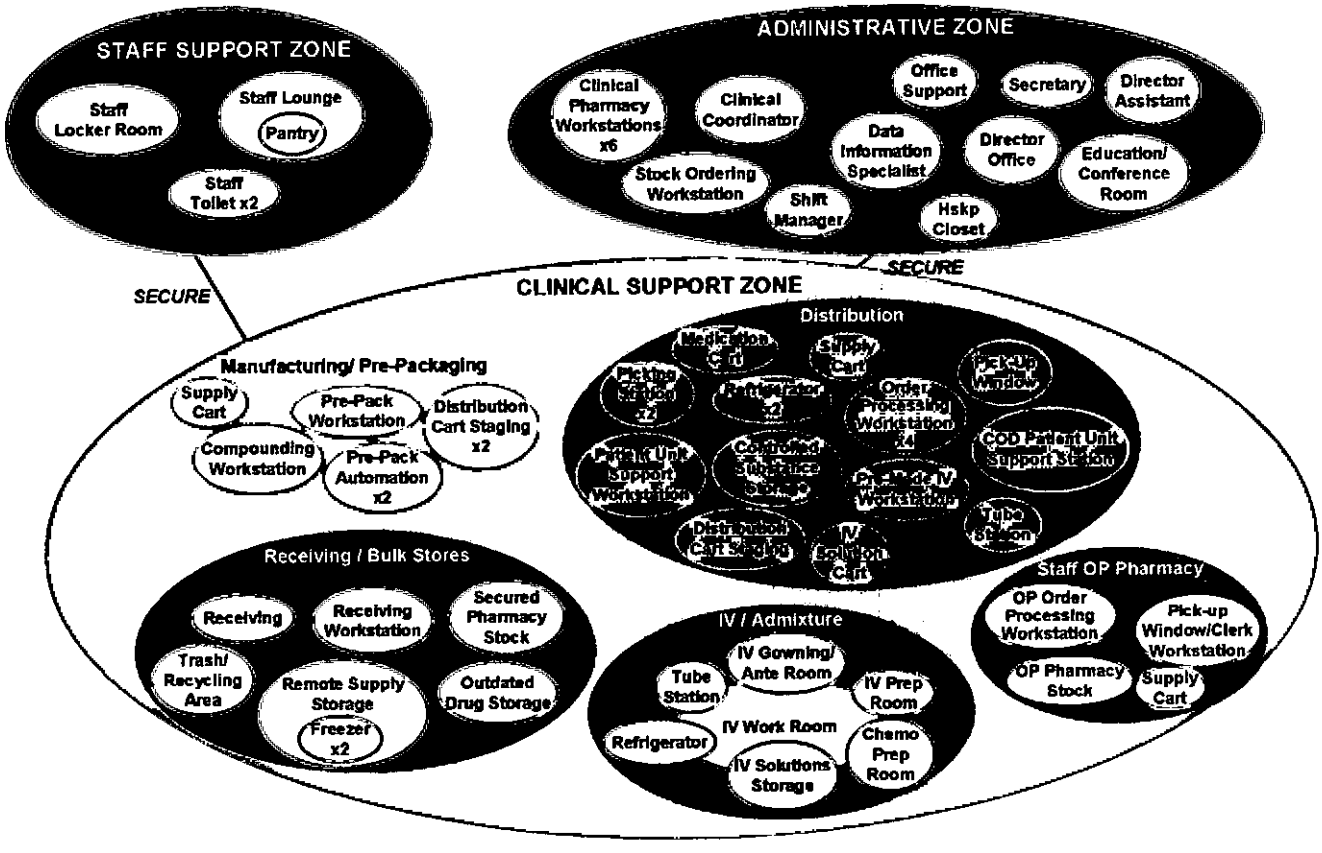
The following zones within the pharmacy are:

- Receiving/Bulk Stores
- Manufacturing/Pre-Packaging
- Distribution
- IV/Admixture
- Staff OP Pharmacy
- Staff/Administrative Support

Special construction is required to provide appropriate security. The pharmacy should be configured so that internal operations take place in a totally secure environment. Provisions should be made to allow visitors into some peripheral spaces within the Satellite Pharmacy without going through internal work areas.

Pharmacy - Operational Overview

All medications are ordered and received directly by the Pharmacy. Currently pharmaceutical deliveries are handled through the main loading dock, but in the future could be delivered through the planned access point in the new addition. General Stores personnel do not handle or process this delivery. Within the dedicated receiving area for pharmacy, a receiving workstation will control the access and process inventory deliveries to either the centralized secured pharmacy stock or the controlled substance storage area within the distribution zone. IV solution storage will be held in a separate area easily accessible to the IV/Admixture area. The secured pharmacy stock must be adjacent to the receiving area, but easily accessible to the distribution zone. A trash/recycling area is provided to hold any waste accumulated from the break-down of deliveries. A secured area for the holding of outdated drug storage will be held in the receiving area until pick up for disposal.



The manufacturing/repackaging area is to accommodate the process of developing unit doses for those medications that are supplied in bulk and to barcode product as needed for tracking and distribution to the floors. The area is to have one workstation with a computer and a sink with the associated table top automation adjacent. An area to stage carts for distribution of packaged product to rest of the pharmacy is also provided.

Pharmacy - Operational Overview

The Pharmacy will include a USP 797 compliant IV prep suite with an anteroom adjoining two rooms with hoods, one for chemo and hazardous compounding with externally exhausted negative flow and one with positive pressure for other sterile compounding.

The anteroom will incorporate a staff gowning area and one pass-through refrigerator. IV's will be delivered in bulk on a regularly scheduled basis and on demand as necessary to inpatient units. Special orders and chemo will be hand-delivered by pharmacy technicians. Pneumatic tubes will also be used when appropriate as should be located within the IV work room adjacent to the Anteroom.

The distribution area will handle all order processing and fill of non-IV medications, as well as, the restocking of medication carts and automated dispensing unit. Controlled substances will be held for ease of access with this area in a secured automated dispensing unit. Four order processing workstations will handle first-dose and STAT orders. Two large unit dose picking stations will fill these orders which will then be verified by the pharmacist prior to delivery. Currently the staff pharmacist do all order entry and verification. A separate workstation is provided to process inventory for the automated dispensing units. Pre-made IV's will be bar coded and processed at a dedication workstation with adjacent space to stage an exchange cart stocked with fluid.

Prescriptions for staff are filled in a separate zone with dedicated stock. The order processing workstation should be adjacent to a designated secured pick-up window for staff only. A phone will be required by the staff pick-up window, so the staff can notify pharmacists of their arrival to pick up prescriptions. An adjacent pick-up station is to be provided to accommodate any patient orders being picked-up by staff.

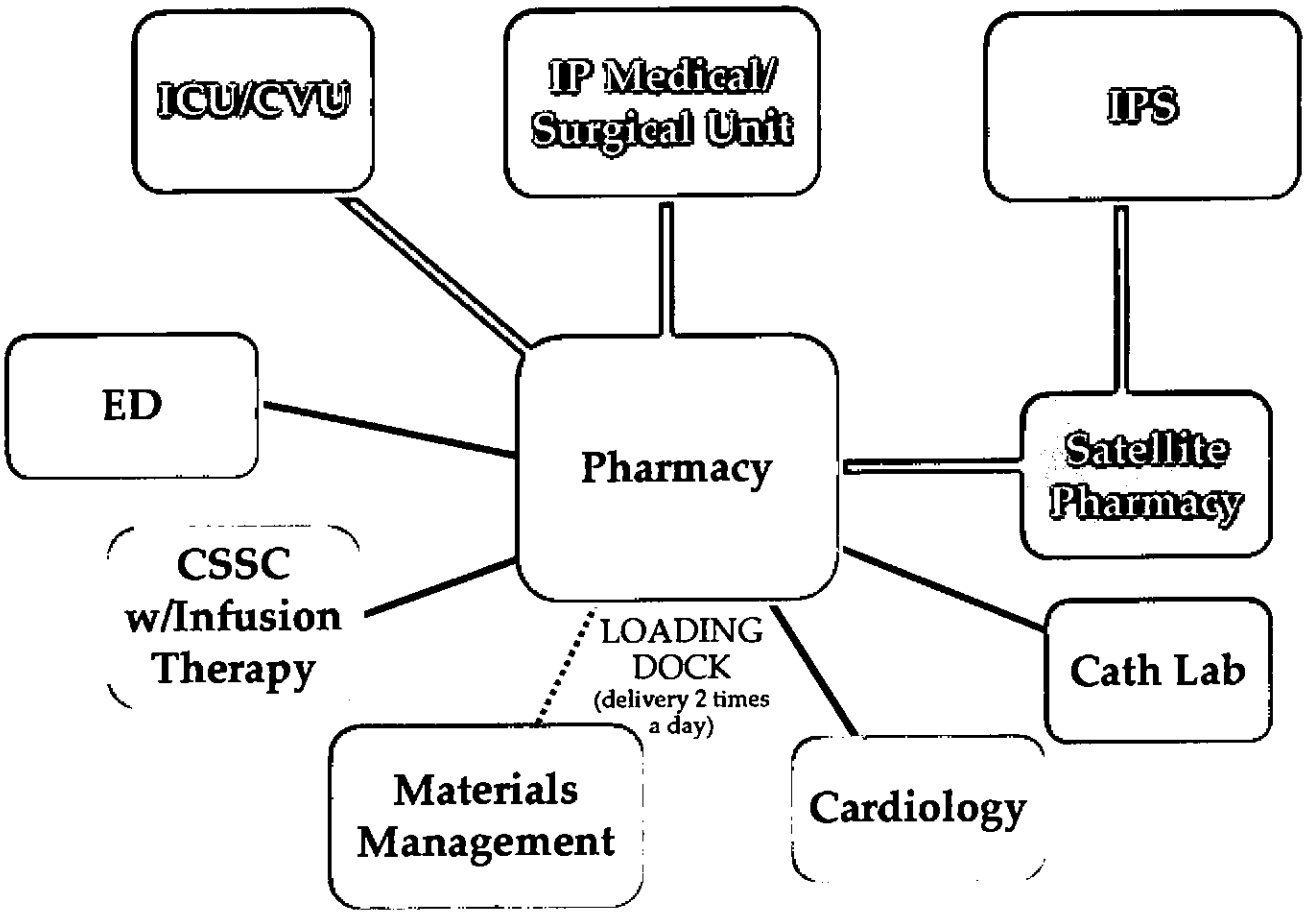
Staff and administrative support elements should be placed within the Pharmacy in such a way as to allow an appropriate level of privacy / isolation from primary pharmacy functions, yet should also allow staff and administrative personnel appropriate oversight and access. An entrance to accommodate visitors and vendors to the pharmacy should be secure but available. This access point will be controlled by the secretary.

The Pharmacy's Director office is to be directly adjacent to the secretary work area. Additional private offices are to be provided for the Director Assistant, Clinical Coordinator, Shift Supervisor, and the Data Information Specialist. A separate workroom with six workstations will accommodate the Clinical Pharmacists. The administrative work areas will share an office support space for copier, printers, fax and office supply storage.. An education/conference room with seating for 10 is also to be provided. A staff lounge with seating for eight and a small pantry area should be adjacent to the staff locker area.

Pharmacy - Staffing, Hours of Operation, Key Relationships

Key Adjacencies / Relationships

Pharmacy needs to be in proximity to patient care areas, particularly ICU and Surgery. Immediate access to the staff and material handling elevators is essential. Access from the receiving dock to Pharmacy receiving and storage must be easy and direct without passing through the internal work spaces.



SIZE OF PROJECT

The Hospital meets and exceeds IHFPB utilization standards for all clinical services with designated IHFPB target use rates. Refer to Attachment GRC-6(1) for the historical and projected utilization of each clinical service affected by the project for the years 2005-2020, the second full year following project completion. Attachment GRC-6(1) indicates that while Palos Community Hospital's utilization continues to grow, projections are based on modest growth rates for each department. See the table on the following page for a comparison of historical and projected average annual growth rates for each clinical service affected by the project for the years 2005-2020.

Projected utilization for each clinical service is based primarily on the department's historical utilization rates. Other key assumptions in developing the utilization projections include the continued growth and aging of the service area population and continuing increases in severely ill patients. Projected utilization also assumes continued growth and development of the Medical Staff and establishment of a new Hospitalist program.

The population in the Hospital's service area is projected to continue increasing at an average 1.0% annual growth through 2020 (see population projections in Attachment GRC-6(2A).) The service area's elderly population is expected to increase 2.5% per year through 2012 (see Attachment GRC-4.) The elderly are the fastest growing population in the service area.

The Hospital serves a significant elderly population, comprising 12.8% of the area's population, which is higher than in Illinois or the U.S. See Attachment GRC-6(2) which documents this ratio and the elderly population's substantially higher inpatient use rates in the Hospital's service area. Similarly, while the Hospital's overall market share is 23.5%, it serves between 27% and 30% of the area's elderly (refer back to Attachment GRC-4(4).) In fact, the Hospital admits far more patients from skilled nursing facilities (SNFs) than any other Illinois hospital. In 2005 Palos Community Hospital admitted 887 SNF patients, almost 50% higher than the next highest hospital's 605 patients (Attachment GRC-6(3).)

The Hospital is a major care provider for the severely ill, as indicated by its high co-morbidity index (see Attachment GRC-6(4) for documentation of the Hospital's high acuity level and co-morbidity index.) Given the large portion of elderly in the service area, their medical needs, and chronic disease conditions, the Hospital anticipates that the trend towards serving larger and larger severely ill patients will continue.

The Hospital's medical staff has grown almost 9% in the last eight (8) years, from 474 physicians to 515 physicians. Ninety-nine percent (99%) of the medical staff is Board certified. The Hospital has adopted a medical staff development plan to ensure continued recruitment of physicians to replace physicians who retire. The plan includes formation of Palos Medical Group, an integrated (employed) physician practice group and establishment of a Hospitalist program (see Attachment GRC-6(5) for additional information.)

PALOS COMMUNITY HOSPITAL
Comparison of Historical and Projected Utilization, 2005 - 2020
Average Annual Rates of Change

Clinical Service	Historical Utilization Average Increase 2005 - 2007	Projected Utilization Average Increase 2008 - 2020
Medical Surgical*		
Patient Days	5.8%	2.5%
Intensive Care		
Admissions	9.5%	3.0%
Patient Days	5.4%	3.0%
Surgery		
Number of Hours	4.0%	2.8%
Endoscopy		
Number of Hours	6.9%	2.8%
Special/ Minor Procedures	slight decline	held constant
Infusion/ Other Outpatient treatments	13.3%	1.8%
**Respiratory Therapy procedures ** **	0.5%	0.5%
Laboratory		
Visits	4.5%	2.5%
FTE	101	held constant
Pharmacy		
Doses	4.5%	3.0%
Orders	6.9%	3.0%
Outpatient & Pre-Admission Testing	held constant	held constant
Inpatient Dialysis* **		
Patients	20.9%	2.0%
Treatment	11.3%	2.0%
Emergency Department		
Visits	1.9%	1.9%
Admissions Unit		
Admissions	7.8%	2.3%
Cardiology		
ECG/ EKG	8.8%	2.0%
All Other Procedures	3.7%	2.0%
Nuclear Medicine **		
Visits	6.3%	4.1%
Procedures	4.3%	4.1%
Radiology		
General Procedures	2.4%	2.2%
CT Procedures	1.6%	1.5%
Ultrasound Procedures	4.4%	3.5%
Mammography Procedures	2.5%	2.0%

* Includes M-S Observation Days
** Historical Data spans from 2006 thru June 2008
*** Historical Data spans from 2005 thru May 2008

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED UTILIZATION

MEDICAL/SURGICAL

	Historical				Projected											
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Medical Surgical Admissions	15,640	15,292	15,892	16,289	16,697	17,114	17,542	17,980	18,430	18,891	19,363	19,847	20,343	20,852	21,373	21,907
% Change		-2.2%	3.9%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
Medical Surgical Patient Days	68,617	71,241	75,404	77,289	79,221	81,202	83,232	85,313	67,446	89,632	91,872	94,169	96,523	98,937	101,410	103,945
% Change		3.8%	5.8%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
* Observation Patient Days	2,253	4,395	3,699	3,791	3,886	3,983	4,083	4,185	4,290	4,397	4,507	4,620	4,735	4,853	4,975	5,099
% Change		95.1%	-15.8%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
Total Medical Surgical Unit Days	70,870	75,636	79,103	81,081	83,108	85,185	87,315	89,498	91,735	94,029	96,379	98,789	101,259	103,790	106,385	109,044
% Change		6.7%	4.6%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
Average Increase 2005-2007			5.8%													
Average Daily Census (ADC)	194	207	217	222	228	233	239	245	251	258	264	271	277	284	291	299
Average Length of Stay (ALOS)	4.39	4.66	4.74	4.74	4.74	4.74	4.74	4.74	4.74	4.74	4.74	4.74	4.74	4.74	4.74	4.74
Licensed Medical Surgical Beds	315	315	315	315	315	315	315	315	315	315	315	315	306	306	306	306
Staffed Medical Surgical Beds	266	267	274	278	278	278	278	278								
ds in Transition due to Modernization (134)									-32	-34	-34	-34				
** Total Beds Physically Available	315	315	315	315	315	315	315	315	283	281	281	281	306	306	306	306
Occupancy of Licensed Beds	62%	66%	69%	71%	72%	74%	76%	78%	80%	82%	84%	86%	91%	93%	95%	98%
Occupancy of Staffed Beds	73%	78%	79%	80%	82%	84%	86%	88%								
Occupancy of Physically Available Beds	62%	66%	69%	71%	72%	74%	76%	76%	89%	92%	94%	96%	91%	93%	95%	98%
CON Justified M/S Beds (@ 88%)	221	235	246	252	259	265	272	279	286	293	300	308	315	323	331	339

Observation patients are treated on medical surgical patient care units.

* The significant increase in inpatients in 2007 and 2008 was due to an overly conservative interpretation of CMS rules relating to observation status by hospital staff in 2006, resulting in a higher volume of patients placed in observation status. Implementation of case management review and physician documentation of inpatient criteria resulted in appropriate classification of patients, and more inpatients.

** The project modernizes 134 M/S beds converting the beds to private rooms. These beds are in four nursing units; one nursing unit will be modernized per year after construction of the East Wing .

Annualized Jan-Jun 2008

Source: PCH Meditech Utilization Statistics/Planning; Projections - NCI Consulting

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED UTILIZATION

INTENSIVE CARE

	Historical			Projected												
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Intensive Care Admissions	1,411	1,535	1,693	1,770	1,823	1,878	1,934	1,992	2,052	2,113	2,177	2,242	2,309	2,379	2,450	2,524
% Change		8.8%	10.3%	4.5%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Average Annual 2005-2007			9.5%													
Intensive Care Patient Days	5,348	5,689	5,942	6,090	6,273	6,461	6,655	6,854	7,060	7,272	7,490	7,715	7,946	8,184	8,430	8,683
% Change		6.4%	4.4%	2.5%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Average Annual 2005-2007			5.4%													
Average Daily Census (ADC)	15	16	16	17	17	18	18	19	19	20	21	21	22	22	23	24
Average Length of Stay (ALOS)	3.8	3.7	3.5	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4
Authorized Beds	24	24	24											36	36	36
% Occupancy on 24 Authorized Beds	61%	65%	68%	70%												
% Occupancy on 18 Operational Beds	81%	87%	90%	93%												
% Occupancy on 36 Proposed Beds														62%	64%	66%

INTENSIVE CARE BEDS:	
Existing	24 ICU Beds
IHFPB Std. 60% by 2018	44 ICU Beds
Proposed	36 ICU Beds

Annualized 2008 Jan-Jun 2008
PCH has a lowest ICU ALOS of all area hospitals.
Source: PCH Meditech Utilization Statistics, Projections - NCI Consulting

INTEGRATED PROCEDURE SERVICES (IPS)

	EXISTING	CON PROPOSED
IPS - OR PROCEDURE ZONE	12	13
IPS - ENDOSCOPY ZONE	3	4
IPS - INTERVENTIONAL ZONE (SPECIALS)	1	1
IPS -INTERNVENTIONAL ZONE (MINOR PROCEDURES)	1	1
Total Procedure Rooms IPS:	17	19

PROCEDURE HOURS:

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
	Projected Growth															
IPS - OR PROCEDURE ZONE	15,794	16,498	17,155	17,717	18,163	18,720	19,095	19,477	19,866	20,263	21,198	21,622	22,054	22,495	22,945	23,404
IHFPB Rooms Allowed (1,500 hours per room)	10.5	11.0	11.4	11.8	12.1	12.5	12.7	13.0	13.2	13.5	14 1	14.4	14.7	15 0	15.3	15.6
IPS - ENDOSCOPY ZONE*	5,058	5,225	5,752	4,940	5,912	6,076	6,244	6,418	6,596	6,779	6,967	7,161	7,359	7,564	7,774	7,990
IHFPB Rooms Allowed (1,500 hours per room)	3 4	3.5	3.8	3.3	3.9	4.1	4.2	4.3	4.4	4.5	4.6	4.8	4.9	5 0	5.2	5 3
IPS - INTERVENTIONAL ZONE (SPECIALS)	2,153	2,031	1,993	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000
IHFPB Rooms Allowed (2,000 hours per room)	1.1	1.0	1.0	1.0	1.0	1 0	1.0	1.0	1.0	1.0	1.0	1.0	1 0	1.0	1.0	1 0
IPS -INTERNVENTIONAL ZONE (MINOR PROCEDURES)	4,032	3,080	2,975	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005
IHFPB Rooms Allowed (2,000 visits per room)	2 0	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1 5	1.5	1.5	1.5	1.5
TOTAL IHFPB ROOMS ALLOWED																23.4

PROCEDURE ROOMS:

EXISITING**	15	17	17	17	17	17	17	17	17	17	17	17	17			
PROPOSED														19	19	19

OPERATING ROOMS	13 Includes 1 cystoscopy
GI/ENDO	4
SPECIAL/INTERVENTIONAL	1
MINOR PROCEDURES	1

RECOVERY ROOMS:

4 PER PROCEDURE ROOM, EXCLUDING 2 ROOMS FOR SPECIAL/MINOR PROCEDURES ROOM = 17 PX ROOMS

PROPOSED RECOVERY POSITIONS:									
CALCULATED TOTAL POSITIONS BASED ON 17 PX ROOMS:	68	68	68	68	68	68	68	68
PACU	15	15	15	15	15	15	15	15
CSSC (PRE AND POST - STAGE II & OUTPATIENT)	50	50	50	50	50	50	50	50
TOTAL RECOVERY POSITIONS	65	65	65	65	65	65	65	65
PLUS INFUSION THERAPY/OTHER OUTPATIENT PROCEDURES (IN CSSC ZONE)	5	5	5	5	5	5	5	5

** 2 CVORs added in 2005*

Project includes only one smaller OR for cystoscopy.

In AHQs - 2 existing cysto rooms are reported with General ORs since they are located in Surgery.

In 2007 one surgeon retired; 1 physician went to part time; & another physician was on LOA several months. In 2008 PCH added two new general surgeons.

Source:PCH - Surgical Services Statistics

LOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

SURGERY

	Historical		Projected Growth													
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
HOURS OF SURGERY																
Inpatient	9,063	10,147	10,655	11,242	11,186	11,984	12,223	12,468	12,717	12,972	13,760	14,035	14,316	14,602	14,894	15,192
Outpatient	6,731	6,351	6,500	6,475	6,977	6,737	6,871	7,009	7,149	7,292	7,438	7,586	7,738	7,893	8,051	8,212
Total	15,794	16,498	17,155	17,717	18,163	18,720	19,095	19,477	19,866	20,263	21,198	21,622	22,054	22,495	22,945	23,404
Annual % Change		4.5%	4.0%	3.3%	2.5%	3.1%	2.0%	2.0%	2.0%	2.0%	4.6%	2.0%	2.0%	2.0%	2.0%	2.0%
Average Increase 2005-2007			4.0%													
NUMBER OF PATIENTS																
Inpatient	4,097	4,427	4,517	4,607	4,699	4,793	4,889	4,987	5,087	5,189	5,292	5,398	5,506	5,616	5,729	5,843
Outpatient	4,676	4,402	4,232	4,317	4,403	4,491	4,581	4,672	4,766	4,861	4,958	5,058	5,159	5,262	5,367	5,475
Total	8,773	8,829	8,749	8,924	9,102	9,285	9,470	9,660	9,853	10,050	10,251	10,456	10,665	10,878	11,096	11,318
Average Inpatient Increase, 2005-2007			5.1%													
Annual % Change		0.6%	-0.9%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
Average Time/Procedure																
Inpatient	2.2	2.3	2.4	2.4	2.5	2.5	2.5	2.5	2.5	2.5	2.6	2.6	2.6	2.6	2.6	2.6
Outpatient	1.4	1.4	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5
Total	1.8	1.9	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.1	2.1	2.1	2.1	2.1	2.1
STANDARDS																
Capacity per OR (Hours)	1,500															
Total Capacity	15,000	18,000	18,000	18,000	18,000	18,000	18,000	18,000	18,000	18,000	18,000	18,000	18,000	19,500	19,500	19,500
Number of ORs based on hours	10.5	11.0	11.4	11.8	12.1	12.5	12.7	13.0	13.2	13.5	14.1	14.4	14.7	15.0	15.3	15.6
NUMBER OF OPERATING ROOMS (EXISTING & PROPOSED)																
Operating Rooms:*	10	12	12	12	12	12	12	12	12	12	12	12	12	13	13	13

Project includes only one smaller OR for cystoscopy.
In AHOs - 2 existing cysto rooms are reported with General ORs since they are located in Surgery.
** 2 CVORs added in 2005 (one is for emergency back-up)*
Palos recently added two new general surgeons to replace the one who retired in 2007 and the one surgeon who went from full time to part time.
One physician who was on LOA for several months in 2007 has returned.
Source: PCH - Surgical Services Statistics

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

GI / ENDOSCOPY

	Historical			Projected Growth												
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
NUMBER OF HOURS - GI/ENDO																
Inpatient	1,201	1,194	1,443	1,486	1,486	1,531	1,577	1,624	1,673	1,723	1,775	1,828	1,883	1,939	1,997	2,057
Outpatient	3,857	4,031	4,309	4,425	4,425	4,545	4,668	4,794	4,923	5,056	5,192	5,333	5,477	5,624	5,776	5,932
Total	5,058	5,225	5,752	5,912	5,912	6,076	6,244	6,418	6,596	6,779	6,967	7,161	7,359	7,564	7,774	7,990
Annual % Change		*3.3%*	*10.1%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*
Average Increase 2005-2007			6.9%													
NUMBER OF CASES/PROCEDURES																
Inpatient	1,434	1,416	1,524	1,551	1,576	1,604	1,633	1,663	1,692	1,723	1,754	1,785	1,818	1,850	1,884	1,918
Outpatient	4,676	4,784	4,549	4,685	4,417	4,549	4,686	4,826	4,971	5,120	5,274	5,432	5,595	5,763	5,936	6,114
Total GI/Endo Procedures	6,110	6,200	6,073	6,237	5,993	6,153	6,319	6,489	6,663	6,843	7,028	7,217	7,412	7,613	7,819	8,031
Average Inpatient Increase 2005-2007			3.1%													
Annual % Change		*1.5%*	*-2.0%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*
Average Time/Procedure																
Inpatient	0.8	0.8	0.9	1.0	0.9	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.1	1.1
Outpatient	0.8	0.8	0.9	0.9	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Total	0.8	0.8	0.9	0.9	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
STANDARDS																
Capacity per Room (hours)	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*
Number of Rooms based on hours	3.4	3.5	3.8	3.9	3.9	4.1	4.2	4.3	4.4	4.5	4.6	4.8	4.9	5.0	5.2	5.3
NUMBER OF PROCEDURE ROOMS (EXISTING & PROPOSED)																
GI/Endo Procedure Rooms	3	3	3	3	3	3	3	3	3	3	3	3	3	4	4	4

Palos recently added two new general surgeons to replace the one who retured in 2007 and the one surgeon who went from full time to part time. One physician who was on LOA for several months in 2007 has returned.

Source: PCH - Surgical Services Statistics - Outpatient Department

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

SPECIAL PROCEDURES / INTERVENTIONAL RADIOLOGY

PROCEDURES	Historical		Projected Growth													
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Inpatient	1,485	1,441	1,473	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500
Outpatient	668	544	520	500	500	500	500	500	500	500	500	500	500	500	500	500
Total	2,153	2,031	1,993	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000
Annual % Change		*-5.7%*	*-1.9%*	*0.4%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
STANDARDS																
Capacity per Room (Pxs)	2000 procedures															
Percent Utilization	107.7%	101.6%	99.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Number of Rooms based on hours	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1

MINOR PROCEDURES

	Historical		Projected Growth													
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Minor Procedure Visits	4,032	3,080	2,975	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005
Annual % Change		*-23.6%*	*-3.4%*	*1.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
Number of Rooms (Existing & Proposed)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
TOTALS	6,185	5,111	4,968	5,005	5,005	5,005	5,005	5,005	5,005	5,005	5,005	5,005	5,005	5,005	5,005	5,005
NUMBER OF PROCEDURE ROOMS (EXISTING & PROPOSED)																
Special Procedures/Interventional Radiology	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Minor Procedures	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1

Annualized Jan-Mar 2008
Source: PCH - Special Procedures Statistics (Radiology)

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

INFUSION THERAPY

TREATMENTS	Historical			Projected Growth												
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
OUTPATIENT INFUSION THERAPY																
Treatment Volumes	1508	1658	1908	1927	1966	2005	2045	2086	2128	2170	2214	2258	2280	2303	2326	2349
Annual % Change		9.9%	15.1%	1.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	1.0%	1.0%	1.0%	1.0%
Average Increase 2005-2007			13.3%													
Proposed Positions									One Pod in the Center for Short Stay Care					5	5	5

Volumes were projected at 2% per year through 2015 and then only 1% through 2020. Reimbursement changes and/or shift to home health for some treatments may affect the overall long-term volume.
Treatments included: Infusion (non-chemo), antibx, transfusion, Ferrlicit, epidural blocks, port draws, etc.
Source: PCH - Surgical Services, NCI Consulting

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

RESPIRATORY THERAPY

		Projected Growth														
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Number of Procedures:																
Inpatient	254,880	157,682	159,012	159,807	160,606	161,409	162,216	163,027	163,842	164,662	165,485	166,312	167,144	167,980	168,820	169,664
Outpatient	2,574	5,567	5,029	5,034	5,135	5,237	5,342	5,449	5,558	5,669	5,783	5,898	6,016	6,136	6,259	6,384
Total	257,454	163,249	164,041	164,841	165,741	166,647	167,558	168,476	169,400	170,331	171,267	172,211	173,160	174,116	175,079	176,048
% of Change	-	-36.6%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.6%	0.6%	0.6%	0.6%	0.6%
Visits/Patients:																
Total		65,300	65,616	67,585	62,982	63,326	63,672	64,021	64,372	64,726	65,082	65,440	65,801	66,164	66,530	66,898

Procedures not comparable between 2005 & 2006 due to changes in counting practices (bundling); conversion to Meditech Information system (2006)
Volumes above exclude Pulmonary Function
Outpatient includes Emergency Department

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

LABORATORY SERVICES

	Historical			Projected Growth												
Number of Laboratory Studies:	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Inpatient	465,964	452,157	504,280	541,020	554,546	568,409	582,619	597,185	612,114	627,417	643,103	659,180	675,660	692,551	709,865	727,612
Outpatient*	405,293	452,030	465,955	385,472	395,109	404,987	415,111	425,489	436,126	447,029	458,205	469,660	481,402	493,437	505,773	518,417
Studies Performed Under Contract	34,109	44,027	55,645	67,772	69,466	71,203	72,983	74,808	76,678	78,595	80,560	82,574	84,638	86,754	88,923	91,146
Total	871,257	904,187	970,235	994,264	1,019,121	1,044,599	1,070,714	1,097,481	1,124,918	1,153,041	1,181,867	1,211,414	1,241,699	1,272,742	1,304,561	1,337,175
Annual % Change		3.8%	7.3%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
Average Annual 2005-2007			5.5%													
FTEs	101	101	100	101	101	101	101	101	101	101	101	101	101	101	101	101

	Historical				Projected Growth											
Number of Visits (Venipunctures):*	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Inpatient	107,172	111,256	120,451	131,220	134,501	137,863	141,310	144,842	148,463	152,175	155,979	159,879	163,876	167,973	172,172	176,476
Outpatient*	44,582	55,058	54,876	52,544	53,858	55,204	56,584	57,999	59,449	60,935	62,458	64,020	65,620	67,261	68,942	70,666
ED	9,209	12,369	13,155	14,456	14,817	15,188	15,568	15,957	16,356	16,765	17,184	17,613	18,054	18,505	18,968	19,442
Total	160,963	166,314	175,327	198,220	203,176	208,255	213,461	218,798	224,268	229,874	235,621	241,512	247,550	253,738	260,082	266,584
% of Change		3.3%	5.4%	13.1%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%

Outpatient includes Emergency Department
Annualized Jan-Mar 2008
Source: PCH, Laboratory

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

PHARMACY SERVICES

				Projected Growth												
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
DOSES																
Inpatient	1,367,718	1,325,912	1,447,592	1,682,748	1,733,230	1,785,227	1,838,784	1,893,948	1,950,766	2,009,289	2,069,568	2,131,655	2,195,604	2,261,473	2,329,317	2,399,196
Outpatient*	106,552	155,870	159,748	169,936	175,034	180,285	185,694	191,264	197,002	202,912	209,000	215,270	221,728	228,380	235,231	242,288
Total	1,474,270	1,481,782	1,607,340	1,852,684	1,908,265	1,965,512	2,024,478	2,085,212	2,147,769	2,212,202	2,278,568	2,346,925	2,417,332	2,489,852	2,564,548	2,641,484
% of Change		0.5%	8.5%	15.3%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Average Increase 2005-2007			4.5%													
ORDERS																
Total		660,888	706,538	791,712	815,463	839,927	865,125	891,079	917,811	945,346	973,706	1,002,917	1,033,005	1,063,995	1,095,915	1,128,792
Average Increase 2006-2007			6.9%	12.1%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
FTEs	51	51	53	53	53	53	53	53	55	55	55	55	57	60	60	60

** Outpatient includes Emergency Department*
Orders data provided beginning with conversion to Meditech Information system (2006) for consistency
Annualized Jan-Mar 2008
Source: PCH - Pharmacy statistics

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

OUTPATIENT & PRE-ADMISSION TESTING

	Historical		Projected Growth												
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
OUTPATIENT & PRE-ADMISSION TESTING**															
Outpatient Testing	77,766	77,842	78,000	78,000	78,000	78,000	78,000	78,000	78,000	78,000	78,000	78,000	78,000	78,000	78,000
Health Testing	4,406	3,587	3,800	3,800	3,800	3,800	3,800	3,800	3,800	3,800	3,800	3,800	3,800	3,800	3,800
Total	82,172	81,429	81,800	81,800	81,800	81,800	81,800	81,800	81,800	81,800	81,800	81,800	81,800	81,800	81,800
Annual % Change		*0.1%*	*0.2%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*

***Includes lab outpatient testing, outpatient EKG, pre-surgical testing including imaging and interview with nurse. Outpatient data provided beginning with conversion to Meditech Information system for consistency (2006). Source: PCH Planning - Meditech ESS Utilization Statistics; 2008 annualized Jan-Jun*

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

INPATIENT DIALYSIS

	Historical			Projected Growth												
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Number of Patients	244	375	426	406	414	422	431	439	448	457	466	476	485	495	505	515
% Change		54%	14%	-5%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Average Increase 2005-2008				20.9%												
Number of Treatments	971	1,384	1,452	1,255	1,280	1,306	1,332	1,358	1,386	1,413	1,442	1,470	1,500	1,530	1,560	1,592
% Change		43%	5%	-14%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Average Increase 2005-2008				11.3%												

Exisiting stations	4
Proposed stations	4
Allowed GSF	1,880
Proposed GSF	1,105

Increase projected based on inpatient projections.
Annualized Jan-May 2008
Source: PCH - Hemodialysis statistics

PALO[illegible]OMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

EMERGENCY DEPARTMENT

	Projected Growth															
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
EMERGENCY DEPARTMENT VISITS																
Visits	47,055	48,490	48,854	48,516	49,438	50,377	51,334	52,310	53,304	54,316	55,348	56,400	57,472	58,563	59,676	60,810
Annual % Change		*3.0%*	*0.8%*	*-0.7%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*
Average Change 2005-2007			*1.9%*													
Patients Leaving Without Being Seen	1,217	1,338	1,520	1,687	Patients leaving without being seen included above until additional capacity operational.											
Annual % Change		9.9%	13.6%	11.1%												
Average Change 2005-2007			11.8%													
ADMISSIONS FROM THE EMERGENCY DEPARTMENT																
Admitted from ED	15,699	14,652	15,510	15,980	15,820	16,121	16,427	16,739	17,057	17,381	17,711	18,048	18,391	18,740	19,096	19,459
Annual % Change		*-6.7%*	*5.9%*	*3.0%*	*-1.0%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*
Percent ED Visits Admitted	33.4%	30.2%	31.7%	32.9%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%
TREATMENT ROOMS BY TYPE																
Isolation (19)	2	2	2	2	2	2	2	2	2	2	2	2	2	4	4	4
Trauma (CC#1, CC#2)	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Exam / Treatment	16	16	16	16	16	16	16	16	16	16	16	16	16	25	25	25
Total Number of Treatment Rooms	20	20	20	20	20	20	20	20	20	20	20	20	20	31	31	31
STANDARDS																
Capacity per Room	*2,000*															
Total Capacity	*40,000*	*40,000*	*40,000*	*40,000*	*40,000*	*40,000*	*40,000*	*40,000*	*40,000*	*40,000*	*40,000*	*40,000*	*40,000*	*62,000*	*62,000*	*62,000*
Number of Rooms based on capacity	*23.5*	*24.2*	*24.4*	*24.3*	*24.7*	*25.2*	*25.7*	*26.2*	*26.7*	*27.2*	*27.7*	*28.2*	*28.7*	*29.3*	*29.8*	*30.4*
NUMBER OF EMERGENCY DEPARTMENT TREATMENT ROOMS (EXISTING & PROPOSED)																
Treatment Rooms	20	20	20	20	20	20	20	20	20	20	20	20	20	31	31	31

Projections include portion of patients that LWBS - or patients that present to the emergency department but leave prior to being seen/treated.
Annualized Jan-Mar 2008
Source: PCH, Utilization Statistics, Planning (ESS); Projections: Planning/NCI Consulting

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

ADMISSIONS UNIT

	Projected Growth															
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Emergency Room																
Visits	47,055	48,490	48,854	48,516	49,438	50,377	51,334	52,310	53,304	54,316	55,348	56,400	57,472	58,563	59,676	60,810
Annual % Change		*3.0%*	*0.8%*	*-0.7%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*
Average Increase 2005 - 2007			*1.9%*													
Admitted from ED	15,699	14,652	15,510	15,980	15,820	16,121	16,427	16,739	17,057	17,381	17,711	18,048	18,391	18,740	19,098	19,459
Annual % Change		*-6.7%*	*5.9%*	*3.0%*	*-1.0%*	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%
Percent ED Visits Admitted	33.4%	30.2%	31.7%	32.9%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%
Admissions Unit																
ED Admissions	15,699	14,652	15,510	15,980	15,820	16,121	16,427	16,739	17,057	17,381	17,711	18,048	18,391	18,740	19,098	19,459
Observation Admissions (M/S & Peds)	2,696	4,769	4,067	3,792	3,906	4,023	4,144	4,268	4,396	4,528	4,664	4,804	4,948	5,096	5,249	5,406
Direct Admissions	1,829	3,955	3,798	3,879	3,996	4,116	4,239	4,366	4,497	4,632	4,771	4,914	5,062	5,214	5,370	5,531
Total	**20,224**	**23,376**	**23,375**	**23,651**	**23,722**	**24,260**	**24,810**	**25,373**	**25,950**	**26,541**	**27,146**	**27,766**	**28,400**	**29,050**	**29,715**	**30,397**
Annual % Change		*15.6%*	*0.0%*	*1.2%*	*0.3%*	*2.3%*	*2.3%*	*2.3%*	*2.3%*	*2.3%*	*2.3%*	*2.3%*	*2.3%*	*2.3%*	*2.3%*	*2.3%*
Average Increase 2005-2007			*7.8%*													
NUMBER OF BAYS	0	0	0	0	0	0	0	0	0	0	0	0	0	14	14	14
IHFPB STANDARDs																
744.6 GSF per room																
Total GSF Allowed																
2,000 Visits/Room (Bay)														*10,424*	*10,424*	*10,424*
Number of Bays Allowed														*15*	*15*	*15*

With between 30-35% of ED visits resulting in an inpatient admission, PCH's ED acuity is higher than that of hospitals with lower ED admission rates
"2007 AHQ data corrected on May 1, 2008, as follows: M/S observation admissions were 3,699, not 3,402. Pediatric obs admission were 368 = total 4,067.
Source: PCH Utilization Statistics

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

ECG/EKG:

	Historical		Projected Growth													
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Number of ECG/EKG Procedures:																
Inpatient	18,591	19,626	21,273	21,698	22,132	22,575	23,027	23,487	23,957	24,436	24,925	25,423	25,932	26,450	26,979	27,519
Outpatient*	11,921	15,690	14,675	14,969	15,268	15,573	15,885	16,202	16,526	16,857	17,194	17,538	17,889	18,247	18,611	18,984
Total	30,512	35,316	35,948	36,667	37,400	38,148	38,911	39,689	40,483	41,293	42,119	42,961	43,820	44,697	45,591	46,503
Annual % Change		*15.7%*	*1.8%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*
Average change 2005-2007			8.8%													

CARDIOLOGY:

	Historical		Projected Growth													
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Number of Procedures:																
Inpatient	37,333	36,187	39,168	39,951	40,750	41,565	42,397	43,245	44,110	44,992	45,892	46,809	47,746	48,700	49,674	50,668
Outpatient*	22,659	27,075	25,312	25,818	26,335	26,861	27,399	27,946	28,505	29,076	29,657	30,250	30,855	31,472	32,102	32,744
Total	59,992	63,262	64,480	65,770	67,085	68,427	69,795	71,191	72,615	74,067	75,549	77,060	78,601	80,173	81,776	83,412
Annual % Change		*5.5%*	*1.9%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*
Average change 2005-2007			3.7%													

Procedures included above under Cardiodiology:
ECG (EKG)
Stress
Stress Echo
Echo
Dobutamine Stress Echo
Adenosine Stress with Nuclear Imaging
Dobutamine Stress with Nuclear Imaging
Tilt Table
TEE (Transesophogeal Echo)
Holter Monitor
Event Monitor (30 day)
Pacemaker checks

** Outpatient includes Emergency Department*
Source: PCH - Cardiology Department statistics

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

NUCLEAR MEDICINE

	Projected Growth															
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
PROCEDURES																
Inpatient	4,865	3,960	4,365	4,578	4,738	4,932	5,135	5,345	5,564	5,793	6,030	6,277	6,535	6,803	7,081	7,372
Outpatient	6,309	7,713	7,546	8,082	8,365	8,708	9,065	9,437	9,823	10,226	10,645	11,082	11,536	12,009	12,502	13,014
Total	11,174	11,673	11,911	12,660	13,103	13,640	14,200	14,782	15,388	16,019	16,675	17,359	18,071	18,812	19,583	20,386
Annual % Change		*4.5%*	*2.0%*	*6.3%*	*3.5%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*
Average Annual Increase 2005-2008			3.3%	4.3%												
VISITS																
Inpatient		842	928	974	1,008	1,049	1,092	1,137	1,184	1,232	1,283	1,336	1,390	1,447	1,507	1,568
Outpatient		1,587	1,605	1,719	1,779	1,852	1,928	2,007	2,089	2,175	2,264	2,357	2,454	2,554	2,659	2,768
Total		2,429	2,533	2,693	2,787	2,902	3,021	3,144	3,273	3,408	3,547	3,693	3,844	4,002	4,166	4,337
Annual % Change			*4.3%*	*6.3%*	*3.5%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*

Nuclear medicine not available at PCH satellite facilities, projections assume entire service area.
** Annualized Jan-Jun 2008*
Source: Radiology Department Monthly Statistics & NCI Consulting (projections)

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ATTACHMENT GRC - 6 (1)
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IMAGING - ROOMS AND MACHINES, BY TYPE
Existing and Proposed

Radiology		AHQ 2007	EXISTING (2008)	PROPOSED (2018)	
GENERAL MACHINES	General Radiography/Flouroscopy	8	9	12	*1 new in 2008*
	GENERAL RADIOLOGY TOTAL	**8**	**9**	**12**	
OTHER*	Bone density/DEXA	n/a	1	1	*See * below*
	Sterotactic (Breast Biopsy)	n/a	1	1	*See * below*
SPECIAL MACHINES	Angiographic	1	1	1	*Will be located in CSSC - Special Procedures Room*
	CT Scanner	3	3	4	
	Mammography	3	3	4	
	Sonographic (ultrasound)	6	7	8	*1 new in 2008*
	Tomographic (multi-directional)	0	0	0	
	SPECIAL RADIOLOGY TOTALS	**13**	**16**	**19**	
	DIAGNOSTIC RAD GRAND TOTALS	**21**	**25**	**31**	
Nuclear Medicine					
NUCLEAR MEDICINE	Nuclear Medicine Cameras	3	3	5	
	TOTALS	**3**	**3**	**5**	
	GRAND TOTALS: RAD & NM	24	28	36	

** No category on AHQ for Bone density/DEXA room & Sterotactic breast biopsy room.*
DEXA volumes are reported with General/Flouro
Stereotactic volumes are reported in mammography

LOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

RADIOLOGY

	Historical			Projected Growth												
PROCEDURES	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
GENERAL																
Inpatient	20,141	22,503	23,902	25,178	26,185	27,233	28,322	29,455	30,633	31,858	33,133	34,458	35,836	37,270	38,760	40,311
Outpatient	48,822	47,591	48,448	47,386	47,860	48,338	48,822	49,310	49,803	50,301	50,804	51,312	51,825	52,344	52,867	53,396
Total	68,963	70,094	72,350	72,564	74,045	75,571	77,144	78,765	80,436	82,159	83,937	85,770	87,662	89,613	91,627	93,707
Annual % Change		1.6%	3.2%	0.3%	2.0%	2.1%	2.1%	2.1%	2.1%	2.1%	2.2%	2.2%	2.2%	2.2%	2.2%	2.3%
Average Increase 2005-2007			2.4%													
CT																
Inpatient	7,177	7,760	8,319	8,662	8,792	8,924	9,058	9,194	9,331	9,471	9,613	9,758	9,904	10,053	10,203	10,356
Outpatient	28,013	28,411	27,955	27,816	28,233	28,657	29,087	29,523	29,966	30,415	30,871	31,335	31,805	32,282	32,766	33,257
Total	35,130	36,171	36,274	36,478	37,025	37,581	38,144	38,716	39,297	39,887	40,485	41,092	41,709	42,334	42,969	43,614
Annual % Change		3.0%	0.3%	0.6%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%
Average Increase 2005-2007			1.6%													
ULTRASOUND																
Inpatient	6,001	6,527	7,099	7,204	7,492	7,852	8,244	8,607	8,986	9,381	9,794	10,225	10,675	11,145	11,624	12,135
Outpatient	13,098	12,335	13,676	13,358	13,759	14,130	14,512	14,947	15,396	15,857	16,333	16,823	17,328	17,848	18,383	18,953
Total	19,099	18,862	20,775	20,562	21,251	21,982	22,756	23,554	24,381	25,239	26,127	27,048	28,003	28,992	30,007	31,088
Annual % Change		-1.2%	10.1%	-1.0%	3.4%	3.4%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.6%
Average Increase 2005-2007			4.4%													
MAMMOGRAPHY																
Inpatient	61	42	33	30	31	31	31	31	31	31	31	31	31	31	31	31
Outpatient	11,972	11,697	12,574	13,096	13,489	13,759	14,034	14,315	14,601	14,893	15,191	15,494	15,804	16,120	16,443	16,772
Total	12,001	11,739	12,607	13,126	13,519	13,790	14,065	14,346	14,632	14,924	15,222	15,526	15,836	16,152	16,474	16,803
Annual % Change		-2.2%	7.4%	4.1%	3.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
Average Increase 2005-2007			2.5%													
VISITS*																
CT																
Inpatient		2,156	2,311	2,471	2,483	2,496	2,508	2,521	2,533	2,546	2,559	2,572	2,584	2,597	2,610	2,623
Outpatient		7,895	6,207	5,694	5,600	5,500	5,500	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000
Total		10,051	8,518	8,165	8,083	7,996	8,008	7,521	7,533	7,546	7,559	7,572	7,584	7,597	7,610	7,623
Annual % Change			-15.3%	-4.1%	-1.0%	-1.1%	0.2%	-6.1%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
Average Increase 2005-2007																
ULTRASOUND																
Inpatient		3,144	3,413	3,602	3,746	3,896	4,067	4,246	4,433	4,628	4,832	5,044	5,266	5,498	5,740	5,993
Outpatient		6,089	7,020	6,338	6,528	6,724	6,926	7,133	7,347	7,568	7,795	8,029	8,270	8,518	8,773	9,036
Total		9,233	10,433	9,940	10,274	10,620	10,993	11,380	11,781	12,196	12,627	13,073	13,536	14,016	14,513	15,029
Annual % Change			13.0%	-4.7%	3.4%	3.4%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.6%
Average Increase 2005-2007																
MAMMOGRAPHY																
Inpatient		42	33	30	31	31	32	32	32	33	33	35	37	37	37	38
Outpatient		11,029	11,651	11,848	12,203	12,448	12,696	12,950	13,209	13,474	13,743	14,018	14,298	14,584	14,876	15,173
Total		11,071	11,684	11,878	12,234	12,479	12,728	12,982	13,241	13,506	13,777	14,053	14,335	14,621	14,912	15,212
Annual % Change			5.6%	1.7%	3.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
Average Increase 2005-2007																

Annualized Jan-Jun 2008

** Visit volumes provided beginning with conversion to Meditech Information system (2006) for consistency*
CT visits declined in 2006 due to addition of CT service at off-site outpatient facility.
Source: Radiology Department Monthly Statistics, Meditech Outpatient Visits (ESS) & NCI Consulting

IMAGING - ROOMS AND MACHINES, BY TYPE
Existing and Proposed

Radiology		AHQ 2007	EXISTING (2008)	PROPOSED (2018)	
GENERAL MACHINES	General Radiography/Flouroscopy	8	9	12	*1 new in 2008*
	GENERAL RADIOLOGY TOTAL	8	9	12	
OTHER*	Bone density/DEXA	n/a	1	1	*See * below*
	Sterotactic (Breast Biopsy)	n/a	1	1	*See * below*
SPECIAL MACHINES	Angiographic	1	1	1	*Will be located in CSSC - Special Procedures Room*
	CT Scanner	3	3	4	
	Mammography	3	3	4	
	Sonographic (ultrasound)	6	7	8	*1 new in 2008*
	Tomographic (multi-directional)	0	0	0	
	SPECIAL RADIOLOGY TOTALS	13	16	19	
	DIAGNOSTIC RAD GRAND TOTALS	21	25	31	
Nuclear Medicine					
NUCLEAR MEDICINE	Nuclear Medicine Cameras	3	3	5	
	TOTALS	3	3	5	
GRAND TOTALS: RAD & NM		24	28	36	

** No category on AHQ for Bone density/DEXA room & Sterotactic breast biopsy room.*
DEXA volumes are reported with General/Flouro
Stereotactic volumes are reported in mammography

HISTORICAL AND PROJECTED POPULATION
Primary Service Area
Palos Community Hospital

		1990 Census	2000 Census	% change 1990-2000	Estimated 2007	% change 2000-2007	Projected 2010	% change 2000-2010	Projected 2020	% change 2010-2020
CORE										
60462	Orland Park	34,905	37,952	8.7%	39,429	13.0%	39,778	4.8%	40,963	3.0%
60467	Orland Park	9,020	21,053	133.4%	27,063	200.0%	29,147	38.4%	37,322	28.0%
60463	Palos Heights	16,248	19,918	22.6%	14,269	-12.2%	14,690	-26.2%	16,186	10.2%
60464	Palos Park	9,852	10,226	3.8%	10,165	3.2%	10,248	0.2%	10,528	2.7%
60465	Palos Hills	18,505	18,133	-2.0%	17,668	-4.5%	17,320	-4.5%	16,207	-6.4%
60482	Worth	12,134	12,112	-0.2%	10,564	-12.9%	10,360	-14.5%	9,708	-6.3%
60453	Oak Lawn	57,545	55,297	-3.9%	53,586	-6.9%	52,730	-4.6%	49,974	-5.2%
60455	Bridgeview	12,773	14,946	17.0%	15,195	19.0%	15,006	0.4%	14,392	-4.1%
60457	Hickory Hills	10,684	13,476	26.1%	12,560	17.6%	12,374	-8.2%	11,772	-4.9%
60458	Justice	15,932	14,124	-11.3%	14,407	-9.6%	14,552	3.0%	15,047	3.4%
60459	Burbank	26,439	28,208	6.7%	27,323	3.3%	27,046	-4.1%	26,143	-3.3%
60415	Chicago Ridge	12,166	14,086	15.8%	13,658	12.3%	13,451	-4.5%	12,782	-5.0%
60805	Evergreen Park	20,874	20,911	0.2%	19,687	-5.7%	19,117	-8.6%	17,333	-9.3%
60655	Mt. Greenwood	29,296	29,185	-0.4%	26,854	-8.3%	25,856	-11.4%	22,791	-11.9%
60803	Alsip	19,818	22,148	11.8%	22,528	13.7%	22,123	-0.1%	20,825	-5.9%
60445	Midlothian-Cres	24,304	25,900	6.6%	25,286	4.0%	25,212	-2.7%	24,639	-2.3%
60452	Oak Forest	27,524	28,038	1.9%	28,224	2.5%	28,283	0.9%	28,480	0.7%
60477	Tinley Pk-CC Hi	45,173	55,215	22.2%	42,738	-5.4%	44,444	-19.5%	50,638	13.9%
60487	Tinley Pk- new				22,337		23,459		27,622	17.7%
60423	Frankfort	17,949	24,825	38.3%	31,658	76.4%	35,167	41.7%	49,921	42.0%
60448	Mokena	11,242	19,224	71.0%	25,176	123.9%	27,461	42.8%	36,683	33.6%
60451	New Lenox	18,099	27,040	49.4%	35,900	98.4%	39,459	45.9%	54,075	37.0%
60439	Lemont	13,023	19,852	52.4%	22,669	74.1%	23,627	19.0%	27,122	14.8%
60441	Lockport	39,959	48,739	22.0%	39,811	-0.4%	44,301	-9.1%	63,257	42.8%
60491	Homer Glen- new				25,623		27,476		34,679	26.2%
TOTAL PCH SERVICE AREA		**503,464**	**580,608**	77,144	**624,378**	43,770	**642,687**	62,079	**719,089**	76402
Percent Change				15.3%		7.5%		10.7%		11.9%
Average Annual Percent Change				1.5%		1.1%		1.1%		1.2%

Sources: Historical and estimated data from U.S. Census
Projected data from Claritas, prepared by Navigant Consulting, Inc. and Palos Community Hospital.

Source: Claritas, Navigant Consulting, Inc.

ATTACHMENT GRC-6(2A)

Inpatient Utilization - PCH Service Area (2004 - 2007)

	2004	2005	2006	2007*	2007 (9 mos)
Total Inpatient Admissions Age 0-17, PCH Service Area	5,698	6,254	5,906	3,103	2,327
Total Inpatient Admissions Age 18-44, PCH Service Area	18,316	19,448	18,458	19,460	14,595
Total Inpatient Admissions Age 45-64, PCH Service Area	18,234	20,211	20,247	21,528	16,146
Total Inpatient Admissions Age 65+, PCH Service Area	32,161	35,580	35,126	36,496	27,372
PCH Service Area Population Age 0-17	152,869	153,585	154,191	154,800	
PCH Service Area Population Age 18-44	219,684	219,968	220,295	220,623	
PCH Service Area Population Age 45-64	156,508	160,826	164,784	168,840	
PCH Service Area Population Age 65+	76,514	78,388	79,296	80,215	
Inpatient Utilization Per 1,000 Pop. Age 0-17, PCH Service Area	37.27	40.72	38.30	20.04	
Inpatient Utilization Per 1,000 Pop. Age 18-44, PCH Service Area	83.37	88.41	83.79	88.20	
Inpatient Utilization Per 1,000 Pop. Age 45-64, PCH Service Area	116.50	125.67	122.87	127.51	
Inpatient Utilization Per 1,000 Pop. Age 65+, PCH Service Area	420.33	453.90	442.97	454.98	
Age 65+ Utilization Growth Rate		*8.0%*	*-2.4%*	*2.7%*	
Total Inpatient Admissions (Source: COMPdata)	**74,409**	**81,493**	**79,737**	**80,587**	60,440
Total Service Area Population (Source: Claritas)	**605,575**	**612,767**	**618,567**	**624,478**	
Inpatient Utilization (Admits per 1,000 Population)	**122.87**	**132.99**	**128.91**	**129.05**	

*2007 COMPdata figures annualized based on 9 months of actual data (Jan-Sept).

Note: Analysis does not include normal newborns (DRG 391).

PCH Service Area Projected Population Growth (Source: Claritas)

	Claritas Projected Population CAGR (2005-2010)	(2007-2013)
PCH Service Area Population Age 0-17	0.5%	0.4%
PCH Service Area Population Age 18-44	0.1%	0.1%
PCH Service Area Population Age 45-64	2.8%	1.9%
PCH Service Area Population Age 65+	2.4%	2.5%
PCH Service Area Population (All Ages)	**1.2%**	**1.0%**

The age 65 and older cohort, by far, utilizes the most inpatient services and is also the fastest growing segment of the population within PCH's service area.

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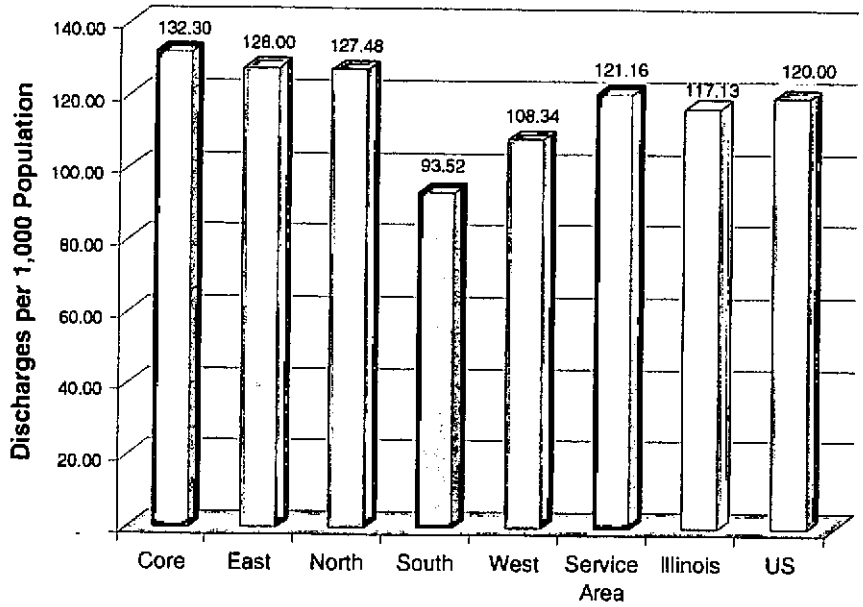
Inpatient Utilization by Service Area

Inpatient Utilization, 2005
Use Rate per 1,000 Population



Percent of Population by Age Cohort, 2005

Region	% of Population	
	Age 45-64	Age 65+
Core	29.8%	17.0%
East	26.5%	10.7%
North	24.4%	15.2%
South	26.2%	7.4%
West	25.6%	9.4%
Total Service Area	26.2%	12.8%
Illinois	21.5%	12.1%
United States	22.0%	12.4%

Source: Claritas, US Census Data, IL COMPdata, PCH Internal Discharge Data, Navigant Analysis.

Observations

- With almost half the population age 45 or older, the Core Service Area's utilization rate is about 10% higher than the state-wide and U.S. rates
- But, the percent of age 45-64 and age 65+ population is, respectively, almost 10% and 5% higher than the state and U.S. percentages, which partially explains the above average use rates in the Core market
- As expected due to the younger population, the South and West Service Areas currently have substantially lower utilization rates
- Additionally, the average length of stay for patients originating from the South/West are lower at 4.3 days versus almost 5.0 days for patients from the Core/North/East areas

PCH Serving the SNF Population

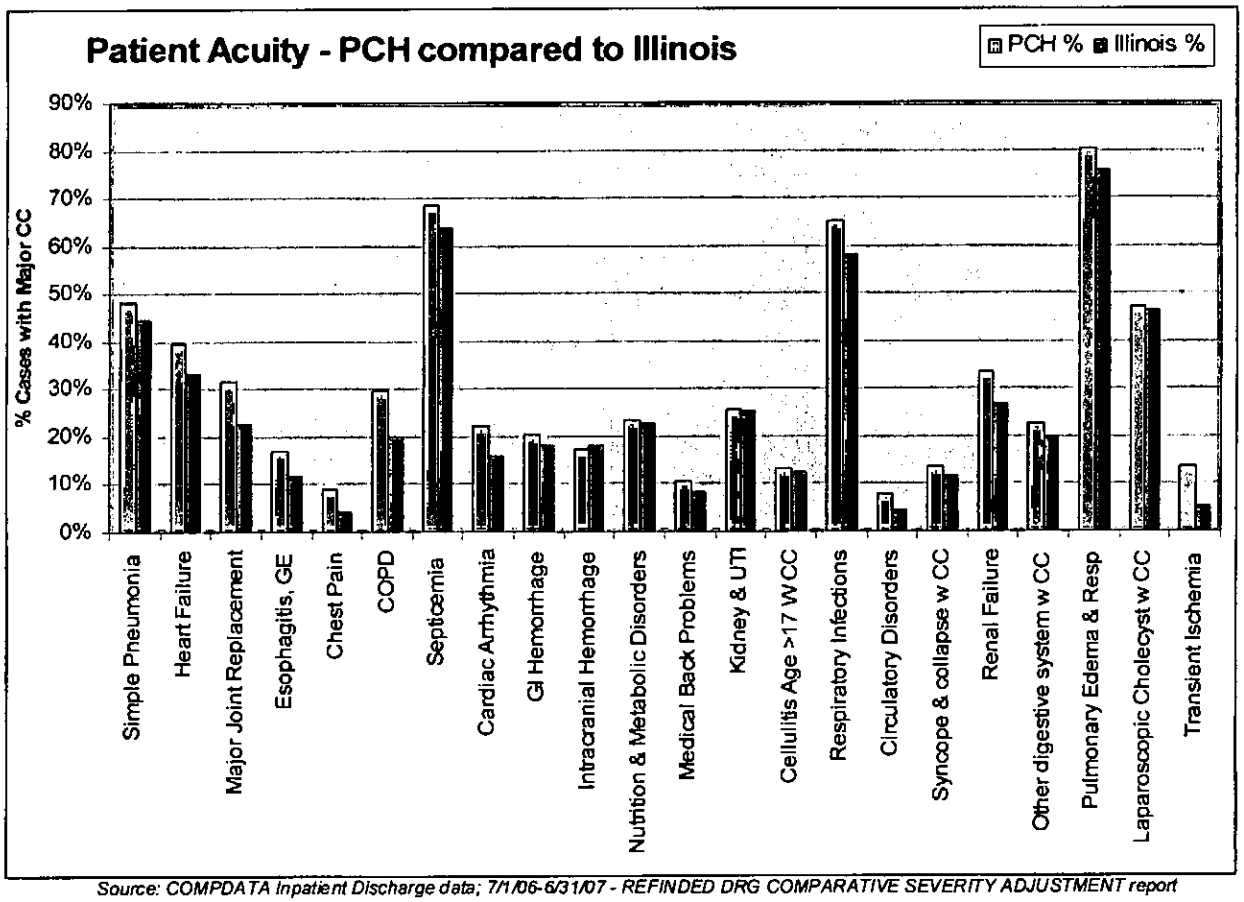
Transfers from Skilled Nursing Facilities (SNFs), 2005

Hospital	Admit Source: Transfer from SNF
Palos Community Hospital	887
Kindred Hospital - Chicago Northlake	605
Rockford Memorial Hospital	468
Rush North Shore Medical Center	356
Silver Cross Hospital	271
Adventist Hinsdale Hospital	209
Saint Mary Of Nazareth Hospital Center	188
Advocate Christ Hospital & Medical Center	185
Holy Cross Hospital	184
Vista Health-Victory Memorial Hospital	156
Advocate South Suburban Hospital	155
St Francis Hospital & Health Center - Blue Is.	135
Oak Forest Hospital Of Cook County	131
Advocate Lutheran General Hospital	118
Adventist Lagrange Memorial Hospital	113
Macneal Hospital	107

- Reinforcing the point that PCH currently serves an older patient population in comparison to other Illinois hospitals:
  - Of all hospitals in the state, PCH admitted, by far, the most transfers from skilled nursing facilities (SNFs) in 2005
  - Local competitors such as Christ, South Suburban and St. Francis also ranked highly on the list, but were far behind PCH in volume of transfers/admissions from SNFs

Source: COMPdata, NCI Analysis.

PCH Top DRG W CC
7/1/2006 through 6/30/2007
Severity Adjustment Comparative Analysis



Source: COMPDATA Inpatient Discharge data; 7/1/06-6/31/07 - REFINDED DRG COMPARATIVE SEVERITY ADJUSTMENT report
High volume medical surgical DRGs

- **A comparison of the category – Major, which is the highest severity adjustment for medical DRGs, as a percentage of total discharges at PCH compared to all Illinois hospital discharges supports the fact that PCH treats more acute patients than most hospitals in Illinois, as reflected in PCH admissions from the ED, patient age and chronic and comorbid conditions.**

The COMPdata Refined DRG is a method for refining or risk-adjusting DRG assignments and reducing the variances of resource consumption within DRGs. Refined DRG uses the DRG assignment and regroups DRGs in Adjacent DRGs (ADRGs). The key data elements that are included in the ADRG assignment are the same as those used for DRG assignment-patient age, patient gender, discharge status, diagnosis and procedure codes, with more emphasis placed on the patient complications and comorbidities through secondary diagnosis. The secondary diagnosis codes are the critical variable in the Refined DRG methodology for distinguishing peak adjustment levels, or often times referred to as severity levels.

Following the assignment of DRG to ADRG, intensity levels are assigned based on resource utilization. For medical DRGs, there are three (3) intensity levels: Baseline (0), Minor (1), and Major (2). For surgical DRGs, an additional level of Catastrophic (3) is added. The RDGR system does not classify discharges where the patient dies within 48 hours of admission. Outliers are identified as other.

Source data (COMdata report) attached.

Source: COMPdata Report Catalog

Refined DRG Comparative Severity Adjustment

COMPdata

COMPdata Report: DRG SEVERITY ADJUSTED
Reporting Period: 07/01/2006 THROUGH 06/30/2007

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DRG / PROVIDER FACILITY																	
089 SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC																	
PALOS COMMUNITY HOSPITAL	780	5.09	22,036	0	0.00	0	400	4.30	18,139	381	6.01	26,454	0	0.00	0	9	1.22	8,215
EDWARD HOSPITAL	649	4.49	23,348	0	0.00	0	298	3.63	16,308	347	5.27	27,823	0	0.00	0	4	1.25	10,573
ADVOCATE GOOD SAMARITAN HOSPITAL - DOWNERS GROVE	627	5.11	27,956	0	0.00	0	277	4.41	22,899	341	5.78	32,554	0	0.00	0	9	1.33	9,389
PROVENA SAINT JOSEPH MEDICAL CENTER - JOLIET	804	4.98	24,282	1	3.00	18,057	306	4.23	20,330	285	5.79	28,490	0	0.00	0	2	1.00	11,441
BLESSING HOSPITAL AT 11TH STREET	577	4.77	13,472	0	0.00	0	316	4.42	11,992	246	5.42	15,872	0	0.00	0	15	1.33	5,285
ADVOCATE CHRIST HOSPITAL & MEDICAL CENTER	571	4.90	23,279	0	0.00	0	297	4.12	18,697	268	5.85	28,748	0	0.00	0	6	1.17	5,910
NORTHWEST COMMUNITY HOSPITAL - ARLINGTON HEIGHTS	556	4.47	18,778	0	0.00	0	294	4.26	17,821	251	4.85	20,542	0	0.00	0	11	1.27	4,091
MEMORIAL MEDICAL CENTER - SPRINGFIELD	537	5.38	17,798	0	0.00	0	267	4.55	14,373	262	6.34	21,628	0	0.00	0	8	1.50	6,695
ADVOCATE LUTHERAN GENERAL HOSPITAL	470	4.62	20,714	0	0.00	0	256	4.13	17,648	205	5.37	24,682	0	0.00	0	9	1.33	11,839
CONDELL MEDICAL CENTER	437	5.17	15,793	1	1.00	15,671	235	4.49	13,599	196	6.09	18,731	0	0.00	0	5	1.40	3,798
MACNEAL HOSPITAL	437	4.25	18,809	2	3.00	13,341	237	3.88	17,079	192	4.84	21,395	0	0.00	0	6	1.00	6,202
ST FRANCIS HOSPITAL - EVANSTON	427	4.59	24,357	1	1.00	5,736	236	4.04	21,189	187	5.37	28,754	0	0.00	0	3	1.00	4,959
ST FRANCIS HOSPITAL & HEALTH CENTER - BLUE ISLAND	422	4.66	20,634	1	2.00	11,097	202	4.13	18,218	218	5.17	22,976	0	0.00	0	1	1.00	7,482
OSF SAINT FRANCIS MEDICAL CENTER	419	4.68	20,141	0	0.00	0	263	4.01	16,592	152	5.88	28,545	0	0.00	0	4	1.25	10,154
ALEXIAN BROTHERS MEDICAL CENTER	413	5.56	27,423	1	1.00	8,284	191	4.51	21,207	218	6.57	33,280	0	0.00	0	3	1.00	5,362
SWEDISH COVENANT HOSPITAL	411	4.88	28,318	1	1.00	12,116	203	4.25	21,901	203	5.60	31,118	0	0.00	0	4	1.50	10,169
ROCKFORD MEMORIAL HOSPITAL	404	4.57	18,856	0	0.00	0	215	4.05	15,447	184	5.27	23,073	0	0.00	0	5	1.20	10,234
RESURRECTION MEDICAL CENTER	395	5.01	25,868	1	4.00	22,025	248	4.65	23,345	140	5.81	30,579	0	0.00	0	6	1.00	7,706
NORTHWESTERN MEMORIAL HOSPITAL	388	4.19	24,011	1	3.00	12,352	231	3.45	18,901	156	5.29	31,654	0	0.00	0	0	0.00	0
ELMHURST MEMORIAL HOSPITAL	382	5.19	29,446	0	0.00	0	218	4.67	25,706	157	6.10	35,624	0	0.00	0	7	1.29	7,358
INGALLS HOSPITAL	365	5.12	20,875	2	3.00	11,918	240	4.62	19,289	122	6.15	24,538	0	0.00	0	1	2.00	9,050
SILVER CROSS HOSPITAL	365	4.46	17,509	0	0.00	0	223	3.88	14,830	138	5.49	21,991	0	0.00	0	4	1.25	12,214
DECATUR MEMORIAL HOSPITAL	362	5.05	14,981	0	0.00	0	216	4.50	12,981	138	6.12	18,384	0	0.00	0	8	1.38	9,376
TRINITY REGIONAL HEALTH SYSTEM- ROCK ISLAND	361	4.86	11,635	1	1.00	5,101	212	4.73	10,870	141	5.27	13,174	0	0.00	0	7	1.29	4,759
PROVENA UNITED SAMARITANS MED CTR- LOGAN	358	4.49	20,359	1	1.00	8,878	184	4.15	17,944	172	4.89	23,080	0	0.00	0	1	1.00	8,066
CENTRAL DUPAGE HOSPITAL	350	4.83	30,306	1	5.00	29,596	193	4.30	26,135	153	5.56	35,902	0	0.00	0	3	2.00	13,463
ADVENTIST LAGRANGE MEMORIAL HOSPITAL	341	5.14	24,845	1	1.00	15,028	173	3.96	19,487	158	6.68	31,735	0	0.00	0	9	1.22	7,977
ADVOCATE TRINITY HOSPITAL - CHICAGO	336	4.28	19,451	0	0.00	0	170	3.77	16,859	164	4.84	22,233	0	0.00	0	2	1.00	11,621
VISTA MEDICAL CENTER EAST	332	4.81	18,109	0	0.00	0	160	4.09	14,889	184	5.88	21,813	0	0.00	0	8	1.13	6,593
ST ELIZABETH'S HOSPITAL - BELLEVILLE	329	3.91	14,774	0	0.00	0	213	3.57	13,723	114	4.59	16,951	0	0.00	0	2	1.50	2,536
ST JAMES HOSPITAL & HEALTH CENTERS/OLYMPIA FIELDS CAMPUS	324	4.19	18,688	0	0.00	0	181	3.61	16,133	142	4.95	21,956	0	0.00	0	1	2.00	17,161
SWEDISHAMERICAN HOSPITAL	323	4.20	15,627	0	0.00	0	178	3.63	13,682	141	4.99	18,283	0	0.00	0	4	1.00	8,502
ADVOCATE ILLINOIS MASONIC MEDICAL CENTER	320	4.34	27,996	0	0.00	0	172	3.16	20,523	148	5.77	36,917	0	0.00	0	2	2.00	19,338
ST JAMES HOSPITAL & HEALTH CENTERS/CHICAGO HEIGHTS CAMPUS	320	5.08	19,229	1	4.00	12,471	168	4.26	15,805	149	6.10	23,331	0	0.00	0	4	1.25	10,198
SHERMAN HOSPITAL	319	4.74	23,466	1	5.00	26,020	162	3.93	19,530	154	5.64	27,788	0	0.00	0	2	1.00	9,744
ADVENTIST HINSDALE HOSPITAL	314	4.87	24,923	1	3.00	19,075	188	4.24	21,369	144	5.63	29,269	0	0.00	0	1	1.00	2,171
GLENBROOK HOSPITAL	310	4.25	19,930	3	5.67	26,771	185	3.97	18,321	117	4.78	22,866	0	0.00	0	5	1.20	6,683
PROVENA MERCY MEDICAL CENTER	308	4.16	25,897	0	0.00	0	136	3.75	22,807	168	4.60	29,215	0	0.00	0	6	1.50	8,687
ADVOCATE SOUTH SUBURBAN HOSPITAL	305	4.62	21,672	0	0.00	0	158	4.25	19,386	142	5.15	24,648	0	0.00	0	5	1.40	9,360
JOHN H STROGER JR. HOSPITAL OF COOK COUNTY	302	3.77	10,884	9	2.33	6,734	211	3.36	9,793	80	5.08	14,261	0	0.00	0	2	1.50	5,702
LORLE FOUNDATION HOSPITAL	300	3.46	16,699	1	2.00	7,092	142	2.96	14,598	152	4.00	19,075	0	0.00	0	5	1.60	6,055
MEMORIAL HOSPITAL - BELLEVILLE	292	5.85	19,027	0	0.00	0	143	4.92	16,042	147	6.81	22,150	0	0.00	0	2	1.00	2,912
ANDERSON HOSPITAL	288	4.35	14,890	0	0.00	0	161	3.90	13,228	122	5.07	17,453	0	0.00	0	5	1.20	5,945
ST JOHN'S HOSPITAL	288	5.15	17,816	0	0.00	0	140	4.84	15,416	144	5.56	20,495	0	0.00	0	4	1.50	5,368
ST MARY'S HOSPITAL - CENTRALIA	287	4.75	11,219	0	0.00	0	135	4.31	10,272	149	5.22	12,160	0	0.00	0	3	1.33	7,104
SARAH BUSH LINCOLN HEALTH CENTER	286	4.60	13,274	0	0.00	0	171	4.26	12,352	114	5.15	14,705	0	0.00	0	1	2.00	7,779

Revised DRG Comparative Severity Adjustment

COMPdata

COMPdata Report: DRG SEVERITY ADJUSTED
Reporting Period: 07/01/2006 THROUGH 06/30/2007

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DRG / PROVIDER FACILITY	Total			Burn			Minor			Major			Catastrophic			Other		
CENTEGRA HOSPITAL - MCHENRY	284	4.51	17,865	0	0.00	0	159	3.87	14,859	123	5.39	21,977	0	0.00	0	2	1.00	3,883
ST ANTHONY'S MEMORIAL HOSPITAL - EFFINGHAM	284	5.04	11,314	0	0.00	0	172	4.82	10,629	108	5.54	12,648	0	0.00	0	4	1.25	4,747
OSF SAINT ANTHONY MEDICAL CENTER	283	5.20	20,970	0	0.00	0	137	4.80	17,544	144	5.63	24,439	0	0.00	0	2	1.00	5,876
RIVERSIDE MEDICAL CENTER - KANKAKEE	282	5.79	19,183	0	0.00	0	129	4.76	14,903	151	6.73	23,003	0	0.00	0	2	1.00	6,812
GOOD SAMARITAN REGIONAL HEALTH CENTER - MOUNT VERNON	280	5.54	13,887	1	1.00	7,372	178	5.28	13,384	100	6.10	14,900	0	0.00	0	1	1.00	8,672
PROVIDENT HOSPITAL OF COOK COUNTY	280	4.17	7,594	3	1.33	3,283	208	3.80	6,727	69	5.39	10,396	0	0.00	0	0	0.00	0
HOLY CROSS HOSPITAL	280	5.77	23,274	3	5.33	22,349	136	4.68	19,093	141	6.83	27,328	0	0.00	0	0	0.00	0
PROVENA ST MARY'S HOSPITAL	278	5.64	25,653	1	4.00	22,133	122	4.81	21,074	153	6.37	29,563	0	0.00	0	2	2.00	7,616
ST ALEXIUS MEDICAL CENTER	270	4.82	24,643	0	0.00	0	126	3.83	19,441	141	5.40	29,648	0	0.00	0	3	1.33	7,873
DELNOR-COMMUNITY HOSPITAL	268	4.70	27,271	0	0.00	0	163	4.40	24,242	102	5.26	32,592	0	0.00	0	3	1.67	10,900
EVANSTON HOSPITAL	267	4.15	21,272	0	0.00	0	153	4.14	20,049	108	4.32	24,016	0	0.00	0	6	1.17	3,055
LOUIS A WEISS MEMORIAL HOSPITAL	266	4.42	22,143	0	0.00	0	149	3.72	18,294	115	5.37	27,456	0	0.00	0	2	1.50	3,317
METHODIST MEDICAL CENTER OF ILLINOIS - PEORIA	265	5.26	22,873	1	3.00	7,915	129	4.10	16,802	130	6.58	29,607	0	0.00	0	5	1.20	7,385
OUR LADY OF THE RESURRECTION MEDICAL CENTER	264	5.44	25,294	0	0.00	0	131	4.89	21,562	132	6.20	29,070	0	0.00	0	1	2.00	15,839
RUSH NORTH SHORE MEDICAL CENTER	264	5.86	21,441	0	0.00	0	140	4.66	17,184	123	6.83	26,451	0	0.00	0	1	1.00	1,127
HERRIN HOSPITAL	259	5.22	16,419	0	0.00	0	141	4.57	13,920	112	6.25	20,206	0	0.00	0	6	1.50	4,464
PROCTOR HOSPITAL	248	5.50	16,682	2	5.00	11,672	125	5.04	14,958	115	6.22	19,136	0	0.00	0	6	1.33	7,216
RUSH UNIVERSITY MEDICAL CENTER	248	3.81	24,301	1	1.00	3,465	142	3.35	21,104	103	4.52	29,197	0	0.00	0	2	1.50	9,612
THE UNIVERSITY OF CHICAGO MEDICAL CENTER	241	3.94	30,025	0	0.00	0	112	3.39	24,055	127	4.46	35,481	0	0.00	0	2	1.00	17,793
KISHWAUKEE COMMUNITY HOSPITAL	239	5.26	24,750	2	9.50	31,015	124	4.76	21,608	111	5.83	28,474	0	0.00	0	2	1.00	6,601
CENTEGRA HOSPITAL - WOODSTOCK	229	4.78	19,353	0	0.00	0	96	4.22	16,781	130	5.28	21,613	0	0.00	0	3	1.33	3,750
CROSSROADS COMMUNITY HOSPITAL	227	4.51	22,307	0	0.00	0	144	4.43	20,643	78	4.82	25,774	0	0.00	0	5	2.00	16,145
BROMENN REGIONAL MEDICAL CENTER - NORMAL	218	4.48	14,939	0	0.00	0	124	3.86	12,463	90	5.43	18,742	0	0.00	0	4	1.00	6,120
PASSAVANT AREA HOSPITAL	215	5.39	18,366	1	6.00	17,274	126	4.88	15,999	88	6.22	22,117	0	0.00	0	2	1.00	6,759
HIGHLAND PARK HOSPITAL	212	4.62	21,145	1	2.00	12,678	115	4.37	18,962	95	4.99	23,975	0	0.00	0	1	2.00	11,589
ST MARY'S HOSPITAL - STREATOR	212	5.77	12,738	0	0.00	0	118	5.59	12,245	92	6.20	13,663	0	0.00	0	4	1.25	5,186
HEARTLAND REGIONAL MEDICAL CENTER	211	4.97	27,856	0	0.00	0	79	4.14	21,859	128	5.59	32,182	0	0.00	0	4	1.50	7,959
MCDONOUGH DISTRICT HOSPITAL	209	5.00	12,963	1	6.00	14,024	149	5.05	12,569	56	4.98	14,390	0	0.00	0	3	1.33	5,560
LOYOLA UNIVERSITY MEDICAL CENTER	208	3.57	15,819	0	0.00	0	108	2.92	11,719	98	4.33	20,085	0	0.00	0	2	1.50	7,385
ALTON MEMORIAL HOSPITAL	207	4.50	21,330	0	0.00	0	110	3.95	18,564	96	5.16	24,621	0	0.00	0	1	2.00	9,732
PROVENA COVENANT MEDICAL CENTER	206	3.83	15,674	0	0.00	0	95	3.43	14,161	110	4.21	17,061	0	0.00	0	1	1.00	6,775
SAINT JOSEPH HOSPITAL - CHICAGO	206	4.75	23,535	0	0.00	0	111	4.15	20,078	91	5.84	28,352	0	0.00	0	4	1.00	9,911
PEKIN HOSPITAL	205	5.14	20,941	1	2.00	12,122	107	5.22	21,284	94	5.20	21,010	0	0.00	0	3	1.33	9,488
RUSH-COPLEY MEDICAL CENTER	205	4.25	28,228	0	0.00	0	97	3.77	24,475	103	4.83	32,709	0	0.00	0	5	1.60	8,728
OSF ST MARY MEDICAL CENTER	204	5.39	15,817	0	0.00	0	102	4.97	13,868	102	5.81	17,765	0	0.00	0	0	0.00	0
SAINT MARY OF NAZARETH HOSPITAL CENTER	204	5.01	25,825	0	0.00	0	126	4.46	22,779	76	6.01	31,230	0	0.00	0	2	1.50	12,416
PROVENA SAINT JOSEPH HOSPITAL - ELGIN	203	4.77	28,075	0	0.00	0	105	4.31	24,495	97	5.29	32,152	0	0.00	0	1	2.00	8,652
ADVOCATE GOOD SHEPHERD HOSPITAL	200	4.38	17,950	1	7.00	34,615	122	4.02	15,636	75	4.95	21,846	0	0.00	0	2	1.00	4,664
LAKE FOREST HOSPITAL	200	4.28	23,062	0	0.00	0	90	3.58	18,476	108	4.92	27,090	0	0.00	0	2	1.00	11,914
MOUNT SINAI HOSPITAL	197	4.08	17,892	4	1.00	7,646	115	3.58	15,736	77	4.98	21,780	0	0.00	0	1	1.00	8,662
SAINT ELIZABETH HOSPITAL CHICAGO	195	5.35	23,649	0	0.00	0	100	4.31	18,979	94	6.50	28,778	0	0.00	0	1	2.00	8,730
WEST SUBURBAN MEDICAL CENTER	194	3.34	17,487	2	2.50	11,671	103	2.62	13,783	88	4.22	21,998	0	0.00	0	1	1.00	15,737
ST MARY'S HOSPITAL - DECATUR	193	4.96	12,805	0	0.00	0	127	4.63	11,120	66	5.59	16,048	0	0.00	0	0	0.00	0
ILLINOIS VALLEY COMMUNITY HOSPITAL	192	4.68	15,670	0	0.00	0	132	4.20	13,870	56	6.04	20,424	0	0.00	0	4	1.25	8,498
MEMORIAL HOSPITAL	178	4.54	15,251	0	0.00	0	97	4.00	12,905	80	5.24	18,220	0	0.00	0	1	1.00	5,292
HARRISBURG MEDICAL CENTER, INC	174	4.82	10,250	0	0.00	0	73	3.73	7,762	97	5.78	12,342	0	0.00	0	4	1.25	4,925

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Revised DRG Comparative Severity Adjustment

COMPdata

COMPdata Report: DRG SEVERITY ADJUSTED
Reporting Period: 07/01/2006 THROUGH 06/30/2007

DRG PROVIDER FACILITY	Total			Baseline			Minor			Major			Catastrophic			Other		
CGH MEDICAL CENTER	173	4.07	16,193	0	0.00	0	91	3.81	14,437	79	4.46	18,702	0	0.00	0	3	1.67	3,362
MEMORIAL HOSPITAL OF CARBONDALE	172	3.72	13,861	0	0.00	0	82	3.45	12,616	79	4.06	15,465	0	0.00	0	1	1.00	1,648
SAINT ANTHONY'S HEALTH CENTER - ALTON	168	4.38	27,230	0	0.00	0	81	3.54	22,578	86	5.20	31,643	0	0.00	0	1	2.00	24,573
OTTAWA REGIONAL HOSPITAL & HEALTHCRE CENTER	167	3.51	12,060	0	0.00	0	85	3.42	11,106	78	3.72	13,402	0	0.00	0	4	1.50	6,145
UNIVERSITY OF ILLINOIS MEDICAL CENTER AT CHICAGO	167	4.43	22,178	0	0.00	0	102	3.48	17,036	65	5.92	30,248	0	0.00	0	0	0.00	0
GALESBURG COTTAGE HOSPITAL	165	5.92	24,348	1	1.00	2,899	57	5.19	20,281	107	6.36	26,712	0	0.00	0	0	0.00	0
JERSEY COMMUNITY HOSPITAL	165	4.19	10,009	0	0.00	0	88	4.28	10,028	73	4.33	10,374	0	0.00	0	8	1.33	5,297
OSF ST JOSEPH MEDICAL CENTER - BLOOMINGTON	162	4.62	20,223	0	0.00	0	93	4.01	16,946	66	5.62	25,345	0	0.00	0	3	1.33	9,103
MORRIS HOSPITAL & HEALTHCARE CENTERS	160	4.88	19,067	0	0.00	0	78	4.50	16,294	77	5.51	22,683	0	0.00	0	5	1.00	6,846
IROQUOIS MEMORIAL HOSPITAL & RESIDENT HOME	155	4.25	11,842	0	0.00	0	51	4.04	10,717	104	4.35	12,098	0	0.00	0	0	0.00	0
ST MARGARET'S HEALTH	150	4.43	13,369	0	0.00	0	96	4.48	13,335	52	4.46	13,852	0	0.00	0	2	1.00	2,435
TAYLORVILLE MEMORIAL HOSPITAL	143	5.09	11,437	0	0.00	0	64	4.33	9,419	77	5.82	13,257	0	0.00	0	2	1.50	5,961
FAYETTE COUNTY HOSPITAL	140	3.48	10,464	0	0.00	0	92	3.40	9,486	46	3.74	12,823	0	0.00	0	2	1.00	2,135
GATEWAY REGIONAL	138	5.06	37,043	0	0.00	0	71	4.28	31,055	65	6.03	44,369	0	0.00	0	2	1.00	11,485
GENESIS MEDICAL CENTER-ILLINI CAMPUS	138	4.09	11,721	0	0.00	0	88	4.00	11,156	48	4.35	13,004	0	0.00	0	2	1.50	5,681
GOTTLIEB MEMORIAL HOSPITAL	135	5.84	41,789	0	0.00	0	77	5.05	34,961	58	7.05	51,879	0	0.00	0	2	2.00	22,169
ROSELAND COMMUNITY HOSPITAL	134	6.01	29,757	1	7.00	31,377	76	4.57	21,840	56	8.05	40,667	0	0.00	0	1	1.00	18,870
RUSH OAK PARK HOSPITAL	128	4.88	19,660	0	0.00	0	64	3.63	14,878	61	5.93	25,149	0	0.00	0	3	1.87	10,077
GRAHAM HOSPITAL	121	5.40	14,801	0	0.00	0	88	5.33	14,198	32	5.72	16,544	0	0.00	0	1	1.00	12,050
KATHERINE SHAW BETHEA HOSPITAL	119	4.22	22,127	1	3.00	11,859	68	4.26	19,995	47	4.38	26,549	0	0.00	0	3	1.00	4,596
THOREK HOSPITAL & MEDICAL CENTER	117	5.85	19,140	0	0.00	0	49	5.08	15,565	68	6.40	21,717	0	0.00	0	0	0.00	0
HARDIN COUNTY GENERAL HOSPITAL	116	4.82	7,395	0	0.00	0	71	4.68	6,762	45	5.04	8,394	0	0.00	0	0	0.00	0
ST FRANCIS HOSPITAL - LITCHFIELD	113	4.73	10,299	1	5.00	18,786	71	4.58	9,982	36	5.44	11,726	0	0.00	0	5	1.60	2,826
WESTLAKE HOSPITAL	111	4.68	26,512	0	0.00	0	56	4.39	23,955	54	5.04	29,592	0	0.00	0	1	1.00	3,348
SOUTH SHORE HOSPITAL	108	8.26	23,214	2	1.50	4,853	49	6.63	17,060	55	10.22	30,029	0	0.00	0	2	1.00	4,907
KEWANEE HOSPITAL	105	4.41	15,565	0	0.00	0	72	4.26	15,085	31	4.97	17,510	0	0.00	0	2	1.00	2,677
FERRELL HOSPITAL	100	3.69	9,014	0	0.00	0	69	3.70	8,398	29	3.83	10,777	0	0.00	0	2	1.50	4,719
GREENVILLE REGIONAL HOSPITAL	95	3.82	7,917	0	0.00	0	51	3.37	6,872	43	4.40	9,193	0	0.00	0	1	2.00	6,359
ST JOSEPH'S HOSPITAL - HIGHLAND	95	3.88	7,758	1	1.00	3,894	66	3.98	7,903	24	4.13	8,453	0	0.00	0	4	1.50	2,158
SAINT ANTHONY HOSPITAL - CHICAGO	91	5.96	26,542	0	0.00	0	54	5.37	22,294	37	6.81	32,742	0	0.00	0	0	0.00	0
UNION COUNTY HOSPITAL DISTRICT	91	3.54	7,682	0	0.00	0	63	3.54	8,071	27	3.63	7,697	0	0.00	0	1	1.00	986
RED BUD REGIONAL HOSPITAL	86	3.85	10,766	0	0.00	0	57	3.47	10,041	27	4.22	12,851	0	0.00	0	2	1.00	3,295
JACKSON PARK HOSPITAL	82	3.38	20,107	0	0.00	0	58	2.97	18,019	24	4.38	25,153	0	0.00	0	0	0.00	0
SHELBY MEMORIAL HOSPITAL	79	3.39	9,130	0	0.00	0	59	3.37	9,095	19	3.58	9,554	0	0.00	0	1	1.00	3,175
ST JOSEPH'S HOSPITAL - BREESE	76	4.71	12,473	0	0.00	0	50	4.46	11,207	27	5.26	15,171	0	0.00	0	1	2.00	2,940
PERRY MEMORIAL HOSPITAL	77	4.06	9,024	0	0.00	0	43	4.19	8,722	29	4.31	10,320	0	0.00	0	5	1.60	4,107
NORWEGIAN-AMERICAN HOSPITAL	75	4.87	19,090	2	5.00	18,639	38	3.82	15,276	35	5.89	23,257	0	0.00	0	0	0.00	0
MORETTO HOSPITAL	73	4.78	11,604	6	1.83	4,102	40	4.85	10,041	27	5.33	15,587	0	0.00	0	0	0.00	0
ILLINI COMMUNITY HOSPITAL - PITTSFIELD	71	4.15	10,366	0	0.00	0	38	4.08	10,008	32	4.31	10,882	0	0.00	0	1	2.00	7,467
SALEM TOWNSHIP HOSPITAL	70	4.60	9,121	0	0.00	0	41	4.24	8,739	29	5.10	9,659	0	0.00	0	0	0.00	0
FRANKLIN HOSPITAL	68	3.72	8,826	0	0.00	0	40	3.55	8,683	26	4.15	7,342	0	0.00	0	2	1.50	2,976
HIGHLAND MEMORIAL HOSPITAL	68	4.78	14,608	0	0.00	0	51	4.53	13,048	15	6.07	21,064	0	0.00	0	2	1.50	6,024
LAWRENCE COUNTY MEMORIAL HOSPITAL	66	3.52	7,200	0	0.00	0	44	3.82	7,632	18	3.33	7,317	0	0.00	0	4	1.00	1,910
OAK FOREST HOSPITAL OF COOK COUNTY	63	8.02	9,821	0	0.00	0	40	4.45	6,887	23	8.74	14,924	0	0.00	0	0	0.00	0
LINCOLN PARK HOSPITAL	62	5.56	26,187	1	2.00	9,445	34	4.88	22,533	27	6.56	31,410	0	0.00	0	0	0.00	0
OSF SAINT JAMES HOSPITAL	62	4.40	14,412	0	0.00	0	36	4.39	13,517	25	4.52	15,882	0	0.00	0	1	2.00	10,384

