ORIGINAL

11-019

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED
MAY 16 2011
HEALTH FACILITIES & SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

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

Applicant /Co-Applicant Identification

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

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

Type of Ownership of Applicant/Co-Applicant

- ☒ Non-profit Corporation
- ☐ For-profit Corporation
- ☐ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
- ☐ Sole Proprietorship
- ☐ Other

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

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

Primary Contact

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

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

Additional Contact

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

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

Additional Contact

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

Name:	Sonja Reece, FACHE
Title:	Director, Government Affairs and Property Management
Company Name:	Advocate BroMenn Medical Center
Address:	1304 Franklin Avenue, Normal, IL 61761
Telephone Number:	(309) 268-5482
E-mail Address:	sonja.reece@advocatehealth.com
Fax Number:	(309) 888-0961

Additional Contact

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

Name:	Janet Scheuerman
Title:	Senior Consultant
Company Name:	PRISM Healthcare Consulting
Address:	1808 Woodmere Drive, Valparaiso, IN 46383
Telephone Number:	(219) 464-3969
E-mail Address:	jscheuerman@consultprism.com
Fax Number:	(219) 464-0027

Additional Contact

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

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

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

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Street Address:	4440 West 95th Street
City and Zip Code:	Oak Lawn 60453-2699
County: Suburban Cook	Health Service Area 7 Health Planning Area: A-04

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

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

Type of Ownership of Applicant/Co-Applicant

☒ Non-profit Corporation ☐ Partnership
☐ For-profit Corporation ☐ Governmental
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Fax Number:	(708) 684-5707

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Telephone Number:	(312) 876-7815
E-mail Address:	jourth@arnstein.com
Fax Number:	(312) 876-6215

Post Permit Contact

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

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

Site Ownership

[Provide this information for each applicable site]

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

Address of Site Owner: 2025 Windsor Drive, Oak Brook, IL 60523

Street Address or Legal Description of Site:

Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.

APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

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

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

Address of Site Owner: 4440 W. 95th Street, Oak Lawn, IL 60453

- ☒ Non-profit Corporation
- ☐ For-profit Corporation
- ☐ Limited Liability Company
- ☐ Partnership
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- ☐ Other

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- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.
- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**

APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Organizational Relationships

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

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

Flood Plain Requirements

[Refer to application instructions.]

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

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

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

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

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

DESCRIPTION OF PROJECT

1. Project Classification

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

Part 1110 Classification:	Part 1120 Applicability or Classification: [Check one only.]
☐ Substantive	☐ Part 1120 Not Applicable
☒ Non-substantive	☐ Category A Project
	☒ Category B Project
	☐ DHS or DVA Project

2. Narrative Description

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

Advocate Health Care Network and Advocate Health and Hospitals Corporation d/b/a Advocate Christ Medical Center/Advocate Hope Children's Hospital (ACMC/AHCH, Medical Center), the applicants, propose to construct a 9-story building to house ambulatory care services as well as multidisciplinary institutes and other non clinical space.

The building would house the following functions on each level:

Ground Level – Entrance and Lobby, Registration, Education Resource Center, Lobby Café, Women's Services, Fetal Diagnostics, Central Sterile Processing and Supply, Materials Management and Environmental Services, and Mechanical Space

Level 1 – Pre-Admission Testing, Laboratory, Pulmonary Function Testing, General Radiology and Fluoroscopy, Ultrasound, and Shell Space

Level 2 – Endoscopy, Phase II Recovery, Mammography, Electronic Medical Records Support and Retail Pharmacy

Level 3 – Surgery, Phase I Recovery (PACU)

Level 4 – Interstitial Mechanical Space

Level 5 – CT, PET/CT, MRI and Nuclear Medicine

Level 6 – Heart and Vascular Institute including Non Invasive Cardiology, CHF Clinic, Cardiac Rehabilitation, and Advanced Heart Failure/VAD/Transplant Clinic

Level 7 – Neuroscience Institute including Neurodiagnostics, Pain Management Center, Outpatient Therapy (Physical, Occupational, Speech, Audiology, and Wound Therapy), and the Neuro Medical Clinic

Level 8 – Cancer Institute including Infusion Therapy, Satellite Pharmacy, Cancer MD Clinic, and Research.

Cooling towers will be located at the ninth level of the structure.

A stacking diagram and floor plans of the proposed structure is included as Narrative, Exhibit 1.

The Patient Protection and Affordable Care Act of 2010 challenges all aspects of the American health care system to reassess how health care is delivered in order to improve access, enhance quality, and reduce cost. Long before the passage of the health reform act, however, Advocate

Health Care, recognized as one of the leading health care systems in the nation, began working diligently on many fronts to accomplish these same goals.

The Medical Center is one of the flagship hospitals of Advocate Health Care. According to the *Crain's Chicago Business Magazine*, November 15, 2010, the Medical Center recorded more patient days and the highest bed occupancy of any hospital in the greater Chicago area in 2009. On April 25, 2010, *Crain's* also reported that the Advocate Medical Group, which includes 700 board certified physicians, provided 1,300,000 outpatient visits in 2009; this medical group provides access to health services at the Medical Center and at other Advocate facilities. According to the most recent Illinois Medicaid Hospital Listing, Hospital Reimbursement Regular Reports, the Medical Center is ranked fourth in Illinois for total covered Medicaid days.

ACMC/AHCH is integrally involved in the Advocate System's initiatives to improve access, enhance quality, and reduce cost. The challenges to advance the Systems' initiatives and to address the 2010 national health care reform legislation came at the same time that the Medical Center is experiencing very serious space constraints. According to Kurt Salmon Associates, a nationally respected facility planning firm, the Medical Center has approximately 1,260,000 BGSF of space when national standards for similar facilities suggest that it should have from 1,750,000 to 2,100,000 BGSF. This is a deficit from 490,000 BGSF to 840,000 BGSF.

Over the last 50 years, the Medical Center has matured from a 200-bed community hospital to a 700+ bed regional center providing tertiary and quaternary care to the residents of the greater south and southwest Chicago area and beyond.

Tertiary care is provided by specialists working in a medical center that has personnel and facilities to treat seriously ill and severely injured patients. Patients are often referred to a tertiary care facility from smaller hospitals for lifesaving care in advanced intensive care units and for advanced treatments including complex surgery. Quaternary care is an extension of tertiary care; quaternary care represents even more advanced levels of treatment which are highly specialized and available in only a few facilities. Experimental medicine, service-oriented surgeries, and other less common approaches to diagnostics and treatment are the essence of quaternary care.

The hospital was constructed at a time when outpatient care occurred essentially in emergency departments, physicians' offices, in dispensaries for the poor, or in patients' homes. Today, the Medical Center provides outpatient care for approximately 350,000 visits each year. Of these,

85 percent, or about 1,000 visits per day, occur in the hospital. Outpatients are commingled with inpatients in surgery, imaging, and other hospital departments originally designed for only inpatients; outpatients are squeezed into spaces that were once conference rooms and storage areas; and, they are seen in any other spaces that were appropriated. At a referral facility, such as the Medical Center, acutely ill inpatients and trauma/emergency patients always take precedence over outpatients so that outpatient exams or procedures are often delayed or must be rescheduled. For all of these reasons the most pressing need at the Medical Center today is for outpatient space.

The Medical Center studied a range of options to resolve this very serious space shortfall. To respond to the immediate need for outpatient space, the Medical Center is proposing to construct a 9-level Ambulatory Pavilion with immediate access to the hospital via a connector.

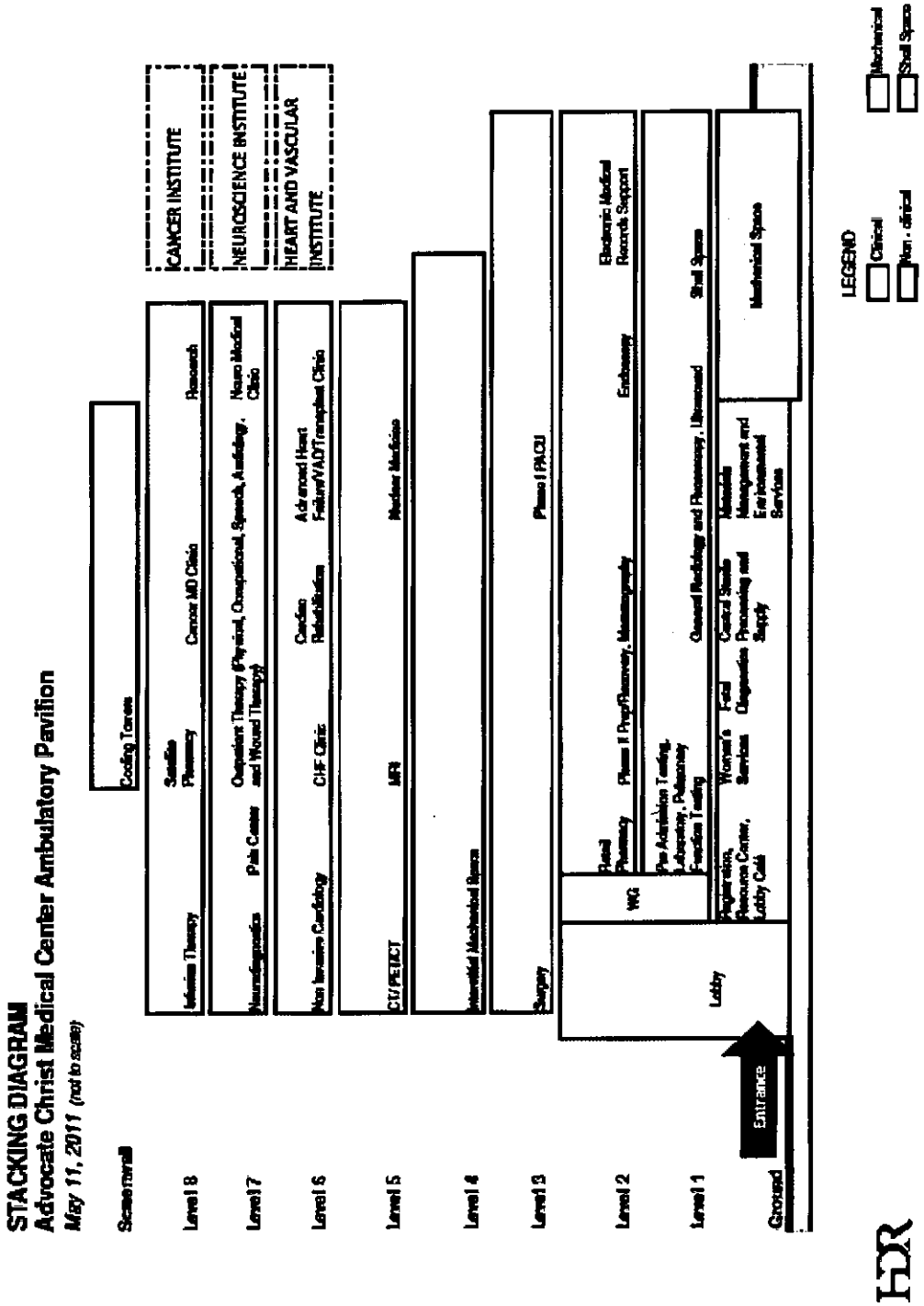
Appropriate space to accommodate the ever-increasing number of routine and complex ambulatory cases will help accomplish the goals of both Advocate as well as state and federal health care reform initiatives to increase access, enhance quality, and lower cost of care.