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DRG PROVIDER FACILITY	Total			Base			Minor			Major			Catastrophic			Other		
FAIRFIELD MEMORIAL HOSPITAL	81	4.07	12,748	0	0.00	0	38	3.95	12,003	22	4.41	14,289	0	0.00	0	1	1.00	7,022
ABRAHAM LINCOLN MEMORIAL HOSPITAL	59	4.53	12,394	0	0.00	0	30	4.30	11,862	29	4.76	12,944	0	0.00	0	0	0.00	0
ADVENTIST GLENOAKS HOSPITAL	59	4.61	27,780	0	0.00	0	31	4.10	23,277	28	5.61	32,767	0	0.00	0	0	0.00	0
WABASH GENERAL HOSPITAL DISTRICT	59	4.85	11,304	0	0.00	0	28	4.23	9,288	33	5.33	12,892	0	0.00	0	0	0.00	0
HILLSBORO AREA HOSPITAL	57	3.63	6,992	0	0.00	0	46	3.61	6,646	11	3.73	7,602	0	0.00	0	0	0.00	0
OSF HOLY FAMILY MEDICAL CENTER	57	3.81	11,388	0	0.00	0	32	3.84	10,875	25	3.78	12,044	0	0.00	0	0	0.00	0
CLAY COUNTY HOSPITAL - FLORA	56	4.46	8,583	0	0.00	0	38	4.47	8,837	16	4.88	8,868	0	0.00	0	2	1.00	915
VALLEY WEST COMMUNITY HOSPITAL	55	3.64	16,020	0	0.00	0	39	3.44	14,836	16	4.13	18,905	0	0.00	0	0	0.00	0
GIBSON AREA HOSPITAL & HEALTH SERVICES	54	4.98	18,750	0	0.00	0	30	5.20	17,606	21	5.14	22,211	0	0.00	0	3	1.67	5,963
MASSAC MEMORIAL HOSPITAL	54	5.06	9,744	0	0.00	0	33	4.70	9,334	20	5.80	10,429	0	0.00	0	1	2.00	9,598
PARIS COMMUNITY HOSPITAL	53	4.00	7,759	0	0.00	0	37	4.16	7,424	16	3.63	8,533	0	0.00	0	0	0.00	0
MARSHALL BROWNING HOSPITAL	52	4.63	13,087	0	0.00	0	22	4.82	12,826	27	4.85	13,875	0	0.00	0	3	1.33	7,914
SPARTA COMMUNITY HOSPITAL	52	4.50	8,743	0	0.00	0	35	4.77	9,678	14	4.50	8,041	0	0.00	0	3	1.33	1,098
CRAWFORD MEMORIAL HOSPITAL	51	4.41	9,455	0	0.00	0	26	4.08	8,375	23	5.04	11,228	0	0.00	0	2	1.50	3,114
ST JOSEPH MEMORIAL HOSPITAL - MURPHYSBORO	51	5.08	14,285	1	3.00	10,886	31	5.00	13,541	18	5.50	18,133	0	0.00	0	1	2.00	7,495
MIDWESTERN REGIONAL MEDICAL CENTER	50	4.70	28,744	0	0.00	0	17	3.59	21,576	33	5.27	32,436	0	0.00	0	0	0.00	0
HAMMOND-HENRY HOSPITAL	49	3.78	8,695	0	0.00	0	27	3.52	6,159	19	4.58	8,320	0	0.00	0	3	1.00	1,228
JOHN AND MARY E KIRBY HOSPITAL	49	3.29	7,580	0	0.00	0	30	3.20	6,957	18	3.75	9,359	0	0.00	0	3	1.67	4,322
MEMORIAL HOSPITAL - CHESTER	47	3.70	7,871	0	0.00	0	34	3.65	8,045	11	3.73	8,142	0	0.00	0	2	1.00	3,424
THOMAS H BOYD MEMORIAL HOSPITAL	46	2.96	5,516	0	0.00	0	26	2.36	4,296	20	3.70	7,102	0	0.00	0	0	0.00	0
DR JOHN WARNER HOSPITAL	45	4.56	10,865	0	0.00	0	27	4.33	11,142	17	5.12	10,995	0	0.00	0	1	1.00	1,182
MASON DISTRICT HOSPITAL	45	3.40	8,275	0	0.00	0	27	3.11	7,251	16	4.19	10,677	0	0.00	0	2	1.00	2,884
SARAH D CULBERTSON MEMORIAL HOSPITAL	45	3.24	7,699	0	0.00	0	28	3.57	8,288	16	2.81	7,033	0	0.00	0	1	1.00	1,889
MENDOTA COMMUNITY HOSPITAL	45	4.64	13,022	0	0.00	0	32	4.75	12,339	13	5.08	14,703	0	0.00	0	0	0.00	0
CARLINVILLE AREA HOSPITAL	44	4.66	10,492	0	0.00	0	30	4.70	10,658	14	4.57	9,709	0	0.00	0	0	0.00	0
ROCHELLE COMMUNITY HOSPITAL	44	4.30	11,516	0	0.00	0	25	4.24	10,347	18	4.50	13,551	0	0.00	0	1	2.00	4,093
KENNETH HALL REGIONAL HOSPITAL	43	5.35	12,914	1	4.00	14,389	15	4.80	10,859	27	5.70	14,002	0	0.00	0	0	0.00	0
HAMILTON MEMORIAL HOSPITAL DISTRICT	42	3.79	8,197	0	0.00	0	18	4.17	8,194	23	3.61	8,371	0	0.00	0	1	1.00	2,255
HOOPESTON COMMUNITY MEMORIAL HOSPITAL	41	3.29	9,058	0	0.00	0	25	3.04	7,632	16	3.89	11,286	0	0.00	0	0	0.00	0
MEMORIAL HOSPITAL - CARTHAGE	40	3.85	8,815	0	0.00	0	23	3.57	7,522	17	4.24	10,563	0	0.00	0	0	0.00	0
MERCY HARVARD HOSPITAL	38	3.53	12,918	0	0.00	0	17	3.35	11,945	21	3.67	13,702	0	0.00	0	0	0.00	0
PINCKNEYVILLE COMMUNITY HOSPITAL	38	3.74	6,677	0	0.00	0	26	4.04	6,581	12	3.08	6,883	0	0.00	0	0	0.00	0
PANA COMMUNITY HOSPITAL	36	3.89	7,593	0	0.00	0	28	3.57	6,917	8	5.00	9,959	0	0.00	0	0	0.00	0
EUREKA COMMUNITY HOSPITAL	33	4.30	9,560	0	0.00	0	27	3.93	8,402	6	6.00	14,767	0	0.00	0	0	0.00	0
TOUCHETTE REGIONAL HOSPITAL	33	6.36	15,949	0	0.00	0	21	5.81	14,024	11	7.91	20,307	0	0.00	0	1	1.00	8,426
WASHINGTON COUNTY HOSPITAL - NASHVILLE	31	3.87	7,804	0	0.00	0	19	3.89	7,819	12	3.83	8,038	0	0.00	0	0	0.00	0
MERCER COUNTY HOSPITAL	28	5.86	12,189	0	0.00	0	17	7.18	13,587	11	3.82	10,028	0	0.00	0	0	0.00	0
COMMUNITY MEMORIAL HOSPITAL - STAUNTON	22	4.18	10,637	0	0.00	0	14	4.64	11,100	8	3.38	9,827	0	0.00	0	0	0.00	0
MIDWEST MEDICAL CENTER	18	3.22	8,124	0	0.00	0	16	3.25	8,159	2	3.00	5,643	0	0.00	0	0	0.00	0
HUNDRED HOSPITAL - CHICAGO NORTHLAKE	17	21.00	75,561	0	0.00	0	8	17.83	69,156	11	22.73	79,054	0	0.00	0	0	0.00	0
SACRED HEART HOSPITAL	17	5.41	19,087	1	1.00	3,221	10	5.00	17,106	6	6.83	25,034	0	0.00	0	0	0.00	0
HUNDRED CHICAGO CENTRAL HOSPITAL-CHICAGO	10	17.60	59,131	0	0.00	0	5	18.00	56,924	5	17.60	61,338	0	0.00	0	0	0.00	0
MORRISON COMMUNITY HOSPITAL	8	4.38	11,055	0	0.00	0	8	4.38	11,055	0	0.00	0	0	0.00	0	0	0.00	0
CHILDREN'S MEMORIAL HOSPITAL	7	8.29	43,213	0	0.00	0	5	5.80	34,901	2	7.50	63,992	0	0.00	0	0	0.00	0
MARIANJOY REHABILITATION HOSPITAL & CLINICS	7	17.43	30,593	0	0.00	0	4	15.50	27,097	3	20.00	35,254	0	0.00	0	0	0.00	0
HUNDRED HOSPITAL - SYCAMORE - SYCAMORE	6	25.50	104,760	0	0.00	0	1	10.00	30,349	5	28.60	119,642	0	0.00	0	0	0.00	0

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Revised DRG Comparative Severity Adjustment

COMPdata

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DRG PROVIDER FACILITY	Total			Baseline			Minor			Major			Catastrophic			Other		
	Cases	ALOS	AVG CHG	Cases	ALOS	AVG CHG	Cases	ALOS	AVG CHG	Cases	ALOS	AVG CHG	Cases	ALOS	AVG CHG	Cases	ALOS	AVG CHG
ADVOCATE BETHANY HOSPITAL	4	23.25	87,444	0	0.00	0	1	22.00	58,927	3	23.67	98,950	0	0.00	0	0	0.00	0
REHABILITATION INSTITUTE OF CHICAGO	3	20.00	43,596	0	0.00	0	0	0.00	0	3	20.00	43,596	0	0.00	0	0	0.00	0
TRINITY MEDICAL CENTER 7TH STREET CAMPUS - MOLINE	3	5.33	11,822	0	0.00	0	0	0.00	0	3	5.33	11,822	0	0.00	0	0	0.00	0
HOLY FAMILY MEDICAL CENTER	2	18.00	72,261	0	0.00	0	1	16.00	58,393	1	20.00	86,129	0	0.00	0	0	0.00	0
RML SPECIALTY HOSPITAL	2	18.00	52,801	0	0.00	0	1	16.00	45,938	1	20.00	59,665	0	0.00	0	0	0.00	0
ALEXIAN BROTHERS BEHAVIORAL HEALTH HOSPITAL	1	8.00	10,835	0	0.00	0	1	8.00	10,835	0	0.00	0	0	0.00	0	0	0.00	0
LA RABIDA CHILDREN'S HOSPITAL	1	3.00	6,492	0	0.00	0	0	0.00	0	1	3.00	6,492	0	0.00	0	0	0.00	0
TOTAL FOR: 089 SIMPLE PNEUMONIA & PLEURISY AGE >17 W C	38,047	4.74	19,544	76	3.04	12,452	19,574	4.19	16,472	15,959	5.50	23,688	0	0.00	0	438	1.32	7,066

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DRG / PROVIDER FACILITY	Fatal			Severe			Major			Moderate			Catastrophic			Other		
127 HEART FAILURE & SHOCK																		
ADVOCATE CHRIST HOSPITAL & MEDICAL CENTER	1,114	4.73	23,439	70	2.83	13,712	675	3.98	18,739	357	6.63	34,767	0	0.00	0	12	1.42	7,556
INGALLS HOSPITAL	816	5.74	22,417	72	3.84	15,208	485	5.30	20,572	258	7.17	27,918	0	0.00	0	1	2.00	18,749
NORTHWEST COMMUNITY HOSPITAL - ARLINGTON HEIGHTS	797	4.27	18,637	31	3.06	14,226	517	3.86	16,927	234	5.51	23,753	0	0.00	0	15	1.47	6,847
PALOS COMMUNITY HOSPITAL	775	5.38	23,391	34	2.74	14,911	423	4.58	19,536	305	6.95	30,217	0	0.00	0	13	1.23	10,852
JOHN H STROGER JR. HOSPITAL OF COOK COUNTY	765	3.68	10,923	197	2.82	8,222	451	3.61	10,598	115	5.51	16,924	0	0.00	0	2	1.50	5,394
PROVENA SAINT JOSEPH MEDICAL CENTER - JOLIET	709	4.90	23,790	33	3.15	14,297	411	4.29	19,685	255	6.25	31,798	0	0.00	0	10	1.30	11,368
ST FRANCIS HOSPITAL & HEALTH CENTER - BLUE ISLAND	697	4.61	20,364	49	2.94	13,514	425	3.90	17,111	221	6.37	28,238	0	0.00	0	2	2.00	16,318
RESURRECTION MEDICAL CENTER	654	5.37	28,572	66	3.73	18,890	365	4.74	24,137	208	7.30	41,036	0	0.00	0	15	1.27	6,244
ADVOCATE TRINITY HOSPITAL - CHICAGO	615	4.17	18,150	78	2.99	13,218	387	3.84	18,858	169	5.43	23,745	0	0.00	0	1	2.00	4,879
MEMORIAL HOSPITAL - BELLEVILLE	591	4.83	15,842	42	3.05	10,853	362	4.30	14,427	170	6.72	21,240	0	0.00	0	17	1.59	4,318
SILVER CROSS HOSPITAL	591	4.41	17,028	51	2.82	10,523	340	3.58	13,804	200	6.21	24,168	0	0.00	0	0	0.00	0
THE UNIVERSITY OF CHICAGO MEDICAL CENTER	572	4.48	33,263	26	3.65	22,969	332	3.64	25,547	211	5.95	46,759	0	0.00	0	3	1.00	27,042
NORTHWESTERN MEMORIAL HOSPITAL	587	4.65	25,241	43	2.33	13,864	352	3.97	21,794	172	6.64	35,141	0	0.00	0	0	0.00	0
ADVOCATE SOUTH SUBURBAN HOSPITAL	562	4.57	20,994	50	3.00	14,672	329	4.05	18,115	179	8.04	28,309	0	0.00	0	4	1.75	9,522
LOYOLA UNIVERSITY MEDICAL CENTER	543	4.14	19,760	28	3.57	14,858	334	3.33	15,885	177	5.82	28,168	0	0.00	0	4	1.00	8,848
OUR LADY OF THE RESURRECTION MEDICAL CENTER	542	5.07	24,181	55	3.87	17,000	329	4.77	21,574	154	6.30	32,577	0	0.00	0	4	1.50	14,053
ADVOCATE LUTHERAN GENERAL HOSPITAL	535	4.30	21,455	49	2.90	11,451	313	3.85	19,048	160	5.89	30,608	0	0.00	0	13	1.08	4,459
PROVIDENT HOSPITAL OF COOK COUNTY	518	4.09	6,981	140	2.89	4,739	274	4.09	6,716	104	5.68	10,696	0	0.00	0	0	0.00	0
HOLY CROSS HOSPITAL	512	5.17	21,086	65	3.40	12,410	296	4.54	17,083	150	7.21	32,773	0	0.00	0	1	2.00	22,679
CONDELL MEDICAL CENTER	501	4.99	13,624	23	3.63	14,586	289	4.24	11,113	176	6.65	18,227	0	0.00	0	13	1.38	5,437
EDWARD HOSPITAL	500	4.60	28,644	12	2.33	14,955	283	3.87	22,278	204	5.75	33,445	0	0.00	0	1	2.00	15,046
RUSH UNIVERSITY MEDICAL CENTER	500	4.45	28,919	26	2.19	14,828	282	3.32	19,972	188	6.54	39,397	0	0.00	0	4	1.00	8,773
WEST SUBURBAN MEDICAL CENTER	493	3.38	19,273	64	1.91	13,159	296	3.18	18,200	130	4.65	24,937	0	0.00	0	3	1.33	10,030
OSF SAINT FRANCIS MEDICAL CENTER	484	4.70	20,950	24	2.58	11,720	303	3.99	16,685	151	8.59	31,321	0	0.00	0	6	1.67	12,231
MACNEAL HOSPITAL	483	4.21	19,923	36	3.17	14,100	289	3.53	16,712	158	5.74	27,364	0	0.00	0	2	1.50	8,204
ST ELIZABETH'S HOSPITAL - BELLEVILLE	481	4.84	18,530	28	3.69	13,926	294	4.12	16,039	152	6.59	24,822	0	0.00	0	7	1.14	4,811
SWEDISHAMERICAN HOSPITAL	478	4.49	17,809	21	2.67	9,710	269	3.59	14,150	185	6.05	24,202	0	0.00	0	3	1.67	8,393
ST JOHN'S HOSPITAL	476	4.53	17,559	29	3.31	12,192	287	3.85	14,086	155	6.48	25,264	0	0.00	0	5	1.60	9,223
TRINITY REGIONAL HEALTH SYSTEM- ROCK ISLAND	475	3.73	9,159	31	2.48	8,450	318	3.54	8,541	115	4.83	12,238	0	0.00	0	11	1.18	2,455
MEMORIAL MEDICAL CENTER - SPRINGFIELD	473	4.83	14,381	19	2.16	8,701	271	4.09	11,782	179	6.32	19,087	0	0.00	0	4	1.25	4,436
ELMHURST MEMORIAL HOSPITAL	458	5.22	28,918	22	2.50	15,996	289	4.37	22,942	145	7.39	43,010	0	0.00	0	2	1.00	12,745
ALEXIAN BROTHERS MEDICAL CENTER	444	5.47	27,515	24	2.63	16,858	252	4.59	22,276	162	7.41	38,067	0	0.00	0	6	1.33	5,327
CENTRAL DUPAGE HOSPITAL	431	4.48	28,135	17	2.41	15,204	241	3.76	22,098	165	5.92	39,115	0	0.00	0	8	1.00	11,002
ST JAMES HOSPITAL & HEALTH CENTERS/CHICAGO HEIGHTS CAMPUS	430	5.36	21,232	40	2.98	12,052	250	4.62	17,644	139	7.42	30,389	0	0.00	0	1	1.00	12,599
ST FRANCIS HOSPITAL - EVANSTON	427	4.70	25,597	36	3.22	15,850	196	4.18	22,215	191	5.58	31,184	0	0.00	0	4	1.75	12,301
DECATUR MEMORIAL HOSPITAL	421	4.52	14,819	18	3.17	7,908	237	4.06	12,987	149	5.77	19,636	0	0.00	0	17	1.29	5,457
SWEDISH COVENANT HOSPITAL	420	5.30	26,953	32	3.19	16,008	218	4.28	20,233	164	7.20	38,707	0	0.00	0	6	1.33	8,222
ADVOCATE GOOD SAMARITAN HOSPITAL - DOWNERS GROVE	414	4.79	28,306	9	1.89	14,993	203	3.80	21,729	197	6.04	36,302	0	0.00	0	5	1.20	4,270
ADVENTIST LAGRANGE MEMORIAL HOSPITAL	398	4.98	24,173	17	2.53	14,562	205	4.10	19,574	171	6.39	31,173	0	0.00	0	5	1.20	5,970
CENTEGRA HOSPITAL - MCHENRY	382	4.60	19,487	29	2.55	12,001	195	3.82	15,970	154	6.05	25,734	0	0.00	0	4	1.25	4,660
JACKSON PARK HOSPITAL	381	4.08	27,232	73	2.77	17,703	183	3.50	22,053	123	5.76	40,805	0	0.00	0	2	1.00	14,164
PRESSING HOSPITAL AT 11TH STREET	372	4.80	14,880	18	3.17	8,354	217	3.91	12,543	132	6.07	20,022	0	0.00	0	5	1.20	4,087
SAINT JOSEPH HOSPITAL - CHICAGO	369	5.06	25,381	26	2.46	12,701	223	4.48	22,189	117	6.83	34,636	0	0.00	0	3	1.33	11,668
RUSH NORTH SHORE MEDICAL CENTER	363	5.62	21,795	16	2.75	12,879	215	4.84	18,414	127	7.48	29,104	0	0.00	0	5	1.60	10,660
ST JAMES HOSPITAL & HEALTH CENTERS/OLYMPIA FIELDS CAMPUS	363	4.25	20,166	20	2.10	10,654	209	3.81	16,838	133	5.61	26,881	0	0.00	0	1	1.00	12,819
SOUTH MEDICAL CENTER EAST	361	4.95	19,103	28	2.93	11,062	200	4.73	17,868	125	5.98	23,662	0	0.00	0	8	1.50	11,885

Refined DRG Comparative Severity Adjustment

COMPdata Report: DRG SEVERITY ADJUSTED
Reporting Period: 07/01/2006 THROUGH 06/30/2007

DRG PROVIDER FACILITY	Total			Baseline			Minor			Major			Catastrophic			Other		
PROVENA UNITED SAMARITANS MED CTR- LOGAN	360	4.55	20,558	18	3.06	13,680	207	3.99	17,665	129	5.83	26,447	0	0.00	0	6	1.17	14,417
CARLE FOUNDATION HOSPITAL	358	3.54	16,231	7	2.43	10,544	201	2.78	12,887	148	4.65	21,097	0	0.00	0	2	1.00	14,076
PROVENA COVENANT MEDICAL CENTER	358	3.82	16,227	15	2.27	11,063	185	3.25	13,651	153	4.75	20,119	0	0.00	0	5	1.40	7,964
ROSELAND COMMUNITY HOSPITAL	354	5.05	26,336	37	3.16	17,373	187	4.73	23,954	130	6.05	32,319	0	0.00	0	0	0.00	0
GLENBROOK HOSPITAL	344	4.28	21,286	21	3.29	17,160	199	3.64	18,834	117	5.38	26,768	0	0.00	0	7	1.29	11,723
ADVOCATE ILLINOIS MASONIC MEDICAL CENTER	341	4.78	29,441	20	2.35	14,382	201	3.81	22,837	119	6.87	43,246	0	0.00	0	1	1.00	15,128
ST ALEXIUS MEDICAL CENTER	324	5.05	26,566	23	3.70	18,727	177	4.24	21,516	118	6.69	36,671	0	0.00	0	6	1.83	6,887
UNIVERSITY OF ILLINOIS MEDICAL CENTER AT CHICAGO	320	4.00	20,057	28	2.11	11,486	188	3.54	16,524	102	5.41	28,877	0	0.00	0	2	2.00	22,268
GOTTLIEB MEMORIAL HOSPITAL	305	5.62	42,055	22	4.41	29,847	180	5.03	36,934	93	7.51	57,730	0	0.00	0	10	1.30	15,088
MOUNT SINAI HOSPITAL	304	4.14	19,817	27	2.30	12,304	170	3.34	18,222	102	6.11	28,372	0	0.00	0	5	1.20	8,077
METHODIST MEDICAL CENTER OF ILLINOIS - PEORIA	303	5.10	24,461	12	2.75	12,248	170	4.14	18,421	118	6.84	34,782	0	0.00	0	3	1.00	10,387
ADVOCATE GOOD SHEPHERD HOSPITAL	302	4.57	19,531	18	2.61	12,123	175	4.13	16,669	105	5.76	26,049	0	0.00	0	4	1.25	6,976
ROCKFORD MEMORIAL HOSPITAL	299	4.20	17,829	20	2.55	10,487	181	3.54	14,269	96	5.85	26,160	0	0.00	0	2	1.50	13,575
SARAH BUSH LINCOLN HEALTH CENTER	298	4.77	12,974	16	2.81	9,334	190	4.17	10,852	91	6.40	18,099	0	0.00	0	1	1.00	8,137
SHERMAN HOSPITAL	286	5.05	24,641	19	2.79	13,674	157	4.10	19,149	107	6.96	35,162	0	0.00	0	3	1.33	6,220
OSF SAINT ANTHONY MEDICAL CENTER	285	4.64	19,011	13	2.62	13,726	157	4.06	16,118	108	5.91	24,269	0	0.00	0	7	1.71	12,619
RIVERSIDE MEDICAL CENTER - KANKAKEE	283	4.77	16,635	11	3.64	11,225	168	3.93	13,440	103	6.29	22,563	0	0.00	0	1	1.00	2,361
SAINT MARY OF NAZARETH HOSPITAL CENTER	283	5.74	30,081	22	3.32	16,394	188	5.53	28,451	74	7.05	38,450	0	0.00	0	1	1.00	15,216
CENTEGRA HOSPITAL - WOODSTOCK	273	4.16	18,159	13	3.23	13,104	145	3.15	14,374	111	5.68	24,012	0	0.00	0	4	1.25	9,378
RUSH-COPLEY MEDICAL CENTER	271	3.76	29,012	16	2.44	20,420	155	3.37	25,904	94	4.78	37,080	0	0.00	0	6	1.50	5,797
ST MARY'S HOSPITAL - CENTRALIA	266	4.56	10,506	30	2.97	7,678	159	4.19	9,224	71	6.31	14,953	0	0.00	0	6	1.50	6,025
EVANSTON HOSPITAL	264	4.43	21,861	17	2.76	12,483	149	3.78	18,270	87	6.28	32,328	0	0.00	0	11	1.18	2,223
RUSH OAK PARK HOSPITAL	259	4.70	19,389	17	2.47	11,179	151	4.62	18,417	90	5.31	22,668	0	0.00	0	1	1.00	10,680
SOUTH SHORE HOSPITAL	244	6.60	19,713	32	4.69	13,445	131	6.27	17,648	80	7.99	25,717	0	0.00	0	1	1.00	10,486
ANDERSON HOSPITAL	240	4.66	15,622	19	2.74	9,821	117	4.06	13,163	97	6.01	20,725	0	0.00	0	7	1.14	1,756
NORWEGIAN-AMERICAN HOSPITAL	240	4.71	17,408	22	3.41	11,536	137	4.47	16,019	79	5.57	21,427	0	0.00	0	2	2.00	18,387
HERRIN HOSPITAL	239	4.95	15,304	8	3.50	13,503	135	4.26	12,257	90	6.33	20,677	0	0.00	0	6	1.50	5,678
ADVENTIST HINSDALE HOSPITAL	235	4.50	22,387	9	2.67	15,920	133	3.64	18,382	87	6.22	30,319	0	0.00	0	6	1.33	5,052
GATEWAY REGIONAL	232	5.32	40,102	27	4.07	27,872	139	4.71	35,625	64	7.31	56,060	0	0.00	0	2	1.00	5,671
ST ANTHONY'S MEMORIAL HOSPITAL - EFFINGHAM	222	4.26	9,712	28	3.39	8,051	116	3.97	8,604	75	5.15	12,242	0	0.00	0	3	1.67	4,651
GOOD SAMARITAN REGIONAL HEALTH CENTER - MOUNT VERNON	220	4.60	11,902	25	2.88	6,824	138	4.08	10,470	55	6.80	18,139	0	0.00	0	2	1.00	2,705
PROVENA MERCY MEDICAL CENTER	218	4.08	24,125	17	2.59	17,016	99	3.74	22,716	97	4.82	27,664	0	0.00	0	5	1.60	7,536
LOUIS A WEISS MEMORIAL HOSPITAL	214	4.90	24,013	11	3.09	16,033	117	4.21	19,543	85	6.13	31,250	0	0.00	0	1	2.00	19,686
DELNOR-COMMUNITY HOSPITAL	213	4.51	26,139	5	2.80	15,790	141	3.94	21,887	66	5.91	36,133	0	0.00	0	1	1.00	17,696
GENESIS MEDICAL CENTER-ILLINI CAMPUS	213	3.41	10,127	16	2.56	8,403	139	3.25	9,528	53	4.28	12,718	0	0.00	0	5	1.20	4,848
SACRED HEART HOSPITAL	213	4.53	13,701	79	3.67	11,229	108	4.83	14,811	26	5.27	16,605	0	0.00	0	0	0.00	0
ROCTOR HOSPITAL	211	5.38	18,836	9	2.44	10,281	114	4.42	13,105	84	7.19	23,006	0	0.00	0	4	1.25	8,337
HWAUKEE COMMUNITY HOSPITAL	210	4.69	20,567	7	3.14	14,452	148	4.30	18,450	51	6.29	28,816	0	0.00	0	4	1.50	6,966
NT ANTHONY HOSPITAL - CHICAGO	204	5.82	24,917	20	2.95	13,485	119	4.75	19,961	65	8.66	37,471	0	0.00	0	0	0.00	0
NNETH HALL REGIONAL HOSPITAL	193	4.72	11,465	15	3.00	7,097	99	4.68	10,991	79	5.10	12,889	0	0.00	0	0	0.00	0
OVENA ST MARY'S HOSPITAL	192	5.51	27,220	6	3.00	16,315	86	4.03	20,417	100	6.92	33,726	0	0.00	0	0	0.00	0
OMENN REGIONAL MEDICAL CENTER - NORMAL	191	4.25	14,911	13	2.77	9,242	111	3.54	11,770	64	5.92	21,997	0	0.00	0	3	1.00	4,547
F ST MARY MEDICAL CENTER	191	5.16	15,260	9	3.00	9,085	134	4.53	13,268	47	7.45	22,336	0	0.00	0	1	1.00	8,961
N MEMORIAL HOSPITAL	188	4.45	15,435	13	3.08	9,844	113	4.24	14,040	60	5.27	19,589	0	0.00	0	2	1.00	5,924
H MEDICAL CENTER	187	3.88	15,791	10	2.10	12,199	115	3.63	14,755	60	4.72	18,684	0	0.00	0	2	2.00	6,534
STLAKE HOSPITAL	184	4.48	23,601	14	3.50	17,414	118	3.73	19,860	52	6.46	33,753	0	0.00	0	0	0.00	0

ATTACHMENT GRC-6(4)
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Refined DRG Comparative Severity Adjustment

COMPdata

COMPdata Report: DRG SEVERITY ADJUSTED
Reporting Period: 07/01/2006 THROUGH 06/30/2007

09/08/2008
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DRG / PROVIDER FACILITY																		
LORETTO HOSPITAL	183	5.28	11,912	25	2.92	6,677	111	4.86	10,238	46	7.67	18,883	0	0.00	0	1	1.00	7,855
ST MARY'S HOSPITAL - DECATUR	183	4.97	13,583	11	3.45	9,135	116	4.83	12,853	53	5.75	16,370	0	0.00	0	3	2.00	8,886
MEMORIAL HOSPITAL OF CARBONDALE	180	3.71	14,792	7	1.86	9,872	90	3.61	13,537	78	4.12	17,035	0	0.00	0	5	1.60	9,264
SAINT ANTHONY'S HEALTH CENTER - ALTON	180	4.70	31,451	7	2.29	21,274	98	4.30	27,887	76	5.47	37,195	0	0.00	0	1	1.00	10,147
SAINT ELIZABETH HOSPITAL CHICAGO	179	5.54	24,807	10	3.30	14,598	111	4.52	18,670	57	7.98	38,764	0	0.00	0	1	1.00	11,372
LAKE FOREST HOSPITAL	175	4.41	24,358	20	2.85	15,303	98	3.79	20,052	57	6.04	34,938	0	0.00	0	0	0.00	0
HIGHLAND PARK HOSPITAL	174	4.68	22,004	11	3.09	15,645	118	4.30	20,585	44	6.16	27,431	0	0.00	0	1	2.00	20,590
ALTON MEMORIAL HOSPITAL	169	5.14	23,584	7	2.43	16,038	90	3.97	17,227	71	6.94	32,468	0	0.00	0	1	2.00	17,758
OSF ST JOSEPH MEDICAL CENTER - BLOOMINGTON	169	4.80	20,869	13	2.38	11,125	103	3.98	16,614	50	7.30	32,558	0	0.00	0	3	1.67	14,412
PROVENA SAINT JOSEPH HOSPITAL - ELGIN	167	5.19	28,251	11	4.82	21,052	91	4.10	21,808	59	7.34	41,464	0	0.00	0	6	1.33	9,261
THOREK HOSPITAL & MEDICAL CENTER	155	6.06	19,141	19	4.05	11,710	67	4.93	15,429	89	7.72	24,792	0	0.00	0	0	0.00	0
PASSAVANT AREA HOSPITAL	151	4.57	14,449	33	3.58	11,770	69	3.99	12,041	46	6.37	20,383	0	0.00	0	3	1.33	8,299
OAK FOREST HOSPITAL OF COOK COUNTY	150	5.45	6,769	23	3.96	5,914	105	5.21	7,841	22	8.14	15,703	0	0.00	0	0	0.00	0
ST MARGARET'S HEALTH	145	3.97	12,279	9	4.11	11,132	93	3.82	11,586	40	4.48	14,730	0	0.00	0	3	1.67	5,143
GALESBURG COTTAGE HOSPITAL	144	5.19	22,588	21	3.87	15,867	77	4.61	18,693	45	6.98	32,601	0	0.00	0	1	2.00	12,748
LINCOLN PARK HOSPITAL	142	5.29	21,328	19	4.47	15,143	91	5.09	19,863	32	6.34	29,728	0	0.00	0	0	0.00	0
IROQUOIS MEMORIAL HOSPITAL & RESIDENT HOME	139	3.61	10,192	0	0.00	0	66	3.17	8,606	72	4.06	11,748	0	0.00	0	1	1.00	2,880
MORRIS HOSPITAL & HEALTHCARE CENTERS	138	4.15	15,985	7	3.14	11,284	85	3.48	13,345	45	5.62	21,714	0	0.00	0	1	2.00	12,727
ST MARY'S HOSPITAL - STREATOR	133	4.43	11,183	5	3.40	9,317	77	3.97	9,715	49	5.37	13,806	0	0.00	0	2	1.50	8,097
KATHERINE SHAW BETHEA HOSPITAL	128	3.62	19,530	11	2.91	15,221	68	3.25	16,008	43	4.60	26,816	0	0.00	0	4	1.25	12,919
FAYETTE COUNTY HOSPITAL	124	2.87	8,803	25	2.20	6,844	70	2.86	8,335	29	3.48	11,619	0	0.00	0	0	0.00	0
SHELBY MEMORIAL HOSPITAL	124	3.28	9,659	12	2.42	7,136	87	3.23	9,399	25	3.68	11,772	0	0.00	0	0	0.00	0
PEKIN HOSPITAL	123	4.85	22,717	11	2.55	13,136	72	4.57	20,614	37	6.38	30,647	0	0.00	0	3	1.33	10,526
HEARTLAND REGIONAL MEDICAL CENTER	122	4.44	28,670	4	2.50	18,124	50	3.72	20,232	63	5.38	36,159	0	0.00	0	5	1.40	28,715
HARRISBURG MEDICAL CENTER, INC	120	4.33	9,823	6	1.83	5,158	68	3.75	8,335	44	5.70	12,919	0	0.00	0	2	1.00	8,311
ILLINOIS VALLEY COMMUNITY HOSPITAL	119	4.32	13,637	16	3.38	10,667	74	4.18	12,682	27	5.52	18,549	0	0.00	0	2	1.00	6,449
KEWANEE HOSPITAL	118	3.46	12,914	10	2.30	8,116	74	3.31	11,790	32	4.31	17,608	0	0.00	0	2	1.00	3,409
JERSEY COMMUNITY HOSPITAL	117	4.09	9,481	11	2.91	5,869	69	3.93	8,932	37	4.76	11,514	0	0.00	0	0	0.00	0
TAYLORVILLE MEMORIAL HOSPITAL	117	3.91	10,172	12	2.92	7,620	81	3.69	9,511	23	4.61	14,068	0	0.00	0	1	2.00	4,743
MCDONOUGH DISTRICT HOSPITAL	108	4.45	11,928	16	4.81	11,654	51	4.55	12,011	36	4.64	12,447	0	0.00	0	5	1.00	8,223
TOUCHETTE REGIONAL HOSPITAL	104	5.99	15,126	15	3.80	9,448	62	5.81	13,251	25	8.16	23,764	0	0.00	0	2	1.00	7,848
OTTAWA REGIONAL HOSPITAL & HEALTHCRE CENTER	97	2.95	10,919	13	2.46	9,630	54	2.65	9,586	27	4.00	14,918	0	0.00	0	3	1.00	4,507
ST JOSEPH MEMORIAL HOSPITAL - MURPHYSBORO	95	4.64	12,067	8	2.50	7,005	60	4.75	11,773	27	5.15	14,831	0	0.00	0	2	1.00	1,452
ADVENTIST GLENOAKS HOSPITAL	92	4.57	24,815	5	2.80	16,535	41	3.59	19,693	42	6.07	32,648	0	0.00	0	4	1.00	5,438
PERRY MEMORIAL HOSPITAL	88	3.41	7,255	11	2.64	4,956	47	3.38	7,005	28	3.96	8,949	0	0.00	0	2	1.00	2,040
GRAHAM HOSPITAL	85	4.68	14,498	13	3.08	10,120	54	4.91	14,822	16	5.63	17,710	0	0.00	0	2	1.50	8,427
ACHLAND MEMORIAL HOSPITAL	80	4.08	13,211	9	3.33	12,107	53	3.94	12,469	17	5.00	18,315	0	0.00	0	1	2.00	9,688
ASSAC MEMORIAL HOSPITAL	78	4.65	8,405	14	3.00	6,375	40	4.53	7,803	23	6.04	10,992	0	0.00	0	1	1.00	1,354
AWRENCE COUNTY MEMORIAL HOSPITAL	75	3.33	7,645	12	3.42	7,454	39	3.36	7,365	21	3.52	8,849	0	0.00	0	3	1.33	3,606
T FRANCIS HOSPITAL - LITCHFIELD	75	3.84	8,832	11	4.00	9,782	48	3.79	8,544	15	4.07	9,563	0	0.00	0	1	1.00	1,264
ED BUD REGIONAL HOSPITAL	75	4.00	13,611	3	2.67	7,931	31	3.29	10,395	39	4.77	16,802	0	0.00	0	2	2.00	5,983
ARDIN COUNTY GENERAL HOSPITAL	72	3.99	6,356	8	4.00	5,725	38	3.55	5,693	26	4.62	7,520	0	0.00	0	0	0.00	0
JOSEPH'S HOSPITAL - BREESE	72	4.21	11,692	6	2.50	9,310	50	4.30	11,590	14	5.07	13,910	0	0.00	0	2	1.00	5,886
AY COUNTY HOSPITAL - FLORA	70	3.66	6,445	4	3.00	4,398	63	3.97	6,647	2	3.50	6,679	0	0.00	0	1	1.00	1,464
SF SAINT JAMES HOSPITAL	67	4.00	14,599	6	2.50	9,818	44	3.80	13,818	15	5.53	19,827	0	0.00	0	2	1.50	6,912
JOSEPH'S HOSPITAL - HIGHLAND	65	4.02	7,796	5	2.60	4,751	30	4.07	7,545	29	4.31	8,883	0	0.00	0	1	1.00	5,446

Refined DRG Comparative Severity Adjustment

COMPdata

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DRG / PROVIDER FACILITY	Total			Baseline			Minor			Major			Catastrophic			Other		
UNION COUNTY HOSPITAL DISTRICT	65	5.60	7,435	7	24.29	5,987	35	2.91	6,061	21	4.29	10,836	0	0.00	0	2	1.00	843
ABRAHAM LINCOLN MEMORIAL HOSPITAL	64	4.38	13,135	2	3.00	7,502	29	4.03	11,648	32	4.88	15,065	0	0.00	0	1	1.00	5,754
HAMILTON MEMORIAL HOSPITAL DISTRICT	60	3.68	6,048	20	3.40	5,476	27	3.78	5,638	13	3.92	7,761	0	0.00	0	0	0.00	0
MENDOTA COMMUNITY HOSPITAL	60	4.18	11,432	10	2.50	7,265	33	3.91	10,624	17	5.71	15,454	0	0.00	0	0	0.00	0
FAIRFIELD MEMORIAL HOSPITAL	59	2.97	9,099	12	2.83	9,096	31	3.03	8,811	14	3.14	9,774	0	0.00	0	2	1.50	8,842
CROSSROADS COMMUNITY HOSPITAL	57	3.56	18,164	5	3.20	10,102	30	3.23	14,332	22	4.09	25,221	0	0.00	0	0	0.00	0
MEMORIAL HOSPITAL - CHESTER	57	3.67	7,332	13	2.62	5,644	32	3.75	7,357	10	5.30	10,855	0	0.00	0	2	1.00	1,275
PARIS COMMUNITY HOSPITAL	55	4.31	8,289	8	3.38	5,576	36	4.42	8,885	10	5.00	9,080	0	0.00	0	1	1.00	643
SALEM TOWNSHIP HOSPITAL	54	4.17	8,063	4	3.25	5,516	22	3.64	6,970	27	4.85	9,561	0	0.00	0	1	1.00	1,873
DR JOHN WARNER HOSPITAL	53	3.30	7,869	9	2.22	4,763	27	3.19	7,944	16	4.19	9,831	0	0.00	0	1	2.00	2,398
FRANKLIN HOSPITAL	52	3.58	6,536	12	3.17	7,393	27	3.74	6,108	11	3.91	7,003	0	0.00	0	2	2.00	4,606
MEMORIAL HOSPITAL - CARTHAGE	51	3.53	7,332	6	1.87	3,736	32	3.81	7,411	11	4.18	9,633	0	0.00	0	2	1.00	4,195
VALLEY WEST COMMUNITY HOSPITAL	51	2.73	10,598	3	2.00	7,796	36	2.39	9,536	12	3.92	14,486	0	0.00	0	0	0.00	0
WABASH GENERAL HOSPITAL DISTRICT	51	3.49	8,144	7	2.86	6,428	35	3.51	8,186	9	3.89	9,318	0	0.00	0	0	0.00	0
CRAWFORD MEMORIAL HOSPITAL	47	4.04	9,003	10	3.90	7,034	23	3.57	8,335	12	5.50	12,988	0	0.00	0	2	1.50	2,616
SPARTA COMMUNITY HOSPITAL	46	3.28	7,454	8	3.88	8,089	21	2.86	6,586	16	3.69	8,889	0	0.00	0	1	1.00	814
OSF HOLY FAMILY MEDICAL CENTER	45	3.82	11,004	3	2.67	10,112	24	3.83	10,017	18	4.00	12,469	0	0.00	0	0	0.00	0
PANA COMMUNITY HOSPITAL	44	3.05	6,073	10	2.80	5,112	23	3.00	6,408	10	3.50	6,444	0	0.00	0	1	2.00	4,247
HOOPESTON COMMUNITY MEMORIAL HOSPITAL	43	2.84	7,401	8	2.13	5,155	20	2.65	6,692	14	3.57	9,780	0	0.00	0	1	2.00	6,258
FERRELL HOSPITAL	42	3.40	6,449	15	3.33	5,848	13	3.48	6,144	12	3.75	8,276	0	0.00	0	2	1.50	1,978
CARLINVILLE AREA HOSPITAL	41	3.66	8,783	5	3.80	9,044	19	3.63	7,872	17	3.65	9,726	0	0.00	0	0	0.00	0
MERCY HARVARD HOSPITAL	39	2.72	9,696	6	2.33	8,320	19	2.16	8,060	13	3.85	13,242	0	0.00	0	1	1.00	2,947
GREENVILLE REGIONAL HOSPITAL	38	3.26	7,555	2	2.50	4,738	21	2.67	6,170	15	4.20	9,870	0	0.00	0	0	0.00	0
HILLSBORO AREA HOSPITAL	38	3.24	6,768	8	2.63	5,272	24	3.38	6,911	5	3.80	8,413	0	0.00	0	1	2.00	7,087
PINCKNEYVILLE COMMUNITY HOSPITAL	38	3.16	5,831	16	2.63	5,155	20	3.50	6,048	2	4.00	9,073	0	0.00	0	0	0.00	0
ILLINI COMMUNITY HOSPITAL - PITTSFIELD	37	3.81	9,599	4	2.25	5,100	19	3.68	8,087	14	4.43	12,938	0	0.00	0	0	0.00	0
MARSHALL BROWNING HOSPITAL	38	3.89	12,909	2	1.50	7,757	24	3.63	11,837	9	5.33	17,434	0	0.00	0	1	2.00	8,229
MIDWESTERN REGIONAL MEDICAL CENTER	35	4.74	29,927	3	3.67	21,986	18	3.22	20,096	14	6.93	44,268	0	0.00	0	0	0.00	0
JOHN AND MARY E KIRBY HOSPITAL	32	2.84	6,198	4	3.50	7,060	18	2.39	5,929	9	3.67	6,746	0	0.00	0	1	1.00	2,650
COMMUNITY MEMORIAL HOSPITAL - STAUNTON	30	3.70	9,710	0	0.00	0	15	3.47	8,546	14	4.07	11,005	0	0.00	0	1	2.00	9,041
GIBSON AREA HOSPITAL & HEALTH SERVICES	29	4.03	14,536	1	3.00	7,308	18	4.39	15,648	10	3.50	13,258	0	0.00	0	0	0.00	0
ROCHELLE COMMUNITY HOSPITAL	28	3.25	8,981	2	1.50	3,702	20	3.05	7,309	6	4.50	16,220	0	0.00	0	0	0.00	0
SARAH D CULBERTSON MEMORIAL HOSPITAL	23	3.61	7,683	4	2.75	5,902	12	4.25	8,314	6	3.17	8,484	0	0.00	0	1	2.00	2,423
MASON DISTRICT HOSPITAL	22	3.77	8,937	2	3.50	9,628	13	3.62	8,190	6	4.67	11,502	0	0.00	0	1	1.00	1,874
REHABILITATION INSTITUTE OF CHICAGO	22	15.09	32,090	3	17.00	37,748	9	12.33	24,888	10	17.00	36,874	0	0.00	0	0	0.00	0
MERCER COUNTY HOSPITAL	20	3.45	7,886	1	1.00	3,633	12	3.17	7,004	7	4.29	9,433	0	0.00	0	0	0.00	0
THOMAS H BOYD MEMORIAL HOSPITAL	19	2.95	5,261	3	1.67	2,800	8	3.38	5,553	7	3.14	5,985	0	0.00	0	1	2.00	5,237
EUREKA COMMUNITY HOSPITAL	16	3.50	8,578	1	5.00	8,192	10	3.30	7,583	4	4.25	12,099	0	0.00	0	1	1.00	4,832
RAYMOND-HENRY HOSPITAL	15	2.87	5,449	2	2.50	5,069	7	2.71	5,126	6	3.17	5,952	0	0.00	0	0	0.00	0
KINDRED HOSPITAL - CHICAGO NORTHLAKE	15	15.73	56,146	2	3.50	19,449	4	24.50	83,535	9	14.56	52,128	0	0.00	0	0	0.00	0
KINDRED CHICAGO CENTRAL HOSPITAL-CHICAGO	10	26.50	104,071	0	0.00	0	2	25.00	82,693	7	30.57	124,768	0	0.00	0	1	1.00	1,948
ADRIANJOY REHABILITATION HOSPITAL & CLINICS	7	13.00	23,250	0	0.00	0	5	11.00	18,752	2	18.00	34,494	0	0.00	0	0	0.00	0
CHILDREN'S MEMORIAL HOSPITAL	6	20.67	300,094	0	0.00	0	5	20.60	297,724	1	21.00	311,945	0	0.00	0	0	0.00	0
WASHINGTON COUNTY HOSPITAL - NASHVILLE	6	3.33	5,194	0	0.00	0	6	3.33	5,194	0	0.00	0	0	0.00	0	0	0.00	0
NORTHWEST MEDICAL CENTER	6	2.33	4,311	2	1.50	2,729	3	2.67	5,324	1	3.00	4,438	0	0.00	0	0	0.00	0
KINDRED HOSPITAL - SYCAMORE - SYCAMORE	4	32.75	125,191	0	0.00	0	2	37.00	119,914	2	28.50	130,469	0	0.00	0	0	0.00	0

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ATTACHMENT GRC-6(4)
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Revised DRG Comparative Severity Adjustment

COMPdata

COMPdata Report: DRG SEVERITY ADJUSTED
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DRG / PROVIDER FACILITY	Total			Baseline			Minor			Major			Catastrophic			Other		
	Cases	ALOS	AVG CHG	Cases	ALOS	AVG CHG	Cases	ALOS	AVG CHG	Cases	ALOS	AVG CHG	Cases	ALOS	AVG CHG	Cases	ALOS	AVG CHG
HOLY FAMILY MEDICAL CENTER	3	20.00	75,750	0	0.00	0	1	23.00	87,847	2	18.50	69,701	0	0.00	0	0	0.00	0
RML SPECIALTY HOSPITAL	3	15.00	52,679	0	0.00	0	1	10.00	33,593	2	17.50	62,222	0	0.00	0	0	0.00	0
MORRISON COMMUNITY HOSPITAL	3	4.00	6,571	0	0.00	0	3	4.00	6,571	0	0.00	0	0	0.00	0	0	0.00	0
SCHWAB REHABILITATION HOSPITAL	2	14.50	27,566	0	0.00	0	1	12.00	20,912	1	17.00	34,221	0	0.00	0	0	0.00	0
VAN MATRE HEALTHSOUTH REHABILITATION HOSPITAL	1	1.00	735	0	0.00	0	0	0.00	0	1	1.00	735	0	0.00	0	0	0.00	0
TOTAL FOR: 127 HEART FAILURE & SHOCK	43,531	4.63	20,017	3,551	3.07	12,104	25,106	4.06	16,934	14,348	6.13	27,812	0	0.00	0	526	1.35	7,928

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Refined DRG Comparative Severity Adjustment

COMPdata

09/08/2008

COMPdata Report: DRG SEVERITY ADJUSTED
Reporting Period: 07/01/2006 THROUGH 06/30/2007

DRG / PROVIDER FACILITY																		
544 MAJOR JOINT REPL OR REATTACH LOWER EXT (EFF 10/05)																		
RUSH UNIVERSITY MEDICAL CENTER	1,850	2.40	56,875	1,343	1.97	54,424	274	2.79	57,086	213	3.90	65,530	20	10.20	128,721	0	0.00	0
CENTRAL DUPAGE HOSPITAL	1,143	3.26	53,348	669	2.84	51,351	226	3.41	53,478	227	4.05	57,291	21	6.43	72,926	0	0.00	0
NORTHWESTERN MEMORIAL HOSPITAL	1,095	3.55	41,899	719	3.11	39,038	130	3.58	41,141	212	4.08	45,992	34	9.56	79,776	0	0.00	0
GLENBROOK HOSPITAL	1,057	3.30	46,813	270	3.04	48,871	522	3.11	45,487	243	3.77	48,403	22	5.64	59,986	0	0.00	0
MEMORIAL MEDICAL CENTER - SPRINGFIELD	947	3.22	30,647	561	2.82	29,271	199	3.32	30,002	166	3.87	33,239	21	7.90	53,046	0	0.00	0
RUSH NORTH SHORE MEDICAL CENTER	843	3.50	37,126	464	3.08	34,401	220	3.34	37,985	144	4.37	41,281	15	10.33	68,941	0	0.00	0
NORTHWEST COMMUNITY HOSPITAL - ARLINGTON HEIGHTS	673	4.01	42,068	267	3.39	38,981	170	3.69	40,793	209	4.64	45,057	27	7.15	57,492	0	0.00	0
CARLE FOUNDATION HOSPITAL	672	3.47	35,687	342	2.91	32,602	112	3.19	34,880	179	4.11	38,664	39	6.31	54,853	0	0.00	0
ADVOCATE CHRIST HOSPITAL & MEDICAL CENTER	662	4.06	37,606	353	3.40	34,154	151	3.71	36,953	129	5.12	41,877	29	9.34	64,029	0	0.00	0
OSF SAINT FRANCIS MEDICAL CENTER	652	3.88	42,411	184	3.28	40,440	306	3.67	40,682	144	4.82	43,553	18	9.83	82,818	0	0.00	0
EDWARD HOSPITAL	637	3.85	42,878	311	3.38	40,363	137	3.72	42,535	184	4.37	44,939	25	7.00	62,537	0	0.00	0
PALOS COMMUNITY HOSPITAL	591	4.88	45,178	168	3.90	40,904	217	4.47	43,659	187	5.66	48,062	19	9.95	71,938	0	0.00	0
ADVENTIST HINSDALE HOSPITAL	578	4.22	53,834	253	3.75	50,249	166	4.10	54,023	138	4.64	58,601	21	6.14	77,355	0	0.00	0
OSF SAINT ANTHONY MEDICAL CENTER	564	3.84	34,010	308	3.32	31,642	109	3.84	32,388	125	4.66	36,957	22	7.55	58,444	0	0.00	0
DECATUR MEMORIAL HOSPITAL	548	4.40	37,316	308	3.90	35,502	120	4.09	36,125	107	5.27	40,148	15	10.80	63,650	0	0.00	0
ST ANTHONY'S MEMORIAL HOSPITAL - EFFINGHAM	522	3.82	31,653	294	3.45	31,268	128	3.83	31,689	86	4.80	32,284	14	5.57	35,250	0	0.00	0
ALEXIAN BROTHERS MEDICAL CENTER	517	4.66	51,512	223	3.50	45,886	111	4.46	49,240	150	5.39	55,117	33	9.88	80,773	0	0.00	0
ST JOHN'S HOSPITAL	517	3.80	35,298	303	3.19	33,917	91	3.76	34,547	105	4.95	37,208	18	7.72	51,194	0	0.00	0
ADVOCATE LUTHERAN GENERAL HOSPITAL	479	4.07	39,247	232	3.19	35,419	104	3.77	37,122	124	5.27	43,325	19	8.53	71,014	0	0.00	0
ELMHURST MEMORIAL HOSPITAL	455	5.32	62,333	219	4.50	56,406	105	4.84	61,046	109	6.03	62,726	22	12.23	125,523	0	0.00	0
RIVERSIDE MEDICAL CENTER - KANKAKEE	444	3.37	33,837	175	3.03	31,600	153	3.21	33,404	104	3.74	36,424	12	7.17	49,578	0	0.00	0
METHODIST MEDICAL CENTER OF ILLINOIS - PEORIA	416	3.98	59,082	86	3.12	55,835	190	3.53	56,627	120	4.29	58,594	22	9.59	102,540	0	0.00	0
INGALLS HOSPITAL	405	3.66	40,603	272	3.14	38,841	72	3.49	38,540	45	5.69	48,487	16	7.63	61,048	0	0.00	0
BROMENN REGIONAL MEDICAL CENTER - NORMAL	395	3.80	34,398	263	3.29	32,462	59	3.92	33,710	68	5.02	39,056	7	10.57	89,041	0	0.00	0
MEMORIAL HOSPITAL - BELLEVILLE	387	4.12	22,497	179	3.74	20,347	88	4.18	22,833	95	4.44	23,923	25	5.44	31,299	0	0.00	0
DELNOR-COMMUNITY HOSPITAL	382	3.37	53,834	224	2.69	49,356	66	3.35	52,948	85	4.79	63,420	7	8.14	89,065	0	0.00	0
SWEDISHAMERICAN HOSPITAL	381	3.80	43,674	126	3.42	40,187	150	3.57	44,056	83	4.35	45,452	22	7.27	57,791	0	0.00	0
LOYOLA UNIVERSITY MEDICAL CENTER	380	3.26	35,355	194	2.81	32,205	90	3.18	35,217	82	4.09	38,224	14	7.86	63,095	0	0.00	0
ST ALEXIUS MEDICAL CENTER	357	4.25	54,581	147	3.24	48,697	77	4.14	51,582	105	4.73	58,170	28	8.04	80,311	0	0.00	0
PROVENA SAINT JOSEPH MEDICAL CENTER - JOLIET	345	4.26	53,959	141	3.25	50,367	74	3.96	50,775	112	4.91	56,360	16	9.39	80,238	0	0.00	0
ADVOCATE GOOD SAMARITAN HOSPITAL - DOWNERS GROVE	340	4.40	50,028	127	3.58	45,895	110	4.09	48,996	86	4.93	51,757	17	9.82	80,286	0	0.00	0
TRINITY REGIONAL HEALTH SYSTEM- ROCK ISLAND	335	4.01	28,051	168	3.60	27,182	98	3.71	27,761	53	4.19	28,881	15	10.07	43,844	0	0.00	0
LAKE FOREST HOSPITAL	330	3.93	38,206	171	3.44	33,083	63	3.83	35,873	85	4.89	41,630	11	6.36	46,227	0	0.00	0
CENTEGRA HOSPITAL - MCHENRY	312	3.98	37,449	169	3.13	33,758	80	3.45	34,867	50	5.84	42,305	13	11.92	82,671	0	0.00	0
CONDELL MEDICAL CENTER	300	4.30	25,232	150	3.52	29,060	59	4.10	17,171	84	5.11	24,396	27	7.11	23,560	0	0.00	0
ROCKFORD MEMORIAL HOSPITAL	295	3.78	42,594	147	3.22	39,839	69	3.62	41,936	71	4.83	47,653	8	8.25	53,976	0	0.00	0
OSF ST MARY MEDICAL CENTER	292	3.79	31,294	188	3.38	30,763	55	3.78	30,412	43	4.93	33,563	6	8.67	39,609	0	0.00	0
MACNEAL HOSPITAL	288	4.62	48,217	114	3.75	44,841	52	3.98	46,631	101	4.82	48,823	21	9.85	67,056	0	0.00	0
RESURRECTION MEDICAL CENTER	285	4.98	40,772	163	4.01	35,156	36	4.58	36,491	63	5.62	43,180	23	10.65	80,680	0	0.00	0
MEMORIAL HOSPITAL OF CARBONDALE	278	4.16	41,905	108	3.48	40,385	83	3.96	40,293	71	5.13	44,358	14	5.57	50,755	0	0.00	0
THE UNIVERSITY OF CHICAGO MEDICAL CENTER	276	3.72	63,874	168	3.05	57,600	36	3.42	58,214	56	4.43	69,425	16	8.88	119,607	0	0.00	0
HENDERSON HOSPITAL	275	4.27	36,070	141	3.61	34,052	51	4.25	36,338	73	4.74	37,595	10	7.50	52,005	0	0.00	0
SILVER CROSS HOSPITAL	272	4.15	33,151	133	3.74	30,864	47	3.91	31,346	86	4.67	36,150	6	7.33	54,992	0	0.00	0
ADVENTIST LAGRANGE MEMORIAL HOSPITAL	271	4.59	51,656	63	3.78	49,881	88	3.94	48,116	102	4.87	52,754	18	8.94	68,907	0	0.00	0
LOUIS A WEISS MEMORIAL HOSPITAL	265	3.91	56,975	94	3.14	50,841	81	3.49	53,483	70	4.26	61,806	20	7.95	83,736	0	0.00	0
ADVOCATE GOOD SHEPHERD HOSPITAL	264	3.60	38,516	173	3.18	37,048	52	3.90	39,086	30	4.17	38,832	9	7.89	62,371	0	0.00	0

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Refined DRG Comparative Severity Adjustment

COMPdata

COMPdata Report: DRG SEVERITY ADJUSTED
Reporting Period: 07/01/2006 THROUGH 06/30/2007

DRG / PROVIDER/FACILITY	Total			Catastrophic			Major			Severe			Moderate			Other		
OSF ST JOSEPH MEDICAL CENTER - BLOOMINGTON	262	3.56	34,820	183	3.07	32,994	48	3.40	34,779	40	4.95	38,748	11	6.82	47,776	0	0.00	0
PROCTOR HOSPITAL	261	3.84	38,220	116	3.39	36,823	71	3.92	38,162	68	4.13	39,179	6	8.50	55,022	0	0.00	0
ST FRANCIS HOSPITAL - EVANSTON	237	5.43	56,152	109	4.67	51,419	40	5.00	56,390	75	6.24	56,171	13	8.46	83,453	0	0.00	0
SHERMAN HOSPITAL	233	3.81	36,039	106	3.25	32,153	66	3.53	33,964	52	4.25	44,794	9	4.78	46,444	0	0.00	0
PROVENA SAINT JOSEPH HOSPITAL - ELGIN	228	3.87	64,463	74	3.31	59,767	74	3.31	60,807	62	4.53	68,393	18	6.22	85,514	0	0.00	0
GENESIS MEDICAL CENTER-ILLINI CAMPUS	223	3.52	30,815	147	3.37	30,792	46	3.61	29,324	20	3.65	28,759	10	5.00	37,674	0	0.00	0
BLESSING HOSPITAL AT 11TH STREET	220	4.53	38,745	80	3.91	36,650	54	3.72	37,736	74	4.89	36,863	12	10.08	68,862	0	0.00	0
CENTEGRA HOSPITAL - WOODSTOCK	210	3.77	37,768	88	3.32	36,085	66	3.62	36,817	46	4.70	41,267	10	4.50	42,761	0	0.00	0
PROVENA COVENANT MEDICAL CENTER	206	3.89	48,168	68	3.07	43,322	56	3.43	48,819	70	4.29	46,464	12	8.42	80,186	0	0.00	0
HERRIN HOSPITAL	202	4.73	46,901	83	4.27	46,275	49	4.37	45,768	60	5.18	48,600	10	7.60	47,457	0	0.00	0
PROVENA MERCY MEDICAL CENTER	202	3.41	47,822	91	3.02	45,901	55	3.04	47,167	46	4.02	49,735	10	6.10	60,096	0	0.00	0
ST FRANCIS HOSPITAL & HEALTH CENTER - BLUE ISLAND	201	4.67	57,832	75	3.33	52,345	30	4.13	54,464	86	5.74	61,577	10	7.10	76,886	0	0.00	0
WEST SUBURBAN MEDICAL CENTER	201	5.04	54,592	74	3.50	49,999	44	4.61	52,815	66	6.05	57,234	17	8.94	68,931	0	0.00	0
ST JAMES HOSPITAL & HEALTH CENTERS/CHICAGO HEIGHTS CAMPUS	197	4.34	43,286	57	3.35	39,392	68	3.78	42,048	65	5.22	46,089	7	9.57	60,977	0	0.00	0
ADVOCATE SOUTH SUBURBAN HOSPITAL	193	3.20	34,590	125	2.81	32,738	35	2.80	34,556	27	5.22	41,065	6	4.67	44,243	0	0.00	0
PASSAVANT AREA HOSPITAL	192	3.80	37,538	129	3.22	36,685	34	4.09	37,876	24	6.17	41,438	5	5.20	38,470	0	0.00	0
PROVENA ST MARY'S HOSPITAL	192	3.65	39,664	60	2.90	34,723	73	3.51	37,692	50	4.20	44,260	9	6.78	63,079	0	0.00	0
SAINT ANTHONY'S HEALTH CENTER - ALTON	189	3.84	46,043	121	3.28	41,730	26	3.77	47,816	36	5.08	54,217	8	8.00	76,316	0	0.00	0
GOOD SAMARITAN REGIONAL HEALTH CENTER - MOUNT VERNON	185	4.51	27,292	68	4.16	25,916	48	4.04	28,646	55	4.95	28,317	14	6.14	32,151	0	0.00	0
MORRIS HOSPITAL & HEALTHCARE CENTERS	178	3.64	27,847	109	2.92	25,883	38	3.64	28,224	27	5.52	32,294	6	8.33	41,255	0	0.00	0
ST MARGARET'S HEALTH	178	4.10	35,082	93	3.62	32,917	29	3.86	35,892	51	4.59	37,518	5	5.80	45,831	0	0.00	0
FHN MEMORIAL HOSPITAL	177	3.11	32,702	103	2.33	31,257	28	2.57	30,594	34	3.65	32,645	12	9.58	50,185	0	0.00	0
UNIVERSITY OF ILLINOIS MEDICAL CENTER AT CHICAGO	176	6.02	61,925	95	5.07	56,158	25	6.20	69,963	41	6.63	63,291	15	9.47	81,335	0	0.00	0
RUSH-COPLEY MEDICAL CENTER	174	3.88	49,189	58	3.26	44,226	48	3.48	48,223	52	3.94	49,042	16	7.13	76,550	0	0.00	0
HEARTLAND REGIONAL MEDICAL CENTER	173	5.23	53,820	47	4.00	47,989	31	4.97	52,031	81	5.41	51,929	14	8.93	88,291	0	0.00	0
SWEDISH COVENANT HOSPITAL	173	4.34	54,418	86	3.52	51,139	32	4.22	54,158	41	4.85	53,346	12	8.83	82,794	0	0.00	0
ADVOCATE ILLINOIS MASONIC MEDICAL CENTER	172	4.11	54,809	108	3.68	51,206	23	4.04	54,275	32	4.81	61,028	9	7.00	77,312	0	0.00	0
CGH MEDICAL CENTER	166	4.46	35,088	88	3.98	32,873	44	4.32	33,994	28	5.00	36,666	8	8.63	59,414	0	0.00	0
ST MARY'S HOSPITAL - DECATUR	164	4.79	39,757	86	4.20	38,876	32	4.72	37,369	38	5.37	40,950	8	8.63	53,117	0	0.00	0
KISHWAUKEE COMMUNITY HOSPITAL	159	3.82	48,888	81	3.40	46,892	26	3.81	48,984	47	4.02	50,351	5	9.00	66,965	0	0.00	0
HIGHLAND PARK HOSPITAL	158	4.32	42,832	71	3.34	39,432	34	4.12	39,980	47	5.40	48,317	6	8.67	56,264	0	0.00	0
GALESBURG COTTAGE HOSPITAL	154	4.12	44,819	100	3.77	42,053	30	4.17	45,704	18	5.06	51,798	6	7.00	65,556	0	0.00	0
ADVOCATE TRINITY HOSPITAL - CHICAGO	152	2.53	27,594	95	2.03	25,958	30	3.13	29,377	25	3.44	30,817	2	5.50	38,352	0	0.00	0
VISTA MEDICAL CENTER EAST	149	3.97	51,819	85	3.46	50,195	29	3.52	50,456	32	4.94	52,839	3	12.67	100,132	0	0.00	0
SARAH BUSH LINCOLN HEALTH CENTER	146	3.91	37,776	64	3.14	37,203	35	3.54	35,984	42	4.81	37,203	5	8.80	62,455	0	0.00	0
GOTTLIEB MEMORIAL HOSPITAL	144	5.92	84,985	72	5.17	80,119	35	5.11	80,487	30	7.53	90,444	7	10.71	134,128	0	0.00	0
NEUROLOGIC & ORTHOPEDIC INSTITUTE OF CHICAGO	144	2.92	51,971	93	2.85	52,052	30	3.03	52,754	20	3.05	50,609	1	3.00	48,162	0	0.00	0
[illegible]TON MEMORIAL HOSPITAL	141	4.38	41,367	92	3.80	38,419	16	3.88	40,888	25	5.96	44,095	8	7.00	67,704	0	0.00	0
[illegible]TEWAY REGIONAL	141	3.96	72,167	95	3.55	68,306	22	3.82	69,374	20	5.10	79,755	4	9.00	141,272	0	0.00	0
[illegible]INT JOSEPH HOSPITAL - CHICAGO	138	4.26	39,431	76	3.13	34,720	12	3.08	35,053	42	5.19	41,059	8	11.88	82,204	0	0.00	0
[illegible]ANSTON HOSPITAL	135	4.57	49,559	44	3.27	44,464	43	3.88	48,822	39	6.23	54,349	9	7.00	57,238	0	0.00	0
[illegible]KIN HOSPITAL	134	3.84	35,522	78	3.36	32,912	26	3.35	33,765	26	4.77	39,718	4	10.50	70,578	0	0.00	0
[illegible]INOIS VALLEY COMMUNITY HOSPITAL	128	3.45	31,878	73	3.18	30,088	37	3.65	33,178	16	4.06	35,909	2	5.00	40,777	0	0.00	0
[illegible] JAMES HOSPITAL & HEALTH CENTERS/OLYMPIA FIELDS CAMPUS	120	3.61	37,482	54	2.96	35,356	44	3.38	35,587	19	5.26	41,997	3	8.33	74,149	0	0.00	0
[illegible]LY CROSS HOSPITAL	116	3.83	48,114	66	3.27	47,592	29	3.45	46,588	19	4.95	48,288	2	5.50	56,820	0	0.00	0
[illegible]ROSSROADS COMMUNITY HOSPITAL	103	3.13	71,259	69	2.89	70,171	24	3.17	72,420	9	3.78	74,825	1	6.00	88,153	0	0.00	0

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Refined DRG Comparative Severity Adjustment

COMPdata

COMPdata Report: DRG SEVERITY ADJUSTED
Reporting Period: 07/01/2006 THROUGH 06/30/2007

DRG / PROVIDER FACILITY	Total			Routine			Minor			Major			Catastrophic			Other		
PROVENA UNITED SAMARITANS MED CTR- LOGAN	99	4.65	65,697	28	3.64	58,461	31	4.23	63,836	31	5.48	71,584	9	6.33	74,348	0	0.00	0
ST MARY'S HOSPITAL - STREATOR	95	3.83	33,903	15	3.33	33,304	53	3.58	33,402	22	4.09	34,198	5	6.60	39,720	0	0.00	0
ST ELIZABETH'S HOSPITAL - BELLEVILLE	88	5.16	35,238	32	4.03	32,593	13	4.54	32,410	35	5.69	35,745	8	8.38	48,171	0	0.00	0
KATHERINE SHAW BETHEA HOSPITAL	87	3.69	48,029	45	3.36	47,560	25	3.88	46,761	14	3.86	48,616	3	6.00	62,581	0	0.00	0
GRAHAM HOSPITAL	86	3.84	38,015	42	3.52	37,051	33	3.48	37,348	8	4.13	45,700	3	5.67	38,347	0	0.00	0
OUR LADY OF THE RESURRECTION MEDICAL CENTER	79	5.35	42,925	34	4.82	40,811	18	4.50	39,745	24	6.33	45,429	3	8.67	65,922	0	0.00	0
OSF SAINT JAMES HOSPITAL	78	3.75	30,615	32	3.16	28,739	21	3.19	29,758	16	5.06	34,185	7	5.14	33,610	0	0.00	0
RUSH OAK PARK HOSPITAL	71	4.32	28,780	40	3.45	25,875	13	4.54	27,911	14	5.36	30,514	4	6.75	54,583	0	0.00	0
MCDONOUGH DISTRICT HOSPITAL	60	3.57	39,383	36	3.22	39,818	7	4.29	32,902	13	3.92	39,899	4	4.25	45,130	0	0.00	0
PERRY MEMORIAL HOSPITAL	60	4.43	37,352	28	3.86	37,559	8	4.13	35,841	25	5.08	38,348	1	3.00	20,721	0	0.00	0
HAMMOND-HENRY HOSPITAL	53	3.58	29,602	46	3.52	30,424	2	3.00	12,705	5	4.40	28,800	0	0.00	0	0	0.00	0
OTTAWA REGIONAL HOSPITAL & HEALTHCRE CENTER	50	4.52	21,320	23	4.00	19,381	14	4.21	22,241	13	5.77	23,756	0	0.00	0	0	0.00	0
JOHN H STROGER JR. HOSPITAL OF COOK COUNTY	48	6.56	24,405	33	6.85	19,094	6	6.67	25,368	7	14.14	41,428	2	17.00	49,557	0	0.00	0
WESTLAKE HOSPITAL	41	5.76	45,510	15	3.47	37,879	6	6.17	54,772	16	7.44	50,771	4	7.00	39,185	0	0.00	0
LINCOLN PARK HOSPITAL	39	4.48	70,764	15	4.33	72,166	7	3.86	68,696	18	4.83	71,946	1	8.00	80,063	0	0.00	0
MOUNT SINAI HOSPITAL	38	5.71	75,002	11	3.64	66,701	8	4.75	65,845	12	5.75	69,283	7	10.00	108,314	0	0.00	0
ST FRANCIS HOSPITAL - LITCHFIELD	34	4.41	30,021	21	4.24	30,271	6	4.67	27,177	7	4.71	31,707	0	0.00	0	0	0.00	0
THOREK HOSPITAL & MEDICAL CENTER	33	5.61	41,440	12	4.33	38,247	4	8.50	45,956	15	5.67	42,961	2	7.00	52,158	0	0.00	0
ABRAHAM LINCOLN MEMORIAL HOSPITAL	31	4.74	28,223	8	3.67	27,110	12	4.83	26,815	11	4.73	28,604	2	7.50	37,916	0	0.00	0
SAINT MARY OF NAZARETH HOSPITAL CENTER	30	6.53	48,862	12	5.25	44,900	6	8.67	53,158	10	6.00	46,622	2	10.50	70,950	0	0.00	0
GIBSON AREA HOSPITAL & HEALTH SERVICES	29	3.76	36,221	20	3.65	37,742	5	4.20	41,919	4	3.75	35,993	0	0.00	0	0	0.00	0
SAINT ELIZABETH HOSPITAL CHICAGO	27	6.96	51,338	15	4.40	42,787	4	7.50	47,957	7	11.14	64,462	1	14.00	101,255	0	0.00	0
MEMORIAL HOSPITAL - CHESTER	25	4.04	19,106	21	3.86	19,254	1	8.00	25,034	2	3.00	11,390	1	8.00	25,516	0	0.00	0
ST MARY'S HOSPITAL - CENTRALIA	25	6.00	32,012	13	4.38	29,063	5	5.60	28,653	5	6.20	38,682	2	12.00	47,850	0	0.00	0
KEWANEE HOSPITAL	24	4.29	35,203	11	3.45	36,024	6	4.83	32,872	6	4.83	34,415	1	7.00	44,677	0	0.00	0
MERCY HARVARD HOSPITAL	24	3.50	48,704	12	3.17	47,218	8	3.50	50,907	5	3.60	43,727	1	7.00	78,198	0	0.00	0
RICHLAND MEMORIAL HOSPITAL	22	7.14	31,623	8	6.25	27,263	0	0.00	0	11	7.18	33,519	3	9.33	36,296	0	0.00	0
ST JOSEPH'S HOSPITAL - BREESE	21	4.43	24,023	15	4.00	23,629	2	5.50	25,597	3	4.00	22,999	1	10.00	29,855	0	0.00	0
VALLEY WEST COMMUNITY HOSPITAL	20	4.15	52,024	8	4.00	49,506	8	4.25	56,536	6	4.17	48,524	0	0.00	0	0	0.00	0
MENDOTA COMMUNITY HOSPITAL	19	4.47	38,164	13	4.00	33,321	2	5.00	47,117	4	5.75	39,926	0	0.00	0	0	0.00	0
WABASH GENERAL HOSPITAL DISTRICT	19	4.26	33,977	16	4.25	33,352	0	0.00	0	3	4.33	37,310	0	0.00	0	0	0.00	0
ROCHELLE COMMUNITY HOSPITAL	16	4.19	44,635	1	4.00	42,488	6	3.67	43,313	9	4.56	45,755	0	0.00	0	0	0.00	0
ADVENTIST GLENOAKS HOSPITAL	15	4.27	55,665	7	3.14	52,526	4	4.50	49,898	4	6.00	67,875	0	0.00	0	0	0.00	0
SACRED HEART HOSPITAL	15	5.60	54,898	12	5.67	54,294	2	5.50	59,301	1	5.00	53,339	0	0.00	0	0	0.00	0
CRAWFORD MEMORIAL HOSPITAL	12	4.92	37,143	9	4.44	36,718	3	6.33	38,419	0	0.00	0	0	0.00	0	0	0.00	0
SAINT ANTHONY HOSPITAL - CHICAGO	12	6.33	49,833	5	3.40	43,424	4	7.50	52,585	2	7.50	46,975	1	14.00	76,581	0	0.00	0
OSF HOLY FAMILY MEDICAL CENTER	11	4.91	46,348	1	4.00	52,014	5	5.20	47,830	5	4.80	43,733	0	0.00	0	0	0.00	0
KENNETH HALL REGIONAL HOSPITAL	9	6.22	31,478	2	4.00	28,664	2	4.00	27,199	4	6.50	35,651	1	6.00	32,970	0	0.00	0
MORETTO HOSPITAL	9	10.78	43,261	3	6.33	28,680	0	0.00	0	5	8.60	34,807	1	35.00	129,449	0	0.00	0
JERSEY COMMUNITY HOSPITAL	8	5.50	19,789	1	4.00	15,410	1	6.00	17,916	6	5.67	20,831	0	0.00	0	0	0.00	0
NORWEGIAN-AMERICAN HOSPITAL	8	8.13	54,888	1	2.00	34,134	3	6.67	40,759	3	6.33	48,753	1	24.00	142,433	0	0.00	0
ST JOSEPH'S HOSPITAL - HIGHLAND	8	4.88	38,166	2	3.50	45,415	2	4.50	33,354	3	6.67	33,494	1	3.00	31,485	0	0.00	0
FAYETTE COUNTY HOSPITAL	7	3.86	36,473	3	3.33	44,427	1	4.00	45,727	2	5.00	34,846	1	3.00	20,508	0	0.00	0
JACKSON PARK HOSPITAL	7	9.29	57,652	1	14.00	43,311	1	6.00	37,087	3	5.67	32,047	2	14.00	113,523	0	0.00	0
MASON DISTRICT HOSPITAL	7	5.29	22,018	2	4.00	18,874	1	7.00	30,368	4	5.50	22,502	0	0.00	0	0	0.00	0
HARRISBURG MEDICAL CENTER, INC	6	8.83	35,587	1	7.00	35,221	1	7.00	32,986	3	8.67	29,605	1	13.00	56,496	0	0.00	0

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ATTACHMENT G(CC-6(4))

Refined DRG Comparative Severity Adjustment

COMPdata

COMPdata Report: DRG SEVERITY ADJUSTED
Reporting Period: 07/01/2006 THROUGH 06/30/2007

DRG / PROVIDER FACILITY	Total			Baseline			Minor			Major			Catastrophic			Other		
	Cases	ALOS	AVG CHG	Cases	ALOS	AVG CHG	Cases	ALOS	AVG CHG	Cases	ALOS	AVG CHG	Cases	ALOS	AVG CHG	Cases	ALOS	AVG CHG
SPARTA COMMUNITY HOSPITAL	6	4.33	27,876	3	4.00	26,427	1	4.00	27,022	1	3.00	25,770	1	7.00	35,185	0	0.00	0
RED BUD REGIONAL HOSPITAL	5	4.20	39,479	2	5.50	42,085	3	3.33	37,742	0	0.00	0	0	0.00	0	0	0.00	0
TOUCHETTE REGIONAL HOSPITAL	5	5.40	28,017	4	5.75	28,821	1	4.00	24,800	0	0.00	0	0	0.00	0	0	0.00	0
ILLINI COMMUNITY HOSPITAL - PITTSFIELD	4	5.25	16,909	0	0.00	0	0	0.00	0	3	5.33	15,789	1	5.00	20,270	0	0.00	0
SALEM TOWNSHIP HOSPITAL	4	6.00	19,595	1	5.00	20,530	2	5.00	16,587	0	0.00	0	1	9.00	24,675	0	0.00	0
CARLINVILLE AREA HOSPITAL	3	5.00	21,116	0	0.00	0	2	4.50	21,658	1	6.00	20,030	0	0.00	0	0	0.00	0
EUREKA COMMUNITY HOSPITAL	3	3.67	28,653	1	3.00	24,433	1	4.00	28,916	1	4.00	32,611	0	0.00	0	0	0.00	0
TAYLORVILLE MEMORIAL HOSPITAL	3	6.67	22,052	0	0.00	0	0	0.00	0	2	4.00	18,372	1	12.00	29,414	0	0.00	0
IROQUOIS MEMORIAL HOSPITAL & RESIDENT HOME	3	3.67	25,337	0	0.00	0	1	4.00	21,249	1	4.00	32,106	1	3.00	22,655	0	0.00	0
COMMUNITY MEMORIAL HOSPITAL - STAUNTON	3	5.00	16,370	2	3.50	11,709	0	0.00	0	1	8.00	25,691	0	0.00	0	0	0.00	0
ROSELAND COMMUNITY HOSPITAL	2	10.50	53,698	1	7.00	40,796	0	0.00	0	1	14.00	66,600	0	0.00	0	0	0.00	0
CHILDREN'S MEMORIAL HOSPITAL	1	2.00	34,362	1	2.00	34,362	0	0.00	0	0	0.00	0	0	0.00	0	0	0.00	0
SOUTH SHORE HOSPITAL	1	13.00	73,264	0	0.00	0	0	0.00	0	0	0.00	0	1	13.00	73,264	0	0.00	0
PROVIDENT HOSPITAL OF COOK COUNTY	1	11.00	13,980	0	0.00	0	1	11.00	13,980	0	0.00	0	0	0.00	0	0	0.00	0
MEMORIAL HOSPITAL - CARTHAGE	1	3.00	25,187	1	3.00	25,187	0	0.00	0	0	0.00	0	0	0.00	0	0	0.00	0
TOTAL FOR: 544 MAJOR JOINT REPL OR REATTACH LOWER EX	33,347	3.90	43,469	16,629	3.25	40,564	7,871	3.72	42,497	7,520	4.78	46,719	1,327	8.21	67,219	0	0.00	0

Medical Staff

Key statistical information regarding the Hospital's medical staff is summarized below.

Total Medical Staff	**515**
Percentage of Total Medical Staff that is Board Certified	**99%**

Source: Hospital Medical Staff Records, 2008

The Hospital has a large and stable active medical staff. The loyalty of the medical staff is reflected through its less than typical splitting behavior. The average age of the active medical staff is slightly less than 50 years old. The average age of the physicians recently added to the medical staff was 40 years old while those that resigned/retired were older. Departures from the medical staff were related to increasing malpractice insurance costs, physician re-locations, medical/health issues and retirement.

The number of Palos physicians expected to retire in the next 5 years is 6%, where a total of 27% will have retired within 10 years, and a total of 47% will have retired in 15 years. By 2021, only 53% of the current staff will be less than the age of 65. Nearly 50% of both current and projected total physician supply is within primary care.

To maintain an appropriate number and complement of physicians, the Hospital has adopted a medical staff development plan that identifies physician needs by specialty on an annual basis. This plan also addresses the accessibility and practice patterns of current and new physicians. Components of plan include:

1) **Recruitment of new physicians to PCH Medical Staff**
2) **The formation of Palos Medical Group – an integrated (employed) physician practice group consisting of the following specialties: family practice, internal medicine, general surgery and OB/Gyne.**
3) **Implementation of a Hospitalist program.**

Net Gain in Physicians:

Since 2006, over 70 new physicians were appointed to PCH's medical staff; 33 retired or resigned for a net gain of 33 physicians since 2006.

	2006	2007	2008 YTD	**Total**
Internal Medicine/Family Practice	4	6	-	**10**
OB/Gyne	2	-	-	**2**
Pediatrics	4	7	-	**11**
General Surgery	1	2	-	**3**
Cardiology	1	4	4	**9**
All Other	15	11	10	**36**
Total Added to Medical Staff:	**27**	**30**	**14**	**71**
Net Gain*	**9**	**18**	**6**	**33**

Source: New Medical Staff Appointments, Medical Staff Office memorandums
**Net gain is after subtracting physicians that retired/resigned from the medical staff.*

Sources: NCI Consulting, PCH Medical Staff Rosters, AMI, BCBS website.

Hospitalist Program

It is the Mission of PCH that all of its services – preventive, curative or palliative—shall be delivered with quality of the highest caliber and that PCH shall be committed to continually responding to the health care needs of the community with services that are readily available in a form that enhances their efficient use by physicians and patients.

Acting on its mission and values, PCH is implementing a Hospitalist program that consists of physicians who dedicate all their time to in-hospital care of patients. PCH will employ several board-certified internists, several whose focus is to care for patients in critical care units of the hospital. Hospitalists will assess patients in the Emergency Department, admit patients, arrange for specialty consultants and arrange post-hospital care. They will then refer the patients back to their regular physician for outpatient care.

In addition, hospitalists are available to care for patients who have out-of-town physicians, or patients who do not have an established primary care physician. Patients are able to retain their primary care physician or internist and can be seen by a hospitalist as a complement to their care at Palos Hospital. For example, if a patient comes into the emergency room and their primary care physician is unavailable, the hospitalist can be called to evaluate and treat the patient. For continuity of care, the hospitalist will then notify the primary care physician and work together on treatment.

The Hospitalist facilitates a continuity of care by being able to focus solely on patients in the hospital. When the patient needs to be seen by a doctor, the Hospitalist is there and doesn't have to be called over from his office where he may be with a patient. The Hospitalist is able to review test results quickly and begin treatments in a timely manner, thereby moving the patient closer to discharge. Hospitalists are also at the hospital for a full shift so they are available to review test results sooner and to order follow-up tests immediately if needed, which may reduce the length of hospital stays.

In addition to taking care of patients, Hospitalists are partners with the hospital in improving processes and outcomes. They participate on multidisciplinary patient care teams, ethics teams and a variety of quality improvement teams.

There are many benefits to be realized with this program, for both the patient and the patient's family: greater continuity of care, more in-person coordination of care; reduced length of stay. Patients who present to the emergency department and require admission are seen in a more timely manner, which expedites transfer out of the emergency department to the inpatient unit. A hospitalist cares for patients only in the hospital and has no outside medical practice. This allows hospitalists to devote their full attention to care for and treat patients in the hospital. Discharges should occur earlier in the day so you can start recovering sooner in the comfort of your own home.

Source: http://www.todayshospitalist.com; Source: Wachter RM, Goldman L. The Hospitalist Movement 5 Years Later. JAMA. 2002;287:487–9; Health Care Market Trends and the Evolution of Hospitalist Use and Roles; Hoangmai H Pham, MD, MPH,1 Kelly J Devers, PhD,2 Sylvia Kuo, PhD,3 and Robert Berenson, MD4 (http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1490059)

SECTION VI. REVIEW CRITERIA RELATING TO ESTABLISHMENT OF ADDITIONAL BEDS OR SUBSTANTIAL CHANGE IN BED CAPACITY (BEDS)

This section is applicable to all projects proposing the establishment of additional beds or the conversion of beds from one category of service to another.

A. **Criterion 1110.320(b), Allocation of Additional Beds** NOT APPLICABLE

Read this criterion and explain how establishment of the new category of service will improve the distribution or accessibility of the service. Include any supporting documentation.

APPEND DOCUMENTATION AS ATTACHMENT BEDS-1 AFTER THE LAST PAGE OF THIS SECTION.

B. **Criterion 1110.320(c), Addition of Beds to Existing Facilities**

Read this criterion and address the following:

1. If applicable, explain why it is not architecturally or programmatically feasible to rearrange and use presently underutilized bed capacity for this project.

2. Provide documentation that there will not be sufficient space in the proposed room to accommodate any additional beds.

3. Provide a comparison of the applicant facility's average length of stay with the length of stay of any similar facilities in the planning area. If there is a discrepancy, provide a rationale.

APPEND DOCUMENTATION AS ATTACHMENT BEDS-2 AFTER THE LAST PAGE OF THIS SECTION.

ADDITION OF BEDS TO EXISTING FACILITIES

The Hospital will add 12 ICU beds to its current authorized capacity of 24 ICU beds. The new 36 ICU beds will be located in the proposed East Wing, as follows: 24 beds on the 7th Floor and 12 beds on the 6th Floor. The space vacated by the ICUs will be modernized for Respiratory Therapy, Inpatient Dialysis, Medical Staff On-Call and Hospitalist Services.

Historical Utilization

ICU occupancy rates for each of the last three (3) years exceed the IHFPB's target occupancy rate of 60%, as follows (see Attachment Beds-2(1):)

ICU UTILIZATION

Year	Beds	Patient Days	Occupancy Rate
2005	24	5,348	61%
2006	24	5,689	65%
2007	24	5,942	68%

The ICU, in the East Building, was built in 1974 (see schemes, Attachment Bed-2(2).) Its awkward design, with two disconnected units, requires high staffing levels for patient visualization, and some patient rooms lack windows and share non-ADA compliant toilets. For these reasons, the Hospital operates only 18 ICU beds and its actual ICU occupancy was much higher (refer back to Attachment Beds-2(1).)

ICU UTILIZATION

Year	Beds	Patient Days	Occupancy Rate
2005	18	5,348	81%
2006	18	5,689	87%
2007	18	5,942	90%

Infeasibility of Converting Underutilized Services

Most of the Hospital's nursing units were built by 1978, and are at least 30 years old. Notably, the existing 24-bed ICU occupies only 10,846 gsf, 452 gsf per bed (see Attachment Beds-2(3), existing/proposed gsf.) Other nursing units are very small by modern standards, with small, semi-private rooms and severely undersized staff and support areas. Excluding the new 16-bed cardiovascular unit (CVU) built in 2005, the remaining 299 M/S beds contain only 275 gsf per bed, occupying 82,315 gsf (93,260 existing gsf minus 10,945 gsf of "as is" space in the CVU.) Other inpatient services have similar space constraints. Pediatrics and AMI Services contain only 5,872 gsf and 18,438 gsf, respectively. The modern ICU requires 653 department gsf (dgsf) per bed or 23,490 dgsf (see rationale in Attachment GRC-5.) In addition, all existing units are configured as long, narrow units which are operationally obsolete for a modern ICU requiring patient visualization.

Therefore, while other acute care services operate below IHFPB target occupancies, it is not feasible to convert such small units which are at least 30 years old, to modern ICUs.

The Proposed Size of the ICU Rooms

Each ICU room will have only 174 net usable gsf. Please see the scheme, Attachment Beds-2(4), which documents that there is not sufficient space to accommodate an additional bed.

Comparison of ICU Average Length of Stay

The ICU average length of stay (ALOS) was 3.5 days in 2007 (see Attachment Beds-2(5).) The data are from the 2007 AHQ and document that Palos had the lowest ICU ALOS in Planning Area A-4. The average ALOS in 2007 was 6.2 in Planning Area A-4. The next lowest ALOS in the area was 4.3 days at St. Francis Hospital in Blue Island.

Palos has well-established Utilization Review /Quality Assurance standards. These processes, conducted on a continuous basis, review length of say, utilization, and staffing patterns to ensure their appropriateness. However, the high occupancies and crowding in the existing ICU also contribute to the ICU's shorter length of stay.