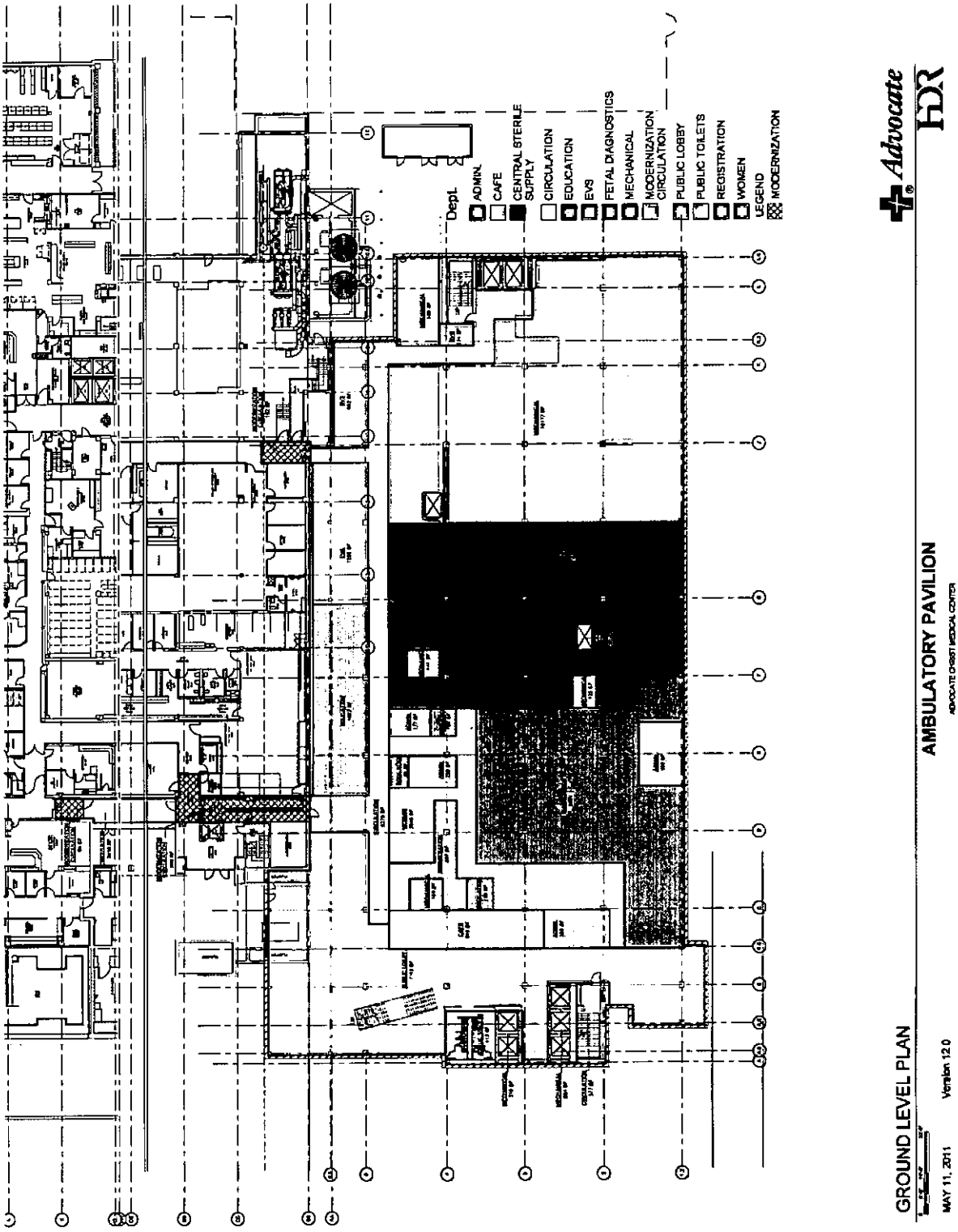
The applicant anticipates the need to modernize space vacated by outpatient areas in the hospital, shell space that is included in the new construction, as well as additional new construction on the Medical Center's campus at some time in the future.

It is expected that the Ambulatory Pavilion will be completed by December 31, 2014. Project includes 306,993 DGSF of new construction and 1,341 DGSF of modernization. Total project cost is expected to be $202,301,558.

Project has received strong community support; letters of support are included in Narrative, Exhibit 2 and in Appendix 2.

In accordance with the Illinois Administrative Code, Chapter II, Section 1110.40 (b), the project is classified as non-substantive because it is entirely limited to outpatient clinical service areas and non clinical space. Nonetheless, the Medical Center has elected to include Attachment 43, a Safety Net Impact Statement.


STACKING DIAGRAM
Advocate Christ Medical Center Ambulatory Pavilion
May 11, 2011 (not to scale)
Screenwall
Level 8
Level 7
Level 6
Level 5
Level 4
Level 3
Level 2
Level 1
Ground
Entrance
Cooling Towers
Satellite Pharmacy
Infusion Therapy
Cancer MD Clinic
Research
Outpatient Therapy (Physical, Occupational, Speech, Audiology, and Wound Therapy)
Neuro Medical Clinic
Pain Center
Neurodiagnostics
Cardiac Rehabilitation
Advanced Heart Failure/VAD/Transplant Clinic
Non Invasive Cardiology
CHF Clinic
Modular Medicine
MRI
CT/PET/CT
Shelled Mechanical Space
Phase I PACU
Surgery
Retail Pharmacy
Phase II Prep/Recovery, Mammography
Endoscopy
Electronic Medical Records Support
WIC
Pre-Admission Testing, Laboratory, Pulmonary Function Testing
General Radiology and Fluoroscopy, Ultrasound
Shell Space
Lobby
Registration, Resource Center, Lobby Café
Women's Services
Fetal Diagnostics
Central Sterile Processing and Supply
Materials Management and Environmental Services
Mechanical Space
LEGEND
Clinical
Non - clinical
Mechanical
Shell Space
HDR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PUBLIC TOILETS
REGISTRATION
WOMEN
LEGEND
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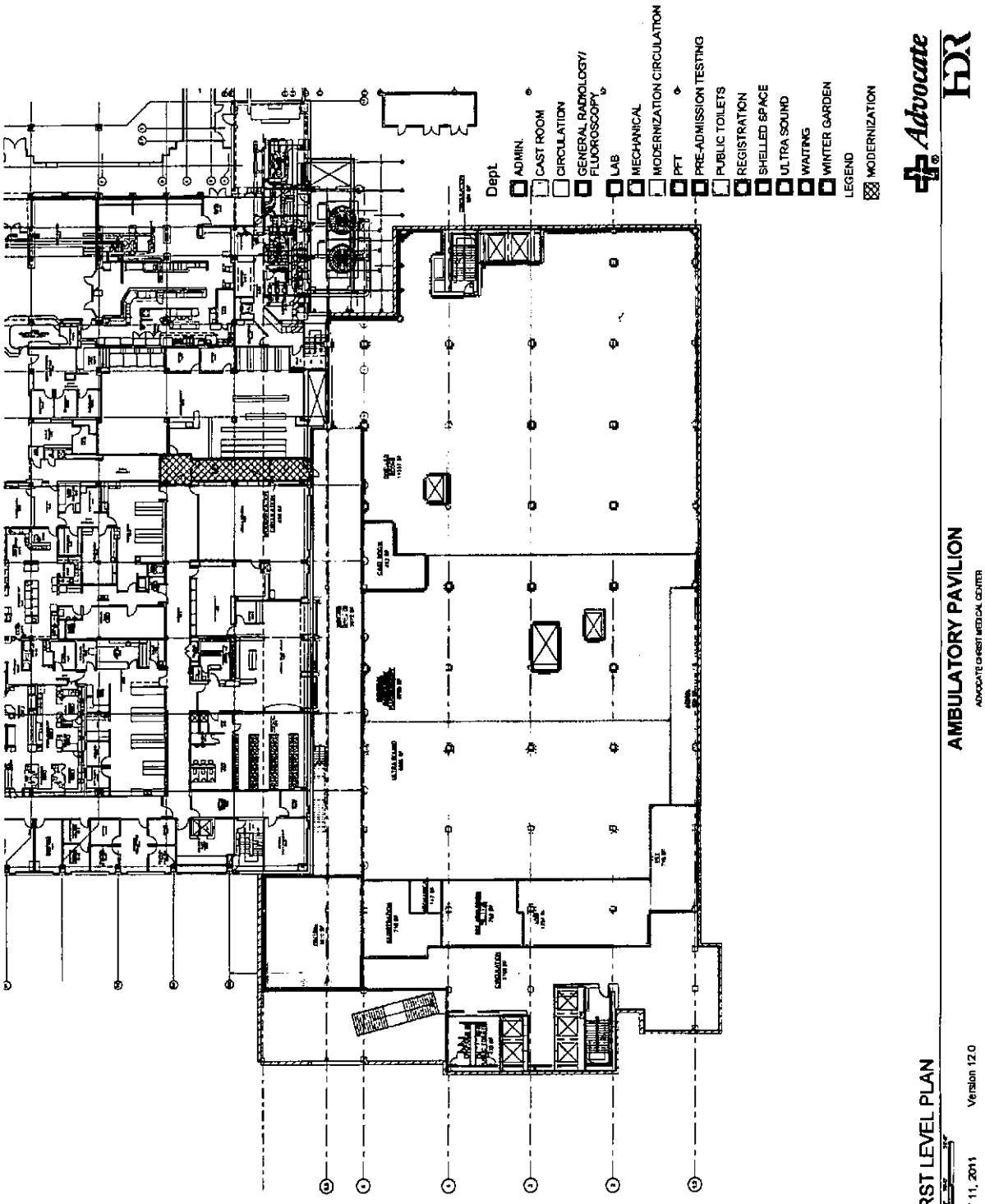
AMBULATORY PAVILION
ADVOCATE CHRIST MEDICAL CENTER
GROUND LEVEL PLAN
MAY 11, 2011
Version 12.0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PFT
PRE-ADMISSION TESTING
PUBLIC TOILETS
REGISTRATION
SHELLED SPACE
ULTRA SOUND
WAITING
WINTER GARDEN
LEGEND
MODERNIZATION
Advocate
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FIRST LEVEL PLAN
MAY 11, 2011
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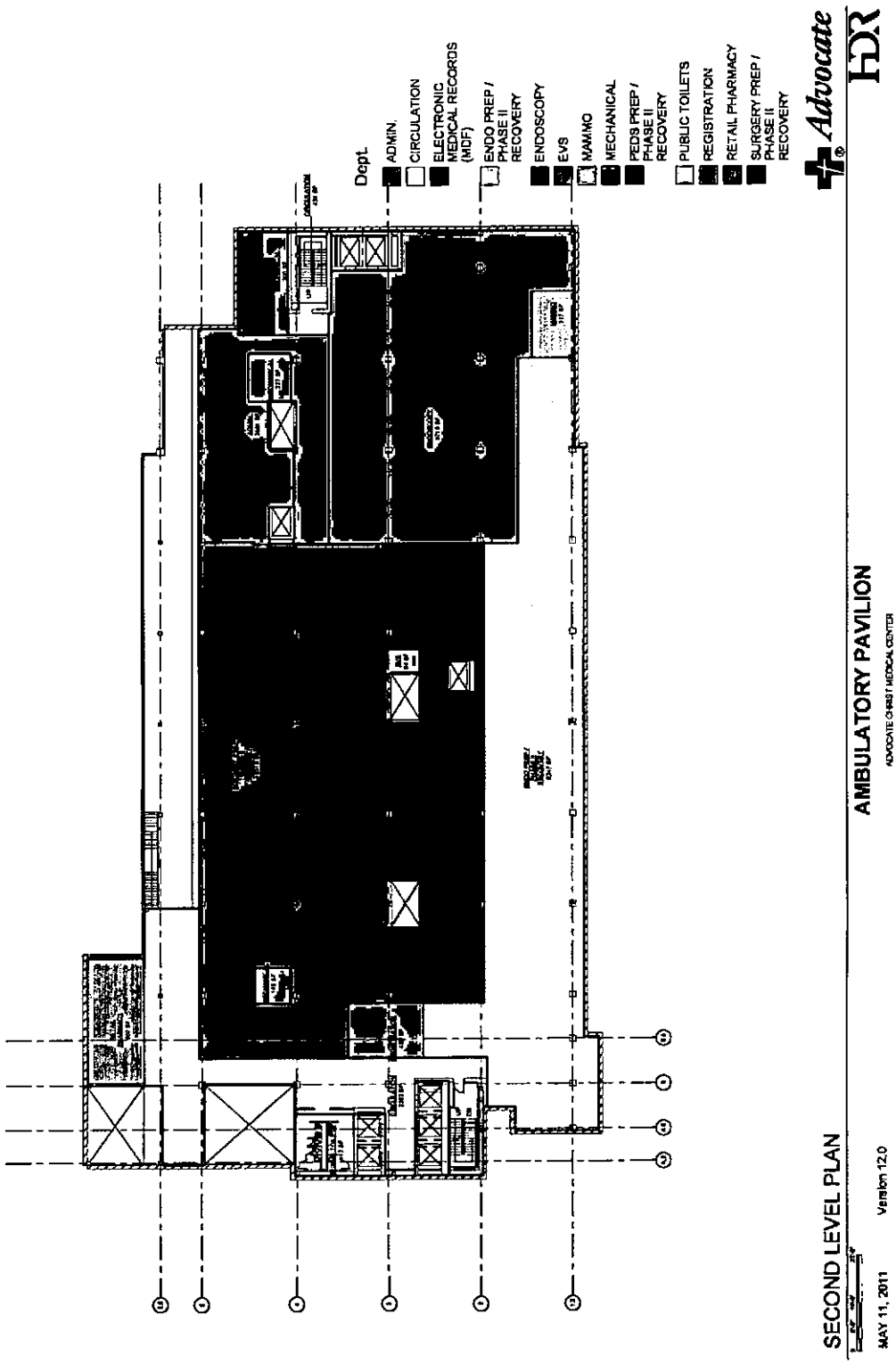
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EVS
MAMMO
MECHANICAL
PED9 PREP / PHASE II RECOVERY
PUBLIC TOILETS
REGISTRATION
RETAIL PHARMACY
SURGERY PREP / PHASE II RECOVERY
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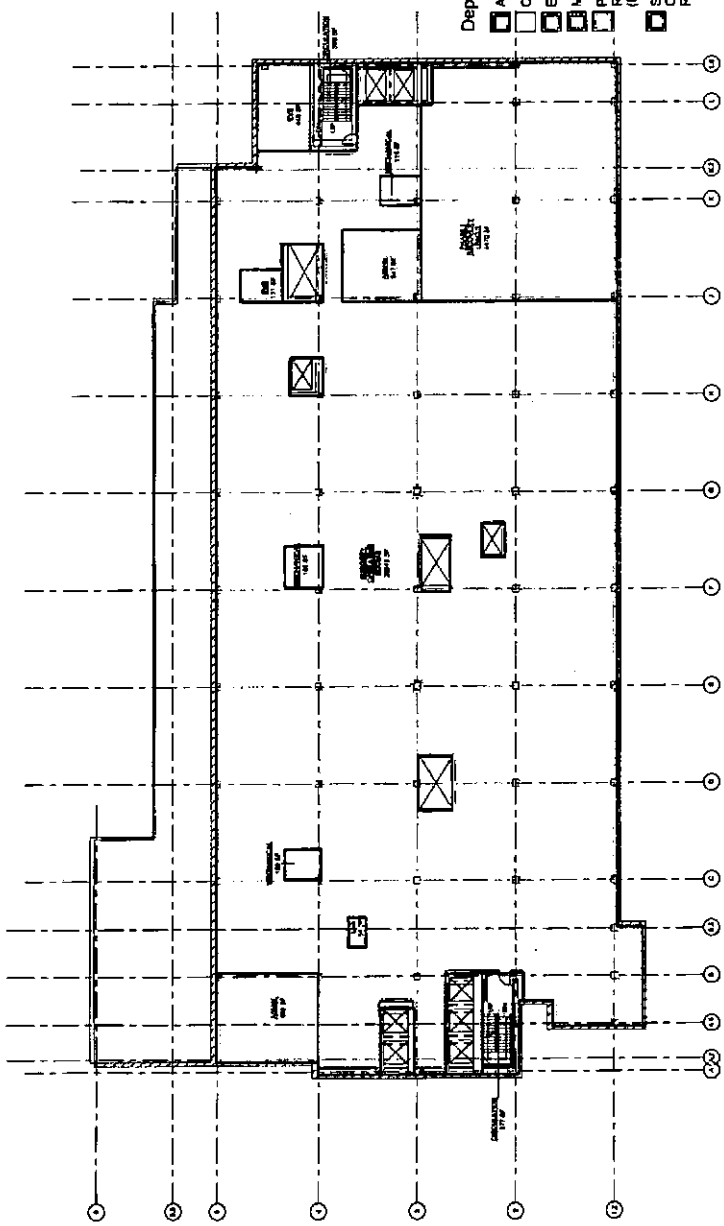