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED UTILIZATION

INTENSIVE CARE

	Historical			Projected												
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Intensive Care Admissions	1,411	1,535	1,693	1,770	1,823	1,878	1,934	1,992	2,052	2,113	2,177	2,242	2,309	2,379	2,450	2,524
% Change		8.8%	10.3%	4.5%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Average Annual 2005-2007			9.5%													
Intensive Care Patient Days	5,348	5,689	5,942	6,090	6,273	6,461	6,655	6,854	7,060	7,272	7,490	7,715	7,946	8,184	8,430	8,683
% Change		6.4%	4.4%	2.5%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Average Annual 2005-2007			5.4%													
Average Daily Census (ADC)	15	16	16	17	17	18	18	19	19	20	21	21	22	22	23	24
Average Length of Stay (ALOS)	3.8	3.7	3.5	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4
Authorized Beds	24	24	24											36	36	36
% Occupancy on 24 Authorized Beds	61%	65%	68%	70%												
% Occupancy on 18 Operational Beds	81%	87%	90%	93%												
% Occupancy on 36 Proposed Beds														62%	64%	66%

INTENSIVE CARE BEDS:	
Existing	**24 ICU Beds**
IHFPB Std. 60% by 2018	**44 ICU Beds**
Proposed	**36 ICU Beds**

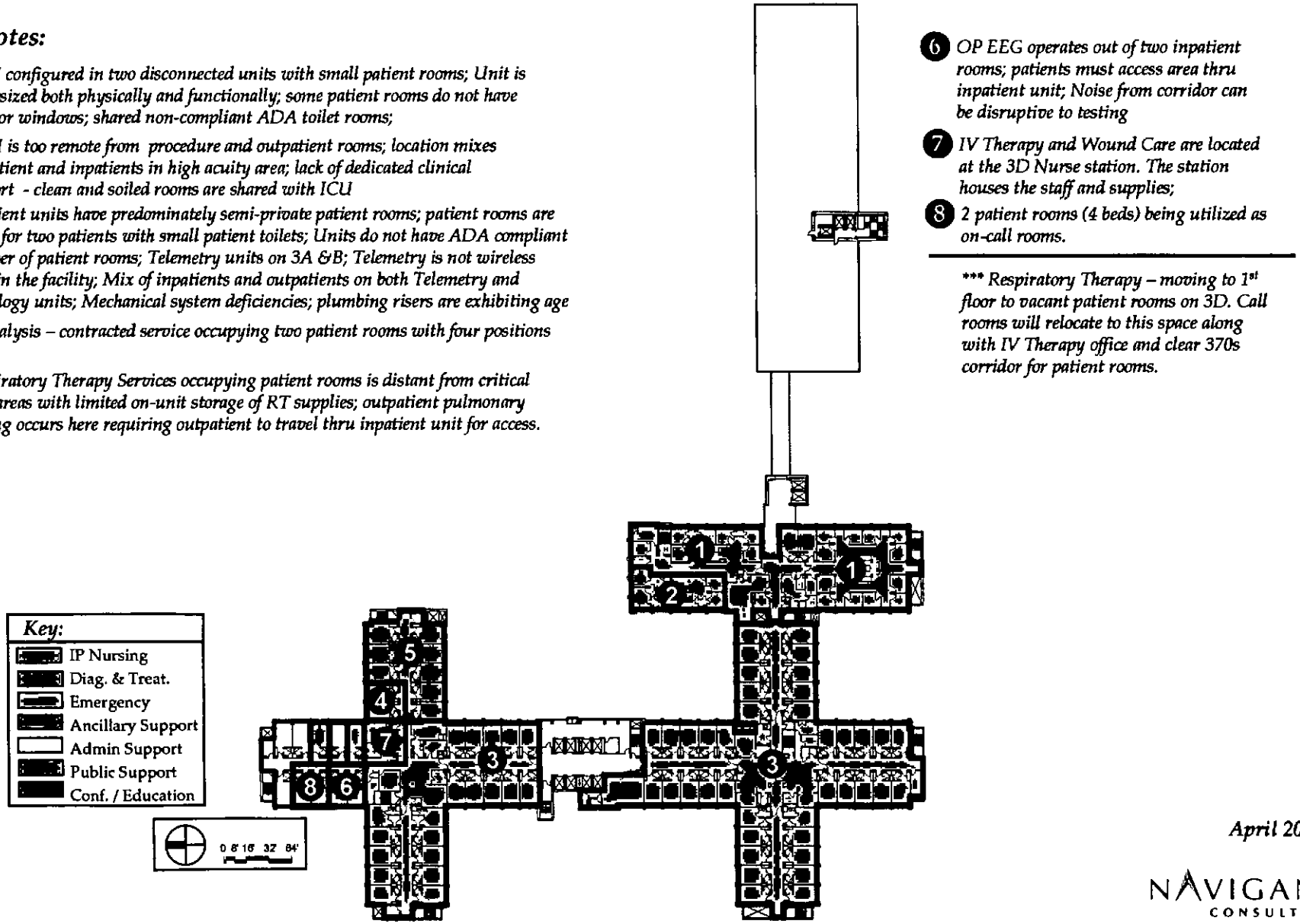
Annualized 2008 Jan-Jun 2008
PCH has a lowest ICU ALOS of all area hospitals.
Source: PCH Meditech Utilization Statistics, Projections - NCI Consulting

Existing Conditions Overview –Level 3

Key Notes:

1. *ICCU configured in two disconnected units with small patient rooms; Unit is undersized both physically and functionally; some patient rooms do not have exterior windows; shared non-compliant ADA toilet rooms;*
2. *SSTU is too remote from procedure and outpatient rooms; location mixes outpatient and inpatients in high acuity area; lack of dedicated clinical support - clean and soiled rooms are shared with ICU*
3. *Inpatient units have predominately semi-private patient rooms; patient rooms are small for two patients with small patient toilets; Units do not have ADA compliant number of patient rooms; Telemetry units on 3A &B; Telemetry is not wireless with in the facility; Mix of inpatients and outpatients on both Telemetry and Oncology units; Mechanical system deficiencies; plumbing risers are exhibiting age*
4. *IP Dialysis – contracted service occupying two patient rooms with four positions*
6. *Respiratory Therapy Services occupying patient rooms is distant from critical care areas with limited on-unit storage of RT supplies; outpatient pulmonary testing occurs here requiring outpatient to travel thru inpatient unit for access. ****
6. *OP EEG operates out of two inpatient rooms; patients must access area thru inpatient unit; Noise from corridor can be disruptive to testing*
7. *IV Therapy and Wound Care are located at the 3D Nurse station. The station houses the staff and supplies;*
8. *2 patient rooms (4 beds) being utilized as on-call rooms.*

**** Respiratory Therapy – moving to 1st floor to vacant patient rooms on 3D. Call rooms will relocate to this space along with IV Therapy office and clear 370s corridor for patient rooms.*



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ATTACHMENT BEDS-2(2)
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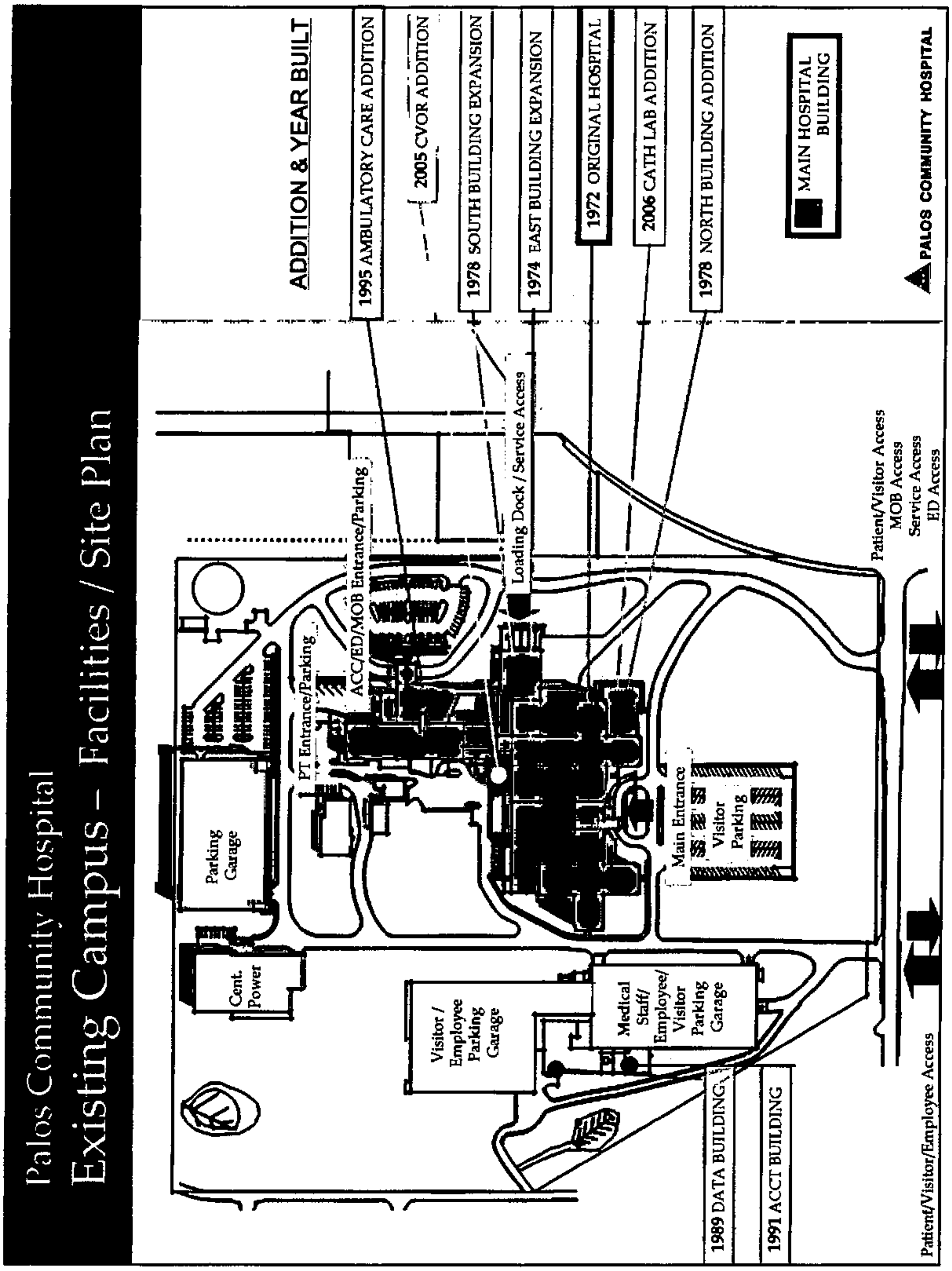
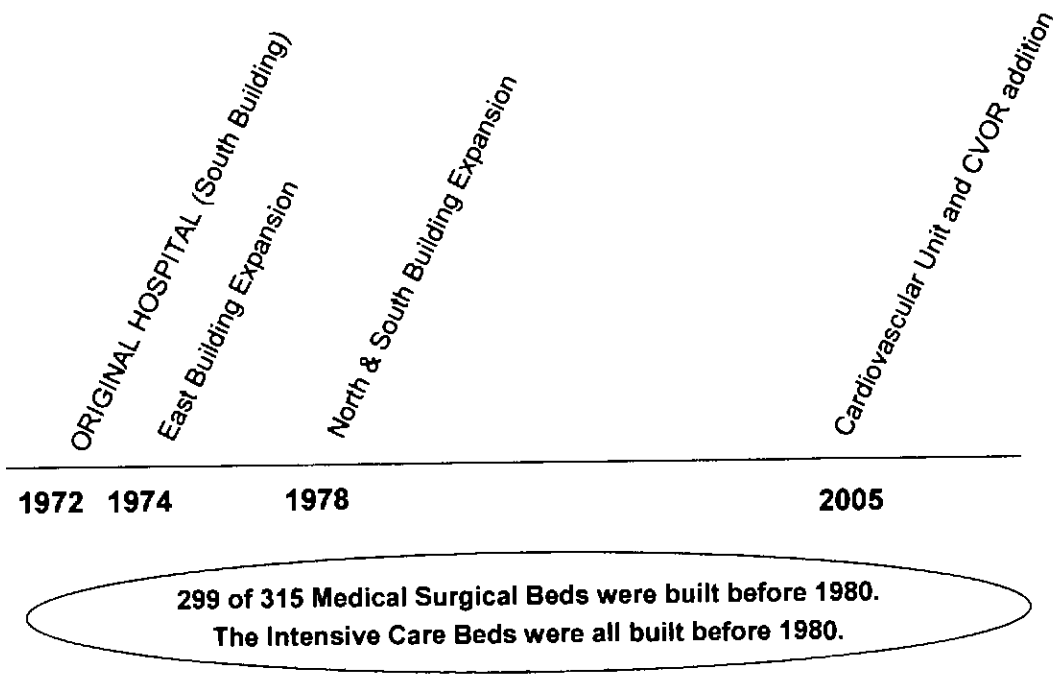
April 2006

NAVIGANT CONSULTING


Palos Community Hospital
Existing Campus – Facilities / Site Plan
ADDITION & YEAR BUILT
1995 AMBULATORY CARE ADDITION
2005 CVOR ADDITION
1978 SOUTH BUILDING EXPANSION
1974 EAST BUILDING EXPANSION
1972 ORIGINAL HOSPITAL
2006 CATH LAB ADDITION
1978 NORTH BUILDING ADDITION
MAIN HOSPITAL BUILDING
PALOS COMMUNITY HOSPITAL
Loading Dock / Service Access
ACC/ED/MOB Entrance/Parking
PT Entrance/Parking
Parking Garage
Cent. Power
Visitor / Employee Parking Garage
Medical Staff/ Employee/ Visitor Parking Garage
Main Entrance
Visitor Parking
Patient/Visitor Access
MOB Access
Service Access
ED Access
1989 DATA BUILDING
1991 ACCT BUILDING
Patient/Visitor/Employee Access

Opening Dates of Existing Patient Care Units



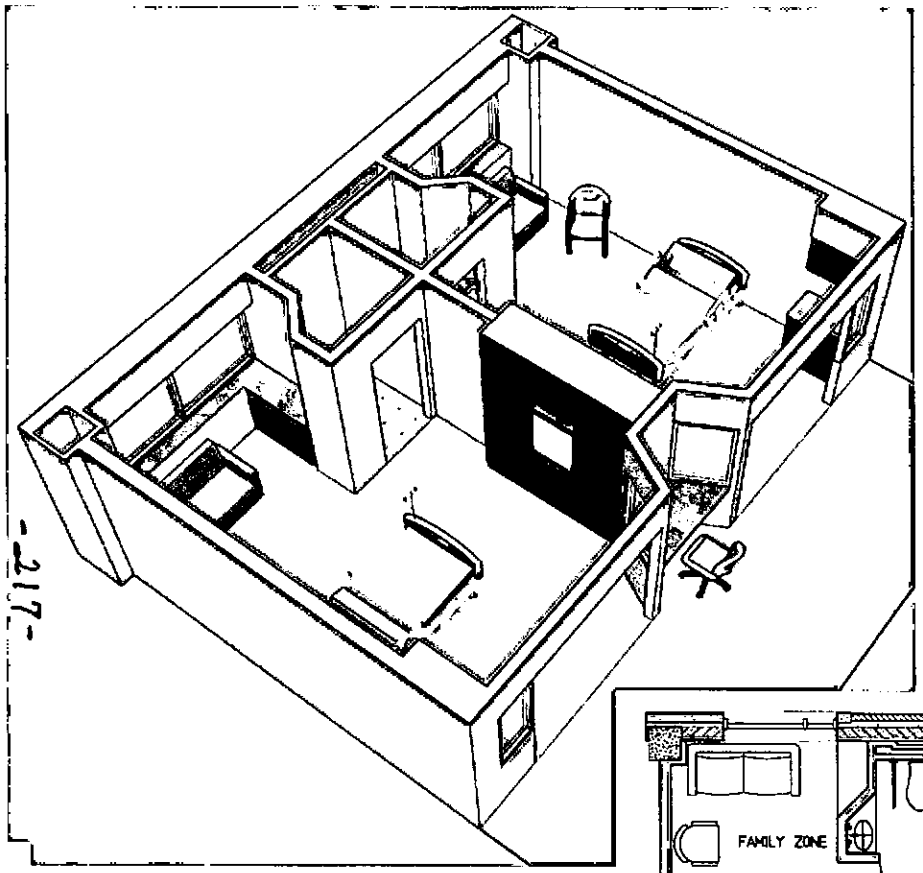
299 of 315 Medical Surgical Beds were built before 1980.
The Intensive Care Beds were all built before 1980.

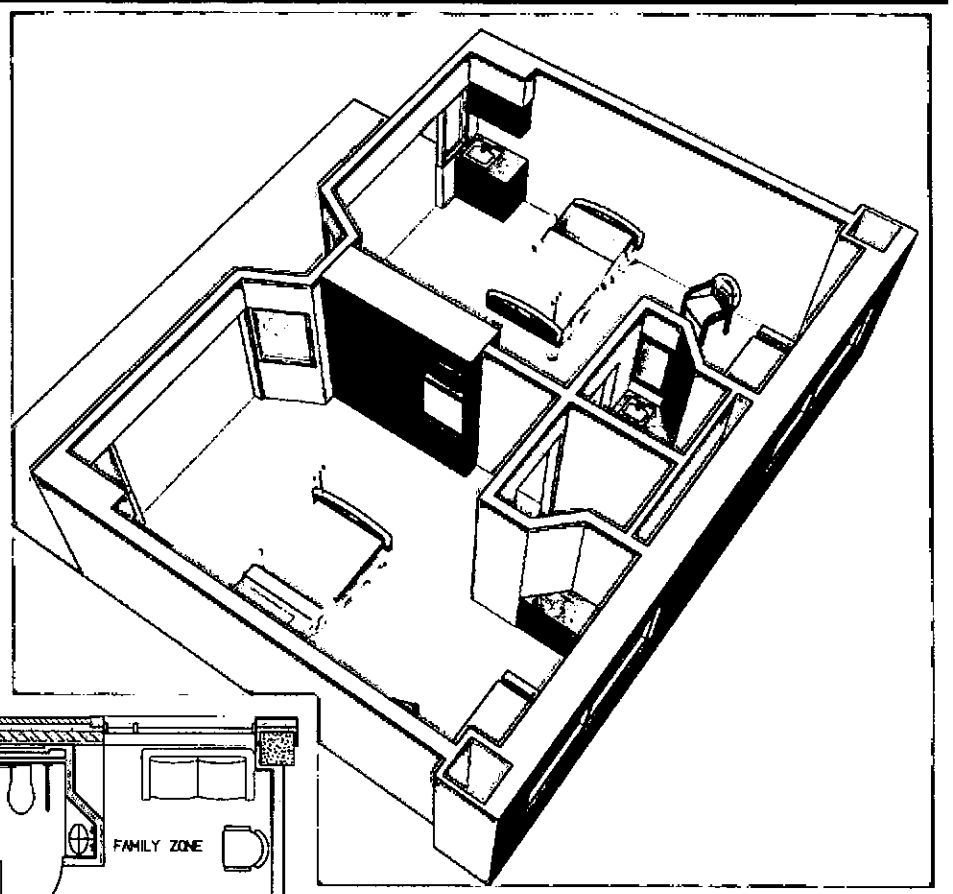
Source: PCH Planning

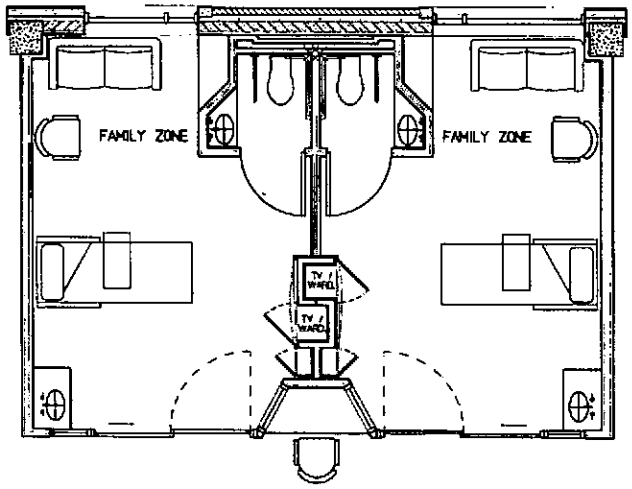
CLINICAL SERVICE	GSF*		Amount of Proposed Total GSF That Is:				Department GSF **
	Existing	Proposed	New	Remodeled	As Is	Vacated	
Medical Surgical	93,260	180,085	91,790	77,330	10,945		84, 825
Intensive Care	10,846	25,650	25,650			10,846	23,490
INTEGRATED PROCEDURE SERVICES							37,590
A) Surgery	19,166	37,354	37,354			19,166	
B) Endoscopy	2,961	3,468	3,468			2,961	
C) Special Procedures	946	2,004	2,004			946	
RECOVERY							22,380
A) PACU	2,092	3,750	3,750			2,092	3,350
B) Center for Short Stay Care	14,572	22,940	22,940			14,572	19,030
Respiratory Therapy	1,485	5,425	1,060	4,365		1,485	1,060
Laboratory	9,362	22,487	22,487			9,362	18,880
Pharmacy	4,135	8,229	8,229			4,135	7,360
Outpatient & Pre-Admission Testing	1,265	4,730	4,730			1,265	4,180
Inpatient Dialysis	717	1,105		1,105		717	1,105
Emergency Department	12,361	22,814		11,435	11,379		22,818
Admissions Unit	0	6,696		6,696			6,696
Cardiology	4,299	6,661		6,661		4,299	6,661
Nuclear Medicine	1,652	6,766		6,766		1,652	6,766
Radiology	20,068	31,732		16,889	14,843	2,421	31,732
Sub Total Clinical	199,187	391,876	223,462	131,247	37,167	75,919	

* GSF for new construction areas include external circultion i.e. BGSF. Modernized areas are DGSF,
* * Department GSF include internal circulation with 1/2 adjacent corridor space and exclude external circulation.
See Attachment GRC-5(2) for department gsf.

Palos Community Hospital
ICU Prototype







260 SF

174 Net Usable SF

M&CA

ATTACHMENT BEDS-2(4)

COMPARISON OF AVERAGE LENGTH OF STAY

Planning Area A-4 Hospitals

MEDICAL/SURGICAL

Planning Area A-4 Hospitals	Admissions	2007 Total Days	ALOS
Adventist LaGrange Memorial Hospital	7,036	33,752	4.8
Advocate Christ Medical Center	25,030	120,203	4.8
Advocate South Suburban Hospital	10,248	39,968	3.9
Ingalls Memorial Hospital	13,682	59,616	4.4
Little Company of Mary Hospital & Health Care Center	12,760	55,266	4.3
Oak Forest Hospital	1,976	15,820	8.0
Palos Community Hospital	**15,892**	**75,404**	**4.7**
RM Health Providers Limited Partnership	777	25,200	32.4
St. Francis Hospital & Health Center	10,339	48,808	4.7
St. James Hospital & Health Center (Olympia Fields)	9,132	39,289	4.3
St. James Hospital & Health Center (Chicago Heights)	9,388	44,486	4.7
TOTALS	116,260	557,812	**4.8**

INTENSIVE CARE

	Direct Admissions	2007 Total Days	ALOS
Adventist LaGrange Memorial Hospital	599	3,836	6.4
Advocate Christ Medical Center	3,869	26,180	6.8
Advocate South Suburban Hospital	950	4,698	4.9
Ingalls Memorial Hospital	348	7,339	21.1
Little Company of Mary Hospital & Heath Care Center	937	8,664	9.2
Oak Forest Hospital	385	2,020	5.2
Palos Community Hospital	**1,693**	**5,942**	**3.5**
RM Health Providers Limited Partnership	0	0	0.0
St. Francis Hospital & Health Center	1,328	5,773	4.3
St. James Hospital & Health Center (Olympia Fields)	1,061	5,712	5.4
St. James Hospital & Health Center (Chicago Heights)	688	3,615	5.3
TOTALS	11858	73,779	**6.2**

Source: Illinois Department of Public Health, 2007 AHQ Hospital Profiles.
Note: AHQ ALOS calculation for Palos' M/S was 5.0, a calculation discrepancy.

ATTACHMENT BEDS-2(5)

SECTION VII. REVIEW CRITERIA RELATING TO ALL MODERNIZATION PROJECTS (MOD)

This section is applicable to all projects proposing modernization. Modernization includes, but is not limited to: expanding a department, acquiring major medical equipment, remodeling, or constructing additions or new buildings.

(A.) Specific Information Requirements

Indicate if the following areas or departments are to be modernized and provide the information as applicable.

1. AMBULATORY CARE (Include all outpatient clinics) -- Is this area being modernized?
   __Yes ✓No
   If yes, provide:
   a. The number of visits for each of the last three years:

      Year _____
      Number _____
   b. The number of treatment/examination rooms: Existing _____ Proposed _____

2. AMBULATORY SURGERY TREATMENT CENTERS-- Is this area being modernized?
   __Yes ✓No
   If yes, provide:
   a. The number of procedures for each of the last three years:

      Year _____
      Number _____
   b. The number of visits for each of the last three years:

      Year _____
      Number _____
   c. The number of operating rooms for each of the last three years:

      Year _____
      Number _____

3. CARDIAC CATHETERIZATION -- Is this area being modernized? Yes __ No ✓

   If yes, provide the number of inpatient, outpatient, and total procedures (patient visits) performed on adults and on pediatric patients for each of the past three years:

ADULT		PEDIATRIC	
Year	_____	Year	_____
Inpatient	_____	Inpatient	_____
Outpatient	_____	Outpatient	_____
Total	_____	Total	_____

4. EEG DEPARTMENT OR AREA -- Is this area being modernized? __Yes ✓No
If yes, provide the number of inpatient, outpatient, and total procedures for each of the pas three years:

Year _____
Inpatient _____
Outpatient _____
Total _____

(5.) EKG DEPARTMENT OR AREA -- Is this area being modernized? _√_Yes __No
If yes, provide the number of inpatient, outpatient, and total procedures for each of the pas three years:

Year	2005	2006	2007
Inpatient	18,591	19,626	21,273
Outpatient	11,921	15,690	14,675
Total	30,512	35,316	35,948

(6.) HEMODIALYSIS SERVICES -- Is this area being modernized? _√_Yes __No
If yes, provide the following information:

a. The number of treatment stations: existing __4__ proposed __4__

b. The number of treatments performed for each of the last three years:

Year	2005	2006	2007
Treatments	971	1,384	1,452

7. LABOR-DELIVERY-RECOVERY -- Is this area being modernized? __Yes ✓No
If yes, provide the following information:

a. The number of

Labor rooms ____
Delivery/birthing rooms ____
Recovery stations ____
LDR's ____
LDRP rooms

b. The number of procedures and deliveries for each of the last three years:

Year _____
Procedures _____
Deliveries _____

(8.) LABORATORY SERVICES -- Is this area being modernized? _√_Yes __No
If yes, provide the number of equivalent full-time employees (FTE's) employed in the laboratory __101__

9. MAGNETIC RESONANCE IMAGING -- Is this area being modernized? __Yes √No
If yes, provide the following information for each of the last three years:

Year _____
Number of visits _____
Number of scans _____

10. NURSERY (other than neonatal intensive care units) -- Is this area being modernized?
__Yes ✓No
If yes, provide the following for each of the last three years:
Year _____
Number of newborns _____
Number of patient days _____

11. OCCUPATIONAL THERAPY -- Is this area being modernized? __Yes ✓No
If yes, provide the following information for each of the last three years:
Year _____
Inpatient treatments _____
Outpatient treatments _____
Number of visits _____

12. PHYSICAL THERAPY -- Is this area being modernized? __Yes ✓No
If yes, provide the following information for each of the last three years.
Year _____
Inpatient treatments _____
Outpatient treatments _____
Total treatments _____
Number of visits _____

13. PULMONARY FUNCTION -- Is this area being modernized? __Yes √ No
If yes, provide the following information for each of the last three years.

Year	2005	2006	2007
Inpatient procedures			
Outpatient procedures			
Total procedures			
Number of visits			

(14.) RECOVERY (SURGICAL) -- Is this area being modernized? _√_Yes __No
If yes, provide the existing and proposed number of stations by type:

	Existing	Proposed
Inpatient	10	15
Outpatient Stage 1		
Outpatient Stage II	31	50 (Additional 5 stations for treatments.)

(15.) RESPIRATORY THERAPY -- Is this area being modernized? _√_Yes __No
If yes, provide the following information for each of the last three years.

Year	2005	2006	2007
Inpatient treatments	254,880	157,682	159,012
Outpatient treatments	2,574	5,567	5,029
Total treatments	257,454	163,249	164,041
Number of visits	N/A	65,300	65,616

(16.) DIAGNOSTIC RADIOLOGY -- Is this area being modernized? _√_Yes __No
If yes, provide the following information classifying procedure rooms as general or special according to the type of machines employed.

General machines are:
-Radiographic
-Fluoroscopic
-Radiographic/Flouroscopic
-Tomographic (linear)

Special machines are:
-Angiographic
-CT Scanner
-Mammography
-Sonographic (ultrasound)
-Tomographic (multi-directional)

a. Provide the number of existing and proposed general procedure rooms by machine type.

b. Provide the number of existing and proposed special procedure rooms by machine type.

APPEND DOCUMENTATION AS ATTACHMENT MOD-1A AFTER THE LAST PAGE OF THIS SECTION.

(17.) EMERGENCY SERVICES -- Is this area being modernized? _√_Yes __No

If yes, provide the following information:

a. The number of existing and proposed treatment/examination rooms;

b. A list of any of the above rooms that are or will be used for purposes other than general treatment;

c. The number of visits for each of the last three years.

APPEND DOCUMENTATION AS ATTACHMENT MOD-1B AFTER THE LAST PAGE OF THIS SECTION.

(18.) INPATIENT BED AREA -- Is this area being modernized? _√_Yes __No
If yes, provide the following information:

a. The number of existing and proposed private rooms, semi-private rooms, and three or more occupancy rooms (by category of service for each type of room) for the entire facility and for the project;

b. Line drawings showing the configuration of the unit(s) being modernized.

APPEND DOCUMENTATION AS ATTACHMENT MOD-1C AFTER THE LAST PAGE OF THIS SECTION.

(19) NUCLEAR MEDICINE -- Is this area being modernized? _√_Yes __No
If yes, provide the following information:

a. A list of the existing and proposed major pieces of equipment;

b. The existing and proposed number of procedure rooms;

c. The number of inpatient, outpatient, and total procedures done for each of the last three years;

d. A breakdown of the procedures into types of procedures and machine time/procedure for the last year.

APPEND DOCUMENTATION AS ATTACHMENT MOD-1D AFTER THE LAST PAGE OF THIS SECTION.

20. RADIATION THERAPY -- Is this area being modernized? __Yes ✓No
If yes, provide the following information:

a. The number of treatments and the number of "courses of treatment" for each of the last three years;

b. A list of the existing and proposed pieces of megavoltage equipment.

APPEND DOCUMENTATION AS ATTACHMENT MOD-1E AFTER THE LAST PAGE OF THIS SECTION.

(21) SURGERY -- Is this area being modernized? _√_Yes __No
If yes, provide the following information:

a. The existing and proposed number of procedure rooms. Indicate the use of these rooms such as general, open heart, eye, endoscopy, and cystology. Indicate how many rooms are dedicated solely to outpatient surgery, solely to inpatient surgery, and how many are used for both.

b. The inpatient, outpatient, and total hours of utilization (including clean-up and set-up time) for each of the last three years;

c. The total hours of utilization (including clean-up and set-up time) for each type of procedure room for each of the last three years;

d. The number of inpatient, outpatient, and total surgical visits for each type of surgical specialty for each of the last three years.

APPEND DOCUMENTATION AS ATTACHMENT MOD-1F AFTER THE LAST PAGE OF THIS SECTION.

(22) OTHER DEPARTMENTS OR AREAS - Are any other areas being modernized?
_√_Yes __No
If yes, identify the area(s) and provide workload data for each area for each of the last three years.

APPEND DOCUMENTATION AS ATTACHMENTS MOD-1G, MOD-1H, MOD-1I, MOD 1J, et AFTER THE LAST PAGE OF THIS SECTION.

(B.) **Criterion 1110.420(b), Modern Facilities**

A criterion must be claimed for EACH department or area to be modernized. The justification for each department or area must be on a separate page. Choose the criterion or criteria which most clearly approximates the reason for proposing the modernization.

At least ONE of the following two criteria must be claimed for EACH department or area proposed for modernization.

(1.) Read criterion 1110.420.b.1. **This criterion cannot be used to justify any increase in square footage. If expansion of a department is proposed, criterion 1110.420.b.2 must be claimed.**

Indicate if this criterion is claimed and submit the following:

a. the age of the building or piece of equipment;

b. the downtime experienced on the piece of equipment for each of the last three years;

c. the cost of repair experienced on the piece of equipment for each of the last three years;

d. a detailed explanation of why and how it was determined that the building or piece of equipment was deteriorated and needs to be replaced;

e. provide copies of any licensing, certification, or fire protection citations.

APPEND DOCUMENTATION AS ATTACHMENT MOD-2 AFTER THE LAST PAGE OF THIS SECTION.

(2.) Read Criterion 1110.420(b)(2). Identify if this criterion is claimed and submit the following information:

a. a detailed explanation of why and how it was determined that expansion of the department or area was necessary;

b. a discussion of the alternatives considered to expanding the department (e.g. increasing the hours or days of operation) and why the alternatives were rejected.

APPEND DOCUMENTATION AS ATTACHMENT MOD-3 AFTER THE LAST PAGE OF THIS SECTION.

C. Criterion 1110.420(c) Major Medical Equipment NOT APPLICABLE

Read Criterion 1110.420(c) and provide documentation that the equipment will achieve or exceed the applicable target utilization levels specified in Appendix B of Part 1110 within 12 months after becoming operational.

APPEND DOCUMENTATION AS ATTACHMENT MOD-4 AFTER THE LAST PAGE OF THIS SECTION.

MODERN FACILITIES

Summary of Attachments

CLINICAL SERVICES	ATTACHMENT
Radiology	MOD-1A
Emergency Department	MOD-1B
Inpatient Services Number of Beds by Room Type Beds Discontinued, by Room Number Line Drawings of Inpatient Units	MOD-1C
Nuclear Medicine	MOD-1D
Integrated Procedure Services & Recovery	MOD-1F
Surgery	MOD-1F
GI/Endo	MOD-1G
Special & Minor Procedures	MOD-1H
Infusion Therapy/Outpatient Procedures	MOD-1I
Pharmacy	MOD-1J
Cardiology	MOD-1K
Admission Unit	MOD-1L
Outpatient & Pre-Admission Testing	MOD-1M
Inpatient Dialysis	MOD-1N

ATTACHMENT MOD-1

IMAGING - ROOMS AND MACHINES, BY TYPE
Existing and Proposed

Radiology		AHQ 2007	EXISTING (2008)	PROPOSED (2018)	
GENERAL MACHINES	General Radiography/Flouroscopy	8	9	12	*1 new in 2008*
	GENERAL RADIOLOGY TOTAL	**8**	**9**	**12**	
OTHER*	Bone density/DEXA	n/a	1	1	*See * below*
	Sterotactic (Breast Biopsy)	n/a	1	1	*See * below*
SPECIAL MACHINES	Angiographic	1	1	1	*Will be located in CSSC - Special Procedures Room*
	CT Scanner	3	3	4	
	Mammography	3	3	4	
	Sonographic (ultrasound)	6	7	8	*1 new in 2008*
	Tomographic (multi-directional)	0	0	0	
	SPECIAL RADIOLOGY TOTALS	**13**	**16**	**19**	
	DIAGNOSTIC RAD GRAND TOTALS	**21**	**25**	**31**	
Nuclear Medicine					
NUCLEAR MEDICINE	Nuclear Medicine Cameras	3	3	5	
	TOTALS	**3**	**3**	**5**	
	GRAND TOTALS: RAD & NM	24	28	36	

** No category on AHQ for Bone density/DEXA room & Sterotactic breast biopsy room.*
DEXA volumes are reported with General/Flouro
Stereotactic volumes are reported in mammography

ALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

RADIOLOGY

	Historical		Projected Growth													
PROCEDURES	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
GENERAL																
Inpatient	20,141	22,503	23,902	25,178	26,185	27,233	28,322	29,455	30,633	31,858	33,133	34,458	35,836	37,270	38,760	40,311
Outpatient	48,822	47,591	48,448	47,386	47,860	48,338	48,822	49,310	49,803	50,301	50,804	51,312	51,825	52,344	52,867	53,396
Total	68,963	70,094	72,350	72,564	74,045	75,571	77,144	78,765	80,436	82,159	83,937	85,770	87,662	89,613	91,627	93,707
Annual % Change		1.6%	3.2%	0.3%	2.0%	2.1%	2.1%	2.1%	2.1%	2.1%	2.2%	2.2%	2.2%	2.2%	2.2%	2.3%
Average Increase 2005-2007			2.4%													
CT																
Inpatient	7,177	7,760	8,319	8,662	8,792	8,924	9,058	9,194	9,331	9,471	9,613	9,758	9,904	10,053	10,203	10,356
Outpatient	28,013	28,411	27,955	27,816	28,233	28,657	29,087	29,523	29,966	30,415	30,871	31,335	31,805	32,282	32,766	33,257
Total	35,130	36,171	36,274	36,478	37,025	37,581	38,144	38,716	39,297	39,887	40,485	41,092	41,709	42,334	42,969	43,614
Annual % Change		3.0%	0.3%	0.6%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%
Average Increase 2005-2007			1.6%													
ULTRASOUND																
Inpatient	6,001	6,527	7,099	7,204	7,492	7,852	8,244	8,607	8,986	9,381	9,794	10,225	10,675	11,145	11,624	12,135
Outpatient	13,098	12,335	13,676	13,358	13,759	14,130	14,512	14,947	15,396	15,857	16,333	16,823	17,328	17,848	18,383	18,953
Total	19,099	18,862	20,775	20,562	21,251	21,982	22,756	23,554	24,381	25,239	26,127	27,048	28,003	28,992	30,007	31,088
Annual % Change		-1.2%	10.1%	-1.0%	3.4%	3.4%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.6%
Average Increase 2005-2007			4.4%													
MAMMOGRAPHY																
Inpatient	61	42	33	30	31	31	31	31	31	31	31	31	31	31	31	31
Outpatient	11,972	11,697	12,574	13,096	13,489	13,759	14,034	14,315	14,601	14,893	15,191	15,494	15,804	16,120	16,443	16,772
Total	12,001	11,739	12,607	13,126	13,519	13,790	14,065	14,346	14,632	14,924	15,222	15,526	15,836	16,152	16,474	16,803
Annual % Change		-2.2%	7.4%	4.1%	3.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
Average Increase 2005-2007			2.5%													
VISITS*																
CT																
Inpatient		2,156	2,311	2,471	2,483	2,496	2,508	2,521	2,533	2,546	2,559	2,572	2,584	2,597	2,610	2,623
Outpatient		7,895	6,207	5,694	5,600	5,500	5,500	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000
Total		10,051	8,518	8,165	8,083	7,996	8,008	7,521	7,533	7,546	7,559	7,572	7,584	7,597	7,610	7,623
Annual % Change			-15.3%	-4.1%	-1.0%	-1.1%	0.2%	-6.1%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
Average Increase 2005-2007																
ULTRASOUND																
Inpatient		3,144	3,413	3,602	3,746	3,896	4,067	4,246	4,433	4,628	4,832	5,044	5,266	5,498	5,740	5,993
Outpatient		6,089	7,020	6,338	6,528	6,724	6,926	7,133	7,347	7,568	7,795	8,029	8,270	8,518	8,773	9,036
Total		9,233	10,433	9,940	10,274	10,620	10,993	11,380	11,781	12,196	12,627	13,073	13,536	14,016	14,513	15,029
Annual % Change			13.0%	-4.7%	3.4%	3.4%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.6%
Average Increase 2005-2007																
MAMMOGRAPHY																
Inpatient		42	33	30	31	31	32	32	32	33	33	35	37	37	37	38
Outpatient		11,029	11,651	11,848	12,203	12,448	12,696	12,950	13,209	13,474	13,743	14,018	14,298	14,584	14,876	15,173
Total		11,071	11,684	11,878	12,234	12,479	12,728	12,982	13,241	13,506	13,777	14,053	14,335	14,621	14,912	15,212
Annual % Change			5.6%	1.7%	3.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
Average Increase 2005-2007																

Annualized Jan-Jun 2008

* *Visit volumes provided beginning with conversion to Meditech Information system (2006) for consistency*
CT visits declined in 2006 due to addition of CT service at off-site outpatient facility.
Source: Radiology Department Monthly Statistics, Meditech Outpatient Visits (ESS) & NCI Consulting

PALO[redacted]NITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

EMERGENCY DEPARTMENT

	Projected Growth															
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
EMERGENCY DEPARTMENT VISITS																
Visits	47,055	48,490	48,854	48,516	49,438	50,377	51,334	52,310	53,304	54,316	55,348	56,400	57,472	58,563	59,676	60,810
Annual % Change		*3.0%*	*0.8%*	*-0.7%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*
Average Change 2005-2007			*1.9%*													
Patients Leaving Without Being Seen	1,217	1,338	1,520	1,687	Patients leaving without being seen included above until additional capacity operational.											
Annual % Change		9.9%	13.6%	11.1%												
Average Change 2005-2007			11.8%													
ADMISSIONS FROM THE EMERGENCY DEPARTMENT																
Admitted from ED	15,699	14,652	15,510	15,980	15,820	16,121	16,427	16,739	17,057	17,381	17,711	18,048	18,391	18,740	19,096	19,459
Annual % Change		*-6.7%*	*5.9%*	*3.0%*	*-1.0%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*
Percent ED Visits Admitted	33.4%	30.2%	31.7%	32.9%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%
TREATMENT ROOMS BY TYPE																
Isolation (19)	2	2	2	2	2	2	2	2	2	2	2	2	2	4	4	4
Trauma (CC#1, CC#2)	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Exam / Treatment	16	16	16	16	16	16	16	16	16	16	16	16	16	25	25	25
Total Number of Treatment Rooms	20	20	20	20	20	20	20	20	20	20	20	20	20	31	31	31
STANDARDS																
Capacity per Room	*2,000*															
Total Capacity	*40,000*	*40,000*	*40,000*	*40,000*	*40,000*	*40,000*	*40,000*	*40,000*	*40,000*	*40,000*	*40,000*	*40,000*	*40,000*	*62,000*	*62,000*	*62,000*
Number of Rooms based on capacity	*23.5*	*24.2*	*24.4*	*24.3*	*24.7*	*25.2*	*25.7*	*26.2*	*26.7*	*27.2*	*27.7*	*28.2*	*28.7*	*29.3*	*29.8*	*30.4*
NUMBER OF EMERGENCY DEPARTMENT TREATMENT ROOMS (EXISTING & PROPOSED)																
Treatment Rooms	20	20	20	20	20	20	20	20	20	20	20	20	20	31	31	31

Projections include portion of patients that LWBS - or patients that present to the emergency department but leave prior to being seen/treated.
Annualized Jan-Mar 2008
Source: PCH, Utilization Statistics, Planning (ESS); Projections: Planning/NCI Consulting

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ATTACHMENT MOD-1B

PALOS COMMUNITY HOSPITAL

MODERN FACILITIES
INPATIENT BED AREAS

Number of Rooms by Service
Present and Proposed

Service	Number of Beds Per Room	Before Rooms	Before Beds	After Rooms	After Beds
Medical/Surgical	1	31	31	306	306
	2	142	284	-	-
Subtotal		173	315	306	306
Pediatrics*	1	1	1	1	1
	2	7	14	7	14
Subtotal		8	15	8	15
Obstetrics*	1	26	26	26	26
	2	1	2	1	2
Subtotal		27	28	27	28
ICU	1	24	24	36	36
	2	-	-	-	-
Subtotal		24	24	36	36
AMI	1	4	4	4	4
	2	22	44	22	44
Subtotal		26	48	26	48
GRAND TOTAL		258	430 *	403	433*

NOTE: Number of authorized beds consistent with the 2007 IDPH Annual Bed Report. Previous authorized capacity indicated 6 more beds (2 Pediatric beds and 4 OB.)

SOURCE: Palos Community Hospital 2007 IDPH Annual Bed Report.

ATTACHMENT MOD-1C
Page 1 of 9

PROPOSED
ROOM/BED INVENTORY

				2007 ANNUAL BED REPORT					CON - EAST WING EXPANSION	
Floor		Bed Type	Room	Rooms	Physically Available	Reserve	TOTAL	Proposed Bed Capacity	Conversion TO PRIVATE ROOM NOTES	Beds Discontinued
2	N	Psych	270-1	0		1		1		
2	N	Psych	270-2	0	1			1		
2	N	Psych	270-3	0		1		1		
2	N	Psych	270-4	0		1		1		
2	N	Psych	271-1							
2	N	Psych	273	1	2			2		
2	N	Psych	275	1	2			2		
2	N	Psych	277	1	2			2		
2	N	Psych	278	1	2			2		
2	N	Psych	279	1	2			2		
2	N	Psych	280	1	2			2		
2	N	Psych	281	1	2			2		
2	N	Psych	282	1	2			2		
2	N	Psych	283	1	2			2	No change	
2	N	Psych	284	1	2			2		
2	N	Psych	285	1	2			2		
2	N	Psych	286	1		2		2		
2	N	Psych	287	1	2			2		
2	N	Psych	288	1		2		2		
2	N	Psych	290	1	2			2		
2	N	Psych	291	1		2		2		
2	N	Psych	292	1	2			2		
2	N	Psych	293	1	2			2		
2	N	Psych	294	1	2			2		
2	N	Psych	295	1	2			2		
2	N	Psych	296	1	2			2		
2	N	Psych	297	1	2			2		
				22	39	6	48	48	PSYCHIATRIC INPATIENT BEDS	n/a
2	S	OB	205	0	0			0		
2	S	OB	208	0	0			0		
2	S	OB	209	0	0			0		
2	S	OB	210	1	1			1		
2	S	OB	211	1	1			1		
2	S	OB	212	1	1			1		
2	S	OB	213	1	1			1		
2	S	OB	214	1	1			1		
2	S	OB	215	0						
2	S	OB	216	1	1			1		
2	S	OB	217	1	1			1		
2	S	OB	218	1	1			1		
2	S	OB	219	1	1			1		
2	S	OB	220	1	1			1		
2	S	OB	221	1	1			1		
2	S	OB	222	1	1			1	No change	
2	S	OB	223	1	1			1		
2	S	OB	224	1	1			1		
2	S	OB	225	0						
2	S	OB	226	1	1			1		
2	S	OB	227	1	1			1		
2	S	OB	229	1	2			2		
2	S	OB	230	1	1			1		
2	S	OB	231	1	1			1		
2	S	OB	232	1	1			1		
2	S	OB	233	1	1			1		
2	S	OB	234	1		1		1		
2	S	OB	235	1	1			1		
2	S	OB	236	1	1			1		
2	S	OB	237	1	1			1		
2	S	OB	238	1	1			1		
2	S	OB	239	1	1			1		
				27	27	1	28	28	OBSTERICAL BEDS	n/a
2	E	Peds	240	1	1			1		
2	E	Peds	242	1	2			2		
2	E	Peds	243	1						
2	E	Peds	244	1	2			2		
2	E	Peds	245	1	2			2	No change	
2	E	Peds	246	1	2			2		
2	E	Peds	247	1	2			2		
2	E	Peds	248	1	2			2		
2	E	Peds	249	1	2			2		
					15	0	15	15	PEDIATRIC BEDS	n/a

PROPOSED
ROOM/BED INVENTORY

Floor		Bed Type	Room	Rooms	Physically Available	Reserve	TOTAL	Proposed Bed Capacity	Conversion TO PRIVATE ROOM NOTES	Beds Discontinued
3	E	ICU	355-1	1	1			0		
3	E	ICU	355-2	1	1			0		
3	E	ICU	355-3	1	1			0		
3	E	ICU	355-4	1	1			0		
3	E	ICU	355-5	1	1			0		
3	E	ICU	355-6	1	1			0		
3	E	ICU	355-7	1	1			0		
3	E	ICU	355-8	1	1			0		
3	E	ICU	355-9	1	1			0		
3	E	ICU	355-10	1	1			0		
3	E	ICU	355-11	1	1			0		
3	E	ICU	355-12	1	1			0	Converted to non patient bed space: Inpatient Dialysis, Respiratory Therapy, Medical Staff Facilities & Support	
3	E	ICU	356-7	1	1			0		
3	E	ICU	356-8	1	1			0		
3	E	ICU	356-9	1	1			0		
3	E	ICU	356-10	1	1			0		
3	E	ICU	356-11	1	1			0		
3	E	ICU	356-12	1	1			0		
3	E	ICU	357-1	1	1			0		
3	E	ICU	357-2	1	1			0		
3	E	ICU	357-3	1	1			0		
3	E	ICU	357-4	1	1			0		
3	E	ICU	357-5	1	1			0		
3	E	ICU	357-6	1	1			0		
				24	24	0	24	36	ICU BEDS MOVE TO NEW EAST WING ADDITION	
3	S	Med/Surg	300	1	2			1	Converted to PRIVATE patient room	
3	S	Med/Surg	301	1	2			1	Converted to PRIVATE patient room	
3	S	Med/Surg	302	1	2			1	Converted to PRIVATE patient room	
3	S	Med/Surg	303	1	2			1	Converted to PRIVATE patient room	
3	S	Med/Surg	304	1	2			1	Converted to PRIVATE patient room	
3	S	Med/Surg	305	1	2			1	Converted to PRIVATE patient room	
3	S	Med/Surg	306	1	2			1	Converted to PRIVATE patient room	
3	S	Med/Surg	307	1	2			1	Converted to PRIVATE patient room	
3	S	Med/Surg	308	1	2			0	Converts to Staff/Ancillary Support	
3	S	Med/Surg	309	1	2			0	Converts to Staff/Ancillary Support	
3	S	Med/Surg	310	1	2			0	Converts to Staff/Ancillary Support	
3	S	Med/Surg	311	1	2			0	Converts to Staff/Ancillary Support	
3	S	Med/Surg	312	1	2			1	Converted to PRIVATE patient room	
3	S	Med/Surg	313	1	2			1	Converted to PRIVATE patient room	
3	S	Med/Surg	314	1	2			1	Converted to PRIVATE patient room	
3	S	Med/Surg	315	1	2			1	Converted to PRIVATE patient room	
3	S	Med/Surg	316	1	2			1	Converted to PRIVATE patient room	
3	S	Med/Surg	317	1	2			1	Converted to PRIVATE patient room	
3	S	Med/Surg	318	1	2			1	Converted to PRIVATE patient room	
3	S	Med/Surg	319	1	2			1	Converted to PRIVATE patient room	
3	S	Med/Surg	320	1	2			0	Converts to Staff/Ancillary Support	
3	S	Med/Surg	321	1	2			0	Converts to Staff/Ancillary Support	
3	S	Med/Surg	322	1	2			1	Converted to PRIVATE patient room	
3	S	Med/Surg	323	1	2			1	Converted to PRIVATE patient room	
3	S	Med/Surg	324	1	2			1	Converted to PRIVATE patient room	
3	S	Med/Surg	325	1	2			1	Converted to PRIVATE patient room	
3	S	Med/Surg	326	1	2			1	Converted to PRIVATE patient room	
3	S	Med/Surg	327	1	2			1	Converted to PRIVATE patient room	
3	S	Med/Surg	328	1	1			1	Converted to PRIVATE patient room	
3	S	Med/Surg	329	1	1			1	Converted to PRIVATE patient room	
3	S	Med/Surg	330	1	2			1	Converted to PRIVATE patient room	
3	S	Med/Surg	331	1	2			1	Converted to PRIVATE patient room	
3	S	Med/Surg	332	1	2			1	Converted to PRIVATE patient room	
3	S	Med/Surg	333	1	2			1	Converted to PRIVATE patient room	
3	S	Med/Surg	334	1	2			1	Converted to PRIVATE patient room	
3	S	Med/Surg	335	1	2			1	Converted to PRIVATE patient room	
3	S	Med/Surg	336	1	2			1	Converted to PRIVATE patient room	
3	S	Med/Surg	337	1	2			1	Converted to PRIVATE patient room	
3	S	Med/Surg	338	1	2			1	Converted to PRIVATE patient room	
3	S	Med/Surg	339	1	2			1	Converted to PRIVATE patient room	
				20	78	0	78	34	BEDS AFTER Converted TO PRIVATE ROOMS	-44

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PROPOSED
ROOM/BED INVENTORY

Floor		Bed Type	Room	Rooms	Privately Available	Reserve	TOTAL	Proposed Bed Capacity	Conversion TO PRIVATE ROOM NOTES	Beds Discontinued
3	N	Med/Surg	360	1	2			1	Converted to PRIVATE patient room	
3	N	Med/Surg	361	1	2			1	Converted to PRIVATE patient room	
3	N	Med/Surg	362	1	2			1	Converted to PRIVATE patient room	
3	N	Med/Surg	363	1	2			1	Converted to PRIVATE patient room	
3	N	Med/Surg	364	1	2			1	Converted to PRIVATE patient room	
3	N	Med/Surg	365	1	2			1	Converted to PRIVATE patient room	
3	N	Med/Surg	366	1		2		1	Converted to PRIVATE patient room	
3	N	Med/Surg	367	1	2			1	Converted to PRIVATE patient room	
3	N	Med/Surg	368	1		2		0	Converts to Staff/Ancillary Support	
3	N	Med/Surg	369	1				0	Converts to Staff/Ancillary Support	
3	N	Med/Surg	370	1	1	1		0	Converts to Staff/Ancillary Support	
3	N	Med/Surg	371	1	1	1		0	Converts to Staff/Ancillary Support	
3	N	Med/Surg	372	1	1	1		1	Converted to PRIVATE patient room	
3	N	Med/Surg	373	1	1	1		1	Converted to PRIVATE patient room	
3	N	Med/Surg	374	1	1	1		1	Converted to PRIVATE patient room	
3	N	Med/Surg	375	1	1	1		1	Converted to PRIVATE patient room	
3	N	Med/Surg	376	1		2		1	Converted to PRIVATE patient room	
3	N	Med/Surg	377	1	2			1	Converted to PRIVATE patient room	
3	N	Med/Surg	378	1	2			1	Converted to PRIVATE patient room	
3	N	Med/Surg	379	1	2			1	Converted to PRIVATE patient room	
3	N	Med/Surg	380	1	2			1	Converted to PRIVATE patient room	
3	N	Med/Surg	381	1	2			1	Converted to PRIVATE patient room	
3	N	Med/Surg	382	1	2			1	Converted to PRIVATE patient room	
3	N	Med/Surg	383	1	2			1	Converted to PRIVATE patient room	
3	N	Med/Surg	384	1	2			1	Converted to PRIVATE patient room	
3	N	Med/Surg	385	1	2			1	Converted to PRIVATE patient room	
3	N	Med/Surg	386	1	2			1	Converted to PRIVATE patient room	
3	N	Med/Surg	387	1	2			1	Converted to PRIVATE patient room	
3	N	Med/Surg	388	1	1			1	Converted to PRIVATE patient room	
3	N	Med/Surg	389	1	1			1	Converted to PRIVATE patient room	
3	N	Med/Surg	390	1				0	Converts to Staff/Ancillary Support	
3	N	Med/Surg	391	1	2			0	Converts to Staff/Ancillary Support	
3	N	Med/Surg	392	1				0	Converts to Staff/Ancillary Support	
3	N	Med/Surg	393	1	2			0	Converts to Staff/Ancillary Support	
3	N	Med/Surg	394	1		1		1	Converted to PRIVATE patient room	
3	N	Med/Surg	395	1	2			1	Converted to PRIVATE patient room	
3	N	Med/Surg	396	1		1		1	Converted to PRIVATE patient room	
3	N	Med/Surg	397	1	2			1	Converted to PRIVATE patient room	
3	N	Med/Surg	398	1		1		1	Converted to PRIVATE patient room	
3	N	Med/Surg	399	1	2			1	Converted to PRIVATE patient room	
				40	54	15	69	32	BEDS AFTER Converted TO PRIVATE ROOMS	-37
4	S	Med/Surg	400	1	2			1	Converted to PRIVATE patient room	
4	S	Med/Surg	401	1	2			1	Converted to PRIVATE patient room	
4	S	Med/Surg	402	1	2			1	Converted to PRIVATE patient room	
4	S	Med/Surg	403	1	2			1	Converted to PRIVATE patient room	
4	S	Med/Surg	404	1	2			1	Converted to PRIVATE patient room	
4	S	Med/Surg	405	1	2			1	Converted to PRIVATE patient room	
4	S	Med/Surg	406	1	2			1	Converted to PRIVATE patient room	
4	S	Med/Surg	407	1	2			1	Converted to PRIVATE patient room	
4	S	Med/Surg	408	1	2			0	Converts to Staff/Ancillary Support	
4	S	Med/Surg	409	1	2			0	Converts to Staff/Ancillary Support	
4	S	Med/Surg	410	1	2			0	Converts to Staff/Ancillary Support	
4	S	Med/Surg	411	1	2			0	Converts to Staff/Ancillary Support	
4	S	Med/Surg	412	1	2			1	Converted to PRIVATE patient room	
4	S	Med/Surg	413	1	2			1	Converted to PRIVATE patient room	
4	S	Med/Surg	414	1	2			1	Converted to PRIVATE patient room	
4	S	Med/Surg	415	1	2			1	Converted to PRIVATE patient room	
4	S	Med/Surg	416	1	1			1	Converted to PRIVATE patient room	
4	S	Med/Surg	417	1	1			1	Converted to PRIVATE patient room	
4	S	Med/Surg	418	1	1			1	Converted to PRIVATE patient room	
4	S	Med/Surg	419	1	1			1	Converted to PRIVATE patient room	
4	S	Med/Surg	420	1	2			1	Converted to PRIVATE patient room	
4	S	Med/Surg	421	1	2			1	Converted to PRIVATE patient room	
4	S	Med/Surg	422	1	2			1	Converted to PRIVATE patient room	
4	S	Med/Surg	423	1	2			1	Converted to PRIVATE patient room	
4	S	Med/Surg	424	1	2			1	Converted to PRIVATE patient room	
4	S	Med/Surg	425	1	2			1	Converted to PRIVATE patient room	
4	S	Med/Surg	426	1	2			1	Converted to PRIVATE patient room	
4	S	Med/Surg	427	1	2			1	Converted to PRIVATE patient room	
4	S	Med/Surg	428	1	1			1	Converted to PRIVATE patient room	
4	S	Med/Surg	429	1	1			1	Converted to PRIVATE patient room	
4	S	Med/Surg	430	1	2			0	Converts to Staff/Ancillary Support	
4	S	Med/Surg	431	1	2			0	Converts to Staff/Ancillary Support	
4	S	Med/Surg	432	1	2			1	Converted to PRIVATE patient room	
4	S	Med/Surg	433	1	2			1	Converted to PRIVATE patient room	
4	S	Med/Surg	434	1	1	1		1	Converted to PRIVATE patient room	
4	S	Med/Surg	435	1	1	1		1	Converted to PRIVATE patient room	
4	S	Med/Surg	436	1	1	1		1	Converted to PRIVATE patient room	
4	S	Med/Surg	437	1	1	1		1	Converted to PRIVATE patient room	
4	S	Med/Surg	438	1	1	1		1	Converted to PRIVATE patient room	
4	S	Med/Surg	439	1	1	1		1	Converted to PRIVATE patient room	
				40	68	6	74	34	BEDS AFTER Converted TO PRIVATE ROOMS	-40

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PROPOSED
ROOM/BED INVENTORY

Floor		Bed Type	Room	Rooms	Physically Available	Reserve	TOTAL	Proposed Bed Capacity	Conversion TO PRIVATE ROOM NOTES	Beds Discontinued
4	E	Med/Surg	440	1	1			1		
4	E	Med/Surg	441	1	1			1		
4	E	Med/Surg	442	1	1			1		
4	E	Med/Surg	443	1	1			1		
4	E	Med/Surg	444	1	1			1		
4	E	Med/Surg	445	1	1			1		
4	E	Med/Surg	446	1	1			1		
4	E	Med/Surg	447	1	1			1		
4	E	Med/Surg	448	0				0		
4	E	Med/Surg	449	0				0	No change	
4	E	Med/Surg	450	0				0		
4	E	Med/Surg	451	1	1			1		
4	E	Med/Surg	452	0				0		
4	E	Med/Surg	453	1	1			1		
4	E	Med/Surg	454	1	1			1		
4	E	Med/Surg	455	1	1			1		
4	E	Med/Surg	456	1	1			1		
4	E	Med/Surg	457	1	1			1		
4	E	Med/Surg	458	1	1			1		
4	E	Med/Surg	459	1	1			1		
				16	16	0	16	16	MEDICAL SURGICAL PRIVATE PATIENT ROOMS	0
4	N	Med/Surg	460	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	461	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	462	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	463	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	464	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	465	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	466	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	467	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	468	1	2			0	Converts to Staff/Ancillary Support	
4	N	Med/Surg	469	1	2			0	Converts to Staff/Ancillary Support	
4	N	Med/Surg	470	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	471	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	472	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	473	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	474	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	475	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	476	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	477	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	478	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	479	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	480	1	2			0	Converts to Staff/Ancillary Support	
4	N	Med/Surg	481	1	2			0	Converts to Staff/Ancillary Support	
4	N	Med/Surg	482	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	483	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	484	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	485	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	486	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	487	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	488	1	1			1	Converted to PRIVATE patient room	
4	N	Med/Surg	489	1	1			1	Converted to PRIVATE patient room	
4	N	Med/Surg	490	1	2			0	Converts to Staff/Ancillary Support	
4	N	Med/Surg	491	1	2			0	Converts to Staff/Ancillary Support	
4	N	Med/Surg	492	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	493	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	494	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	495	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	496	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	497	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	498	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	499	1	2			1	Converted to PRIVATE patient room	
4	N	Med/Surg	499	1	2			1	Converted to PRIVATE patient room	
				40	78	0	78	[redacted] 34 [redacted] BEDS AFTER Converted TO PRIVATE ROOMS [redacted]		-44

EXISTING BEDS	
Total Licensed Beds	436
Medical Surgical Beds	315
ICU Beds	24

[redacted] PROPOSED BEDS [redacted]	
[redacted] 433 [redacted]	Total INPATIENT BEDS [redacted]
[redacted] 150 [redacted]	Medical Surgical Beds (EXISTING FACILITY) [redacted]
[redacted] 156 [redacted]	Medical Surgical Beds (NEW EAST WING) [redacted]
[redacted] 306 [redacted]	Total Medical Surgical Beds (less 9 beds*) [redacted]
[redacted] 36 [redacted]	Total Intensive Care Beds (plus 9 beds) [redacted]

Discontinuing 185 existing Medical Surgical beds in the process of converting semi-private to private patient rooms.

Replacing 156 Beds in new addition for a net loss of 9 beds, as indicated.

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PROPOSED
ROOM/BED INVENTORY

					2007 ANNUAL BED REPORT			CON - EAST WING EXPANSION	
Floor		Bed Type	Room	Rooms	Physically Available	Reserve	TOTAL	Proposed Bed Capacity	Conversion TO PRIVATE ROOM NOTES
2	N	Psych	270-1	0		1		1	
2	N	Psych	270-2	0	1			1	
2	N	Psych	270-3	0		1		1	
2	N	Psych	270-4	0		1		1	
2	N	Psych	271-1						
2	N	Psych	273	1	2			2	
2	N	Psych	275	1	2			2	
2	N	Psych	277	1	2			2	
2	N	Psych	278	1	2			2	
2	N	Psych	279	1	2			2	
2	N	Psych	280	1	2			2	
2	N	Psych	281	1	2			2	
2	N	Psych	282	1	2			2	
2	N	Psych	283	1	2			2	No change
2	N	Psych	284	1	2			2	
2	N	Psych	285	1	2			2	
2	N	Psych	286	1		2		2	
2	N	Psych	287	1	2			2	
2	N	Psych	288	1		2		2	
2	N	Psych	290	1	2			2	
2	N	Psych	291	1		2		2	
2	N	Psych	292	1	2			2	
2	N	Psych	293	1	2			2	
2	N	Psych	294	1	2			2	
2	N	Psych	295	1	2			2	
2	N	Psych	296	1	2			2	
2	N	Psych	297	1	2			2	
				22	30	9	48	48	PSYCHIATRIC INPATIENT BEDS
2	S	OB	205	0	0			0	
2	S	OB	206	0	0			0	
2	S	OB	209	0	0			0	
2	S	OB	210	1	1			1	
2	S	OB	211	1	1			1	
2	S	OB	212	1	1			1	
2	S	OB	213	1	1			1	
2	S	OB	214	1	1			1	
2	S	OB	215	0					
2	S	OB	216	1	1			1	
2	S	OB	217	1	1			1	
2	S	OB	218	1	1			1	
2	S	OB	219	1	1			1	
2	S	OB	220	1	1			1	
2	S	OB	221	1	1			1	
2	S	OB	222	1	1			1	No change
2	S	OB	223	1	1			1	
2	S	OB	224	1	1			1	
2	S	OB	225	0					
2	S	OB	226	1	1			1	
2	S	OB	227	1	1			1	
2	S	OB	229	1	2			2	
2	S	OB	230	1	1			1	
2	S	OB	231	1	1			1	
2	S	OB	232	1	1			1	
2	S	OB	233	1	1			1	
2	S	OB	234	1		1		1	
2	S	OB	235	1	1			1	
2	S	OB	236	1	1			1	
2	S	OB	237	1	1			1	
2	S	OB	238	1	1			1	
2	S	OB	239	1	1			1	
				27	27	1	28	28	OBSTERICAL BEDS
2	E	Peds	240	1	1			1	
2	E	Peds	242	1	2			2	
2	E	Peds	243	1					
2	E	Peds	244	1	2			2	
2	E	Peds	245	1	2			2	No change
2	E	Peds	246	1	2			2	
2	E	Peds	247	1	2			2	
2	E	Peds	248	1	2			2	
2	E	Peds	249	1	2			2	
					15	0	15	15	PEDIATRIC BEDS

PROPOSED
ROOM/BED INVENTORY

				2007 ANNUAL BED REPORT				CON - EAST WING EXPANSION	
Floor		Bed Type	Room	Rooms	Physically Available	Reserve	TOTAL	Proposed Bed Capacity	Conversion TO PRIVATE ROOM NOTES
3	E	ICU	355-1	1	1			0	
3	E	ICU	355-2	1	1			0	
3	E	ICU	355-3	1	1			0	
3	E	ICU	355-4	1	1			0	
3	E	ICU	355-5	1	1			0	
3	E	ICU	355-6	1	1			0	
3	E	ICU	355-7	1	1			0	
3	E	ICU	355-8	1	1			0	
3	E	ICU	355-9	1	1			0	
3	E	ICU	355-10	1	1			0	
3	E	ICU	355-11	1	1			0	
3	E	ICU	355-12	1	1			0	Converted to non patient bed space: Inpatient Dialysis, Respiratory Therapy, Medical Staff Facilities & Support
3	E	ICU	356-7	1	1			0	
3	E	ICU	356-8	1	1			0	
3	E	ICU	356-9	1	1			0	
3	E	ICU	356-10	1	1			0	
3	E	ICU	356-11	1	1			0	
3	E	ICU	356-12	1	1			0	
3	E	ICU	357-1	1	1			0	
3	E	ICU	357-2	1	1			0	
3	E	ICU	357-3	1	1			0	
3	E	ICU	357-4	1	1			0	
3	E	ICU	357-5	1	1			0	
3	E	ICU	357-6	1	1			0	
				24	24	0	24	36	ICU BEDS MOVE TO NEW EAST WING ADDITION
3	S	Med/Surg	300	1	2			1	Converted to PRIVATE patient room
3	S	Med/Surg	301	1	2			1	Converted to PRIVATE patient room
3	S	Med/Surg	302	1	2			1	Converted to PRIVATE patient room
3	S	Med/Surg	303	1	2			1	Converted to PRIVATE patient room
3	S	Med/Surg	304	1	2			1	Converted to PRIVATE patient room
3	S	Med/Surg	305	1	2			1	Converted to PRIVATE patient room
3	S	Med/Surg	306	1	2			1	Converted to PRIVATE patient room
3	S	Med/Surg	307	1	2			1	Converted to PRIVATE patient room
3	S	Med/Surg	308	1	2			0	Converts to Staff/Ancillary Support
3	S	Med/Surg	309	1	2			0	Converts to Staff/Ancillary Support
3	S	Med/Surg	310	1	2			0	Converts to Staff/Ancillary Support
3	S	Med/Surg	311	1	2			0	Converts to Staff/Ancillary Support
3	S	Med/Surg	312	1	2			1	Converted to PRIVATE patient room
3	S	Med/Surg	313	1	2			1	Converted to PRIVATE patient room
3	S	Med/Surg	314	1	2			1	Converted to PRIVATE patient room
3	S	Med/Surg	315	1	2			1	Converted to PRIVATE patient room
3	S	Med/Surg	316	1	2			1	Converted to PRIVATE patient room
3	S	Med/Surg	317	1	2			1	Converted to PRIVATE patient room
3	S	Med/Surg	318	1	2			1	Converted to PRIVATE patient room
3	S	Med/Surg	319	1	2			1	Converted to PRIVATE patient room
3	S	Med/Surg	320	1	2			0	Converts to Staff/Ancillary Support
3	S	Med/Surg	321	1	2			0	Converts to Staff/Ancillary Support
3	S	Med/Surg	322	1	2			1	Converted to PRIVATE patient room
3	S	Med/Surg	323	1	2			1	Converted to PRIVATE patient room
3	S	Med/Surg	324	1	2			1	Converted to PRIVATE patient room
3	S	Med/Surg	325	1	2			1	Converted to PRIVATE patient room
3	S	Med/Surg	326	1	2			1	Converted to PRIVATE patient room
3	S	Med/Surg	327	1	2			1	Converted to PRIVATE patient room
3	S	Med/Surg	328	1	1			1	Converted to PRIVATE patient room
3	S	Med/Surg	329	1	1			1	Converted to PRIVATE patient room
3	S	Med/Surg	330	1	2			1	Converted to PRIVATE patient room
3	S	Med/Surg	331	1	2			1	Converted to PRIVATE patient room
3	S	Med/Surg	332	1	2			1	Converted to PRIVATE patient room
3	S	Med/Surg	333	1	2			1	Converted to PRIVATE patient room
3	S	Med/Surg	334	1	2			1	Converted to PRIVATE patient room
3	S	Med/Surg	335	1	2			1	Converted to PRIVATE patient room
3	S	Med/Surg	336	1	2			1	Converted to PRIVATE patient room
3	S	Med/Surg	337	1	2			1	Converted to PRIVATE patient room
3	S	Med/Surg	338	1	2			1	Converted to PRIVATE patient room
3	S	Med/Surg	339	1	2			1	Converted to PRIVATE patient room
				20	78	0	78	34	BEDS AFTER Converted TO PRIVATE ROOMS

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PROPOSED
ROOM/BED INVENTORY

				2007 ANNUAL BED REPORT				CON - EAST WING EXPANSION	
Floor		Bed Type	Room	Rooms	Physically Available	Reserve	TOTAL	Proposed Bed Capacity	Conversion TO PRIVATE ROOM NOTES
3	N	Med/Surg	360	1	2			1	Converted to PRIVATE patient room
3	N	Med/Surg	361	1	2			1	Converted to PRIVATE patient room
3	N	Med/Surg	362	1	2			1	Converted to PRIVATE patient room
3	N	Med/Surg	363	1	2			1	Converted to PRIVATE patient room
3	N	Med/Surg	364	1	2			1	Converted to PRIVATE patient room
3	N	Med/Surg	365	1	2			1	Converted to PRIVATE patient room
3	N	Med/Surg	366	1		2		1	Converted to PRIVATE patient room
3	N	Med/Surg	367	1	2			1	Converted to PRIVATE patient room
3	N	Med/Surg	368	1		2		0	Converts to Staff/Ancillary Support
3	N	Med/Surg	369	1				0	Converts to Staff/Ancillary Support
3	N	Med/Surg	370	1	1	1		0	Converts to Staff/Ancillary Support
3	N	Med/Surg	371	1	1	1		0	Converts to Staff/Ancillary Support
3	N	Med/Surg	372	1	1	1		1	Converted to PRIVATE patient room
3	N	Med/Surg	373	1	1	1		1	Converted to PRIVATE patient room
3	N	Med/Surg	374	1	1	1		1	Converted to PRIVATE patient room
3	N	Med/Surg	375	1	1	1		1	Converted to PRIVATE patient room
3	N	Med/Surg	376	1		2		1	Converted to PRIVATE patient room
3	N	Med/Surg	377	1	2			1	Converted to PRIVATE patient room
3	N	Med/Surg	378	1	2			1	Converted to PRIVATE patient room
3	N	Med/Surg	379	1	2			1	Converted to PRIVATE patient room
3	N	Med/Surg	380	1	2			1	Converted to PRIVATE patient room
3	N	Med/Surg	381	1	2			1	Converted to PRIVATE patient room
3	N	Med/Surg	382	1	2			1	Converted to PRIVATE patient room
3	N	Med/Surg	383	1	2			1	Converted to PRIVATE patient room
3	N	Med/Surg	384	1	2			1	Converted to PRIVATE patient room
3	N	Med/Surg	385	1	2			1	Converted to PRIVATE patient room
3	N	Med/Surg	386	1	2			1	Converted to PRIVATE patient room
3	N	Med/Surg	387	1	2			1	Converted to PRIVATE patient room
3	N	Med/Surg	388	1	1			1	Converted to PRIVATE patient room
3	N	Med/Surg	389	1	1			1	Converted to PRIVATE patient room
3	N	Med/Surg	390	1				0	Converts to Staff/Ancillary Support
3	N	Med/Surg	391	1	2			0	Converts to Staff/Ancillary Support
3	N	Med/Surg	392	1				0	Converts to Staff/Ancillary Support
3	N	Med/Surg	393	1	2			0	Converts to Staff/Ancillary Support
3	N	Med/Surg	394	1		1		1	Converted to PRIVATE patient room
3	N	Med/Surg	395	1	2			1	Converted to PRIVATE patient room
3	N	Med/Surg	396	1		1		1	Converted to PRIVATE patient room
3	N	Med/Surg	397	1	2			1	Converted to PRIVATE patient room
3	N	Med/Surg	398	1		1		1	Converted to PRIVATE patient room
3	N	Med/Surg	399	1	2			1	Converted to PRIVATE patient room
				40	54	15	69	32	BEDS AFTER Converted TO PRIVATE ROOMS
4	S	Med/Surg	400	1	2			1	Converted to PRIVATE patient room
4	S	Med/Surg	401	1	2			1	Converted to PRIVATE patient room
4	S	Med/Surg	402	1	2			1	Converted to PRIVATE patient room
4	S	Med/Surg	403	1	2			1	Converted to PRIVATE patient room
4	S	Med/Surg	404	1	2			1	Converted to PRIVATE patient room
4	S	Med/Surg	405	1	2			1	Converted to PRIVATE patient room
4	S	Med/Surg	406	1	2			1	Converted to PRIVATE patient room
4	S	Med/Surg	407	1	2			1	Converted to PRIVATE patient room
4	S	Med/Surg	408	1	2			0	Converts to Staff/Ancillary Support
4	S	Med/Surg	409	1	2			0	Converts to Staff/Ancillary Support
4	S	Med/Surg	410	1	2			0	Converts to Staff/Ancillary Support
4	S	Med/Surg	411	1	2			0	Converts to Staff/Ancillary Support
4	S	Med/Surg	412	1	2			1	Converted to PRIVATE patient room
4	S	Med/Surg	413	1	2			1	Converted to PRIVATE patient room
4	S	Med/Surg	414	1	2			1	Converted to PRIVATE patient room
4	S	Med/Surg	415	1	2			1	Converted to PRIVATE patient room
4	S	Med/Surg	416	1	1			1	Converted to PRIVATE patient room
4	S	Med/Surg	417	1	1			1	Converted to PRIVATE patient room
4	S	Med/Surg	418	1	1			1	Converted to PRIVATE patient room
4	S	Med/Surg	419	1	1			1	Converted to PRIVATE patient room
4	S	Med/Surg	420	1	2			1	Converted to PRIVATE patient room
4	S	Med/Surg	421	1	2			1	Converted to PRIVATE patient room
4	S	Med/Surg	422	1	2			1	Converted to PRIVATE patient room
4	S	Med/Surg	423	1	2			1	Converted to PRIVATE patient room
4	S	Med/Surg	424	1	2			1	Converted to PRIVATE patient room
4	S	Med/Surg	425	1	2			1	Converted to PRIVATE patient room
4	S	Med/Surg	426	1	2			1	Converted to PRIVATE patient room
4	S	Med/Surg	427	1	2			1	Converted to PRIVATE patient room
4	S	Med/Surg	428	1	1			1	Converted to PRIVATE patient room
4	S	Med/Surg	429	1	1			1	Converted to PRIVATE patient room
4	S	Med/Surg	430	1	2			0	Converts to Staff/Ancillary Support
4	S	Med/Surg	431	1	2			0	Converts to Staff/Ancillary Support
4	S	Med/Surg	432	1	2			1	Converted to PRIVATE patient room
4	S	Med/Surg	433	1	2			1	Converted to PRIVATE patient room
4	S	Med/Surg	434	1	1	1		1	Converted to PRIVATE patient room
4	S	Med/Surg	435	1	1	1		1	Converted to PRIVATE patient room
4	S	Med/Surg	436	1	1	1		1	Converted to PRIVATE patient room
4	S	Med/Surg	437	1	1	1		1	Converted to PRIVATE patient room
4	S	Med/Surg	438	1	1	1		1	Converted to PRIVATE patient room
4	S	Med/Surg	439	1	1	1		1	Converted to PRIVATE patient room
				40	68	6	74	34	BEDS AFTER Converted TO PRIVATE ROOMS

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PROPOSED
ROOM/BED INVENTORY

				2007 ANNUAL BED REPORT				CON - EAST WING EXPANSION	
Floor		Bed Type	Room	Rooms	Physically Available	Reserve	TOTAL	Proposed Bed Capacity	Conversion TO PRIVATE ROOM NOTES
4	E	Med/Surg	440	1	1			1	
4	E	Med/Surg	441	1	1			1	
4	E	Med/Surg	442	1	1			1	
4	E	Med/Surg	443	1	1			1	
4	E	Med/Surg	444	1	1			1	
4	E	Med/Surg	445	1	1			1	
4	E	Med/Surg	446	1	1			1	
4	E	Med/Surg	447	1	1			1	
4	E	Med/Surg	448	0				0	
4	E	Med/Surg	449	0				0	No change
4	E	Med/Surg	450	0				0	
4	E	Med/Surg	451	1	1			1	
4	E	Med/Surg	452	0				0	
4	E	Med/Surg	453	1	1			1	
4	E	Med/Surg	454	1	1			1	
4	E	Med/Surg	455	1	1			1	
4	E	Med/Surg	456	1	1			1	
4	E	Med/Surg	457	1	1			1	
4	E	Med/Surg	458	1	1			1	
4	E	Med/Surg	459	1	1			1	
				16	16	0	16	16	MEDICAL SURGICAL PRIVATE PATIENT ROOMS
4	N	Med/Surg	460	1	2			1	Converted to PRIVATE patient room
4	N	Med/Surg	461	1	2			1	Converted to PRIVATE patient room
4	N	Med/Surg	462	1	2			1	Converted to PRIVATE patient room
4	N	Med/Surg	463	1	2			1	Converted to PRIVATE patient room
4	N	Med/Surg	464	1	2			1	Converted to PRIVATE patient room
4	N	Med/Surg	465	1	2			1	Converted to PRIVATE patient room
4	N	Med/Surg	466	1	2			1	Converted to PRIVATE patient room
4	N	Med/Surg	467	1	2			1	Converted to PRIVATE patient room
4	N	Med/Surg	468	1	2			0	Converts to Staff/Ancillary Support
4	N	Med/Surg	469	1	2			0	Converts to Staff/Ancillary Support
4	N	Med/Surg	470	1	2			1	Converted to PRIVATE patient room
4	N	Med/Surg	471	1	2			1	Converted to PRIVATE patient room
4	N	Med/Surg	472	1	2			1	Converted to PRIVATE patient room
4	N	Med/Surg	473	1	2			1	Converted to PRIVATE patient room
4	N	Med/Surg	474	1	2			1	Converted to PRIVATE patient room
4	N	Med/Surg	475	1	2			1	Converted to PRIVATE patient room
4	N	Med/Surg	476	1	2			1	Converted to PRIVATE patient room
4	N	Med/Surg	477	1	2			1	Converted to PRIVATE patient room
4	N	Med/Surg	478	1	2			1	Converted to PRIVATE patient room
4	N	Med/Surg	479	1	2			1	Converted to PRIVATE patient room
4	N	Med/Surg	480	1	2			0	Converts to Staff/Ancillary Support
4	N	Med/Surg	481	1	2			0	Converts to Staff/Ancillary Support
4	N	Med/Surg	482	1	2			1	Converted to PRIVATE patient room
4	N	Med/Surg	483	1	2			1	Converted to PRIVATE patient room
4	N	Med/Surg	484	1	2			1	Converted to PRIVATE patient room
4	N	Med/Surg	485	1	2			1	Converted to PRIVATE patient room
4	N	Med/Surg	486	1	2			1	Converted to PRIVATE patient room
4	N	Med/Surg	487	1	2			1	Converted to PRIVATE patient room
4	N	Med/Surg	488	1	1			1	Converted to PRIVATE patient room
4	N	Med/Surg	489	1	1			1	Converted to PRIVATE patient room
4	N	Med/Surg	490	1	2			0	Converts to Staff/Ancillary Support
4	N	Med/Surg	491	1	2			0	Converts to Staff/Ancillary Support
4	N	Med/Surg	492	1	2			1	Converted to PRIVATE patient room
4	N	Med/Surg	493	1	2			1	Converted to PRIVATE patient room
4	N	Med/Surg	494	1	2			1	Converted to PRIVATE patient room
4	N	Med/Surg	495	1	2			1	Converted to PRIVATE patient room
4	N	Med/Surg	496	1	2			1	Converted to PRIVATE patient room
4	N	Med/Surg	497	1	2			1	Converted to PRIVATE patient room
4	N	Med/Surg	498	1	2			1	Converted to PRIVATE patient room
4	N	Med/Surg	499	1	2			1	Converted to PRIVATE patient room
				40	78	0	78	34	BEDS AFTER Converted TO PRIVATE ROOMS

EXISTING BEDS		PROPOSED BEDS
Total Licensed Beds	436	Total INPATIENT BEDS
		Medical Surgical Beds (EXISTING FACILITY)
		Medical Surgical Beds (NEW EAST WING)
Medical Surgical Beds	315	Total Medical Surgical Beds (less 8 beds*)
ICU Beds	24	Total Intensive Care Beds (plus 8 beds)

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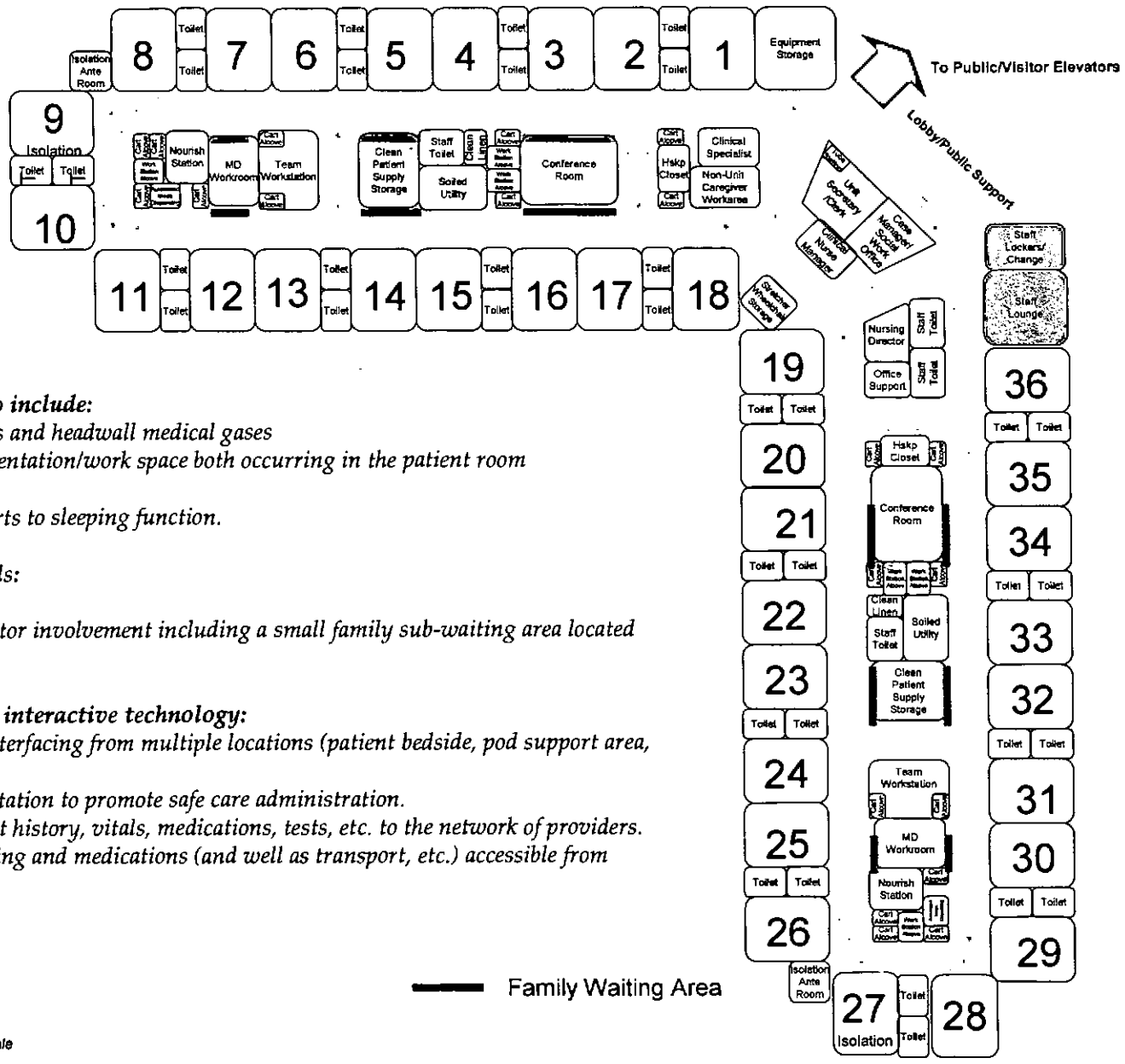
EAST WING ADDITION
Prototypical Med/Surg Unit



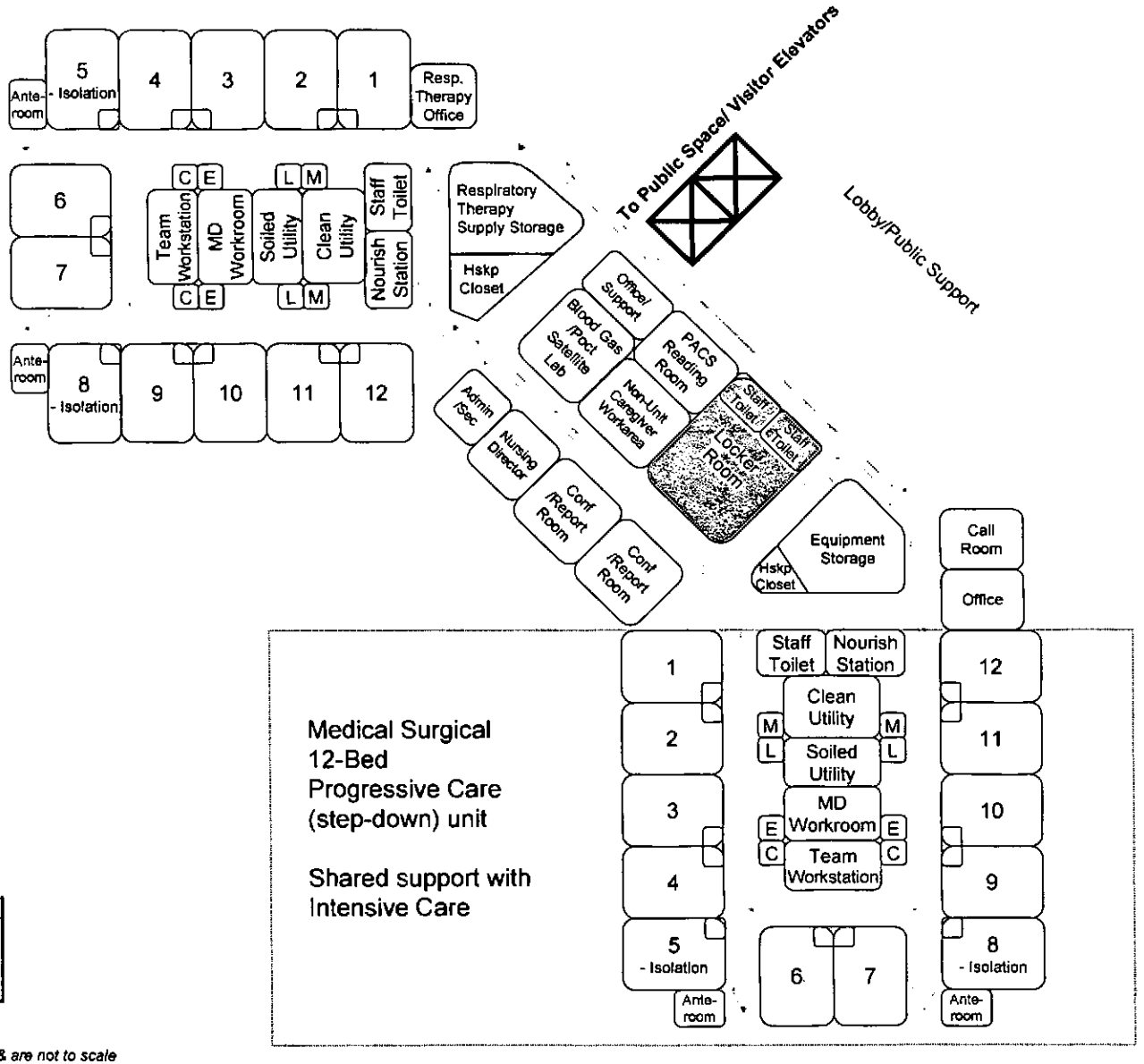
All rooms are private and configured to include:
- *Patient zone with monitoring capabilities and headwall medical gases*
- *Staff zone with hand washing and documentation/work space both occurring in the patient room*
- *Full patient toilet and shower*
- *Family zone with seating area that converts to sleeping function.*

Units are configured into "pods" of beds:
- *Each pod consists of 18 beds.*
- *Units configuration supports family/visitor involvement including a small family sub-waiting area located within the unit itself.*

Units are planned to employ advanced interactive technology:
- *Patient monitoring system that allows interfacing from multiple locations (patient bedside, pod support area, team area, off-site).*
- *Bedside scanning and real-time documentation to promote safe care administration.*
- *Electronic Medical Record linking patient history, vitals, medications, tests, etc. to the network of providers.*
- *Secure online order entry system for testing and medications (and well as transport, etc.) accessible from multiple locations.*

Note: Not all program elements shown.
Diagrams illustrate adjacencies and flow & are not to scale

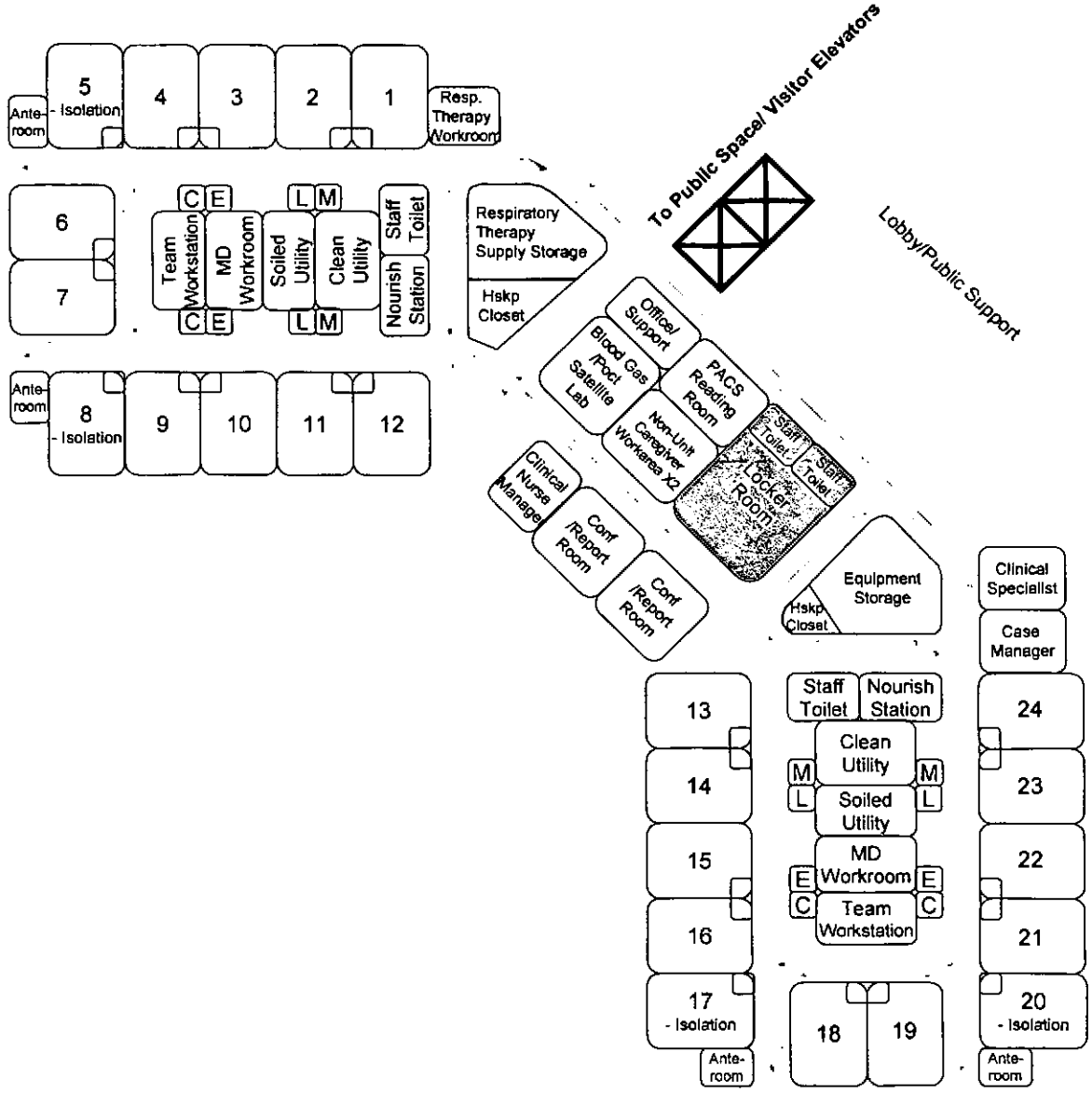
EAST WING ADDITION
Intensive Care Unit &
Progressive Care Units – Floor 6



Abbreviation Key:
C – Crash Cart
E – Equipment Alcove
M – Automated Medication Dispensing
L – Linen Exchange Cart Alcove

Note: Not all program elements shown.
Diagrams illustrate adjacencies and flow & are not to scale

EAST WING ADDITION
Intensive Care Unit – Floor 7



Abbreviation Key:
C – Crash Cart
E – Equipment Alcove
M – Automated Medication Dispensing
L – Linen Exchange Cart Alcove

Note: Not all program elements shown.
Diagrams illustrate adjacencies and flow & are not to scale

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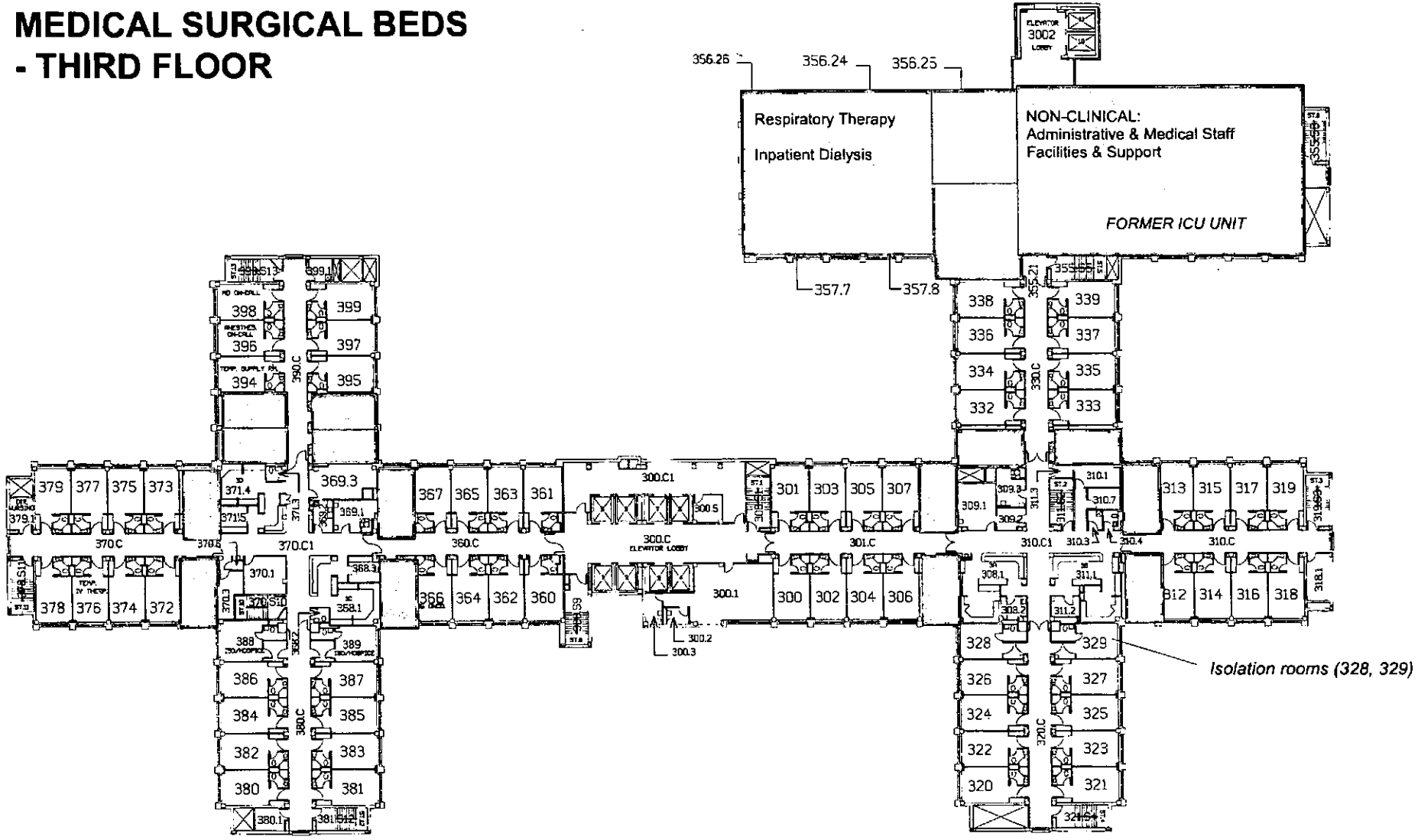
MEDICAL SURGICAL BEDS
- THIRD FLOOR



Indicates conversion to ancillary/staff/unit support.

THIRD FLOOR:
66 MEDICAL/SURGICAL BEDS

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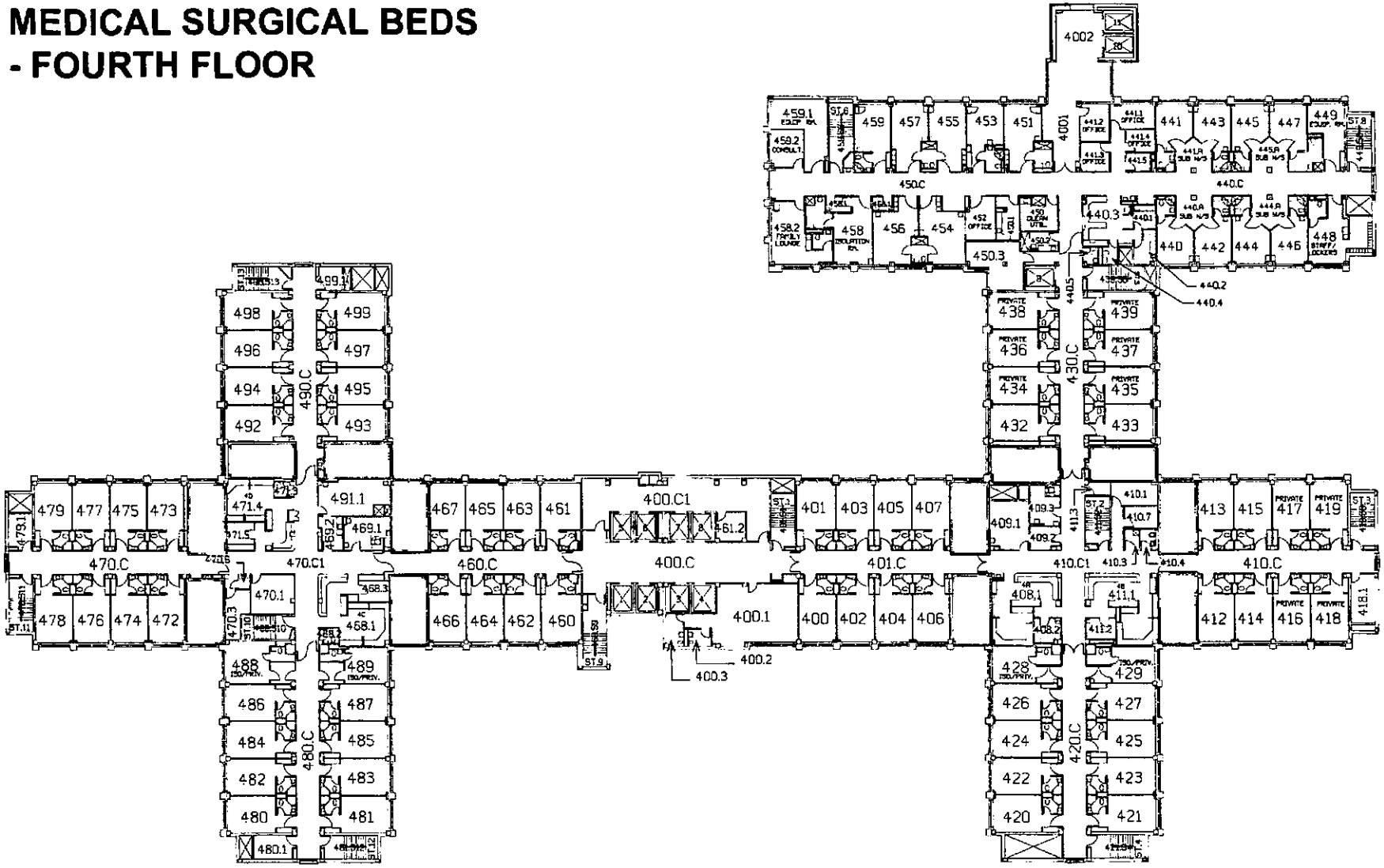
MEDICAL SURGICAL BEDS
- FOURTH FLOOR



PALOS COMMUNITY HOSPITAL
PALOS HEIGHTS, ILLINOIS
FOURTH FLOOR PLAN
NORTH

Indicates conversion to ancillary/staff/unit support.

FOURTH FLOOR:
84 MEDICAL/SURGICAL BEDS

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IMAGING - ROOMS AND MACHINES, BY TYPE
Existing and Proposed

Radiology		AHQ 2007	EXISTING (2008)	PROPOSED (2018)	
GENERAL MACHINES	General Radiography/Flouroscopy	8	9	12	*1 new in 2008*
	GENERAL RADIOLOGY TOTAL	**8**	**9**	**12**	
OTHER*	Bone density/DEXA	n/a	1	1	*See * below*
	Sterotactic (Breast Biopsy)	n/a	1	1	*See * below*
SPECIAL MACHINES	Angiographic	1	1	1	*Will be located in CSSC - Special Procedures Room*
	CT Scanner	3	3	4	
	Mammography	3	3	4	
	Sonographic (ultrasound)	6	7	8	*1 new in 2008*
	Tomographic (multi-directional)	0	0	0	
	SPECIAL RADIOLOGY TOTALS	**13**	**16**	**19**	
	DIAGNOSTIC RAD GRAND TOTALS	**21**	**25**	**31**	
Nuclear Medicine					
NUCLEAR MEDICINE	Nuclear Medicine Cameras	3	3	5	
	TOTALS	**3**	**3**	**5**	
	GRAND TOTALS: RAD & NM	24	28	36	

** No category on AHQ for Bone density/DEXA room & Sterotactic breast biopsy room.*
DEXA volumes are reported with General/Flouro
Stereotactic volumes are reported in mammography

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

NUCLEAR MEDICINE

	Projected Growth															
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
PROCEDURES																
Inpatient	4,865	3,960	4,365	4,578	4,738	4,932	5,135	5,345	5,564	5,793	6,030	6,277	6,535	6,803	7,081	7,372
Outpatient	6,309	7,713	7,546	8,082	8,365	8,708	9,065	9,437	9,823	10,226	10,645	11,082	11,536	12,009	12,502	13,014
Total	11,174	11,673	11,911	12,660	13,103	13,640	14,200	14,782	15,388	16,019	16,675	17,359	18,071	18,812	19,583	20,386
Annual % Change		*4.5%*	*2.0%*	*6.3%*	*3.5%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*
Average Annual Increase 2005-2008			3.3%	4.3%												
VISITS																
Inpatient		842	928	974	1,008	1,049	1,092	1,137	1,184	1,232	1,283	1,336	1,390	1,447	1,507	1,568
Outpatient		1,587	1,605	1,719	1,779	1,852	1,928	2,007	2,089	2,175	2,264	2,357	2,454	2,554	2,659	2,768
Total		2,429	2,533	2,693	2,787	2,902	3,021	3,144	3,273	3,408	3,547	3,693	3,844	4,002	4,166	4,337
Annual % Change			*4.3%*	*6.3%*	*3.5%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*

Nuclear medicine not available at PCH satellite facilities, projections assume entire service area.
** Annualized Jan-Jun 2008*
Source: Radiology Department Monthly Statistics & NCI Consulting (projections)

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INTEGRATED PROCEDURE SERVICES (IPS)

	EXISTING	CON PROPOSED
IPS - OR PROCEDURE ZONE	12	13
IPS - ENDOSCOPY ZONE	3	4
IPS - INTERVENTIONAL ZONE (SPECIALS)	1	1
IPS -INTERNVENTIONAL ZONE (MINOR PROCEDURES)	1	1
Total Procedure Rooms IPS:	17	19

PROCEDURE HOURS:	Projected Growth															
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
IPS - OR PROCEDURE ZONE	15,794	16,498	17,155	17,717	18,163	18,720	19,095	19,477	19,866	20,263	21,198	21,622	22,054	22,495	22,945	23,404
IHFPB Rooms Allowed (1,500 hours per room)	10.5	11.0	11.4	11.8	12.1	12.5	12.7	13.0	13.2	13.5	14.1	14.4	14.7	15.0	15.3	15.6
IPS - ENDOSCOPY ZONE*	5,058	5,225	5,752	4,940	5,912	6,076	6,244	6,418	6,596	6,779	6,967	7,161	7,359	7,564	7,774	7,990
IHFPB Rooms Allowed (1,500 hours per room)	3.4	3.5	3.8	3.3	3.9	4.1	4.2	4.3	4.4	4.5	4.6	4.8	4.9	5.0	5.2	5.3
IPS - INTERVENTIONAL ZONE (SPECIALS)	2,153	2,031	1,993	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000
IHFPB Rooms Allowed (2,000 hours per room)	1.1	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
IPS -INTERNVENTIONAL ZONE (MINOR PROCEDURES)	4,032	3,080	2,975	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005
IHFPB Rooms Allowed (2,000 visits per room)	2.0	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5
TOTAL IHFPB ROOMS ALLOWED																23.4
PROCEDURE ROOMS:																
EXISITING**	15	17	17	17	17	17	17	17	17	17	17	17	17			
PROPOSED														19	19	19

OPERATING ROOMS	13	Includes 1 cystoscopy
GI/ENDO	4	
SPECIAL/INTERVENTIONAL	1	
MINOR PROCEDURES	1	

RECOVERY ROOMS:

4 PER PROCEDURE ROOM, EXCLUDING 2 ROOMS FOR SPECIAL/MINOR PROCEDURES ROOM = 17 PX ROOMS

PROPOSED RECOVERY POSITIONS:									
CALCULATED TOTAL POSITIONS BASED ON 17 PX ROOMS:	68	68	68	68	68	68	68	68
PACU	15	15	15	15	15	15	15	15
CSSC (PRE AND POST - STAGE II & OUTPATIENT)	50	50	50	50	50	50	50	50
TOTAL RECOVERY POSITIONS	65	65	65	65	65	65	65	65
PLUS INFUSION THERAPY/OTHER OUTPATIENT PROCEDURES (IN CSSC ZONE)	5	5	5	5	5	5	5	5

* 2 CVORs added in 2005
Project includes only one smaller OR for cystoscopy.
In AHQs - 2 existing cysto rooms are reported with General ORs since they are located in Surgery.
In 2007 one surgeon retired; 1 physician went to part time; & another physician was on LOA several months. In 2008 PCH added two new general surgeons.

Source:PCH - Surgical Services Statistics

LOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

SURGERY

	Historical		Projected Growth													
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
HOURS OF SURGERY																
Inpatient	9,063	10,147	10,655	11,242	11,186	11,984	12,223	12,468	12,717	12,972	13,760	14,035	14,316	14,602	14,894	15,192
Outpatient	6,731	6,351	6,500	6,475	6,977	6,737	6,871	7,009	7,149	7,292	7,438	7,586	7,738	7,893	8,051	8,212
Total	15,794	16,498	17,155	17,717	18,163	18,720	19,095	19,477	19,866	20,263	21,198	21,622	22,054	22,495	22,945	23,404
Annual % Change		4.5%	4.0%	3.3%	2.5%	3.1%	2.0%	2.0%	2.0%	2.0%	4.6%	2.0%	2.0%	2.0%	2.0%	2.0%
Average Increase 2005-2007			4.0%													
NUMBER OF PATIENTS																
Inpatient	4,097	4,427	4,517	4,607	4,699	4,793	4,889	4,987	5,087	5,189	5,292	5,398	5,506	5,616	5,729	5,843
Outpatient	4,676	4,402	4,232	4,317	4,403	4,491	4,581	4,672	4,766	4,861	4,958	5,058	5,159	5,262	5,367	5,475
Total	8,773	8,829	8,749	8,924	9,102	9,285	9,470	9,660	9,853	10,050	10,251	10,456	10,665	10,878	11,096	11,318
Average Inpatient Increase, 2005-2007			5.1%													
Annual % Change		0.6%	-0.9%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
Average Time/Procedure																
Inpatient	2.2	2.3	2.4	2.4	2.5	2.5	2.5	2.5	2.5	2.5	2.6	2.6	2.6	2.6	2.6	2.6
Outpatient	1.4	1.4	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5
Total	1.8	1.9	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.1	2.1	2.1	2.1	2.1	2.1
STANDARDS																
Capacity per OR (Hours)	1,500															
Total Capacity	15,000	16,000	16,000	16,000	16,000	16,000	16,000	16,000	16,000	16,000	16,000	16,000	16,000	19,500	19,500	19,500
Number of ORs based on hours	10.5	11.0	11.4	11.8	12.1	12.5	12.7	13.0	13.2	13.5	14.1	14.4	14.7	15.0	15.3	15.6
NUMBER OF OPERATING ROOMS (EXISTING & PROPOSED)																
Operating Rooms:*	10	12	12	12	12	12	12	12	12	12	12	12	12	13	13	13

Project includes only one smaller OR for cystoscopy.
In AHQs - 2 existing cysto rooms are reported with General ORs since they are located in Surgery.
** 2 CVORs added in 2005 (one is for emergency back-up)*
Palos recently added two new general surgeons to replace the one who retired in 2007 and the one surgeon who went from full time to part time.
One physician who was on LOA for several months in 2007 has returned.
Source. PCH - Surgical Services Statistics

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

GI / ENDOSCOPY

	Historical			Projected Growth												
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
NUMBER OF HOURS - GI/ENDO																
Inpatient	1,201	1,194	1,443	1,486	1,486	1,531	1,577	1,624	1,673	1,723	1,775	1,828	1,883	1,939	1,997	2,057
Outpatient	3,857	4,031	4,309	4,425	4,425	4,545	4,668	4,794	4,923	5,056	5,192	5,333	5,477	5,624	5,776	5,932
Total	5,058	5,225	5,752	5,912	5,912	6,076	6,244	6,418	6,596	6,779	6,967	7,161	7,359	7,564	7,774	7,990
Annual % Change		*3.3%*	*10.1%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*
Average Increase 2005-2007			6.9%													
NUMBER OF CASES/PROCEDURES																
Inpatient	1,434	1,416	1,524	1,551	1,576	1,604	1,633	1,663	1,692	1,723	1,754	1,785	1,818	1,850	1,884	1,918
Outpatient	4,676	4,784	4,549	4,685	4,417	4,549	4,686	4,826	4,971	5,120	5,274	5,432	5,595	5,763	5,936	6,114
Total GI/Endo Procedures	6,110	6,200	6,073	6,237	5,993	6,153	6,319	6,489	6,663	6,843	7,028	7,217	7,412	7,613	7,819	8,031
Average Inpatient Increase 2005-2007			3.1%													
Annual % Change		*1.5%*	*-2.0%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*
Average Time/Procedure																
Inpatient	0.8	0.8	0.9	1.0	0.9	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.1	1.1
Outpatient	0.8	0.8	0.9	0.9	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Total	0.8	0.8	0.9	0.9	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
STANOARDS																
Capacity per Room (hours)	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*
Number of Rooms based on hours	3.4	3.5	3.8	3.9	3.9	4.1	4.2	4.3	4.4	4.5	4.6	4.8	4.9	5.0	5.2	5.3
NUMBER OF PROCEDURE ROOMS (EXISTING & PROPOSED)																
GI/Endo Procedure Rooms	3	3	3	3	3	3	3	3	3	3	3	3	3	4	4	4

Palos recently added two new general surgeons to replace the one who retured in 2007 and the one surgeon who went from full time to part time.
One physician who was on LOA for several months in 2007 has returned.
Source: PCH - Surgical Services Statistics - Outpatient Department

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

SPECIAL PROCEDURES / INTERVENTIONAL RADIOLOGY

PROCEDURES	Historical		Projected Growth														
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Inpatient	1,485	1,441	1,473	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500
Outpatient	668	544	520	500	500	500	500	500	500	500	500	500	500	500	500	500
Total	2,153	2,031	1,993	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000
Annual % Change		*-5.7%*	*-1.9%*	*0.4%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
STANDARDS																
Capacity per Room (Pxs)	2000 procedures															
Percent Utilization	107.7%	101.6%	99.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Number of Rooms based on hours	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1

MINOR PROCEDURES

	Historical		Projected Growth													
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Minor Procedure Visits	4,032	3,080	2,975	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005
Annual % Change		*-23.6%*	*-3.4%*	*1.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
Number of Rooms (Existing & Proposed)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
TOTALS	6,185	5,111	4,968	5,005	5,005	5,005	5,005	5,005	5,005	5,005	5,005	5,005	5,005	5,005	5,005	5,005
NUMBER OF PROCEDURE ROOMS (EXISTING & PROPOSED)																
Special Procedures/Interventional Radiology	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Minor Procedures	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1

Annualized Jan-Mar 2008
Source: PCH - Special Procedures Statistics (Radiology)

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ATTACHMENT MOD-1H

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

INFUSION THERAPY

TREATMENTS

	Historical			Projected Growth												
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
OUTPATIENT INFUSION THERAPY																
Treatment Volumes	1508	1658	1908	1927	1966	2005	2045	2086	2128	2170	2214	2258	2280	2303	2326	2349
Annual % Change		9.9%	15.1%	1.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	1.0%	1.0%	1.0%	1.0%
Average Increase 2005-2007			13.3%													
Proposed Positions									**One Pod in the Center for Short Stay Care**					**5**	**6**	**5**

Volumes were projected at 2% per year through 2015 and then only 1% through 2020. Reimbursement changes and/or shift to home health for some treatments may affect the overall long-term volume.
Treatments included: Infusion (non-chemo), antibx, transfusion, Ferrlicit, epidural blocks, port draws, etc.
Source: PCH - Surgical Services, NCI Consulting

ATTACHMENT MOD-11

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

PHARMACY SERVICES

			Projected Growth													
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
DOSES																
Inpatient	1,367,718	1,325,912	1,447,592	1,682,748	1,733,230	1,785,227	1,838,784	1,893,948	1,950,766	2,009,289	2,069,568	2,131,655	2,195,604	2,261,473	2,329,317	2,399,196
Outpatient*	106,552	155,870	159,748	169,936	175,034	180,285	185,694	191,264	197,002	202,912	209,000	215,270	221,728	228,380	235,231	242,288
Total	1,474,270	1,481,782	1,607,340	1,852,684	1,908,265	1,965,512	2,024,478	2,085,212	2,147,769	2,212,202	2,278,568	2,346,925	2,417,332	2,489,852	2,564,548	2,641,484
% of Change		0.5%	8.5%	15.3%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Average Increase 2005-2007			4.5%													
ORDERS																
Total		660,888	706,538	791,712	815,463	839,927	865,125	891,079	917,811	945,348	973,708	1,002,917	1,033,005	1,063,995	1,095,915	1,128,792
Average Increase 2006-2007			6.9%	12.1%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
FTEs	51	51	53	53	53	53	53	53	55	55	55	55	57	60	60	60

*Outpatient includes Emergency Department
Orders data provided beginning with conversion to Meditech Information system (2006) for consistency
Annualized Jan-Mar 2008
Source: PCH - Pharmacy statistics

ATTACHMENT MOD-1J

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PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

ECG/EKG:

	Historical		Projected Growth													
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Number of ECG/EKG Procedures:																
Inpatient	18,591	19,626	21,273	21,698	22,132	22,575	23,027	23,487	23,957	24,436	24,925	25,423	25,932	26,450	26,979	27,519
Outpatient*	11,921	15,690	14,675	14,969	15,268	15,573	15,885	16,202	16,526	16,857	17,194	17,538	17,889	18,247	18,611	18,984
Total	30,512	35,316	35,948	36,667	37,400	38,148	38,911	39,689	40,483	41,293	42,119	42,961	43,820	44,697	45,591	46,503
Annual % Change		*15.7%*	*1.8%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*
Average change 2005-2007			8.8%													

CARDIOLOGY:

	Historical		Projected Growth													
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Number of Procedures:																
Inpatient	37,333	36,187	39,168	39,951	40,750	41,565	42,397	43,245	44,110	44,992	45,892	46,809	47,746	48,700	49,674	50,668
Outpatient*	22,659	27,075	25,312	25,818	26,335	26,861	27,399	27,946	28,505	29,076	29,657	30,250	30,855	31,472	32,102	32,744
Total	59,992	63,262	64,480	65,770	67,085	68,427	69,795	71,191	72,615	74,067	75,549	77,060	78,601	80,173	81,776	83,412
Annual % Change		*5.5%*	*1.9%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*
Average change 2005-2007			3.7%													

Procedures included above under Cardiodiology:
ECG (EKG)
Stress
Stress Echo
Echo
Dobutamine Stress Echo
Adenosine Stress with Nuclear Imaging
Dobutamine Stress with Nuclear Imaging
Tilt Table
TEE (Transesophogeal Echo)
Holter Monitor
Event Monitor (30 day)
Pacemaker checks

** Outpatient includes Emergency Department*
Source: PCH - Cardiology Department statistics

ATTACHMENT MOD-1K

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

ADMISSIONS UNIT

	Projected Growth															
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Emergency Room																
Visits	47,055	48,490	48,854	48,516	49,438	50,377	51,334	52,310	53,304	54,316	55,348	56,400	57,472	58,563	59,676	60,810
Annual % Change		*3.0%*	*0.8%*	*-0.7%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*
Average Increase 2005 - 2007			*1.9%*													
Admitted from ED	15,699	14,652	15,510	15,980	15,820	16,121	16,427	16,739	17,057	17,381	17,711	18,048	18,391	18,740	19,096	19,459
Annual % Change		*-6.7%*	*5.9%*	*3.0%*	*-1.0%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*
Percent ED Visits Admitted	33.4%	30.2%	31.7%	32.9%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%
Admissions Unit																
ED Admissions	15,699	14,652	15,510	15,980	15,820	16,121	16,427	16,739	17,057	17,381	17,711	18,048	18,391	18,740	19,096	19,459
Observation Admissions (M/S & Peds)	2,696	4,769	4,067	3,792	3,906	4,023	4,144	4,268	4,396	4,528	4,664	4,804	4,948	5,096	5,249	5,406
Direct Admissions	1,829	3,955	3,798	3,879	3,996	4,116	4,239	4,366	4,497	4,632	4,771	4,914	5,062	5,214	5,370	5,531
Total	**20,224**	**23,376**	**23,375**	**23,651**	**23,722**	**24,260**	**24,810**	**25,373**	**25,950**	**26,541**	**27,146**	**27,766**	**28,400**	**29,050**	**29,715**	**30,397**
Annual % Change		*15.6%*	*0.0%*	*1.2%*	*0.3%*	*2.3%*	*2.3%*	*2.3%*	*2.3%*	*2.3%*	*2.3%*	*2.3%*	*2.3%*	*2.3%*	*2.3%*	*2.3%*
Average Increase 2005-2007			*7.8%*													
NUMBER OF BAYS	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**14**	**14**	**14**
IHFPB STANDARDs																
744.6 GSF per room																
Total GSF Allowed														*10,424*	*10,424*	*10,424*
2,000 Visits/Room (Bay)																
Number of Bays Allowed														*15*	*15*	*15*

With between 30-35% of ED visits resulting in an inpatient admission, PCH's ED acuity is higher than that of hospitals with lower ED admission rates
"2007 AHQ data corrected on May 1, 2008, as follows: M/S observation admissions were 3,699, not 3,402. Pediatric obs admission were 368 = total 4,067.
Source: PCH Utilization Statistics

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

OUTPATIENT & PRE-ADMISSION TESTING

	Historical		Projected Growth												
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
OUTPATIENT & PRE-ADMISSION TESTING**															
Outpatient Testing	77,766	77,842	78,000	78,000	78,000	78,000	78,000	78,000	78,000	78,000	78,000	78,000	78,000	78,000	78,000
Health Testing	4,406	3,587	3,800	3,800	3,800	3,800	3,800	3,800	3,800	3,800	3,800	3,800	3,800	3,800	3,800
Total	82,172	81,429	81,800	81,800	81,800	81,800	81,800	81,800	81,800	81,800	81,800	81,800	81,800	81,800	81,800
Annual % Change		*0.1%*	*0.2%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*

***Includes lab outpatient testing, outpatient EKG, pre-surgical testing including imaging and interview with nurse.*
Outpatient data provided beginning with conversion to Meditech Information system for consistency (2006).
Source: PCH Planning - Meditech ESS Utilization Statistics; 2008 annualized Jan-Jun

ATTACHMENT MOD-1M

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

INPATIENT DIALYSIS

	Historical			Projected Growth												
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Number of Patients	244	375	426	406	414	422	431	439	448	457	466	476	485	495	505	515
% Change		54%	14%	-5%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Average Increase 2005-2008				20.9%												
Number of Treatments	971	1,384	1,452	1,255	1,280	1,306	1,332	1,358	1,386	1,413	1,442	1,470	1,500	1,530	1,560	1,592
% Change		43%	5%	-14%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Average Increase 2005-2008				11.3%												

Exisiting stations	4
Proposed stations	4
Allowed GSF	1,880
Proposed GSF	1,105

Increase projected based on inpatient projections.
Annualized Jan-May 2008
Source: PCH - Hemodialysis statistics

-2555-

ATTACHMENT MOD-1N

MODERN FACILITIES
Deterioration

MEDICAL/SURGICAL SERVICES

The Hospital proposes to modernize Medical/Surgical (M/S) Services due to the age, condition and configuration of the nursing units. Four (4) of the Hospital's five M/S nursing units are over 30 years, obsolete, deteriorating and need to be replaced. The project discontinues 165 M/S beds in semi-private rooms in these units, converting the rooms to private rooms; renovates the rooms and nursing units to modern standards of care; and replaces the deteriorating infrastructure (plumbing and HVAC) in the buildings which house the units. The project replaces the 165 obsolete beds with 156 M/S beds in the East Wing.

Deterioration

Of the total 315 M/S beds, 95% (299 beds) were built by 1978 (see site plan and timeline in Attachment MOD-2A(1) for the construction dates of the inpatient units.) (The other 16 beds are in the new cardiovascular unit built in 2005.) The 299 M/S beds are in three (3) buildings: the South Building (Original Hospital) built in 1972; its East Building expansion built in 1974; and the North Building built in 1973.

The 299 M/S beds are on the 3rd and 4th Floors. See Attachment MOD-2A(2) for schematic assessments of the existing conditions in these units by Navigant Consulting, Inc. (NCI.) Deterioration of the M/S units is indicated by the following conditions:

- **Piping systems are failing, especially the plumbing risers. Problem systems include both hot water recirculation and sanitary line failures. The Hospital has replaced a limited number of these plumbing risers but, due to patient care disruption, intend to replace the remaining upon completion of the East Wing, in a phased patient room renovation minimizing disruption.**

- **The patient rooms have inadequate fresh air exchange. Patient rooms use fan-coil units to for heating, ventilation, and air conditioning (HVAC.) Modern healthcare design requires significantly more fresh air exchanges and does not allow fan-coil units.**

- **Patient rooms have inadequate oxygen-flow capacity which would require larger piping.**

- **Patient rooms in the South Building do not have medical air.**

- **Washrooms do not meet the handicapped accessibility (ADA) standards for size.**

- **Patient rooms are not protected by a fire sprinkler system.**

- **Sprayed on fireproofing is under the ceiling in the South Building and contains asbestos. Removal and replacement is safer as part of a major patient room renovation project when isolation is easier.**

Of the 299 M/S beds in aging structures, 284 beds (95%) are in obsolete, small, semi-private rooms (refer back to Attachment MOD-1C.) Besides lacking privacy, these rooms do not accommodate needed equipment; lack adequate toilet facilities; inhibit adequate infection control; and are a challenge to keep fully occupied due to companion issues. The nursing units are also obsolete and only have 259 gsf per bed (see below.)

The Project

The project discontinues 165 of these obsolete 299 M/S beds, identified by room number in Attachment MOD-1C(1), and builds 156 M/S replacement beds in the new East Wing, a net loss of 9 M/S beds. The replacement beds are in appropriately sized, private rooms and have small family/visitor zones with seating that converts for sleeping over (see prototypical M/S room in Attachment MOD-2A (3).) The replacement M/S units incorporate advanced, interactive technology which improves patient care, communication and efficiency. The new units provide space for visiting clinicians i.e. pharmacists, therapists, physicians, which enhances multi-disciplinary, patient-focused care. For operational and functional description of the units, see Attachment MOD-2A(4); schematic design is in Attachment MOD-2A(5).

When East Wing construction is complete, the remaining 134 M/S beds (299 – 165 =134), would be completely refurbished over a four-year period in a second phase of modernization. Upon project completion the Hospital will have 306 M/S beds with state-of-the art facilities.

Necessary Replacement

The need for 306 M/S beds is based on increasing M/S utilization, numerous elderly, seriously ill patients, and continued growth and aging of the service area population. M/S days increased 5.8% per year between 2005 and 2007 (see Attachment MOD-2A(6).) The growth is due to higher lengths of stay (ALOS), principally from elderly patients who have more serious illnesses and conditions, and more observation patients. Observation patients are treated in inpatient units to conserve experienced, nursing staff whose numbers are at a premium.

Between 2005 and 2007 the Hospital's M/S ALOS increased 8%, from 4.39 days to 4.74 days. This increase is due principally to the Hospital's high number of seriously ill, elderly admits. In 2005 the Hospital admitted far more patients from skilled nursing facilities (SNFs) than any other Illinois hospital. See Attachment MOD-2A(7) which shows that Palos admitted 887 SNF patients in 2005 which is almost 50% higher than the next highest hospital which admitted only 605 patients! Yet, the Hospital's ALOS is lower than the 4.8 day average of other hospital's in Planning Area A-4 (see Attachment 2A(8).)

The high number of elderly admissions is due to the high elderly population in the service area, 12.8% of population, which is higher than Illinois or the U.S. See Attachment MOD-2A(9) for documentation of this ratio and the substantially higher inpatient use rates in the service area for this population. Similarly, while the Hospital's overall market share is 23.5%, it serves between 27% and 30% of the area's elderly (see Attachment GRC-4(4).) Given the medical needs of the elderly, combined with their chronic disease conditions, patients tend to be sicker.

Another indication that the Hospital's M/S patients have higher acuity is reflected in the Hospital's high co-morbidity index which is among the highest in Illinois (see Attachment MOD-2A(10).)

As M/S utilization increased at an average of 5.8% per year between 2005 and 2007, occupancy rates also increased, from 73% to 79% on staffed beds. However, the need to replace M/S beds is higher than occupancy rates indicate due to the following:

Lack of support space on the units constrains the ability to staff more than 278 beds and renovation will take 134 beds out of service over a four-year period;

Peak census statistics require 8 beds above average occupancies; and

Semi-private rooms are a challenge to fully occupy due to companion issues i.e. gender and infection control issues, forcing patients to wait for service in the ED when a bed may be empty in an unusable semi-private room.

As M/S occupancy continues to rise, the Hospital continues to staff more beds, from 267 to 278 beds, respectively, between 2005 and 2008. After M/S occupancy reached 90% in January 2008 on 274 staffed beds, the Hospital relocated Respiratory Therapy from M/S Unit 3 – North to the main floor to open four (4) additional M/S beds (see Attachment MOD-2A(11) for recent, monthly occupancy and schematics of 3-North.)

Due to a lack of support space in the units, the Hospital is unable to staff additional beds. While the 299 beds are either physically available or in reserve, support space for staff, equipment, and supplies are at maximum capacity. No space is available for family/visitors. The 315 beds have 93,260 gross square feet (gsf.) See Attachment MOD-2A(12). The 299 M/S have 77,300 gsf, or 259 gsf per bed, as the 16-bed CVU built in 2005 occupies 10,945 gsf. The M/S units' limited space is another measure of obsolescence. Medical carts are routinely "stored" in corridors. Routine supplies i.e. isolation carts, IVAC pumps, bedside commodes, geri-chairs etc. are stored in remote locations and must be delivered to the unit when needed.

With modest increases of 2.5% per year in patient days, which is less than half of the actual annual growth of 5.8% over the last three years, the 278 staffed beds would be 88% occupied by 2013 when the major renovation begins (refer back to Attachment MOD-2A(6).) The renovation will require the Hospital to close one nursing unit per year for four (4) years. Patients will be forced into fewer beds, and occupancy will exceed 90% during the renovation.

Occupancy rates, whether on licensed or staffed beds, mask the need to cover the peak census. See Attachment MOD-2A(13) which indicates that the Hospital's midday census averaged an additional 8 patients more than its midnight census.

The overlap in discharges and admissions in the midday which cause the peak census, also contribute to over-crowding in the Emergency Department (ED), when a MS bed is not available. In the first three months of 2008 over 41% of ED patients waited at least 2 hours for admission bed. Another 11% waited at least 8 hours for admission.

The need to replace and renovate 290 M/S beds (156 replacement beds in the East Wing and 134 renovated beds in existing M/S units) is also based on growth and aging in the service area population. Service area population is expected to increase 1.0% per year from 2007 through 2020 (see population projections in Attachment GRC-4.) The service area's elderly population is expected to increase 2.5% per year through 2012. The elderly are the fastest growing population in the service area.

Compliance with IHFPB Target Utilization

M/S patient days are expected to grow at a modest 2.5% per year, significantly less than the actual growth of 5.8% per year between 2005 and 2007 and congruent with the projected increase of the service area's elderly population through 2012. With this modest growth the Hospital's 306 M/S beds would be appropriately utilized at over 88% as follows:

Medical/Surgical Occupancy – 2020

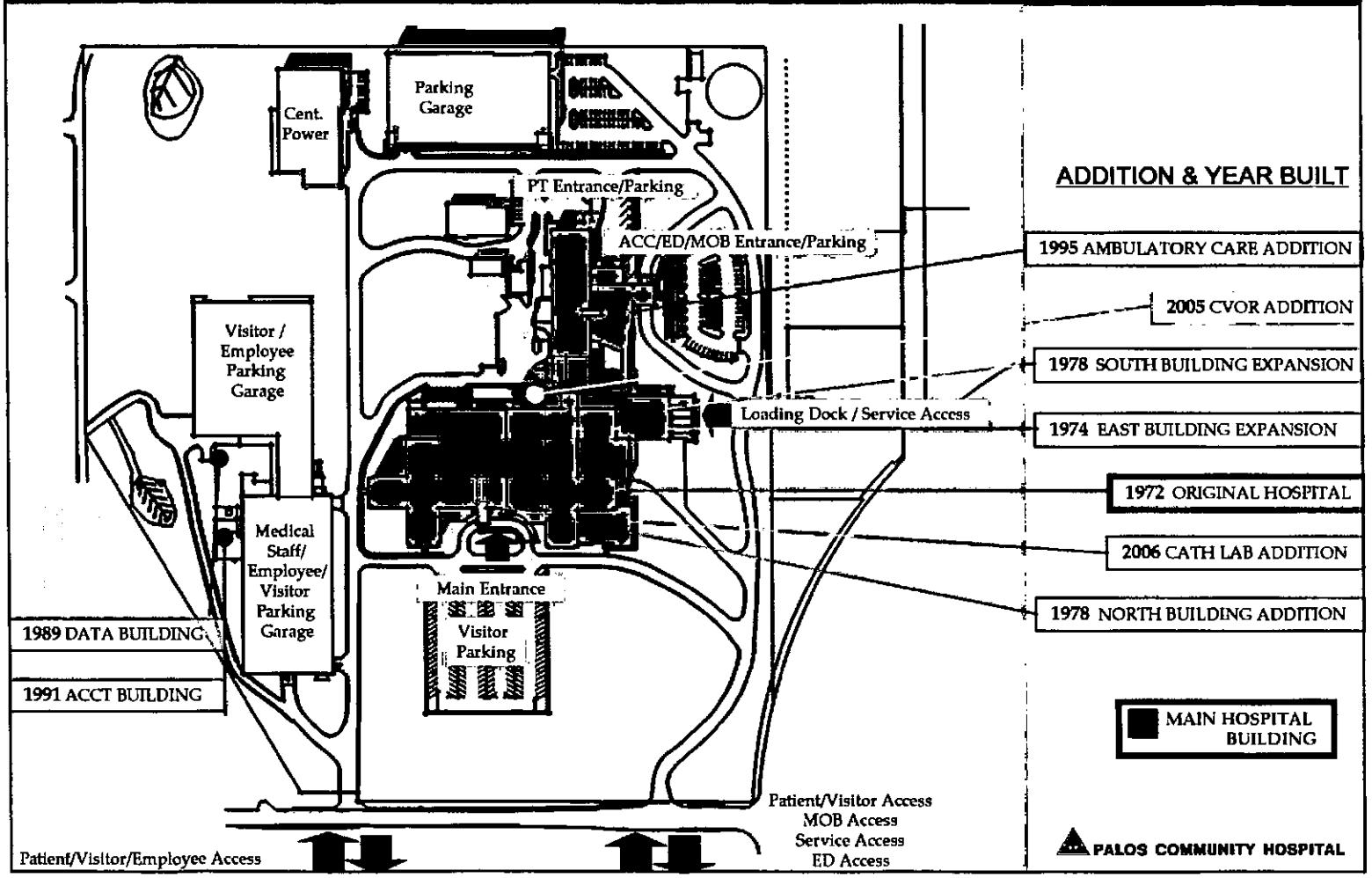
Beds	M/S Patient Days Only	IHFPB Standards	Beds Allowed
306	103,945	88%	324

Beds	M/S Days with Observation	IHFPB Standards	Beds Allowed
306	109,044	88%	339

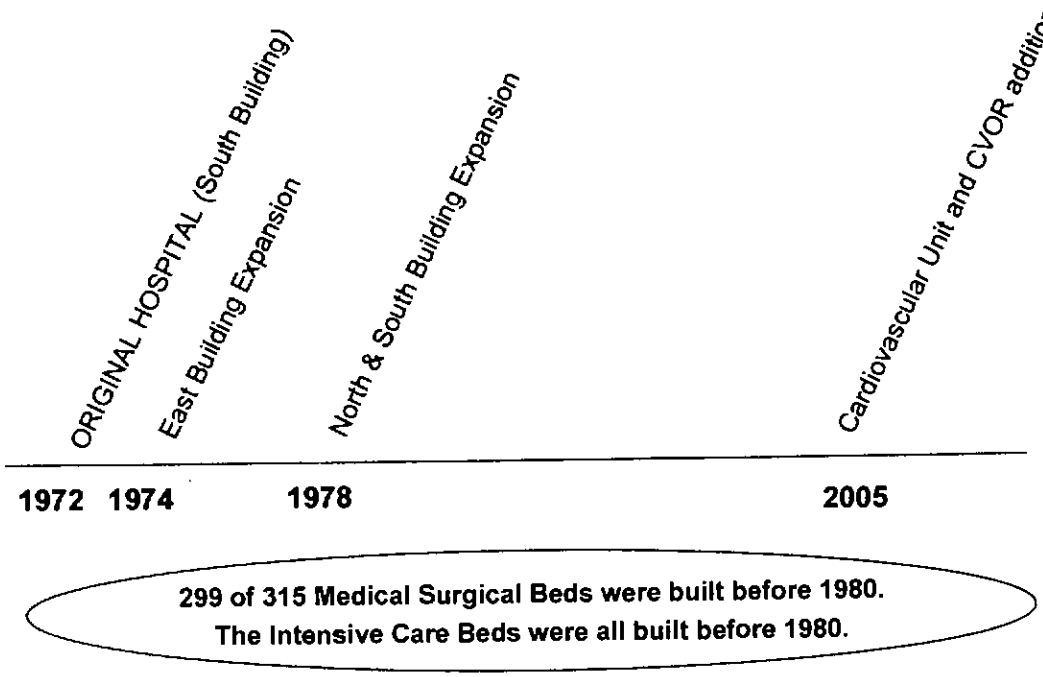
While the Hospital has 16 modern M/S beds, the other 299 are deteriorating and obsolete. The Hospital needs to replaec 290 of these 299 beds (156 replacement beds in the East Wing and 134 modernized beds) to ensure access to modern M/S services in the community.

Upon project completion the Hospital would have 306 modern M/S beds.

Palos Community Hospital
Existing Campus – Facilities / Site Plan



Opening Dates of Existing Patient Care Units



299 of 315 Medical Surgical Beds were built before 1980.
The Intensive Care Beds were all built before 1980.

Source: PCH Planning

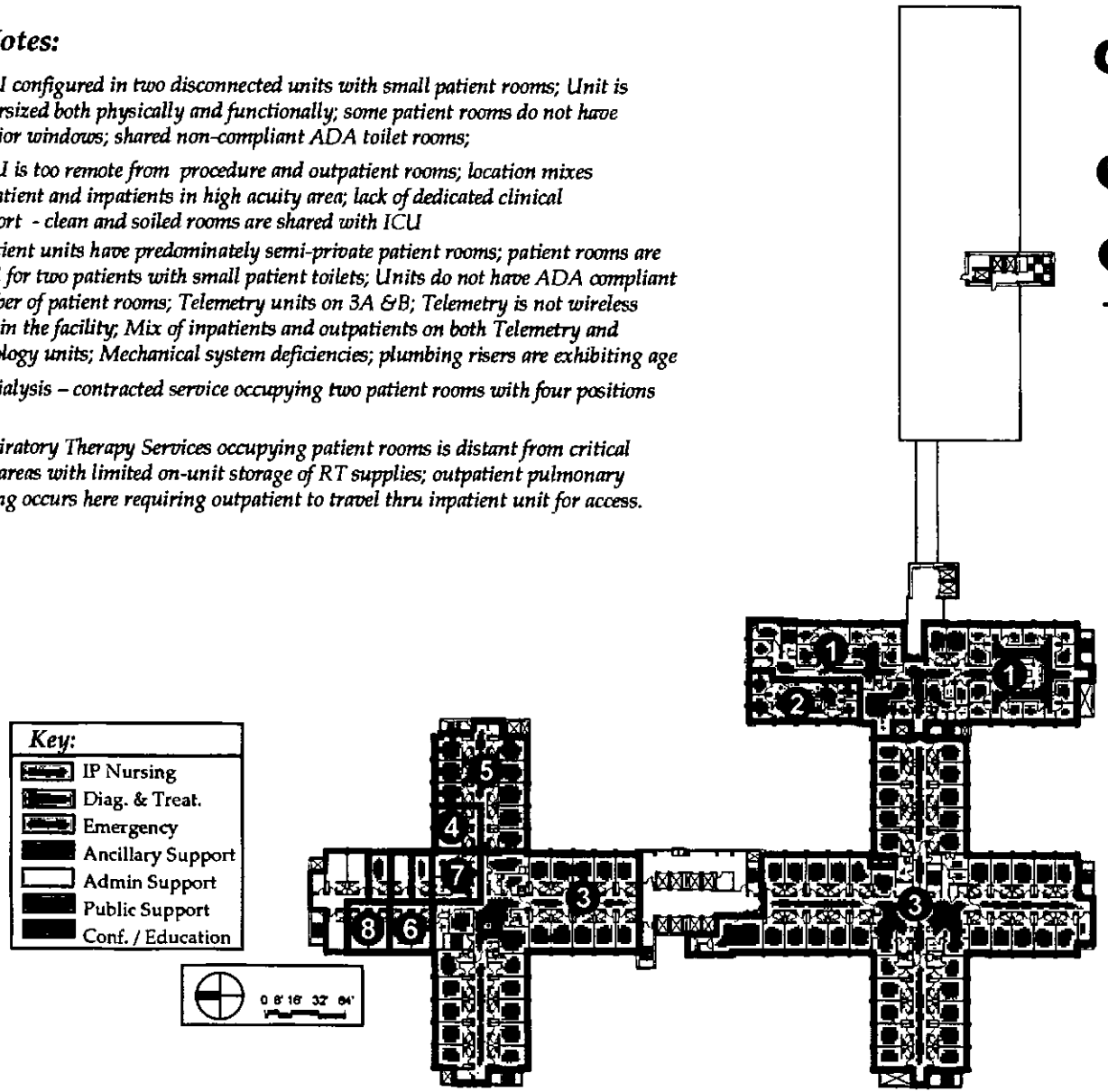
Existing Conditions Overview –Level 3

Key Notes:

1. *ICCU configured in two disconnected units with small patient rooms; Unit is undersized both physically and functionally; some patient rooms do not have exterior windows; shared non-compliant ADA toilet rooms;*
2. *SSTU is too remote from procedure and outpatient rooms; location mixes outpatient and inpatients in high acuity area; lack of dedicated clinical support - clean and soiled rooms are shared with ICU*
3. *Inpatient units have predominately semi-private patient rooms; patient rooms are small for two patients with small patient toilets; Units do not have ADA compliant number of patient rooms; Telemetry units on 3A &B; Telemetry is not wireless with in the facility; Mix of inpatients and outpatients on both Telemetry and Oncology units; Mechanical system deficiencies; plumbing risers are exhibiting age*
4. *IP Dialysis – contracted service occupying two patient rooms with four positions*
6. *Respiratory Therapy Services occupying patient rooms is distant from critical care areas with limited on-unit storage of RT supplies; outpatient pulmonary testing occurs here requiring outpatient to travel thru inpatient unit for access. ****

6. *OP EEG operates out of two inpatient rooms; patients must access area thru inpatient unit; Noise from corridor can be disruptive to testing*
7. *IV Therapy and Wound Care are located at the 3D Nurse station. The station houses the staff and supplies;*
8. *2 patient rooms (4 beds) being utilized as on-call rooms.*

**** Respiratory Therapy – moving to 1st floor to vacant patient rooms on 3D. Call rooms will relocate to this space along with IV Therapy office and clear 370s corridor for patient rooms.*



April 2006

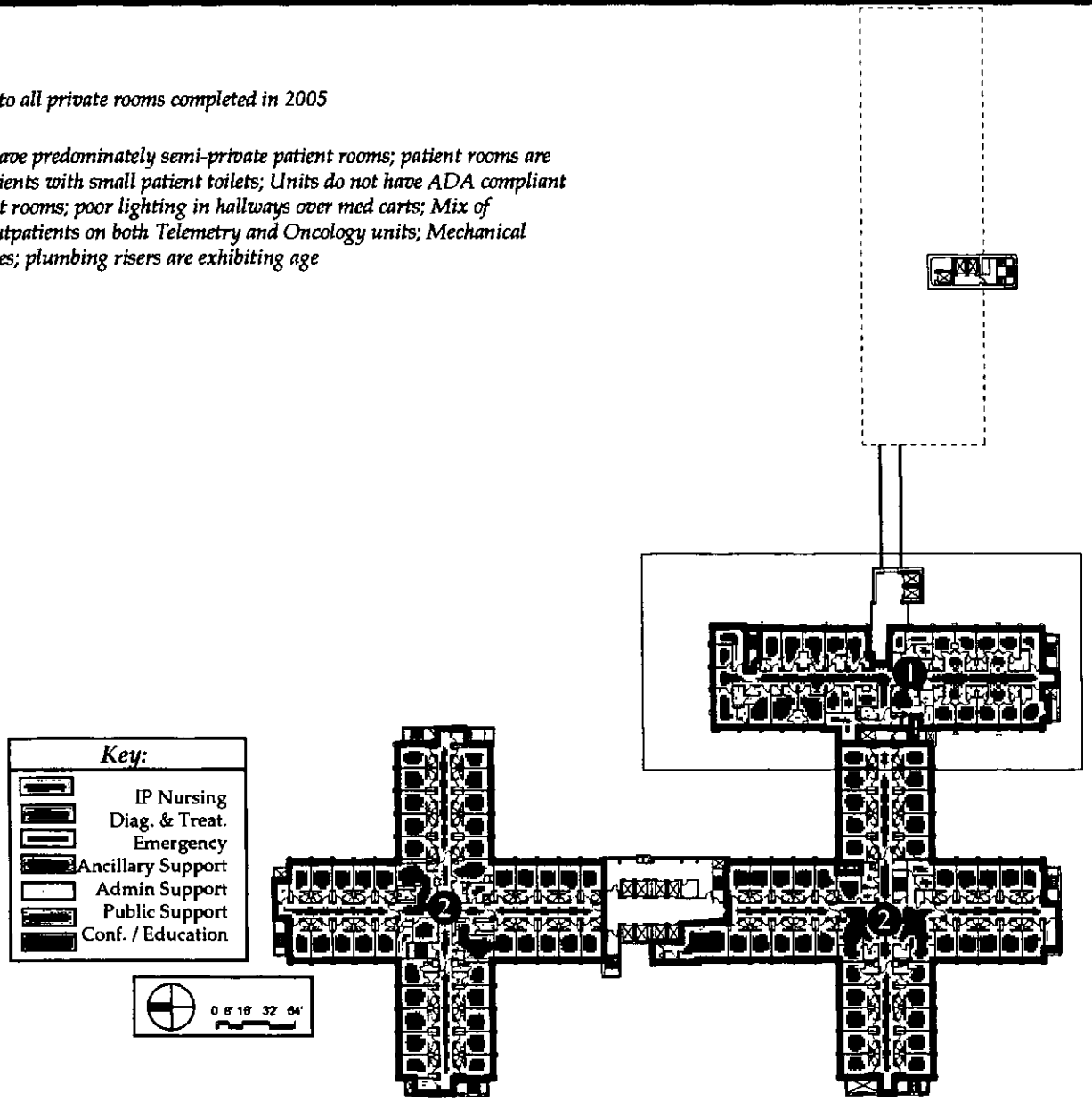
NAVIGANT CONSULTING

Existing Conditions Overview –Level 4

Key Notes:

1. *CVU renovation to all private rooms completed in 2005*

2. *Inpatient units have predominately semi-private patient rooms; patient rooms are small for two patients with small patient toilets; Units do not have ADA compliant number of patient rooms; poor lighting in hallways over med carts; Mix of inpatients and outpatients on both Telemetry and Oncology units; Mechanical system deficiencies; plumbing risers are exhibiting age*



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ATTACHMENT MOD-2A(2)
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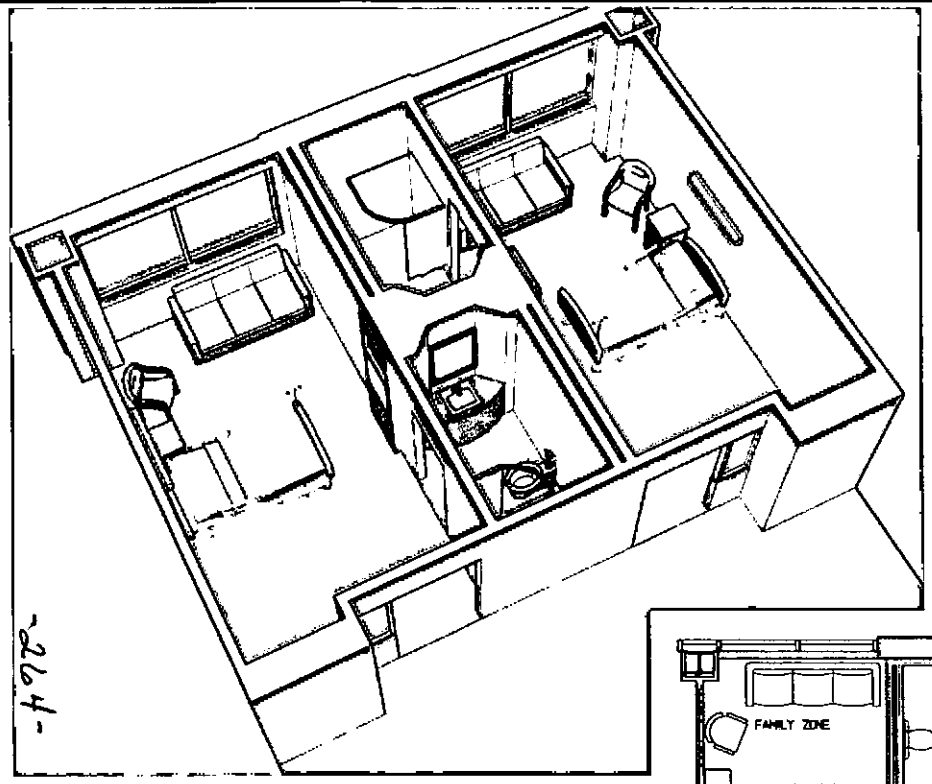
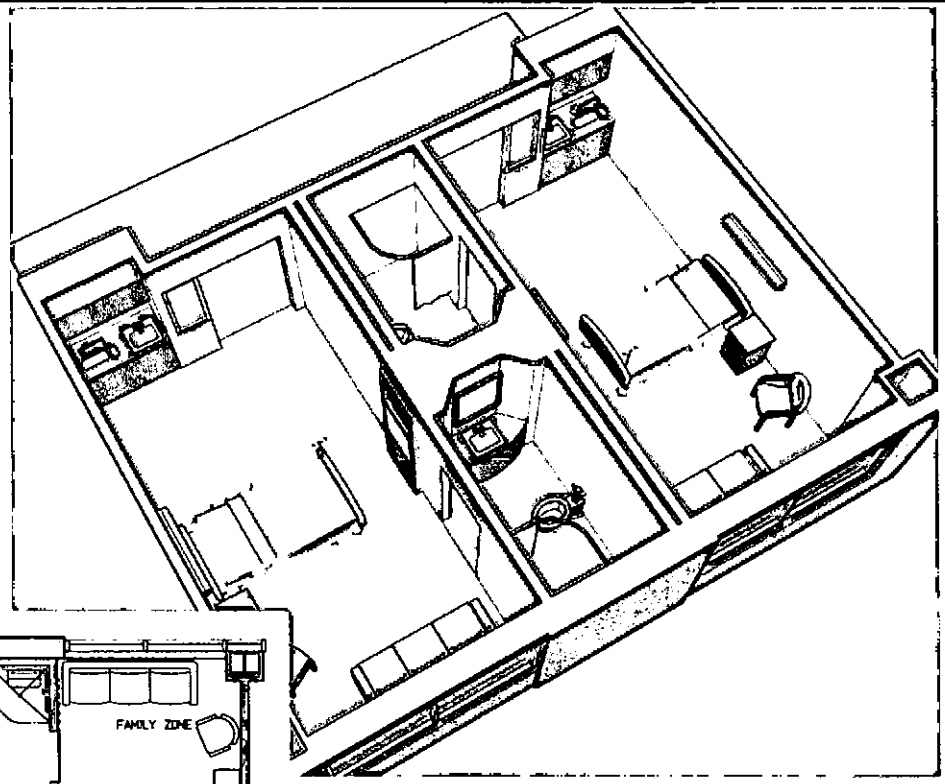
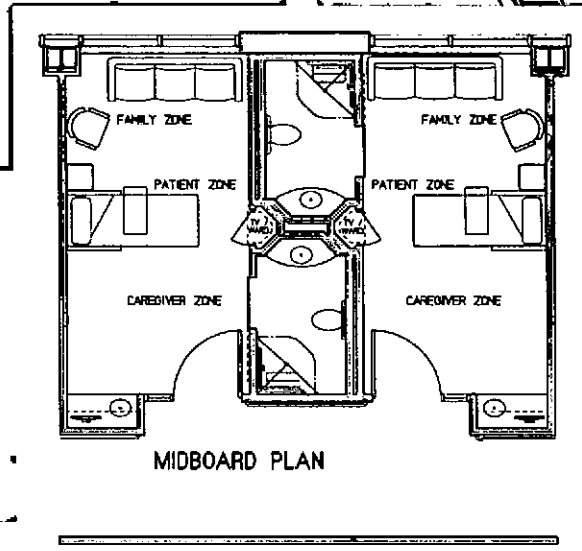
NAVIGANT CONSULTING

Palos Community Hospital
Med/Surg Prototype







MIDBOARD PLAN

255 SF

165 Net Usable SF

M&CA

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ATTACHMENT MOD-2A(3)

Acute Care Units- General Description

Acute Care Unit Design Principles

Palos Community Hospital's new Acute Care Inpatient Units will provide nursing services to both medical and surgical patients. The design of the Acute Care Units is to be based on the following key operational concepts:

All rooms are to be private and configured to include:

- Patient zone with monitoring capabilities and headwall medical gases.
- Staff zone with hand-washing and documentation/work space both occurring in the room
- Full patient toilet and shower to allow for future flexibility of room utilization (i.e., step-down or universal bed models).
- Family zone with seating area that converts to sleeping function.

Units are to be configured into "pods" of beds:

- Each pod consists of 18 beds.
- Pod support areas are to be organized around a central team station with convenient access to clean supplies, medication dispensing/prep areas and nourishment station.
- Unit configuration should support family/visitor involvement including a small family sub-waiting area located within the unit itself.

Units to be planned to employ advanced, interactive technology:

- Patient monitoring system that allows interfacing from multiple locations (patient bedside, pod support area, team area, off-site).
- Bedside scanning and real-time documentation to promote safe care administration.
- Electronic Medical Record linking patient history, vitals, medications, tests, etc. to the network of providers.
- Secure online order entry system for testing and medications (as well as transport, etc.) accessible from multiple locations.

Acute Care Units - General Description

Acute Care Unit Design Principles *(continued)*

Units should support multidisciplinary patient care practices:

- Clinical pharmacists to be deployed to support the units.
- Non-unit provider support space to be provided to allow for space for documentation, access to phone and reference material.

Communication systems providing:

- Two-way, tiered, real-time communication between patient and nurse (as appropriate).
- Two-way, real-time communication between care delivery team and non-clinical support staff.
- Direct communication between physician and nurse (VoIP).
- Multiple lines of communication are supported and leveraged to minimize noise from overhead paging.

During the functional space planning process, the planning team completed a matrix of leading critical care operational practices. The matrix indicates which leading practices are currently in place now, could be implemented now and/or should be designed in to the operational and physical planning on the new units. A prioritization of these practices (high, medium, and low) was indicated by the team. Any impact on the design of the facility (flow, adjacency, square foot, cost) was then determined. Only some of the practices have a significant facility related impact, as such any support partner for integrating these concepts is also indicated (IT, supply chain, facilities management). The supply chain category was applied for all logistics/materials partners such as dietary, pharmacy, lab, housekeeping etc. Ideally, the various support partners should follow-up with the planning team to indicate their ability to continue and/or implement these leading practices in the future.

Acute Care Units - Operational Overview

Patient Care / Clinical Operations

The design of the Acute Care Units will facilitate a patient-focused care delivery model that is versatile and mobile, such that can be executed from strategically positioned sites at various levels of proximity to the bedside. Nursing staff should have the ability to carry out monitoring and charting functions from the bedside, from caregiver workstations positioned immediately outside patient rooms, or from each pod's team workstation.

The team workstation supporting the 18 bed pod is to sized for four staff at any given time and is to include the central monitoring station. The physicians will have access to a separate MD workroom each with four workstations to avoid congestion and noise at the main team station. The optimal location of the MD workroom – adjacent to the team station or closer to the unit secretary – is to be finalized during schematic design. The location of MD workroom is linked to the timeline around the implementation of physician order entry in that until such time this function becomes fully operational, there will be a need for the MDs to be close to the unit secretary.

Automated medication dispensing stations will be deployed at one for every 18 beds in order to facilitate convenient access to medications and minimize wait times during peak activity periods. STAT and special order medications will be delivered via a pneumatic tube station from the main pharmacy. A tube station is to be located at the main unit secretary workstation.

A nourishment station, and clean and soiled utility rooms are to be centrally located within each 18-be pod to minimize travel distances and decrease staff "catch and fetch" activities. If the configuration allows, the clean and soiled utility rooms should ideally be accessed from both sides of the corridor. One linen cart alcove is to be provided that will be shared among the 18 beds. While each 18-bed pod has a dedicated report/conference room, they do not necessarily have to be located within the primary 18-bed clinical area. Each pod will have a separate report at shift change and thus two rooms are required.

While every two beds has an adjacent equipment/cart alcove to stage frequently used equipment or carts, such as contact isolation carts, less frequently used equipment and specialty carts are to be stored in large equipment room on each 36- bed unit. A stretcher/wheelchair storage area is to be located on each floor. All bed storage is to occur off the floor in a central location.

In support of a multi-disciplinary care team, non-unit caregivers such as the clinical pharmacists, dieticians, social workers and case managers will be provided a separate workroom on each 36-bed unit to support their clinical activities while on the floor.

Non-clinical Support Spaces

Support spaces for staff, administrative activities, and family/visitors will be provided on each 18-bed unit. The design of the staff and family support areas in particular should convey a calm or "off-stage" atmosphere. Staff support space for each unit should be aggregated together and positioned in an area relatively proximate to the main patient care zones yet maintaining separation and quiet. Since the staff does not typically change clothes on the unit, a shared locker room for both male and female staff will be provided. The locker room is to be configured with "Z" style lockers and a separate coat closet for longer items. Two staff toilets are to be provided adjacent to the locker rooms. A staff lounge with pantry area and is to accommodate 8 staff in a dining style seating arrangement.

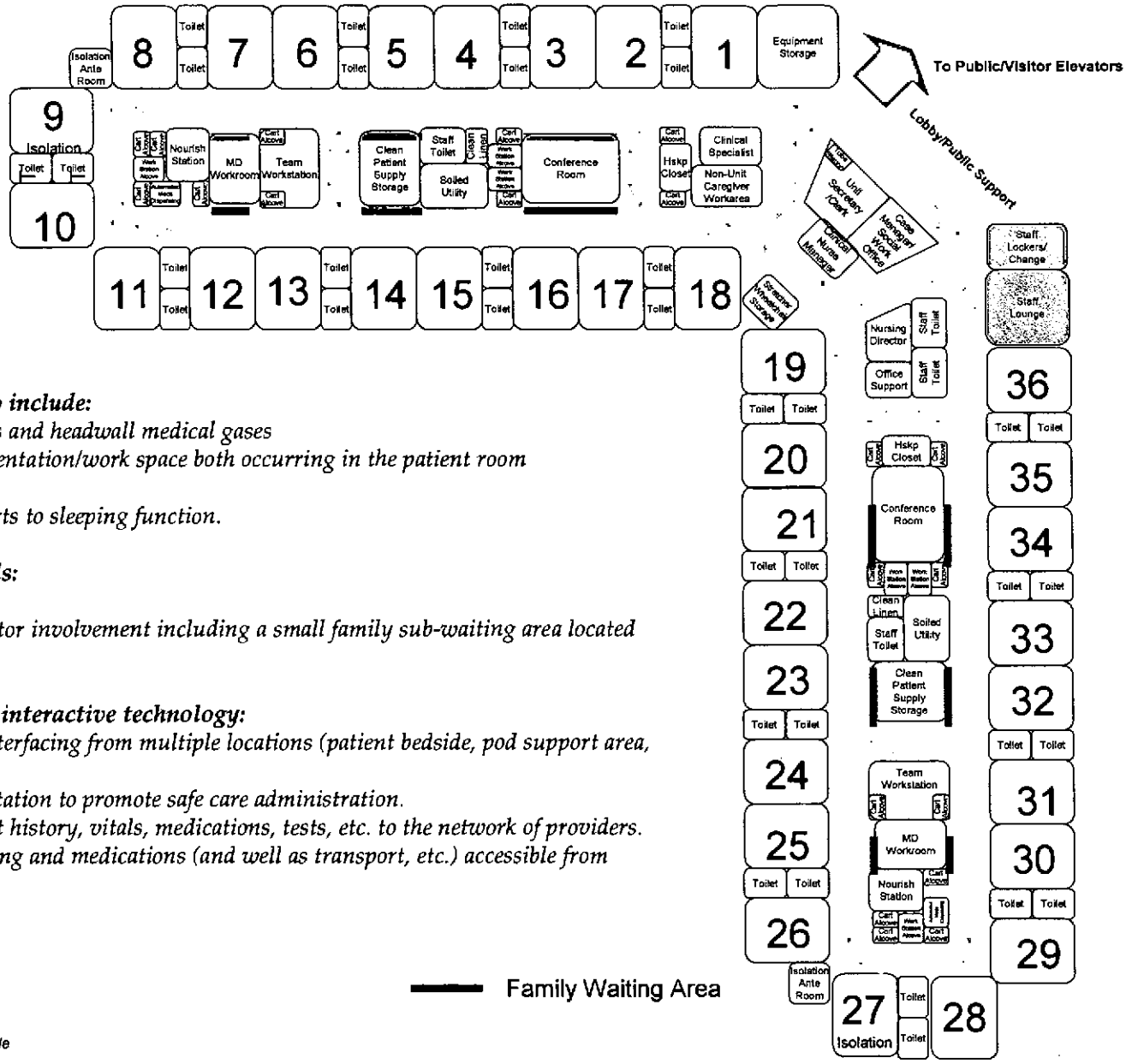
The family support for each 36-bed unit should be located to avoid cross-traffic of clinical staff and material flows. The area is to be supervised the unit secretary workstation positioned between the internal space of the unit and the family waiting room. The family waiting area is to accommodate approximately 18 people and should be arranged into separate casual seating groups. Additional family support includes educational/business workstations for access to internet and phone, a hospitality station and a hospitality stations adjacent to provide access to coffee, refrigerator, ice machine, and vending. In addition, smaller family sub-waiting areas located on each 18-bed pod will allow a place for family members to step outside of the room during procedure or exams without having to return to the main waiting area.

Administrative support for each unit is to include a private office for the Nursing Director and Clinical Nurse Manager, as well as, two shared offices that will accommodate the Charge Nurse, Clinical Educator, Case Manager and Social Worker. One additional office on each unit is programmed for a Clinical Specialist, but this office may not be required on each unit as the Clinical Specialist may actually cover two units. In addition to the office space, a central area for a large floor copier, scanner/fax, and storage of office supplies is to be provided.

Proposed Hours of Operations

24 hours / 7 days per week

EAST WING ADDITION
Prototypical Med/Surg Unit



All rooms are private and configured to include:
- *Patient zone with monitoring capabilities and headwall medical gases*
- *Staff zone with hand washing and documentation/work space both occurring in the patient room*
- *Full patient toilet and shower*
- *Family zone with seating area that converts to sleeping function.*

Units are configured into "pods" of beds:
- *Each pod consists of 18 beds.*
- *Units configuration supports family/visitor involvement including a small family sub-waiting area located within the unit itself.*

Units are planned to employ advanced interactive technology:
- *Patient monitoring system that allows interfacing from multiple locations (patient bedside, pod support area, team area, off-site).*
- *Bedside scanning and real-time documentation to promote safe care administration.*
- *Electronic Medical Record linking patient history, vitals, medications, tests, etc. to the network of providers.*
- *Secure online order entry system for testing and medications (and well as transport, etc.) accessible from multiple locations.*

Note: Not all program elements shown.
Diagrams illustrate adjacencies and flow & are not to scale

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED UTILIZATION

MEDICAL/SURGICAL

	Historical			Projected												
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Medical Surgical Admissions	15,840	15,292	15,892	16,289	16,697	17,114	17,542	17,980	18,430	18,891	19,363	19,847	20,343	20,852	21,373	21,907
% Change		-2.2%	3.9%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
Medical Surgical Patient Days	66,617	71,241	75,404	77,289	79,221	81,202	83,232	85,313	87,446	89,632	91,872	94,169	96,523	98,937	101,410	103,945
% Change		6.8%	5.8%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
* Observation Patient Days	2,253	4,395	3,699	3,791	3,886	3,983	4,083	4,185	4,290	4,397	4,507	4,620	4,735	4,853	4,975	5,099
% Change		95.1%	-15.8%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
Total Medical Surgical Unit Days	70,870	75,636	79,103	81,081	83,108	85,185	87,315	89,498	91,735	94,029	96,379	98,789	101,259	103,790	106,385	109,044
% Change		6.7%	4.6%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
Average Increase 2005-2007			**5.8%**													
Average Daily Census (ADC)	194	207	217	222	228	233	239	245	251	258	264	271	277	284	291	299
Average Length of Stay (ALOS)	4.39	4.66	4.74	4.74	4.74	4.74	4.74	4.74	4.74	4.74	4.74	4.74	4.74	4.74	4.74	4.74
Licensed Medical Surgical Beds	315	315	315	315	315	315	315	315	315	315	315	315	306	306	306	306
Staffed Medical Surgical Beds	266	267	274	278	278	278	278	278								
ds in Transition due to Modernization (134)									-32	-34	-34	-34				
** Total Beds Physically Available	315	315	315	315	315	315	315	315	283	281	281	281	306	306	306	306
Occupancy of Licensed Beds	62%	66%	69%	71%	72%	74%	76%	78%	80%	82%	84%	86%	91%	93%	95%	98%
Occupancy of Staffed Beds	73%	78%	79%	80%	82%	84%	86%	88%								
Occupancy of Physically Available Beds	62%	66%	69%	71%	72%	74%	76%	78%	89%	92%	94%	96%	91%	93%	95%	98%
CON Justified M/S Beds (@ 88%)	221	235	246	252	259	265	272	279	286	293	300	308	315	323	331	339

Observation patients are treated on medical surgical patient care units.

* The significant increase in inpatients in 2007 and 2008 was due to an overly conservative interpretation of CMS rules relating to observation status by hospital staff in 2006, resulting in a higher volume of patients placed in observation status. Implementation of case management review and physician documentation of inpatient criteria resulted in appropriate classification of patients, and more inpatients.

** The project modernizes 134 M/S beds converting the beds to private rooms. These beds are in four nursing units; one nursing unit will be modernized per year after construction of the East Wing .

Annualized Jan-Jun 2008

Source: PCH Meditech Utilization Statistics/Planning; Projections - NCI Consulting

PCH Serving the SNF Population

Transfers from Skilled Nursing Facilities (SNFs), 2005

Hospital	Admit Source: Transfer from SNF
Palos Community Hospital	887
Kindred Hospital - Chicago Northlake	605
Rockford Memorial Hospital	468
Rush North Shore Medical Center	356
Silver Cross Hospital	271
Adventist Hinsdale Hospital	209
Saint Mary Of Nazareth Hospital Center	188
Advocate Christ Hospital & Medical Center	185
Holy Cross Hospital	184
Vista Health-Victory Memorial Hospital	156
Advocate South Suburban Hospital	155
St Francis Hospital & Health Center - Blue Is.	135
Oak Forest Hospital Of Cook County	131
Advocate Lutheran General Hospital	118
Adventist Lagrange Memorial Hospital	113
Macneal Hospital	107

- Reinforcing the point that PCH currently serves an older patient population in comparison to other Illinois hospitals:
  - Of all hospitals in the state, PCH admitted, by far, the most transfers from skilled nursing facilities (SNFs) in 2005
  - Local competitors such as Christ, South Suburban and St. Francis also ranked highly on the list, but were far behind PCH in volume of transfers/admissions from SNFs

Source: COMPdata, NCI Analysis.

COMPARISON OF AVERAGE LENGTH OF STAY

Planning Area A-4 Hospitals

MEDICAL/SURGICAL

Planning Area A-4 Hospitals	Admissions	2007 Total Days	ALOS
Adventist LaGrange Memorial Hospital	7,036	33,752	4.8
Advocate Christ Medical Center	25,030	120,203	4.8
Advocate South Suburban Hospital	10,248	39,968	3.9
Ingalls Memorial Hospital	13,682	59,616	4.4
Little Company of Mary Hospital & Health Care Center	12,760	55,266	4.3
Oak Forest Hospital	1,976	15,820	8.0
Palos Community Hospital	**15,892**	**75,404**	**4.7**
RM Health Providers Limited Partnership	777	25,200	32.4
St. Francis Hospital & Health Center	10,339	48,808	4.7
St. James Hospital & Health Center (Olympia Fields)	9,132	39,289	4.3
St. James Hospital & Health Center (Chicago Heights)	9,388	44,486	4.7
TOTALS	116,260	557,812	**4.8**

INTENSIVE CARE

	Direct Admissions	2007 Total Days	ALOS
Adventist LaGrange Memorial Hospital	599	3,836	6.4
Advocate Christ Medical Center	3,869	26,180	6.8
Advocate South Suburban Hospital	950	4,698	4.9
Ingalls Memorial Hospital	348	7,339	21.1
Little Company of Mary Hospital & Heath Care Center	937	8,664	9.2
Oak Forest Hospital	385	2,020	5.2
Palos Community Hospital	**1,693**	**5,942**	**3.5**
RM Health Providers Limited Partnership	0	0	0.0
St. Francis Hospital & Health Center	1,328	5,773	4.3
St. James Hospital & Health Center (Olympia Fields)	1,061	5,712	5.4
St. James Hospital & Health Center (Chicago Heights)	688	3,615	5.3
TOTALS	11858	73,779	**6.2**

Source: Illinois Department of Public Health, 2007 AHQ Hospital Profiles.
Note: AHQ ALOS calculation for Palos' M/S was 5.0, a calculation discrepancy.

ATTACHMENT MOD-2A(8)

Inpatient Utilization - PCH Service Area (2004 - 2007)

	2004	2005	2006	2007*	2007 (9 mos)
Total Inpatient Admissions Age 0-17, PCH Service Area	5,698	6,254	5,906	3,103	2,327
Total Inpatient Admissions Age 18-44, PCH Service Area	18,316	19,448	18,458	19,460	14,595
Total Inpatient Admissions Age 45-64, PCH Service Area	18,234	20,211	20,247	21,528	16,146
Total Inpatient Admissions Age 65+, PCH Service Area	32,161	35,580	35,126	36,496	27,372
PCH Service Area Population Age 0-17	152,869	153,585	154,191	154,800	
PCH Service Area Population Age 18-44	219,684	219,968	220,295	220,623	
PCH Service Area Population Age 45-64	156,508	160,826	164,784	168,840	
PCH Service Area Population Age 65+	76,514	78,388	79,296	80,215	
Inpatient Utilization Per 1,000 Pop. Age 0-17, PCH Service Area	37.27	40.72	38.30	20.04	
Inpatient Utilization Per 1,000 Pop. Age 18-44, PCH Service Area	83.37	88.41	83.79	88.20	
Inpatient Utilization Per 1,000 Pop. Age 45-64, PCH Service Area	116.50	125.67	122.87	127.51	
Inpatient Utilization Per 1,000 Pop. Age 65+, PCH Service Area	420.33	453.90	442.97	454.98	
Age 65+ Utilization Growth Rate		*8.0%*	*-2.4%*	*2.7%*	
Total Inpatient Admissions (Source: COMPdata)	**74,409**	**81,493**	**79,737**	**80,587**	60,440
Total Service Area Population (Source: Claritas)	**605,575**	**612,767**	**618,567**	**624,478**	
Inpatient Utilization (Admits per 1,000 Population)	**122.87**	**132.99**	**128.91**	**129.05**	

*2007 COMPdata figures annualized based on 9 months of actual data (Jan-Sept).

Note: Analysis does not include normal newborns (DRG 391).

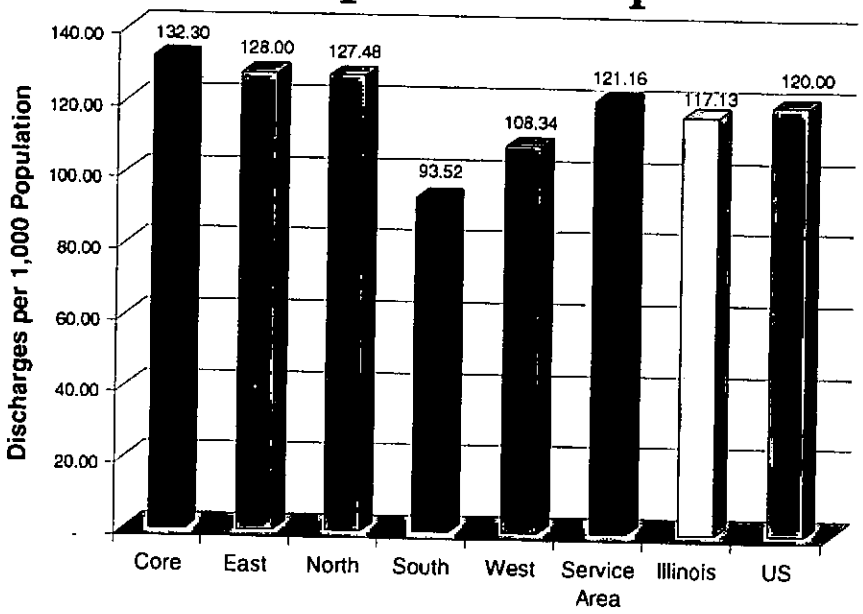
PCH Service Area Projected Population Growth (Source: Claritas)

	Claritas Projected Population CAGR	
	(2005-2010)	(2007-2013)
PCH Service Area Population Age 0-17	0.5%	0.4%
PCH Service Area Population Age 18-44	0.1%	0.1%
PCH Service Area Population Age 45-64	2.8%	1.9%
PCH Service Area Population Age 65+	2.4%	2.5%
PCH Service Area Population (All Ages)	**1.2%**	**1.0%**

The age 65 and older cohort, by far, utilizes the most inpatient services and is also the fastest growing segment of the population within PCH's service area.

Inpatient Utilization by Service Area

Inpatient Utilization, 2005
Use Rate per 1,000 Population



Percent of Population by Age Cohort, 2005

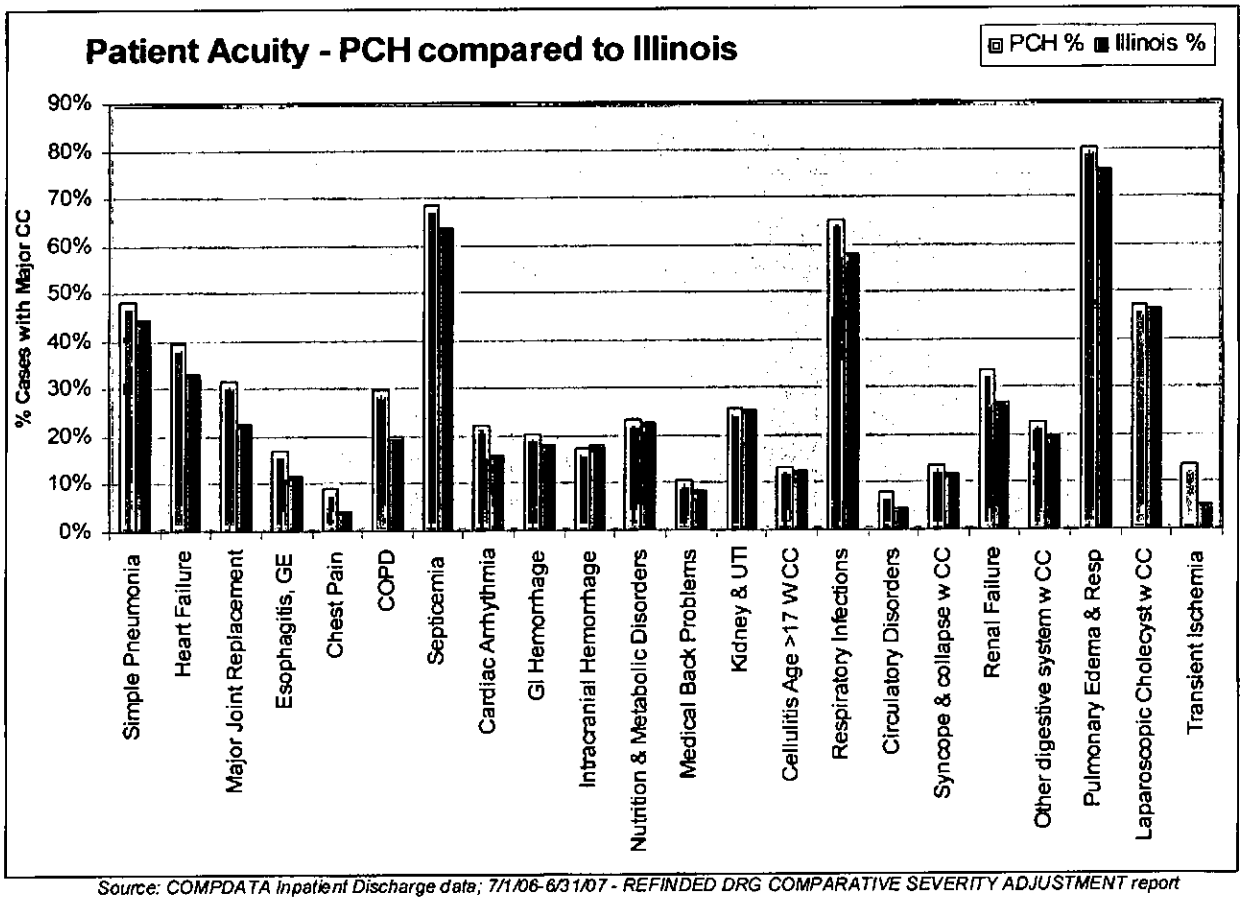
Region	% of Population	
	Age 45-64	Age 65+
Core	29.8%	17.0%
East	26.5%	10.7%
North	24.4%	15.2%
South	26.2%	7.4%
West	25.6%	9.4%
Total Service Area	**26.2%**	**12.8%**
Illinois	21.5%	12.1%
United States	22.0%	12.4%

Source: Claritas, US Census Data, IL COMPdata, PCH Internal Discharge Data, Navigant Analysis.

Observations

- With almost half the population age 45 or older, the Core Service Area's utilization rate is about 10% higher than the state-wide and U.S. rates
- But, the percent of age 45-64 and age 65+ population is, respectively, almost 10% and 5% higher than the state and U.S. percentages, which partially explains the above average use rates in the Core market
- As expected due to the younger population, the South and West Service Areas currently have substantially lower utilization rates
- Additionally, the average length of stay for patients originating from the South/West are lower at 4.3 days versus almost 5.0 days for patients from the Core/North/East areas

PCH Top DRG W CC
7/1/2006 through 6/30/2007
Severity Adjustment Comparative Analysis



Source: COMPDATA Inpatient Discharge data; 7/1/06-6/31/07 - REFINDED DRG COMPARATIVE SEVERITY ADJUSTMENT report
High volume medical surgical DRGs

- **A comparison of the category – Major, which is the highest severity adjustment for medical DRGs, as a percentage of total discharges at PCH compared to all Illinois hospital discharges supports the fact that PCH treats more acute patients than most hospitals in Illinois, as reflected in PCH admissions from the ED, patient age and chronic and comorbid conditions.**

The COMPdata Refinded DRG is a method for refining or risk-adjusting DRG assignments and reducing the varances of resource consumption within DRGs. Refined DRG uses the DRG assignment and regroups DRGs in Adjacent DRGs (ADRGs). The key data elements that are included in the ADRG assignment are the same as those used for DERG assignment-patient age, patient gender, discharge status, diagnosis and procedure codes, with more emphasis placed on the patient complications and comorbidities through secondary diagnosis. The secondary diagnosis codes are the critical variable in the Refinded DRG methodology for distinguishing peak adjustment levels , or often times referred to as severity levels.

Following the assignment of DRG to ADRG, intensity levels are assigned based on resource utilization. For medical DRGs, there are three (3) intensity levels: Baseline (0), Minor (1), and Major (2). For surgical DRGs, an additional level of Catastrophic (3) is added. The RDGR system does not classify discharges where the patient dies within 48 hours of admission. Outliers are identified as other.

Source: COMPdata Report Catalog

PALOS COMMUNITY HOSPITAL

MEDICAL/SURGICAL ADMISSIONS & PATIENT DAYS BY MONTH

Month	Admissions	Inpatient Days	Observation Patient Days	Total Patient Days	Licensed Beds	Licensed Occupancy %	Staffed Beds	Staffed Occupancy %
January, 2006	1,258	6,304	516	6,820	315	69.8%	267	82.4%
February, 2006	1,154	5,414	435	5,849	315	66.3%	267	70.7%
March, 2006	1,323	6,344	373	6,717	315	68.8%	267	81.2%
April, 2006	1,213	5,863	361	6,224	315	65.9%	267	75.2%
May, 2006	1,346	6,038	350	6,388	315	65.4%	267	77.2%
June, 2006	1,234	5,811	334	6,145	315	65.0%	267	74.2%
July, 2006	1,227	5,505	339	5,844	315	59.8%	267	70.6%
August, 2006	1,348	6,181	340	6,521	315	66.8%	271	77.6%
September, 2006	1,278	5,637	316	5,953	315	63.0%	267	71.9%
October, 2006	1,354	6,177	303	6,480	315	66.4%	274	76.3%
November, 2006	1,220	5,674	284	5,958	315	63.0%	274	70.1%
December, 2006	1,311	6,180	296	6,476	315	66.3%	274	76.2%
2006 Totals	15,266	71,128	4,247	75,375	315	65.6%	274	75.4%
January, 2007	1,404	6,759	287	7,046	315	72.2%	274	83.0%
February, 2007	1,273	6,033	259	6,292	315	68.9%	274	74.1%
March, 2007	1,408	6,777	278	7,055	315	72.2%	274	83.1%
April, 2007	1,338	6,117	289	6,406	315	67.8%	274	75.4%
May, 2007	1,384	6,415	271	6,686	315	68.5%	274	78.7%
June, 2007	1,294	5,998	328	6,326	315	66.9%	274	74.5%
July, 2007	1,336	6,407	326	6,733	315	69.0%	274	79.3%
August, 2007	1,290	6,083	343	6,426	315	65.8%	274	75.7%
September, 2007	1,230	5,947	292	6,239	315	66.0%	274	73.5%
October, 2007	1,348	6,237	339	6,576	315	67.3%	274	77.4%
November, 2007	1,246	5,944	361	6,305	315	66.7%	274	74.2%
December, 2007	1,329	6,409	323	6,732	315	68.9%	274	79.3%
2007 Totals	15,880	75,126	3,696	78,822	315	68.6%	274	78.8%
January, 2008	1,424	7,185	421	7,606	315	77.9%	274	89.5%
February, 2008	1,303	6,868	363	7,231	315	79.2%	278	83.9%
March, 2008	1,379	7,107	346	7,453	315	76.3%	278	86.5%
April, 2008	1,286	6,099	350	6,449	315	66.0%	278	74.8%
May, 2008	1,302	6,228	440	6,668	315	73.0%	278	77.4%
YTD 2008 Totals	6,694	33,487	1,920	35,407	315	73.9%	278	84.3%

October 2006 - 30 beds opened and staffed; Feb 2008 4 additional beds opened

ATTACHMENT MOD-2A(11)
Page 1 of 2

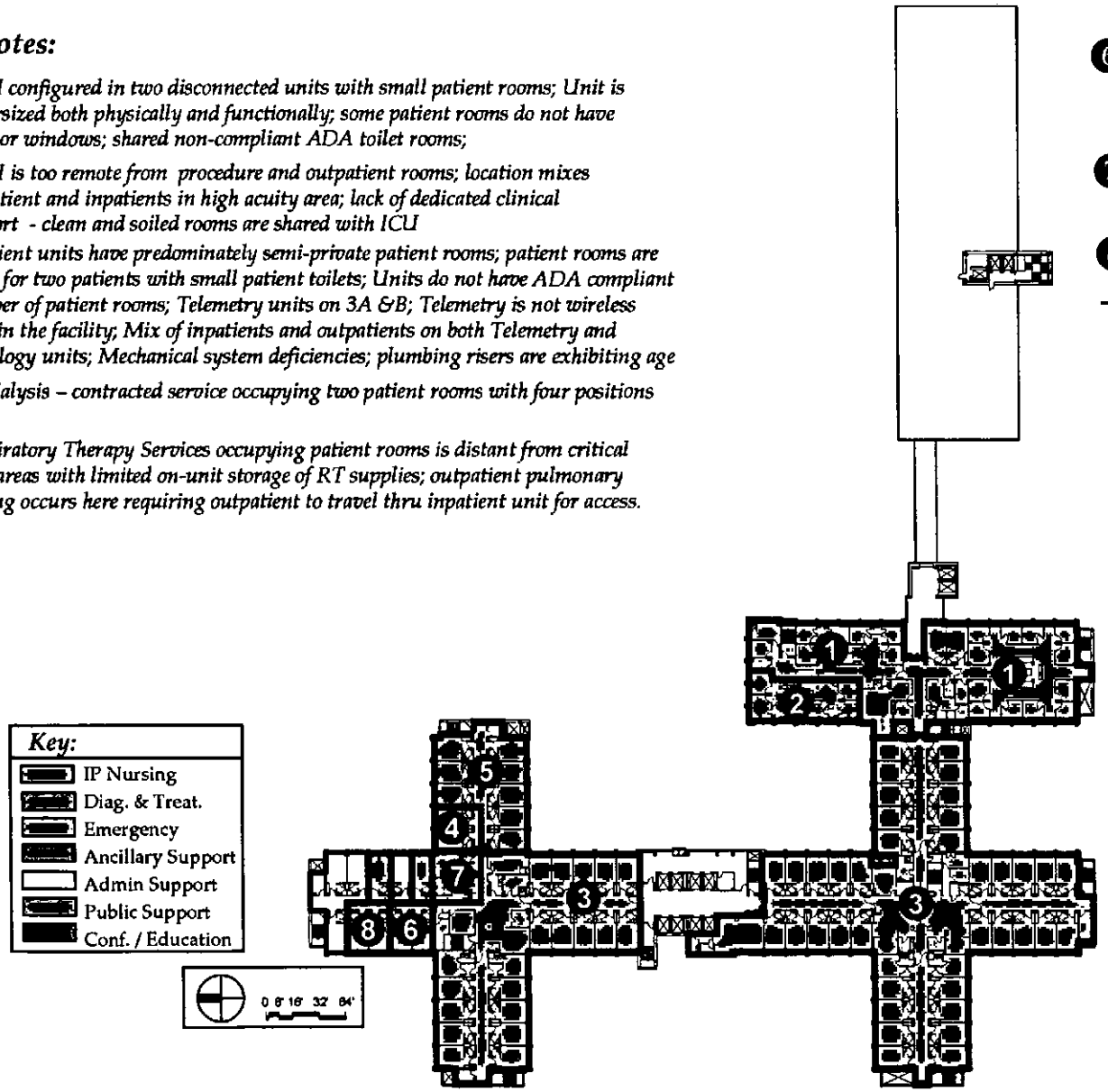
Existing Conditions Overview –Level 3

Key Notes:

1. *ICCU configured in two disconnected units with small patient rooms; Unit is undersized both physically and functionally; some patient rooms do not have exterior windows; shared non-compliant ADA toilet rooms;*
2. *SSTU is too remote from procedure and outpatient rooms; location mixes outpatient and inpatients in high acuity area; lack of dedicated clinical support - clean and soiled rooms are shared with ICU*
3. *Inpatient units have predominately semi-private patient rooms; patient rooms are small for two patients with small patient toilets; Units do not have ADA compliant number of patient rooms; Telemetry units on 3A &B; Telemetry is not wireless with in the facility; Mix of inpatients and outpatients on both Telemetry and Oncology units; Mechanical system deficiencies; plumbing risers are exhibiting age*
4. *IP Dialysis – contracted service occupying two patient rooms with four positions*
6. *Respiratory Therapy Services occupying patient rooms is distant from critical care areas with limited on-unit storage of RT supplies; outpatient pulmonary testing occurs here requiring outpatient to travel thru inpatient unit for access. ****

6. *OP EEG operates out of two inpatient rooms; patients must access area thru inpatient unit; Noise from corridor can be disruptive to testing*
7. *IV Therapy and Wound Care are located at the 3D Nurse station. The station houses the staff and supplies;*
8. *2 patient rooms (4 beds) being utilized as on-call rooms.*

**** Respiratory Therapy – moving to 1st floor to vacant patient rooms on 3D. Call rooms will relocate to this space along with IV Therapy office and clear 370s corridor for patient rooms.*



April 2006

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ATTACHMENT MOD-2A(11)
Page 2 of 2

SIZE AND SCOPE

CLINICAL SERVICE	GSF* Existing	GSF* Proposed	Amount of Proposed Total GSF That is: New	Remodeled	As Is	Vacated	Department GSF **
Medical Surgical	93,260	180,065	91,790	77,330	10,945		84, 825
Intensive Care	10,846	25,650	25,650			10,846	23,490
INTEGRATED PROCEDURE SERVICES							37,590
A) Surgery	19,166	37,354	37,354			19,166	
B) Endoscopy	2,961	3,468	3,468			2,961	
C) Special Procedures	946	2,004	2,004			946	
RECOVERY							22,388
A) PACU	2,092	3,750	3,750			2,092	3,350
B) Center for Short Stay Care	14,572	22,940	22,940			14,572	19,030
Respiratory Therapy	1,485	5,425	1,060	4,365		1,485	1,060
Laboratory	9,362	22,487	22,487			9,362	18,880
Pharmacy	4,135	8,229	8,229			4,135	7,360
Outpatient & Pre-Admission Testing	1,265	4,730	4,730			1,265	4,180
Inpatient Dialysis	717	1,105		1,105		717	1,105
Emergency Department	12,361	22,814		11,435	11,379		22,818
Admissions Unit	0	6,696		6,696			6,696
Cardiology	4,299	6,661		6,661		4,299	6,661
Nuclear Medicine	1,652	6,766		6,766		1,652	6,766
Radiology	20,068	31,732		16,889	14,843	2,421	31,732
Sub Total Clinical	199,187	391,876	223,462	131,247	37,167	75,919	

* GSF for new construction areas include external circultion i.e. BGSF. Modernized areas are DGSF,

** Department GSF include internal circulation with 1/2 adjacent corridor space and exclude external circulation. See Attachment GRC-5(2) for department gsf.