Advocate HDR

AMBULATORY PAVILION
ADVOCATE CHRIST MEDICAL CENTER

THIRD LEVEL PLAN

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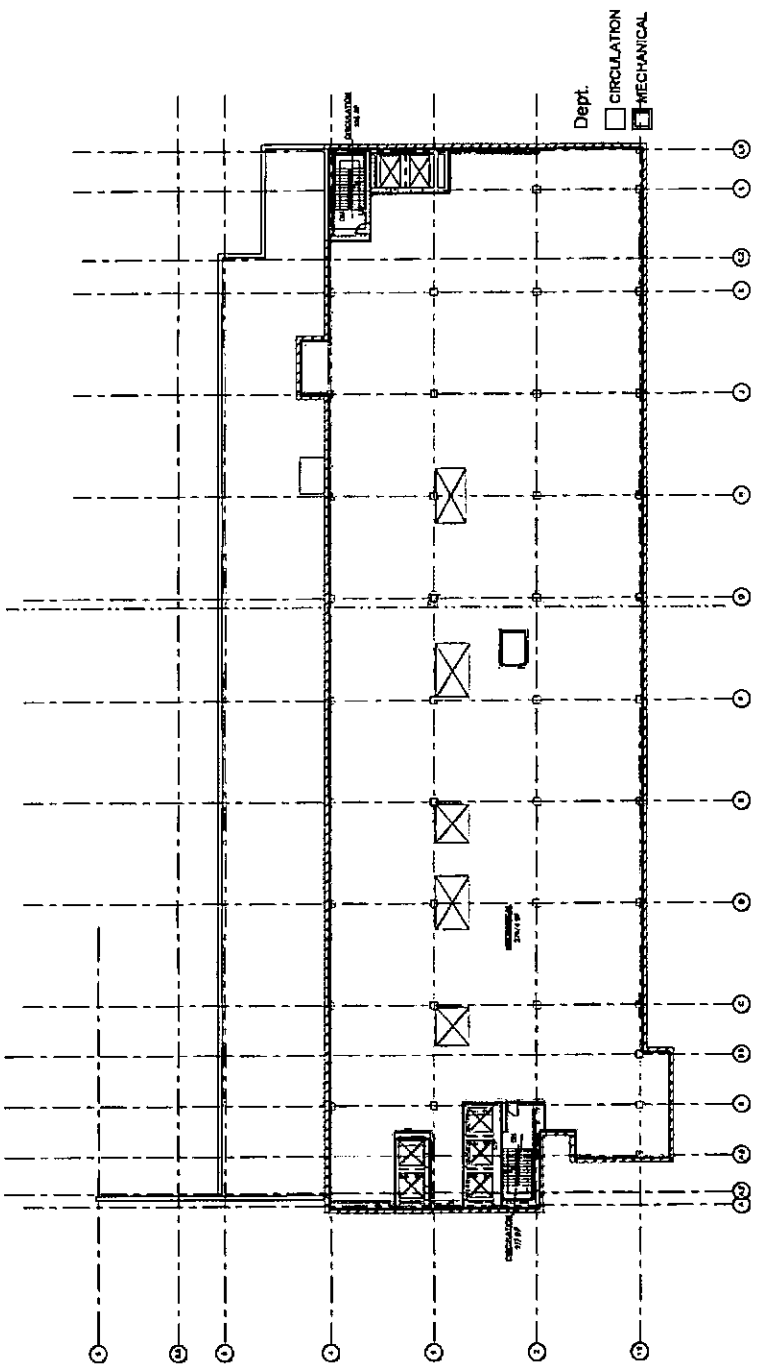
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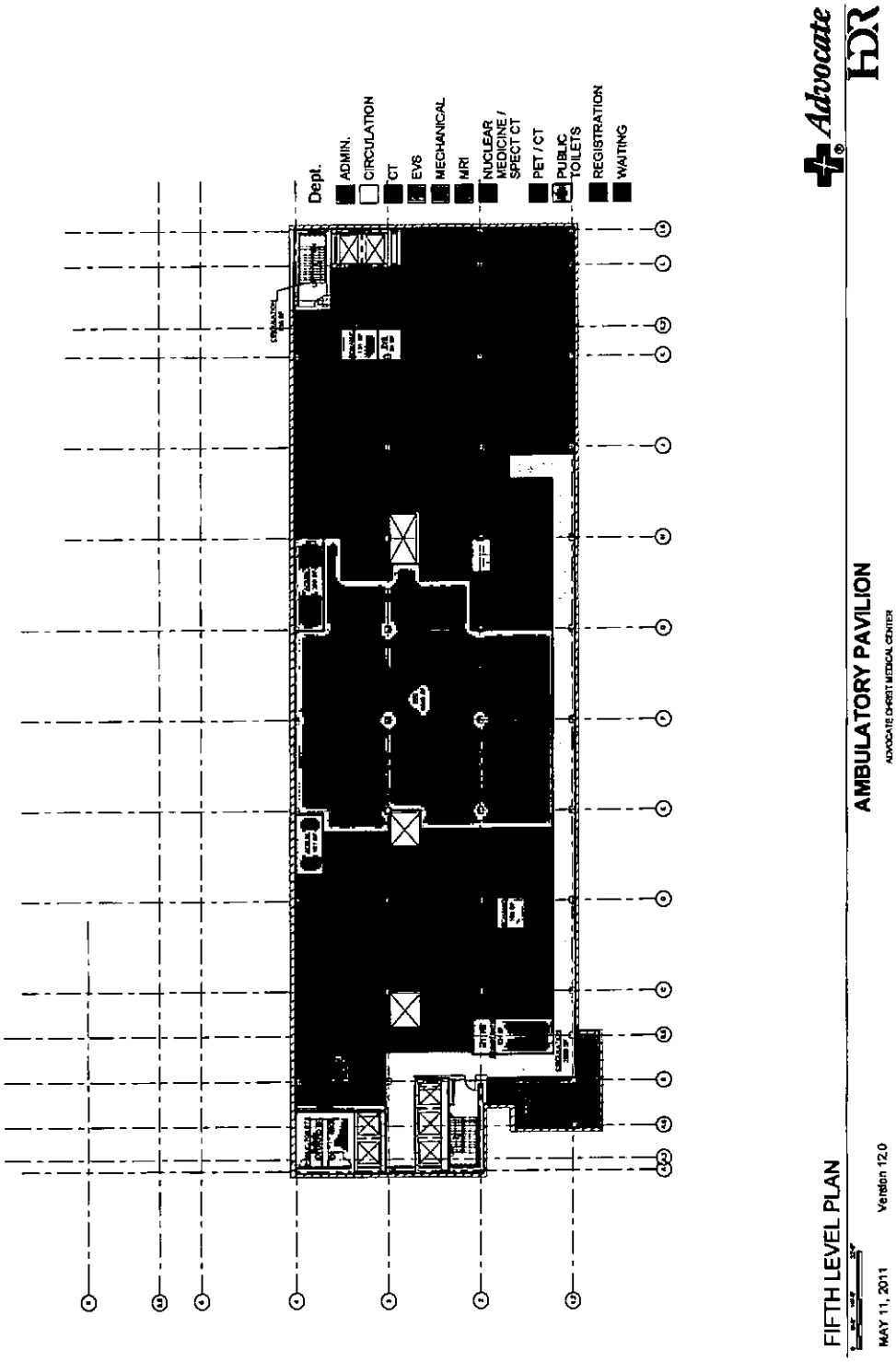
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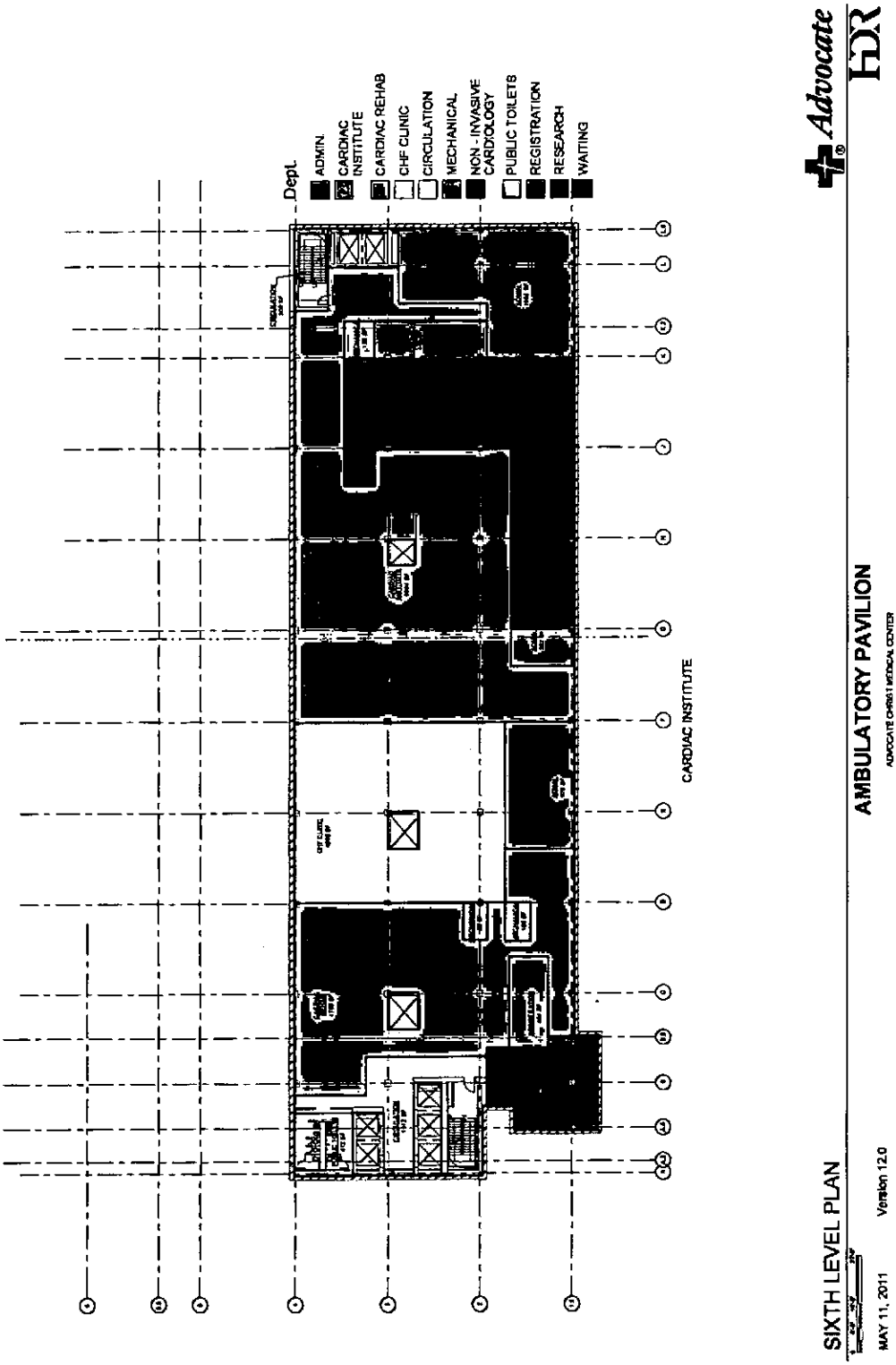
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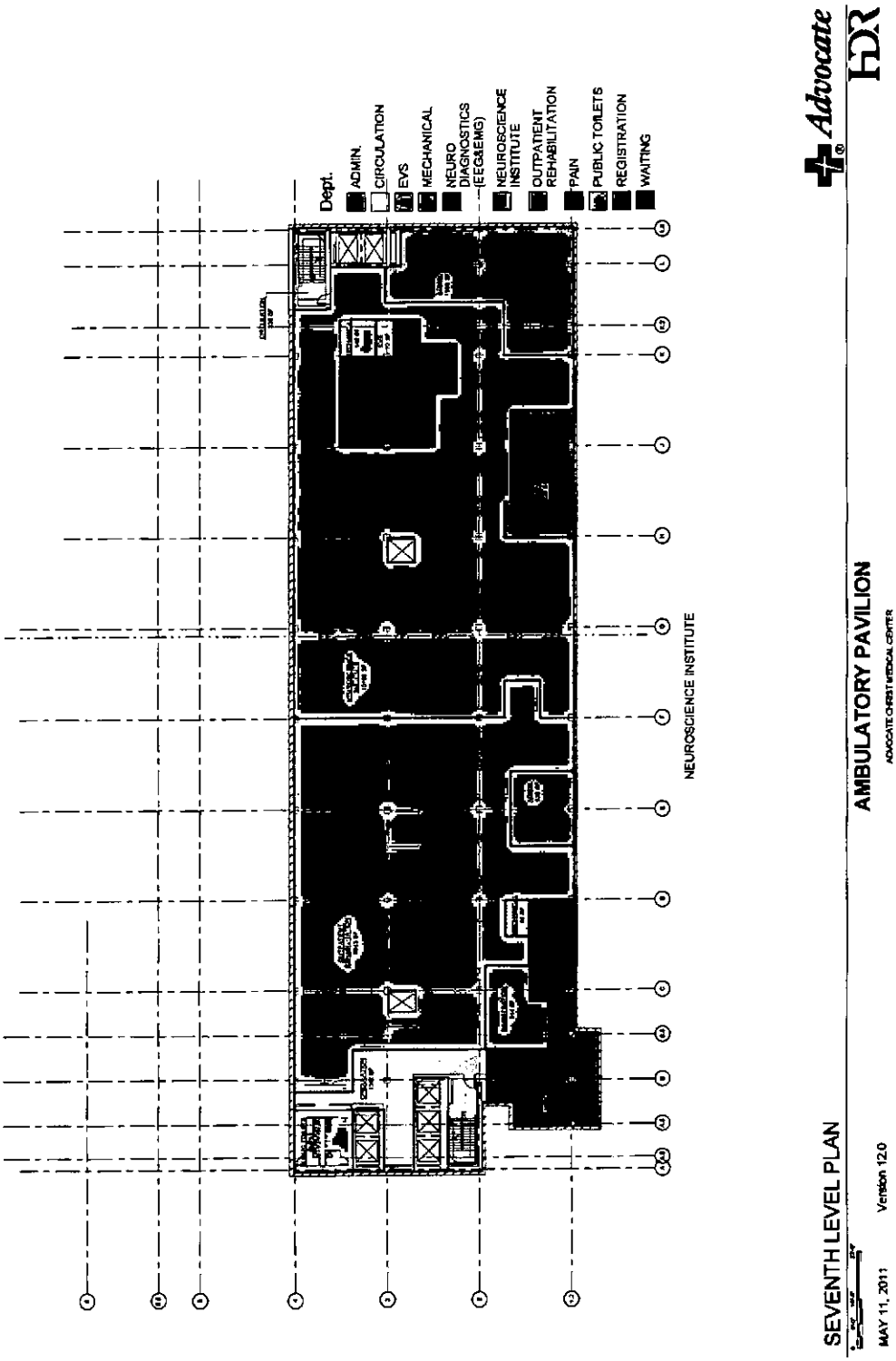
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PUBLIC TOILETS
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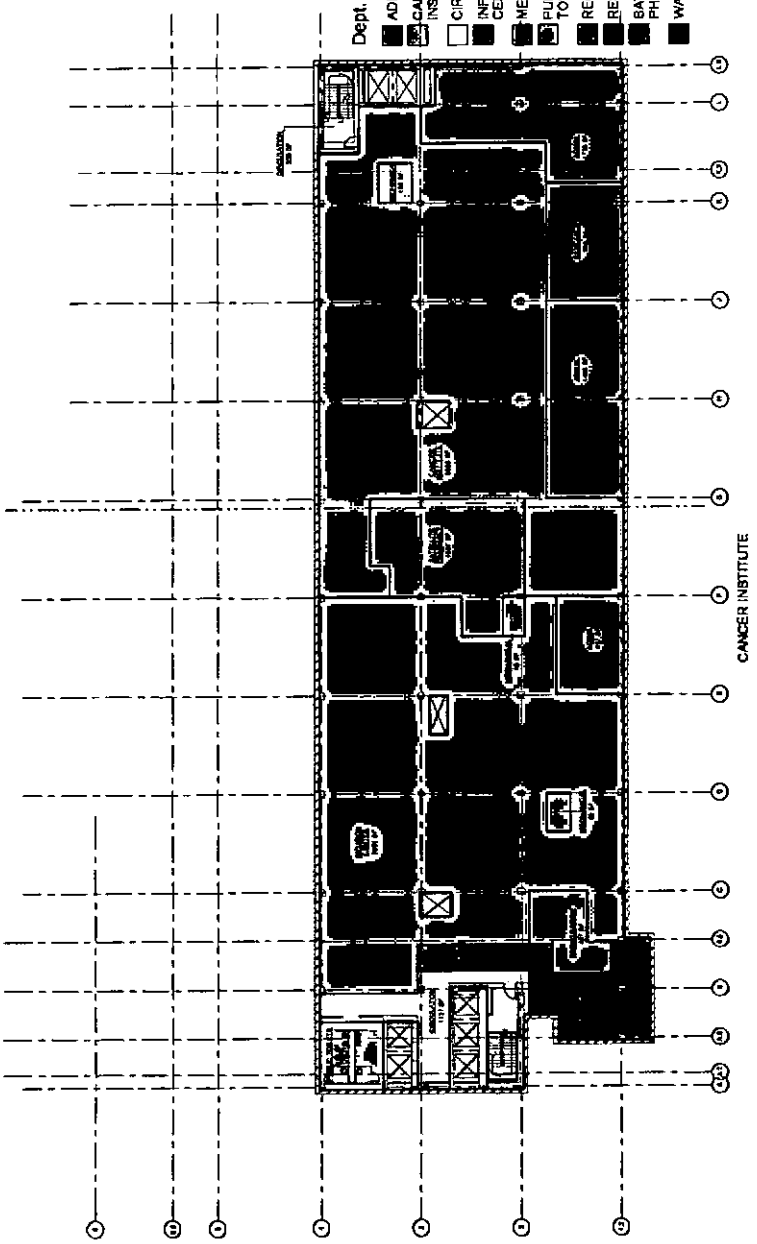
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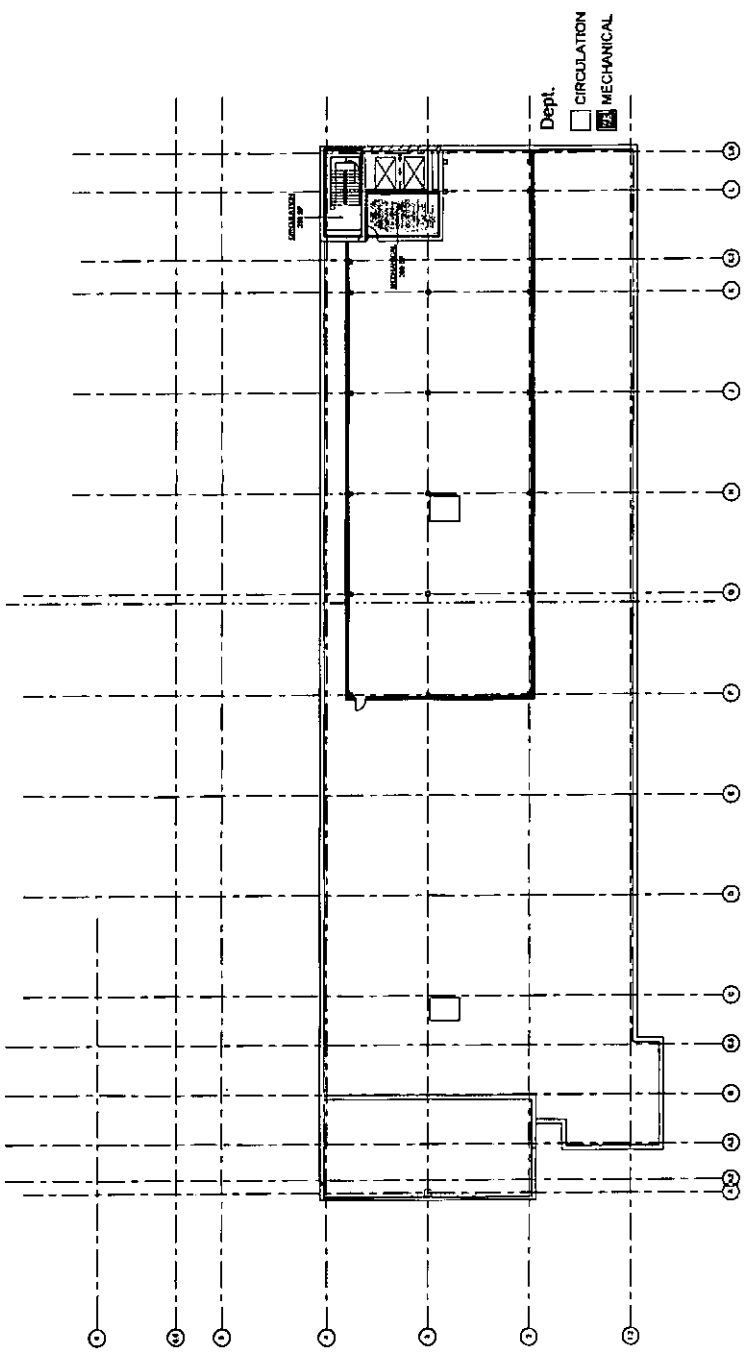