PEAK CENSUS Med/Surg

	Peak Census			Staffed		Licensed			
	Midnight	9AM	Variance	Peak Occupancy %	M/S Beds	Peak Occupancy %	M/S Beds	Number of Days in the month Occupancy was > 80%*	% of Time (Days) in the Month Staffed Occupancy was > 82%*
Jan-07	256	260	4	95%	274	83%	315	25	81%
Feb-07	249	253	4	92%	274	80%	315	23	82%
Mar-07	255	265	10	97%	274	84%	315	26	84%
Apr-07	247	251	4	92%	274	80%	315	20	67%
May-07	246	252	6	92%	274	80%	315	22	71%
Jun-07	238	248	10	91%	274	79%	315	14	47%
Jul-07	241	250	9	91%	274	79%	315	19	61%
Aug-07	232	244	12	89%	274	77%	315	10	32%
Sep-07	230	238	8	87%	274	76%	315	13	43%
Oct-07	234	240	6	88%	274	76%	315	17	55%
Nov-07	239	250	11	91%	274	79%	315	17	57%
Dec-07	240	248	8	91%	274	79%	315	20	65%
			8					**226**	
								62%	

74	Days Occupancy was > 82%(Jan-Mar 2007)
90	Total days Jan-Mar 2007
16	Days occupancy < 82% between Jan-March

* ADC was ≥ 219 (80%)

=219/274 80%

Inpatient Bed Midday Effect

Midday effect occurs in a full hospital unit when patients are admitted during the morning hours of any given day before an equal number of patients can be discharged from that unit. The resulting overlap causes the average daily census taken midday to be greater than that taken at 12 am.

In the example below, the beginning of the admit days, colored red, overlap for a duration of 8 hours with the end of the discharge day of the previous patient. As shown in the example, a lower ALOS tends to increase the midday ADC, because as patients cycle through the unit more frequently the occurrence of midday overlap increases.

A longer duration of overlap time will also increase the midday ADC. Operational factors such as clinical practice patterns/MD productivity, availability of alternative accommodations (nursing home/rehab unit), wait times for testing results, and technology/IS systems have an impact on the ability to discharge patients in a timely fashion.

	Beds	ALOS	12am ADC	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Discharge Day	Midday Effect	Midday ADC
Unit X	Bed 1	2.3	1											43%	8 Hours	1.14
	Bed 2	3.3	1											30%	8 Hours	1.10
	Bed 3	4.3	1											23%	8 Hours	1.08
	Bed 4	5.3	1											19%	8 Hours	1.06

Admit Patient Day *Normal Patient Day* *Midday Overlap Time*

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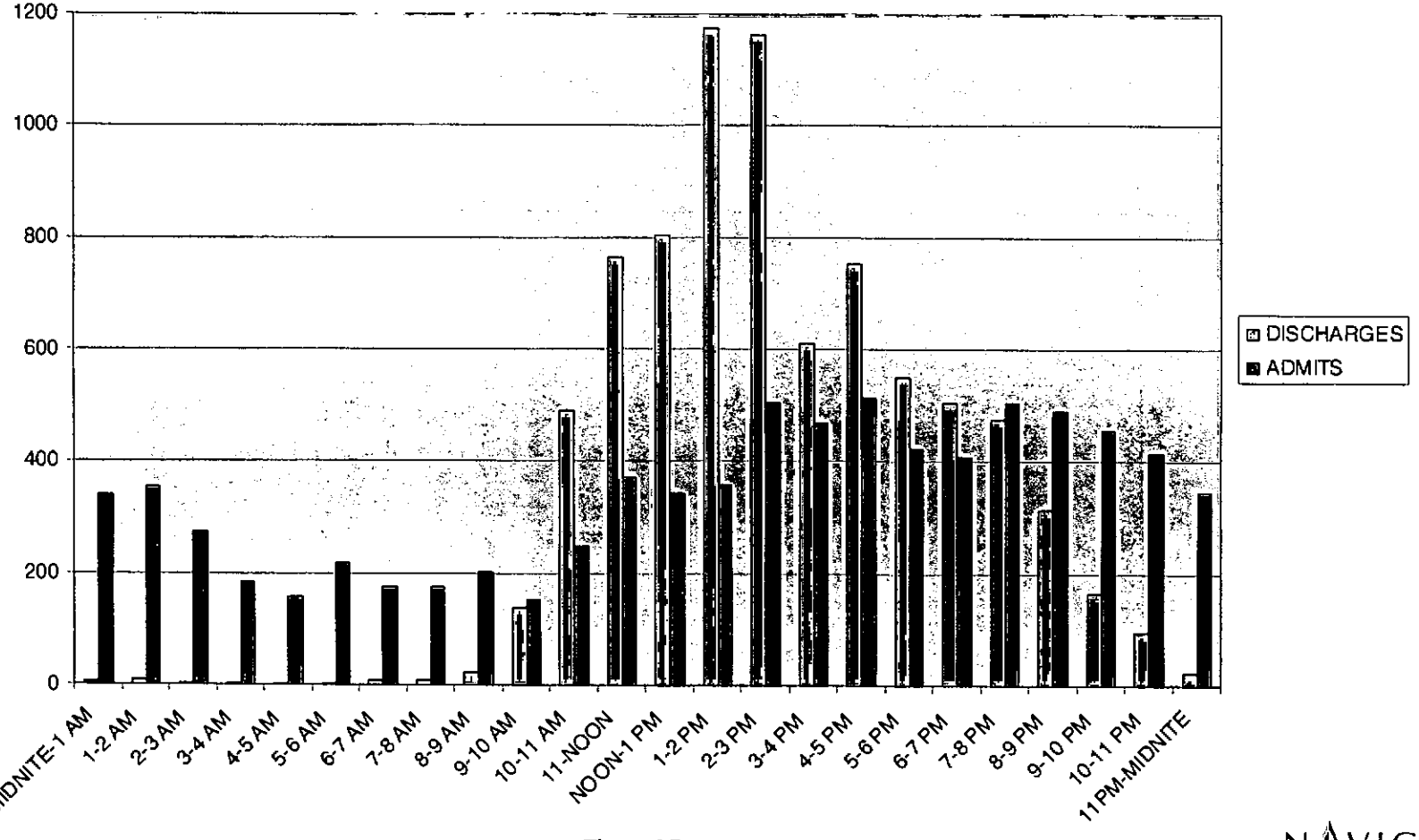
Inpatient Beds – PCH Admit/Discharge Overlap

The chart illustrates the pattern of admissions and discharges by time of day. A majority of the discharges are occurring between 11 a.m. and 5 p.m. The admissions are made at all hours although most take place between 2 p.m. and 11 p.m. Since 75% of inpatients are admitted through the ED, it is possible that inpatients are being held in the ED until later in the day when beds become available.



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MODERN FACILITIES
Deterioration

INTENSIVE CARE SERVICES

The Hospital proposes to modernize and expand Intensive Care (ICU) Services due to the age, condition and configuration of the existing 24-bed unit. The project relocates ICU to East Wing and adds 12 ICU beds, a 24-bed ICU on the 7th Floor and a 12-bed ICU on the 6th Floor.

The IHFPB Inventory (Update 8/15/08) identifies a need for 32 additional ICU beds in Planning Area A-4.

Deterioration

The existing ICU, built in 1974, is obsolete and deteriorating and needs to be replaced. The 24-bed ICU is on the 3rd Floor of the East Building. See Attachment MOD-2B(1) for schematic assessment of the existing condition of the unit by Navigant Consulting, Inc. (NCI.) Deterioration of the ICU is indicated by the following conditions:

- **Piping systems are failing, especially the plumbing risers. Problem systems include both hot water recirculation and sanitary line failures. The Hospital has replaced a limited number of these plumbing risers but, due to patient care disruption, intend to replace the remaining upon completion of the East Wing, in a phased patient room renovation minimizing disruption.**

- **The patient rooms have inadequate fresh air exchange. Patient rooms use fan-coil units to for heating, ventilation, and air conditioning (HVAC.) Modern healthcare design requires significantly more fresh air exchanges and does not allow fan-coil units.**

- **Patient rooms have inadequate oxygen-flow capacity which requires larger piping.**

- **Washrooms do not meet the handicapped accessibility (ADA) standards for size.**

- **Patient rooms are not protected by a fire sprinkler system.**

- **ICU rooms are extremely small, and a few are non-compliant without windows.**

- **CCU rooms are approximately 140 square feet making the use of any equipment in the room challenging.**

- **CCU rooms have swing out toilets in the actual patient room, which is a highly undesirable situation.**

- **Bedside dialysis water supply and return is unacceptable.**

The 24-bed ICU has only 10,846 gross square feet (gsf) and is obsolete with only 452 gsf/bed.

The Project

The project adds 12 ICU beds. The existing 24-bed unit would be vacated and two new ICUs would be built in the East Wing, a 24-bed ICU on the 7th Floor and a 12-bed unit on the 6th Floor (see prototypical ICU in Attachment MOD-2B(2).) The new ICU beds would be appropriately sized and have small family/visitor zones with seating that converts for sleeping over (see prototypical ICU room in Attachment MOD-2B (3).) The new ICUs incorporate advanced, interactive technology which improves patient care, communication and efficiency. The new ICUs provide space for visiting clinicians i.e. pharmacists, therapists, physicians, allowing multi-disciplinary, patient-focused care. For facilities-related operating principles see Attachment MOD-2B(4).

Necessary Replacement

The need for 36 ICU beds is based on increasing utilization, numerous elderly, seriously ill patients, and continued growth and aging of the service area population. ICU days increased 5.4% per year between 2005 and 2007. The growth is due to increases in ICU admissions which averaged 9.5% per year between 2005 and 2007 (see Attachment MOD-2B(5).) The Hospital's ICU ALOS of 3.5 days is the lowest in Planning Area A-4 (see Attachment 2B(6).)

Increasing ICU utilization is due, in part, to the Hospital's high number of seriously ill, elderly admits. In 2005 the Hospital admitted far more patients from skilled nursing facilities (SNFs) than any other Illinois hospital. See Attachment MOD-2B(7) which shows that Palos admitted 887 SNF patients in 2005 which is almost 50% higher than the next highest hospital which admitted only 605 patients!

The high number of elderly admissions is due to the high elderly population in the service area, 12.8% of population, which is higher than Illinois or the U.S. See Attachment MOD-2B(8) for documentation of this ratio and the substantially higher inpatient use rates in the service area for this population. Given the medical needs of the elderly, combined with their chronic disease conditions, patients tend to be sicker. An indication that the Hospital's ICU patients have higher acuity is reflected in the Hospital's high co-morbidity index which is among the highest in Illinois (see Attachment MOD-2B(8A).)

As ICU patient days increased at an average 5.4% per year between 2005 and 2007, ICU occupancy rates also increased, from 61% to 68% on 24 licensed beds during this period. ICU occupancy on the 18 staffed ICU beds increased from 81% to 90% during this period. (The Hospital does not staff the other six (6) ICU beds due to the awkward configuration of the ICU, two disconnected units with non-compliant patient rooms without windows.) See Attachments MOD-2B(5) and 2B(9) for yearly and monthly occupancy data, respectively.

Occupancy rates, whether on licensed or staffed beds, mask the need for beds to cover the peak census. See Attachment MOD-2B(10) which indicates that, based on the Hospital's midday census, about 85% of the time the ICU exceeded 60% (310 days of 365 days!)

The overlap in discharges and admissions in the midday which cause peak census, also contribute to over-crowding in the Emergency Department (ED), when a bed is not available. In the first three months of 2008 over 41% of ED patients waited at least 2 hours for admission. Another 11% waited at least 8 hours for admission.

The need to replace the obsolete ICU and add 12 more ICU beds is also based on growth and aging in the service area population. Service area population is expected to increase 1.0% per year from 2007 through 2020 (see population projections in Attachment GRC-4.) The service area's elderly population is expected to increase 2.5% per year through 2012. The elderly are the fastest growing population in the service area.

Compliance with IHFPB Target Utilization

ICU patient days are expected to grow at a modest 3.0% per year, significantly less than the actual growth of 5.4% per year between 2005 and 2007 and congruent with the projected increase of the service area's elderly population through 2012. With this modest growth, the Hospital's 36 ICU beds would be appropriately utilized at over 60% as follows:

Intensive Care (ICU) Occupancy – 2020

Beds	ICU Patient Days	Project Occupancy	IHFPB Standards	Beds Allowed
36	8,683	66%	60%	40

The Hospital needs to replace its 24 obsolete ICU beds and add 12 more ICU beds to ensure access to modern ICU services in the community.

Existing Conditions Overview –Level 3

Key Notes:

1. *ICCU configured in two disconnected units with small patient rooms; Unit is undersized both physically and functionally; some patient rooms do not have exterior windows; shared non-compliant ADA toilet rooms;*
2. *SSTU is too remote from procedure and outpatient rooms; location mixes outpatient and inpatients in high acuity area; lack of dedicated clinical support - clean and soiled rooms are shared with ICU*
3. *Inpatient units have predominately semi-private patient rooms; patient rooms are small for two patients with small patient toilets; Units do not have ADA compliant number of patient rooms; Telemetry units on 3A &B; Telemetry is not wireless with in the facility; Mix of inpatients and outpatients on both Telemetry and Oncology units; Mechanical system deficiencies; plumbing risers are exhibiting age*
4. *IP Dialysis – contracted service occupying two patient rooms with four positions*
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6. *OP EEG operates out of two inpatient rooms; patients must access area thru inpatient unit; Noise from corridor can be disruptive to testing*
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8. *2 patient rooms (4 beds) being utilized as on-call rooms.*

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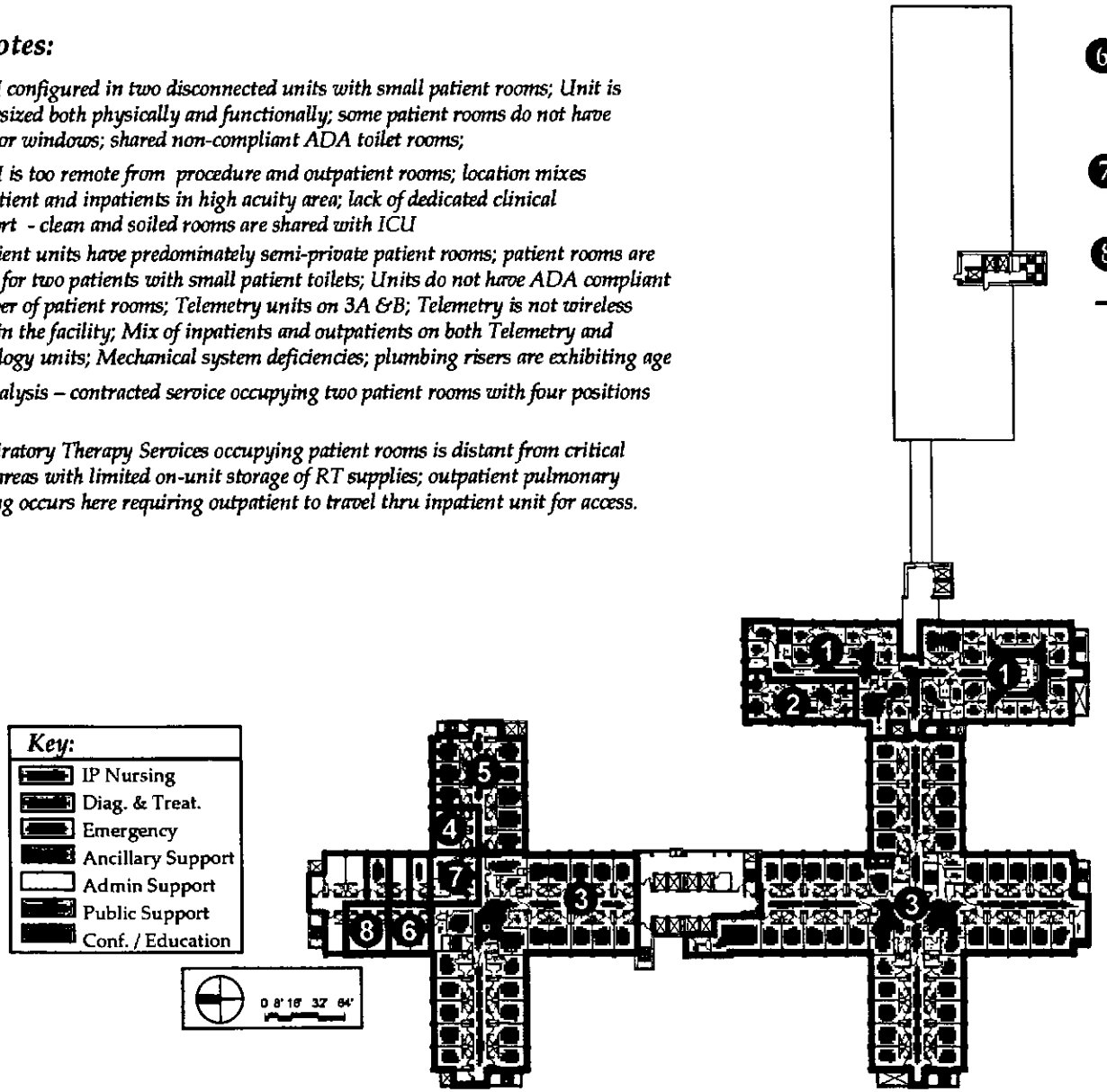

April 2006

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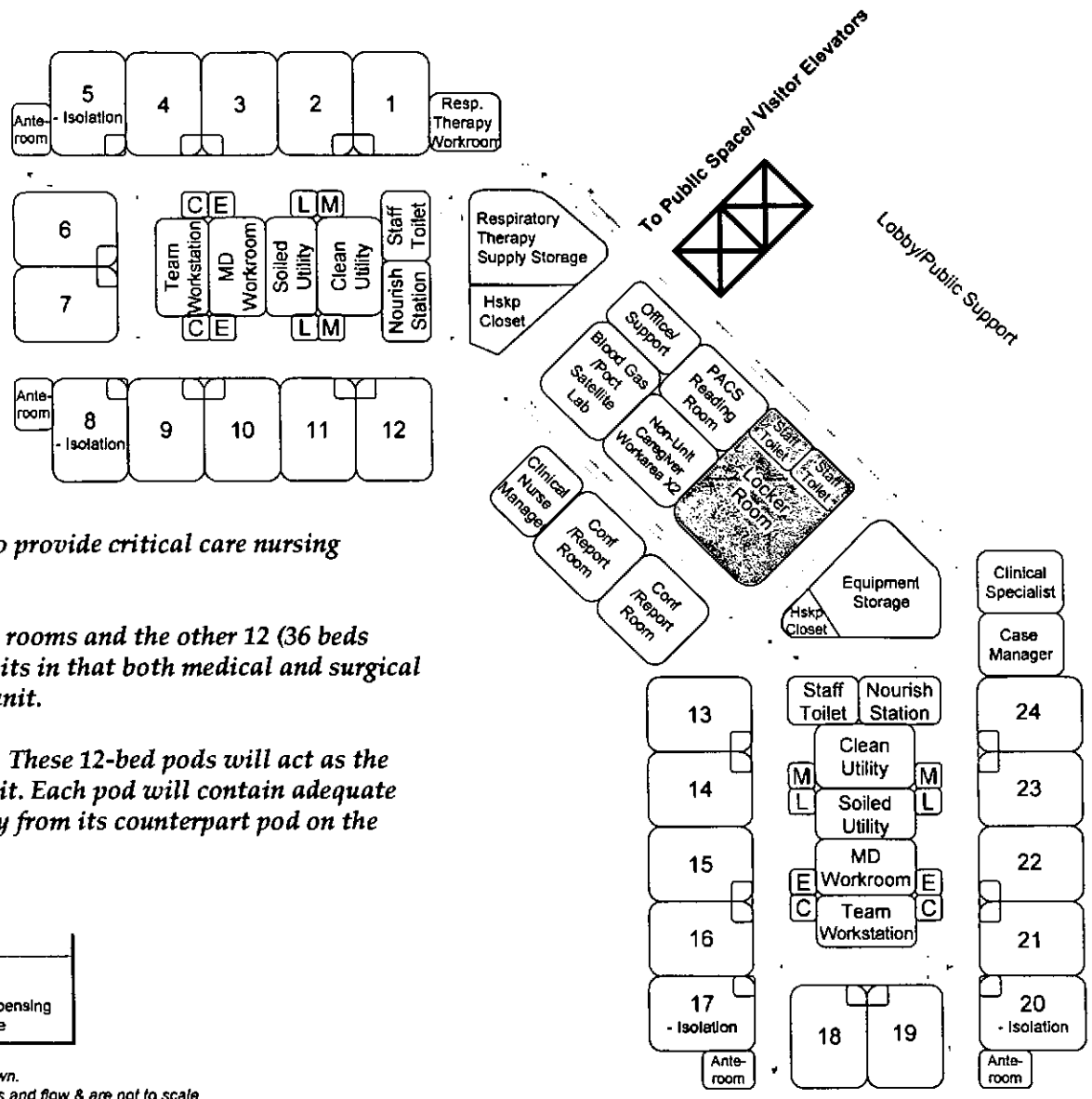
EAST WING ADDITION
Prototypical ICU



The two new proposed ICUs are planned to provide critical care nursing capacity through 2020.

One ICU is two contain 24 private patient rooms and the other 12 (36 beds total). They are planned to be universal units in that both medical and surgical patients will be accommodated on either unit.

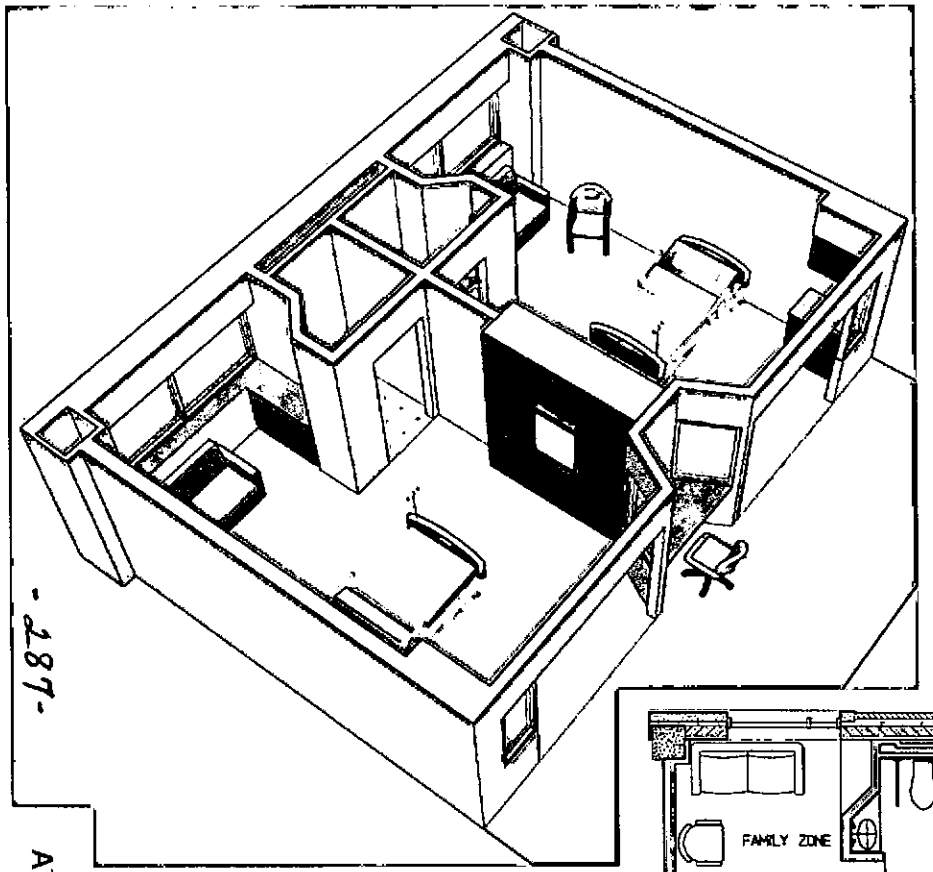
ICUs are organized into "pods" of 12 beds. These 12-bed pods will act as the primary organizational element for the unit. Each pod will contain adequate support functions to operate independently from its counterpart pod on the floor.

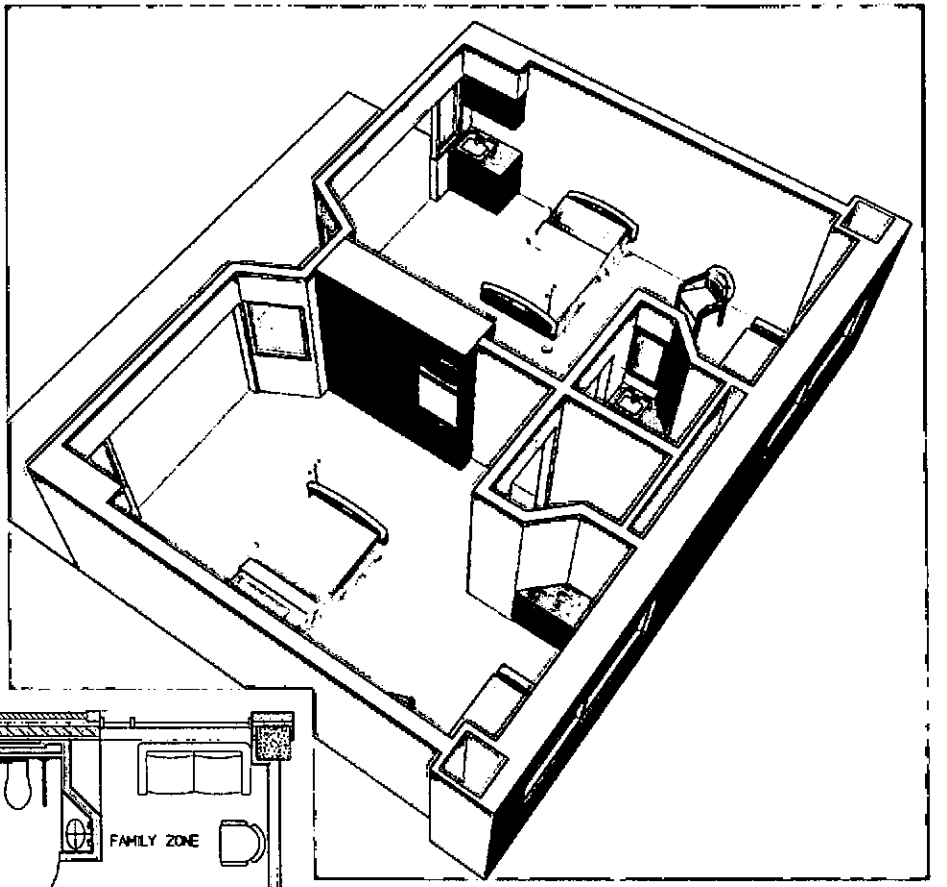
Abbreviation Key:
C – Crash Cart
E – Equipment Alcove
M – Automated Medication Dispensing
L – Linen Exchange Cart Alcove

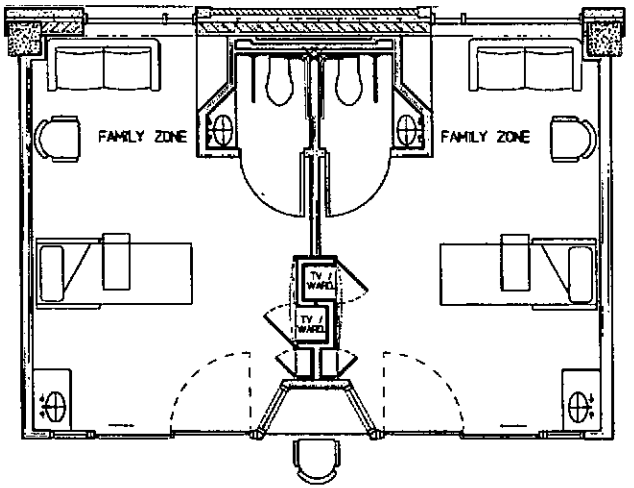
Note: Not all program elements shown.
Diagrams illustrate adjacencies and flow & are not to scale

Palos Community Hospital

ICU Prototype







260 SF

174 Net Usable SF

M&CA

-187-

ATTACHMENT MOD-2B(3)

ICU - Facilities-related Operating Principles

All rooms are to be private and configured to include -

- Patient zone with monitoring capabilities and headwall medical gases
- Dialysis treatment will be available in all rooms
- Staff zone to include hand-washing and documentation/work space both inside the room and directly outside the room at a caregiver workstation that maintains patient visualization
- Full patient toilet with shower to allow for future flexibility
- Family zone should allow for seating area that converts to sleeping function

Units are configured into "pods" of beds-

- Each pod consists of 12 beds.
- Pod support areas are to be organized around a central team station with convenient access to clean supplies, medication dispensing/prep areas and nourishment station.
- Configuration of beds within each pod supports visualization from caregiver workstation
- Unit configuration should support family/visitor involvement

Units should support multidisciplinary patient care practices-

- Clinical pharmacists to be deployed to support the units
- Non-unit provider support space is provided to allow for space for documentation, access to phone and reference material
- Respiratory Therapy will have designated support space for storage of supplies as well as work areas for documentation.

NAVIGANT CONSULTING

ICU - Facilities-related Operating Principles

Units area planned to employ advanced, interactive technology-

- Patient monitoring system that allows interfacing from multiple locations (patient bedside, pod support area, team area, off-site).
- Bedside scanning and real-time documentation promotes safe care administration.
- Electronic Medical Record links patient history, vitals, medications, tests, etc. to the network of providers.
- Secure online order entry system for testing and medications (as well as transport, etc.) is accessible from multiple locations.

Communication systems are to be employed as follows:

- Two-way, tiered, real-time communication between patient and nurse (as appropriate);
- Two-way, real-time communication between care delivery team and non-clinical support staff;
- Direct communication between physician and nurse (VoIP);
- Multiple lines of communication are supported and leveraged to minimize noise from overhead paging.

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED UTILIZATION

INTENSIVE CARE

	Historical			Projected												
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Intensive Care Admissions	1,411	1,535	1,693	1,770	1,823	1,878	1,934	1,992	2,052	2,113	2,177	2,242	2,309	2,379	2,450	2,524
% Change		8.8%	10.3%	4.5%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Average Annual 2005-2007			9.5%													
Intensive Care Patient Days	5,348	5,689	5,942	6,090	6,273	6,461	6,655	6,854	7,060	7,272	7,490	7,715	7,946	8,184	8,430	8,683
% Change		6.4%	4.4%	2.5%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Average Annual 2005-2007			5.4%													
Average Daily Census (ADC)	15	16	16	17	17	18	18	19	19	20	21	21	22	22	23	24
Average Length of Stay (ALOS)	3.8	3.7	3.5	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4
Authorized Beds	24	24	24											36	36	36
% Occupancy on 24 Authorized Beds	61%	65%	68%	70%												
% Occupancy on 18 Operational Beds	81%	87%	90%	93%												
% Occupancy on 36 Proposed Beds														62%	64%	66%

INTENSIVE CARE BEDS:	
Existing	24 ICU Beds
IHFPB Std. 60% by 2018	44 ICU Beds
Proposed	36 ICU Beds

Annualized 2008 Jan-Jun 2008
PCH has a lowest ICU ALOS of all area hospitals.
Source: PCH Meditech Utilization Statistics, Projections - NCI Consulting

ATTACHMENT MOD-2B(5)

COMPARISON OF AVERAGE LENGTH OF STAY

Planning Area A-4 Hospitals

MEDICAL/SURGICAL

Planning Area A-4 Hospitals	Admissions	2007 Total Days	ALOS
Adventist LaGrange Memorial Hospital	7,036	33,752	4.8
Advocate Christ Medical Center	25,030	120,203	4.8
Advocate South Suburban Hospital	10,248	39,968	3.9
Ingalls Memorial Hospital	13,682	59,616	4.4
Little Company of Mary Hospital & Health Care Center	12,760	55,266	4.3
Oak Forest Hospital	1,976	15,820	8.0
Palos Community Hospital	**15,892**	**75,404**	**4.7**
RM Health Providers Limited Partnership	777	25,200	32.4
St. Francis Hospital & Health Center	10,339	48,808	4.7
St. James Hospital & Health Center (Olympia Fields)	9,132	39,289	4.3
St. James Hospital & Health Center (Chicago Heights)	9,388	44,486	4.7
TOTALS	116,260	557,812	**4.8**

INTENSIVE CARE

	Direct Admissions	2007 Total Days	ALOS
Adventist LaGrange Memorial Hospital	599	3,836	6.4
Advocate Christ Medical Center	3,869	26,180	6.8
Advocate South Suburban Hospital	950	4,698	4.9
Ingalls Memorial Hospital	348	7,339	21.1
Little Company of Mary Hospital & Heath Care Center	937	8,664	9.2
Oak Forest Hospital	385	2,020	5.2
Palos Community Hospital	**1,693**	**5,942**	**3.5**
RM Health Providers Limited Partnership	0	0	0.0
St. Francis Hospital & Health Center	1,328	5,773	4.3
St. James Hospital & Health Center (Olympia Fields)	1,061	5,712	5.4
St. James Hospital & Health Center (Chicago Heights)	688	3,615	5.3
TOTALS	11858	73,779	**6.2**

Source: Illinois Department of Public Health, 2007 AHQ Hospital Profiles.
Note: AHQ ALOS calculation for Palos' M/S was 5.0, a calculation discrepancy.

ATTACHMENT MOD-2B(6)

PCH Serving the SNF Population

Transfers from Skilled Nursing Facilities (SNFs), 2005

Hospital	Admit Source: Transfer from SNF
Palos Community Hospital	887
Kindred Hospital - Chicago Northlake	605
Rockford Memorial Hospital	468
Rush North Shore Medical Center	356
Silver Cross Hospital	271
Adventist Hinsdale Hospital	209
Saint Mary Of Nazareth Hospital Center	188
Advocate Christ Hospital & Medical Center	185
Holy Cross Hospital	184
Vista Health-Victory Memorial Hospital	156
Advocate South Suburban Hospital	155
St Francis Hospital & Health Center - Blue Is.	135
Oak Forest Hospital Of Cook County	131
Advocate Lutheran General Hospital	118
Adventist Lagrange Memorial Hospital	113
Macneal Hospital	107

- Reinforcing the point that PCH currently serves an older patient population in comparison to other Illinois hospitals:
  - Of all hospitals in the state, PCH admitted, by far, the most transfers from skilled nursing facilities (SNFs) in 2005
  - Local competitors such as Christ, South Suburban and St. Francis also ranked highly on the list, but were far behind PCH in volume of transfers/admissions from SNFs

Source: COMPdata, NCI Analysis.

NAVIGANT CONSULTING

Inpatient Utilization - PCH Service Area (2004 - 2007)

	2004	2005	2006	2007*	2007 (9 mos)
Total Inpatient Admissions Age 0-17, PCH Service Area	5,698	6,254	5,906	3,103	2,327
Total Inpatient Admissions Age 18-44, PCH Service Area	18,316	19,448	18,458	19,460	14,595
Total Inpatient Admissions Age 45-64, PCH Service Area	18,234	20,211	20,247	21,528	16,146
Total Inpatient Admissions Age 65+, PCH Service Area	32,161	35,580	35,126	36,496	27,372
PCH Service Area Population Age 0-17	152,869	153,585	154,191	154,800	
PCH Service Area Population Age 18-44	219,684	219,968	220,295	220,623	
PCH Service Area Population Age 45-64	156,508	160,826	164,784	168,840	
PCH Service Area Population Age 65+	76,514	78,388	79,296	80,215	
Inpatient Utilization Per 1,000 Pop. Age 0-17, PCH Service Area	37.27	40.72	38.30	20.04	
Inpatient Utilization Per 1,000 Pop. Age 18-44, PCH Service Area	83.37	88.41	83.79	88.20	
Inpatient Utilization Per 1,000 Pop. Age 45-64, PCH Service Area	116.50	125.67	122.87	127.51	
Inpatient Utilization Per 1,000 Pop. Age 65+, PCH Service Area	420.33	453.90	442.97	454.98	
Age 65+ Utilization Growth Rate		*8.0%*	*-2.4%*	*2.7%*	
Total Inpatient Admissions (Source: COMPdata)	**74,409**	**81,493**	**79,737**	**80,587**	60,440
Total Service Area Population (Source: Claritas)	**605,575**	**612,767**	**618,567**	**624,478**	
Inpatient Utilization (Admits per 1,000 Population)	**122.87**	**132.99**	**128.91**	**129.05**	

*2007 COMPdata figures annualized based on 9 months of actual data (Jan-Sept).

Note: Analysis does not include normal newborns (DRG 391).

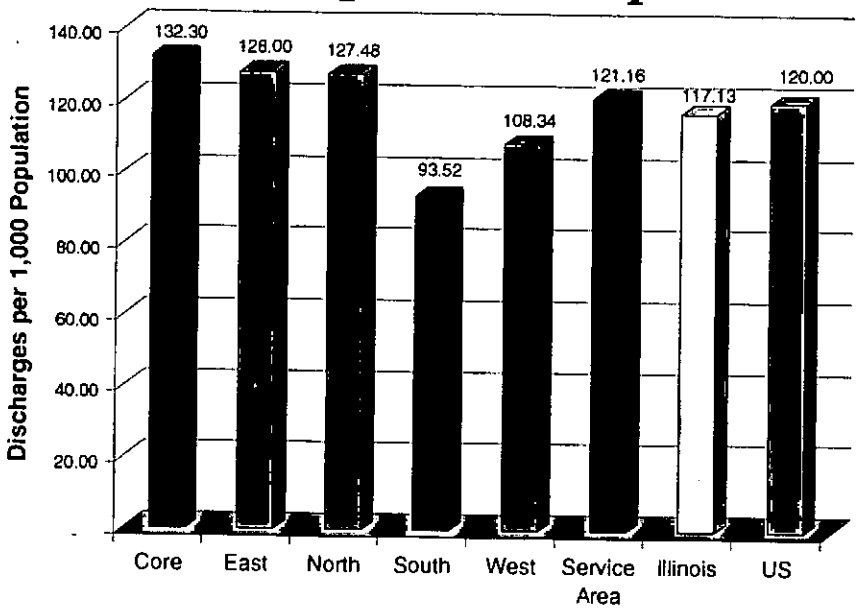
PCH Service Area Projected Population Growth (Source: Claritas)

	Claritas Projected Population CAGR (2005-2010)	(2007-2013)
PCH Service Area Population Age 0-17	0.5%	0.4%
PCH Service Area Population Age 18-44	0.1%	0.1%
PCH Service Area Population Age 45-64	2.8%	1.9%
PCH Service Area Population Age 65+	2.4%	2.5%
PCH Service Area Population (All Ages)	**1.2%**	**1.0%**

The age 65 and older cohort, by far, utilizes the most inpatient services and is also the fastest growing segment of the population within PCH's service area.

Inpatient Utilization by Service Area

Inpatient Utilization, 2005
Use Rate per 1,000 Population



Percent of Population by Age Cohort, 2005

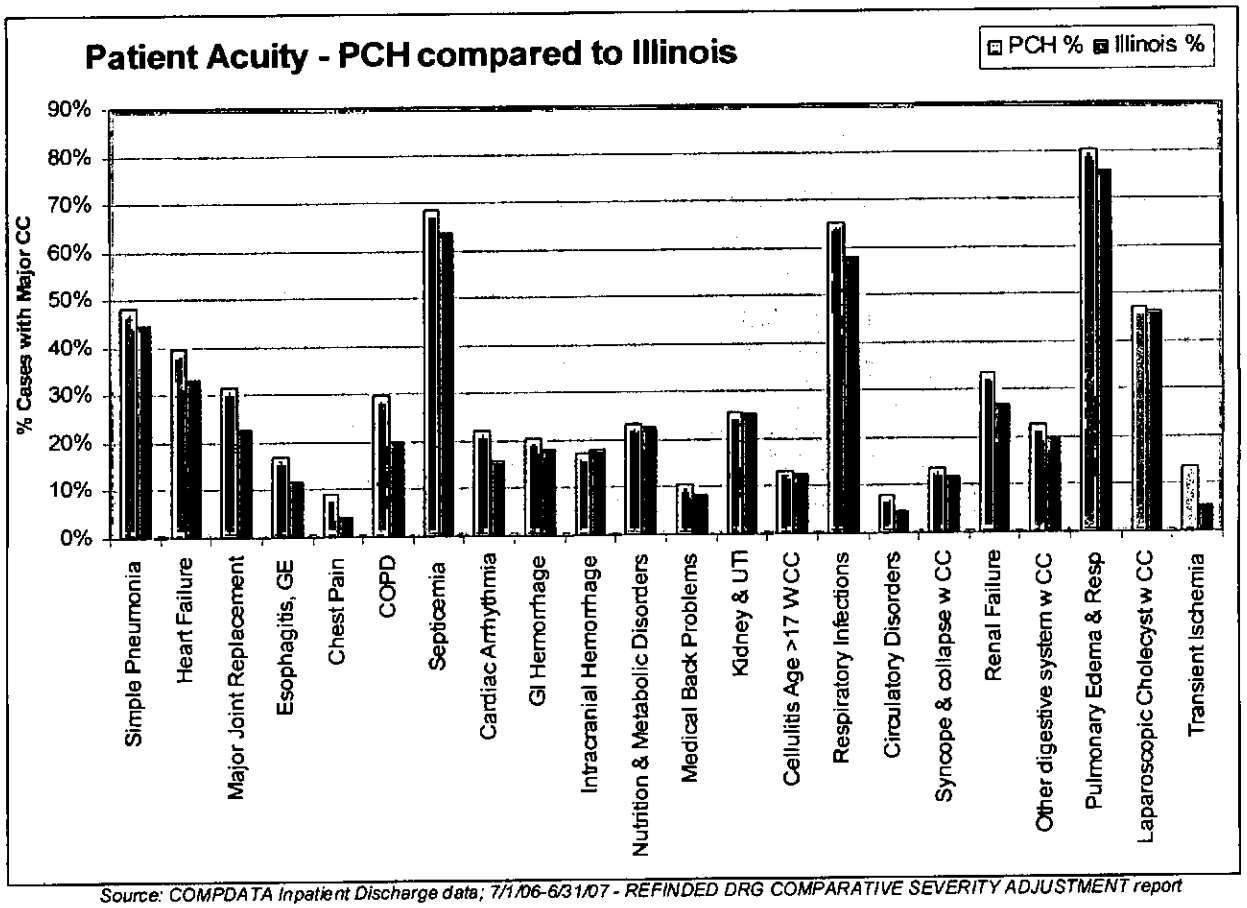
Region	% of Population	
	Age 45-64	Age 65+
Core	29.8%	17.0%
East	26.5%	10.7%
North	24.4%	15.2%
South	26.2%	7.4%
West	25.6%	9.4%
Total Service Area	26.2%	12.8%
Illinois	21.5%	12.1%
United States	22.0%	12.4%

Source: Claritas, US Census Data, IL COMPdata, PCH Internal Discharge Data, Navigant Analysis.

Observations

- With almost half the population age 45 or older, the Core Service Area's utilization rate is about 10% higher than the state-wide and U.S. rates
- But, the percent of age 45-64 and age 65+ population is, respectively, almost 10% and 5% higher than the state and U.S. percentages, which partially explains the above average use rates in the Core market
- As expected due to the younger population, the South and West Service Areas currently have substantially lower utilization rates
- Additionally, the average length of stay for patients originating from the South/West are lower at 4.3 days versus almost 5.0 days for patients from the Core/North/East areas

PCH Top DRG W CC
7/1/2006 through 6/30/2007
Severity Adjustment Comparative Analysis



Source: COMPDATA Inpatient Discharge data; 7/1/06-6/31/07 - REFINDED DRG COMPARATIVE SEVERITY ADJUSTMENT report
High volume medical surgical DRGs

- **A comparison of the category – Major, which is the highest severity adjustment for medical DRGs, as a percentage of total discharges at PCH compared to all Illinois hospital discharges supports the fact that PCH treats more acute patients than most hospitals in Illinois, as reflected in PCH admissions from the ED, patient age and chronic and comorbid conditions.**

The COMPdata Refined DRG is a method for refining or risk-adjusting DRG assignments and reducing the variances of resource consumption within DRGs. Refined DRG uses the DRG assignment and regroups DRGs in Adjacent DRGs (ADRGs). The key data elements that are included in the ADRG assignment are the same as those used for DRG assignment-patient age, patient gender, discharge status, diagnosis and procedure codes, with more emphasis placed on the patient complications and comorbidities through secondary diagnosis. The secondary diagnosis codes are the critical variable in the Refined DRG methodology for distinguishing peak adjustment levels, or often times referred to as severity levels.

Following the assignment of DRG to ADRG, intensity levels are assigned based on resource utilization. For medical DRGs, there are three (3) intensity levels: Baseline (0), Minor (1), and Major (2). For surgical DRGs, an additional level of Catastrophic (3) is added. The RDGR system does not classify discharges where the patient dies within 48 hours of admission. Outliers are identified as other.

Source data (COMdata report) attached.

Source: COMPdata Report Catalog

Attachment MOD-2B(8A)

PALOS COMMUNITY HOSPITAL

INTENSIVE CARE ADMISSIONS & PATIENT DAYS BY MONTH

Month	Admissions	Patient Days	Operating Beds	Occupancy Percentage	Licensed Beds	Occupancy Percentage
January, 2006	128	480	18	86.0%	24	64.5%
February, 2006	99	433	18	85.9%	24	64.4%
March, 2006	124	512	18	91.8%	24	68.8%
April, 2006	133	453	18	83.9%	24	62.9%
May, 2006	98	487	18	87.3%	24	65.5%
June, 2006	122	450	18	83.3%	24	62.5%
July, 2006	130	461	18	82.6%	24	62.0%
August, 2006	138	497	18	89.1%	24	66.8%
September, 2006	135	456	18	84.4%	24	63.3%
October, 2006	156	497	18	89.1%	24	66.8%
November, 2006	141	464	18	85.9%	24	64.4%
December, 2006	140	510	18	91.4%	24	68.5%
2006 Totals	1,544	5,700	18	86.8%	24	65.1%
		3.7 days				
January, 2007	146	527	18	94.4%	24	70.8%
February, 2007	140	458	18	90.9%	24	68.2%
March, 2007	121	549	18	98.4%	24	73.8%
April, 2007	136	511	18	94.6%	24	71.0%
May, 2007	156	494	18	88.5%	24	66.4%
June, 2007	152	469	18	86.9%	24	65.1%
July, 2007	137	498	18	89.2%	24	66.9%
August, 2007	152	478	18	88.5%	24	66.4%
September, 2007	141	487	18	90.2%	24	65.5%
October, 2007	134	501	18	89.8%	24	67.3%
November, 2007	143	476	18	88.1%	24	66.1%
December, 2007	146	493	18	88.4%	24	66.3%
2007 Totals	1,704	5,941	18	90.4%	24	67.8%
		3.5 days				
January, 2008	144	553	18	99.1%	24	74.3%
February, 2008	150	509	18	101.0%	24	75.7%
March, 2008	163	525	18	94.1%	24	70.6%
April, 2008	135	453	18	81.2%	24	60.9%
May, 2008	148	507	18	100.6%	24	75.4%
YTD 2008 Totals	740	2,547	18	93.1%	24	69.8%
		3.4 days				

ATTACHMENT MOD-2B(9)

PEAK CENSUS ICU

	ADC (Midnight)	ADC (9 AM)	Staffed Occupancy %	Licensed Occupancy %	Days ADC was ≥ 15	% Days in the month ADC was ≥ 15
Jan-07	18	18	100%	75%	29	94%
Feb-07	18	18	100%	75%	27	96%
Mar-07	18	18	100%	75%	31	100%
Apr-07	18	18	100%	75%	27	90%
May-07	18	18	100%	75%	25	81%
Jun-07	18	18	100%	75%	24	80%
Jul-07	18	18	100%	75%	24	77%
Aug-07	18	18	100%	75%	19	61%
Sep-07	18	18	100%	75%	26	87%
Oct-07	18	18	100%	75%	28	90%
Nov-07	18	18	100%	75%	26	87%
Dec-07	18	18	100%	75%	24	77%
					310	
					310 days in 2007,	85%
					ICU census was > 60%*	of days in 2007, ICU census was > 60%*

MODERN FACILITIES
Deterioration

INTEGRATED PROCEDURE SERVICES

Integrated Procedure Services (IPS) will combine Surgery, GI/Endoscopy, and Interventional Radiology (IR) into one functionally and physically integrated space. Combining these proccdural services immediately facilitates efficiencies in shared staff and support space. Integrating procedural services also provides long-term flexibility in care delivery.

The Hospital proposes to relocate, centralize and expand Surgery, GI/Endo and IR Services. These services occupy a total of 23,073 gross square feet (gsf) on the 1st Floor. These services will be relocated to the 1st Floor of the new East Wing, occupying 37,590 department gsf. The project adds two (2) treatment rooms, as follows:

	Number of Treatment Rooms	
Integrated Procedure Services	Existing	Proposed
Surgery	12	13
GI/Endo	3	4
Interventional Radiology (IR)		
Special Procedures	1	1
Minor Procedures	1	1
Total	17	19

Spacc vacated by Surgery will be modernized primarily for non-clinical services, including Medical Records, Conference, Quality Assurance, and Risk Management. GI/Endo's vacated space will be used to expand the Emergency Department. Special Procedures vacated space will be used to expand Diagnostic Radiology (refer back to existing and proposed schematics.)

The Hospital proposes to modernize and expand IPS. Due to their age, size and configuration the facilities are obsolete. The need for the project is based on increases in historical utilization and projected growth and aging of the population in the service area.

Deterioration

Surgery is in a building which is over 30 years old and the facilities are obsolete and need to be replaced. See Attachment MOD-2C(2) for schematic assessment of the existing conditions of the facilities by Navigant Consulting, Inc. (NCI.) Obsolescence of the procedure services is indicated by the following conditions:

Surgical suites are over 30 years old and all the rooms are very small. Larger ORs are needed to accommodate the latest advances in technology; to allow for additional personnel, proper staff circulation, improved efficiency and ease of maintenance and cleaning; for patient and staff safety; and to improve flexibility and efficiency, allowing any case to be done in any room, eliminating the need and wait for 'specialty' rooms.

Surgical suites do not employ a sterile core philosophy for segregation of sterile and non-sterile materials.

Temperature controls and HVAC do not for rapidly adjust and maintain temperature.

The operating rooms are not protected by a fire sprinkler system.

Operating rooms need increased electrical power, better surgical lighting, and use of equipment booms, better video and information technology.

Operating rooms do not have dedicated waste anesthesia gas disposal (WAGD) system.

Existing services are seriously undersized, another measure of their obsolescence. Surgery and GI/Endo currently occupy only 22,127 gsf (refer back to Attachment MOD-3) which indicates that Surgery has only 19,166 gsf and GI/Endo has 2,961 gsf.) Based on IHFPB standards their combined 15 existing ORs are seriously (40%) undersized, and could justify 31,170 gsf, as follows:

IHFPB Standard for 15 ORs is 15 ORs X 2,078 gsf per room	= 31,170 gsf allowed
Palos Community Hospital's existing 15 ORs	= 22,127 gsf
IHFPB Standard Allows	= 9,043 additional gsf
	= 40% undersized

Interventional Radiology (IR) is also undersized, occupying only 946 gsf. Based on IHFPB standards IR's two (2) rooms could justify 2,772 gsf, as follows:

IHFPB Standard for 2 rooms X 1,386 gsf per room	= 2,772 gsf allowed
Palos Community Hospital's existing 2 rooms	= 946 gsf
IHFPB Standard Allows	= 1,827 additional gsf
	= 193% undersized

<u>Necessary Replacement</u>

Between 2005 and 2007 surgery hours and inpatient visits increased at an average 4.0% and 5.1% per year, respectively. Surgery hours and visits are projected to grow at an average 2.8% and 2.0% per year, respectively, through 2020 (see Attachment MOD-2C(1) for historical and projected utilization.) Based on this modest growth Surgery can justify the need for the proposed 13 operating rooms (ORs) by the year 2020 as follows:

IHFPB Standard for 13 ORs is 13 ORs X 1,500 hours per OR	= 19,500 hours
Palos Community Hospital's 13 ORs	= 23,404 hours
IHFPB Standard Allows	= 16 ORs

GI/Endo hours and inpatient visits increased at an average 6.9% and 3.1% per year, respectively, between 2005 and 2007. GI/Endo hours and visits are projected to grow at 2.8% and 2.7%per year, respectively, through 2020 (see Attachment MOD-2C (1).) Based on this modest growth GI/Endo can justify the need for the proposed four (4) operating rooms (ORs) by the year 2020 as follows:

IHFPB Standard for 4 ORs is 4 ORs X 1,500 hours per OR = 6,000 hours
Palos Community Hospital's 4 ORs = 7,990 hours
IHFPB Standard Allows = 5 ORs

The utilization of Intervention Radiology (IR), both Special Procedures and Minor Procedures, has declined over the past three years. While utilization increased slightly in 2008, utilization is held flat through 2020 (see Attachment MOD-2C(1).) Based on current utilization which is held constant through 2020, IR can justify the need for the two (2) existing rooms in the year 2020 as follows:

IHFPB Standard for two rooms is 2,000 visits per room = 4,000 visits
Palos Community Hospital's 2rooms = 5,005 visits
IHFPB Standard Allows = 2 rooms

Projected growth and aging of the population in the service area contribute to the need to modernize and expand IPS. Service area population is expected to increase 1.0% per year from 2007 through 2020 (see population projections in Attachment GRC-4.) The service area's elderly population is expected to increase 2.5% per year through 2012. The elderly are the fastest growing population in the service area.

Therefore, based on historical increases in utilization, modest utilization projections, growth and aging of the service area population and IHFPB standards, the Hospital could justify a total of 23 procedure rooms, as follows: Surgery, 16; GI/Endo, 5; and IR 2 rooms. The Hospital proposes to add two (2) rooms to its current 17 rooms, for a total of only 19 rooms.

Please refer to "Necessary Expansion," in Attachment MOD-3C for justification of the 37,590 gsf for IPS.

INTEGRATED PROCEDURE SERVICES (IPS)

	EXISTING	CON PROPOSED
IPS - OR PROCEDURE ZONE	12	13
IPS - ENDOSCOPY ZONE	3	4
IPS - INTERVENTIONAL ZONE (SPECIALS)	1	1
IPS -INTERNVENTIONAL ZONE (MINOR PROCEDURES)	1	1
Total Procedure Rooms IPS:	17	19

	Projected Growth															
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
PROCEDURE HOURS:																
IPS - OR PROCEDURE ZONE	15,794	16,498	17,155	17,717	18,163	18,720	19,095	19,477	19,866	20,263	21,198	21,622	22,054	22,495	22,945	23,404
IHFPB Rooms Allowed (1,500 hours per room)	10.5	11.0	11.4	11.8	12.1	12.5	12.7	13.0	13.2	13.5	14.1	14.4	14.7	15.0	15.3	15.6
IPS - ENDOSCOPY ZONE*	5,058	5,225	5,752	4,940	5,912	6,076	6,244	6,418	6,596	6,779	6,967	7,161	7,359	7,564	7,774	7,990
IHFPB Rooms Allowed (1,500 hours per room)	3.4	3.5	3.8	3.3	3.9	4.1	4.2	4.3	4.4	4.5	4.6	4.8	4.9	5.0	5.2	5.3
IPS - INTERVENTIONAL ZONE (SPECIALS)	2,153	2,031	1,993	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000
IHFPB Rooms Allowed (2,000 hours per room)	1.1	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
IPS -INTERNVENTIONAL ZONE (MINOR PROCEDURES)	4,032	3,080	2,975	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005
IHFPB Rooms Allowed (2,000 visits per room)	2.0	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5
TOTAL IHFPB ROOMS ALLOWED																23.4
PROCEDURE ROOMS:																
EXISITING**	15	17	17	17	17	17	17	17	17	17	17	17	17			
PROPOSED														19	19	19

OPERATING ROOMS	13 Includes 1 cystoscopy
GI/ENDO	4
SPECIAL/INTERVENTIONAL	1
MINOR PROCEDURES	1

RECOVERY ROOMS: 4 PER PROCEDURE ROOM, EXCLUDING 2 ROOMS FOR SPECIAL/MINOR PROCEDURES ROOM = 17 PX ROOMS

CALCULATED TOTAL POSITIONS BASED ON 17 PX ROOMS:	68	68	68	68	68	68	68	68	68
PROPOSED RECOVERY POSITIONS: PACU	15	15	15	15	15	15	15	15	15
CSSC (PRE AND POST - STAGE II & OUTPATIENT)	50	50	50	50	50	50	50	50	50
TOTAL RECOVERY POSITIONS	65	65	65	65	65	65	65	65	65
PLUS INFUSION THERAPY/OTHER OUTPATIENT PROCEDURES (IN CSSC ZONE)	5	5	5	5	5	5	5	5	5

** 2 CVORs added in 2005*

Project includes only one smaller OR for cystoscopy.

In AHQs - 2 existing cysto rooms are reported with General ORs since they are located in Surgery.

In 2007 one surgeon retired; 1 physician went to part time; & another physician was on LOA several months. In 2008 PCH added two new general surgeons.

Source:PCH - Surgical Services Statistics

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

SURGERY

	Historical			Projected Growth												
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
HOURS OF SURGERY																
Inpatient	9,063	10,147	10,655	11,242	11,186	11,984	12,223	12,468	12,717	12,972	13,760	14,035	14,316	14,602	14,894	15,192
Outpatient	6,731	6,351	6,500	6,475	6,977	6,737	6,871	7,009	7,149	7,292	7,438	7,586	7,738	7,893	8,051	8,212
Total	15,794	16,498	17,155	17,717	18,163	18,720	19,095	19,477	19,866	20,263	21,198	21,622	22,054	22,495	22,945	23,404
Annual % Change		4.5%	4.0%	3.3%	2.5%	3.1%	2.0%	2.0%	2.0%	2.0%	4.6%	2.0%	2.0%	2.0%	2.0%	2.0%
Average Increase 2005-2007			4.0%													
NUMBER OF PATIENTS																
Inpatient	4,097	4,427	4,517	4,607	4,699	4,793	4,889	4,987	5,087	5,189	5,292	5,398	5,506	5,616	5,729	5,843
Outpatient	4,676	4,402	4,232	4,317	4,403	4,491	4,581	4,672	4,766	4,861	4,958	5,058	5,159	5,262	5,367	5,475
Total	8,773	8,829	8,749	8,924	9,102	9,285	9,470	9,660	9,853	10,050	10,251	10,456	10,665	10,878	11,096	11,318
Average Inpatient Increase, 2005-2007			5.1%													
Annual % Change		0.6%	-0.9%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
Average Time/Procedure																
Inpatient	2.2	2.3	2.4	2.4	2.5	2.5	2.5	2.5	2.5	2.5	2.6	2.6	2.6	2.6	2.6	2.6
Outpatient	1.4	1.4	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5
Total	1.8	1.9	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.1	2.1	2.1	2.1	2.1	2.1
STANDARDS																
Capacity per OR (Hours)	1,500															
Total Capacity	15,000	18,000	18,000	18,000	18,000	18,000	18,000	18,000	18,000	18,000	18,000	18,000	18,000	19,500	19,500	19,500
Number of ORs based on hours	10.5	11.0	11.4	11.8	12.1	12.5	12.7	13.0	13.2	13.5	14.1	14.4	14.7	15.0	15.3	15.6
NUMBER OF OPERATING ROOMS (EXISTING & PROPOSED)																
Operating Rooms:*	10	12	12	12	12	12	12	12	12	12	12	12	12	13	13	13

Project includes only one smaller OR for cystoscopy.
In AHQs - 2 existing cysto rooms are reported with General ORs since they are located in Surgery.
** 2 CVORs added in 2005 (one is for emergency back-up)*
Palos recently added two new general surgeons to replace the one who retired in 2007 and the one surgeon who went from full time to part time.
One physician who was on LOA for several months in 2007 has returned.
Source: PCH - Surgical Services Statistics

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PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

GI / ENDOSCOPY

	Historical		Projected Growth													
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
NUMBER OF HOURS - GI/ENDO																
Inpatient	1,201	1,194	1,443	1,486	1,486	1,531	1,577	1,624	1,673	1,723	1,775	1,828	1,883	1,939	1,997	2,057
Outpatient	3,857	4,031	4,309	4,425	4,425	4,545	4,668	4,794	4,923	5,056	5,192	5,333	5,477	5,624	5,776	5,932
Total	5,058	5,225	5,752	5,912	5,912	6,076	6,244	6,418	6,596	6,779	6,967	7,161	7,359	7,564	7,774	7,990
Annual % Change		*3.3%*	*10.1%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*
Average Increase 2005-2007			6.9%													
NUMBER OF CASES/PROCEDURES																
Inpatient	1,434	1,416	1,524	1,551	1,576	1,604	1,633	1,663	1,692	1,723	1,754	1,785	1,818	1,850	1,884	1,918
Outpatient	4,676	4,784	4,549	4,685	4,417	4,549	4,686	4,826	4,971	5,120	5,274	5,432	5,595	5,763	5,936	6,114
Total GI/Endo Procedures	6,110	6,200	6,073	6,237	5,993	6,153	6,319	6,489	6,663	6,843	7,028	7,217	7,412	7,613	7,819	8,031
Average Inpatient Increase 2005-2007			3.1%													
Annual % Change		*1.5%*	*-2.0%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*
Average Time/Procedure																
Inpatient	0.8	0.8	0.9	1.0	0.9	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.1	1.1
Outpatient	0.8	0.8	0.9	0.9	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Total	0.8	0.8	0.9	0.9	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
STANDARDS																
Capacity per Room (hours)	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*
Number of Rooms based on hours	3.4	3.5	3.8	3.9	3.9	4.1	4.2	4.3	4.4	4.5	4.6	4.8	4.9	5.0	5.2	5.3
NUMBER OF PROCEDURE ROOMS (EXISTING & PROPOSED)																
GI/Endo Procedure Rooms	3	3	3	3	3	3	3	3	3	3	3	3	3	4	4	4

Palos recently added two new general surgeons to replace the one who retired in 2007 and the one surgeon who went from full time to part time.
One physician who was on LOA for several months in 2007 has returned.
Source: PCH - Surgical Services Statistics - Outpatient Department

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ATTACHMENT MOD-2C(1)
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PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

SPECIAL PROCEDURES / INTERVENTIONAL RADIOLOGY

PROCEDURES	Historical			Projected Growth												
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Inpatient	1,485	1,441	1,473	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500
Outpatient	668	544	520	500	500	500	500	500	500	500	500	500	500	500	500	500
Total	2,153	2,031	1,993	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000
Annual % Change		*-5.7%*	*-1.9%*	*0.4%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
STANDARDS																
Capacity per Room (Pxs)	2000 procedures															
Percent Utilization	107.7%	101.6%	99.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Number of Rooms based on hours	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1

MINOR PROCEDURES

	Historical			Projected Growth												
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Minor Procedure Visits	4,032	3,080	2,975	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005
Annual % Change		*-23.6%*	*-3.4%*	*1.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
Number of Rooms (Existing & Proposed)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
TOTALS	6,185	5,111	4,968	5,005	5,005	5,005	5,005	5,005	5,005	5,005	5,005	5,005	5,005	5,005	5,005	5,005
NUMBER OF PROCEDURE ROOMS (EXISTING & PROPOSED)																
Special Procedures/Interventional Radiology	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Minor Procedures	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1

Annualized Jan-Mar 2008
Source: PCH - Special Procedures Statistics (Radiology)

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PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

INFUSION THERAPY

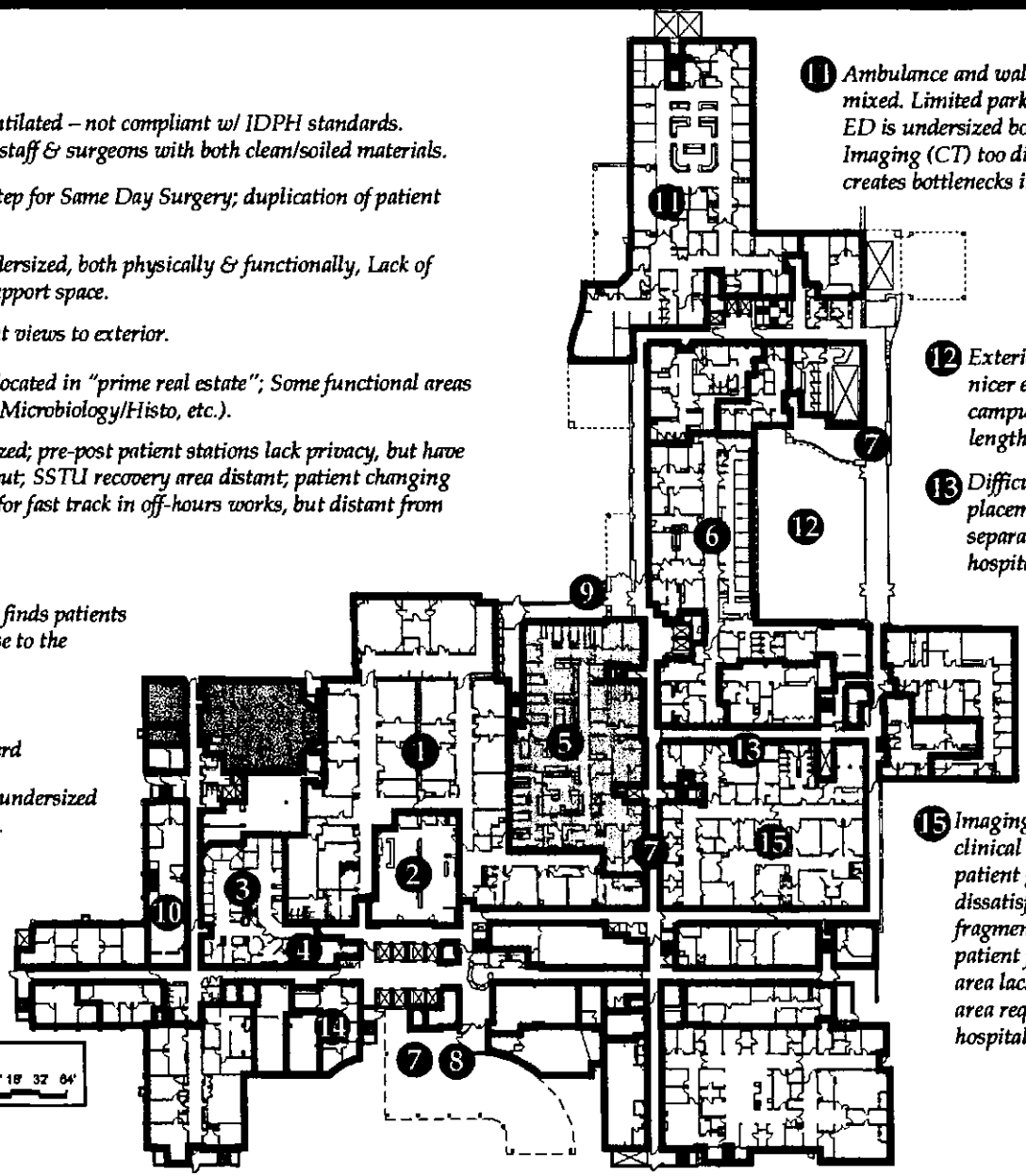
TREATMENTS	Historical			Projected Growth												
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
OUTPATIENT INFUSION THERAPY																
Treatment Volumes	1508	1658	1908	1927	1966	2005	2045	2086	2128	2170	2214	2258	2280	2303	2326	2349
Annual % Change		9.9%	15.1%	1.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	1.0%	1.0%	1.0%	1.0%
Average Increase 2005-2007			13.3%													
Proposed Positions									**One Pod in the Center for Short Stay Care**					**5**	**5**	**5**

Volumes were projected at 2% per year through 2015 and then only 1% through 2020. Reimbursement changes and/or shift to home health for some treatments may affect the overall long-term volume.
Treatments included: Infusion (non-chemo), antibx, transfusion, Ferricit, epidural blocks, port draws, etc.
Source: PCH - Surgical Services, NCI Consulting

Existing Conditions Overview – Level 1

Key Notes:

1. *Surgery – ORs undersized and under ventilated – not compliant w/ IDPH standards. Overall configuration mixes all patients, staff & surgeons with both clean/soiled materials.*
2. *PACU undersized; often used as initial step for Same Day Surgery; duplication of patient prep in holding area*
3. *Same Day Surgery – patient stations undersized, both physically & functionally, Lack of patient/family privacy; limited clinical support space.*
4. *Surgery Waiting very undersized without views to exterior.*
5. *Lab is positioned well with surgery, but located in "prime real estate"; Some functional areas within the lab are dated and undersized (Microbiology/Histo, etc.).*
6. *Outpatient treatment spaces well organized; pre-post patient stations lack privacy, but have natural light; clinical support is spread out; SSTU recovery area distant; patient changing areas claustrophobic. Utilization of area for fast track in off-hours works, but distant from central ED.*
7. *Two entrances for outpatients oftentimes finds patients at the wrong entrance requiring a traverse to the opposite end of the hospital*
8. *Entrance dark & uninviting*
9. *CVOR patient transfer to CVU is awkward*
10. *Medical Records, as noted previously, is undersized & separated into four areas on two levels.*
11. *Ambulance and walk-in emergency traffic is mixed. Limited parking. Ambulances must back in. ED is undersized both physically & functionally. Imaging (CT) too distant. Delays in lab results creates bottlenecks in system*
12. *Exterior Courtyard is one of the nicer environmental features of the campus. "Helps" to reduce the length of walk to services*
13. *Difficult to determine exact placement of required smoke separations within the original hospital*
14. *Cashiers & Financial Counselors should be located adjacent to OP Registration*
15. *Imaging undersized with inadequate clinical support; Unisex nature of patient gown area can lead to patient dissatisfaction; Mammography area is fragmented, undersized and not patient friendly; Inpatient holding area lacks supervision; Ultrasound area requires updating; Lack of in-hospital MRI requires transfer*



NAVIGANT CONSULTING

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ATTACHMENT MOD-2C(2)

MODERN FACILITIES

Necessary Expansion

ATTACHMENT	CLINICAL SERVICE	GSF* Existing	GSF* Proposed	Amount of Proposed Total GSF That Is: New	Remodeled	As Is	Vacated	Department GSF*
MOD - 3A	Medical Surgical	93,260	180,065	91,790	77,330	10,945		84, 825
MOD - 3B	Intensive Care	10,846	25,650	25,650			10,846	23,490
MOD - 3C	INTEGRATED PROCEDURE SERVICES							37,590
	A) Surgery	19,166	37,354	37,354			19,166	
	B) Endoscopy	2,961	3,468	3,468			2,961	
	C) Special Procedures	946	2,004	2,004			946	
MOD - 3D	RECOVERY							22,380
	A) PACU	2,092	3,750	3,750			2,092	3,350
	B) Center for Short Stay Care	14,572	22,940	22,940			14,572	19,030
MOD - 3E	Respiratory Therapy	1,485	5,425	1,060	4,365		1,485	1,060
MOD - 3F	Laboratory	9,362	22,487	22,487			9,362	18,880
MOD - 3G	Pharmacy	4,135	8,229	8,229			4,135	7,360
MOD - 3H	Outpatient & Pre-Admission Testing	1,265	4,730	4,730			1,265	4,180
MOD - 3I	Inpatient Dialysis	717	1,105		1,105		717	1,105
MOD - 3J	Emergency Department	12,361	22,814		11,435	11,379		22,818
MOD - 3K	Admissions Unit	0	6,696		6,696			6,696
MOD - 3L	Cardiology	4,299	6,661		6,661		4,299	6,661
MOD - 3M	Nuclear Medicine	1,652	6,766		6,766		1,652	6,766
MOD - 3N	Radiology	20,068	31,732		16,889	14,843	2,421	31,732
	Sub Total Clinical	**199,187**	**391,876**	**223,462**	**131,247**	**37,167**	**75,919**	

MODERN FACILITIES
Necessary Expansion

MEDICAL/SURGICAL SERVICES

The Hospital proposes a major expansion and modernization of Medical/Surgical (M/S) Services. The project adds 84,825 department gsf in the East Wing for 156 replacement beds; modernizes 77,330 gsf; discontinues 165 M/S beds in small, semi-private rooms; converts 134 beds to private rooms; replaces the infrastructure (plumbing and HVAC) in buildings which house the M/S nursing units; and results in a net loss of 9 M/S beds, for a total of 306 M/S beds upon project completion. The 306 M/S beds would contain 180,065 gsf (refer back to Attachment GRC-5, justifying the need for the proposed 544 gsf per bed in the East Wing.)

Necessary Expansion

Of the 315 M/S beds, 95% (299 beds) were built 35 years ago (refer back to the site plan showing construction dates in Attachment MOD-2A(1).) The 299 M/S beds are in three (3) buildings: the South Building (Original Hospital) built in 1972; its East Building expansion built in 1974; and the North Building built in 1973. The other 16 beds in the new cardiovascular unit (CVU) were modernized in 2005. With only 16 modern M/S beds, the Hospital needs to expand to replace 290 of these 299 deteriorating and obsolete beds.

Of the 299 M/S beds in aging structures, 284 beds (95%) are in obsolete, small, semi-private rooms (refer back to Attachment MOD-1C.) Besides lacking privacy, these rooms do not accommodate needed equipment; lack adequate toilet facilities; inhibit adequate infection control; and are a challenge to keep fully occupied due to companion issues (see patient comments following this analysis on Pages 5 and 6 of Attachment MOD-3A.)

The 299 M/S beds are in four (4) small, obsolete M/S nursing units which lack adequate patient and staff support space. The 315 M/S beds occupy 93,260 gsf; the 16-bed CVU occupies 10,945 gsf; and the remaining 299 M/S beds have 77,300 gsf, or 259 gsf per bed (see Attachment MOD-3.) The severe lack of space requires staff to store medical carts" in corridors. Routine supplies i.e. isolation carts, IVAC pumps, bedside commodes, geri-chairs etc. are stored in remote locations, delivered to the unit when needed.

Necessary Replacement

The need for 306 M/S beds is based on increasing M/S utilization, numerous elderly, seriously ill patients, and continued growth and aging of the service area population. M/S days increased 5.8% per year between 2005 and 2007 (see Attachment MOD-3A(1).) The growth is due to higher lengths of stay (ALOS), principally from elderly patients who have more serious illnesses and conditions, and more observation patients. Observation patients are treated in inpatient units to conserve experienced, nursing staff whose numbers are at a premium.

Between 2005 and 2007 the Hospital's M/S ALOS increased 8%, from 4.39 days to 4.74 days. This increase is due principally to the Hospital's high number of seriously ill, elderly admits. In 2005 the Hospital admitted far more patients from skilled nursing facilities (SNFs) than any other Illinois hospital. Refer back to Attachment MOD-2A(7) which shows that Palos Community Hospital admitted 887 SNF patients in 2005 which is almost 50% higher than the next highest hospital, which admitted only 605 patients! Yet, the Hospital's ALOS is lower than the 4.8 day average of other hospital's in Planning Area A-4 (see to Attachment 2A(8).)

The high number of elderly admissions is due to the high elderly population in the service area, 12.8% of population, which is higher than Illinois or the U.S. See Attachment MOD-2A(9) for documentation of this ratio and the substantially higher inpatient use rates in the service area for this population. Similarly, while the Hospital's overall market share is 23.5%, it serves between 27% and 30% of the area's elderly (refer back to Attachment GRC-4(4).) Given the medical needs of the elderly, combined with their chronic disease conditions, patients tend to be sicker. The severity of patients' illness is reflected in the Hospital's high co-morbidity index, among the highest in Illinois (see Attachment MOD-2A(10).)

While M/S patient days increased at an average of 5.8% per year between 2005 and 2007, occupancy rates also increased, from 73% to 79% on staffed beds (Attachment MOD-3.) However, the need to replace M/S beds is higher than occupancy rates indicate for the following reasons:

Lack of support space on the units constrains the ability to staff more than 278 beds and renovation will take 134 beds out of service over a four-year period;

Peak census statistics require 8 beds above average occupancies; and

Semi-private rooms are a challenge to fully occupy due to companion issues i.e. gender and infection control issues, forcing patients to wait for service in the ED when a bed may be empty in an unusable semi-private room.

As M/S occupancy continues to rise, the Hospital continues to staff more beds, from 267 to 278 beds, respectively, between 2005 and 2008. When occupancy reached 90% in January 2008 on 274 staffed beds, the Hospital was forced to relocate Respiratory Therapy from M/S Unit 3 – North to the main floor to open four (4) additional M/S beds (refer back to Attachment MOD-2A(11) for recent, monthly occupancy and schematics of 3-North.)

The 299 M/S have only 77,300 gsf, or 259 gsf per bed (see Attachment MOD-3.) While the 299 beds are either physically available or in reserve, support space for staff, equipment, and supplies are at maximum capacity. Medical carts are routinely "stored" in corridors. Routine supplies i.e. isolation carts, IVAC pumps, bedside commodes, geri-chairs etc. are stored in remote locations and must be delivered to the unit when needed. No space is available for family/visitors. The M/S units' limited space is another measure of obsolescence. Due to a lack of support space in the units, the Hospital is unable to staff additional beds.

With modest increases of 2.5% per year in patient days, less than half of the actual annual growth of 5.8% over the last three years, the 278 staffed beds would be 88% occupied by 2013 when the major renovation begins (refer back to Attachment MOD-2A(6).) The renovation will require the Hospital to close one nursing unit per year for four (4) years. Patients will be forced into fewer beds, and occupancy will exceed 90% during the renovation.

Occupancy rates, whether on licensed or staffed beds, mask the need to cover peak census. See Attachment MOD-2A(13) which indicates that the Hospital's midday census averaged an additional 8 patients more than its midnight census. The overlap in discharges and admissions in the midday, which cause the peak census, contributes to over-crowding in the Emergency Department (ED), when a MS bed is not available. In the first three months of 2008 over 41% of ED patients waited at least 2 hours for admission to a bed; another 11% waited at least 8 hours.

The need to replace and renovate 290 of the 299 M/S beds (156 replacement beds in the East Wing and 134 renovated beds in existing M/S units) is also based on growth and aging in the service area population. Service area population is expected to increase 1.0% per year from 2007 through 2020 (see population projections in Attachment GRC-4.) The service area's elderly population is expected to increase 2.5% per year through 2012. The elderly are the fastest growing population in the service area.

Upon project completion the Hospital would have 306 modern MS beds in appropriately sized, private rooms, each with a small space for family/visitor seating that converts for sleeping over (see prototypical M/S room in Attachment MOD-2A (3).) The M/S nursing units would incorporate advanced, interactive technology improving care, communication and efficiency. The new units provide space for visiting clinicians i.e. pharmacists, therapists, physicians, allowing multi-disciplinary, patient-focused care. For operational and functional description of the units, see Attachment MOD-2A(4); schematic design is in Attachment MOD-2A(5).

Compliance with IHFPB Target Utilization

M/S patient days are expected to grow at a modest 2.5% per year, significantly less than the actual growth of 5.8% per year between 2005 and 2007 and congruent with the projected increase of the service area's elderly population through 2012. With this modest growth the Hospital's 306 M/S beds would be appropriately utilized at over 88% as follows:

Medical/Surgical Occupancy – 2020

Beds	M/S Patient Days Only	IHFPB Standards	Beds Allowed
306	103,945	88%	324

Beds	M/S Days with Observation	IHFPB Standards	Beds Allowed
306	109,044	88%	339

Alternatives

The Hospital considered the following four alternatives to the project:

(1) Do nothing and ignore the need to ensure access to modern M/S services;
(2) Modernize existing space;
(3) Build an addition to the existing hospital; and
(4) Build a new hospital.

Alternative 1: Do Nothing

The alternative of doing notbing was considered not viable. M/S is an important acute care service and more and more patients are presenting witb serious illness and conditions. There is a need to expand the service to provide both modern private rooms and nursing units. Doing nothing ignores the current and projected needs for modern M/S services in the community.

Estimated Cost of Doing Nothing:

The capital cost of doing nothing appears to be minimal. However, patients bear non-monetary costs waiting for admission when M/S beds are not available due to "companion" issues. Staff and patients bear other costs in crowded, antiquated nursing units when service is inefficient and less effective. Therefore, there is "no capital cost" associated with this "no benefit" option.

Alternative 2: Modernize Existing Space
Upon construction of the proposed East Wing addition with 156 replacement M/S beds, the Hospital can modernize 134 existing M/S beds. Without the proposed East Wing, the Hospital does not have sufficient space anywhere in its current facilities for expanding the Hospital to provide modern M/S patient rooms and nursing units.

Estimated Cost of Modernizing the 134 M/S Beds:
The estimated cost of modernizing existing space is the project cost.

Alternative 3: Build an Addition to the Existing Hospital
Due to the lack of available space, the Hospital determined that it was necessary to build an addition to house the 156 replacement beds. See Attachment GRC-3 for discussion of alternative additions.

Alternative 4: Build a new Hospital
This option represents an expensive, unnecessary duplication of existing services.

Estimated Cost of Building a new Hospital:
Building a new hospital is the most expensive option. See Attachment GRC-3 which indicates that a new hospital of comparable scope and size is upwards of $700 million.

Refer to the following two pages for Patient Comments from the Press Ganey Inpatient Satisfaction Survey, 2008.

COMMENTS FROM PATIENTS

Directly from Press Ganey Inpatient Satisfaction Surveys – 2008 – Room Section Comments

- "Bad experience having roommate. Stay up at night when new person admitted at midnight. Uncomfortable sharing same bathroom. Why double rooms?"
- "My roommate was fine & staff always closed curtains for privacy, but even being deaf in one ear, I heard all my roommate's doctors, nurses, aids conversations and I'm sure she heard mine. Due to our illnesses we both had bathroom concerns, so a shared bathroom was also a concern."
- "Staff cannot help intruding on your privacy while attending two bed rooms. Staff/personnel in all departments were pleasant and helpful – but 2 bed rooms are stressful, not restful and uncivilized. Patients sharing a room have the potential of spreading sickness and should be discontinued."
- "Roommate loud & noisy."
- "Other patient had breathing machine on at night. It was very loud."
- "Too much noise at night. Roommate seemed to need a lot of attention every night, which meant no sleep for me."
- "Bed neighbor & visitors were very noise and disrespectful to others (too many people (visitors) in the room. 3 or 4 at a time."
- "Kind of noisy at night. My roommate snored really, really loud."
- "I requested another room. Roommate was a raving lunatic, I could not sleep."
- "My roommate – the last 2 days of my stay was very disruptive & loud when he was awake."
- "Surgery was delayed 2 days, person next to me had a bad cold and I got it."
- "An 88 year old woman was put in my room. She had a very bad cough, Alzheimer's patient and didn't have control of her bowels or urine. I was most concerned with her coughing and hoping I wouldn't catch her cough."
- "Very sick patient as neighbor. She was in much pain."
- "Noise from roommates TV – she had it on all day & night & did not use ear phone."
- "Roommates machine would continuously go off and other patients screaming throughout the night."
- "The other patient's family members were coming up before visiting hours and were very rude. And did not leave when asked."

COMMENTS FROM PATIENTS continued...

- "Roommate had the TV on all night; I asked the CNA to turn it off if it was on later than II:00. Also, another room had TV volume loud, until I mentioned to a CNA that 12: 30 am the TV would be lower in volume or turned off. Both patients were awake and talking. They complied."
- "My room partner had many visitors each time. Very loud talking and laughing. No consideration for me. Also, TV on late. What about the rule of 2 visitors per patient."
- "Person in Bed 1 had her TV on all night. You should have a master switch at the nurse's station to turn off all TVs at least by 12 or 1:00. Number of visitors should be limited for every given patient."
- "I had 6 days in hospital & had 3 different roommates."
- "My roommate's monitor kept going off at all hours."
- "Three different roommates requiring constant attention, both day and night. I was constantly being awakened at night by the bright overhead lights as people entered the room. During m y 2 week stay, only 2 nurses used flashlights."
- "Roommate kept me up day and night. After three days room was changed (much better after that)."
- "I do remember partner kept TV on late and had so many visitors every day."
- "A couple of male patients screaming day & night. First roommate noisy."
- "Person by window was in control of temperature."
- "My roommate had diarrhea on the floor by his bed. The odor would not leave the room. It was sickening."
- "The reason it was "hot" in the room is that my roommate kept her curtain pulled blocking air to my side of the room."
- "My roommate had many visitors – this was very frustrating and I had no privacy."
- "Roommate had visitors past visiting hours – talked on cell phone all night long."
- "Roommate had very noisy visitors."
- "Roommate had light on all night (lights should be out at 10:00 p.m.). Had TV all night loud. It was bad in the room, she had control."
- "I was placed with an old woman who had dementia and kept me up at night."
- "Roommate's visitors too noisy. Sometime more than two visitors at one time."

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED UTILIZATION

MEDICAL/SURGICAL

	Historical			Projected												
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Medical Surgical Admissions	15,840	15,292	15,892	16,289	16,697	17,114	17,542	17,980	18,430	18,891	19,363	19,847	20,343	20,852	21,373	21,907
% Change		-2.2%	3.9%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
Medical Surgical Patient Days	68,617	71,241	75,404	77,289	79,221	81,202	83,232	85,313	87,446	89,632	91,872	94,169	96,523	98,937	101,410	103,945
% Change		3.8%	5.8%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
* Observation Patient Days	2,253	4,395	3,699	3,791	3,886	3,983	4,083	4,185	4,290	4,397	4,507	4,620	4,735	4,853	4,975	5,099
% Change		95.1%	-15.8%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
Total Medical Surgical Unit Days	70,870	75,636	79,103	81,081	83,108	85,185	87,315	89,498	91,735	94,029	96,379	98,789	101,259	103,790	106,385	109,044
% Change		6.7%	4.6%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
Average Increase 2005-2007			**5.8%**													
Average Daily Census (ADC)	194	207	217	222	228	233	239	245	251	258	264	271	277	284	291	299
Average Length of Stay (ALOS)	4.39	4.66	4.74	4.74	4.74	4.74	4.74	4.74	4.74	4.74	4.74	4.74	4.74	4.74	4.74	4.74
Licensed Medical Surgical Beds	315	315	315	315	315	315	315	315	315	315	315	315	306	306	306	306
Staffed Medical Surgical Beds	266	267	274	278	276	278	278	278								
Js in Transition due to Modernization (134)									-32	-34	-34	-34				
** Total Beds Physically Available	315	315	315	315	315	315	315	315	283	281	281	281	308	306	306	306
Occupancy of Licensed Beds	62%	66%	69%	71%	72%	74%	76%	78%	80%	82%	84%	86%	91%	93%	95%	98%
Occupancy of Staffed Beds	73%	78%	79%	80%	82%	84%	86%	88%								
Occupancy of Physically Available Beds	62%	66%	69%	71%	72%	74%	76%	78%	89%	92%	94%	96%	91%	93%	95%	98%
CON Justified M/S Beds (@ 88%)	221	235	246	252	259	265	272	279	286	293	300	308	315	323	331	339

Observation patients are treated on medical surgical patient care units.

* The significant increase in inpatients in 2007 and 2008 was due to an overly conservative interpretation of CMS rules relating to observation status by hospital staff in 2006, resulting in a higher volume of patients placed in observation status. Implementation of case management review and physician documentation of inpatient criteria resulted in appropriate classification of patients, and more inpatients.

** The project modernizes 134 M/S beds converting the beds to private rooms. These beds are in four nursing units; one nursing unit will be modernized per year after construction of the East Wing .

Annualized Jan-Jun 2008

Source: PCH Meditech Utilization Statistics/Planning; Projections - NCI Consulting

MODERN FACILITIES
Necessary Expansion

INTENSIVE CARE SERVICES

The Hospital proposes to modernize and expand Intensive Care (ICU) Services. The project adds 12 ICU beds by building two new ICUs in the East Wing, a 24-bed ICU on the 7th Floor and a 12-bed unit on the 6th Floor (see prototypical ICU in Attachment MOD-2B(2).) Intensive Care Services would expand from 10,846 gsf to 23,490 department gsf (refer back to existing and proposed schematics.) The 36 ICU beds would contain 653 gsf. Please see Attachment GRC-5, justifying the need for the proposed space. The space vacated by ICU on the 3rd Floor would be used to expand Inpatient Dialysis, Respiratory Therapy and Medical Facilities/Support (On-Call and Hospitalist Program.)

There is currently a need for 32 additional ICU beds if Planning Area A-4 (IHFPB Inventory, Update 8/15/08.)

Necessary Expansion

The existing 24-bed ICU is severely undersized. Its 10,846 gross square feet (gsf) is only 452 gsf per bed. ICU rooms are extremely small. The CCU rooms are only about 140 square feet, making the use of any equipment in the room challenging. The CCU rooms have swing out toilets in the actual patient room, which is a highly undesirable situation.

In 2007 the 24 licensed ICU beds operated at 68% occupancy (see Attachment MOD-3B(1).) The Hospital staffs only 18 ICU beds due to limited support space; the ICU's awkward configuration with two unconnected units; and four, noncompliant rooms without windows. In 2007 the 18 staffed ICU beds operated at 90% occupancy (see Attachment MOD-3B(1).) Through May 2008 the ICU's 18 staffed and 24 licensed beds operated at 70% and 93%, respectively (see Attachment MOD-3B(2).)

The need for 36 ICU beds is based on increasing utilization, numerous elderly, seriously ill patients, and continued growth and aging of the service area population. ICU days increased 5.4% per year between 2005 and 2007. The growth is due to increases in ICU admissions which averaged 9.5% per year between 2005 and 2007 (see Attachment MOD-3B(1).) The Hospital's ICU ALOS of 3.5 days is the lowest in Planning Area A-4 (see Attachment 3B(3).)

Increasing ICU utilization is due, in part, to the Hospital's high number of seriously ill, elderly admits. In 2005 the Hospital admitted far more patients from skilled nursing facilities (SNFs) than any other Illinois hospital. Refer back to Attachment MOD-2B(7) which shows that Palos Community Hospital admitted 887 SNF patients in 2005 which is almost 50% higher than the next highest hospital which admitted only 605 patients!

The high number of elderly admissions is due to the high elderly population in the service area, 12.8% of population, which is higher than Illinois or the U.S. Refer back to Attachment MOD-2B(8) for documentation of this ratio and the substantially higher inpatient use rates in the service area for this population. Similarly, while the Hospital's overall market share is 23.5%, it serves between 27% and 30% of the area's elderly (see Attachment GRC-4(4).)

Given the medical needs of the elderly, combined with their chronic disease conditions, patients tend to be sicker. An indication of higher acuity is reflected in the Hospital's high co-morbidity index which is among the highest in Illinois (see Attachment MOD-3B(4).)

As ICU patient days increased at an average 5.4% per year between 2005 and 2007, ICU occupancy rates also increased, from 61% to 68% on 24 licensed beds during this period. Occupancy on the 18 staffed ICU beds increased from 81% to 90% during this period.

Occupancy rates, whether on licensed or staffed beds, mask the need for beds to cover the peak census. Refer back to Attachment MOD-2B(10) which indicates that, based on the Hospital's midday census, the ICU exceeded 60% (310 of 365 days!) about 85% of the time.

The overlap in discharges and admissions in the midday which cause the peak census, also contribute to over-crowding in the Emergency Department (ED), when a bed is not available. In the first three months of 2008 over 41% of ED patients waited at least 2 hours for admission. Another 11% waited at least 8 hours for admission.

The need to replace the obsolete ICU and add 12 more ICU beds is also based on growth and aging in the service area population. Service area population is expected to increase 1.0% per year from 2007 through 2020 (see population projections in Attachment GRC-4.) The service area's elderly population is expected to increase 2.5% per year through 2012. The elderly are the fastest growing population in the service area.

The new 36 ICU beds would be appropriately sized, each with small space for family/visitor seating that converts for sleeping over (see prototypical room in Attachment MOD-2B (3).) The new ICUs incorporate advanced, interactive technology which improves patient care, communication and efficiency. The new ICUs provide space for visiting clinicians i.e. pharmacists, therapists, physicians, enhancing multi-disciplinary, patient-focused care. For facilities-related operating principles see Attachment MOD-2B(4).

Compliance with IHFPB Target Utilization

ICU patient days are expected to grow at a modest 3.0% per year, significantly less than the actual growth of 5.4% per year between 2005 and 2007 and congruent with the projected increase of the service area's elderly population through 2012. With this modest growth, the Hospital's 36 ICU beds would be appropriately utilized at over 60% as follows:

Intensive Care (ICU) Occupancy – 2020

Beds	ICU Patient Days	Project Occupancy	IHFPB Standards	Beds Allowed
36	8,683	66%	60%	40

The Hospital needs to replace its 24 obsolete ICU beds and add 12 more ICU beds to ensure access to modern ICU services in the community.

Alternatives

The Hospital considered the following four alternatives to the project:

(1) Do nothing and ignore the need to ensure access to modern ICU services;
(2) Modernize existing space;
(3) Build an addition to the existing hospital; and
(4) Build a new hospital.