Advocate HDR

AMBULATORY PAVILION

ADVOCATE CHRIST MEDICAL CENTER

ROOF PLAN

MAY 11, 2011 Version 12.0

Support letters from legislative and community leaders.

Supporters of this project include the following:

Senator Christine Rodogno
Representative Kelly Burke
Senator Edward Maloney
Representative Renée Kosel
Senator Maggie Crotty
Police Chief William Villanova
Police Chief Alan Vodicka
Police Chief Michael Saunders
EMS Coordinator Chris Schmelzer
Police Chief Robert Pyznarski
Mayor Eugene Siegel
Ambulance Coordinator Kristen Sisk
EMS Coordinator Tim Reed
EMS Coordinator Anthony Butkus
Fire Chief Timothy Landingham
EMS Coordinator Timothy Grutzius
Village Clerk Carol Bryson
Police Chief Paul Madigan
Police Chief George Yott. Jr.
EMS Coordinator Mark Duke
Fire Chief Bryant Krizik
Police Chief Timothy McCarthy
EMS Bureau Chief Christine Tregoning

DISTRICT OFFICE:
1011 STATE ST., SUITE 210
LEMONT, IL 60439
(630) 243-0800
FAX: (630) 243-0808

CAPITOL OFFICE:
309A STATE HOUSE
SPRINGFIELD, IL 62706
(217) 782-0407
FAX: (217) 782-7818

CHRISTINE RADOGNO
SENATE REPUBLICAN LEADER · 41ST DISTRICT

April 5, 2011

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

Dear Ms. Avery:

I am writing in support of Advocate Christ Medical Center's Certificate of Need application to construct an Ambulatory Pavilion on its Oak Lawn campus. This project will enhance outpatient services in the region as well as directly address this planning board's stated preference for having hospitals expand services at their current locations rather than looking to alternative sites and building brand-new complexes.

As a state senator, I am concerned that Illinois hospitals and other health institutions are prepared to meet the challenges posed by the new environment of health care reform. Emphasis continues to be placed on moving more health care delivery from the inpatient side to the outpatient arena, and the proposed Ambulatory Pavilion project is a significant response to this trend.

Advocate Christ Medical Center is the only tertiary/quaternary facility in the Southland. The residents in the district that I represent depend on the institution's services and on its continuing ability to offer top-flight care. Additionally, with some 5,500 associates and more than 1,000 physicians, the medical center is a major employer in the region. Allowing this institution to proceed with needed expansion will serve to bolster the economic vitality of the region, including the creation of more jobs.

I believe the construction of an Ambulatory Pavilion is necessary if we are to maintain strong, healthy communities well into the future, and I ask that you approve the Certificate of Need for this project.

Sincerely,

Christine Radogno

Christine Radogno
State Senator, 41st District
Illinois Senate Republican Leader

STATE CAPITOL
HOUSE POST OFFICE
SPRINGFIELD, ILLINOIS 62706

STATE OF ILLINOIS
97TH GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

KELLY BURKE
STATE REPRESENTATIVE
36TH DISTRICT

April 4, 2011

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

Dear Ms. Avery:

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

Construction of an Ambulatory Pavilion will improve patient access to outpatient services on Christ Medical Center's main campus, allow the medical center to perform more ambulatory surgeries by adding 14 more operating rooms and position the medical center for meeting the area's future health care demands. Just as importantly, giving the medical center an opportunity to centralize its outpatient services in a new facility will free up space in the main hospital building, and that newly available space will enable the campus to improve patient throughput and expand some of its other clinical programs, including its undersized emergency department and its Level I trauma center – the only Level I trauma center serving the Southland and the South Side of Chicago.

I applaud Advocate Christ Medical Center and Hope Children's Hospital for developing a master facility plan that calls for a state-of-the-art outpatient center. This project demonstrates the medical center's foresight in preparing for the future. I urge members of the Illinois Health Facilities and Services Review Board to approve the institution's Certificate of Need request for an Ambulatory Pavilion.

Sincerely,

Kelly Burke

Kelly Burke
State Representative – 36th District

COMMITTEES:

HIGHER EDUCATION, CHAIR
APPROPRIATIONS II
CONSUMER PROTECTION
LABOR
REDISTRICTING

ILLINOIS STATE SENATE
EDWARD D. MALONEY
STATE SENATOR - 18TH DISTRICT

CAPITOL OFFICE:

ROOM 113A, STATE CAPITOL
SPRINGFIELD, ILLINOIS 62706
PHONE: 217/782-5145
FAX: 217/557-3090

DISTRICT OFFICES:

10400 SOUTH WESTERN AVENUE
CHICAGO, ILLINOIS 60643
PHONE: 773/881-4100
FAX: 773/881-4243

6965 WEST 111TH STREET
WORTH, ILLINOIS 60482
PHONE: 708/448-3510
FAX: 708/448-3535

April 4, 2011

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

Dear Ms. Avery:

I am writing to urge you to approve Advocate Christ Medical Center's Certificate of Need application to construct an Ambulatory Pavilion on its Oak Lawn campus. The project is not only needed as a major enhancement of outpatient services in the region, it directly addresses this planning board's stated preference for having hospitals expand services at their current locations rather than looking at alternative sites and building brand-new complexes.

As a state senator, I am concerned that Illinois hospitals and other health institutions are prepared to meet the challenges posed by the new environment of health care reform. Emphasis continues to be placed on moving more health care delivery from the inpatient side to the outpatient arena, and the proposed Ambulatory Pavilion project is a significant response to this trend.

Just as importantly, construction of the Pavilion will ensure that tertiary-level outpatient care will be provided right on the medical center campus with all its resources. Complex outpatient procedures cannot be performed at off-site locations.

Advocate Christ Medical Center is the only tertiary/quaternary facility in the Southland. The residents in the district that I represent depend on the institution's services and on its continuing ability to offer top-flight care. A new outpatient facility will enable the medical center to centralize its ambulatory services in one location, and that, of course, means improved access to care, enhanced efficiency and a better overall patient and family experience.

Additionally, with some 5,500 associates and more than 1,000 physicians, the medical center is a major employer in the region. Allowing this institution to proceed with needed expansion not only helps guarantee the ongoing availability of necessary health care services, but serves to bolster the economic vitality of the region, including the creation of more jobs.

I believe the construction of the Ambulatory Pavilion is necessary to maintain strong, healthy communities well into the future, and I ask that you approve the Certificate of Need for this project.

Sincerely,

Edward D. Maloney

Edward D. Maloney
State Senator-18th District

Renée Kosel
State Representative • 81st District
Assistant Republican Leader

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

April 2011

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

Dear Ms. Avery:

I am submitting my letter in support of Advocate Christ Medical Center's Certificate of Need application to construct an Ambulatory Pavilion on its Oak Lawn campus. This project is not only needed as a major enhancement of outpatient services in the region, it directly addresses this planning board's stated preference for having hospitals expand services at their current locations rather than looking to alternative sites and building brand new complexes.