Alternative 1: Do Nothing

The alternative of doing nothing was considered not viable. ICU is an important acute care service and more and more patients are presenting with serious illness and conditions. There is a need to expand the service to provide both modern private rooms and nursing units. Doing nothing ignores the current/projected need for modern ICU services in the community.

Estimated Cost of Doing Nothing:

The capital cost of doing nothing appears to be minimal. However, patients bear non-monetary costs waiting for admission when ICU beds are unavailable due to over-crowding. Staff and patients bear other costs in crowded, antiquated nursing units when service is inefficient and less effective. There is "no capital cost" with this "no benefit" option.

Alternative 2: Modernize Existing Space

Excluding the new 16-bed cardiovascular unit (CVU) built in 2005, the Hospital's nursing units were built by 1978, and are at least 30 years old. The nursing units are very small by modern standards, with small, semi-private rooms and severely undersized staff and support areas. Excluding the new 16-bed cardiovascular unit (CVU), the remaining 299 M/S beds contain only 275 gsf per bed. These units will be modernized for continued M/S Services.

Other inpatient services have similar space constraints. Pediatrics and AMI Services contain only 5,872 gsf and 18,438 gsf, respectively. The modern ICU requires 653 department gsf (dgsf) per bed or 23,490 dgsf (see rationale in Attachment GRC-5.) In addition, all existing units are configured as disconnected, narrow units which are operationally obsolete for a modern ICU requiring patient visualization. Therefore, while other acute care services operate below IHFPB target occupancies, it is not feasible to convert such small units which are at least 30 years old, to modern ICUs. The Hospital has no available space anywhere in its current facilities for expanding ICU.

Estimated Cost of Modernizing:

IHFPB standards indicate that modernizing is approximately 70% of new construction.

Alternative 3: Build an Addition to the Existing Hospital

Due to the lack of available space, the Hospital determined that it was necessary to build an addition to house the 36 ICU. See Attachment GRC-3 for discussion of alternative additions.

Alternative 4: Build a new Hospital

This option represents an expensive, unnecessary duplication of existing services.

Estimated Cost of Building a new Hospital:

Building a new hospital is the most expensive option. See Attachment GRC-3 which indicates that a new hospital of comparable scope and size is upwards of $700 million.

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED UTILIZATION

INTENSIVE CARE

	Historical			Projected												
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Intensive Care Admissions	1,411	1,535	1,693	1,770	1,823	1,878	1,934	1,992	2,052	2,113	2,177	2,242	2,309	2,379	2,450	2,524
% Change		8.8%	10.3%	4.5%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Average Annual 2005-2007			9.5%													
Intensive Care Patient Days	5,348	5,689	5,942	6,090	6,273	6,461	6,655	6,854	7,060	7,272	7,490	7,715	7,946	8,184	8,430	8,683
% Change		6.4%	4.4%	2.5%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Average Annual 2005-2007			5.4%													
Average Daily Census (ADC)	15	16	16	17	17	18	18	19	19	20	21	21	22	22	23	24
Average Length of Stay (ALOS)	3.8	3.7	3.5	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4
Authorized Beds	24	24	24											36	36	36
% Occupancy on 24 Authorized Beds	61%	65%	68%	70%												
% Occupancy on 18 Operational Beds	81%	87%	90%	93%												
% Occupancy on 36 Proposed Beds														62%	64%	66%

INTENSIVE CARE BEDS:	
Existing	**24 ICU Beds**
IHFPB Std. 60% by 2018	**44 ICU Beds**
Proposed	**36 ICU Beds**

Annualized 2008 Jan-Jun 2008
PCH has a lowest ICU ALOS of all area hospitals.
Source: PCH Meditech Utilization Statistics, Projections - NCI Consulting

ATTACHMENT MOD-3B(1)

COMPARISON OF AVERAGE LENGTH OF STAY

Planning Area A-4 Hospitals

MEDICAL/SURGICAL

Planning Area A-4 Hospitals	Admissions	2007 Total Days	ALOS
Adventist LaGrange Memorial Hospital	7,036	33,752	4.8
Advocate Christ Medical Center	25,030	120,203	4.8
Advocate South Suburban Hospital	10,248	39,968	3.9
Ingalls Memorial Hospital	13,682	59,616	4.4
Little Company of Mary Hospital & Health Care Center	12,760	55,266	4.3
Oak Forest Hospital	1,976	15,820	8.0
Palos Community Hospital	**15,892**	**75,404**	**4.7**
RM Health Providers Limited Partnership	777	25,200	32.4
St. Francis Hospital & Health Center	10,339	48,808	4.7
St. James Hospital & Health Center (Olympia Fields)	9,132	39,289	4.3
St. James Hospital & Health Center (Chicago Heights)	9,388	44,486	4.7
TOTALS	116,260	557,812	**4.8**

INTENSIVE CARE

	Direct Admissions	2007 Total Days	ALOS
Adventist LaGrange Memorial Hospital	599	3,836	6.4
Advocate Christ Medical Center	3,869	26,180	6.8
Advocate South Suburban Hospital	950	4,698	4.9
Ingalls Memorial Hospital	348	7,339	21.1
Little Company of Mary Hospital & Heath Care Center	937	8,664	9.2
Oak Forest Hospital	385	2,020	5.2
Palos Community Hospital	**1,693**	**5,942**	**3.5**
RM Health Providers Limited Partnership	0	0	0.0
St. Francis Hospital & Health Center	1,328	5,773	4.3
St. James Hospital & Health Center (Olympia Fields)	1,061	5,712	5.4
St. James Hospital & Health Center (Chicago Heights)	688	3,615	5.3
TOTALS	11858	73,779	**6.2**

Source: Illinois Department of Public Health, 2007 AHQ Hospital Profiles.
Note: AHQ ALOS calculation for Palos' M/S was 5.0, a calculation discrepancy.

ATTACHMENT MOD-3B(3)

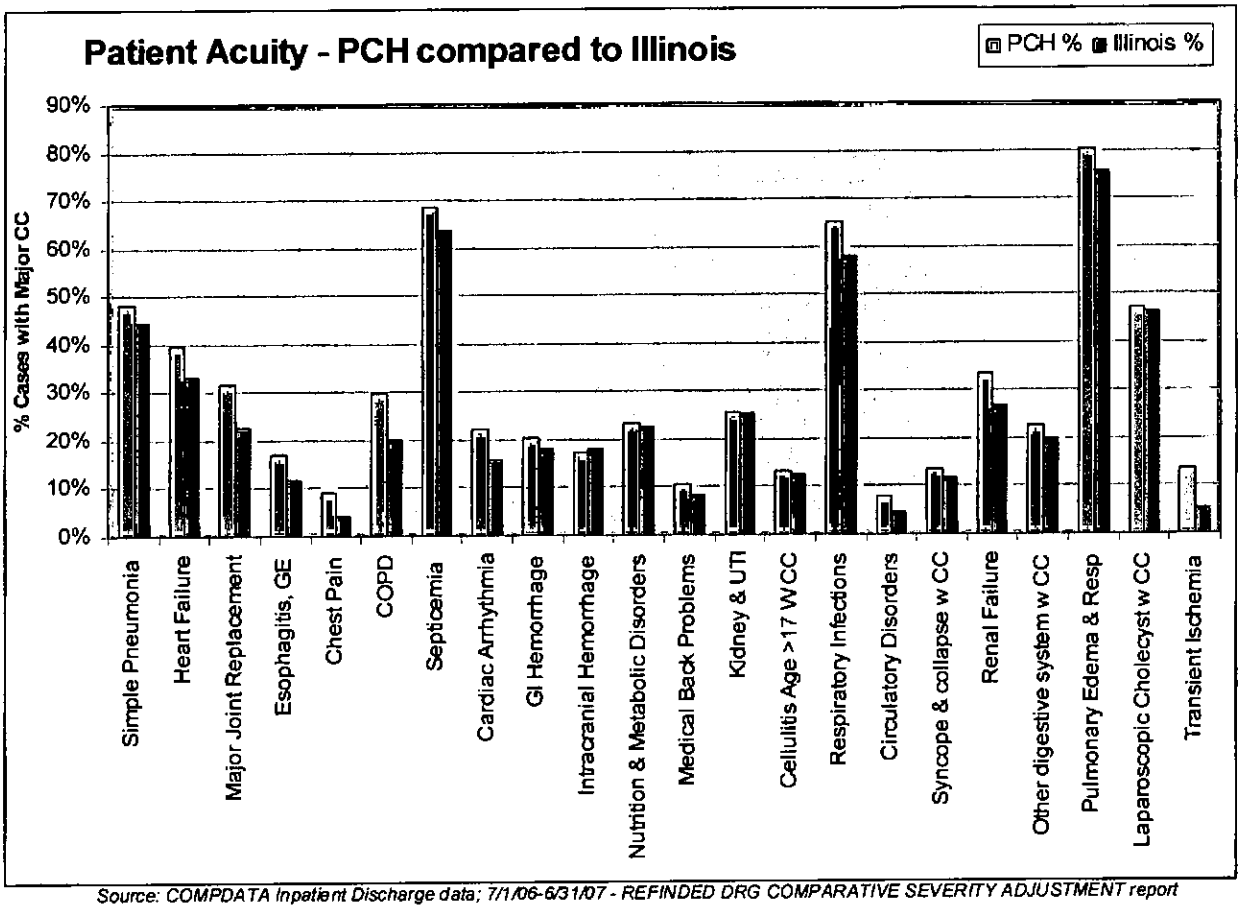
PALOS COMMUNITY HOSPITAL

INTENSIVE CARE ADMISSIONS & PATIENT DAYS BY MONTH

Month	Admissions	Patient Days	Operating Beds	Occupancy Percentage	Licensed Beds	Occupancy Percentage
January, 2006	128	480	18	86.0%	24	64.5%
February, 2006	99	433	18	85.9%	24	64.4%
March, 2006	124	512	18	91.8%	24	68.8%
April, 2006	133	453	18	83.9%	24	62.9%
May, 2006	98	487	18	87.3%	24	65.5%
June, 2006	122	450	18	83.3%	24	62.5%
July, 2006	130	461	18	82.6%	24	62.0%
August, 2006	138	497	18	89.1%	24	66.8%
September, 2006	135	456	18	84.4%	24	63.3%
October, 2006	156	497	18	89.1%	24	66.8%
November, 2006	141	464	18	85.9%	24	64.4%
December, 2006	140	510	18	91.4%	24	68.5%
2006 Totals	1,544	5,700	18	86.8%	24	65.1%
		3.7 days				
January, 2007	146	527	18	94.4%	24	70.8%
February, 2007	140	458	18	90.9%	24	68.2%
March, 2007	121	549	18	98.4%	24	73.8%
April, 2007	136	511	18	94.6%	24	71.0%
May, 2007	156	494	18	88.5%	24	66.4%
June, 2007	152	469	18	86.9%	24	65.1%
July, 2007	137	498	18	89.2%	24	66.9%
August, 2007	152	478	18	88.5%	24	66.4%
September, 2007	141	487	18	90.2%	24	65.5%
October, 2007	134	501	18	89.8%	24	67.3%
November, 2007	143	476	18	88.1%	24	66.1%
December, 2007	146	493	18	88.4%	24	66.3%
2007 Totals	1,704	5,941	18	90.4%	24	67.8%
		3.5 days				
January, 2008	144	553	18	99.1%	24	74.3%
February, 2008	150	509	18	101.0%	24	75.7%
March, 2008	163	525	18	94.1%	24	70.6%
April, 2008	135	453	18	81.2%	24	60.9%
May, 2008	148	507	18	100.6%	24	75.4%
YTD 2008 Totals	740	2,547	18	93.1%	24	69.8%
		3.4 days				

ATTACHMENT MOD-3B(2)

PCH Top DRG W CC
7/1/2006 through 6/30/2007
Severity Adjustment Comparative Analysis



Source: COMPDATA Inpatient Discharge data; 7/1/06-6/31/07 - REFINDED DRG COMPARATIVE SEVERITY ADJUSTMENT report
High volume medical surgical DRGs

- **A comparison of the category – Major, which is the highest severity adjustment for medical DRGs, as a percentage of total discharges at PCH compared to all Illinois hospital discharges supports the fact that PCH treats more acute patients than most hospitals in Illinois, as reflected in PCH admissions from the ED, patient age and chronic and comorbid conditions.**

The COMPdata Refined DRG is a method for refining or risk-adjusting DRG assignments and reducing the variances of resource consumption within DRGs. Refined DRG uses the DRG assignment and regroups DRGs in Adjacent DRGs (ADRGs). The key data elements that are included in the ADRG assignment are the same as those used for DRG assignment-patient age, patient gender, discharge status, diagnosis and procedure codes, with more emphasis placed on the patient complications and comorbidities through secondary diagnosis. The secondary diagnosis codes are the critical variable in the Refined DRG methodology for distinguishing peak adjustment levels, or often times referred to as severity levels.

Following the assignment of DRG to ADRG, intensity levels are assigned based on resource utilization. For medical DRGs, there are three (3) intensity levels: Baseline (0), Minor (1), and Major (2). For surgical DRGs, an additional level of Catastrophic (3) is added. The RDGR system does not classify discharges where the patient dies within 48 hours of admission. Outliers are identified as other.

Source data (COMdata report) attached.

Source: COMPdata Report Catalog

ATTACHMENT MOD-3B(4)

MODERN FACILITIES
Necessary Expansion

INTEGRATED PROCEDURE SERVICES

Integrated Procedure Services (IPS) will combine Surgery, GI/Endoscopy, and Interventional Radiology (IR) into one functionally and physically integrated space. Combining these procedural services immediately facilitates efficiencies in shared staff and support space. Integrating procedural services also provides long-term flexibility in care delivery.

The Hospital proposes to relocate, centralize and expand Surgery, GI/Endo and IR Services. These services occupy a total of 23,073 gross square feet (gsf) on the 1st Floor. These services will be relocated to the 1st Floor of the new East Wing, occupying 37,590 department gsf. The project adds two (2) treatment rooms, as follows:

	Number of Treatment Rooms	
Integrated Procedure Services	Existing	Proposed
Surgery	12	13
GI/Endo	3	4
Interventional Radiology (IR)		
Special Procedures	1	1
Minor Procedures	1	1
Total	17	19

Space vacated by Surgery will be modernized primarily for non-clinical services, including Medical Records, Conference, Quality Assurance, and Risk Management. GI/Endo's vacated space will be used to expand the Emergency Department. Special Procedures vacated space will be used to expand Diagnostic Radiology (refer back to existing and proposed schematics.)

The need for the project is based on increases in historical utilization and projected growth and aging of the population in the service area.

Necessary Expansion

Between 2005 and 2007 surgery hours and inpatient visits increased at an average 4.0% and 5.1% per year, respectively. Surgery hours and visits are projected to grow at an average 2.8% and 2.0% per year, respectively, through 2020 (see Attachment MOD-3C(1) for historical and projected utilization.) Based on this modest growth Surgery can justify the need for the proposed 13 operating rooms (ORs) by the year 2020 as follows:

IHFPB Standard for 13 ORs is 13 ORs X 1,500 hours per OR = 19,500 hours
Palos Community Hospital's 13 ORs = 23,404 hours
IHFPB Standard Allows = 16 ORs

GI/Endo hours and inpatient visits increased at an average 6.9% and 3.1% per year, respectively, between 2005 and 2007. GI/Endo hours and visits are projected to grow at 2.8% and 2.7%per year, respectively, through 2020 (see Attachment MOD-3C (1).) Based on this modest growth GI/Endo can justify the need for the proposed four (4) operating rooms (ORs) by the year 2020 as follows:

IHFPB Standard for 4 ORs is 4 ORs X 1,500 hours per OR = 6,000 hours
Palos Community Hospital's 4 ORs = 7,990 hours
IHFPB Standard Allows = 5 ORs

The utilization of Intervention Radiology (IR), both Special Procedures and Minor Procedures, has declined over the past three years. While utilization increased slightly in 2008, utilization is held flat through 2020 (see Attachment MOD-3C(1).) Based on current utilization which is held constant through 2020, IR can justify the need for the two (2) existing rooms in the year 2020 as follows:

IHFPB Standard for two rooms is 2,000 visits per room = 4,000 visits
Palos Community Hospital's 2rooms = 5,005 visits
IHFPB Standard Allows = 2 rooms

Projected growth and aging of the population in the service area contribute to the need to expand IPS. Service area population is expected to increase 1.0% per year from 2007 through 2020 (see population projections in Attachment GRC-4.) The service area's elderly population is expected to increase 2.5% per year through 2012. The elderly are the fastest growing population in the service area.

Therefore, based on historical increases in utilization, modest utilization projections, growth and aging of the service area population and IHFPB standards, the Hospital could justify a total of 23 proccdure rooms, as follows: Surgery, 16; GI/Endo, 5; and IR 2 rooms. The Hospital proposes to add two (2) rooms to its current 17 rooms, for a total of only 19 rooms.

Surgery and GI/Endo are seriously undersized. The two departments currently occupy only 22,127 gsf. Refer to Attachment MOD-3 which indicates that Surgery has only 19,166 gsf and GI/Endo has 2,961 gsf. Based on IHFPB standards their combined 15 existing ORs are seriously (40%) undersized, and could justify 31,170 gsf, as follows:

IHFPB Standard for 15 ORs is 15 ORs X 2,078 gsf per room = 31,170 gsf allowed
Palos Community Hospital's existing 15 ORs = 22,127 gsf
IHFPB Standard Allows = 9,043 additional gsf
= 40% undersized

Surgery and GI/Endo need to expand to address current operating problems, as follows (see Attachment MOD-3C(2) for a schematic assessment of the existing conditions by NCI):

Surgical suites are over 30 years old and all the rooms are very small. The smallest operating room is only 360 square ft.

Larger operating rooms are needed to accommodate the latest advances in technology and larger equipment needs i.e., lasers, robotics, anesthesia machines, microscopes, instrument tables, C-arms, digital imaging equipment 'switching' stations, etc.

Larger operating rooms are needed to allow for additional personnel, proper staff circulation, improved efficiency and ease of maintenance and cleaning.

Larger operating rooms are needed for patient and staff safety i.e. ceiling booms with articulating arms which support equipment and cords that are now placed on the floor i.e. light sources, insufflators, electrosurgical units, smoke evacuators, cords/cables, etc.

Larger operating rooms are needed to improve flexibility and efficiency, allowing any case to be done in any room, eliminating the need and wait for 'specialty' rooms.

Additional circulation space is needed to improve patient and equipment/supply traffic flow and provide separate paths for clean and contaminated equipment and supplies and a dedicated elevator between the OR and SSP.

Additional space is needed to store equipment and supplies *in lieu of the corridors!*

Additional administrative and support space is needed i.e. office space, classroom, conference room, locker rooms, sleep rooms, etc. *The current classroom serves as office space for the clinical instructor and 3 charge nurses.*

Interventional Radiology (IR) is undersized, occupying only 946 gsf (refer back to Attachment MOD-3.) Based on IHFPB standards IR's two (2) rooms could justify 2,772 gsf, as follows:

IHFPB Standard for 2 rooms X 1,386 gsf per room	= 2,772 gsf allowed
Palos Community Hospital's existing 2 rooms	= 946 gsf
IHFPB Standard Allows	= 1,827 additional gsf
	= 193% undersized

IR needs to expand to address current operating problems, as follows (see Attachment MOD-3C(2) for a schematic assessment of the existing conditions by NCI):

Space is needed to provide an interventional imaging procedure room(s) with accompanying control room.

Space is needed to provide an imaging PACS room for the radiologists.

Additional space is needed for clinical support i.e. clean supply, equipment storage, utility rooms etc.

Additional space is needed for staff support i.e. nursing staff workroom, bathrooms etc.

The proposed IPS addresses both the need for additional space and improved functioning required of modern procedural services. The proposed nineteen (19) procedure rooms are appropriately sized (see prototypical procedure rooms in Attachment MOD-3C(3).) Surgery's thirteen (13) ORs include eight (8) general ORs each at 650 sf; two (2) robotic ORs each at 800 sf; two (2) CV ORs each at 720 sf; and one (1) cystoscopy room at 450 gsf. GI/Endo's four (4) rooms include two (2) with fluoroscopy at 300 sf and two (2) at 250 sf. The one (1) Interventional/Special Procedure room will have 600 sf and the one Minor Procedure room will have 300 sf (refer back to Space Plans in Attachment GRC-5(2).)

IPS provides three functional zones, creating a clean core which guarantees complete separation of the sterile areas (see Attachment MOD-3C(4) for description of IPS Functional Zoning.) IPS provides appropriate space for patient, clinical and other support. See Attachment MOD-3C(5) for operational description and Attachment GRC-5(2) for the Space Plan; concept design is in Attachment MOD-3C(6).

Compliance with IHFPB Space Standards

Bascd on modcst growth in IPS utilization, consistent with historical growth and population projections, IHFPB standards would allow 23 treatment rooms (sec above.) Therefore, IHFPB standards would allow 6 additional treatment rooms.

The project proposes 19 treatment rooms in 37,590 department gsf, and complies with IHFPB space standards, as follows:

IHFPB Standard for 17 ORs is 17 ORs X 2,078 gsf per OR	= 35,326 gsf
IHFPB Standard for 2 procedure rooms is 2 rooms X 1,386 gsf per room	= 2,772 gsf
Total GSF Allowed	= 38,098 gsf
Palos Community Hospital's 17 procedure rooms	= 37,590 gsf
IHFPB Standard Allows	= +508 gsf

IPS is 508 gsf below the IHFPB standard.

Alternatives

The Hospital considered the following four alternatives to the project:

(1) Do nothing and ignore the needs for cxpanding and improving IPS;
(2) Modernize existing space;
(3) Build an addition to the existing hospital; and
(4) Build a new hospital.

Alternative 1: Do Nothing

The alternative of doing nothing was considered not viable. Each of the three (3) separate and distinct scrvices is significantly undersized and functionally obsolcte. As more and more patients present with serious illness and conditions IPS requires significant up-grading, increasing the size and functional operation for more efficient operation.

Surgery operates 16 hours, Monday through Friday, and 8 hours on Saturday. Additional call hours are provided as needed. Endoscopy operates 12 hours, Monday through Friday, and 8 hours on Saturday. Additional call hours are provided as nceded. Hours cannot be extcnded further. Doing nothing ignores the need for improved, efficient IPS Services.

Estimated Cost of Doing Nothing:

The capital cost of doing nothing appears to be minimal. However, staff and patients bear non-monetary costs in over-crowded, functionally obsolete procedure space, including cross-contamination due mixed traffic in clean/soiled space. The project adds necessary space and improves the design and operation of important IPS services, reducing patient stays and improving patient outcomes. There is "no capital cost" with this "no benefit" option.

Alternative 2: Modernize Existing Space
The Hospital has no available space anywhere in its current facilities for expanding the IPS.

Estimated Cost of Modernizing to expand IPS:
IHFPB standards indicate that modernizing is approximately 70% of new construction.

Alternative 3: Build an Addition
Due to the lack of available space, the need to gain staffing efficiencies and to improve patient way-finding, the Hospital determined that it was necessary to build an addition to expand and modernize IPS. See Attachment GRC-3 for discussion of these alternatives.

Alternative 4: Build a new Hospital
This option represents an expensive, unnecessary duplication of existing services.

Estimated Cost of Building a new Hospital:
Building a new hospital is the most expensive option. See Attachment GRC-3 which indicates that a new hospital of comparable scope and size is upwards of $700 million.

INTEGRATED PROCEDURE SERVICES (IPS)

	EXISTING	CON PROPOSED
IPS - OR PROCEDURE ZONE	12	13
IPS - ENDOSCOPY ZONE	3	4
IPS - INTERVENTIONAL ZONE (SPECIALS)	1	1
IPS -INTERNVENTIONAL ZONE (MINOR PROCEDURES)	1	1
Total Procedure Rooms IPS:	17	19

	Projected Growth															
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
PROCEDURE HOURS:																
IPS - OR PROCEDURE ZONE	15,794	16,498	17,155	17,717	18,163	18,720	19,095	19,477	19,866	20,263	21,198	21,622	22,054	22,495	22,945	23,404
IHFPB Rooms Allowed (1,500 hours per room)	10.5	11.0	11.4	11.8	12.1	12.5	12.7	13.0	13.2	13.5	14.1	14.4	14.7	15.0	15.3	15.6
IPS - ENDOSCOPY ZONE*	5,058	5,225	5,752	4,940	5,912	6,076	6,244	6,418	6,596	6,779	6,967	7,161	7,359	7,564	7,774	7,990
IHFPB Rooms Allowed (1,500 hours per room)	3.4	3.5	3.8	3.3	3.9	4.1	4.2	4.3	4.4	4.5	4.6	4.8	4.9	5.0	5.2	5.3
IPS - INTERVENTIONAL ZONE (SPECIALS)	2,153	2,031	1,993	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000
IHFPB Rooms Allowed (2,000 hours per room)	1.1	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
IPS -INTERNVENTIONAL ZONE (MINOR PROCEDURES)	4,032	3,080	2,975	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005
IHFPB Rooms Allowed (2,000 visits per room)	2.0	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5
TOTAL IHFPB ROOMS ALLOWED																23.4
PROCEDURE ROOMS:																
EXISITING**	15	17	17	17	17	17	17	17	17	17	17	17	17			
PROPOSED														19	19	19

OPERATING ROOMS	13 Includes 1 cystoscopy
GI/ENDO	4
SPECIAL/INTERVENTIONAL	1
MINOR PROCEDURES	1

RECOVERY ROOMS: 4 PER PROCEDURE ROOM, EXCLUDING 2 ROOMS FOR SPECIAL/MINOR PROCEDURES ROOM = 17 PX ROOMS

CALCULATED TOTAL POSITIONS BASED ON 17 PX ROOMS:	68	68	68	68	68	68	68	68
PROPOSED RECOVERY POSITIONS: PACU	15	15	15	15	15	15	15	15
CSSC (PRE AND POST - STAGE II & OUTPATIENT)	50	50	50	50	50	50	50	50
TOTAL RECOVERY POSITIONS	65	65	65	65	65	65	65	65
PLUS INFUSION THERAPY/OTHER OUTPATIENT PROCEDURES (IN CSSC ZONE)	5	5	5	5	5	5	5	5

** 2 CVORs added in 2005*

Project includes only one smaller OR for cystoscopy.

In AHQs - 2 existing cysto rooms are reported with General ORs since they are located in Surgery.

In 2007 one surgeon retired; 1 physician went to part time; & another physician was on LOA several months. In 2008 PCH added two new general surgeons.

Source:PCH - Surgical Services Statistics

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

SURGERY

	Historical			Projected Growth												
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
HOURS OF SURGERY																
Inpatient	9,063	10,147	10,655	11,242	11,186	11,984	12,223	12,468	12,717	12,972	13,760	14,035	14,316	14,602	14,894	15,192
Outpatient	6,731	6,351	6,500	6,475	6,977	6,737	6,871	7,009	7,149	7,292	7,438	7,586	7,738	7,893	8,051	8,212
Total	15,794	16,498	17,155	17,717	18,163	18,720	19,095	19,477	19,866	20,263	21,198	21,622	22,054	22,495	22,945	23,404
Annual % Change		4.5%	4.0%	3.3%	2.5%	3.1%	2.0%	2.0%	2.0%	2.0%	4.6%	2.0%	2.0%	2.0%	2.0%	2.0%
Average Increase 2005-2007			4.0%													
NUMBER OF PATIENTS																
Inpatient	4,097	4,427	4,517	4,607	4,699	4,793	4,889	4,987	5,087	5,189	5,292	5,398	5,506	5,616	5,729	5,843
Outpatient	4,676	4,402	4,232	4,317	4,403	4,491	4,581	4,672	4,766	4,861	4,958	5,058	5,159	5,262	5,367	5,475
Total	8,773	8,829	8,749	8,924	9,102	9,285	9,470	9,660	9,853	10,050	10,251	10,456	10,665	10,878	11,096	11,318
Average Inpatient Increase, 2005-2007			5.1%													
Annual % Change		0.6%	-0.9%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
Average Time/Procedure																
Inpatient	2.2	2.3	2.4	2.4	2.5	2.5	2.5	2.5	2.5	2.5	2.6	2.6	2.6	2.6	2.6	2.6
Outpatient	1.4	1.4	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5
Total	1.8	1.9	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.1	2.1	2.1	2.1	2.1	2.1
STANDARDS																
Capacity per OR (Hours)	1,500															
Total Capacity	15,000	18,000	18,000	18,000	18,000	18,000	18,000	18,000	18,000	18,000	18,000	18,000	18,000	19,500	19,500	19,500
Number of ORs based on hours	10.5	11.0	11.4	11.8	12.1	12.5	12.7	13.0	13.2	13.5	14.1	14.4	14.7	15.0	15.3	15.6
NUMBER OF OPERATING ROOMS (EXISTING & PROPOSED)																
Operating Rooms:*	10	12	12	12	12	12	12	12	12	12	12	12	12	13	13	13

Project includes only one smaller OR for cystoscopy.
In AHQs - 2 existing cysto rooms are reported with General ORs since they are located in Surgery.
** 2 CVORs added in 2005 (one is for emergency back-up)*
Palos recently added two new general surgeons to replace the one who retired in 2007 and the one surgeon who went from full time to part time.
One physician who was on LOA for several months in 2007 has returned.
Source: PCH - Surgical Services Statistics

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PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

GI / ENDOSCOPY

	Historical		Projected Growth													
	2005	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
NUMBER OF HOURS - GI/ENDO																
Inpatient	1,201	1,194	1,443	1,486	1,486	1,531	1,577	1,624	1,673	1,723	1,775	1,828	1,883	1,939	1,997	2,057
Outpatient	3,857	4,031	4,309	4,425	4,425	4,545	4,668	4,794	4,923	5,056	5,192	5,333	5,477	5,624	5,776	5,932
Total	5,058	5,225	5,752	5,912	5,912	6,076	6,244	6,418	6,596	6,779	6,967	7,161	7,359	7,564	7,774	7,990
Annual % Change		*3.3%*	*10.1%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*
Average Increase 2005-2007			6.9%													
NUMBER OF CASES/PROCEDURES																
Inpatient	1,434	1,416	1,524	1,561	1,576	1,604	1,633	1,663	1,692	1,723	1,754	1,785	1,818	1,850	1,884	1,918
Outpatient	4,676	4,784	4,549	4,685	4,417	4,549	4,686	4,826	4,971	5,120	5,274	5,432	5,595	5,763	5,936	6,114
Total GI/Endo Procedures	6,110	6,200	6,073	6,237	5,993	6,153	6,319	6,489	6,663	6,843	7,028	7,217	7,412	7,613	7,819	8,031
Average Inpatient Increase 2005-2007			3.1%													
Annual % Change		*1.5%*	*-2.0%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*
Average Time/Procedure																
Inpatient	0.8	0.8	0.9	1.0	0.9	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.1	1.1
Outpatient	0.8	0.8	0.9	0.9	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Total	0.8	0.8	0.9	0.9	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
STANDARDS																
Capacity per Room (hours)	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*
Number of Rooms based on hours	3.4	3.5	3.8	3.9	3.9	4.1	4.2	4.3	4.4	4.5	4.6	4.8	4.9	5.0	5.2	5.3
NUMBER OF PROCEDURE ROOMS (EXISTING & PROPOSED)																
GI/Endo Procedure Rooms	3	3	3	3	3	3	3	3	3	3	3	3	3	4	4	4

Palos recently added two new general surgeons to replace the one who retured in 2007 and the one surgeon who went from full time to part time. One physician who was on LOA for several months in 2007 has returned.

Source: PCH - Surgical Services Statistics - Outpatient Department

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PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

SPECIAL PROCEDURES / INTERVENTIONAL RADIOLOGY

PROCEDURES	Historical		Projected Growth													
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Inpatient	1,485	1,441	1,473	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500
Outpatient	668	544	520	500	500	500	500	500	500	500	500	500	500	500	500	500
Total	2,153	2,031	1,993	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000
Annual % Change		*-5.7%*	*-1.9%*	*0.4%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
STANDARDS																
Capacity per Room (Pxs)	2000 procedures															
Percent Utilization	107.7%	101.6%	99.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Number of Rooms based on hours	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1

MINOR PROCEDURES

	Historical		Projected Growth													
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Minor Procedure Visits	4,032	3,080	2,975	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005
Annual % Change		*-23.6%*	*-3.4%*	*1.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
Number of Rooms (Existing & Proposed)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
TOTALS	6,185	5,111	4,968	5,005	5,005	5,005	5,005	5,005	5,005	5,005	5,005	5,005	5,005	5,005	5,005	5,005
NUMBER OF PROCEDURE ROOMS (EXISTING & PROPOSED)																
Special Procedures/Interventional Radiology	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Minor Procedures	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1

Annualized Jan-Mar 2008
Source: PCH - Special Procedures Statistics (Radiology)

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PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

INFUSION THERAPY

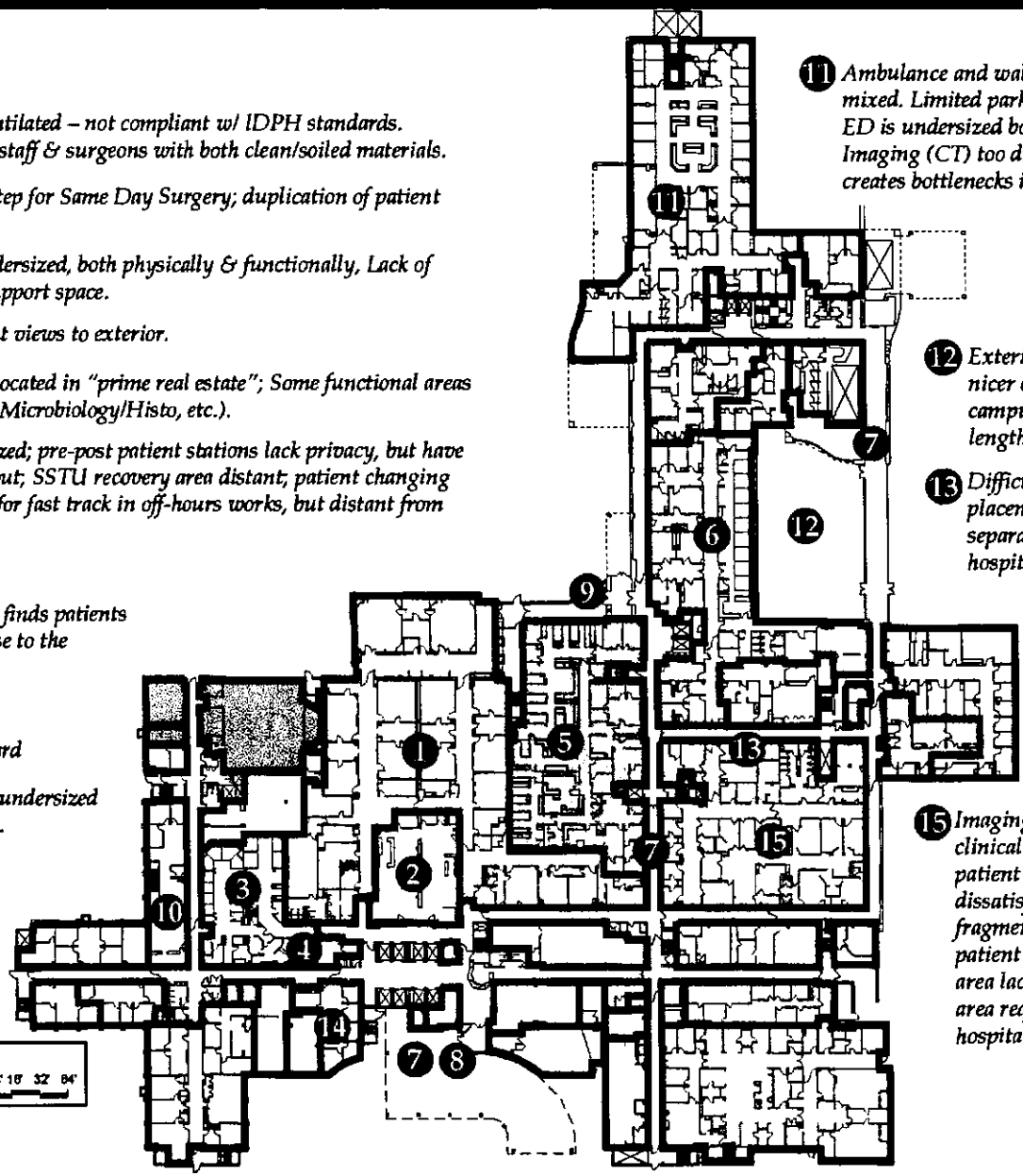
TREATMENTS	Historical			Projected Growth												
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
OUTPATIENT INFUSION THERAPY																
Treatment Volumes	1508	1658	1908	1927	1966	2005	2045	2086	2128	2170	2214	2258	2280	2303	2326	2349
Annual % Change		9.9%	15.1%	1.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	1.0%	1.0%	1.0%	1.0%
Average Increase 2005-2007			13.3%													
Proposed Positions									One Pod in the Center for Short Stay Care					**5**	**5**	**5**

Volumes were projected at 2% per year through 2015 and then only 1% through 2020. Reimbursement changes and/or shift to home health for some treatments may affect the overall long-term volume.
Treatments included: Infusion (non-chemo), antibx, transfusion, Ferrlicit, epidural blocks, port draws, etc.
Source: PCH - Surgical Services, NCI Consulting

Existing Conditions Overview – Level 1

Key Notes:

1. *Surgery – ORs undersized and under ventilated – not compliant w/ IDPH standards. Overall configuration mixes all patients, staff & surgeons with both clean/soiled materials.*
2. *PACU undersized; often used as initial step for Same Day Surgery; duplication of patient prep in holding area*
3. *Same Day Surgery – patient stations undersized, both physically & functionally, Lack of patient/family privacy; limited clinical support space.*
4. *Surgery Waiting very undersized without views to exterior.*
5. *Lab is positioned well with surgery, but located in "prime real estate"; Some functional areas within the lab are dated and undersized (Microbiology/Histo, etc.).*
6. *Outpatient treatment spaces well organized; pre-post patient stations lack privacy, but have natural light; clinical support is spread out; SSTU recovery area distant; patient changing areas claustrophobic. Utilization of area for fast track in off-hours works, but distant from central ED.*
7. *Two entrances for outpatients oftentimes finds patients at the wrong entrance requiring a traverse to the opposite end of the hospital*
8. *Entrance dark & uninviting*
9. *CVOR patient transfer to CVU is awkward*
10. *Medical Records, as noted previously, is undersized & separated into four areas on two levels.*
11. *Ambulance and walk-in emergency traffic is mixed. Limited parking. Ambulances must back in. ED is undersized both physically & functionally. Imaging (CT) too distant. Delays in lab results creates bottlenecks in system*
12. *Exterior Courtyard is one of the nicer environmental features of the campus. "Helps" to reduce the length of walk to services*
13. *Difficult to determine exact placement of required smoke separations within the original hospital*
14. *Cashiers & Financial Counselors should be located adjacent to OP Registration*
15. *Imaging undersized with inadequate clinical support; Unisex nature of patient gown area can lead to patient dissatisfaction; Mammography area is fragmented, undersized and not patient friendly; Inpatient holding area lacks supervision; Ultrasound area requires updating; Lack of in-hospital MRI requires transfer*



NAVIGANT CONSULTING

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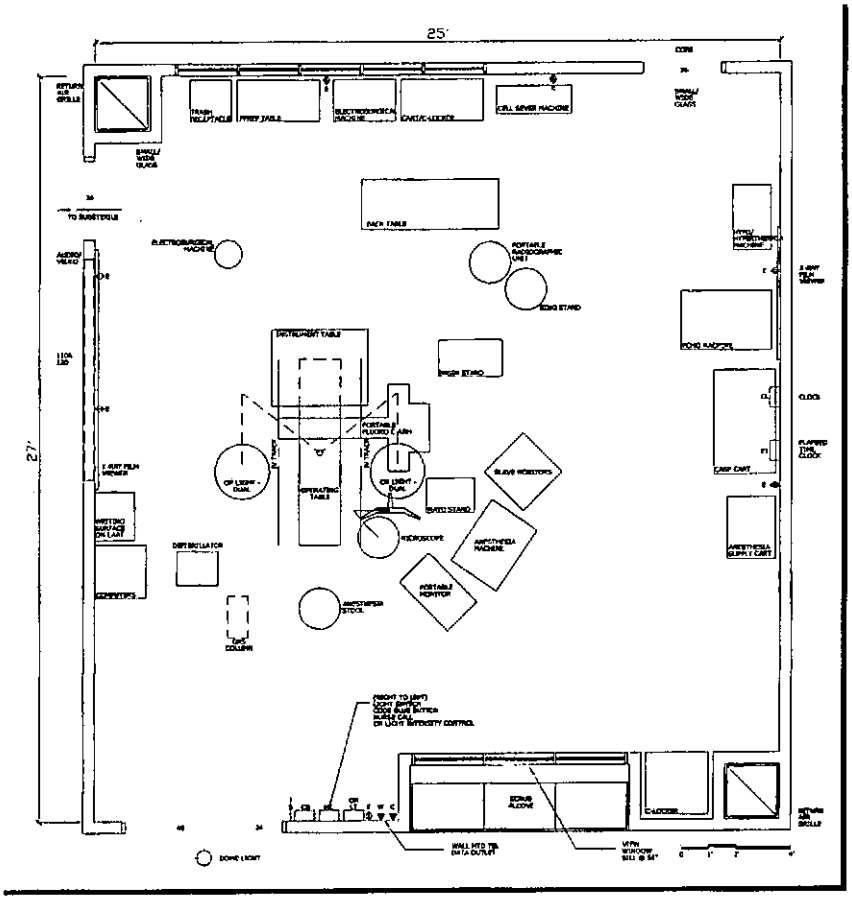
ATTACHMENT MOD-3C(2)

IPS - Procedure Room Prototypes

Room prototypes were developed primarily to assist in the sizing of the overall facility. Additional detailed design and refinement of the interior arrangement of the rooms will be completed and finalized during the architectural design process.

Operating Room

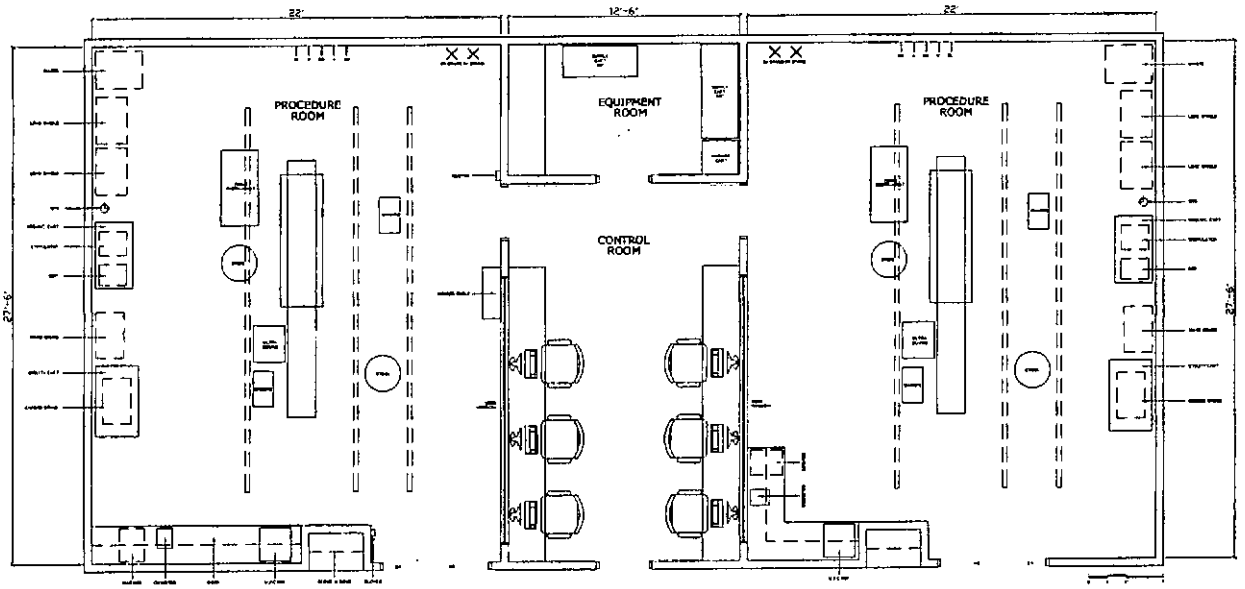
The IPS will be configured based on a **650 SF** universal OR design concept allowing all ORs in the suite to accommodate all inpatient and outpatient procedures. If the CVORs are to be relocated they are to be configured as currently constructed.



IPS - Procedure Room Prototypes

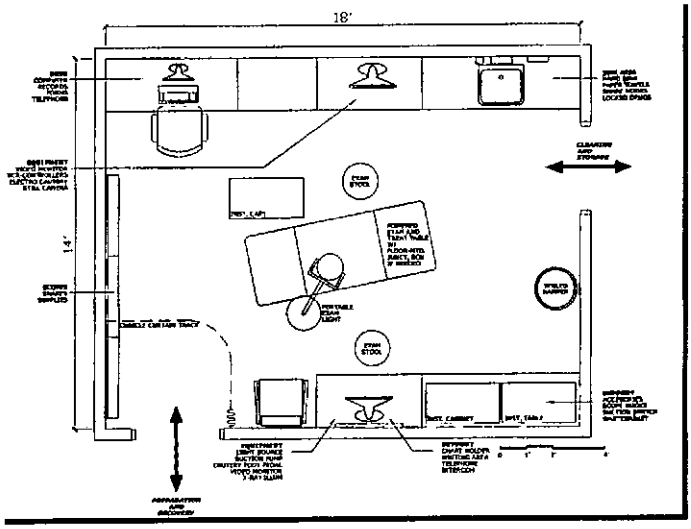
Interventional Radiology Procedure Room

The IR procedure rooms are to be sized comparably to an OR at **600 SF** each. Each procedure room will share a control room and equipment storage room containing back-up supplies, etc.



GI/Endoscopy Procedure Room

A standard GI/Endoscopy procedure rooms are to be sized at **250 SF** each. Two rooms are to be configured for fluoroscopy and as such size slightly larger at **300 SF**. The procedure rooms will share a scope processing and storage area.



IPS - Functional Zoning

The IPS will be organized into three primary zones, with segments of each zone serving each of the three IPS procedural services.

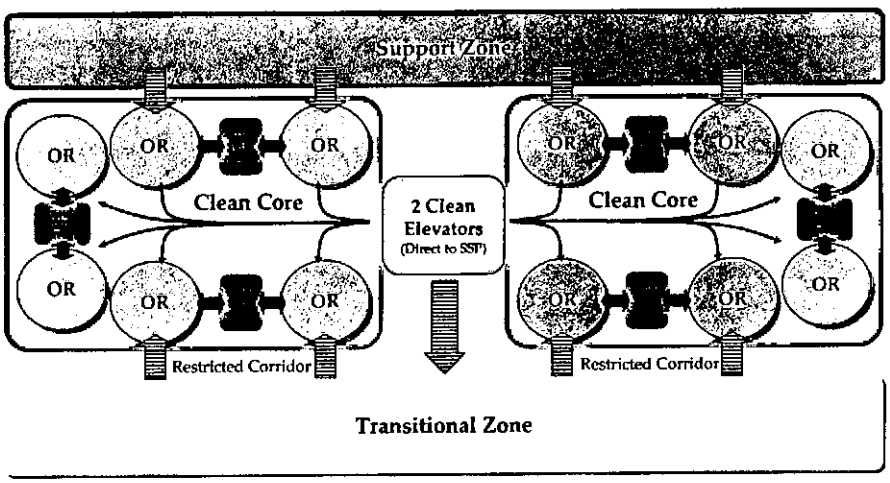
- The **procedure zone** will include the ORs and the OR clean core, the IR labs, and the GI/Endo labs and scope cleaning areas.
- The **transitional zone** will contain those elements required to directly support the clinical processes which take place in the procedure zone but that should not be contained in the clean core or ORs/procedure rooms themselves (e.g. equipment storage and scrub stations). The primary transitional zone will serve the OR and clean core and with some elements shared by the GI and IR labs (e.g. PACS reading room). The satellite pharmacy and anesthesia workroom will also be contained in the main transitional zone. Transitional zones with support space specifically for GI and IR suites are to be provided adjacent to their respective procedure zones.
- The **shared support zone** will contain staff and administrative support areas serving all procedural services, an anesthesia satellite, and a shared soiled processing area.

The procedural and transitional zones will be highly restricted and will require scrub attire. Access to the transitional zone is to predominately occur through each locker room; other direct access points to transitional zone should be limited.

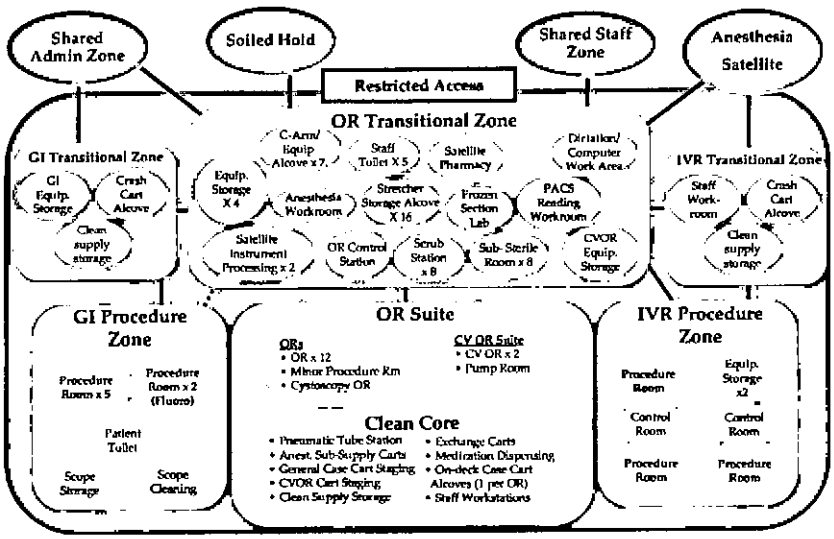
	Procedure Zone	Transitional Zone	Shared Support Zone
Surgery	ORs & clean core	Primary transitional zone; some functions are shared between services	Shared among all services
IR Lab	IR procedure rooms	IR-oriented secondary transitional zone; contains IR-dedicated support elements	Shared among all services
GI/Endo Lab	GI/Endo procedure rooms and scope storage and cleaning	GI/Endo-oriented secondary transitional zone; contains GI/Endo-dedicated support elements	Shared among all services

IPS - Functional Zoning

The implementation of clean core concept was deemed by the planning team as the optimal organization structure for the operating rooms. The planning team also determined that one IR room and the cysto room should have access to the clean core, but the minor procedure room should not. The cystoscopy room is to be configured to support anesthesia and if an emergency case occurs, additional equipment can be brought to the room as needed.



Support functions such as scrub sinks, sub-sterile workrooms, equipment storage rooms, etc. will be housed in the main transitional zone. Support for GI and IR will be contained in similar but smaller transitional zones dedicated to each of these services.



Larger format diagrams contained in Appendix

IPS - Operational Overview

Material/Supply Flow

The IPS will integrate a number of supply inflow/storage/outflow concepts that are designed to optimize access to supplies for clinical staff, efficiency in the use of storage space, and separation of clean and soiled material traffic flows.

Storage of clean supplies will be distributed throughout the IPS facility in a decentralized manner. Frequently used clean supplies will be stored "on-deck" in smaller quantities within the procedure rooms themselves. Case specific instrumentation and supplies will be provided via an open case cart system for surgical procedures. Clean surgical case carts will be staged within SSP and will be transported to the clean core via two dedicated elevators. First case of the day carts will be staged in the rooms with the following case held in "on-deck" alcoves adjacent to the procedure rooms where they will be stored until their respective ORs are turned over for the next case. CVOR case carts will be staged separate from the main OR. These carts will be held in the CVOR (first case or ready for emergent case), in the CVOR sterile room and/or in the immediate adjacent area in the clean core. They will not be held in SSP.

Additional surgical back-up supplies will be located within the clean core or the sub-sterile rooms adjacent to each OR. The clean core will also hold specialty and emergency carts, anesthesia supplies, 2 automated mediation dispensing units and a pneumatic tube station. A work area for two staff with computers, phone and a printer will be centrally located to coordinate the activities between SSP and IPS. The GI and IR additional supplies will be located within their respective transitional zones.

Soiled instrumentation requiring rapid turn-around will be sterilized for reuse during a procedure or between procedures in one of two sterile instrument processing rooms located in the OR transitional zone. These rooms are to be configured for clean/soiled separation with access from the transitional zone and a pass-thru to the clean core. All other instrumentation will return to SSP for processing through the soiled elevator located in the sub-decontamination area.

To facilitate room turnover and to avoid items being staged in the corridors, a housekeeping/soiled holding room is to be provided at 1 per 2 ORs/procedure rooms (including GI and IR). These are intended to be used as temporary holding areas until the items are moved to the sub-decontamination area and transferred via the dedicated elevator either to SSP or removed to appropriate waster removal location. (soiled linen, trash, biohazard etc.)

IPS - Operational Overview

Clinical & Administrative Support

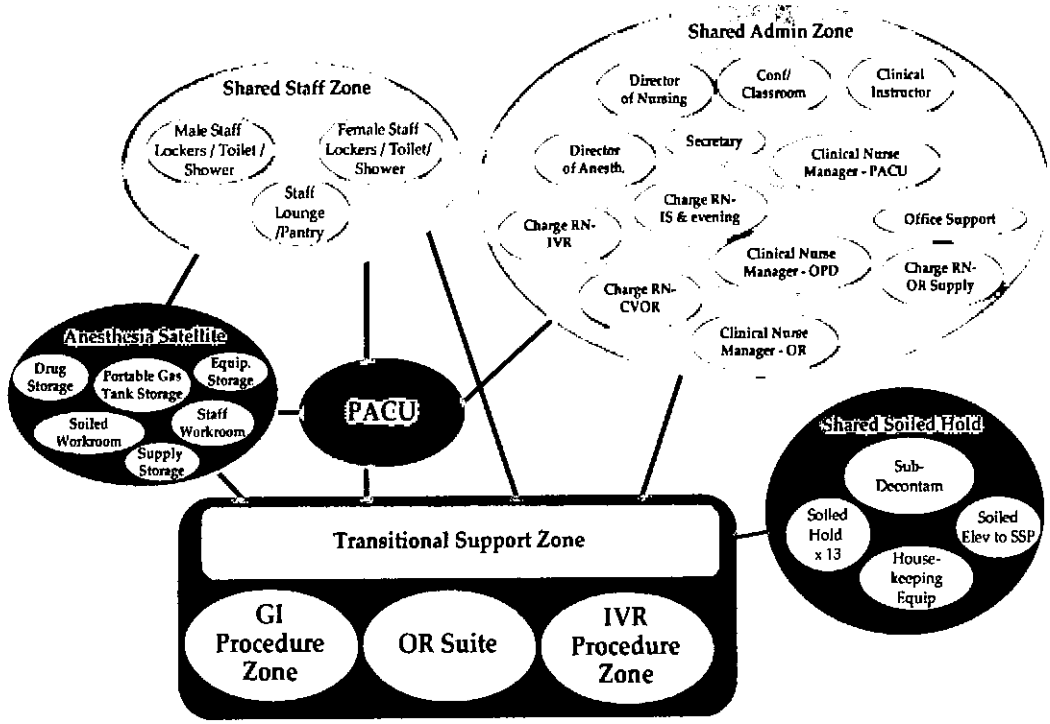
Equipment will be held in any of four distributed large equipment rooms. It is planned that all IPS related equipment be tagged with an RFID device that will allow staff to determine location of a given item within the IPS suite. Larger pieces and/or frequently used pieces of equipment such as C-arms will be stored in dedicated alcoves with appropriate electrical/data support. To facilitate faster room turnover, these alcoves can also serve as "parking spots" for other equipment prior to their return to the main equipment storage rooms. It is intended that these alcoves will be utilized to avoid equipment being stored/staged in the corridors.

The ORs are to be organized into clusters of two each sharing a scrub station with visualization into each OR and sub-sterile room. Sub-sterile rooms are to be accessible from both the room and the transitional corridor. A stretcher holding alcove is to be located adjacent to the entrance to each OR and IR procedure room to allow stretchers to be "parked" without interfering with the corridor circulation pathway; patients will be transferred from the procedure room on the same stretcher as they arrive on. The GI rooms do not require stretcher holding alcoves as the patient remains on the transport stretcher during the procedure.

Given the relocation of the lab to the lower level of the new addition, connection to the anatomical pathology section of the lab will be accomplished via a dedicated dumbwaiter avoiding the need for a separate frozen section lab within the IPS. Pathologists may still assist in the retrieval of the specimen, but testing will occur within the main lab. Results will be provided to the surgeon either in person or via phone and electronic result submission. Both the GI lab and OR send a significant number of specimens to the lab which would suggest the location of the dumbwaiter be convenient to both areas. Blood products will be received from the Blood Bank located in the lab via the pneumatic tube station. This is a change in current practice and protocols will be revised to reflect processes at other institutions where this method of transfer is utilized.

Pharmacy will continue to provide service to the IPS through a satellite. Anesthesia and PACU are primary customers of the pharmacy services in this area. Center for Short Stay Care and the ICU units above will be support from this location for items that fall outside of the stock in their automated dispensing units. Pneumatic tube connection from the satellite to these locations as well as to the main pharmacy is critical. The satellite pharmacy is sized for three picking workstations, two anesthesia med cart tray holders, a full sized refrigerator, and two computer workstations/reference area. All drugs/supplies are to be stored on high density shelving. The satellite is to have secured access with a pick-up station/window location.

IPS - Operational Overview



Larger format diagram contained in Appendix

The anesthesia satellite, central soiled holding area, and administrative and staff support areas will be shared with all IPS functions. CSSC is to have dedicated staff support functions separate from IPS. Shared family visitor support space will be provided adjacent to the CSSC.

An Anesthesia satellite is to be provided as a "home base" for all anesthesia activities taking place within IPS. The area will feature a 20-station work area as well as separate areas for storage of supplies, equipment, and portable medical gases tanks. Two PACS reading/work rooms are to be located adjacent to the GI fluoroscopy and IVR rooms. Four dictation/computer work areas are to be distributed throughout the transitional zone of the IPS to allow physicians/surgeons to chart and return calls between cases.

A shared administrative support area will contain private offices for the Directors of Anesthesia and Nursing as well as for the Charge RN's and Clinical Nurse Managers. Appropriate office and secretarial support will be provided as well as a conference/ classroom that can accommodate 20 people in a conference style arrangement.

The shared staff support area is to contain male and female lockers, on-call rooms and a staff lounge with pantry. The number of lockers indicated in the space program accommodates the projected staff and surgeons. The locker rooms are to be provided with integrated toilet and shower areas and space for storage of surgical attire.

IPS - Operational Overview

All locker rooms are to be configured so as to serve as a transition zone between the restricted and unrestricted area of the IPS. Staff must be able to access the locker room in street clothes from the unrestricted side of the locker room and exit in clean surgical attire into the transitional area. The staff lounge is to be located within the transitional zone; it is intended as a shared IPS lounge that is capable of seating 25 people in a dining seating arrangement.

The Medical Staff Lounge, which is utilized by both IPS and non-IPS medical staff, will be relocated into the new addition. Presently, the surgical staff has locker space adjacent to the Medical Staff Lounge area and uses this room as their access point to the surgery suite. If the relocated Medical Staff Lounge can not be positioned to act as a transition zone similar to that as described for the staff locker rooms above, an additional surgeon/IPS Physician lounge will need to be added to the program.

In addition, four on-call rooms are to be provided to support the on-call surgical team. Each room will sleep two staff. Dedicated toilet/shower rooms are not required as these rooms are to be in close proximity to the IPS locker rooms.

Proposed Hours of Operation

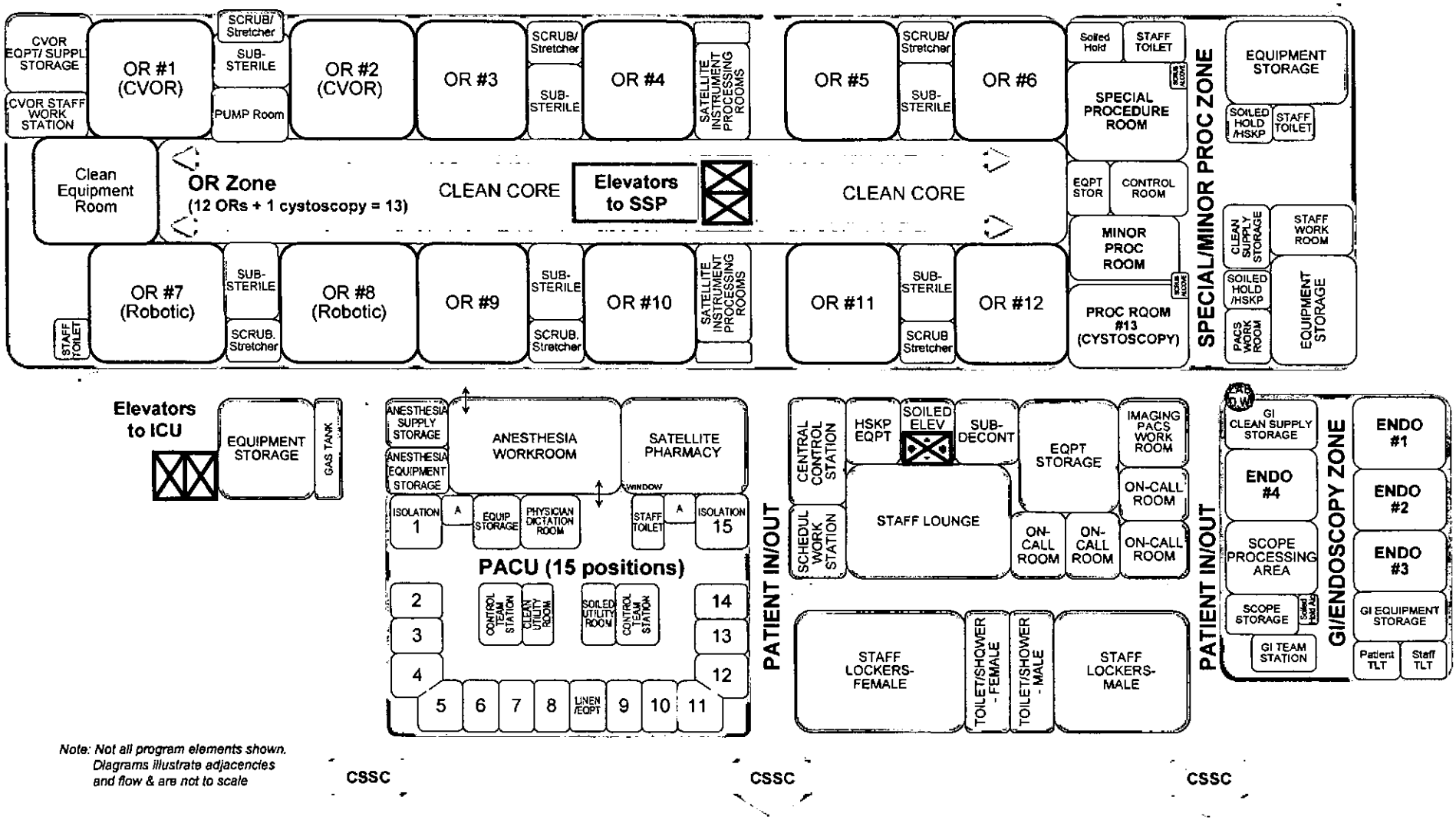
Surgery:
Mon-Fri – 16 hrs/day, Sat – 8 hrs, Sun – on-call (Most cases are done by 5:30)
8 Ors are staffed Mon-Fri from 7:00 a.m. - 3:00 p.m.
6 Ors from 3:00 p.m. - 5:30 p.m.
3 Ors from 5:30 p.m. - 7:00 p.m.
2 Ors from 7:00 p.m. - 11:00 p.m.
1 OR is staffed on Saturday from 7:00 a.m. - 12:00 p.m. (80% of cases is done by 12:00 both scheduled and unscheduled)
On call coverage is provided during unscheduled weekday, weekend and holiday hours.

Endoscopy/Minor Surgery:
Mon-Fri 7:00am-5:30pm, Sat 7:00am-3:30pm;
On-call coverage for emergency endoscopies after hours.

Interventional Imaging: Mon-Fri 7:30am-4:30pm (on call 24/7)

Integrated Procedure Services / PACU

The planned Integrated Procedure Services (IPS) will combine Surgery, Interventional Imaging (special procedures), and GI/Endo services into a single functionally and physically integrated space. The combination of these three procedures services will facilitate immediate realizable efficiencies in sharing of resources and staff as well as long term flexibility in care delivery.



Note: Not all program elements shown. Diagrams illustrate adjacencies and flow & are not to scale

MODERN FACILITIES
Necessary Expansion

RECOVERY SERVICES

The Hospital proposes to centralize, modernize and expand Recovery Services. Recovery currently occupies two separate areas on the 1st Floor and occupies a total of 16,664 gsf. Combining these recovery services immediately facilitates efficiencies in shared staff and support space, and provides long-term flexibility in care delivery. Recovery would be consolidated into 22,380 department gsf and relocated to the 1st Floor of the new East Wing, adjacent to Integrated Procedure Services (IPS.) Space vacated by Surgery's recovery will be remodeled primarily to expand Medical Records; space vacated by GI/Endo's recovery will be remodeled to establish the new Admissions Unit. The project adds twenty-four (24) recovery stations, increasing from 41 to 65 recovery stations (see below.)

The need to expand Recovery is based on increases in historical and projected utilization of Integrated Procedure Services (IPS) and projected growth and aging of the population in the service area. See Attachment MOD-3D(1) for historical and projected utilization of Integrated Procedure Services (IPS). Between 2005 and 2007 surgical and GI/Endo hours increased at average rates of 4.0% and 6.9% per year, respectively. The project is based on average increases in hours of 2.8% per year through 2020 Surgical and GI/Endo hours.

Projected growth and aging of the population in the service area contribute to the need to expand both IPS and Recovery. Service area population is expected to increase 1.0% per year from 2007 through 2020 (see population projections in Attachment GRC-4.) The service area's elderly population is expected to increase 2.5% per year through 2012. The elderly are the fastest growing population in the service area.

Necessary Expansion

The project adds two (2) procedure rooms to IPS, an increase from 17 to 19 rooms. The project adds 24 recovery stations, increasing from 41 to 65 stations, as follows:

	Number of Recovery Stations	
Recovery Service	Existing	Proposed
PACU – Stage 1 Inpatients	10	15
Center for Short Stay Care (CSSC)		
All pre-operation care		
Stage 2 Recovery: Inpatients & Outpatients	31	50
Total Recovery Stations	41	65
Stations in CSSC for Outpatient Treatment		5
Grand Total		70

Recovery needs to expand to provide additional clinical and support space and address current operating problems, as follows (see Attachment MOD-3D(3) for a schematic assessment of the existing conditions by NCI):

Recovery areas are over 30 years old. The stations are small, open areas with no privacy. Literature supports the trend for pre-operative spaces to be larger and more private. The pre-op areas should offer 3-sided rooms with a glass door on the front, not big areas with curtains between the beds" (OR Manager, May 2005).

Additional space is needed to accommodate the volume of pre- and post-operative patients to and from the IPS, allowing separate paths for patients and equipment/supplies.

Additional space will eliminate duplication of two pre-operative preparation processes i.e. in Same Day Surgery and the Holding Area, improving efficiency.

Additional space is needed for patient support i.e. caregiver workstations, bathrooms, nutritional support areas, patient locker rooms, supply/equipment storage, etc.

Additional space is needed for administrative support i.e., office, conference room, staff locker room, counseling rooms for family/physician meetings, etc. *Support space (clinical and administrative) is lacking in the existing department.*

The need for isolation rooms may be addressed with the 3-sided room design and the addition of ante-rooms. *There is no accommodation for isolation in the existing building.*

Additional space is needed for anesthesiologists for the review/preparation of inpatients immediately before surgery.

Additional space is needed for shared family/public support i.e., waiting room, bathrooms, access to phones and internet; area for greeter/registration etc.

The proposed Recovery (PACU and CSSC) addresses the need for additional space and improved functioning required of modern recovery services (see the Space Plan in Attachment GRC-5(2) and the general description and operational overviews prepared by NCI in Attachment MOD-3D(4).)

<u>Compliance with IHFPB Utilization and Space Standards</u>
The IHFPB standard allows 4 stations per operating room (OR) or procedure room. Therefore the proposed 65 recovery stations conform to IHFPB standards, as follows:

19 ORs/procedure rooms X 4 recovery stations per room = 76 stations allowed

Based on historical utilization, modest utilization projections, growth and aging of the service area population and IHFPB standards, the Hospital can justify six (6) more procedure rooms for a total of 23 procedure rooms, as follows: Surgery, 16; GI/Endo, 5; and IR 2 rooms (refer back to Attachment MOD-3C.) The IHFPB standard allows 180 gsf per recovery station, or 16,560 gsf based for 23 allowable treatment rooms. The project proposes 22,380 dgsf, and appears to exceed the IHFPB standard by 5,820 gsf. Please refer to the line drawings of the two recovery areas in Attachment MOD-3D(2).

Post Anesthesia Services Unit (PACU

The Post Anesthesia Care Unit (PACU) serves stage 1 inpatients, is located directly adjacent to Integrated Procedure Services (Surgery, GI/Endo, Interventional Imaging, & Minor Procedures) and contains 3,350 gsf. The drawings, together with the detailed, room-by-room space program for the PACU in Attachment GRC-5(2), document the appropriate use of space in PACU.

PACU has 15 recovery positions which occupy 1,920 dgsf, over 57% of dgsf. Thirteen (13) of the 15 stations are stretcher bays separated by curtains each with only 80 nsf. Two recovery positions are isolation rooms of 120 nsf each. Any apparent excess PACU space is in necessary support functions which contain only 1,430 dgsf (see to Attachment GRC-5(2) for room-by-room detail.) These support functions include control/team station and areas for physician dictation, clean/soiled utility, linen cart & equipment storage, staff hand-washing, a pneumatic tube, and housekeeping.

Center For Short Stay Care (CSSC)

The Center for Short Stay Care (CSSC) will provide pre-operation services to both inpatients and outpatients; stage 2 recovery for inpatients and outpatients undergoing surgical, GI/Endoscopic, interventional radiology, and minor procedures in the adjacent IPS area; and nursing care for those patients requiring outpatient treatments such as infusion, IV medication, and hydration. Outpatients transferred from either PACU or directly from their procedure room will be cared for in the CSSC until they are ready to be discharged to home.

The CSSC combines all recovery areas and minor outpatient procedures into one functionally and physically integrated space, facilitating efficiencies in shared staff and support space and providing long-term flexibility in care delivery. The CSSC is adjacent to the PACU and contains 19,030 dgsf. The apparent excess space in Recovery is due to three factors affecting the CSSC: (1) CSSC accommodates outpatient treatment; (2) CSSC's 55 recovery positions offer privacy; and (3) CSSC decentralizes staff/ support space for visualization (see concept drawings in Attachment MOD-3D(2).)

Therefore, CSSC accommodates three distinct functions: preparation and staging for all IPS procedures; Stage 2 recovery for inpatients and outpatients; and direct treatment, observation and recovery for various outpatients. Outpatient procedures performed in the CSSC include infusion therapy, epidural blocks, Rhogam injections, blood patches, bone marrow aspirations, and PEG replacements. The CSSC will function in a unique, decentralized unit with 55 private positions arranged in eleven pods of five positions each (see line drawing and concept diagram again in Attachment MOD-3D(2).) The eleven 5-position clusters are interchangeable with one 5-position cluster designed for isolation. The Hospital anticipates that at any given time five of the 55 positions (9.1%) will be used for the above outpatient treatments.

Therefore, approximately 1,732 dgsf (19,030 dgsf X 9.1%) will be for outpatient treatment.

Each private recovery position is 130 nsf (see Attachment GRC-5(9) for the prototypical private recovery position.) The rooms are three-sided with sliding glass fronts to optimize patient visualization. The rooms add 4,098 dgsf over the standard 80 nsf cubicle, as follow:

Additional Space for Private Stations			
Private station - Attachment GRC-5(9)	=	130	net usable square feet
Standard curtained cubicle (see PACU)	=	-80	"
Difference	=	50	nsf added/station
55 private recovery stations	=	X 55	
Total nsf added	=	2,750	nsf added for 55 stations
Departmental circulation space (1.49)	=	4,098	departmental gsf

Therefore, 4,098 dgsf in recovery is due to the private nature of the 55 stations.

The cluster configuration optimizes patient visualization in the CSSC, bringing the caregiver closer to the patient. This decentralization requires that each cluster contain selective staff and support areas. Each of the ten, non-isolation pods has a total of 155 nsf for a caregiver workstation sized for two staff, hand washing sink, patient toilet, and two supply carts for linen and patient supplies. The 10 pods serving 50 recovery positions have 1,550 nsf for these staff/support areas, 2,325 dgsf adding an internal circulation factor of 1.5 (see CSSC Space Program in Attachment GRC-5(2).)

Additional support space is shared between the clusters, including crash cart/equipment alcove, soiled holding rooms, nourishment station, and clean/soiled utility rooms. The CSSC has a centralized IV therapy station with two workstations and space to store an IV cart.

In summary, the CSSC integrates Stage 2 recovery for all procedures and provides outpatient treatment space for various infusion/outpatient procedures. Integration eliminates the need to build and staff separate recovery/treatment areas for each service, increasing efficiencies. The apparent excess space within Recovery is most probably due to the following three factors: (1) outpatient treatment space which adds 1,782 dgsf; (2) the 55 private recovery positions which add 4,098 dgsf; and (3) decentralized staff support space which adds at least 2,325 dgsf. These important functional design components add 8,205 dgsf to Recovery.

Alternatives

The Hospital considered the following four alternatives to the project:

(1) Do nothing and ignore the needs for expanding and improving Recovery;
(2) Modernize existing space;
(3) Build an addition to the existing hospital; and
(4) Build a new hospital.

Alternative 1: Do Nothing

The alternative of doing nothing was considered not viable. Recovery services need to grow to keep pace with the growth in IPS (see Attachment MOD-3C.) Existing recovery areas are significantly undersized and functionally obsolete. As more and more patients present with serious illness and conditions Recovery Services require significant up-grading, increasing the size and functional operation for more efficient operation.

Recovery services operate 17 hours, Monday through Friday, and provides on call coverage for emergent cases on weekends and holidays. Additional call hours or over night coverage is provided as needed during peak census. Hours cannot be extended further. Doing nothing ignores the need for improved, efficient recovery services.

Estimated Cost of Doing Nothing:
The capital cost of doing nothing appears to be minimal. However, staff and patients bear non-monetary costs in over-crowded, functionally obsolete recovery space, including cross-contamination due mixed traffic in clean/soiled space. The project adds necessary space and improves the design and operation of important recovery services, reducing patient stays and improving patient outcomes. Therefore, there is "no capital cost" associated with this "no benefit" option.

Alternative 2: Modernize Existing Space
The Hospital has no available space in its current facilities to expand recovery services.

Estimated Cost of Modernizing to expand recovery:
IHFPB standards indicate that modernizing is approximately 70% of new construction.

Alternative 3: Build an Addition
Due to the lack of available space, the Hospital determined that it was necessary to build an addition to expand and modernize recovery, and locate recovery adjacent to the new IPS. See Attachment GRC-3 for discussion of these alternatives. The new Center for Short Stay Care (CSSC) combines all stage 2 recovery areas and minor outpatient procedures into one functionally and physically integrated space. The CSSC consolidates all pre-procedure areas, improving operating efficiencies by eliminating duplication of services. Combining these recovery services immediately facilitates efficiencies in shared staff and support space. Integrating recovery services also provides long-term flexibility in care delivery.

See Attachment GRC-3 for discussion of these alternative additions to the project.

Estimated Cost of Building an Addition:
The estimated cost of building the East Wing is the project cost (see Attachment GRC-3.)

Alternative 4: Build a new Hospital
This option represents an expensive, unnecessary duplication of existing services.

Estimated Cost of Building a new Hospital:
Building a new hospital is the most expensive option. See Attachment GRC-3 which indicates that a new hospital of comparable scope and size is upwards of $700 million.

INTEGRATED PROCEDURE SERVICES (IPS)

	EXISTING	CON PROPOSED
IPS - OR PROCEDURE ZONE	12	13
IPS - ENDOSCOPY ZONE	3	4
IPS - INTERVENTIONAL ZONE (SPECIALS)	1	1
IPS -INTERNVENTIONAL ZONE (MINOR PROCEDURES)	1	1
Total Procedure Rooms IPS:	17	19

	Projected Growth															
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
PROCEDURE HOURS:																
IPS - OR PROCEDURE ZONE	15,794	16,498	17,155	17,717	18,163	18,720	19,095	19,477	19,866	20,263	21,198	21,622	22,054	22,495	22,945	23,404
IHFPB Rooms Allowed (1,500 hours per room)	10.5	11.0	11.4	11.8	12.1	12.5	12.7	13.0	13.2	13.5	14.1	14.4	14.7	15.0	15.3	15.6
IPS - ENDOSCOPY ZONE*	5,058	5,225	5,752	4,940	5,912	6,076	6,244	6,418	6,596	6,779	6,967	7,161	7,359	7,564	7,774	7,990
IHFPB Rooms Allowed (1,500 hours per room)	3.4	3.5	3.8	3.3	3.9	4.1	4.2	4.3	4.4	4.5	4.6	4.8	4.9	5.0	5.2	5.3
IPS - INTERVENTIONAL ZONE (SPECIALS)	2,153	2,031	1,993	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000
IHFPB Rooms Allowed (2,000 hours per room)	1.1	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
IPS -INTERNVENTIONAL ZONE (MINOR PROCEDURES)	4,032	3,080	2,975	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005
IHFPB Rooms Allowed (2,000 visits per room)	2.0	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5
TOTAL IHFPB ROOMS ALLOWED																23.4
PROCEDURE ROOMS:																
EXISITING**	15	17	17	17	17	17	17	17	17	17	17	17	17			
PROPOSED														19	19	19

OPERATING ROOMS	13 Includes 1 cystoscopy
GI/ENDO	4
SPECIAL/INTERVENTIONAL	1
MINOR PROCEDURES	1

RECOVERY ROOMS: 4 PER PROCEDURE ROOM, EXCLUDING 2 ROOMS FOR SPECIAL/MINOR PROCEDURES ROOM = 17 PX ROOMS

CALCULATED TOTAL POSITIONS BASED ON 17 PX ROOMS:	68	68	68	68	68	68	68	68	68
PROPOSED RECOVERY POSITIONS: PACU	15	15	15	15	15	15	15	15	15
CSSC (PRE AND POST - STAGE II & OUTPATIENT)	50	50	50	50	50	50	50	50	50
TOTAL RECOVERY POSITIONS	65	65	65	65	65	65	65	65	65
PLUS INFUSION THERAPY/OTHER OUTPATIENT PROCEDURES (IN CSSC ZONE)	5	5	5	5	5	5	5	5	5

** 2 CVORs added in 2005*

Project includes only one smaller OR for cystoscopy.

In AHQs - 2 existing cysto rooms are reported with General ORs since they are located in Surgery.

In 2007 one surgeon retired; 1 physician went to part time; & another physician was on LOA several months. In 2008 PCH added two new general surgeons.

Source:PCH - Surgical Services Statistics

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

SURGERY

	Historical		Projected Growth													
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
HOURS OF SURGERY																
Inpatient	9,063	10,147	10,655	11,242	11,186	11,984	12,223	12,468	12,717	12,972	13,760	14,035	14,316	14,602	14,894	15,192
Outpatient	6,731	6,351	6,500	6,475	6,977	6,737	6,871	7,009	7,149	7,292	7,438	7,586	7,738	7,893	8,051	8,212
Total	15,794	16,498	17,155	17,717	18,163	18,720	19,095	19,477	19,866	20,263	21,198	21,622	22,054	22,495	22,945	23,404
Annual % Change		4.5%	4.0%	3.3%	2.5%	3.1%	2.0%	2.0%	2.0%	2.0%	4.6%	2.0%	2.0%	2.0%	2.0%	2.0%
Average Increase 2005-2007			4.0%													
NUMBER OF PATIENTS																
Inpatient	4,097	4,427	4,517	4,607	4,699	4,793	4,889	4,987	5,087	5,189	5,292	5,398	5,506	5,616	5,729	5,843
Outpatient	4,676	4,402	4,232	4,317	4,403	4,491	4,581	4,672	4,766	4,861	4,958	5,058	5,159	5,262	5,367	5,475
Total	8,773	8,829	8,749	8,924	9,102	9,285	9,470	9,660	9,853	10,050	10,251	10,456	10,665	10,878	11,096	11,318
Average Inpatient Increase, 2005-2007			5.1%													
Annual % Change		0.6%	-0.9%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
Average Time/Procedure																
Inpatient	2.2	2.3	2.4	2.4	2.5	2.5	2.5	2.5	2.5	2.5	2.6	2.6	2.6	2.6	2.6	2.6
Outpatient	1.4	1.4	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5
Total	1.8	1.9	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.1	2.1	2.1	2.1	2.1	2.1
STANDARDS																
Capacity per OR (Hours)	1,500															
Total Capacity	15,000	18,000	18,000	18,000	18,000	18,000	18,000	18,000	18,000	18,000	18,000	18,000	18,000	19,500	19,500	19,500
Number of ORs based on hours	10.5	11.0	11.4	11.8	12.1	12.5	12.7	13.0	13.2	13.5	14.1	14.4	14.7	15.0	15.3	15.6
NUMBER OF OPERATING ROOMS (EXISTING & PROPOSED)																
Operating Rooms:*	10	12	12	12	12	12	12	12	12	12	12	12	12	13	13	13

Project includes only one smaller OR for cystoscopy.
In AHQs - 2 existing cysto rooms are reported with General ORs since they are located in Surgery.
** 2 CVORs added in 2005 (one is for emergency back-up)*
Palos recently added two new general surgeons to replace the one who retired in 2007 and the one surgeon who went from full time to part time.
One physician who was on LOA for several months in 2007 has returned.
Source: PCH - Surgical Services Statistics

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

GI / ENDOSCOPY

	Historical		Projected Growth													
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
NUMBER OF HOURS - GI/ENDO																
Inpatient	1,201	1,194	1,443	1,486	1,486	1,531	1,577	1,624	1,673	1,723	1,775	1,828	1,883	1,939	1,997	2,057
Outpatient	3,857	4,031	4,309	4,425	4,425	4,545	4,668	4,794	4,923	5,056	5,192	5,333	5,477	5,624	5,776	5,932
Total	5,058	5,225	5,752	5,912	5,912	6,076	6,244	6,418	6,596	6,779	6,967	7,161	7,359	7,564	7,774	7,990
Annual % Change		*3.3%*	*10.1%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*	*2.8%*
Average Increase 2005-2007			6.9%													
NUMBER OF CASES/PROCEDURES																
Inpatient	1,434	1,416	1,524	1,551	1,576	1,604	1,633	1,663	1,692	1,723	1,754	1,785	1,818	1,850	1,884	1,918
Outpatient	4,676	4,784	4,549	4,685	4,417	4,549	4,686	4,826	4,971	5,120	5,274	5,432	5,595	5,763	5,936	6,114
Total GI/Endo Procedures	6,110	6,200	6,073	6,237	5,993	6,153	6,319	6,489	6,663	6,843	7,028	7,217	7,412	7,613	7,819	8,031
Average Inpatient Increase 2005-2007			3.1%													
Annual % Change		*1.5%*	*-2.0%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*	*2.7%*
Average Time/Procedure																
Inpatient	0.8	0.8	0.9	1.0	0.9	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.1	1.1
Outpatient	0.8	0.8	0.9	0.9	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Total	0.8	0.8	0.9	0.9	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
STANDARDS																
Capacity per Room (hours)	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*	*1,500*
Number of Rooms based on hours	3.4	3.5	3.8	3.9	3.9	4.1	4.2	4.3	4.4	4.5	4.6	4.8	4.9	5.0	5.2	5.3
NUMBER OF PROCEDURE ROOMS (EXISTING & PROPOSED)																
GI/Endo Procedure Rooms	3	3	3	3	3	3	3	3	3	3	3	3	3	4	4	4

Palos recently added two new general surgeons to replace the one who retired in 2007 and the one surgeon who went from full time to part time. One physician who was on LOA for several months in 2007 has returned.

Source: PCH - Surgical Services Statistics - Outpatient Department

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

SPECIAL PROCEDURES / INTERVENTIONAL RADIOLOGY

PROCEDURES	Historical		Projected Growth													
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Inpatient	1,485	1,441	1,473	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500
Outpatient	668	544	520	500	500	500	500	500	500	500	500	500	500	500	500	500
Total	2,153	2,031	1,993	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000
Annual % Change		*-5.7%*	*-1.9%*	*0.4%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
STANDARDS																
Capacity per Room (Pxs)	2000 procedures															
Percent Utilization	107.7%	101.6%	99.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Number of Rooms based on hours	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1

MINOR PROCEDURES

	Historical		Projected Growth													
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Minor Procedure Visits	4,032	3,080	2,975	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005	3,005
Annual % Change		*-23.6%*	*-3.4%*	*1.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
Number of Rooms (Existing & Proposed)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
TOTALS	6,185	5,111	4,968	5,005	5,005	5,005	5,005	5,005	5,005	5,005	5,005	5,005	5,005	5,005	5,005	5,005
NUMBER OF PROCEDURE ROOMS (EXISTING & PROPOSED)																
Special Procedures/Interventional Radiology	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Minor Procedures	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1

Annualized Jan-Mar 2008
Source: PCH - Special Procedures Statistics (Radiology)

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PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

INFUSION THERAPY

TREATMENTS	Historical			Projected Growth												
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
OUTPATIENT INFUSION THERAPY																
Treatment Volumes	1508	1658	1908	1927	1966	2005	2045	2086	2128	2170	2214	2258	2280	2303	2326	2349
Annual % Change		9.9%	15.1%	1.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	1.0%	1.0%	1.0%	1.0%
Average Increase 2005-2007			13.3%													
Proposed Positions									**One Pod In the Center for Short Stay Care**					**5**	**6**	**5**

Volumes were projected at 2% per year through 2015 and then only 1% through 2020. Reimbursement changes and/or shift to home health for some treatments may affect the overall long-term volume.
Treatments included: Infusion (non-chemo), antibx, transfusion, Ferrlicit, epidural blocks, port draws, etc.
Source: PCH - Surgical Services, NCI Consulting

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ATTACHMENT MOD-3D(1)
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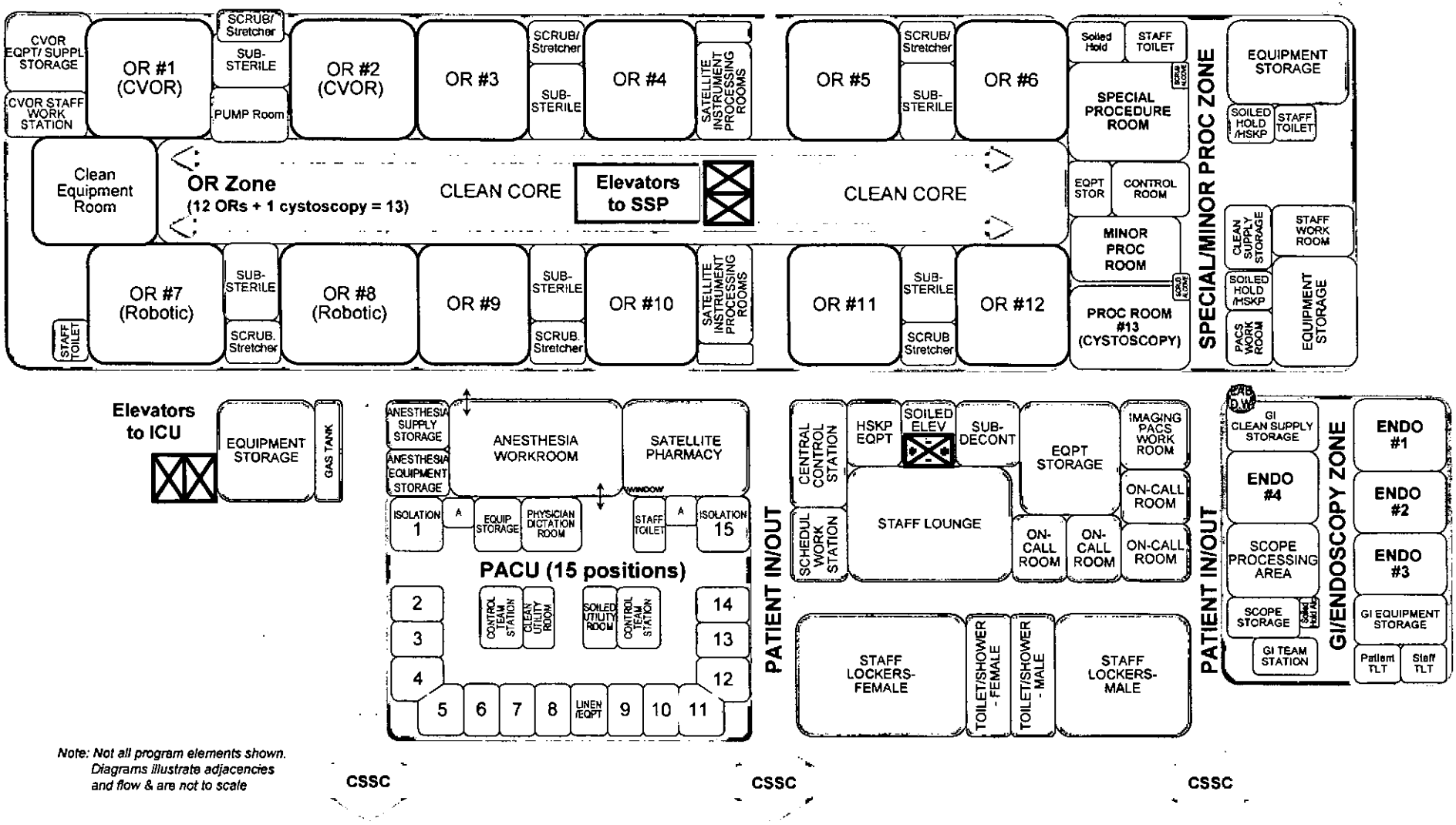
Integrated Procedure Services / PACU

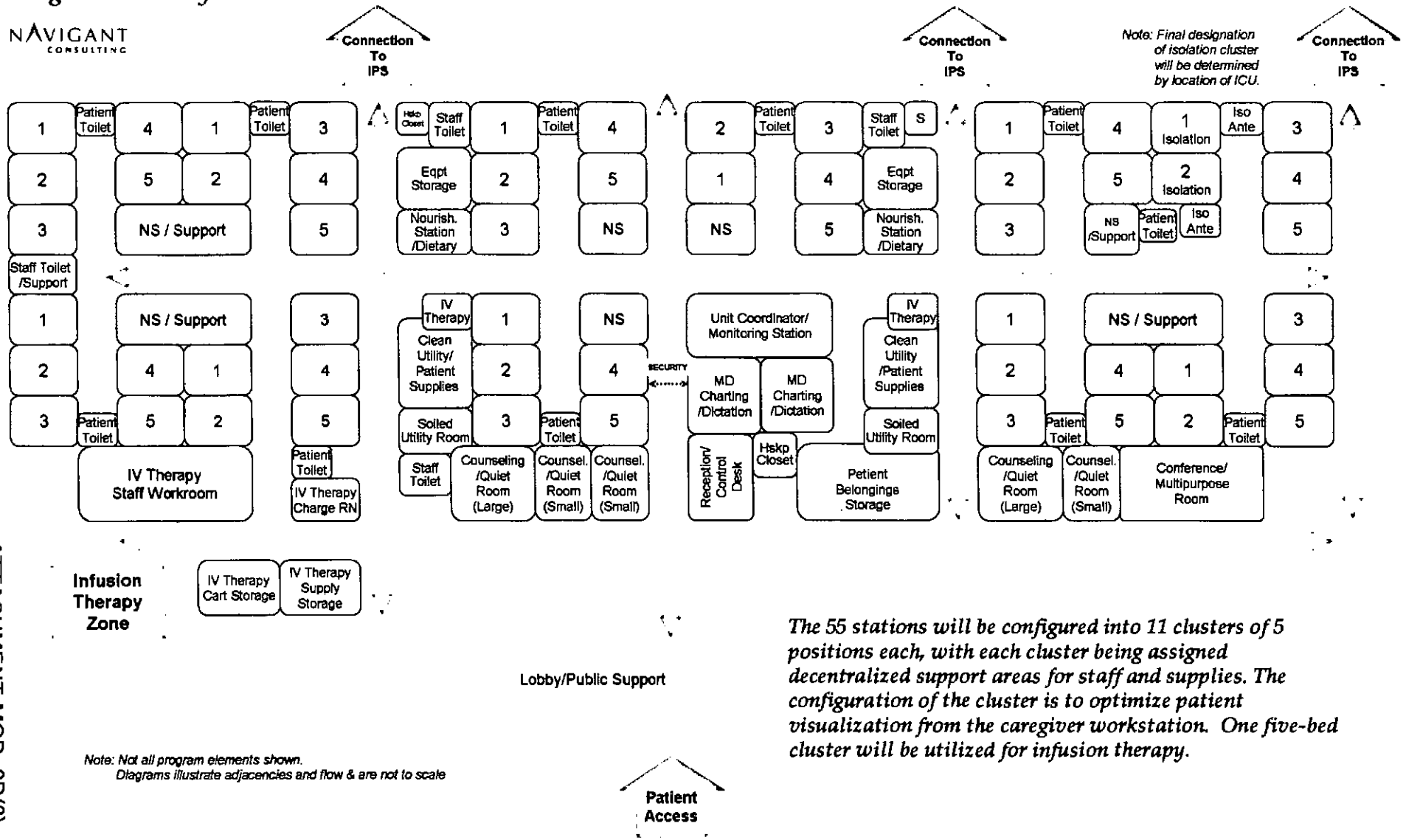
The planned Integrated Procedure Services (IPS) will combine Surgery, Interventional Imaging (special procedures), and GI/Endo services into a single functionally and physically integrated space. The combination of these three procedures services will facilitate immediate realizable efficiencies in sharing of resources and staff as well as long term flexibility in care delivery.