As Assistant House Republican Leader and Illinois State Representative of the 81st Legislative District, I am concerned about Illinois hospitals and other health institutions being prepared to meet the challenges posed by the new environment of health care reform. Emphasis continues to be placed on moving more health care delivery from the inpatient side to the outpatient arena, and the proposed Ambulatory Pavilion project is a significant response to this trend. Equally important is that the construction of the Pavilion will ensure that tertiary-level outpatient care will be provided right on the medical center campus with all its resources. Complex outpatient procedures cannot be performed at off-site locations.

Advocate Christ Medical Center is the only tertiary/quaternary facility in the Southland. The residents in my district depend on the institution's services and on its continuing ability to offer top-level care. A new outpatient facility will enable the medical center to centralize its ambulatory services in one location which means improved access to care, enhanced efficiency and a better overall patient/family experience.

Additionally, with some 5,500 associates and more than 1,000 physicians, the medical center is a major employer in the region. Allowing this institution to proceed with its needed expansion not only helps guarantee the ongoing availability of necessary health care services, but serves to bolster the economic vitality of the region, including the creation of more jobs.

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

Page Two

I believe the construction of an Ambulatory Pavilion is necessary if we are to maintain strong, health communities well into the future. I urge you to approve the Certificate of Need for this project which will greatly enhance outpatient services in the region.

Respectfully submitted,

Renée Kosel
Assistant House Republican Leader
Illinois State Representative – 81st District

Springfield Office: Stratton Office Building Springfield, Illinois 62706 217.782.0424 217.557.7249 fax
District Office: 19201 S. LaGrange Road, Suite 204B, Mokena, Illinois 60448 708.479.4200 708.479.7977 fax

Capitol Office:
125 State Capitol
Springfield, Illinois 62706
(217) 782-9595
(217) 558-6908 Fax

District Office:
5119 W. 159th St.
1st Floor East
Oak Forest, Illinois 60452
(708) 687-5600
(708) 687-5644 Fax

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

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

March 31, 2011

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

Dear Ms. Avery:

I am writing to urge you to approve Advocate Christ Medical Center's Certificate of Need application to construct an Ambulatory Pavilion on its Oak Lawn campus. The project is not only needed as a major enhancement of outpatient services in the region, it directly addresses this planning board's stated preference for having hospitals expand services at their current locations rather than looking to alternative sites and building brand-new complexes.

As a state senator, I am concerned that Illinois hospitals and other health institutions are prepared to meet the challenges posed by the new environment of health care reform. Emphasis continues to be placed on moving more health care delivery from the inpatient side to the outpatient arena, and the proposed Ambulatory Pavilion project is a significant response to this trend. Just as importantly, construction of the Pavilion will ensure the tertiary-level outpatient care will be provided right on the medical center campus with all its resources. Complex outpatient procedures cannot be performed at off-site locations.

Advocate Christ Medical Center is the only tertiary/quaternary facility in the Southland. The residents in the district that I represent depend on the institution's services and on its continuing ability to offer top-flight care. A new outpatient facility will enable the medical center to centralize its ambulatory services in one location, and that, of course, means improved access to care, enhanced efficiency and a better overall patient and family experience.

Additionally, with some 5,500 associates and more than 1,000 physicians, the medical center is a major employer in the region. Allowing this institution to proceed with needed expansion not only helps guarantee the ongoing availability of necessary health care services, but serves to bolster the economic vitality of the region, including the creation of more jobs.

I am confident that the construction of an Ambulatory Pavilion is necessary if we are to maintain strong, healthy communities well into the future, and I ask that you approve the Certificate of Need for this project.

If you have any questions please do not hesitate to contact me at anytime.

Sincerely,

Maggie Crotty

Maggie Crotty
State Senator – 19th District
Assistant Majority Leader

OAK LAWN POLICE DEPARTMENT

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

William Villanova
Chief of Police
SPSC 136th

Roger Pawlowski
Division Chief Administrative
SPSC 123rd

Michael Kaufmann
Division Chief Investigations
FBI/NA 212th

Michael Murray
Division Chief Patrol
SPSC 207th

April 5, 2011

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

Dear Ms. Avery:

I am writing in favor of Advocate Christ Medical Center's proposal to construct an Ambulatory Pavilion. My understanding is that the project, if approved, will free up space in the campus main hospital building, allowing for the hospitals necessary expansion of a number of other clinical programs, including emergency services.

As Police Chief of Oak Lawn, I am acutely aware of the critical role Christ Medical Center plays as a POD hospital (disaster-coordinating hospital in region 7 of Illinois emergency medical services program and as a Level 1 trauma center. The medical center needs more space, and one way of achieving that is by allowing the campus to construct new facilities on its landlocked site. Construction of an Ambulatory Pavilion will help decompress the hospitals emergency department. We depend on Christ Medical Center to continue providing lifesaving medical and surgical care to the residents of our communities, and completion of an Ambulatory Pavilion will help support such a mission.

I respectfully ask that the planning board say "yes" to the medical center's Certificate of Need for a new outpatient facility.

Sincerely

William Villanova
Chief of Police
Oak Lawn Police Department

City of Hickory Hills Police Department
8800 West 87th Street • Hickory Hills, Illinois 60457

Alan T. Vodicka
Chief of Police

Phone
(708) 598-4900

March 31, 2011

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

Dear Ms. Avery:

I am writing this letter in support of Advocate Christ Medical Center's proposal to construct an Ambulatory Pavilion. It is my understanding that this facility, if constructed, will enhance the effectiveness and efficiency of the services offered by Christ Medical Center including clinical programs and emergency services.

As the Police Chief for the City of Hickory Hills with over thirty five years of service as a police officer, I truly appreciate the role that Christ Medical Center plays as a POD hospital in region 7 of Illinois' emergency medical services program and as a Level I trauma center. I firmly believe that construction of an Ambulatory Pavilion will help to alleviate the extensive overcrowding of the hospital's emergency department. As an administrator of an agency devoted to first response, we depend on Christ Medical Center to continue providing lifesaving medical and surgical care to the residents of our community, and the addition of an Ambulatory Pavilion will help support such a mission.

Therefore, I strongly recommend approval of this project.

Sincerely,

Alan Vodicka

Chief of Police

POLICE DEPARTMENT
Village of Evergreen Park
COOK COUNTY, ILLINOIS 60805

178th

MICHAEL D. SAUNDERS
Chief of Police

9420 South Kedzie Avenue
Evergreen Park, Illinois 60805-2385
Telephone 708-422-2142
Fax 708-422-1568

April 1, 2011

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

Dear Ms. Avery:

I am writing in favor of Advocate Christ Medical Center's proposal to construct an Ambulatory Pavilion. My understanding is that the project, if approved, will free up space in the campus' main hospital building, allowing for the hospital's necessary expansion of a number of other clinical programs, including emergency services.

As Police Chief of Evergreen Park, I am acutely aware of the critical role that Christ Medical Center plays as a POD hospital (disaster-coordinating hospital) in region 7 of Illinois' emergency medical services program and as a Level I trauma center. The medical center needs more space, and one way of achieving that is by allowing the campus to construct new facilities on its landlocked site. Construction of an Ambulatory Pavilion will help decompress the hospital's emergency department. We depend on Christ Medical Center to continue providing lifesaving medical and surgical care to the residents of our communities, and completion of an Ambulatory Pavilion will help support such mission.

I respectfully ask the planning board to say "yes" to the medical center's Certificate of Need for a new outpatient facility.

Sincerely,

Michael D. Saunders
Chief of Police

Chicago Ridge Fire Department
E.M.S. Coordinator Chris Schmelzer
10063 Virginia Ave
Chicago Ridge, IL 60415
(708)857-4455 Fax (708)857-4463

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

April 5, 2011

Dear Ms. Avery:

I am writing in favor of Advocate Christ Medical Center's proposal to construct an Ambulatory Pavilion. My understanding is that the project, if approved, will free up much needed space in the campus' main hospital building, allowing for the hospital's necessary expansion of a number of other clinical programs, including emergency services.

As EMS Coordinator for the Chicago Ridge Fire Department, I am acutely aware of the critical role that Christ Medical Center plays as a POD hospital (disaster-coordinating hospital) in region 7 of Illinois' emergency medical services program and as a Level I trauma center. The medical center is in dire need of more space, and one way of achieving that is by allowing the campus to construct new facilities on its landlocked site.

In my 16 years with the Chicago Ridge Fire Department, I have seen a tremendous increase in patient load for both prehospital EMS as well as the Emergency Department at Christ. There was a time when placing a patient on a cart in the hallway or the hospital going on bypass were rare occurrences. It has become common practice now, however. At a time when more people are in legitimate need of our services, it seems wrong of us to lower the standard of care. Construction of an Ambulatory Pavilion will help decompress the hospital's emergency department. We depend on Christ Medical Center to continue providing lifesaving medical and surgical care to the residents of our communities, and completion of an Ambulatory Pavilion will help support such mission.

I respectfully ask the planning board to say "yes" to the medical center's Certificate of Need for a new outpatient facility.

Very Truly Yours,

Chris Schmelzer
EMS Coordinator
Chicago Ridge Fire Department

VILLAGE OF CHICAGO RIDGE

POLICE DEPARTMENT
10426 S. RIDGELAND AVENUE
CHICAGO RIDGE, ILLINOIS 60415

CHIEF ROBERT D. PYZNARSKI

EMERGENCY 911
NON-EMERGENCY
708-425-7831

FAX
708-857-4460

April 4, 2011

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

Dear Ms. Avery:

I am writing this letter to express my support of Advocate Christ Medical Center's proposal to construct an Ambulatory Pavilion on the campus at the Northeast corner of 95th Street and Kilbourn Avenue. I respectfully ask the planning board to approve the medical center's Certificate of Need, for a new outpatient facility.

I am aware of Christ Medical Center's designation as a Level I Trauma Center and, as a police chief; I recognize the importance of having immediate access to these advanced emergency medical services. It is my understanding that currently, outpatient services at Christ Hospital are spread throughout the campus and this new facility would allow for the expansion of a number of other clinical programs, including an expansion of the hospital's emergency department.

Our community greatly depends on Christ Medical Center to continue providing lifesaving medical and surgical care. I believe the addition of an Ambulatory Pavilion will help support such mission.

Sincerely,

Robert D. Pyznarski
Chief of Police

RP/cm

VILLAGE OF CHICAGO RIDGE

10455 S. RIDGELAND AVE. • CHICAGO RIDGE, ILLINOIS 60415 • (708) 425-7700

EUGENE L. SIEGEL
PRESIDENT
CHARLES E. TOKAR
VILLAGE CLERK / COLLECTOR

TRUSTEES:
JUANITA A. BABCOCK
DANIEL A. BADON
MICHAEL R. DAVIES
BRAD C. GROVE
BRUCE D. QUINTOS
JAMES S. SALINOS

April 1, 2011

Courtney R. Avery, Administrator
ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
525 West Jefferson Street, Second Floor
Springfield, IL 62761

Dear Ms. Avery:

As Mayor of the Village of Chicago Ridge, I fully support Advocate Christ Medical Center's application to construct an ambulatory facility on its campus. Elected officials in this community and my entire administrative team are acutely aware that the medical center has reached critical capacity and requires room to grow. Failure to do so will have a negative impact on the institution's ability to continue delivering the highest quality care and providing richness of services to the residents of my community. The proposed facility will centralize outpatient programs in one location, provide needed additional space for ambulatory surgeries and allow room for growth of the institution's very significant cancer, heart and vascular and neurosciences institutes.