Note: Not all program elements shown. Diagrams illustrate adjacencies and flow & are not to scale

Center for Short Stay Care w/ Infusion Therapy
Stage II Recovery

NAVIGANT CONSULTING



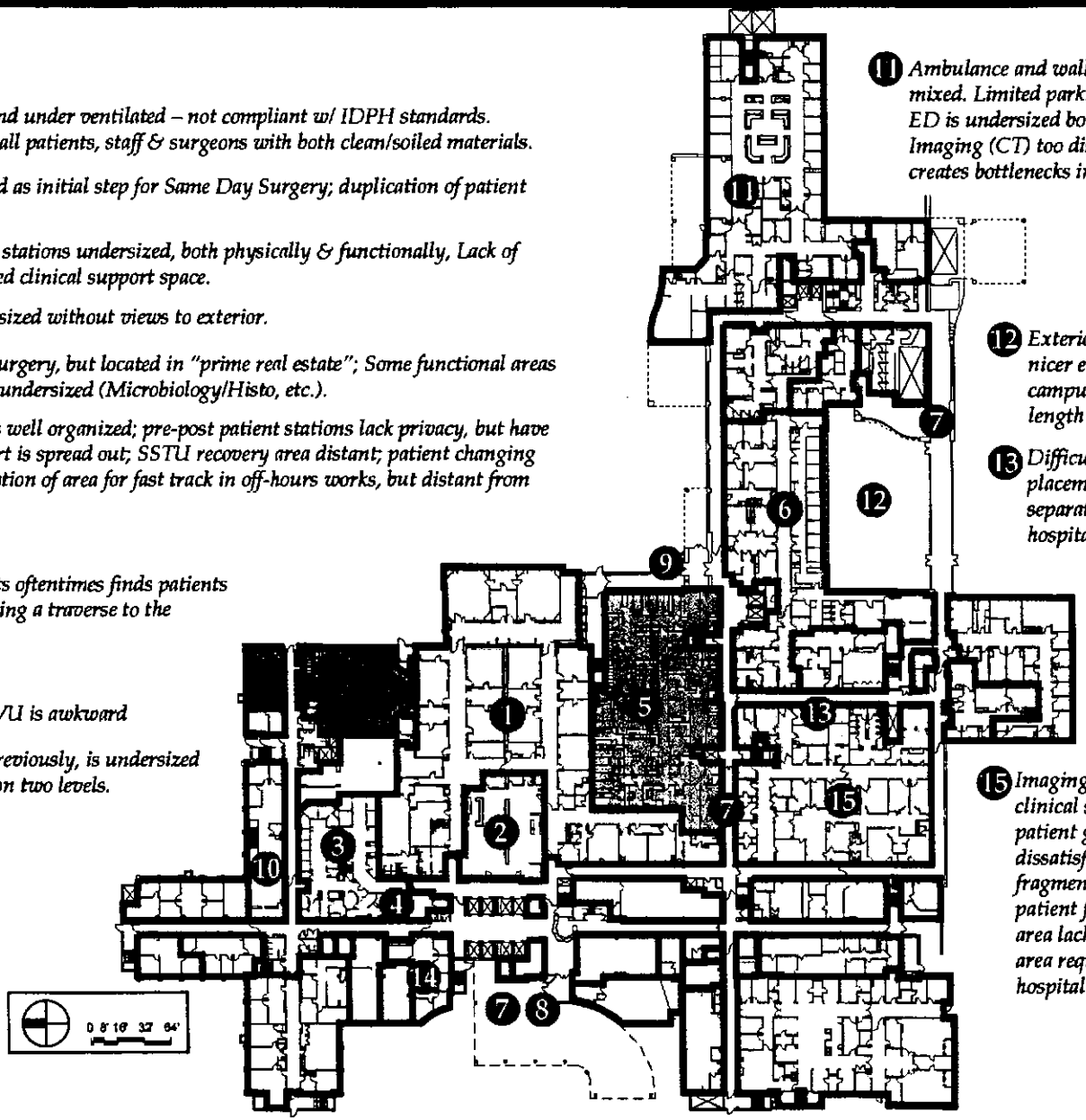
The 55 stations will be configured into 11 clusters of 5 positions each, with each cluster being assigned decentralized support areas for staff and supplies. The configuration of the cluster is to optimize patient visualization from the caregiver workstation. One five-bed cluster will be utilized for infusion therapy.

Note: Not all program elements shown.
Diagrams illustrate adjacencies and flow & are not to scale

Existing Conditions Overview – Level 1

Key Notes:

1. *Surgery – ORs undersized and under ventilated – not compliant w/ IDPH standards. Overall configuration mixes all patients, staff & surgeons with both clean/soiled materials.*
2. *PACU undersized; often used as initial step for Same Day Surgery; duplication of patient prep in holding area*
3. *Same Day Surgery – patient stations undersized, both physically & functionally, Lack of patient/family privacy; limited clinical support space.*
4. *Surgery Waiting very undersized without views to exterior.*
5. *Lab is positioned well with surgery, but located in "prime real estate"; Some functional areas within the lab are dated and undersized (Microbiology/Histo, etc.).*
6. *Outpatient treatment spaces well organized; pre-post patient stations lack privacy, but have natural light; clinical support is spread out; SSTU recovery area distant; patient changing areas claustrophobic. Utilization of area for fast track in off-hours works, but distant from central ED.*
7. *Two entrances for outpatients oftentimes finds patients at the wrong entrance requiring a traverse to the opposite end of the hospital*
8. *Entrance dark & uninviting*
9. *CVOR patient transfer to CVU is awkward*
10. *Medical Records, as noted previously, is undersized & separated into four areas on two levels.*
11. *Ambulance and walk-in emergency traffic is mixed. Limited parking. Ambulances must back in. ED is undersized both physically & functionally. Imaging (CT) too distant. Delays in lab results creates bottlenecks in system*
12. *Exterior Courtyard is one of the nicer environmental features of the campus. "Helps" to reduce the length of walk to services*
13. *Difficult to determine exact placement of required smoke separations within the original hospital*
14. *Cashiers & Financial Counselors should be located adjacent to OP Registration*
15. *Imaging undersized with inadequate clinical support; Unisex nature of patient gown area can lead to patient dissatisfaction; Mammography area is fragmented, undersized and not patient friendly; Inpatient holding area lacks supervision; Ultrasound area requires updating; Lack of in-hospital MRI requires transfer*



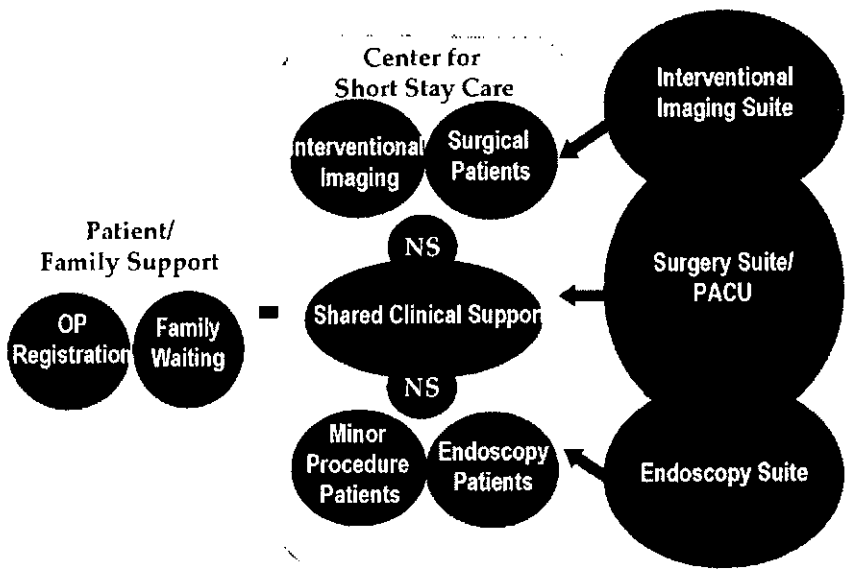
NAVIGANT CONSULTING

CSSC - General Description

Integrated Short Stay Care Concept

Palos Community Hospital's new Center for Short Stay Care will provide preparation and stage 2 recovery services for inpatients and outpatients undergoing surgical, interventional, and GI/Endoscopic procedures in the adjacent Integrated Procedure Services area (IPS). Both inpatients and outpatients will receive pre-procedure care within the CSSC. Outpatients transferred from either PACU or directly from their procedure room will be cared for in the CSSC until they are ready to be discharged to home.

The implementation of the CSSC concept will capitalize on the service integration concept by providing adequate flexibility to allow staffing levels to flex up and down with each day's workload, significantly increasing staffing and space utilization. Additional space efficiency will be gained through the sharing of staff, administrative and family support resources that had previously been separated for each service.

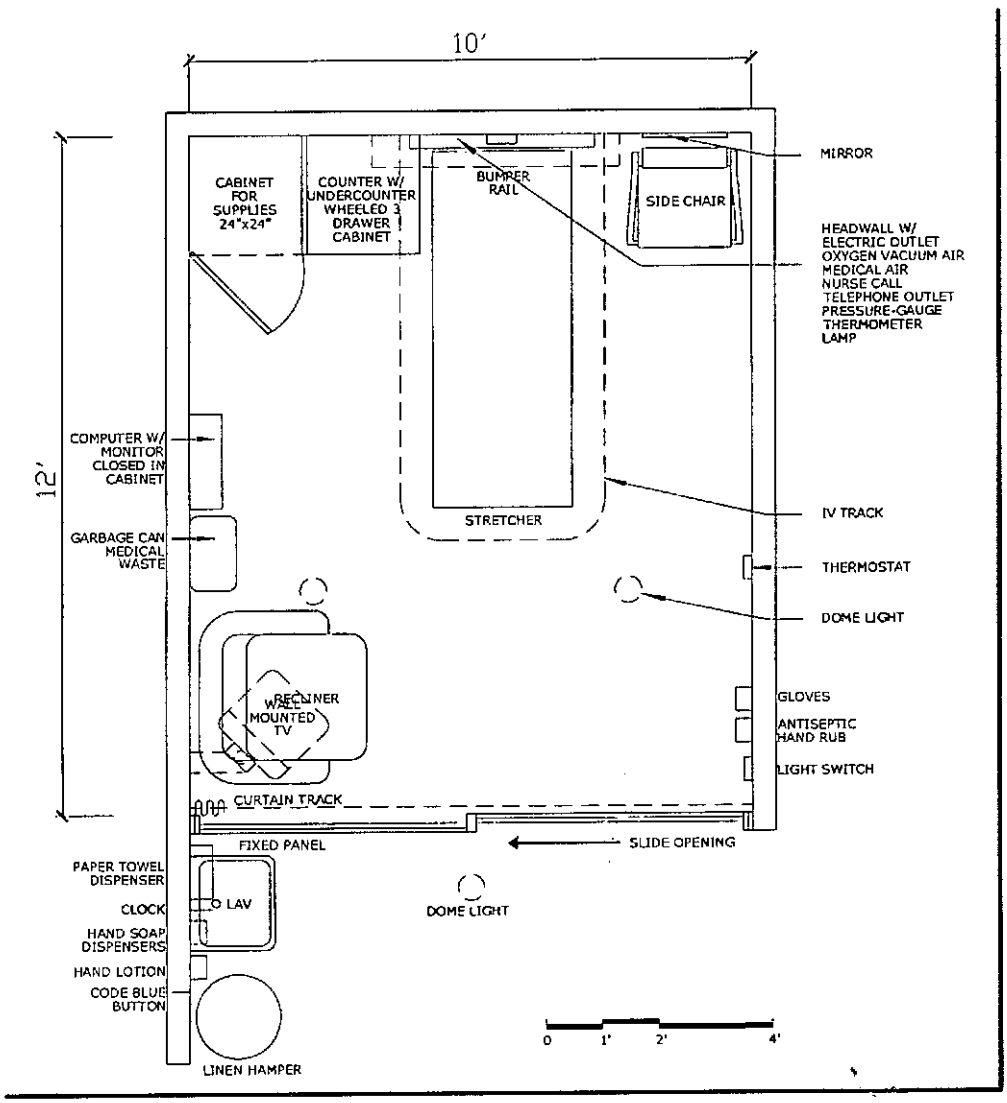


During the functional space planning process, the planning team completed a matrix of leading operational practices. The matrix indicates which leading practices are currently in place now, could be implemented now and/or should be designed in to the operational and physical planning on the new units. A prioritization of these practices (high, medium, and low) was indicated by the team. Any impact on the design of the facility (flow, adjacency, square foot, cost) was then determined. Only some of the practices have a significant facility related impact, and as such any support partner for integrating these concepts is also indicated (IT, supply chain, facilities management). The supply chain category was applied for all logistics/ materials partners such as dietary, pharmacy, lab, housekeeping etc. Ideally, the various support partners should follow-up with the planning team to indicate their ability to continue and/or implement these leading practices in the future.

CSSC - Room Prototypes

Prototypical Private Prep/Recovery Position

For the purpose of sizing the overall center, a prototypical private patient position was developed at **130 net SF**. The room is to be enclosed with sliding glass door and will include patient monitor capabilities, medical gases, space for a stretcher, recliner, one side chair and a hand-washing sink. Five of the 55 total positions to be contained within the CSSC will be configured as isolation positions.



CSSC - Operational Overview

Patient Flows

The CSSC will feature a single entry point for the IPS procedure outpatients (who return home on the same day as their procedure) as well as all same day IPS admit patients (who enter the hospital like an outpatient but are admitted post-procedurally). This single entry point strategy will minimize patients' confusion on the day of procedure as well as promote patient convenience.

Upon arrival to the hospital on the day of procedure, all outpatients and same day admit patients will enter at the Center for Short Stay Care. Most patients will have pre-registered, however a registration support area will be located adjacent to the CSSC should it be necessary to register a patient on the day of the procedure. Outpatients and SDA patients will be escorted to their prep position where they will gown and receive their required pre-procedure care. Patient belongings will be taken to a central secured area by the CSSC staff and held there until discharge.

Inpatients arriving directly from the unit will enter through a separate access point and will be transported directly to their prep position for staging and/or any required prep. Presently the CSSC staff completes any and all inpatient procedure preparation, but PCH is considering shifting this function to the inpatient unit where appropriate.

Once patients have completed the procedure preparation process and their assigned procedure room is indicated as available, they will be taken directly to the room, with no interim holding stops. All holding will occur within the CSSC.

Upon completion of their procedure, surgical inpatients and same day admit patients will virtually always be transferred to the PACU for stage 1 recovery and subsequently back to their assigned acute or critical care unit. If the PACU is "at capacity" and a patient is not ready for transport either due to lack of an available bed or a delay in the transfer process, they may be transferred back to the CSSC for a brief period prior to their eventual transfer to an inpatient unit.

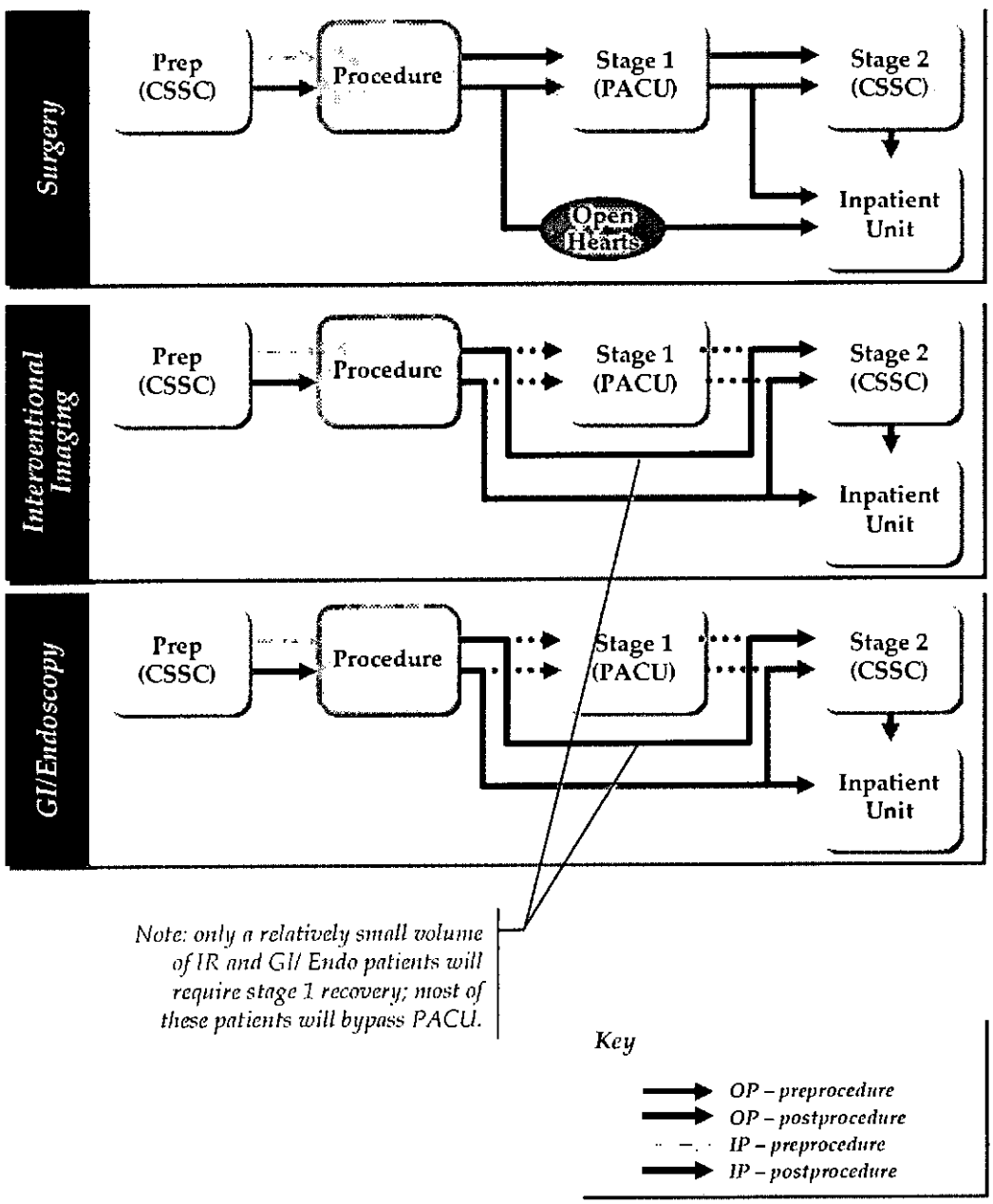
True surgical outpatients who have completed their procedure will be transferred either to the PACU for stage 1 recovery or directly to the CSSC for stage 2 recovery (as the patient's condition allows). The vast majority of Interventional Radiology patients and virtually all GI/Endo patients will bypass PACU and will be transferred directly to the CSSC following their procedure. Patients will not be "assigned" a position within the CSSC and will therefore return for recovery in the next available position. Once an outpatient has met the discharge criteria, the CSSC staff will return their belongings and the patient will be transported via wheelchair to the lobby area.

An RFID patient tracking system will be employed to assist in the coordination of patient flow throughout the IPS and CSSC. The physical control point for the CSSC suite will be the Unit Coordinator/control desk which should be centrally located. A large patient tracking system control board will be located at the IPS control desk, but all staff with varying levels of access will be able view patient location and procedure room status from any computer terminal.

CSSC - Operational Overview

Patient Flow *(continued)*

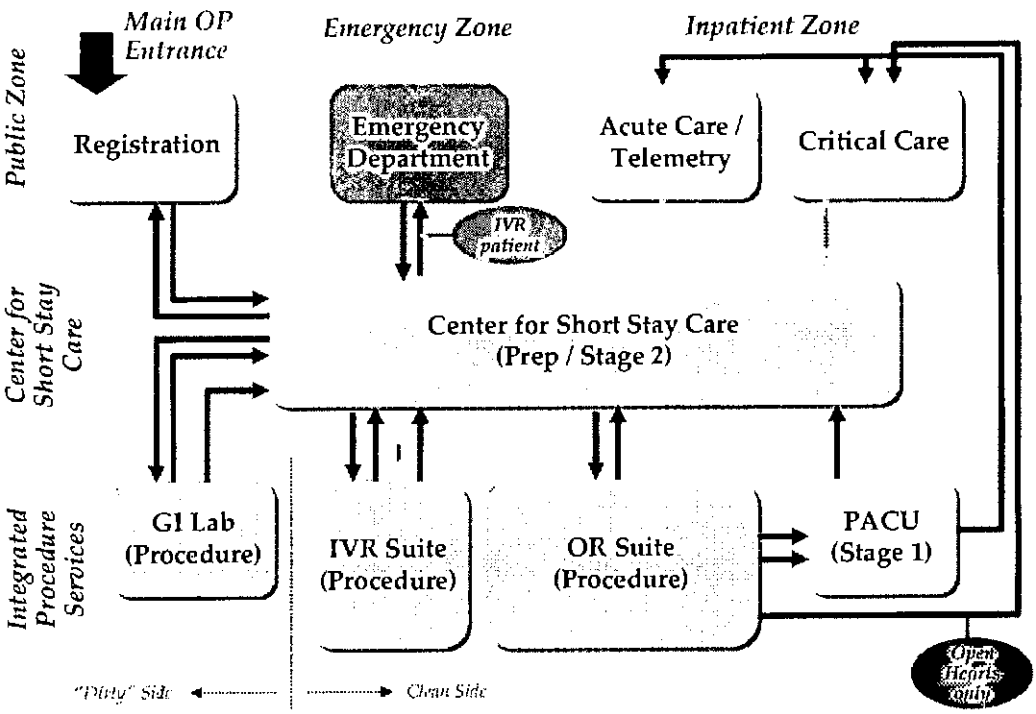
Individual Service Patient Flows



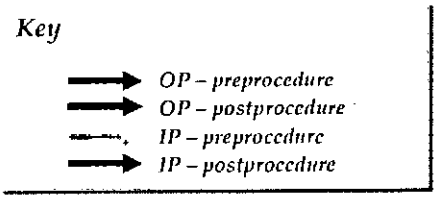
CSSC - Operational Overview

Patient Flow *(continued)*

Individual Service Patient Flows



Note: above diagram does not show very low volume patient flows (e.g. IR and GI PACU usage).



CSSC - Operational Overview

Patient Care / Clinical Operations

The design of the Center for Short Stay Care should facilitate a patient-focused care delivery model that is versatile and mobile, such that can be executed from strategically positioned sites at various levels of proximity to the bedside. Nursing staff should have the ability to carry out monitoring and charting functions from the bedside, from the caregiver workstations located in each pod, or from the unit coordinator/control desk.

The 55 private positions in the CSSC are to be organized into eleven pods of five, with one cluster designated for isolation. Each pod of five is to have a caregiver workstation sized for two staff, hand washing sink, patient toilet, and two supply carts for linen and patient supplies. A crash cart/equipment alcove is to be shared between 2 pods. To facilitate room turnover, a soiled holding rooms are to be provided; one for every ten positions. They are intended to be temporary holding areas for linen and waste until the items can be collected by the housekeeping staff for removal from the center.

Additional clinical support functions shared between 5 or 6 pods (25-30 positions) are i a nourishment station, equipment storage and clean and soiled utility rooms. They are to be centrally located to minimize travel distances. The clean utility room is sized to accommodate space for an automated medication dispensing station (refrigerated). Special order medications will be picked up or hand delivered via a pneumatic tube station from the satellite pharmacy planned as part of the Integrated Procedure Services. A centralized IV therapy team is responsible for starting IVs for most the CSSC patients. Given the large volume of work in CSSC, two workstations for the IV Therapy staff will be provided with space to storage a IV cart.

A Unit Coordinator/Monitoring station will act as the control point for the CSSC. The station, sized for five staff, is to include a pneumatic tube station, central monitoring station, printers, fax and a copier. Given the decentralized care model, this station is not intended to support the entire care provider team. Two physician work rooms are to be located adjacent to the Unit Coordinator station and are to accommodate four computer workstations with telephones and forms/paper supplies, as well as a shared printer.

Patient Belongings will be stored centrally in a secured room. Patient lockers or locker rooms are not required. The room is to be configured similar to a large walk-in closet where patient belongings on kept hangers and/or bags organized by patient last name. Additional floor space in this room is to be allocated for personal durable medical equipment (walkers, canes, wheelchairs, etc.)

CSSC - Operational Overview

Non-clinical Support Spaces

CSSC will have dedicated support spaces for staff and administrative activities, as well as, a Family/Public support function shared with IPS. Staff and family spaces should be relatively segregated from the main patient care areas as well as from each other. The design of the staff and family support areas in particular should convey a calm or "off-stage" atmosphere.

Staff support space should be aggregated together and positioned in an area relatively proximate to the main patient care zones yet maintaining separation and quiet. A female locker room is to be configured with "Z" style lockers and a separate coat closet for longer items. A staff toilet room is to be provided adjacent to the locker room. Male staff will utilize the locker rooms in the adjacent IPS. A staff lounge with pantry area is to accommodate 8 staff in a dining style seating arrangement. On-call room are to be shared with IPS.

A clinical nurse manager office is to be located within the CSSC rather than as a part of the centralized administrative support area in the IPS. A large conference/multipurpose room with seating for 16 is to be provided for staff meetings and educational sessions. The room is to contain a computer workstation set-up for independent clinical education and may potential be used by visiting students.

The Public/Family support should be located to avoid cross-traffic of clinical staff and material flows. The area is to be supervised by a reception/control desk positioned between the internal space of the CSSC and the family waiting room. The family waiting area is to accommodate approximately 150 people and should be arranged into separate casual seating groups. Some seating groups should allow for television viewing. A child's play area is also required.

Surgeons/Physicians will have access to five counseling/quiet rooms to meet with the patient family post-procedure. Four rooms are sized to accommodate a consultation with up to four people and two larger rooms will accommodate six; each room is to be equipped with a PACS viewing station.

Additional family support includes a business center with workstations for access to internet and phone and a hospitality area adjacent to the waiting room providing coffee and other vending. The planning team communicated a desire to provide access to a Café cart that would allow family members to purchase cold sandwiches and other snacks.

Proposed Hours of Operations

The Center for Short Stay care will operate from 5:30 am to 8:30 pm Monday through Friday and Saturday from 5:30 am to 3:30 pm.

RESPIRATORY THERAPY

The Hospital proposes to expand and relocate Respiratory Therapy (RT.) RT would regain its central location on the 3rd Floor, moving into space vacated by ICU which would relocate to the East Wing (refer back to existing and proposed schematics.) Please note that RT is currently in a temporary location on the Hospital's main floor as four (4) M/S beds on the 3rd Floor needed to be opened due to the high census. The project also adds RT equipment storage and one office/workroom near the two new ICUs to improve efficiency, as over 95% of all RT procedures are inpatient procedures. RT would increase from 1,485 gsf to 5,425 gsf. Vacated space would be returned to M/S, remodeled for private M/S rooms.

The need for the project is based on current demand and aging of the service area population. Historical data is not a reliable gauge of need since the Hospital converted to a new information system which "unbundled" procedures (see Attachment MOD-3E(1) for historical and projected utilization.) However, RT is projected to grow at only 0.5% per year which is less than the projected 1.0% annual growth in the service area population from 2007 through 2020 (see population projections in Attachment GRC-4.) The service area's elderly population is expected to increase 2.5% per year through 2012. The elderly are the fastest growing population in the service area.

Necessary Expansion

The RT is seriously undersized as indicated by the following:

Clerical and management offices are limited and inefficient. Department records must be stored off campus.

There is only limited space for educational materials and individualized instruction.

The staff area is only marginally functional with inadequate space during shift changes, department meetings and educational in-services.

There is inadequate storage area for therapist work carts which is inefficient.

The number of lockers for employee valuables is inadequate.

There is inadequate Clean/Soiled Storage, and soiled equipment backs up.

There is inadequate storage for large equipment and disposables. Large equipment, when not in use, must be stored in patient care areas. Some equipment is stored in non-patient areas, which is inefficient and may delay administration of patient care.

Pulmonary diagnostic RT space is so inadequate that staff is unable to properly perform pulmonary stress testing.

There is limited amount of storage area available in the pulmonary diagnostic RT.

The expansion and relocation addresses the issues described above by providing:

More equipment storage, including adequate storage for large equipment, particularly in critical care areas;

Larger accommodations for the staff, including locker area, work area, conference room and an education/reference area;

Larger cleaning areas that are separate from therapist work areas;

More pulmonary diagnostic treatment area to accommodate stress testing and other related testing procedures with sufficient space for storage for equipment and supplies; and

Sufficient and private office space for management.

Compliance with IHFPB Space Standards

RT is expected to grow at only 0.5% per year, from 164,841 procedures in 2007 to 176,048 procedures in 2020. The growth is only half of the 1.0% annual growth in the service area's population through 2020, and significantly less than projected growth in the area's elderly population of 2.5% per year through 2012. Compliance with IHFPB standards is further indication that RT is appropriately sized with 5,425 gsf, as follows:

IHFPB Standard	=	20.5 procedures per gsf
176,048 procedures divided by 20.5	=	8,587 gsf allowed

RT is 3,162 gsf below the IHFPB standard.

Alternatives

The Hospital considered the following four alternatives to the project:

(1) Do nothing and ignore the needs for improved RT space;
(2) Modernize existing space;
(3) Build an addition to the existing hospital; and
(4) Build a new hospital.

Alternative 1: Do Nothing

The alternative of doing nothing was considered not viable. RT is significantly undersized. As more and more patients present with serious illness and conditions, the need for RT will requires more a more efficient operation.

The RT already operates 24/7. Hours cannot be extended further. Doing nothing ignores the current and projected needs for improved, efficient RT Services.

Estimated Cost of Doing Nothing:
The capital cost of doing nothing appears to be minimal. However, staff and patients bear non-monetary costs when RT processes are cramped and therapy is restricted due to space limitations. The project improves access to these important RT services, reducing patient stays and improving patient outcomes. Therefore, there is "no capital cost" associated with this "no benefit" option.

Alternative 2: Modernize Existing Space
The project modernizes existing space by utilizing a portion of the old ICU. The space is centrally located within existing inpatient units.

Estimated Cost of Modernizing to expand RT:
The estimated cost of modernizing existing space is the project cost.

Alternative 3: Build an Addition
To improve efficiency, the project utilizes new space near the two ICUs to store equipment and house a small office/workroom. Over 95% of all RT procedures are inpatient procedures. Providing equipment storage and a small work room near the ICUs reduces time transporting equipment and increases productivity. See Attachment GRC-3 for discussion of alternatives.

The estimated cost of new RT space is the project cost.

Alternative 4: Build a new Hospital
This option represents an expensive, unnecessary duplication of existing services.

Estimated Cost of Building a new Hospital:
Building a new hospital is the most expensive option. See Attachment GRC-3 which indicates that a new hospital of comparable scope and size is upwards of $700 million.

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

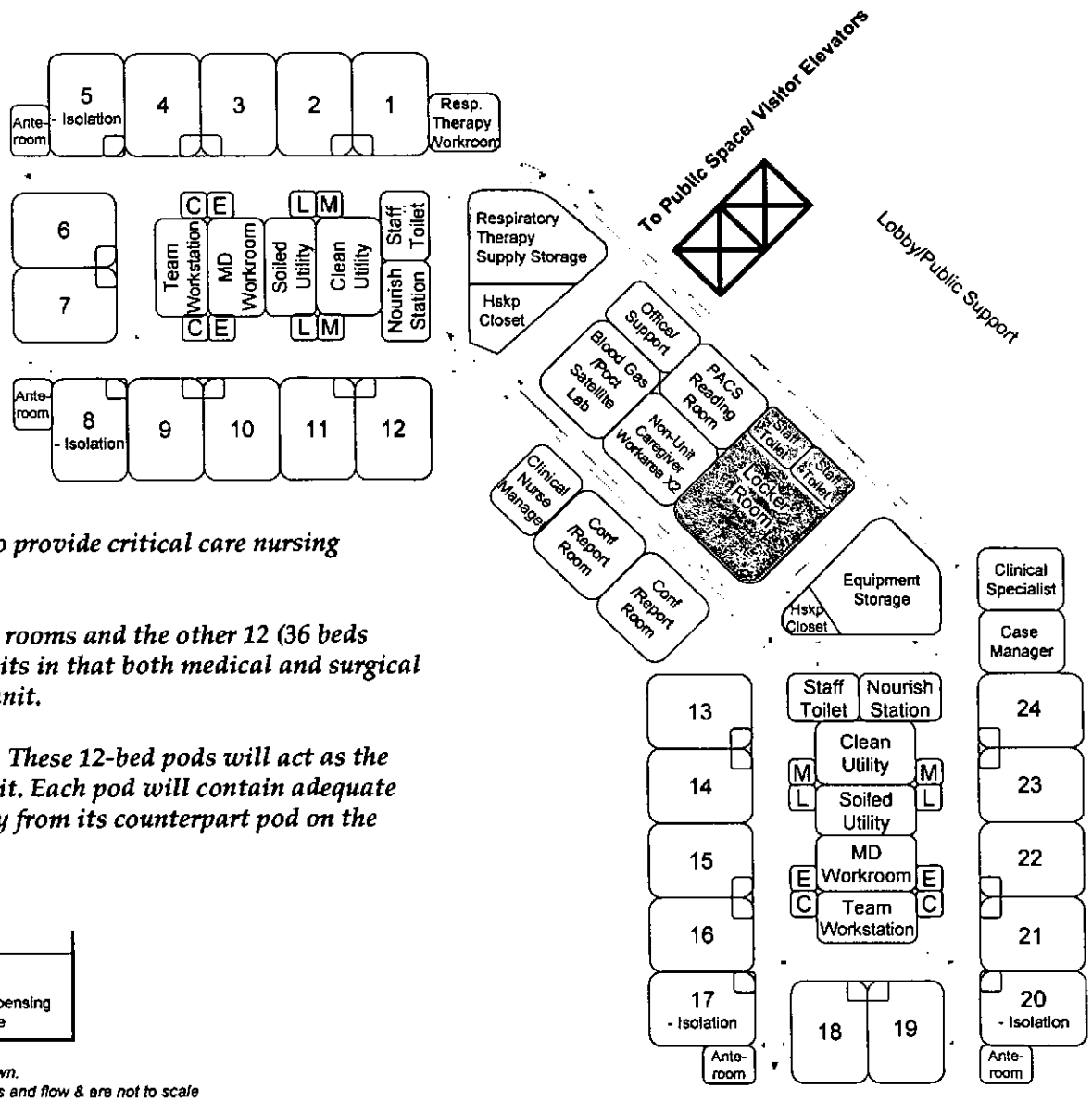
RESPIRATORY THERAPY

	Projected Growth															
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Number of Procedures:																
Inpatient	254,880	157,682	159,012	159,807	160,606	161,409	162,216	163,027	163,842	164,662	165,485	166,312	167,144	167,980	168,820	169,664
Outpatient	2,574	5,567	5,029	5,034	5,135	5,237	5,342	5,449	5,558	5,669	5,783	5,898	6,016	6,136	6,259	6,384
Total	257,454	163,249	164,041	164,841	165,741	166,647	167,558	168,476	169,400	170,331	171,267	172,211	173,160	174,116	175,079	176,048
% of Change	*	-36.6%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.6%	0.6%	0.6%	0.6%	0.6%
Visits/Patients:																
Total		65,300	65,616	67,585	62,982	63,326	63,672	64,021	64,372	64,726	65,082	65,440	65,801	66,164	66,530	66,898

Procedures not comparable between 2005 & 2006 due to changes in counting practices (bundling); conversion to Meditech Information system (2006)
Volumes above exclude Pulmonary Function
Outpatient includes Emergency Department

ATTACHMENT MOD-3E(1)

EAST WING ADDITION
Prototypical ICU



The two new proposed ICUs are planned to provide critical care nursing capacity through 2020.

One ICU is two contain 24 private patient rooms and the other 12 (36 beds total). They are planned to be universal units in that both medical and surgical patients will be accommodated on either unit.

ICUs are organized into "pods" of 12 beds. These 12-bed pods will act as the primary organizational element for the unit. Each pod will contain adequate support functions to operate independently from its counterpart pod on the floor.

Abbreviation Key:
C – Crash Cart
E – Equipment Alcove
M – Automated Medication Dispensing
L – Linen Exchange Cart Alcove

Note: Not all program elements shown.
Diagrams illustrate adjacencies and flow & are not to scale

MODERN FACILITIES
Necessary Expansion

LAB

The Hospital proposes to expand and relocate the Clinical Lab (Lab) which now occupies 9,362 gsf in a central location on the Hospital's main, 1st Floor. Space vacated by Lab will be modernized to expand Diagnostic Radiology, Nuclear Medicine, and Cardiology, improving access to imaging services for Surgery, Emergency and Outpatient Services. The Lab will occupy 18,880 dgsf in the Lower Level of the new East Wing, directly below both Outpatient Testing and Surgery, improving efficiencies (refer back to existing and proposed schematics.)

The need for the project is based on increases in historical utilization and projected growth and aging of the population in the service area. Lab studies and visits increased at an average 5.5% and 4.4% per year, respectively, between 2005 and 2007. The Lab is projected to grow at a modest 2.5% per year. See Attachment MOD-3F(1) for historical and projected Lab utilization. Service area population is expected to increase 1.0% per year from 2007 through 2020 (see population projections in Attachment GRC-4.) The service area's elderly population is expected to increase 2.5% per year through 2012. The elderly are the fastest growing population in the service area.

Necessary Expansion

The current square footage is inadequate at the hospital Lab and is particularly acute in the microbiology and histology sections which cannot add new technologies because of space constraints. These sections have their original 1972 cabinetry. Current space allocated to the core Lab and blood bank is functional but these areas have compromised operational efficiencies because of walls and utilities originally designed over 35 years ago. The growing area of point of care testing currently has no dedicated space and has been integrated, although awkwardly, into other Lab sections. The referral testing area lacks adequate space to process the growing diversity of tests referred to outside specialty laboratories for genetic and molecular testing – approximately 5.5% of total billed tests – and growing. Many of these specialty tests could be offered within the Lab if space for instrumentation and staff were available. The staff support areas for lockers, bathrooms, break-room, and meetings are functional but very crowded.

Storage of refrigerated and non-refrigerated specimens, reagents, chemicals, and consumables is challenging within current space. The Lab in its current location is not accessible to home health agencies for specimen delivery and registration, to referral laboratories for specimen pick-up, and to blood centers for product delivery. Test equipment is becoming larger but able to perform the work of multiple systems. These highly automated systems resembling assembly lines are becoming more prevalent as the shortage of medical technologists grows. This automation requires an open warehouse work environment where instruments can be easily reconfigured.

The Morgue is appropriately located, but may require additional refrigeration space in the future, and there is no space within the existing location to expand. The Lab's adjacency near surgery will be maintained, accommodated by pneumatic tube system.

Lab will provide routine and stat testing for inpatients, outpatients, and outreach clients. Lab will provide the following specialty services: chemistry, hematology, microbiology, histology, cytology, blood bank, phlebotomy and a new molecular biology lab. All functions to be accommodated in the Lab have been designed with consideration toward streamlining of processes and coordinated movement of specimens, supplies, staff and information.

The main Lab area is configured around an "open concept" core lab housing an automated testing line for the core lab with the potential future addition of a second hematology line. Please refer to Attachment MOD-3F(2) for concept diagram. The openness of the core lab will provide the greatest possible flexibility for the configuration of the automated testing equipment while allowing for adequate bench space for non-automated testing. Microbiology, molecular biology, histology, cytology, blood bank, and point-of care testing services will each occupy relatively separate suites within the main footprint, with each configured and equipped to optimally support its respective service (e.g. Microbiology suite has been configured to support use of laminar flow hoods, Cytology and Histology are positioned adjacent to each other, etc). Accessioning services will be consolidated into a separate area and strategically situated as the main point of entry for all specimens. Lab administrative and support spaces have been provided and positioned to allow an appropriate level of functional integration while in no way obstructing workflow. A dedicated, phlebotomy dispatch and cart storage have been integrated within the accessioning area to support the staff handling specimen collection throughout the hospital.

Compliance with IHFPB Space Standards

The Lab is expected to grow at a modest 2.5% per year, significantly less than the growth in historical studies and visits which increased at an average 5.5% and 4.4% per year, respectively, between 2005 and 2007. Growth in the area's elderly population of 2.5% per year through 2012 contributes to the need for the expansion. The Lab is appropriately sized with 18,880 department gsf (dgsf) as follows:

IHFPB Standard	=	225 gsf per FTE
101 FTEs X 225 gsf	=	22,725 gsf allowed

The Lab is 3,845 gsf below the IHFPB standard.

Alternatives

The Hospital considered the following four alternatives to the project:

(1) Do nothing and ignore the needs for improved Lab studies;
(2) Modernize existing space;
(3) Build an addition to the existing hospital; and
(4) Build a new hospital.

Alternative 1: Do Nothing

The alternative of doing nothing was considered not viable. The Lab is significantly undersized. As more and more patients present with serious illness and conditions Lab requires more complex studies and more efficient operation.

The Lab already operates 24/7. Hours cannot be extended further. Doing nothing ignores the current and projected needs for improved, efficient Lab Services.

Estimated Cost of Doing Nothing:
The capital cost of doing nothing appears to be minimal. However, staff and patients bear non-monetary costs when Lab processes are cramped and studies restricted due to space limitations. The project improves access to these important Lab services, reducing patient stays and improving patient outcomes. Therefore, there is "no capital cost" associated with this "no benefit" option.

Alternative 2: Modernize Existing Space
The Hospital has no available space anywhere in its current facilities for expanding the Lab.

Estimated Cost of Modernizing to expand Lab:
IHFPB standards indicate that modernizing is approximately 70% of new construction.

Alternative 3: Build an Addition
Due to the lack of available space, the Hospital determined that it was necessary to build an addition. See Attachment GRC-3 for discussion of these alternatives.

Alternative 4: Build a new Hospital
This option represents an expensive, unnecessary duplication of existing services.

Estimated Cost of Building a new Hospital:
Building a new hospital is the most expensive option. See Attachment GRC-3 which indicates that a new hospital of comparable scope and size is upwards of $700 million.

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

LABORATORY SERVICES

	Historical			Projected Growth												
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Number of Laboratory Studies:																
Inpatient	465,964	452,157	504,280	541,020	554,546	568,409	582,619	597,185	612,114	627,417	643,103	659,180	675,660	692,551	709,865	727,612
Outpatient*	405,293	452,030	465,955	385,472	395,109	404,987	415,111	425,489	436,126	447,029	458,205	469,660	481,402	493,437	505,773	518,417
Studies Performed Under Contract	34,109	44,027	55,645	67,772	69,466	71,203	72,983	74,808	76,678	78,595	60,560	82,574	84,638	86,754	88,923	91,146
Total	871,257	904,187	970,235	994,264	1,019,121	1,044,599	1,070,714	1,097,481	1,124,918	1,153,041	1,181,867	1,211,414	1,241,699	1,272,742	1,304,561	1,337,175
Annual % Change		3.8%	7.3%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
Average Annual 2005-2007			5.5%													
FTEs	101	101	100	101	101	101	101	101	101	101	101	101	101	101	101	101

	Historical															
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Number of Visits (Venipunctures):*																
Inpatient	107,172	111,256	120,451	131,220	134,501	137,863	141,310	144,842	148,463	152,175	155,979	159,879	163,876	167,973	172,172	176,476
Outpatient*	44,582	55,058	54,876	52,544	53,858	55,204	56,584	57,999	59,449	60,935	62,458	64,020	65,620	67,261	68,942	70,666
ED	9,209	12,369	13,155	14,456	14,817	15,188	15,568	15,957	16,356	16,765	17,184	17,613	18,054	18,505	18,968	19,442
Total	160,963	166,314	175,327	198,220	203,176	208,255	213,461	218,798	224,268	229,874	235,621	241,512	247,550	253,738	260,082	266,584
% of Change		3.3%	5.4%	13.1%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%

Outpatient includes Emergency Department
Annualized Jan-Mar 2008
Source: PCH, Laboratory

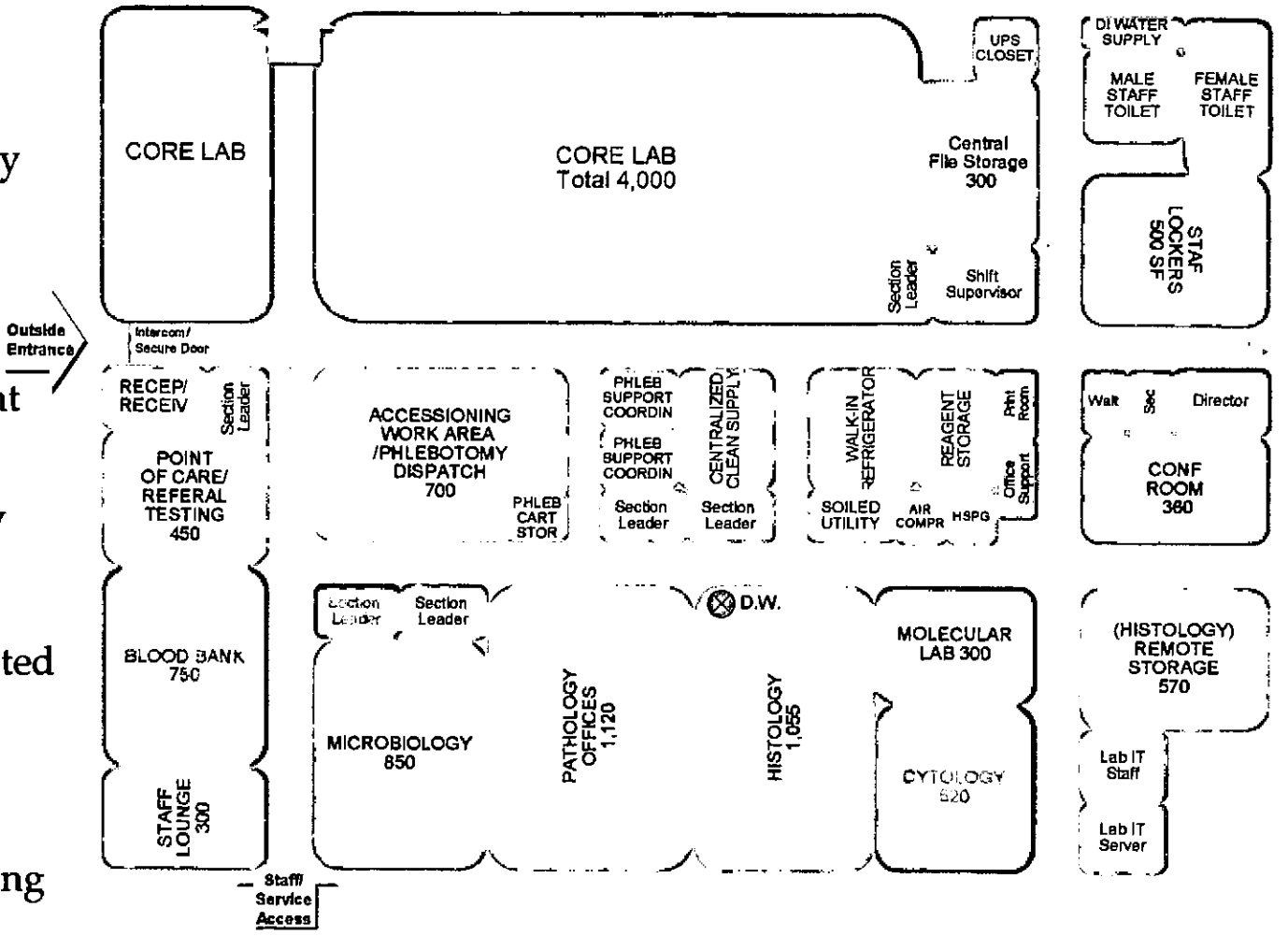
ATTACHMENT MOD-3F(1)

Clinical Lab Concept

The planned replacement Clinical Laboratory will support routine and stat testing for Palos Community Hospital inpatients, outpatients, and outreach home health clients. Some highly specialized or infrequent test types are sent out to reference labs.

The main clinical laboratory area is to be configured around an "open concept" core lab housing an automated testing line for the core lab.

Microbiology, Molecular, Histology, Cytology, Blood Bank and Point-of-care testing services will each occupy relatively separate suites



NAVIGANT CONSULTING

MODERN FACILITIES
Necessary Expansion

Pharmacy Services

Pharmacy is located on the Lower Level, adjacent to Dietary, and contains only 4,135 gsf. It would be re-located to the Lower Level of the East Wing, adjacent to Lab, in 7,360 dgsf. Pharmacy's vacated space will be remodeled to expand adjacent Dietary Services.

Pharmacy needs to expand to meet the increasing demand for services and to incorporate advancing technology in every aspect of its services, including intake, compounding, order entry, and dispensing. The Pharmacy was designed over 30 years ago, and the distribution model, the cart system, has not dramatically changed even though the number of orders, doses, IVs, interventions, pre-packed doses, narcotics dispensed, cart-fill doses etc. has increased on a yearly basis.

The need for the project is based on historical and projected utilization and growth and aging of the service area population. Between 2005 and 2007 Pharmacy utilization increased an average 6.9% and 4.5% per year for orders and doses, respectively. See Attachment MOD-3G(1) for historical and projected utilization. Total population in the service area will continue to grow. Population is expected to grow at 1.0% per year through 2020. The elderly population (aged 65 and over) is projected to increase 2.5% per year through 2012 (see Attachment GRC-4 for historical and projected population.) Based on the above, Pharmacy orders and doses are projected to grow at an average 3.0% per year through 2020.

Necessary Expansion

As a result of these utilization increases, clinical and dispensing staff has also grown. The Pharmacy is open 24/7 and employs 67 team members. Pharmacy clinical support space outside the department is very limited, requiring more support space within the department. New positions include Pharmacy Buyer and a Data Information Pharmacist. These additions increased the number of required computer workstations in Pharmacy. Workstations are added to decrease turn-around time of medications; provide better availability of information as calls/inquiries are received; and increase departmental productivity. Besides the presence of computer workstations on all work counters, workstations have also been placed in the pharmacy conference room. This area is not only a break room but has also been converted into the permanent work area for the Pharmacy Buyer and Data Information Pharmacist. Two additional work stations have been added for pharmacists to perform order entry. This area is also a break area for the staff, which provides for a non-conducive work environment for those at workstations in this area.

Recently, the Pharmacy changed work flow and storage areas for IV medications and preparation to comply with the new USP 797 guidelines (refer back to GRC-5(11).) Pharmacy began bar coding medications which it pre-packs. Increases and changes in workloads increased stock and the need for more terminals for order entry and calls. As drug storage absorbs most available space, Pharmacy added storage shelves to the unit dose section to store drugs in designated areas (standardization) to minimize exceptions and

the potential for medication errors. The current dispensing area is within the order entry area. This location distracts pharmacists during the order entry process which requires total concentration due to the increased complexity of orders, acuity of the patients and numbers of medication orders.

The IV room requirements for USP 797 compliance have changed workflow and what is stored in the IV room. All the pre-made IVs have been moved out of the IV room and are now dispensed from the Pharmacy. A new printer was added to the Pharmacy to accommodate these pre-made IVs and the printing of the labels. A refrigerator was removed from the IV room, assisting compliance with USP 797. These changes crowd an already undersized Pharmacy. Fortunately, Pharmacy cabinetry was able to be rearranged and reconfigured to allow for some changes that need to be implemented.

Automation is being introduced into the pharmacy workflow to help assure medication safety. In the future, all doses which are dispensed in the pharmacy will require bar coding. Bar code labeling of unit doses and prepared doses will require new equipment which is not currently available in the Pharmacy. This equipment requires dedicated terminals and space which is currently not available in the Pharmacy.

The hospital will eventually adopt automatic dispensing machines in the nursing care areas. The new system will assist with first doses, decrease order turn around time and assist with narcotic control. This technology will require work space and workstations within the pharmacy for dose preparation accompanied with carts for delivery of these doses. These functions will all require more space. Pharmacy does not have available space. (Refer back to Detailed Function Space Programming discussion in Attachment GRC-5(12).)

The Pharmacy also lacks a private area to counsel employees with questions. The Clinical office is a galley office for 5 individuals. When the Clinical Coordinator has a meeting with nursing, a physician or sales person, the clinical pharmacists are all in the same office. Lack of privacy impedes a productive work environment.

In conclusion, Pharmacy requires additional space to increase productivity and decrease the potential of medication errors by allowing for an environment that is less disruptive to the registered pharmacists and certified technicians within the pharmacy. The trend towards more doses, orders, IVs etc. per patient because of increased patient acuity and decreased patient days requires more supplies and equipment. New practice guidelines and automation are requiring added equipment, supplies and workstations within the department. All of these changes minimize medication errors to maintain service excellence.

Besides these space limitations, the Pharmacy needs to relocate as its location close to the dock causes ventilation problems. The new Pharmacy will have a designated receiving area which improves both delivery and control. Continued compliance with the new USP guidelines within its existing location is challenging.

Alternatives
The Hospital considered the following four alternatives to the project:

(1) Do nothing and ignore the needs for added space and access;
(2) Modernize existing space;
(3) Build an addition to the existing hospital; and
(4) Build a new hospital.

Alternative 1: Do Nothing

The alternative of doing nothing was considered not viable. Pharmacy needs to expand due to increasing utilization and the need for automation and improved dispensing systems. Pharmacy already operates 24/7. Hours cannot be extended further. Doing nothing ignores the current and projected need for an expanded Pharmacy.

Estimated Cost of Doing Nothing:
The capital cost of doing nothing appears to be minimal. However, staff and patients both bear non-monetary costs. Staff and patients must wait for orders/doses when scheduling processes are slow due to insufficicnt spaee. Staff needs additional space to ensure continued productivity.

Therefore, there is "no capital cost" associated with this "no benefit" option.

Alternative 2: Modernize Existing Space
The Hospital has no available space anywhere in its current facilities for expanding Pharmacy.

Estimated Cost of Modernizing to expand Pharmacy:
IHFPB standards indicate that modernizing is approximately 70% of new construction.

Alternative 3: Build an Addition
Due to the lack of available space, the Hospital determined that it was necessary to build an addition to expand Pharmacy. See Attachment GRC-3 for discussion of these alternatives.

Estimated Cost to Build an Addition to Expand Pharmacy:
The estimated cost of building an addition is the project cost. For the cost of alternative additions, see Attachment GRC-3.

Alternative 4: Build a new Hospital
This option represents an expensive, unnecessary duplication of existing services.

Estimated Cost of Building a new Hospital:
Building a new hospital is the most expensive option. See Attachment GRC-3 which indicates that a new hospital of comparable scope and size is upwards of $700 million.

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

PHARMACY SERVICES

				Projected Growth												
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
DOSES																
Inpatient	1,367,716	1,325,912	1,447,592	1,682,748	1,733,230	1,765,227	1,838,784	1,893,948	1,950,766	2,009,289	2,069,568	2,131,655	2,195,604	2,261,473	2,329,317	2,399,196
Outpatient*	106,552	155,870	159,748	169,936	175,034	180,265	185,694	191,264	197,002	202,912	209,000	215,270	221,728	228,380	235,231	242,288
Total	1,474,270	1,481,782	1,607,340	1,852,684	1,908,265	1,965,512	2,024,478	2,085,212	2,147,769	2,212,202	2,278,568	2,348,925	2,417,332	2,489,852	2,564,548	2,641,484
% of Change		0.5%	8.5%	15.3%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Average Increase 2005-2007			4.5%													
ORDERS																
Total		660,888	706,538	791,712	815,463	839,927	865,125	891,079	917,811	945,346	973,706	1,002,917	1,033,005	1,063,995	1,095,915	1,128,792
Average Increase 2006-2007			6.9%	12.1%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
FTEs	51	51	53	53	53	53	53	53	55	55	55	55	57	60	60	60

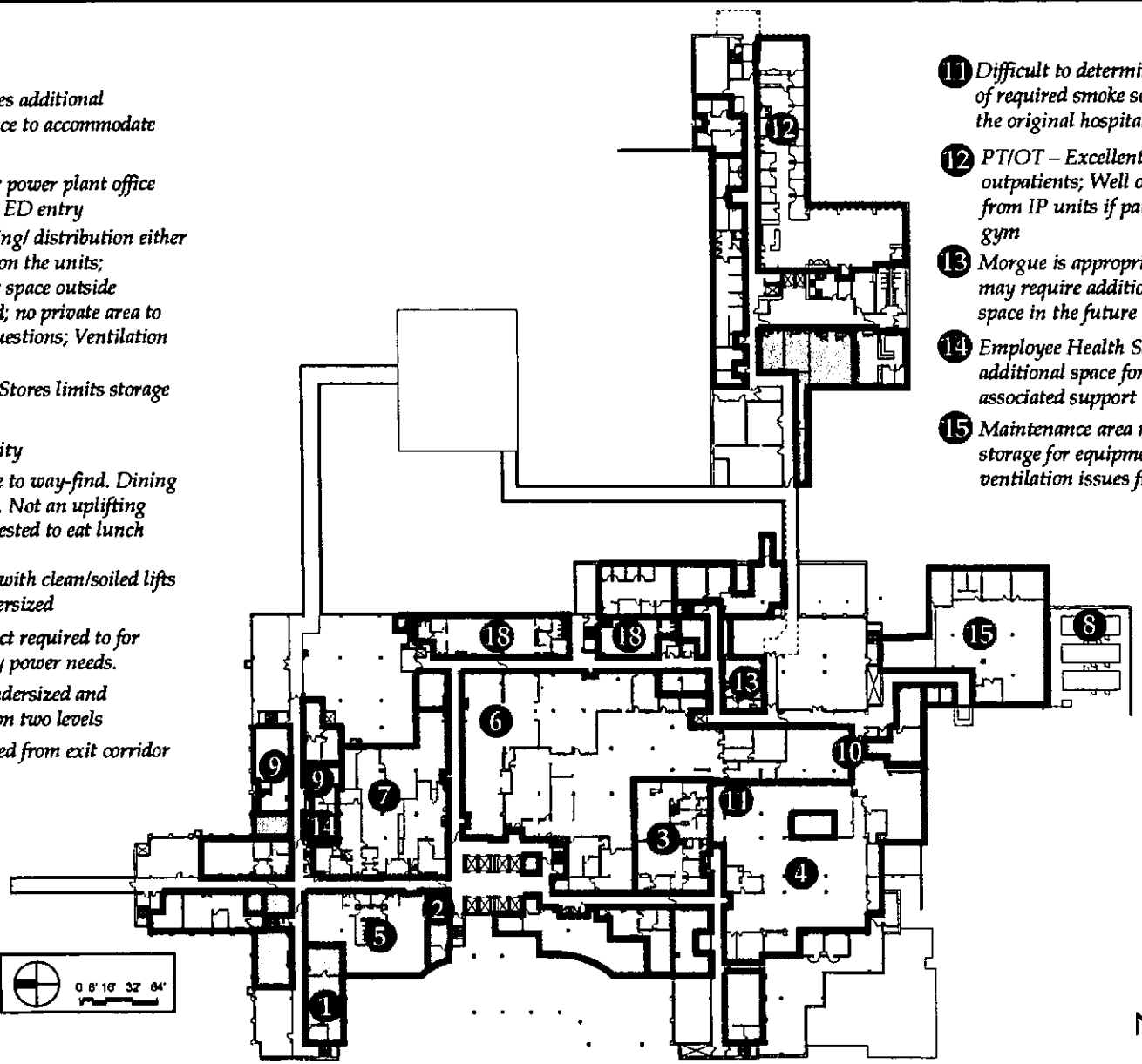
** Outpatient includes Emergency Department*
Orders data provided beginning with conversion to Meditech Information system (2006) for consistency
Annualized Jan-Mar 2008
Source: PCH - Pharmacy statistics

ATTACHMENT MOD-3G(1)

Existing Conditions Overview – Ground Level

Key Notes:

1. *Nursing Education requires additional classroom and support space to accommodate training*
2. *Security dispatch center & power plant office would be ideally located at ED entry*
3. *No automation of processing/ distribution either within the department or on the units; pharmacy clinical support space outside department is very limited; no private area to counsel employees with questions; Ventilation issues from dock*
4. *Low headroom in General Stores limits storage quantities*
5. *Employee lockers at capacity*
6. *Cafeteria is difficult/remote to way-find. Dining room is at/beyond capacity. Not an uplifting environment; visitors requested to eat lunch after 1PM*
7. *SSP – Properly positioned with clean/soiled lifts into surgery, but very undersized*
8. *Emergency generator project required to for compliance with emergency power needs.*
9. *Medical Records is very undersized and segregated into four areas on two levels*
10. *Receiving dock not separated from exit corridor*
11. *Difficult to determine exact placement of required smoke separations within the original hospital*
12. *PT/OT – Excellent access for outpatients; Well organized; distant from IP units if patients need to utilize gym*
13. *Morgue is appropriately located but may require additional refrigeration space in the future*
14. *Employee Health Services requires additional space for exam rooms and associated support*
15. *Maintenance area requires additional storage for equipment/supplies; ventilation issues from dock*



NAVIGANT CONSULTING

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ATTACHMENT MOD-3G(2)

MODERN FACILITIES
Necessary Expansion

OUTPATIENT AND PRE-ADMISSION TESTING

The Hospital proposes to modernize and expand Outpatient and Pre-Admission Testing (Outpatient Testing.) The existing outpatient entrance and testing services are on the Hospital's south side adjacent to the Emergency Department (ED.) Outpatient Testing will vacate the area to allow necessary ED expansion. Outpatient Testing will move to new space on the Hospital's north side and align with a new main entrance, registration area, and expanded, assigned parking (refer back to existing and proposed schematics.) Outpatient Testing would increase from 1,265 gsf to 4,180 department dgsf.

Outpatient and Pre-Admission Testing combines three previously separate diagnostic services (phlebotomy, outpatient EKG, and nutrition/health testing), sharing staff and clinical support. Outpaticnt Testing does not provide imaging services.

The need for the Hospital considered a need assessment by Navigant Consulting, Inc. (NCI) (see Attachments MOD-3H(1) and 3H(1A). However, the Hospital converted to a new Meditech Information system in 2005, making comparison of recent utilization difficult. For this reason the project holds utilization of Outpatient Testing constant through the year 2020. This assumption is conservative considering growth and aging of the service area population. Total population in the service area will continue to grow at 1.0% per year through 2020. The elderly population (aged 65 and over) is projected to increase 2.5% per year through 2012 (see Attachment GRC-4 for bistorical and projected population.)

Necessary Expansion

Outpatient Testing has inadequate space for treatment and support, and includes only the following: one (1) cxam room, one (1) phlebotomy draw room with 4 chairs, (1) one EKG room and onc work arca for health testing nurses. Clinical and administrative support spacc is inadcquatc with no consult area, staff office, storage, clean/soiled utilities, or housekeeping. There is no dedicated family waiting area.

Please see the proposed Space Plan in Attachment GRC-5(2) which identifies the need for the following: six (6) phlebotomy draw stations; two (2) therapeutic draw stations; two (2) EKG rooms; and two (2) consult rooms. Support space would include: two (2) staff work rooms; two (2) staff hand-washing alcoves; two (2) pneumatic tube stations; reception; family waiting; officc; clean/soiled utility; toilets; storage; and housekeeping closet.

Alternatives

The Hospital considered the following four alternatives to the project:

(1) Do nothing and ignore the needs for added space and access;
(2) Modernize existing space;
(3) Build an addition to the existing hospital; and
(4) Build a new hospital.

Alternative 1: Do Nothing

The alternative of doing nothing was considered not viable. There is a need to expand Outpatient Testing to provide larger primary activity space and dedicated support space. Outpatient Testing is open 7 days per week from 5:30 a.m. to 10:00 p.m. Hours cannot be extended further. Doing nothing ignores the need for Outpatient Testing Services in the community.

Estimated Cost of Doing Nothing:

The capital cost of doing nothing appears to be minimal. However, staff and patients both bear non-monetary costs. Patients must wait for procedures when scheduling processes are slow due to insufficient space. The inefficiencies of operating three, separate departments will continue.

Doing nothing relinquisbes the benefits of aligning Outpatient Testing with the new main entrance, registration area, and expanded, assigned parking on the Hospital's north side. Therefore, there is "no capital cost" associated with this "no benefit" option.

Alternative 2: Modernize Existing Space

The Hospital has no available space in its current facilities to expand Outpatient Testing.

Estimated Cost of Modernizing to expand Outpatient Testing:

IHFPB standards indicate that modernizing is approximately 70% of new construction.

Alternative 3: Build an Addition

Due to the lack of available space, the Hospital determined that it was necessary to build an addition. See Attachment GRC-3 for discussion of these alternatives.

Estimated Cost of Building an Addition to expand Outpatient Testing:

See Attachment GRC-3 for discussion of these alternatives. The project cost is the cost of one of these alternatives.

Alternativc 4: Build a new Hospital

This option represents an expensive, unnecessary duplication of existing services.

Estimated Cost of Building a new Hospital:

Building a new hospital is the most expensive option. Sec Attachment GRC-3 which indicatcs that a new hospital of comparable scope and size is upwards of $700 million.

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

OUTPATIENT & PRE-ADMISSION TESTING

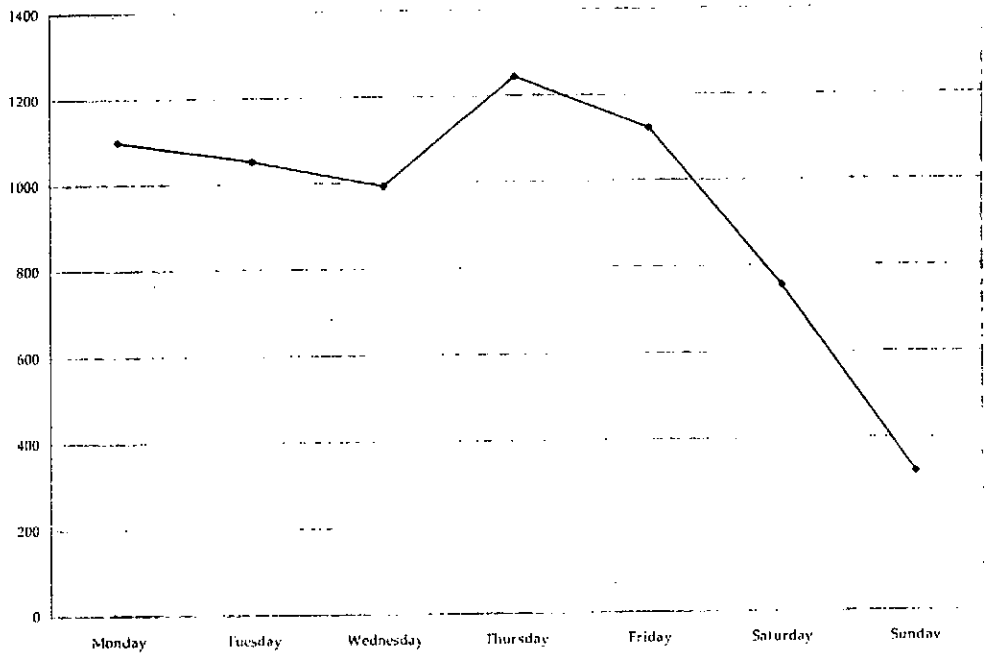
	Historical		Projected Growth												
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
OUTPATIENT & PRE-ADMISSION TESTING**															
Outpatient Testing	77,766	77,842	78,000	78,000	78,000	78,000	78,000	78,000	78,000	78,000	78,000	78,000	78,000	78,000	78,000
Health Testing	4,406	3,587	3,800	3,800	3,800	3,800	3,800	3,800	3,800	3,800	3,800	3,800	3,800	3,800	3,800
Total	82,172	81,429	81,800	81,800	81,800	81,800	81,800	81,800	81,800	81,800	81,800	81,800	81,800	81,800	81,800
Annual % Change		*0.1%*	*0.2%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*

***Includes lab outpatient testing, outpatient EKG, pre-surgical testing including imaging and interview with nurse.*
Outpatient data provided beginning with conversion to Meditech Information system for consistency (2006).
Source: PCH Planning - Meditech ESS Utilization Statistics; 2008 annualized Jan-Jun

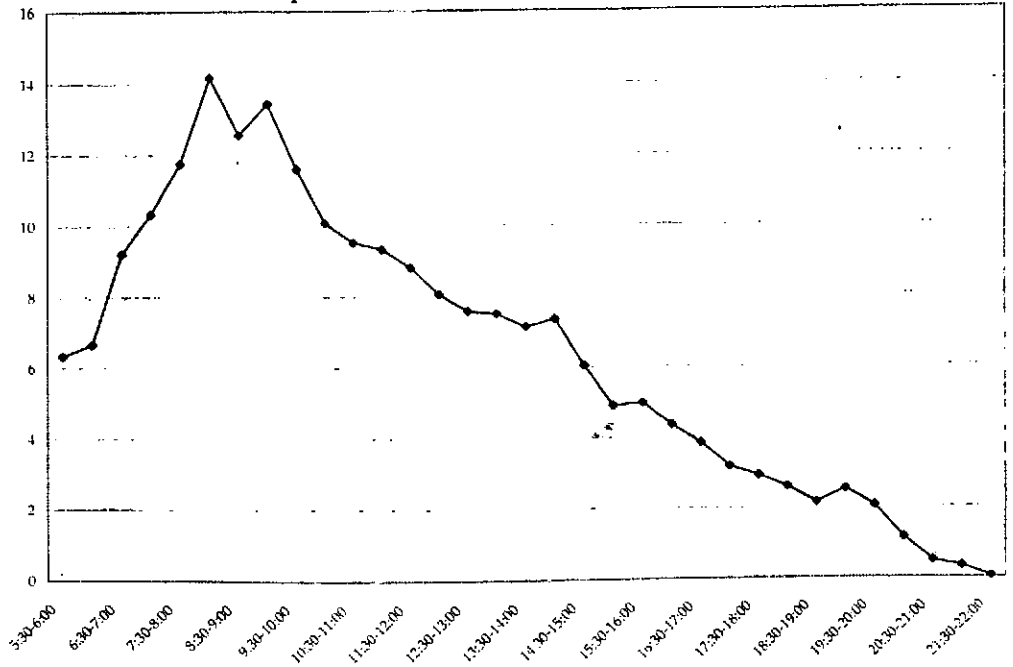
ATTACHMENT MOD-3H(1)

Patient Access – Current Volume Distribution/Patterns

In order to accurately assess the required number of both the phlebotomy and registration positions, an analysis of the current volume distribution by day of week and time of day was conducted. The data showed that 84% of the current ACC Registration volumes occurred Monday through Friday with 11% on Saturday and 5% on Sunday. The highest volume weekday was Thursday; lowest Wednesday. This equates to a weekday peaking factor of 25%.



In March 2007, the average peak registrations was 14.2 from 8:00- 8:30; an overall peak of 26 occurred on Monday, March 5th. Overall average was 7.4 registrations. 78% of the volume occurred between 6 am and 2:30 pm



Patient Access/OP Testing Volume Projections & Capacity

Volume Projections Summary

The required number of registration positions is based on the outpatient volumes for each of the impacted services and the anticipated pre-registration rate for each area.

Service Volume Type	Outpatient Volume Projections				Pre-Reg Rate
	2005	2010	2015	2020	
Lab Visits *	53,833	58,825	68,194	79,056	0%
Health Testing Visits	4,184	4,728	5,201	5,981	98%
Outpatient Cardiology	15,417	19,466	23,528	28,398	
EKG	12,084	14,929	17,583	20,892	0%
Echo/TEE	1,920	2,788	3,642	4,736	98%
Stress Echo	1,208	1,487	1,766	2,104	98%
Dobutamine Stress	204	261	538	667	98%
Outpatient Imaging	45,699	58,192	70,853	86,696	
General Radiology	12,653	15,014	17,833	21,492	98%
CT	9,226	12,852	15,766	19,868	98%
Ultrasound	6,540	8,705	11,155	13,691	98%
Mammography	11,650	13,780	15,914	18,552	34%
Nuclear Medicine	5,631	7,840	10,185	13,093	98%
Future MRI		2,500	2,500	2,500	98%
Outpatient Department	17,037	19,347			98%

Registration Capacity - 2015

The model below assumes a 6 minute average registration time that was based on data from a two week time study completed in March 2008. The number of required registration positions needed to support the 2015 projected volumes for the outpatient testing function given an assumed increase in the pre-registration rate from 0% to 30% is four.

Volumes		Daily Time Demand											Daily Time Supply			Resultant
Service	2015 Annual Visits	Days Year	Avg Daily Visits	Percent Prime Shift	Prime Shift Visits	Peaking Factor	Pre-Reg	Peak Reg Prime Shift	Peak Visits Prime Shift	Avg Mins Reg	Avg Mins Visit	Prime Shift Demand Hours	Prime Shift Hours Day	Percent Util Factor	Avail Room Hours	Projected Positions
Lab Visits	68,194	300	230	85%	200	40%	30%	196	280	6	0	20	9	90%	8.10	2.4 3
Health Testing Visits	5,201	250	20	85%	20	40%	98%	1	28	6	0	0	9	90%	8.10	0.01 0
Outpatient Cardiology	23,528				80											1.9 2
EKG	17,583	250	70	85%	60	40%	30%	59	84	6	5	13	9	90%	8.10	1.6 2
Echo/TEE	3,642	250	10	85%	10	40%	98%	0	14	6	5	1	9	90%	8.10	0.1 0
Stress Echo	1,766	250	7	85%	10	40%	98%	0	14	6	5	1	9	90%	8.10	0.1 0
Dobutamine Stress	538	250	2	85%	-	40%	98%	0	0	6	5	0	9	90%	8.10	0.0 0
Outpatient Imaging	70,853				220											6.6 7
General Radiology	17,833	250	70	85%	60	40%	98%	2	84	6	10	14	9	90%	8.10	1.8 2
CT	15,766	250	60	85%	50	40%	98%	1	70	6	10	12	14	90%	12.60	0.9 1
Ultrasound	11,155	250	40	85%	30	40%	98%	1	42	6	10	7	9	90%	8.10	0.9 1
Mammography	15,914	250	60	85%	50	40%	34%	46	70	6	10	16	9	90%	8.10	2.0 2
Nuclear Medicine	10,185	250	40	85%	30	40%	98%	1	42	6	10	7	9	90%	8.10	0.9 1
Future MRI	2,500	250	10	85%	10	40%	98%	0	14	6	10	2	14	90%	12.60	0.2 0

OP Testing - Functional Capacity

Phlebotomy Capacity 2015

The model below was based on the 2006 volume baseline as indicated below and includes Employee Health visits. A total of 8 positions are required to support the projected 2015 volumes. Therapeutic and neonatal draws will be completed two larger rooms for these private/longer procedures.

Routine OP Phlebotomy			
2006	2010	2015	2020
53,833	58,825	68,194	79,056
9 mins	9 mins	9 mins	9 mins
5 mins	5 mins	5 mins	5 mins
12,561 hrs	13,726 hrs	15,912 hrs	18,446 hrs
40.3 hrs/day	44.0 hrs/day	51.0 hrs/day	59.1 hrs/day
1.40	1.40	1.40	1.40
85%	85%	85%	85%
47.9 hrs	52.4 hrs	60.7 hrs	70.4 hrs
9.00 hrs	9 hrs	9 hrs	9 hrs
85%	85%	85%	85%
6.26	6.84	7.93	9.20
7	7	8	10

Volume
Average Duration
Average Turn-over
Total In-Room Procedure Time
Average In-Room Procedure Time/Day *
Peaking Factor
Percent Prime Time
Daily Design Demand
Capacity/Rm/Day
Target Utilization
Calculated Capacity
Recommened Capacity

* Assumes Prime Shift = 9 hour day/ 6 days/week

EKG Capacity - 2015

All Outpatient EKG testing will be completed in the OP Testing area to avoid multiple stops for patients requiring pre-admission/pre-procedure testing. Average test durations and turnovers are assumed to remain constant. Three EKG/Exam rooms will be required to support the 2015 volume projections. Only two will be provide within the OP Testing area.

Outpatient EKG			
2006	2010	2015	2020
12,084	14,929	17,583	20,892
8 mins	8 mins	8 mins	8 mins
5 mins	5 mins	5 mins	5 mins
2,618 hrs	3,235 hrs	3,810 hrs	4,527 hrs
10.5 hrs/day	12.9 hrs/day	15.2 hrs/day	18.1 hrs/day
1.40	1.40	1.40	1.40
85%	85%	85%	85%
12.5 hrs	15.4 hrs	18.1 hrs	21.5 hrs
8.00 hrs	8.00 hrs	8.00 hrs	8.00 hrs
85%	85%	85%	85%
1.83	2.26	2.67	3.17
2	3	3	4

Volume
Average Duration
Average Turn-over
Total In-Room Procedure Time
Average In-Room Procedure Time/Day *
Peaking Factor
Percent Prime Time
Daily Design Demand
Capacity/Rm/Day
Target Utilization
Calculated Capacity
Recommened Capacity

* Assumes Prime Shift = 8 hour day/ 5 days/week

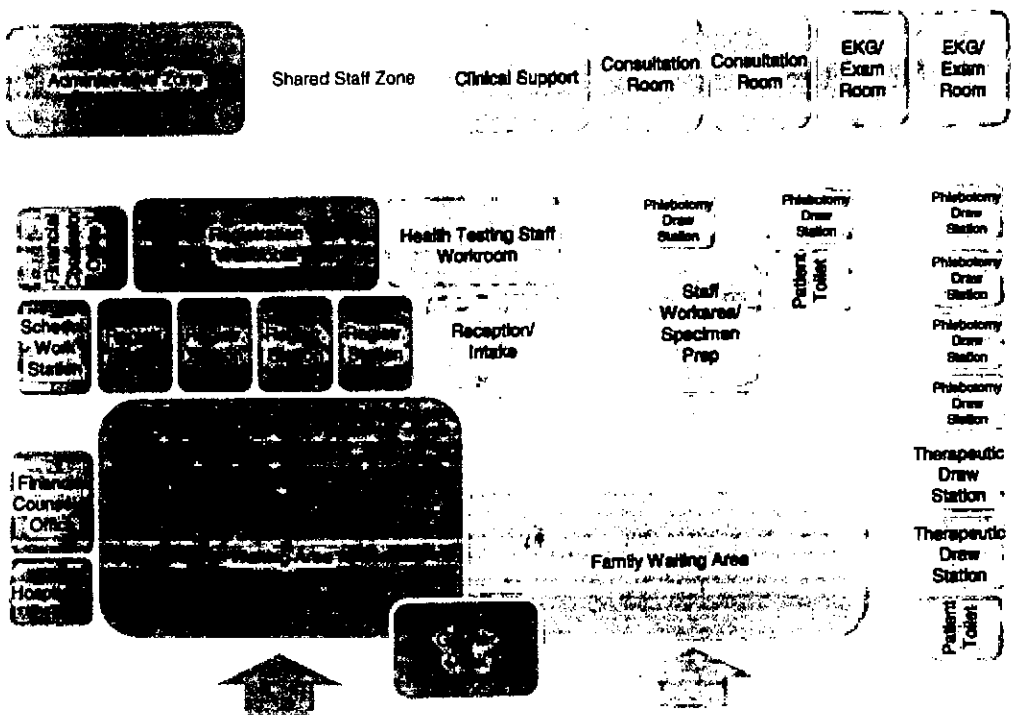
Patient Access/OP Testing - Operational Overview

Although the goal is to have more patients, especially phlebotomy patients pre-register for a day of service, most patients accessing OP Testing will not be pre-registered and the appropriate information and/or verification of orders will need to occur within one of the private registration positions in the adjacent Patient Access area.

Patients will be screened at the outpatient entrance and directed to the appropriate location. A quick stop at the greeter desk in will confirm the patient is at the correct location and begin the process for verification of physician orders. The greeter staff will not be responsible for directing all traffic (patients/visitors) entering through the outpatient entrance. A separate reception/ information point will need to be developed as part of the main outpatient lobby.

If a patient has been pre-registered, their information will be confirmed at the intake area within OP Testing and the patient's arrival will be acknowledged into the system. Unregistered patients will first stop at Patient Access before presenting to OP Testing. Once the patient has completed the necessary steps in the required registration/receiving process, if a testing room/position is not available, they will remain in the patient/family waiting, until the notification by the testing staff. During peak times, patients will be provided pagers to alert them that a room is now available.

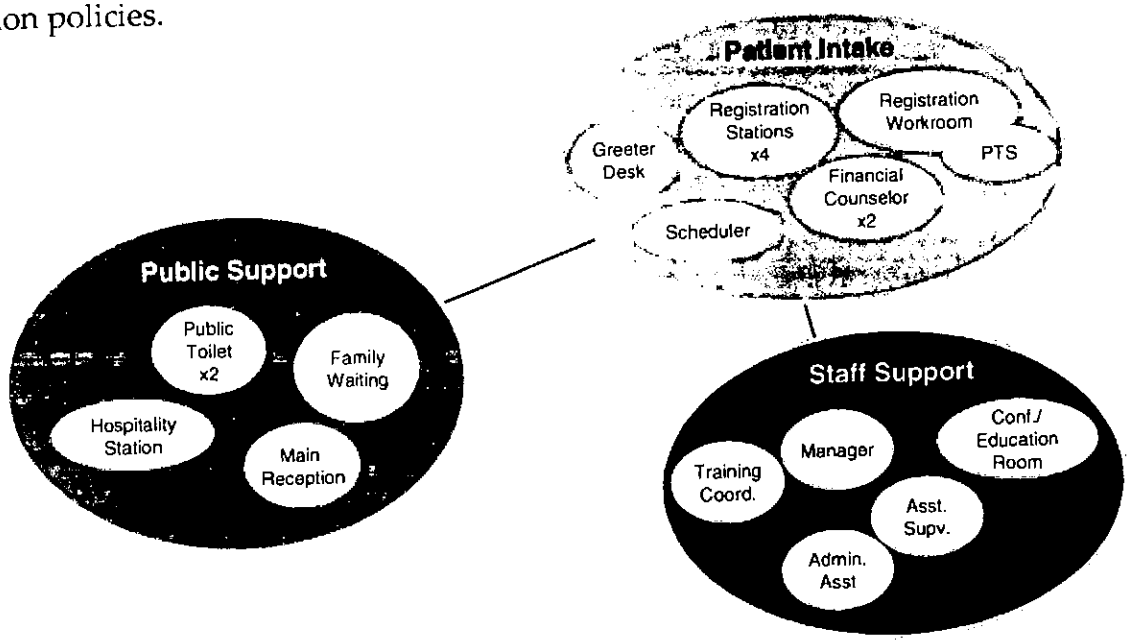
The internal configuration of the both the Patient Access and OP Testing areas should be conducive to patient privacy and convenience as well as efficient patient throughput and space utilization. The public support areas for both functions should be directly adjacent and accessible to one another so as to support the flow of patient between the two functions.



Patient Access/OP Testing - Operational Overview

Patient Access

A registration workroom is to be located directly behind the private registration positions in order to provide access to printers, scanner, copiers, supplies and a dedicated pneumatic tube station. Two private offices for financial counseling will be provided. A scheduling position will allow patients the option of scheduling follow-up testing directly with a patient access staff person, rather than through the phone based central scheduling service. Although co-payments are not currently collected at the time of service, locked cash drawers should be provided so that all positions allow for a potential change in future cash collection policies.



A staff and administrative support zone is to be shared between Patient Access and OP Testing and is to include administrative offices, staff lounge/lockers, and a conference room. The conference room is sized to accommodate seating for 12 and includes a computer workstation for staff to complete clinical education. A private office is to be provided for each manger, as well as, a shared office two assistant supervisors. An administrative assistant and training coordinator will each have a modular workstation. Any necessary office support, such as, copiers, fax, supplies can be accommodated in the patient access registration workroom.

OP Testing

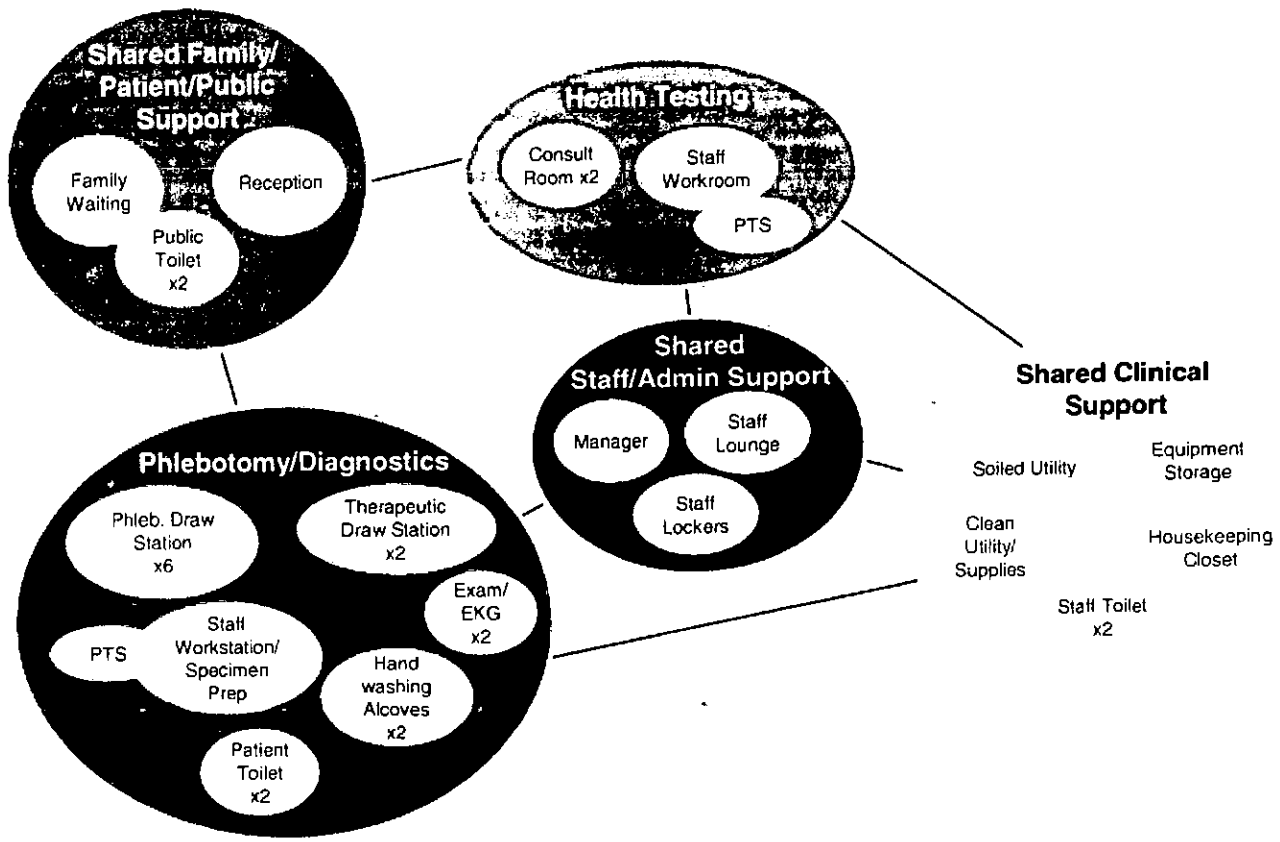
The Phlebotomy/Testing areas is to consist of 6 private draw stations, 2 larger enclosed room draw stations to support therapeutic/specialty phlebotomy, and 2 EKG/Exam rooms. The private draw stations are to be configured as distinct bays divided by hard walls on three sides and a cubicle curtain front. Each draw station is to have a patient chair, computer, appropriate lighting, and a mobile cart for frequently used supplies.

Patient Access/OP Testing - Operational Overview

A central staff workstation/specimen prep area is to have visualization of all draw stations. The staff work area will have a work counter for order verification, limited specimen prep, labeling and three computer workstations for staff. A dedicated pneumatic tube station will connect the area with the main clinical laboratory. A small undercounter refrigerator located in the staff work area will provide nourishment support for patients. Two patient toilets will be provided for specimen collection; a pass-thru from each into the staff work area is required.

The two EKG/Exam rooms are to be configured to support both EKG testing, as well as, the potential exams by either the health testing nursing staff or in rare instances the anesthesiologists. Health Testing will predominately utilize the two private consultation rooms to meet with their pre-surgical/procedure patients. Most of the health testing work will be completed over the phone in the staff workroom which is sized to accommodate 6 staff workstations each with a computer, phone and storage. Health Testing will also require a dedicated pneumatic tube station with the staff workroom.

A clinical support area containing a clean utility/patient supply room, soiled utility room, housekeeping closet, equipment storage and two staff toilets will be shared by both the phlebotomy, EKG and Health Testing staff.



MODERN FACILITIES
Necessary Expansion

INPATIENT DIALYSIS

The Hospital proposes to relocate and expand Inpatient Dialysis. Inpatient Dialysis would remain on the 3rd Floor, moving from two M/S rooms to space vacated by the ICU when it relocates to the new East Wing (refer back to existing and proposed schematics.) Inpatient Dialysis would increase from 717 gsf to 1,105 gsf. Space vacated by Inpatient Dialysis return to M/S, remodeled for private M/S rooms. Inpatient Dialysis will continue to provide 4 stations.

The need for the project is based on historical demand and aging of the service area population. See Attachment MOD-3I(1) for historical and projected utilization. The Hospital served between 244 and 406 acute dialysis patients per year between 2005 and 2008, representing an increase of 20.9% per year. The number of treatments increased an average 11.3% per year during this period, from 971 to 1,255 treatments. Total population in the service area will continue to grow. Population is expected to grow at 1.0% per year through 2020. The elderly population (aged 65 and over) is projected to increase 2.5% per year through 2012 (see Attachment GRC-4 for historical and projected population.) Based on the above factors, Inpatient Dialysis is projected to grow at 2.0% per year.

Necessary Expansion

Inpatient Dialysis is located in inadequate space for treatment and support. While there is no standard for inpatient dialysis, the IHFPB standard for outpatient hemodialysis is 470 gsf per station, or 1,880 gsf. The inpatient service does not require outpatient support functions such as reception, medical records, lockers, lounge, toilets etc. Therefore, the proposed 1,105 gsf, 276 gsf per station, is adequate for the four (4) acute dialysis stations.

Alternatives

The Hospital considered the following four alternatives to the project:

(1) Do nothing and ignore the needs for added space and access;
(2) Modernize existing space;
(3) Build an addition to the existing hospital; and
(4) Build a new hospital.

Alternative 1: Do Nothing/Transport

The alternative of doing nothing was considered not viable. As Inpatient Dialysis's utilization continues to grow, and more and more patients are presenting with serious illness and conditions, there is a need to expand Inpatient Dialysis to provide larger primary activity space and dedicated support space. Inpatient Dialysis must operate 24/7. Doing nothing ignores the current and projected need for Inpatient Dialysis Services.

See Attachment MOD-3I
Page 1 of 2

Estimated Cost of Doing Nothing:
The capital cost of doing nothing appears to be minimal. However, patients cannot wait for inpatient dialysis, as acute kidney failure or loss of function must be treated immediately and cannot suffer scheduling processes. Transport is not an option!

There is "no capital cost" associated with this "no benefit" option.

Alternative 2: Modernize Existing Space
With the current proposcd East Wing addition, the Hospital can relocate Inpatient Dialysis to space vacated by the ICU when it relocates to the East Wing. The proposed location of Inpatient Dialysis, in the middle of general acute care, is a prime space for providing Inpatient Dialysis. Remodeling existing, available space is the lowest cost option.

Estimated Cost of Modernizing to Expand Inpatient Dialysis:
The estimated cost of modernizing existing space is the project cost.

Alternative 3: Build an Addition (see Attachment GRC-3)
Due to the lack of available space, the Hospital determined that it was necessary to build an addition. See Attachment GRC-3 for discussion of these alternatives.

Alternative 4: Build a new Hospital
This option represents an expensive, unnecessary duplication of existing services.

Estimated Cost of Building a new Hospital:
Building a new hospital is the most expensive option. See Attachment GRC-3 which indicates that a new hospital of comparable scope and size is upwards of $700 million.

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

INPATIENT DIALYSIS

	Historical	Projected Growth														
	2005	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Number of Patients	244	375	426	406	414	422	431	439	448	457	466	476	485	495	505	515
% Change		54%	14%	-5%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Average Increase 2005-2008				20.9%												
Number of Treatments	971	1,384	1,452	1,255	1,280	1,306	1,332	1,358	1,386	1,413	1,442	1,470	1,500	1,530	1,560	1,592
% Change		43%	5%	-14%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Average Increase 2005-2008				11.3%												

Exisiting stations	4
Proposed stations	4
Allowed GSF	1,880
Proposed GSF	1,105

Increase projected based on inpatient projections.
Annualized Jan-May 2008
Source: PCH - Hemodialysis statistics

ATTACHMENT MOD-3I(1)

MODERN FACILITIES
Necessary Expansion

EMERGENCY SERVICES

The Hospital proposes a major expansion and modernization of Emergency Services (ED.) The ED would increase from 12,361 gsf to 22,814 gsf through remodeling of space vacated by Outpatient & Pre-Admission Testing, Admitting & Registration, GI/Endo and related Recovery, all located on the Hospital's 1st Floor (refer back to existing and proposed schematics.)

The project adds eleven (11) exam/treatment stations, increasing the number from 20 to 31 stations, including two (2) isolation stations and nine (9) general stations. Upon project completion the Hospital will have 25 general exam/treatment stations, two (2) trauma stations, and four (4) isolation station (see Attachment MOD-1B, existing and proposed exam/treatment rooms, by type.)

The need for the project is based on current demand, historical increases in utilization averaging 1.9% per year, and projected growth and aging of the population in the service area. Based on the above factors, ED utilization is projected to continue growing at the historical rate of 1.9% per year (refer to Attachment MOD-3J(1) for historical and projected utilization and Attachment GRC-4 for historical and projected population increases.)

Historical Utilization

The Hospital's 20 treatment rooms are inadequate to meet even current needs. Based on 2007 ER visits, the Hospital can currently justify an additional 5 exam/treatment rooms, as follows:

EMERGENCY SERVICES UTILIZATION

Year	Visits	IHFPB Standard	Rooms Justified
2007	48,854	2,000 Visits/Room	24.4

While the Hospital efficiently triages patients, the ED is generally backed-up with long waiting times for treatment and patient holding in non-patient areas. The problem of ER congestion is especially challenging as more patients present with more serious illnesses and conditions. Generally one-third of all ED patients arrive by ambulance. Another one-third of ED patients are admitted to the Hospital. Palos has one of the highest ED admission rates in Planning Area A-4 (see Attachment MOD-3J(2), data from the 2006 AHQ.) The Hospital consistently admits over 30% of its ED patients (see Attachment MOD-3J(1).) Professional standards indicate that an ED with an admission rate over 20% is high acuity ("Emergency Department Performance Measures and Benchmarking Summit: The Consensus Statement", Welch, Shari, MD, sjwelch@networld.com.)

High Acuity of Patient Population

PCH serves a very high acuity patient mix in the emergency department. The high acuity of ED patients is due largely to patients over the age of 65, who account for over 30% of all ED visits. The high number of elderly visits is due to the high elderly population in the service area, 12.8% of population, which is higher than Illinois or the U.S. See Attachment MOD-3J(2A) for documentation of this ratio and the substantially higher inpatient use rates in the service area for this population. Similarly, while the Hospital's overall market share is 23.5%, it serves between

27% and 30% of the area's elderly (refer back to Attachment GRC-4(4).) Given the medical needs of this population, combined with their chronic disease conditions, these patients tend to be sicker. They use more resources, stay the longest, and are more likely to be admitted.

Elderly ED visits are increasing more rapidly than any other group. The Hospital's service area has a high concentration of skilled nursing facilities (SNFs) and assisted living facilities. In 2007 nearly 3,300 patients (9 patients per day) came to the ED from a SNF or assisted living facility. The Hospital admits more transfers from SNFs than any other Illinois hospital, 887 patients in 2005 (see Attachment MOD-3J(2B).)

Due to congestion the ED was "on bypass" with local Fire Departments, a total of 236 hours in 2006 (see Attachment MOD-3J(3). In 2007 the total bypass hours were 64. However, 83% of these hours were during three months of January through March. Year to date 2008 bypass hours were 183, all of which were during the three winter months of January through March. Bypass hours during the three winter months of Jan through March 2008 surpassed total annual bypass hours in 2007.

ED Patients who Leave without Being Seen (ED LWBS)

In 2006 and 2007 respectively, 1338 and 1520 patients arrived at the ED but "left without being seen" or having treatment completed. While Palos strives to keep the ED LWBS volumes minimal, during the winter months, LWBS volumes approach 5% or nearly 200 patients a month.

Projected Utilization

The Hospital has determined that eleven (11) additional exam/treatment rooms will be needed to meet the community's growing need for ER services through 2020, the second full year after project completion. The projected need is based on modest annual increases of 1.9% per year consistent with historical growth. The projected increase is lower than the projected increase in the elderly population in the service area, 2.5% per year through 2012. Total population is expected to continue increasing at 1.0% per year through 2020.

Compliance with IHFPB Target Utilization and Space Standards

Based on conservative, projected growth of 1.9% per year, consistent with historical increases and substantial increases in the area's elderly population (2.5% per year), the proposed 31 ER stations would be appropriately utilized as follows:

CY 2020 ER Projected Utilization

ER Visists	ER Rooms	IHFPB Standard
60,810	30.4	2,000 visits/room

The Hospital requests 22,814 gsf which complies with IHFPB space standards, as follows:

Service	ER Rooms	IHFPB Standard	The Hospital GSF
ER	31	744.6 gsf/room	= 23,083 allowable gsf

Alternatives

The Hospital considered four general alternatives for ER expansion, as follows:

(1) Do nothing and continue to manage excessive wait times and transfer patients;
(2) Modernize existing space;
(3) Build an addition; and
(4) Build a new ER/Hospital.

Alternative 1: Do Nothing

To do nothing does not respect the community need for appropriate ER services, and requires patients to wait or transfer for treatment. To do nothing neglects the Hospital's mission to provide necessary medical care. The community needs additional ER capacity.

Estimated Cost of Doing Nothing:

The capital cost of doing nothing appears to be minimal. However, community residents bear non-monetary costs in waiting or transferring for nceded ER. The project cnhances access to these important community servicc. Therefore, there is "no capital cost" associated with this "no benefit" option.

Alternative 2: Modernize Existing Space

With the current proposed East Wing addition, the Hospital can modernize prime space for the ED expansion by remodeling vacated space. This project allows expansion adjacent to the existing ED. This project also maintains an adjacency to Radiology. Without the proposed East Wing, the Hospital does not have sufficient space anywhere in its current facilities for expanding ER services.

Estimated Cost of Modernizing to Expand the ED:

The estimated cost of modernizing existing space is the project cost.

Alternative 3: Build an Addition

Due to the lack of available space, the Hospital determined that it was necessary to build an addition. See Attachment GRC-3 for discussion of these alternatives.

Alternative 4: Build a new Hospital

This option represents an expensive, unnecessary duplication of existing services.

Estimated Cost of Building a new Hospital:

Building a new hospital is the most expensive option. See Attachment GRC-3 which indicates that a new hospital of comparable scope and size is upwards of $700 million.

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

EMERGENCY DEPARTMENT

	Projected Growth															
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
EMERGENCY DEPARTMENT VISITS																
Visits	47,055	48,490	48,854	48,516	49,438	50,377	51,334	52,310	53,304	54,316	55,348	56,400	57,472	58,563	59,676	60,810
Annual % Change		*3.0%*	*0.8%*	*-0.7%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*
Average Change 2005-2007			*1.9%*													
Patients Leaving Without Being Seen	1,217	1,338	1,520	1,687	Patients leaving without being seen included above until additional capacity operational.											
Annual % Change		9.9%	13.6%	11.1%												
Average Change 2005-2007			11.8%													
ADMISSIONS FROM THE EMERGENCY DEPARTMENT																
Admitted from ED	15,699	14,652	15,510	15,980	15,820	16,121	16,427	16,739	17,057	17,381	17,711	18,048	18,391	18,740	19,096	19,459
Annual % Change		*-6.7%*	*5.9%*	*3.0%*	*-1.0%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*
Percent ED Visits Admitted	33.4%	30.2%	31.7%	32.9%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%
TREATMENT ROOMS BY TYPE																
Isolation (19)	2	2	2	2	2	2	2	2	2	2	2	2	2	4	4	4
Trauma (CC#1, CC#2)	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Exam / Treatment	16	16	16	16	16	16	16	16	16	16	16	16	16	25	25	25
Total Number of Treatment Rooms	20	20	20	20	20	20	20	20	20	20	20	20	20	31	31	31
STANDARDS																
Capacity per Room	*2,000*															
Total Capacity	*40,000*	*40,000*	*40,000*	*40,000*	*40,000*	*40,000*	*40,000*	*40,000*	*40,000*	*40,000*	*40,000*	*40,000*	*40,000*	*62,000*	*62,000*	*62,000*
Number of Rooms based on capacity	*23.5*	*24.2*	*24.4*	*24.3*	*24.7*	*25.2*	*25.7*	*26.2*	*26.7*	*27.2*	*27.7*	*28.2*	*28.7*	*29.3*	*29.8*	*30.4*
NUMBER OF EMERGENCY DEPARTMENT TREATMENT ROOMS (EXISTING & PROPOSED)																
Treatment Rooms	20	20	20	20	20	20	20	20	20	20	20	20	20	31	31	31

Projections include portion of patients that LWBS - or patients that present to the emergency department but leave prior to being seen/treated.
Annualized Jan-Mar 2008
Source: PCH, Utilization Statistics, Planning (ESS); Projections: Planning/NCI Consulting

Comparison of Percentage of ER Visits Admitted to the Hospital

Hospitals serving Chicago's South and West Suburbs
2006

% of ED Visits Admitted	Palos	Ingalls	Hinsdale	Good Sam	Christ	Olympia -St James	LaGrange	St James
ED Visits	47055	31590	23479	45335	80774	31354	22888	36990
ED Admits	15699	10658	7360	13210	22768	8609	5696	8862
% Admit	33%	34%	31%	29%	28%	27%	25%	24%

	St. Francis	So Sub	LCM	CDH	Elmhurst	Edward
	38831	40373	44437	55428	45321	71544
	8912	8872	9419	11810	9285	12855
	23%	22%	21%	21%	20%	18%

Source:Data based on 2006 Annual Hospital Questionnaire (IDPH)

ATTACHMENT MOD-3J(2)

Inpatient Utilization - PCH Service Area (2004 - 2007)

	2004	2005	2006	2007*	2007 (9 mos)
Total Inpatient Admissions Age 0-17, PCH Service Area	5,698	6,254	5,906	3,103	2,327
Total Inpatient Admissions Age 18-44, PCH Service Area	18,316	19,448	18,458	19,460	14,595
Total Inpatient Admissions Age 45-64, PCH Service Area	18,234	20,211	20,247	21,528	16,146
Total Inpatient Admissions Age 65+, PCH Service Area	32,161	35,580	35,126	36,496	27,372
PCH Service Area Population Age 0-17	152,869	153,585	154,191	154,800	
PCH Service Area Population Age 18-44	219,684	219,968	220,295	220,623	
PCH Service Area Population Age 45-64	156,508	160,826	164,784	168,840	
PCH Service Area Population Age 65+	76,514	78,388	79,296	80,215	
Inpatient Utilization Per 1,000 Pop. Age 0-17, PCH Service Area	37.27	40.72	38.30	20.04	
Inpatient Utilization Per 1,000 Pop. Age 18-44, PCH Service Area	83.37	88.41	83.79	88.20	
Inpatient Utilization Per 1,000 Pop. Age 45-64, PCH Service Area	116.50	125.67	122.87	127.51	
Inpatient Utilization Per 1,000 Pop. Age 65+, PCH Service Area	420.33	453.90	442.97	454.98	
Age 65+ Utilization Growth Rate		*8.0%*	*-2.4%*	*2.7%*	
Total Inpatient Admissions (Source: COMPdata)	**74,409**	**81,493**	**79,737**	**80,587**	60,440
Total Service Area Population (Source: Claritas)	**605,575**	**612,767**	**618,567**	**624,478**	
Inpatient Utilization (Admits per 1,000 Population)	**122.87**	**132.99**	**128.91**	**129.05**	

*2007 COMPdata figures annualized based on 9 months of actual data (Jan-Sept).

Note: Analysis does not include normal newborns (DRG 391).

PCH Service Area Projected Population Growth (Source: Claritas)

	Claritas Projected Population CAGR	
	(2005-2010)	(2007-2013)
PCH Service Area Population Age 0-17	0.5%	0.4%
PCH Service Area Population Age 18-44	0.1%	0.1%
PCH Service Area Population Age 45-64	2.8%	1.9%
PCH Service Area Population Age 65+	2.4%	2.5%
PCH Service Area Population (All Ages)	**1.2%**	**1.0%**

The age 65 and older cohort, by far, utilizes the most inpatient services and is also the fastest growing segment of the population within PCH's service area.

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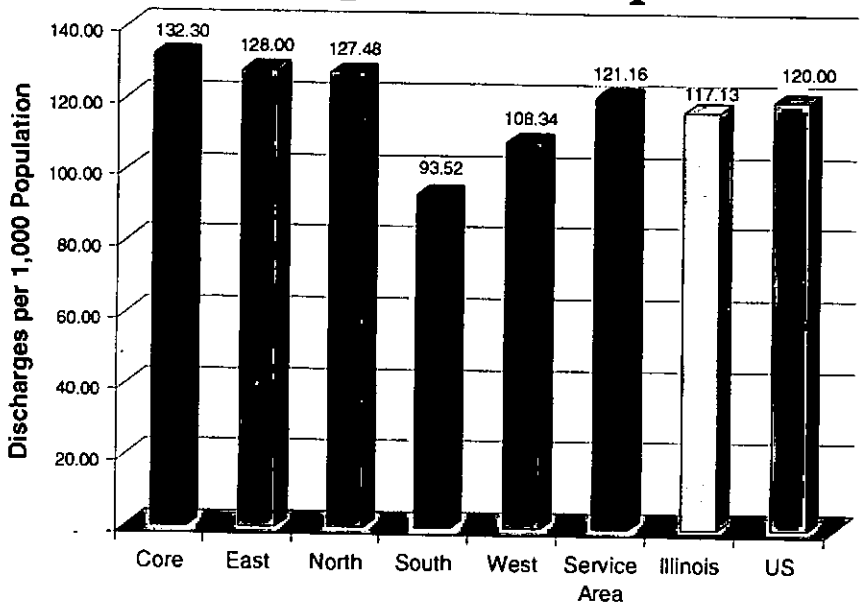
ATTACHMENT MOD-3J(2A)
Page 1 of 2

Inpatient Utilization by Service Area

Inpatient Utilization, 2005
Use Rate per 1,000 Population



Percent of Population by Age Cohort, 2005

Region	% of Population	
	Age 45-64	Age 65+
Core	29.8%	17.0%
East	26.5%	10.7%
North	24.4%	15.2%
South	26.2%	7.4%
West	25.6%	9.4%
Total Service Area	**26.2%**	**12.8%**
Illinois	21.5%	12.1%
United States	22.0%	12.4%

Source: Claritas, US Census Data, IL COMPdata, PCH Internal Discharge Data, Navigant Analysis.

Observations

- With almost half the population age 45 or older, the Core Service Area's utilization rate is about 10% higher than the state-wide and U.S. rates
- But, the percent of age 45-64 and age 65+ population is, respectively, almost 10% and 5% higher than the state and U.S. percentages, which partially explains the above average use rates in the Core market
- As expected due to the younger population, the South and West Service Areas currently have substantially lower utilization rates
- Additionally, the average length of stay for patients originating from the South/West are lower at 4.3 days versus almost 5.0 days for patients from the Core/North/East areas

PCH Serving the SNF Population

Transfers from Skilled Nursing Facilities (SNFs), 2005

Hospital	Admit Source: Transfer from SNF
Palos Community Hospital	887
Kindred Hospital - Chicago Northlake	605
Rockford Memorial Hospital	468
Rush North Shore Medical Center	356
Silver Cross Hospital	271
Adventist Hinsdale Hospital	209
Saint Mary Of Nazareth Hospital Center	188
Advocate Christ Hospital & Medical Center	185
Holy Cross Hospital	184
Vista Health-Victory Memorial Hospital	156
Advocate South Suburban Hospital	155
St Francis Hospital & Health Center - Blue Is.	135
Oak Forest Hospital Of Cook County	131
Advocate Lutheran General Hospital	118
Adventist Lagrange Memorial Hospital	113
Macneal Hospital	107

- Reinforcing the point that PCH currently serves an older patient population in comparison to other Illinois hospitals:
  - Of all hospitals in the state, PCH admitted, by far, the most transfers from skilled nursing facilities (SNFs) in 2005
  - Local competitors such as Christ, South Suburban and St. Francis also ranked highly on the list, but were far behind PCH in volume of transfers/admissions from SNFs

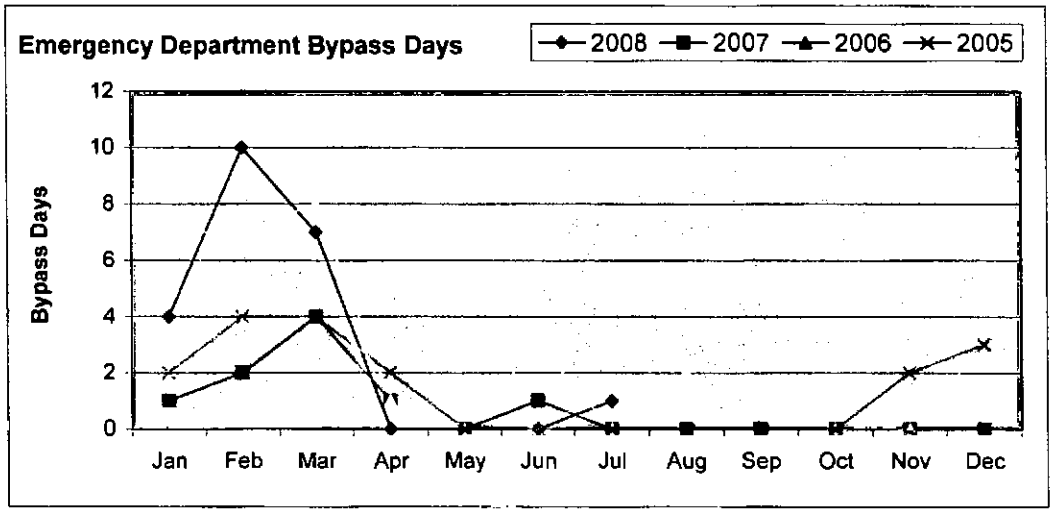
Source: COMPdata, NCI Analysis.

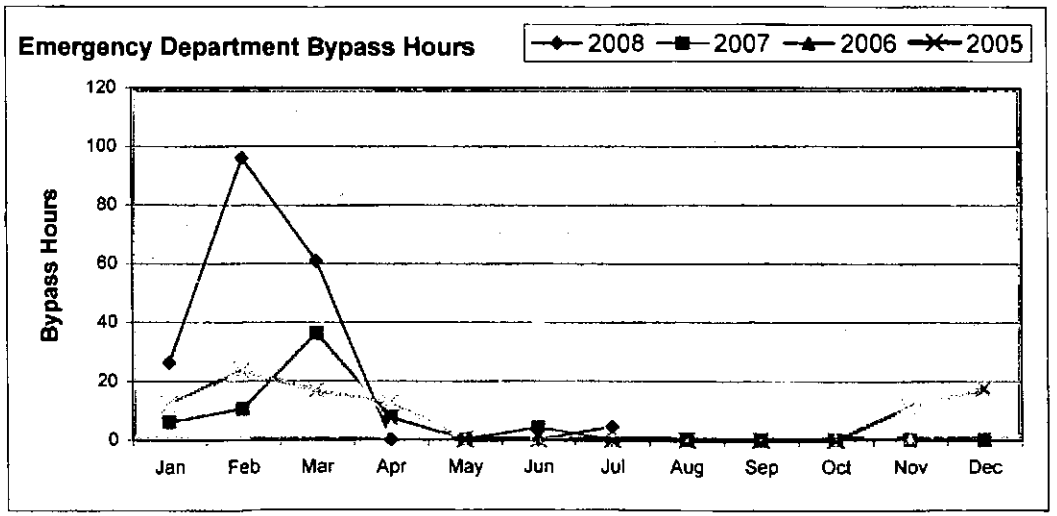
NAVIGANT CONSULTING

Days [redacted]ypass	2008	2007	2006	2005
Jan	4	1	7	2
Feb	10	2	7	4
Mar	7	4	8	4
Apr	0	1	1	2
May	0	0	0	0
Jun	0	1	3	0
Jul	1	0	0	0
Aug		0	2	0
Sep		0	1	0
Oct		0	0	0
Nov		0	0	2
Dec		0	3	3
	22	9	32	17

Hours on Bypass	2008	2007	2006	2005
Jan	26.25	6	57	12
Feb	96	10.5	49	23.5
Mar	61	36.25	43	16.5
Apr	0	7.5	4.5	12.5
May	0	0	0	0
Jun	0	4	41.25	0
Jul	4.5	0	0	0
Aug		0	15	0
Sep		0	8	0
Oct		0	0	0
Nov		0	0	11
Dec		0	18	17.5
	187.75	64.25	235.75	93

Hours Jan- Mar ONLY	2008	2007	2006	2005
	183	53	149	52
		82%	63%	56%





ATTACHMENT MOD-3J(3)

MODERN FACILITIES
Necessary Expansion

ADMISSIONS UNIT

The Hospital proposes to establish an Admissions Unit to expedite treatment of selected inpatients and observation patients. The Admissions Unit would contain 14 intake stations in 6,696 gsf. The project remodels space vacated by GI/Endo, Minor Procedures, Recovery, and Radiology, on the Hospital's 1st Floor (refer back to existing and proposed schematics.)

The Admissions Unit would serve admissions from the ED, direct M/S and Pediatric admissions, and M/S and Pediatric observation patients. (All OB patients would go directly to the OB Unit.) The need for the project is based on increases in these admissions, which averaged 7.8% per year between 2005 and 2007; congestion in the ED, and projected growth and aging of the population Sce Attachment MOD-3K(1) which indicates that in 2007 an Admissions Unit could have served over 23,300 patients. The Admissions Unit is projected to grow at a modest 2.3% per year and would serve almost 30,400 patients by 2020 (refer back to Attachment MOD-3K(1.)

Necessary Expansion

The Admissions Unit would be located adjacent to the expanded Emergency Department (ED), the front door for over three-fourths of all hospital admissions! Of the Hospital's 20,939 inpatient admissions in 2007, 15,510 (74%) came through the ED (see Attachment MOD-3K(1).) Yet these 15,510 patients represent only one in three ED patients. Congestion in the ED needs to be reduced and seriously ill patients need treatment as soon as possible. The Admissions Unit would accomplish both of these tasks in the fourteen (14) individualized reception cubicles for taking patient histories and patient rooms for initiating treatment i.e. administering antibiotics; starting IVs; taking vital signs etc.

The problem of ER congestion is especially challenging as more patients present with more serious illnesses and conditions. Generally one-third of all of the Hospital's ED patients arrive by ambulance. The Hospital consistently admits over 30% of its ED patients and has one of the highest ED admission rates in Planning Area A-4 (see Attachments MOD-3J(1) and 3J(2).) Professional standards indicate that an ED with an admission rate over 20% is high acuity ("Emergency Department Performance Measures and Benchmarking Summit: The Consensus Statement", Welch, Shari, MD, sjwelch@networld.com.)

An Admissions Unit reduces congestion by preparing patients prior to admission with expanded history, physical exams and documentation, fast-tracking protocols essential to modern care. The Admissions Unit allows early treatment, including the rapid institution of medications and protocols such as antibiotic therapy for pneumonia. This care require professionals trained to give inpatient care, and needs to be implemented early in the continuum of care, prior to transfer to a nursing unit where patients receive longer-term monitoring and maintenance care.

Compliance with IHFPB Target Utilization and Space Standards

The Admissions Unit is expected to grow at a modest 2.3% per year, significantly less than the average increase of 7.8% per year between 2005 and 2007. Growth in the area's elderly population of 2.5% per year through 2012 contributes to the need for the 14 stations. The Admissions Unit is appropriately sized with 14 stations in 6,696 gsf as follows:

CY 2020 Admission Unit Projected Utilization

Visists	Rooms	IHFPB Standards	Rooms Allowed
30,397	14	2,000 visits/room	15.2

While there is no specific IHFPB standard for an Admission's Unit, the ER standard would allow 10,424 gsf, and appears to indicate that the 6,696 proposed gsf is reasonable, as follows:

ER Rooms	IHFPB Standard	GSF Allowed
14	744.6 gsf/room	= 10,424 allowable gsf

Alternatives

The Hospital considered the following four alternatives to the project:

(1) Do nothing and ignore the needs of the community for expedited, continuous nursing care in an Admissions Unit;
(2) Modernize existing space;
(3) Build an addition to the existing hospital; and
(4) Build a new hospital.

Alternative 1: Do Nothing

The alternative of doing nothing was considered not viable. As the ED is an incredibly busy place where more and more patients are presenting with serious illness and conditions, there is a need to expedite treatment for admissions. The ED already operates 24 hours per day. Hours cannot be extended further. There is a need to move the seriously ill patient to an adjacent area for histories and early treatment. Doing nothing ignores the current and projected needs for timely hospital admission services in the community.

Estimated Cost of Doing Nothing:

The capital cost of doing nothing appears to be minimal. However, patients bear non-monetary costs waiting for admission when intake processes are slow or cumbersome. The project enhances access to these important community services, reducing patient stays and improving patient outcomes. Therefore, there is "no capital cost" associated with this "no benefit" option.

Alternative 2: Modernize Existing Space

With the current proposed East Wing addition, the Hospital can modernize prime space for the Admissions Unit by remodeling vacated space. The Admissions Unit would be located adjacent to both the expanded ED and Radiology. Without the proposed East Wing, the Hospital does not have sufficient space anywhere in its current facilities for adding an Admission Unit.

Estimated Cost of Modernizing for a new Admission Unit:

The estimated cost of modernizing existing space is the project cost.

Alternative 3: Build a Different Addition

Due to the lack of available space, the Hospital determined that it was necessary to build an addition. See Attachment GRC-3 for discussion of these alternatives.

Alternative 4: Build a new Hospital

This option represents an expensive, unnecessary duplication of existing services.

Estimated Cost of Building a new Hospital:

Building a new hospital is the most expensive option. See Attachment GRC-3 which indicates that a new hospital of comparable scope and size is upwards of $700 million.

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

ADMISSIONS UNIT

	Projected Growth															
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Emergency Room																
Visits	47,055	48,490	48,854	48,516	49,438	50,377	51,334	52,310	53,304	54,316	55,348	56,400	57,472	58,563	59,676	60,810
Annual % Change		*3.0%*	*0.8%*	*-0.7%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*
Average Increase 2005 - 2007			*1.9%*													
Admitted from ED	15,699	14,652	15,510	15,980	15,820	16,121	16,427	16,739	17,057	17,381	17,711	18,048	18,391	18,740	19,096	19,459
Annual % Change		*-6.7%*	*5.9%*	*3.0%*	*-1.0%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*	*1.9%*
Percent ED Visits Admitted	33.4%	30.2%	31.7%	32.9%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%	32.0%
Admissions Unit																
ED Admissions	15,699	14,652	15,510	15,980	15,820	16,121	16,427	16,739	17,057	17,381	17,711	18,048	18,391	18,740	19,096	19,459
Observation Admissions (M/S & Peds)	2,696	4,769	4,067	3,792	3,906	4,023	4,144	4,268	4,396	4,528	4,664	4,804	4,948	5,096	5,249	5,406
Direct Admissions	1,829	3,955	3,798	3,879	3,996	4,116	4,239	4,366	4,497	4,632	4,771	4,914	5,062	5,214	5,370	5,531
Total	**20,224**	**23,376**	**23,375**	**23,651**	**23,722**	**24,260**	**24,810**	**25,373**	**25,950**	**26,541**	**27,146**	**27,766**	**28,400**	**29,050**	**29,715**	**30,397**
Annual % Change		*15.6%*	*0.0%*	*1.2%*	*0.3%*	*2.3%*	*2.3%*	*2.3%*	*2.3%*	*2.3%*	*2.3%*	*2.3%*	*2.3%*	*2.3%*	*2.3%*	*2.3%*
Average Increase 2005-2007			*7.8%*													
NUMBER OF BAYS	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**14**	**14**	**14**
IHFPB STANDARDs																
744.6 GSF per room																
Total GSF Allowed														*10,424*	*10,424*	*10,424*
2,000 Visits/Room (Bay)																
Number of Bays Allowed														*15*	*15*	*15*

With between 30-35% of ED visits resulting in an inpatient admission, PCH's ED acuity is higher than that of hospitals with lower ED admission rates
**2007 AHQ data corrected on May 1, 2008, as follows: M/S observation admissions were 3,699, not 3,402. Pediatric obs admission were 368 = total 4,067.*
Source: PCH Utilization Statistics

MODERN FACILITIES
Necessary Expansion

CARDIOLOGY (Including EKG/ECG Services)

The Hospital proposes to modernize and expand Cardiology. Cardiology would remain on the 1st Floor, moving to space vacated by Lab and Surgery (refer back to existing and proposed schematics.) Cardiology would increase from 4,299 gsf to 6,661 gsf. Space vacated by Cardiology would be modernized for Radiology support - reading rooms, lockers & offices.

The need for the project is based on current demand, historical increases in utilization averaging 8.8% per year for ECG/EKG and 3.7% per year for all other procedures and projected growth and aging of the population in the service area. Based on the above factors, Cardiology utilization is modestly projected to grow at 2.0% per year (refer to Attachment MOD-3L(1) for historical and projected utilization and Attachment GRC-4 for historical and projected population increases of 1.0% per year through 2020 for the total population and 2.5% per year through 2012 for the elderly population.)

Necessary Expansion

Cardiology provides both inpatient and outpatient testing and has five (5) exam rooms. Cardiology is located in inadequate space for treatment and support, including patient staging, outpatient care, staff office space, computer resources, physician viewing areas, etc. There is no dedicated patient sub-holding area. Cardiology does not provide adequate privacy for patients under-going procedures. Furthermore, Cardiology does not provide private spaces for physicians to discuss treatment plans and outcomes. Limited space makes it difficult to stage patients before and in-between tests.

The historical and projected growth in Cardiology requires that Cardiology provide its patients, staff and visitors with additional treatment and designated support space, including the following: sub-wait/staging; patient prep/recovery and inpatient holding; nurse station;; control room; physician reading room; patient consult; workroom; office; clean/soiled utility; patient lockers; patient and staff toilets; janitor closet; linen/equipment storage; and other support spaces. Cardiology now shares many of these functions with Radiology. Sharing these support services will become even more challenging as Nuclear Medicine continues to grow.

Alternatives

The Hospital considered the following four alternatives to the project:

(1) Do nothing and ignore the needs for expanded, more accessible services;
(2) Modernize existing space;
(3) Build a different addition to the existing hospital; and
(4) Build a new hospital.

Alternative 1: Do Nothing

The alternative of doing nothing was considered not viable. As Cardiology's utilization continues to grow, and more and more patients are presenting with serious illness and conditions, there is a need to expand Cardiology to provide larger primary activity space and dedicated support space. Cardiology already operates seven days per week, ten hours per day. Hours cannot be extended further. Doing nothing ignores the current and projected need for Cardiology Services in the community.

Estimated Cost of Doing Nothing:

The capital cost of doing nothing appears to be minimal. However, staff and patients both bear non-monetary costs. Patients must wait for procedures when scheduling processes are slow due insufficient space. Staff wastes valuable time transporting patients to other departments.

Doing nothing ignores access problems for Cardiology outpatients, 40% of Cardiology patients. The project enhances access to Cardiology for outpatients by relocating it adjacent to Outpatient Testing & Registration, conveniently accessible through the Hospital's new main entrance. Cardiology is now in a remote area, distant from other outpatient tests and the main entrance. Therefore, there is "no capital cost" associated with this "no benefit" option.

Alternative 2: Modernize Existing Space

With the current proposed East Wing addition, the Hospital can modernize prime space for Cardiology by remodeling vacated space. The new location would be conveniently adjacent to Outpatient Testing & Registration and eliminates current "way-finding" problems. All outpatients would be directed to the same, new main Hospital entrance. Without the proposed East Wing, the Hospital does not have sufficient space for expanding Cardiology and enhancing outpatient access.

Estimated Cost of Modernizing for a new Admission Unit:

The estimated cost of modernizing existing space is the project cost.

Alternative 3: Build an Addition

Due to the lack of available space, the Hospital determined that it was necessary to build an addition. See Attachment GRC-3 for discussion of these alternatives.

Alternative 4: Build a new Hospital

This option represents an expensive, unnecessary duplication of existing services.

Estimated Cost of Building a new Hospital:

Building a new hospital is the most expensive option. See Attachment GRC-3 which indicates that a new hospital of comparable scope and size is upwards of $700 million.

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

ECG/EKG:

	Historical			Projected Growth												
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Number of ECG/EKG Procedures:																
Inpatient	18,591	19,626	21,273	21,698	22,132	22,575	23,027	23,487	23,957	24,436	24,925	25,423	25,932	26,450	26,979	27,519
Outpatient*	11,921	15,690	14,675	14,969	15,268	15,573	15,885	16,202	16,526	16,857	17,194	17,538	17,889	18,247	18,611	18,984
Total	30,512	35,316	35,948	36,667	37,400	38,148	38,911	39,689	40,483	41,293	42,119	42,961	43,820	44,697	45,591	46,503
Annual % Change		*15.7%*	*1.8%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*
Average change 2005-2007			8.8%													

CARDIOLOGY:

	Historical			Projected Growth												
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Number of Procedures:																
Inpatient	37,333	36,187	39,168	39,951	40,750	41,565	42,397	43,245	44,110	44,992	45,892	46,809	47,746	48,700	49,674	50,668
Outpatient*	22,659	27,075	25,312	25,818	26,335	26,861	27,399	27,946	28,505	29,076	29,657	30,250	30,855	31,472	32,102	32,744
Total	59,992	63,262	64,480	65,770	67,085	68,427	69,795	71,191	72,615	74,067	75,549	77,060	78,601	80,173	81,776	83,412
Annual % Change		*5.5%*	*1.9%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*
Average change 2005-2007			3.7%													

Procedures included above under Cardiodiology:
ECG (EKG)
Stress
Stress Echo
Echo
Dobutamine Stress Echo
Adenosine Stress with Nuclear Imaging
Dobutamine Stress with Nuclear Imaging
Tilt Table
TEE (Transesophogeal Echo)
Holter Monitor
Event Monitor (30 day)
Pacemaker checks

** Outpatient includes Emergency Department*
Source: PCH - Cardiology Department statistics

ATTACHMENT MOD-3L(1)

MODERN FACILITIES
Necessary Expansion

NUCLEAR MEDICINE

The Hospital proposes to modernize and expand Nuclear Medicine. Nuclear Medicine would remain on the 1st Floor, moving to space vacated by Lab and Surgery (refer back to existing and proposed schematics.) Nuclear Medicine would increase from 1,652 gsf to 6,766 gsf. Space vacated by Nuclear Medicine would be modernized for Radiology support. The project adds two (2) rooms for a total of five (5) rooms.

The need for the project is based on historical and projected utilization and growth and aging of the service area population. Utilization increased an average 6.3% per year for visits and 4.3% per for procedures between 2006 and 2008 (annualized from six months' data.) See Attachment MOD-3M(1) for historical and projected utilization. Total population in the service area will continue to grow. Population is expected to grow at 1.0% per year through 2020. The elderly population (aged 65 and over) is projected to increase 2.5% per year through 2012 (see Attachment GRC-4 for historical and projected population.) Based on the above factors, Nuclear Medicine is projected to grow at 4.1% per year.

Necessary Expansion

Nuclear Medicine is located in inadequate space for treatment and support, including patient staging, outpatient care, staff office space, computer resources, physician viewing areas, etc. There is no dedicated family waiting area. Nuclear Medicine does not provide private spaces for physicians to discuss treatment plans and outcomes.

The historical and projected growth in Nuclear Medicine requires that Nuclear Medicine provide its patients, staff and visitors with additional treatment and designated support space, including the following: two more exam rooms, sub-wait/staging; patient prep/recovery and inpatient holding; nurse station; hot lab; equipment alcove; decay room; control room; physician reading room; patient consult; workroom; office; clean/soiled utility; patient lockers; patient and staff toilets; janitor closet; linen/equipment storage; and other support spaces. Nuclear Medicine now shares many of these functions with Radiology. Sharing these support services will become even more challenging as Nuclear Medicine continues to grow.

The proposed space complies with the IHFPB standard of 2.9 procedures per gsf, 20,386 procedures divided by 2.9 procedures per gsf allows 7,030 gsf versus 6,766 proposed gsf.

Alternatives

The Hospital considered the following four alternatives to the project:

(1) Do nothing and ignore the needs for added spacc and access;
(2) Modernize existing space;
(3) Build an addition to the existing hospital; and
(4) Build a new hospital.

Alternative 1: Do Nothing

The alternative of doing nothing was considered not viable. As Nuclear Medicine's utilization continues to grow, and more and more patients are presenting with serious illness and conditions, Nuclear Medicine needs to expand to provide larger clinical and dedicated support space. Nuclear Medicine already operates 11.5 hours per day, Monday through Friday, and 8 hours on Saturday. Hours cannot be extended further. Doing nothing ignores the need for Nuclear Medicine Services in the community.

Estimated Cost of Doing Nothing:
The capital cost of doing nothing appears to be minimal. However, staff and patients both bear non-monetary costs. Patients must wait for procedures when scheduling processes are slow due to insufficient space. Staff wastes valuable time transporting patients to other departments.

Doing nothing ignores access problems for Nuclear Medicine outpatients, 63% of Nuclear Medicine patients. The project enhances access to Nuclear Medicine for outpatients by relocating it within a common Imaging area, adjacent to Outpatient Testing & Registration, conveniently accessible through the Hospital's new main entrance. Nuclear Medicine is now in a remote area, distant from other outpatient tests and the main entrance. Therefore, there is "no capital cost" associated with this "no benefit" option.

Alternative 2: Modernize Existing Space
With the current proposed East Wing addition, the Hospital can modernize prime space for Nuclear Medicine by remodeling vacated space. The new location would be conveniently located for outpatient access and eliminates current "way-finding" problems. All outpatients would be directed to the same, new main entrance. Without the East Wing, the Hospital does not have sufficient space for expanding Nuclear Medicine and enhancing outpatient access.

Estimated Cost of Modernizing to Expand Nuclear Medicine:
The estimated cost of modernizing existing space is the project cost.

Alternative 3: Build an Addition
Due to the lack of available space, the Hospital determined that it was necessary to build an addition. See Attachment GRC-3 for discussion of these alternatives.

Estimated Cost of Building an Addition:
The estimated cost of building the East Wing is the project cost (see Attachment GRC-3.)

Alternative 4: Build a new Hospital
This option represents an expensive, unnecessary duplication of existing services.

Estimated Cost of Building a new Hospital:
Building a new hospital is the most expensive option. See Attachment GRC-3 which indicates that a new hospital of comparable scope and size is upwards of $700 million.

PALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

NUCLEAR MEDICINE

	Projected Growth															
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
PROCEDURES																
Inpatient	4,865	3,960	4,365	4,578	4,738	4,932	5,135	5,345	5,564	5,793	6,030	6,277	6,535	6,803	7,081	7,372
Outpatient	6,309	7,713	7,546	8,082	8,365	8,708	9,065	9,437	9,823	10,226	10,645	11,082	11,536	12,009	12,502	13,014
Total	11,174	11,673	11,911	12,660	13,103	13,640	14,200	14,782	15,388	16,019	16,675	17,359	18,071	18,812	19,583	20,386
Annual % Change		*4.5%*	*2.0%*	*6.3%*	*3.5%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*
Average Annual Increase 2005-2008			3.3%	4.3%												
VISITS																
Inpatient		842	928	974	1,008	1,049	1,092	1,137	1,184	1,232	1,283	1,336	1,390	1,447	1,507	1,568
Outpatient		1,587	1,605	1,719	1,779	1,852	1,928	2,007	2,089	2,175	2,264	2,357	2,454	2,554	2,659	2,768
Total		2,429	2,533	2,693	2,787	2,902	3,021	3,144	3,273	3,408	3,547	3,693	3,844	4,002	4,166	4,337
Annual % Change			*4.3%*	*6.3%*	*3.5%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*	*4.1%*

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Nuclear medicine not available at PCH satellite facilities, projections assume entire service area.
** Annualized Jan-Jun 2008*
Source: Radiology Department Monthly Statistics & NCI Consulting (projections)

ATTACHMENT MOD-3M(1)
Page 1 of 2

IMAGING - ROOMS AND MACHINES, BY TYPE
Existing and Proposed

Radiology		AHQ 2007	EXISTING (2008)	PROPOSED (2018)	
GENERAL MACHINES	General Radiography/Flouroscopy	8	9	12	*1 new in 2008*
	GENERAL RADIOLOGY TOTAL	**8**	**9**	**12**	
OTHER*	Bone density/DEXA	n/a	1	1	*See * below*
	Sterotactic (Breast Biopsy)	n/a	1	1	*See * below*
SPECIAL MACHINES	Angiographic	1	1	1	*Will be located in CSSC - Special Procedures Room*
	CT Scanner	3	3	4	
	Mammography	3	3	4	
	Sonographic (ultrasound)	6	7	8	*1 new in 2008*
	Tomographic (multi-directional)	0	0	0	
	SPECIAL RADIOLOGY TOTALS	**13**	**16**	**19**	
	DIAGNOSTIC RAD GRAND TOTALS	**21**	**25**	**31**	
Nuclear Medicine					
NUCLEAR MEDICINE	Nuclear Medicine Cameras	3	3	5	
	TOTALS	**3**	**3**	**5**	
	GRAND TOTALS: RAD & NM	24	28	36	

** No category on AHQ for Bone density/DEXA room & Sterotactic breast biopsy room.*
DEXA volumes are reported with General/Flouro
Stereotactic volumes are reported in mammography

MODERN FACILITIES
Necessary Expansion

DIAGNSOTIC RADIOLOGY

The Hospital proposes to modernize and expand Diagnostic Radiology (Radiology). Radiology is located on the 1st Floor in 20,068 gsf. The project adds 11,664 gsf by taking space vacated by Lab, Cardiology and Nuclear Medicine. Radiology would have 31,732 gsf. Radiology would add six procedure rooms, as follows: three (3) general rooms and three (3) special rooms: 1 CT, 1 Mammography, and 1 Ultrasound. Upon project completion the Hospital would have 12 general rooms and 19 special rooms, a total of 31 rooms (see Attachment MOD-3N(1) for the historical and projected utilization of Radiology, including room capacities.)

The need for the project is based on historical and projected utilization and growth and aging of the service area population.

Necessary Expansion

Between 2005 and 2007 General Radiology procedures increased an average 2.4% per year, with inpatient use increasing at 9% per year. General procedures are modestly projected to increase an average 2.2% per year.

Historical and projected utilization of Special Radiology is as follows:

	Average Annual Increase	
Special Radiology Procedures	Historical	Projected
CT	1.6%	1.5%
Ultrasound	4.4%	3.5%
Mammography	2.5%	2.0%

Refer again to Attachment MOD-3N(1) for historical and projected utilization of Radiology. Total population in the service area will continue to grow. Population is expected to grow at 1.0% per year through 2020. The elderly population (aged 65 and over) is projected to increase 2.5% per year through 2012 (see Attachment GRC-4 for historical and projected population.) With these modest projections the Hospital will provide a total of 185,212 procedures in 2020. The IHFPB standard is 5.5 procedures per gsf, or 33,675 gsf, 1,943 gsf more than the project.

The need for the three additional general procedure rooms in 2020 is substantiated utilizing IHFPB standards of 6,500 procedures per general room and 2,000 visits per special room:

	General Radiology Rooms	
General Radiology Procedures	Allowed*	Proposed
93,707	15 rooms	12 rooms

* Based on 6,500 procedures per general room.

Special Radiology Visits		Special Radiology Rooms	
		Allowed*	Proposed
CT	7,623	4 rooms	4 rooms
Mammography	15,212	8 rooms	4 rooms
Ultrasound	15,029	8 room	8 rooms

* Based on 2,000 visits per special room.

Radiology needs to be expanded to meet the needs of current and proposed patients. The size and scope of the expansion conforms to all IHFPB guidelines.

Alternatives

The Hospital considered the following four alternatives to the project:

(1) Do nothing and ignore the needs for added space and access;
(2) Modernize existing space;
(3) Build an Addition; and
(4) Build a new hospital.

Alternative 1: Do Nothing

The alternative of doing nothing was considered not viable. As Radiology's utilization continues to grow, and more and more patients are presenting with serious illness and conditions, there is a need to expand Radiology to provide larger primary activity space and dedicated support space. Radiology is staffed 24 hours per day, 7 days per week. Most services operate from 6 a.m. or 7 a.m. to 9 p.m. five days per week and hours cannot be extended. Doing nothing ignores the current and projected need for Radiology Services.

Estimated Cost of Doing Nothing:

The capital cost of doing nothing appears to be minimal. However, staff and patients both bear non-monetary costs. Patients must wait for procedures when scheduling processes are slow due to insufficient space. Staff wastes valuable time transporting patients to other departments.

Alternative 2: Modernize Existing Space

With the current proposed East Wing addition, the Hospital can modernize adjacent space for Radiology by remodeling vacated space. "Modernizing in place" is the lowest-cost option for expanding Radiology. Almost one-half of the department will remain "as is." Without the proposed East Wing, the Hospital does not have sufficient space for expanding Radiology.

Estimated Cost of Modernizing to Expand Radiology:

The estimated cost of modernizing existing space is the project cost.

Alternative 3: Build an Addition (see Attachment GRC-3)

Alternative 4: Build a new Hospital

This option represents an expensive, unnecessary duplication of existing services.

Estimated Cost of Building a new Hospital:

Building a new hospital is the most expensive option. See Attachment GRC-3 which indicates that a new hospital of comparable scope and size is upwards of $700 million.

ALOS COMMUNITY HOSPITAL
HISTORICAL & PROJECTED DEPARTMENTAL WORKLOAD

RADIOLOGY

	Historical			Projected Growth												
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
PROCEDURES																
GENERAL																
Inpatient	20,141	22,503	23,902	25,178	26,185	27,233	28,322	29,455	30,633	31,858	33,133	34,458	35,836	37,270	38,760	40,311
Outpatient	48,822	47,591	48,448	47,386	47,860	48,338	48,822	49,310	49,803	50,301	50,804	51,312	51,825	52,344	52,867	53,396
Total	68,963	70,094	72,350	72,564	74,045	75,571	77,144	78,765	80,436	82,159	83,937	85,770	87,662	89,613	91,627	93,707
Annual % Change		1.6%	3.2%	0.3%	2.0%	2.1%	2.1%	2.1%	2.1%	2.1%	2.2%	2.2%	2.2%	2.2%	2.2%	2.3%
Average Increase 2005-2007			2.4%													
CT																
Inpatient	7,177	7,760	8,319	8,662	8,792	8,924	9,058	9,194	9,331	9,471	9,613	9,758	9,904	10,053	10,203	10,356
Outpatient	28,013	28,411	27,955	27,816	28,233	28,657	29,087	29,523	29,966	30,415	30,871	31,335	31,805	32,282	32,766	33,257
Total	35,130	36,171	36,274	36,478	37,025	37,581	38,144	38,716	39,297	39,887	40,485	41,092	41,709	42,334	42,969	43,614
Annual % Change		3.0%	0.3%	0.6%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%
Average Increase 2005-2007			1.6%													
ULTRASOUND																
Inpatient	6,001	6,527	7,099	7,204	7,492	7,852	8,244	8,607	8,986	9,381	9,794	10,225	10,675	11,145	11,624	12,135
Outpatient	13,098	12,335	13,676	13,358	13,759	14,130	14,512	14,947	15,396	15,857	16,333	16,823	17,328	17,848	18,383	18,953
Total	19,099	18,862	20,775	20,562	21,251	21,982	22,756	23,554	24,381	25,239	26,127	27,048	28,003	28,992	30,007	31,088
Annual % Change		-1.2%	10.1%	-1.0%	3.4%	3.4%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.6%
Average Increase 2005-2007			4.4%													
MAMMOGRAPHY																
Inpatient	61	42	33	30	31	31	31	31	31	31	31	31	31	31	31	31
Outpatient	11,972	11,697	12,574	13,096	13,489	13,759	14,034	14,315	14,601	14,893	15,191	15,494	15,804	16,120	16,443	16,772
Total	12,001	11,739	12,607	13,126	13,519	13,790	14,065	14,346	14,632	14,924	15,222	15,526	15,836	16,152	16,474	16,803
Annual % Change		-2.2%	7.4%	4.1%	3.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
Average Increase 2005-2007			2.5%													
VISITS*																
CT																
Inpatient		2,156	2,311	2,471	2,483	2,496	2,508	2,521	2,533	2,546	2,559	2,572	2,584	2,597	2,610	2,623
Outpatient		7,895	6,207	5,694	5,600	5,500	5,500	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000
Total		10,051	8,518	8,165	8,083	7,996	8,008	7,521	7,533	7,546	7,559	7,572	7,584	7,597	7,610	7,623
Annual % Change			-15.3%	-4.1%	-1.0%	-1.1%	0.2%	-6.1%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
Average Increase 2005-2007																
ULTRASOUND																
Inpatient		3,144	3,413	3,602	3,746	3,896	4,067	4,246	4,433	4,628	4,832	5,044	5,266	5,498	5,740	5,993
Outpatient		6,089	7,020	6,338	6,528	6,724	6,926	7,133	7,347	7,568	7,795	8,029	8,270	8,518	8,773	9,036
Total		9,233	10,433	9,940	10,274	10,620	10,993	11,380	11,781	12,196	12,627	13,073	13,536	14,016	14,513	15,029
Annual % Change			13.0%	-4.7%	3.4%	3.4%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.6%
Average Increase 2005-2007																
MAMMOGRAPHY																
Inpatient		42	33	30	31	31	32	32	32	33	33	35	37	37	37	38
Outpatient		11,029	11,651	11,848	12,203	12,448	12,696	12,950	13,209	13,474	13,743	14,018	14,298	14,584	14,876	15,173
Total		11,071	11,684	11,878	12,234	12,479	12,728	12,982	13,241	13,506	13,777	14,053	14,335	14,621	14,912	15,212
Annual % Change			5.6%	1.7%	3.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
Average Increase 2005-2007																

Annualized Jan-Jun 2008

** Visit volumes provided beginning with conversion to Meditech information system (2006) for consistency*
CT visits declined in 2006 due to addition of CT service at off-site outpatient facility.
Source: Radiology Department Monthly Statistics, Meditech Outpatient Visits (ESS) & NCI Consulting

IMAGING - ROOMS AND MACHINES, BY TYPE
Existing and Proposed

Radiology		AHQ 2007	EXISTING (2008)	PROPOSED (2018)	
GENERAL MACHINES	General Radiography/Flouroscopy	8	9	12	*1 new in 2008*
	GENERAL RADIOLOGY TOTAL	**8**	**9**	**12**	
OTHER*	Bone density/DEXA	n/a	1	1	*See * below*
	Sterotactic (Breast Biopsy)	n/a	1	1	*See * below*
SPECIAL MACHINES	Angiographic	1	1	1	*Will be located in CSSC - Special Procedures Room*
	CT Scanner	3	3	4	
	Mammography	3	3	4	
	Sonographic (ultrasound)	6	7	8	*1 new in 2008*
	Tomographic (multi-directional)	0	0	0	
	SPECIAL RADIOLOGY TOTALS	**13**	**16**	**19**	
	DIAGNOSTIC RAD GRAND TOTALS	**21**	**25**	**31**	
Nuclear Medicine					
NUCLEAR MEDICINE	Nuclear Medicine Cameras	3	3	5	
	TOTALS	**3**	**3**	**5**	
	GRAND TOTALS: RAD & NM	24	28	36	

** No category on AHQ for Bone density/DEXA room & Sterotactic breast biopsy room.*
DEXA volumes are reported with General/Flouro
Stereotactic volumes are reported in mammography

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SECTION VIII. REVIEW CRITERIA RELATING TO MEDICAL-SURGICAL, PEDIATRIC, OBSTETRICS, AND INTENSIVE CARE SERVICES (ACUTE)

The section is applicable to all projects proposing the addition of Medical/Surgical, Obstetric, Pediatric, or ICU beds.

A. Criterion 1110.530(a), Unit Size

Read the criterion and indicate if the existing or proposed facility is located within a MSA.
_√_Yes __No

B. Criterion 1110.530(b), Variances to Computed Bed Need NOT APPLICABLE

Read the criterion and, if applicable, address one of the following variances.

1. Criterion 1110.530(b)(1), High Occupancy. Indicate if chosen and submit the following information:

   a. patient days and admissions for each of the last two years for the service involved;

   b. explain why it is not feasible to convert underutilized services to meet the identified demand;

   c. document that the number of beds proposed will not exceed the number needed to meet the target occupancy.

   d. if projections are utilized to support the need for beds, document the following:

      1) the projections are based upon population projections from the U.S. Bureau of the Census;
      2) the projections are for a period of not more than 5 years from the date the application is submitted;
      3) the projections are zip code based and age specific; and
      4) the projections are based upon the applicant's service area as defined by historical patient origin, and do not include any projected change in market share.

APPEND DOCUMENTATION AS ATTACHMENT ACUTE-1 AFTER THE LAST PAGE OF THIS SECTION.

2. Criterion 1110.530(b)(2), Medically Underserved Population. Indicate if chosen and submit the following information:

   a. a map showing the location of all other area providers;

c. a detailed description of the admission restrictions of the other area facilities;

d. documentation that access is restricted in the planning area;

e. documentation that the number of beds proposed will not exceed the number needed, at the target occupancy rate, to meet the health care needs of the population identified;

f. an explanation of how the proposed project will improve the access to care;

APPEND DOCUMENTATION AS ATTACHMENT ACUTE-2 AFTER THE LAST PAGE OF THIS SECTION.

SECTION XXV. REVIEW CRITERIA RELATING TO FINANCIAL FEASIBILITY (FIN)

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

Does the applicant (or the entity that is responsible for financing the project or is responsible for assuming the applicant's debt obligations in case of default) have a bond rating of "A" or better? Yes ☑ No ☐.

If yes is indicated, submit proof of the bond rating of "A" or better (that is less than two years old) from Fitch's, Moody's or Standard and Poor's rating agencies and go to Section XXVI. If no is indicated, submit the most recent three years' audited financial statements including the following:

1. Balance sheet
2. Income statement
3. Change in fund balance
4. Change in financial position

APPEND THE REQUIRED DOCUMENTS AS ATTACHMENT FINANCIALS AND PLACE AFTER ALL OTHER APPLICATION ATTACHMENTS INCLUDING THE REMAINING ATTACHMENTS FOR THIS SECTION AND FOR SECTION XXVI.

A. Criterion 1120.210(a), Financial Viability

NOT APPLICABLE

1. Viability Ratios

If proof of an "A" or better bond rating has not been provided, read the criterion and complete the following table providing the viability ratios for the most recent three years for which audited financial statements are available. Category B projects must also provide the viability ratios for the first full fiscal year after project completion or for the first full fiscal year when the project achieves or exceeds target utilization (per Part 1100), whichever is later.

Provide Data for Projects Classified as:	Category A or Category B (last three years)			Category B
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. Insert the worksheets after this page.

2. Variance

Compare the viability ratios provided to the Part 1120 Appendix A review standards. If any of the standards for the applicant or for any co-applicant are not met, provide documentation that a person or organization will assume the legal responsibility to meet the debt obligations should the applicant default. The person or organization must demonstrate compliance with the ratios in Appendix A when proof of a bond rating of "A" or better has not been provided.

APPEND DOCUMENTATION AS ATTACHMENT FIN-1 AFTER THE LAST PAGE OF THIS SECTION.

B. Criterion 1120.210(b), Availability of Funds NOT APPLICABLE

If proof of an "A" or better bond rating has not been provided, read the criterion and document that sufficient resources are available to fund the project and related costs including operating start-up costs and operating deficits. Indicate the dollar amount to be provided from the following sources:

_____ Cash & Securities
Provide statements as to the amount of cash/securities available for the project. Identify any security, its value and availability of such funds. Interest to be earned or depreciation account funds to be earned on any asset from the date of application submission through project completion are also considered cash.

_____ Pledges
For anticipated pledges, provide a letter or report as to the dollar amount feasible showing the discounted value and any conditions or action the applicant would have to take to accomplish goal. The time period, historical fund raising experience and major contributors also must be specified.

_____ Gifts and Bequests
Provide verification of the dollar amount and identify any conditions of the source and timing of its use.

_____ Debt Financing (indicate type(s) _____)
For general obligation bonds, provide amount, terms and conditions, including any anticipated discounting or shrinkage) and proof of passage of the required referendum or evidence of governmental authority to issue such bonds;
For revenue bonds, provide amount, terms and conditions and proof of securing the specified amount;
For mortgages, provide a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated;
For leases, provide a copy of the lease including all terms and conditions of the lease including any purchase options.

_____ Governmental Appropriations
Provide 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, provide a resolution or other action of the governmental unit attesting to such future funding.

_____ Grants
Provide a letter from the granting agency as to the availability of funds in terms of the amount, conditions, and time or receipt.

_____ Other Funds and Sources
Provide verification of the amount, terms and conditions, and type of any other funds that will be used for the project.

_____ TOTAL FUNDS AVAILABLE

APPEND DOCUMENTATION AS ATTACHMENT FIN-2 AFTER THE LAST PAGE OF THIS SECTION.

C. Criterion 1120.210(c), Operating Start-up Costs NOT APPLICABLE

If proof of an "A" or better bond rating has not been provided, indicate if the project is classified as a Category B project that involves establishing a new facility or a new category of service? Yes ☐ No ☐. If yes is indicated, read the criterion and provide in the space below the amount of operating start-up costs (the same as reported in Section I of this application) and provide a description of the items or components that comprise the costs. Indicate the source and amount of the financial resources available to fund the operating start-up costs (including any initial operating deficit) and reference the documentation that verifies sufficient resources are available.

SECTION XXVI. REVIEW CRITERIA RELATING TO ECONOMIC FEASIBILITY (ECON)

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

A. Criterion 1120.310(a), Reasonableness of Financing Arrangements NOT APPLICABLE

Is the project classified as a Category B project? Yes ☑ No ☐. If no is indicated this criterion is not applicable. If yes is indicated, has proof of a bond rating of "A" or better been provided? Yes ☑ No ☐. If yes is indicated this criterion is not applicable, go to item B. If no is indicated, read the criterion and address the following:

Are all available cash and equivalents being used for project funding prior to borrowing? ☐ Yes ☐ No

If no is checked, provide a notarized statement signed by two authorized representatives of the applicant entity (in the case of a corporation, one must be a member of the board of directors) that attests to the following:

1. a portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order that the current ratio does not fall below 2.0 times; or
2. 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.

APPEND DOCUMENTATION AS ATTACHMENT ECON-1 AFTER THE LAST PAGE OF THIS SECTION.

B. Criterion 1120.310(b), Conditions of Debt Financing

Read the criterion and provide a notarized statement signed by two authorized representatives of the applicant entity (in the case of a corporation, one must be a member of the board of directors) that attests to the following as applicable:

1. The selected form of debt financing the project will be at the lowest net cost available or if a more costly form of financing is selected, that form is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional debt, term (years) financing costs, and other factors;
2. All or part of the project involves the leasing of equipment or facilities and the expenses incurred with such leasing are less costly than constructing a new facility or purchasing new equipment.

APPEND DOCUMENTATION AS ATTACHMENT ECON-2 AFTER THE LAST PAGE OF THIS SECTION.

C. Criterion 1120.310(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	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
Contingency									
TOTALS									
* Include the percentage (%) of space for circulation									

2. For each piece of major medical equipment included in the proposed project, the applicant must certify one of the following:

   a. that the lowest net cost available has been selected; or

   b. that the choice of higher cost equipment is justified due to such factors as, but not limited to, maintenance agreements, options to purchase, or greater diagnostic or therapeutic capabilities.

APPEND DOCUMENTATION AS ATTACHMENT ECON-3 AFTER THE LAST PAGE OF THIS SECTION.

3. List the items and costs included in preplanning, site survey, site preparation, off-site work, consulting, and other costs to be capitalized. If any project line item component includes costs attributable to extraordinary or unusual circumstances, explain the circumstances and provide the associated dollar amount. When fair market value has been provided for any component of project costs, submit documentation of the value in accordance with the requirements of Part 1190.40.

APPEND DOCUMENTATION AS ATTACHMENT ECON-4 AFTER THE LAST PAGE OF THIS SECTION.

D. Criterion 1120.310(d), Projected Operating Costs

Read the criterion and provide in the space below the facility's projected direct annual operating costs (in current dollars per equivalent patient day or unit of service, as applicable) for the first full fiscal year of operation after project completion or for the first full fiscal year when the project achieves or exceeds target utilization pursuant to 77 Ill. Adm. Code 1100, whichever is later. If the project involves a new category of service, also provide the annual operating costs for the service. Direct costs are the fully allocated costs of salaries, benefits, and supplies. Indicate the year for which the projected operating costs are provided.

E. Criterion 1120.310(e), Total Effect of the Project on Capital Costs

Is the project classified as a category B project? Yes ☑ No ☐. If no is indicated, go to item F. If yes is indicated, provide in the space below the facility's total projected annual capital costs as defined in Part 1120.130(f) (in current dollars per equivalent patient day) for the first full fiscal year of operation after project completion or for the first full fiscal year when the project achieves or exceeds target utilization pursuant to 77 Ill. Adm. Code 1100, whichever is later. Indicate the year for which the projected capital costs are provided.

D. Criterion 1120.310(d), Projected Operating Costs

Read the criterion and provide in the space below the facility's projected direct annual operating costs (in current dollars per equivalent patient day or unit of service, as applicable) for the first full fiscal year of operation after project completion or for the first full fiscal year when the project achieves or exceeds target utilization pursuant to 77 Ill. Adm. Code 1100, whichever is later. If the project involves a new category of service, also provide the annual operating costs for the service. Direct costs are the fully allocated costs of salaries, benefits, and supplies. Indicate the year for which the projected operating costs are provided.

Projected for 2020	**Annual Operating Costs**			**Expense per Equivalent Patient Day**		
	Hospital	Project	Total	Hospital	Project	Total
Salaries/Benefits	$314,232,000	$6,300,000	$320,532,000	$1,637	$33	$1,670
Supplies	$ 84,627,000	$200,000	$ 84,827,000	$441	$ 2	$443
Total	$398,859,000	$6,500,000	$405,359,000	$2,078	**$ 35**	$2,113

Year for which projected operating costs are provided: 2020

Project's projected operating expense per equivalent patient day: $35

E. Criterion 1120.310(e), Total Effect of the Project on Capital Costs

Is the project classified as a category B project? Yes ✓ No . If no is indicated, go to item F. If yes is indicated, provide in the space below the facility's total projected annual capital costs as defined in Part 1120.130(f) (in current dollars per equivalent patient day) for the first full fiscal year of operation after project completion or for the first full fiscal year when the project achieves or exceeds target utilization pursuant to 77 Ill. Adm. Code 1100, whichever is later. Indicate the year for which the projected capital costs are provided.

Projected for 2020	**Annual Capital Costs**			**Expense per Equivalent Patient Day**		
	Hospital	Project	Total	Hospital	Project	Total
Interest	$ 18,254,000	$5,646,000	$23,900,000	$ 95	$ 29	$ 124
Depreciation	$ 14,675,000	$ 7,500,000	$22,175,000	$ 76	$ 39	$ 115
Total	$ 32,929,000	$ 13,146,000	$46,075,000	$ 171	**$ 68**	$ 239

Year for which projected capital costs are provided: 2020

Project's projected capital expense per equivalent patient day: $68

F. Criterion 1120.310(f), Non-patient Related Services NOT APPLICABLE

Is the project classified as a category B project and involve non-patient related services? Yes ☐ No ☐. If no is indicated, this criterion is not applicable. If yes is indicated, read the criterion and document that the project will be self-supporting and not result in increased charges to patients/residents or that increased charges are justified based upon such factors as, but not limited to, a cost benefit or other analysis that demonstrates the project will improve the applicant's financial viability.

APPEND DOCUMENTATION AS ATTACHMENT ECON-5 AFTER THE LAST PAGE OF THIS SECTION.

Palos Community Hospital

12251 S. 80th Avenue Palos Heights, Illinois 60463 (708) 923-4000

September 24, 2008

Re: Palos Community Hospital
Conditions of Debt

Palos Community Hospital, located at 12251 S. 80th Ave. in Palos Heights, Illinois (60463), proposes to modernize medical/surgical services and expand intensive care services and other clinical and non-clinical services and provide for private patient rooms. The project will result in an increase of 12 intensive care beds and a decrease of 9 beds in the medical surgical category of service. Total project cost is **$420,438,329.**

The project will be funded with cash and tax-exempt bonds. The bond terms will be 30 years, secured at the lowest net cost available to Palos Community Hospital.

Sincerely,

Sister Margaret Wright
President

Notarized:

Subscribed and sworn to before me this 24th day of September, 2008.

Signature of Notary

Seal:

"OFFICIAL SEAL"
NANCY K. NAVARRO
Notary Public, State of Illinois
My Commission Expires 06-10-2010

Sincerely,

Hugh Rose
Treasurer

Notarized:

Subscribed and sworn to before me this 24th day of September, 2008.

Signature of Notary

Seal:

"OFFICIAL SEAL"
NANCY K. NAVARRO
Notary Public, State of Illinois
My Commission Expires 06-10-2010

ATTACHMENT ECON - 2

Palos Community Hospital
Palos Heights, IL

East Wing Addition

CON Document:

C. Criterion 1120.310.c, Reasonableness of Project and Related Costs

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		Gross Sq Ft		Gross Sq Ft		Const. $	Mod $	
	New	Modern'zn.	New	Circulation	Modern'zn.	Circulation	(A x C)	(B x E)	
CLINICAL				Included		Included			
Med/Surg Beds	$454.66	$ 360.20	91,790	100%	77,330		$ 41,733,287	$ 27,854,421	$ 69,587,708
Intensive Care Beds	$474.14		25,650	100%			$ 12,161,691	$ -	$ 12,161,691
INTEGRATED PROCEDURE SERVICES			42,826						
A) Surgery	$488.02		37,354	44%			$ 18,229,312	$ -	$ 18,229,312
B) Endoscopy	$464.38		3,468	4%			$ 1,610,466	$ -	$ 1,610,466
C) Special Procedures	$466.00		2,004	2%			$ 933,871	$ -	$ 933,871
RECOVERY			26,690						
A) PACU	$434.20		3,750	4%			$ 1,628,241	$ -	$ 1,628,241
B) Center for Short Stay Care	$414.02		22,940	33%			$ 9,497,619	$ -	$ 9,497,619
Respiratory Therapy	$474.14	$ 249.90	1,060		4,365	15%	$ 502,588	$ 1,090,803	$ 1,593,391
Inpatient Dialysis		$ 332.37			1,105	4%	$ -	$ 367,266	$ 367,266
Outpatient & Pre-Admission Testing	$357.67		4,730				$ 1,691,758	$ -	$ 1,691,758
Laboratory	$375.60		22,487	33%			$ 8,446,117	$ -	$ 8,446,117
Pharmacy	$348.34		8,229	11%			$ 2,866,490	$ -	$ 2,866,490
Emergency Department		$ 402.13			11,435	15%	$ -	$ 4,598,305	$ 4,598,305
Admissions Unit		$ 285.73			6,696	9%	$ -	$ 1,913,258	$ 1,913,258
Cardiology		$ 268.44			6,661	9%	$ -	$ 1,788,089	$ 1,788,089
Nuclear Medicine		$ 416.81			6,766	9%	$ -	$ 2,820,153	$ 2,820,153
Radiology		$ 281.41			16,889	3-9%		$ 5,002,940	$ 5,002,940
Sub-total							$ 99,301,441	$ 45,435,235	$ 144,736,675
Plus Contingency $							$ 9,930,144	$ 6,815,285	$ 16,745,429
Subtotal Clinical $	$488.82	$ 398.11	223,462		131,247		$ 109,231,585	$ 52,250,520	$ 161,482,105

CON Document:

C. Criterion 1120.310.c, Reasonableness of Project and Related Costs

Page 2

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		Gross Sq Ft		Gross Sq Ft		Const. $	Mod $	
	New	Modern'zn.	New	Circulation	Modern'zn.	Circulation	(A x C)	(B x E)	
NON-CLINICAL				Included		Included			
Purchasing	$344.44		3,380	5%			$ 1,164,212		$ 1,164,212
Sterile Supply Processing	$434.20		13,721	19%			$ 5,957,658		$ 5,957,658
Maintenance/Engineering	$314.23		17,235	25%			$ 5,415,780		$ 5,415,780
General Stores	$323.56		5,953	7%			$ 1,926,156		$ 1,926,156
Admitting & Registration	$357.67		3,370	4%			$ 1,205,333		$ 1,205,333
Nursing Administration/Education		$ 218.58	6,210		2,424	1%		$ 529,828	$ 529,828
Medical Staff Facilities/Support	$361.89	$ 270.19	2,514	2%	5,470	8%-10%	$ 909,799	$ 1,477,937	$ 2,387,736
Quality (QA/RM/CM)		$ 244.06			4,179	3%		$ 1,019,906	$ 1,019,906
Transport Services		$ 243.85			2,132	3%		$ 519,880	$ 519,880
Health Info Mgmt		$ 243.31			9,083	12%		$ 2,210,021	$ 2,210,021
Pastoral Care & Other Support Services		$ 244.03			1,997	3%		$ 487,321	$ 487,321
Dietary (Cafeteria & Kitchen)		$ 294.59			14,480	95%		$ 4,265,621	$ 4,265,621
Housekeeping/Linen Services		$ 207.28			6,140	0%		$ 1,272,702	$ 1,272,702
Conference/Education	$411.88	$ 243.31	4,380	4%	5,832	8%	$ 1,804,034	$ 1,419,007	$ 3,223,042
Staff Lockers, Lounge & Support	$413.25	$ 229.97	9,102		675	5%	$ 3,761,402	$ 155,227	$ 3,916,629
Lobby / Public Spaces / Gift Shop	$518.66	$ 280.43	31,822	0%-3%	1,485		$ 16,504,799	$ 416,439	$ 16,921,238
Administration/Offices		$ 243.31			2,095	1%		$ 509,743	$ 509,743
Mechanical/Elect./IT/Shafts	$366.56		63,720	0%			$ 23,357,203		$ 23,357,203
Stairs/Elevators	$366.66		12,800	0%			$ 4,693,248		$ 4,693,248
Plumbing				0%				$ 15,238,075	$ 15,238,075
Air handling				0%				$ 2,287,925	$ 2,287,925
Parking	$331.41	$ 220.58	2,000		640		$ 662,815	$ 141,172	$ 803,987
Sub-total							$ 67,362,438	$ 31,950,804	$ 99,313,242
Plus Contingency $							$ 6,736,244	$ 4,792,621	$ 11,528,864
Subtotal Non-Clinical $			176,207		56,632		$ 74,098,682	$ 36,743,424	$ 110,842,107
TOTALS			399,669		187,879		$ 183,330,267	$ 88,993,944	$ 272,324,211

Total Project GSF	587,548

Total Project Cost:	$420,438,329

Extraordinary Costs

PROJECT COST AND SOURCES OF FUNDS

Description	TOTAL	
Pre-Planning Costs	$ 2,600,610	
Survey and Soils	$ 265,000	
Site Prep & Demolition	$ 9,169,254	
Off-Site Improvements	$ 5,674,036	
New Construction Costs	$ 166,663,879	
New Construction Costs per GSF*	***$ 458.71***	
Modernization Costs (excluding Infrastructure below)	$ 57,542,546	
Infrastructure - Plumbing & Air Handling - see below	$ 19,843,492	
Modernization Costs per GSF*	***$ 368.06***	Excludes infrastructure improvements
Contingencies**	$ 28,274,294	
Architectural / Engineering	$ 13,794,804	
Consulting & Other Fees	$ 9,667,171	
Moveable Capital Equipment	$ 77,962,168	
Bond Issuance Expense	$ 6,000,000	
Net Interest Expense During Construction	$ 21,000,000	
Fair Market Value of Leased Equipment	$ -	
Other Costs to be Capitalized	$ 1,981,074	
Acquisition of Buildings & Property	$ -	
Grand Total (Excluding Land)	**$ 420,438,329**	

Cash & Securities	$	120,438,329
Bond Issues (project related)	$	300,000,000
Total Funds	**$**	**420,438,329**

Extraordinary Costs:

Modernization

Infrastructure: **($121.46 per GSF)** **Total: $19,843,492**

Plumbing Riser Replacements: $17,555,567

The complete plumbing supply and waste risers serving the existing inpatient bed tower have outlived their expected utility. The Hospital has attempted to undergo a separate project wherein the risers were scheduled for replacement in phases. However, after one phase of riser replacements it became apparent that this was not feasible and that the replacement would become more feasible with the conversion to private rooms. So as to maintain a minimum number of available beds, the riser work project must be completed in phases, which further adds to the cost. Consequently, the project was abandoned with the intent to phase the riser replacements with the conversion to private patient rooms.

Air Handling Unit Replacments: $2,287,925

Several air-handling units that serve the areas of modernization will require either upgrading or replacement. Controls equipment and limited amounts of ductwork in multiple systems will need to be replaced to effectively operate as singular air-handling systems.

Escalation: At 7% per year, there is an average of 4 years of escalation in the modernization costs

Since the modernization portion of the project is the backfill after the completion of the east wing sddition, there are between 4 to 6 years of high escalation applicable to the modernization costs as opposed to new construction.

ATTACHMENT ECON-3
Page 3 of 3

** Cost per GSF includes all contingencies*

*** Contingencies of $28,274,294 include 10% ($16,666,388) for new construction and 15% ($11,607,906) for renovation.*

Palos Community Hospital *East Wing Addition*
Palos Heights, IL

	Building Area		
		Total	
	Project Costs		
			Basis for cost estimate
	Pre-Planning Costs		
	Programming	$ 150,610	Navigant FSP
	Master Planning	$ 200,000	Navigant
	Architectural concept & Pre-Basic	$ 100,000	Malthei & Collin & Associates (MCA) Architect
	Pre-Construction Development	$ 150,000	MCA/General Contractor Estimate (GCE)
	Additional Architectural Support	$ 2,000,000	Project Manager (PM) / GCE / MCA
	Subtotal	**$ 2,600,610**	
	Survey and Soils		
	Civil Engineering	$ 200,000	MCA
	Topographical Survey	$ 15,000	MCA
	Geotechnical Investigations	$ 50,000	MCA
	Subtotal	**$ 265,000**	
	Site Prep & Demolition		
	Utility/Infrastructure Mods - Basement	$ 1,090,655	MCA
	Utility/Infrastructure Mods - 1st	$ 1,153,751	MCA
	Utility/Infrastructure Mods - Tower	$ 2,241,402	MCA
	Demo Existing Structures (Carpentry, Print Shop, etc.)	$ 504,623	GCE
	Remove Underground Tanks	$ 104,520	GCE
	Perimeter Bracing North side of ACC	$ 1,162,014	GCE
	Building Tie-ins (New to Old)	$ 2,297,467	GCE
	Grease Trap / Piping Relocation	$ 614,822	GCE
	Subtotal	**$ 9,169,254**	
	Off-Site Improvements		
	Architectural Wall	$ 400,866	MCA
	Site / Garden Work /Landscaping	$ 1,245,223	MCA
	Ring Road & Resurfacing Roads at Completion	$ 1,278,955	MCA
	Relocate Helipad	$ 595,904	MCA
	Asbestos Tile and Mastic Removal	$ 2,153,088	PALOS COMMUNITY HOSPITAL (PCH)
	Subtotal	**$ 5,674,036**	
	Consulting & Other Fees		
	Building Permits & Plan Reviews	$ 540,000	
	IDPH Design Review	$ 45,000	
	MWRD application/review	$ 20,000	PCH
	A/E Design Team Reimbursables	$ 175,000	PM:1.50 PER GSF (NEW & MOD)
	Interior Design / Artwork	$ 3,167,171	PM:0.75 PER GSF (NEW ONLY)
	Project Management Consulting	$ 2,860,000	
	Medical Equipment Planner	$ 380,000	
	Dietary Consultant	$ 65,000	
	Acoustical Consultant	$ 300,000	
	Radiation Shielding Consultant	$ 15,000	
	CON Application/Review/Filing Fees/Consultant	$ 200,000	PCH
	Construction Testing/Observation/Commissioning	$ 950,000	PM/MCA
	HVAC & Hydronics T & B	$ 500,000	PCH
	Technology Design	$ 450,000	PCH/PM 8.50 PER GSF (N&M)
	Subtotal	**$ 9,667,171**	
	Other Costs to be Capitalized		
	Builder's Risk Insurance	$ 300,000	PCH
	Signage - Interior & Exterior	$ 1,181,074	PM:1.50 PER GSF (NEW & MOD)
	Staging, relocation moving costs etc.	$ 500,000	PM:0.75 PER GSF (NEW ONLY)
	Subtotal	**$ 1,981,074**	

** Metropolitan Water Reclamation District (MWRD)*

ATTACHMENT ECON-4

Moody's Investors Service

99 Church Street
New York, NY

May 16, 2007

MBIA Insurance Corporation
113 King Street
Armonk, NY 10504

To Whom It May Concern:

Moody's Investors Service has assigned the rating of Aaa (MBIA Insurance Corporation Insured - Policy No. **495900**) to the **$57,875,000.00, Illinois Finance Authority - Revenue Bonds, Series 2007B (Palos Community Hospital), Periodic Auction Reset Securities (PARS)**, dated May 17, 2007 which sold through negotiation on May 2, 2007. The rating is based upon an insurance policy provided by MBIA Insurance Corporation.

Should you have any questions regarding the above, please do not hesitate to contact Karen Malkowski at (201) 395-6370.

Sincerely yours,

Joann Hempel

Joann Hempel
Vice President / Senior Credit Officer

JH / DC

ATTACHMENT FINANCIALS
(Proof of "A" or better bond rating)

Moody's Investors Service

99 Church Street
New York, NY

May 16, 2007

MBIA Insurance Corporation
113 King Street
Armonk, NY 10504

To Whom It May Concern:

Moody's Investors Service has assigned the rating of **Aaa** (MBIA Insurance Corporation Insured - Policy No. **495490**) to the **$120,145,000.00, Illinois Finance Authority - Revenue Bonds, Series 2007A (Palos Community Hospital)**, dated May 17, 2007 which sold through negotiation on May 2, 2007. The rating is based upon an insurance policy provided by MBIA Insurance Corporation.

Should you have any questions regarding the above, please do not hesitate to contact Karen Malkowski at (201) 395-6370.

Sincerely yours,

Joann Hempel

Joann Hempel
Vice President / Senior Credit Officer

JH / DC

ATTACHMENT FINANCIALS
(Proof of "A" or better bond rating)

STANDARD
&POOR'S

55 Water Street, 38th Floor
New York, NY 10041-0003
tel 212 438-2074
reference no.: 836477

May 15, 2007

MBIA Insurance Corporation
113 King Street
Armonk, NY 10504
Attention: Mr. Adam Carta, Assistant Vice President

Re: ***$57,875,000 Illinois Finance Authority, Revenue Bonds (Palos Community Hospital), Series 2007B, Periodic Auction Rate Securities, (PARS), dated: Date of Delivery, due: May 15, 2018, (POLICY #495900)***

Dear Mr. Carta:

Pursuant to your request for a Standard & Poor's rating on the above-referenced obligations, we have reviewed the information submitted to us and, subject to the enclosed *Terms and Conditions*, have assigned a rating of "AAA". The rating reflects our assessment of the likelihood of repayment of principal and interest based on the bond insurance policy your company is providing. Therefore, rating adjustments may result from changes in the financial position of your company or from alterations in the documents governing the issue.

The rating is not investment, financial, or other advice and you should not and cannot rely upon the rating as such. The rating is based on information supplied to us by you but does not represent an audit. We undertake no duty of due diligence or independent verification of any information. The assignment of a rating does not create a fiduciary relationship between us and you or between us and other recipients of the rating. We have not consented to and will not consent to being named an "expert" under the applicable securities laws, including without limitation, Section 7 of the Securities Act of 1933. The rating is not a "market rating" nor is it a recommendation to buy, hold, or sell the obligations.

This letter constitutes Standard & Poor's permission to you to disseminate the above-assigned rating to interested parties. Standard & Poor's reserves the right to inform its own clients, subscribers, and the public of the rating.

Standard & Poor's relies on the issuer and its counsel, accountants, and other experts for the accuracy and completeness of the information submitted in connection with the rating. This rating is based on financial information and documents we received prior to the issuance of this letter. Standard & Poor's must receive complete documentation relating to this issue no later than 90 days after the date of this letter. Standard & Poor's assumes that the documents you have provided to us are final. If any subsequent changes were made in the final documents, you must notify us of such changes by sending us the revised final documents with the changes clearly marked.

ATTACHMENT FINANCIALS
(Proof of "A" or better bond rating)

Standard & Poor's is pleased to be of service to you. For more information please visit our website at www.standardandpoors.com. If we can be of help in any other way, please contact us. Thank you for choosing Standard & Poor's and we look forward to working with you again.

Sincerely yours,

Standard & Poor's Ratings Services
a division of The McGraw-Hill Companies, Inc.

Standard and Poor's 1000

ak
enclosure

STANDARD
& POOR'S

ATTACHMENT FINANCIALS
(Proof of "A" or better bond rating)

STANDARD
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Standard & Poor's Ratings Services
Terms and Conditions
Applicable To
U.S. Public Finance Ratings

Request for a rating. Standard & Poor's issues public finance ratings for a fee upon request from an issuer, or from an underwriter, financial advisor, investor, insurance company, or other entity, provided that the obligor and issuer (if different from the obligor) each has knowledge of the request. The term "issuer/obligor" in these Terms and Conditions means the issuer and the obligor if the obligor is different from the issuer.

Agreement to Accept Terms and Conditions. Standard & Poor's assigns Public Finance ratings subject to the terms and conditions stated herein and in the rating letter. The issuer/obligor's use of a Standard & Poor's public finance rating constitutes agreement to comply in all respects with the terms and conditions contained herein and in the rating letter and acknowledges the issuer/obligor's understanding of the scope and limitations of the Standard & Poor's rating as stated herein and in the rating letter.

Fees and expenses. In consideration of our analytic review and issuance of the rating, the issuer/obligor agrees to pay Standard & Poor's a rating fee. Payment of the fee is not conditioned on Standard & Poor's issuance of any particular rating. In most cases an annual surveillance fee will be charged for so long as we maintain the rating. The issuer/obligor will reimburse Standard & Poor's for reasonable travel and legal expenses if such expenses are not included in the fee. Should the rating not be issued, the issuer/obligor agrees to compensate Standard & Poor's based on the time, effort, and charges incurred through the date upon which it is determined that the rating will not be issued.

Scope of Rating. The issuer/obligor understands and agrees that (i) an issuer rating reflects Standard & Poor's current opinion of the issuer/obligor's overall financial capacity to pay its financial obligations as they come due, (ii) an issue rating reflects Standard & Poor's current opinion of the likelihood that the issuer/obligor will make payments of principal and interest on a timely basis in accordance with the terms of the obligation, (iii) a rating is an opinion and is not a verifiable statement of fact, (iv) ratings are based on information supplied to Standard & Poor's by the issuer/obligor or by its agents and upon other information obtained by Standard & Poor's from other sources it considers reliable, (v) Standard & Poor's does not perform an audit in connection with any rating and a rating does not represent an audit by Standard & Poor's, (vi) Standard & Poor's relies on the issuer/obligor, its accountants, counsel, and other experts for the accuracy and completeness of the information submitted in connection with the rating and surveillance process, (vii) Standard & Poor's undertakes no duty of due diligence or independent verification of any information, (viii) Standard & Poor's does not and cannot guarantee the accuracy, completeness, or timeliness of the information relied on in connection with a rating or the results obtained from the use of such information, (ix) Standard & Poor's may raise, lower, suspend, place on CreditWatch, or withdraw a rating at any time, in Standard & Poor's sole discretion, and (x) a rating is not a "market" rating nor a recommendation to buy, hold, or sell any financial obligation.

Publication. Standard & Poor's reserves the right to publish, disseminate, or license others to publish or disseminate the rating and the rationale for the rating unless the issuer/obligor specifically requests that the rating be assigned and maintained on a confidential basis. If a confidential rating subsequently becomes public through disclosure by the issuer/obligor or a third party other than Standard & Poor's, Standard & Poor's reserves the right to publish it. Standard & Poor's may publish explanations of Standard & Poor's ratings criteria from time to time and nothing in this Agreement shall be construed as limiting Standard & Poor's ability to modify or refine Standard & Poor's criteria at any time as Standard & Poor's deems appropriate.

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(Proof of "A" or better bond rating)

information provided by the issuer/obligor or its agents. Standard & Poor's reserves the right to withdraw the rating if the issuer/obligor or its agents fails to provide Standard & Poor's with accurate, complete, timely, or reliable information.

Standard & Poor's Not an Advisor, Fiduciary, or Expert. The issuer/obligor understands and agrees that Standard & Poor's is not acting as an investment, financial, or other advisor to the issuer/obligor and that the issuer/obligor should not and cannot rely upon the rating or any other information provided by Standard & Poor's as investment or financial advice. Nothing in this Agreement is intended to or should be construed as creating a fiduciary relationship between Standard & Poor's and the issuer/obligor or between Standard & Poor's and recipients of the rating. The issuer/obligor understands and agrees that Standard & Poor's has not consented to and will not consent to being named an "expert" under the applicable securities laws, including without limitation, Section 7 of the U.S. Securities Act of 1933.

Limitation on Damages. The issuer/obligor agrees that Standard & Poor's, its officers, directors, shareholders, and employees shall not be liable to the issuer/obligor or any other person for any actions, damages, claims, liabilities, costs, expenses, or losses in any way arising out of or relating to the rating or the related analytic services provided for in an aggregate amount in excess of the aggregate fees paid to Standard & Poor's for the rating, except for Standard & Poor's gross negligence or willful misconduct. In no event shall Standard & Poor's, its officers, directors, shareholders, or employees be liable for consequential, special, indirect, incidental, punitive or exemplary damages, costs, expenses, legal fees, or losses (including, without limitation, lost profits and opportunity costs). In furtherance and not in limitation of the foregoing, Standard & Poor's will not be liable in respect of any decisions made by the issuer/obligor or any other person as a result of the issuance of the rating or the related analytic services provided by Standard & Poor's hereunder or based on anything that appears to be advice or recommendations. The provisions of this paragraph shall apply regardless of the form of action, damage, claim, liability, cost, expense, or loss, whether in contract, statute, tort (including, without limitation, negligence), or otherwise. The issuer/obligor acknowledges and agrees that Standard & Poor's does not waive any protections, privileges, or defenses it may have under law, including but not limited to, the First Amendment of the Constitution of the United States of America.

Term. This Agreement shall terminate when the ratings are withdrawn. Notwithstanding the foregoing, the paragraphs above, "Standard & Poor's Not an Advisor, Fiduciary, or Expert" and "Limitation on Damages", shall survive the termination of this Agreement or any withdrawal of a rating.

Third Parties. Nothing in this Agreement, or the rating when issued, is intended or should be construed as creating any rights on behalf of any third parties, including, without limitation, any recipient of the rating. No person is intended as a third party beneficiary to this Agreement or to the rating when issued.

Binding Effect. This Agreement shall be binding on, and inure to the benefit of, the parties hereto and their successors and assigns.

Severability. In the event that any term or provision of this Agreement shall be held to be invalid, void, or unenforceable, then the remainder of this Agreement shall not be affected, impaired, or invalidated, and each such term and provision shall be valid and enforceable to the fullest extent permitted by law.

Complete Agreement. This Agreement constitutes the complete agreement between the parties with respect to its subject matter. This Agreement may not be modified except in a writing signed by authorized representatives of both parties.

Governing Law. This Agreement and the rating letter shall be governed by the internal laws of the State of New York. The parties agree that the state and federal courts of New York shall be the exclusive forums for any dispute arising out of this Agreement and the parties hereby consent to the personal jurisdiction of such courts.

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(Proof of "A" or better bond rating)

STANDARD
&POOR'S

55 Water Street, 38th Floor
New York, NY 10041-0003
tel 212 438-2074
reference no.: 836469

May 15, 2007

MBIA Insurance Corporation
113 King Street
Armonk, NY 10504
Attention: Mr. Adam Carta, Assistant Vice President

Re: ***$120,145,000 Illinois Finance Authority, Revenue Bonds, (Palos Community Hospital), Series 2007A, dated: Date of Delivery, due: May 15, 2019-2023, Term Bonds due: May 15, 2027, May 15, 2032, May 15, 2035, May 1, 2037, (POLICY #495490)***

Dear Mr. Carta:

Pursuant to your request for a Standard & Poor's rating on the above-referenced obligations, we have reviewed the information submitted to us and, subject to the enclosed *Terms and Conditions*, have assigned a rating of "AAA". The rating reflects our assessment of the likelihood of repayment of principal and interest based on the bond insurance policy your company is providing. Therefore, rating adjustments may result from changes in the financial position of your company or from alterations in the documents governing the issue.

The rating is not investment, financial, or other advice and you should not and cannot rely upon the rating as such. The rating is based on information supplied to us by you but does not represent an audit. We undertake no duty of due diligence or independent verification of any information. The assignment of a rating does not create a fiduciary relationship between us and you or between us and other recipients of the rating. We have not consented to and will not consent to being named an "expert" under the applicable securities laws, including without limitation, Section 7 of the Securities Act of 1933. The rating is not a "market rating" nor is it a recommendation to buy, hold, or sell the obligations.

This letter constitutes Standard & Poor's permission to you to disseminate the above-assigned rating to interested parties. Standard & Poor's reserves the right to inform its own clients, subscribers, and the public of the rating.

Standard & Poor's relies on the issuer and its counsel, accountants, and other experts for the accuracy and completeness of the information submitted in connection with the rating. This rating is based on financial information and documents we received prior to the issuance of this letter. Standard & Poor's must receive complete documentation relating to this issue no later than 90 days after the date of this letter. Standard & Poor's assumes that the documents you have provided to us are final. If any subsequent changes were made in the final documents, you must notify us of such changes by sending us the revised final documents with the changes clearly marked.

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(Proof of "A" or better bond rating)

Standard & Poor's is pleased to be of service to you. For more information please visit our website at www.standardandpoors.com. If we can be of help in any other way, please contact us. Thank you for choosing Standard & Poor's and we look forward to working with you again.

Sincerely yours,

Standard & Poor's Ratings Services
a division of The McGraw-Hill Companies, Inc.

Standard and Poors 10/20

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enclosure

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(Proof of "A" or better bond rating)

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Standard & Poor's Ratings Services
Terms and Conditions
Applicable To
U.S. Public Finance Ratings

Request for a rating. Standard & Poor's issues public finance ratings for a fee upon request from an issuer, or from an underwriter, financial advisor, investor, insurance company, or other entity, provided that the obligor and issuer (if different from the obligor) each has knowledge of the request. The term "issuer/obligor" in these Terms and Conditions means the issuer and the obligor if the obligor is different from the issuer.

Agreement to Accept Terms and Conditions. Standard & Poor's assigns Public Finance ratings subject to the terms and conditions stated herein and in the rating letter. The issuer/obligor's use of a Standard & Poor's public finance rating constitutes agreement to comply in all respects with the terms and conditions contained herein and in the rating letter and acknowledges the issuer/obligor's understanding of the scope and limitations of the Standard & Poor's rating as stated herein and in the rating letter.

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STANDARD
POOR'S

ATTACHMENT FINANCIALS
(Proof of "A" or better bond rating)

08-075

Palos Community Hospital

12251 S. 80th Avenue Palos Heights, Illinois 60463 (708) 923-4000

September 24, 2008

RECEIVED

SEP 29 2008

HEALTH FACILITIES
PLANNING BOARD

Jeffrey S. Mark
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Mr. Mark:

CON Application
Major Modernization and East Wing Expansion

Palos Community Hospital is pleased to submit this Certificate of Need (CON) application to modernize Medical/Surgical (M/S) Services and expand Intensive Care (ICU), Surgery, Recovery, Emergency and other clinical and non-clinical services. The project proposes a complete conversion to private patient rooms in its M/S services. Upon project completion the Hospital would have 36 ICU beds and 306 M/S beds, an addition of 12 ICU beds and a net reduction of 9 M/S beds.

The Hospital proposes to build an East Wing with eight levels which would be adjacent and connected to the existing hospital at the northeast corner. The East Wing would contain a total of 399,669 new gross square feet (gsf) including 223,462 gsf for clinical services.

The estimated total project cost is $420,438,329, $250,350,575 for clinical services and $170,087,754 for non-clinical services. The project would be funded by cash and tax-exempt, FHA-guaranteed, fixed-rate bonds issue with a term of thirty years.

Enclosed is a check for $2,500 (#10739), the initial fee deposit.

Thank you for your consideration of this important matter.

Sincerely,

Timothy J. Brosnan
Vice President, Planning and Community Relations

Enclosure
cc: Sister Margaret Wright, President
Margie Zeglen, Director of Planning
Delia Wozniak, DMW and Associates, Inc.

Palos Community Hospital
CAPITAL FUND

12251 S. 80th Avenue
Palos Heights, IL 60463

INVOICE DATE	REFERENCE	INVOICE AMT.	DEDUCTIONS	INVOICE DATE	REFERENCE	INVOICE AMT.	DEDUCTIONS
09/04/08	CON APP SEP	2,500.00	0.00				
TOTAL INVOICE AMT. $	2,500.00	DISCOUNT $	0.00	NET AMOUNT PAID $	2,500.00		

RECEIVED
SEP 29 2008
HEALTH FACILITIES
PLANNING BOARD

Palos Community Hospital
CAPITAL FUND
12251 S. 80th Avenue / Palos Heights, IL 60463

The Northern Trust Company
Chicago, IL
Payable Through
Oakbrook Terrace, IL

10739

70-2382
719

VENDOR
A0109388

DATE
09/24/08

AMOUNT
*****$2,500.00

NOT VALID AFTER (3) MONTHS

PAY *Two thousand, five hundred and 00/100 Dollars*

TO THE ORDER OF
ILLINOIS HEALTH FACILITIES
PLANNING BOARD
525 W. JEFFERSON STREET
2ND FLOOR
SPRINGFIELD, IL 62761

Little Margaret Knight

⑈10739⑈ ⑆071923828⑆ 00000608 79⑈