Particularly important is Christ Medical Center's economic role in the Southland. A recent report, issued by the Metropolitan Chicago Healthcare Council, indicated that the medical center generates $697,358,000 in community economic activity as the dollars earned by medical center associates are spent on groceries, clothing, mortgage payments, rent and other expenses. The medical center also supports the economy through the purchase of goods and services and capital spending. This level of activity, according to the report, has resulted in the creation of literally thousands of new jobs in the region.

Approval of the proposed ambulatory pavilion by the Illinois Health Facilities and Services Review Board will allow Christ Medical Center to take the first major step in launching a very much needed expansion of facilities and services on its own campus here in the Southland. This expansion will help maintain the strength and vitality of the institution, which is such an integral part of our community. A recent space and service assessment by national, independent consultant, Sg2, demonstrated that the medical center is significantly undersized for the number of patients it serves annually and the breadth of programs it provides to the community.

I urge the planning board to approve the construction of an ambulatory pavilion at Advocate Christ Medical Center. The project is critical to the future of the medical center, the health care needs of patients in the region and the ongoing economic growth of the south and southwest suburbs of Chicago.

Sincerely yours,

Eugene L. Siegel
Mayor

PRECISE AMBULANCE SERVICE

9982 Andersen Avenue, Suite E
Chicago Ridge, Illinois 60415
708.857.9100
Fax 708.857.9200

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

Dear Ms. Avery:

I am writing in favor of Advocate Christ Medical Center's proposal to construct an Ambulatory Pavilion. My understanding is that the project, if approved, will free up space on the campus' main hospital building, allowing for the hospital's necessary expansion of a number of other clinical programs, including emergency services.

As EMS Coordinator in Chicago Ridge Precise Ambulance, Christ is our Medical control hospital and therefore I am acutely aware of the critical role Christ Medical Center plays as a POD hospital in region VII of Illinois' emergency medical services program and as a Level 1 trauma center. I am also aware of the need for more space, as a private service Christ is not only visited by myself and other crew members on an emergency basis. The ambulance service also provides transport to outpatient facilities which includes Christ Medical Center. I have firsthand experience of the task of finding the correct department and the task of getting from one side if the facility to the other with a patient for an appointment. This is not just a challenge to the crew but an inconvenience to the patient and their family members. The family members have a very difficult time finding their family member again after they have found parking, and patient s are waiting for their family members to register them so they can proceed with their appointment. The emergency room seems to always be full and more space would impact the community positively.

The medical center needs more space, and one way to achieve that would be to allow the campus to construct new facilities. Construction of an Ambulatory Pavilion will help decompress the hospitals' emergency department and better organize their outpatient services. The community depends on Christ Medical Center to continue providing lifesaving medical and surgical care, and the completion of an Ambulatory Pavilion will help support such a mission.

I respectfully ask the planning board to say "yes" to the medical center's Certificate of Need for a new outpatient facility.

Sincerely

Kristen Sisk

Kristen Sisk
Precise Ambulance Coordinator

City of Burbank
Fire Department

6530 W. 79th Street Burbank, Illinois 60459-1198
(708) 599-7766 Fax (708) 599-9764

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

Dear Ms. Avery:

I beg a little of your time to read this letter and find favor for the proposed Ambulatory Pavillion currently under consideration At Christ Hospital and Medical Center in Oak Lawn.

I have been the EMS Coordinator for Burbank Fire Department for 21 years. I've seen the ever building traffic jam of patient care over the past 6 years. Christ Hospital is on 'Bypass' almost 10 percent of any given day. Obviously the Center is need of more space to facilitate an aging baby boom generation that is to sure decimate the delivery of health care for the next century.

Compounding this is Christ Hospital and Medical Centers POD Hospital responsibilities for any major disaster and/or level one trauma services.

Please, please vote yes on these proposal. Surely surely it will loosened the noose a bit of future health care needs and demands of the public

Sincerely,
Jim Reed, EMS Coordinator

VILLAGE OF BRIDGEVIEW

BRIDGEVIEW FIRE DEPARTMENT

7600 SOUTH OKETO AVENUE
BRIDGEVIEW, ILLINOIS 60455
708-924-8250 • FAX: 708-924-8056

VILLAGE PRESIDENT
STEVEN M. LANDEK

CLERK
JOHN C. ALTAR

TRUSTEES
JAMES A. CECOTT
PATRICIA A. HIGGINSON
NORMA J. PINION
MICHAEL J. PTICEK
CLAUDETTE STRUZIK
MARY M. SUTTON

FIRE CHIEF
TIM LANDINGHAM

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

Dear Ms. Avery:

I am writing in favor of Advocate Christ Medical Center's proposal to construct an Ambulatory Pavilion. My understanding is that the project, if approved, will free up space in the campus' main hospital building, allowing for the hospital's necessary expansion of a number of other clinical programs, including emergency services.

As EMS Coordinator in Bridgeview, I am acutely aware of the critical role that Christ Medical Center plays as a POD hospital (disaster-coordinating hospital) in region 7 of Illinois' emergency medical services program and as a Level I trauma center. The medical center needs more space, and one way of achieving that is by allowing the campus to construct new facilities on its landlocked site. Construction of an Ambulatory Pavilion will help decompress the hospital's emergency department. We depend on Christ Medical Center to continue providing lifesaving medical and surgical care to the residents of our communities, and completion of an Ambulatory Pavilion will help support such mission.

I respectfully ask the planning board to say "yes" to the medical center's Certificate of Need for a new outpatient facility.

Sincerely

A WELL BALANCED COMMUNITY

VILLAGE OF BRIDGEVIEW
BRIDGEVIEW FIRE DEPARTMENT

7500 SOUTH OKETO AVENUE
BRIDGEVIEW, ILLINOIS 60455
708-924-8250 • FAX: 708-924-8056

VILLAGE PRESIDENT
STEVEN M. LANDEK

CLERK
JOHN C. ALTAR

TRUSTEES
JAMES A. CECOTT
PATRICIA A. HOGINSON
NORMA J. PINION
MICHAEL J. PTICEK
CLAUDETTE STRUZIK
MARY M. SUTTON

FIRE CHIEF
TIM LANDINGHAM

April 4, 2011

Mike Maggio
Manager
Office of Public Affairs and Marketing
Advocate Christ Medical Center
4440 W. 95th Street
Oak Lawn, IL 60453

Dear Mr. Maggio,

I'm addressing this letter to you to express my approval for the proposed construction of a new Ambulatory Pavilion, for Advocate Christ Medical Center. If approved, I understand that this will help free up needed space within the campus of the main hospital building, allowing for the expansion of necessary clinical programs, including emergency services.

Being the Fire Chief of the Bridgeview Fire Department, and a paramedic within the system for over 30 years, I'm very well aware of the vital role Christ Hospital Medical Center plays in the region 7 of Illinois, emergency medical services program and as a Level I trauma center.

Construction of a new facility I feel will only improve the quality of medical care at Christ Medical Center. The Bridgeview Fire Department depends on Christ Medical Center, to continue to provide lifesaving medical care to our residents, and the completion of a new Ambulatory Pavilion will continue to support that mission.

I'm respectfully asking the planning review board to approve the medical center's "Certificate of Need" for a new outpatient facility.

Sincerely,

Timothy Landingham
Chief
Bridgeview Fire Department

A WELL BALANCED COMMUNITY

Alsip Fire Department
12600 South Pulaski Avenue
Alsip, Illinois 60803

Station 1: (708) 385-6902 x233
Fax: (708) 371-6019

Station 2: (708) 396-6902 x234
Fax: (708) 489-9476

Charles Geraci
Chief x235

Thomas Styczynski
Deputy Chief x236

Kevin Picker
Deputy Chief x237

April 6, 2011

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

Dear Ms. Avery:

I am writing in favor of Advocate Christ Medical Center's proposal to construct an Ambulatory Pavilion. My understanding is that the project, if approved, will free up space in the campus' main hospital building, allowing for the hospital's necessary expansion of a number of other clinical programs, including emergency services.

As EMS Coordinator in Alsip, I am acutely aware of the critical role that Christ Medical Center plays as a POD hospital (disaster-coordinating hospital) in region 7 of Illinois' emergency medical services program and as a Level I trauma center. The medical center needs more space, and one way of achieving that is by allowing the campus to construct new facilities on its landlocked site. Construction of an Ambulatory Pavilion will help decompress the hospital's emergency department. We depend on Christ Medical Center to continue providing lifesaving medical and surgical care to the residents of our communities, and completion of an Ambulatory Pavilion will help support such mission.

I respectfully ask the planning board to say 'yes' to the medical center's Certificate of Need for a new outpatient facility.

Sincerely,

Timothy Grutzius
EMS Coordinator

Village of Palos Park

"Service to Our Residents and Dedication to the Preservation of Palos Park"

April 5, 2011

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

Dear Ms. Avery:

I have learned that approval of the Illinois Health Facilities and Services Review Board is needed before Advocate Christ Medical Center can proceed with plans to build a new Ambulatory Pavilion where outpatient services can be centralized and provided room for growth.

Christ Medical Center serves as a major tertiary and quaternary care institution currently operating in constricted spaces within 30-, 40- and 50-year-old facilities. Did you know, for example, that the medical center has one of the busiest emergency departments in the state-86,000 emergency visits annually-and a nationally known Level I trauma center, which provides lifesaving treatment for the entire Southland in a space designed for approximately half those visits?

My understanding is that the Ambulatory Pavilion serves, in essence, as a key component in the medical center's planned growth for the next five to 10 years. By centralizing all its outpatient care in one new facility, the medical center will free up space in its main hospital building for later expansion of other clinical services, including emergency care. The medical center also plans to add another sorely needed commodity as part of its campus expansion plans-parking. The present lack of convenient parking on campus during busy periods of the day often results in a frustrating experience for patients, families and visitors who depend on the medical center's health services, but must first circle the lots searching for a difficult-to-find, open parking space before accessing the necessary health care.

According to past reports and news articles, the Illinois Health Facilities and Services Review Board has indicated a preference for having hospitals grow at their current locations rather than look to alternative sites for construction of brand-new complexes. Advocate Christ Medical Center's proposal to build an ambulatory facility on its campus rather than relocate outpatient service speaks directly to the planning board's preference.

For these reasons, I encourage the state planning board to favorably review and approve the construction of an Ambulatory Pavilion at Advocate Christ medical Center in Oak Lawn.

Sincerely,

Carol A. Bryson

Carol A. Bryson, Palos Park Village Clerk

8999 West 123rd Street, Palos Park, IL 60464 / (708) 448-2700 FAX: (708) 448-9542
www.palospark.org info@palospark.org

Department of Police

City of Palos Hills

6565 WEST 103rd STREET ☆ PALOS HILLS, ILLINOIS 60465
TELEPHONE: (708) 598-2882

PAUL J. MADIGAN
Chief of Police

JEFFREY J. CUCIO
Deputy Chief of Police

JAMES G. ROTE
Deputy Chief of Police

5 April 2011

Mike Maggio
Office of Public Affairs and Marketing
Advocate Christ Medical Center
4440 W. 95th Street
Oak Lawn, IL 60453

Mr. Maggio,

I am writing this letter to support the Certificate of Need that would allow the construction of an Ambulatory Pavilion at Advocate Christ Medical Center in Oak Lawn, Illinois.

I am Chief Paul J. Madigan and have been the Chief of Police in the City of Palos Hills for the last 18 years. Advocate Christ Medical Center has been a valuable asset to our community and serves as a very great resource for any medical needs that the Palos Hills Police Department has needed.

From a police standpoint, crimes happen to people of all ages. If medical care is needed, it should be rendered by a hospital that is well equipped and prepared to provide the best care possible. Advocate Christ Medical Center is where 83,000 patients go per year but it was designed to treat half of that number. I, on behalf of the Palos Hills Police Department, respectfully request that this large number of patients be afforded the opportunity to be given the best health care that each of them deserves.

Sincerely,

Paul J. Madigan
Chief of Police

Palos Heights Police Department

7607 West College Drive Palos Heights, Illinois 60463

George L. Yott Jr.
Chief of Police

Admin. (708) 448-5060
Fax: (708) 361-9371

April 5, 2011

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

Dear Ms. Avery,

I am writing in support of Advocate Christ Medical Center's proposal to construct an Ambulatory Pavilion. My understanding of the project is that it will free much needed space in the main hospital building allowing for the expansion of a number of clinical programs, particularly emergency services.

Christ Medical Center plays a critical role as a disaster coordinating hospital in region 7 of Illinois' emergency medical services program and as a level 1 trauma center. Allowing the construction of new facilities will allow for expansion of the hospital's emergency department. The residents of our community depend on Christ Medical Center to provide lifesaving medical and surgical care.

I respectfully ask that the planning board approve the medical center's Certificate of Need for a new outpatient facility.

Sincerely,

George L. Yott Jr.
Chief of Police

ORLAND FIRE PROTECTION DISTRICT

Administration Center

9790 West 151st Street · Orland Park, IL 60462

708/349-0074 · Fax 708/349-0354

www.orlandfire.org

ISO Class 2

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President Patrick Maher
Secretary Salvatore "Sal" Giordano
Treasurer Martin McGill
Trustee Glenn Micheletti
Trustee James Hickey

March 31, 2011

Mr. Mike Maggio
Office of Public Affairs and Marketing
Advocate Christ Medical Center
4440 West 95th Street
Oak Lawn, Illinois 60453

Dear Mr. Maggio:

I am writing in favor of Advocate Christ Medical Center's proposal to construct an Ambulatory Pavilion. My understanding is that the project, if approved, will free up space in the campus' main hospital building, allowing for the hospital's necessary expansion of a number of other clinical programs, including emergency services.

As EMS Administrator of the Orland Fire Protection District, I am acutely aware of the critical role that Christ Medical Center plays as a POD hospital (disaster-coordinating hospital) in region 7 of Illinois' emergency medical services program and as a Level I trauma center. The medical center needs more space, and one way of achieving that is by allowing the campus to construct new facilities on its landlocked site. Construction of an Ambulatory Pavilion will help decompress the hospital's emergency department. We depend on Christ Medical Center to continue providing lifesaving medical and surgical care to the residents of our communities, and completion of an Ambulatory Pavilion will help support such mission.

I respectfully ask the planning board to say "yes" to the medical center's Certificate of Need for a new outpatient facility.

Sincerely,

Mark Duke
EMS Administrator
Orland Fire Protection District

MD:pmt

ORLAND FIRE PROTECTION DISTRICT

Administration Center

9790 West 151st Street · Orland Park, IL 60462

708/349-0071 · Fax 708/349-0354

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ISO Class 2

Board of Trustees
President Patrick Meler
Secretary Salvatore "Bill" Cocciro
Treasurer Martin McGill
Trustee Glenn Michalek
Trustee James Hicker

March 31, 2011

Mr. Mike Maggio
Office of Public Affairs and Marketing
Advocate Christ Medical Center
4440 West 95th Street
Oak Lawn, Illinois 60453

Dear Mr. Maggio:

I am writing in favor of Advocate Christ Medical Center's proposal to construct an Ambulatory Pavilion. My understanding is that the project, if approved, will free up space in the campus' main hospital building, allowing for the hospital's necessary expansion of a number of other clinical programs, including emergency services.

As Fire Chief of the Orland Fire Protection District, I am acutely aware of the critical role that Christ Medical Center plays as a POD hospital (disaster-coordinating hospital) in region 7 of Illinois' emergency medical services program and as a Level I trauma center. The medical center needs more space, and one way of achieving that is by allowing the campus to construct new facilities on its landlocked site. Construction of an Ambulatory Pavilion will help decompress the hospital's emergency department. We depend on Christ Medical Center to continue providing lifesaving medical and surgical care to the residents of our communities, and completion of an Ambulatory Pavilion will help support such mission.

I respectfully ask the planning board to say "yes" to the medical center's Certificate of Need for a new outpatient facility.

Sincerely,

Fire Chief Bryant Krizik
Orland Fire Protection District

BJK/pll

MAYOR
Daniel J. McLaughlin

VILLAGE CLERK
David P. Maher

15100 S. Ravinia Ave.
Orland Park, IL 60462
(708) 349-4111

TRUSTEES
Bernard A. Murphy
Kathleen M. Fenton
Brad S. O'Halloran
James V. Dodge
Edward G. Schussler III
Patricia Gira

DEPARTMENT OF POLICE
Timothy J. McCarthy
CHIEF OF POLICE

March 31, 2011

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

Dear Ms. Avery:

I am writing in favor of Advocate Christ Medical Center's proposal to construct an Ambulatory Pavilion. My understanding is that the project, if approved, will free up space in the campus' main hospital building, allowing for the hospital's necessary expansion of a number of other clinical programs, including emergency services.

As Chief of Police in Orland Park, I am acutely aware of the critical role that Christ Medical Center plays as a POD hospital (disaster-coordinating hospital) in region 7 of Illinois' emergency medical services program and as a Level 1 trauma center. The medical center needs more space, and one way of achieving that is by allowing the campus to construct new facilities ion its landlocked site. Construction of an ambulatory Pavilion will help decompress the hospital's emergency department. We depend on Christ Medical Center to continue providing lifesaving medical and surgical care to the residents of our communities, and completion of an Ambulatory Pavilion will help support such mission.

I respectfully ask the planning board to say 'yes' to the medical center's Certificate of Need for a new outpatient facility.

Sincerely,

Timothy J. McCarthy
Chief of Police
Orland Park Police Department

THE VILLAGE OF
OAK LAWN

OAK LAWN FIRE / RESCUE
6451 WEST 93RD PLACE, OAK LAWN, ILLINOIS 60453

CHIEF GEORGE SHEETS | TELEPHONE: (708) 499-7700 | FACSIMILE: (708) 598-3092
DEPUTY FIRE CHIEF ROBERT TUTKO | TELEPHONE: (708) 499-7705

April, 8th, 2011

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

Dear Ms. Avery,

I am writing in support of Advocate Christ Medical Center's proposal to construct an Ambulatory Pavilion. My understanding is if the project is approved, it will free up much needed space in the campus' main hospital building. This will allow for necessary expansion of a number of other programs, including emergency services.

As EMS Bureau Chief of the Oak Lawn Fire Department, I am acutely aware of the critical role that Advocate Christ Medical Center plays as a POD hospital (disaster-coordinating hospital) in Region VII of Illinois' emergency medical services program and as a Level 1 Trauma Center. There is no doubt the medical center needs more space, and one way to achieve this would be by allowing the construction of new facilities on their site. Construction of an Ambulatory Pavilion will help decompress the hospital's emergency department. We depend on Christ Medical Center to continue providing lifesaving medical and surgical care to the residents of our communities, and completion of an Ambulatory Pavilion will help support this worthy mission.

I respectfully ask the planning board to say "yes" to the medical center's Certificate of Need for a new outpatient facility.

Sincerely,

Christine Tregoning
Bureau Chief-EMS
708-499-7703

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must equal.

PROJECT COSTS AND SOURCES OF FUNDS			
USE OF FUNDS	CLINICAL	NON CLINICAL	TOTAL
Preplanning Costs	$ 862,500	$ 862,500	$ 1,725,000
Site Survey and Soil Investigation	$ 61,500	$ 61,500	$ 123,000
Site Preparation	$ 640,000	$ 640,000	$ 1,280,000
Off Site Work	$ 2,200,150	$ 2,200,150	$ 4,400,300
New Construction Contracts	$ 57,513,723	$ 44,301,102	$ 101,814,825
Modernization Contracts	$ -	$ 195,211	$ 195,211
Contingencies	$ 5,381,600	$ 4,228,400	$ 9,610,000
Architectural/Engineering Fees	$ 2,873,360	$ 2,257,640	$ 5,131,000
Consulting and Other Fees	$ 2,673,048	$ 2,100,252	$ 4,773,300
Movable or Other Equipment (not in construction contracts)	$ 48,000,000	$ 980,000	$ 48,980,000
Bond Issuance Expense (project related)	$ 1,184,600	$ 507,686	$ 1,692,285
Net Interest Expense During Construction (project related)	$ 7,892,946	$ 3,382,691	$ 11,275,637
Fair Market Value of Leased Space or Equipment	$ -	$ -	$ -
Other Costs To Be Capitalized	$ 6,328,560	$ 4,972,440	$ 11,301,000
Acquisition of Building or Other Property (excluding land)	$ -	$ -	$ -
TOTAL USES OF FUNDS	$ 135,611,986	$ 66,689,572	$ 202,301,558
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities			$ 66,918,722
Pledges			$ -
Gifts and Bequests			$ -
Bond Issues (project related)			$ 135,382,836
Mortgages			$ -
Leases (fair market value)			$ -
Governmental Appropriations			$ -
Grants			$ -
Other Funds and Sources			$ -
TOTAL SOURCES OF FUNDS			$ 202,301,558

NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Related Project Costs

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

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

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

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

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

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:

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

Anticipated project completion date (refer to Part 1130.140): December 31, 2014

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

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

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

State Agency Submittals

Are the following submittals up to date as applicable:
☒ Cancer Registry
☒ APORS
☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
☒ All reports regarding outstanding permits
Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements

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

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

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

Facility Bed Capacity and Utilization

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

FACILITY NAME: Advocate Christ Medical Center		CITY: Oak Lawn, IL			
REPORTING PERIOD DATES:		From: 1/1/2009		to: 12/31/09	
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	378	24,287	121,562		378
Obstetrics	39	4,521	11,853		39
Pediatrics	45	3,832	14,332		45
Intensive Care	103	4,817	33,660		103
Comprehensive Physical Rehabilitation	37	857	12,096		37
Acute/Chronic Mental Illness	56	1,642	10,287		56
Neonatal Intensive Care	37	644	13,034		37
General Long Term Care	0				0
Specialized Long Term Care	0				0
Long Term Acute Care	0				0
Dedicated Observation	*15*		*1,556*		
TOTALS:	695	40,600	218,380		695

In May 2009, a Central Decision Unit was added with 15 dedicated observation beds, accounting for 1,556 observation days.
Source: Annual Hospital Questionnaire

Advocate Hope Children's Hospital is an extension of Advocate Christ Medical Center. They operate under one license and submit one annual hospital questionnaire. The bed capacity and utilization report above reflects their combined admissions and patient days.

Facility Bed Capacity and Utilization

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

FACILITY NAME: Advocate Christ Medical Center	**CITY: Oak Lawn, IL**				
REPORTING PERIOD DATES:	**From: 1/1/2010**		**to: 12/31/10**		
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	378	24,570	120,250		378
Obstetrics	39	4,512	11,790		39
Pediatrics	45	3,473	13,187		45
Intensive Care	103	4,978	33,929		103
Comprehensive Physical Rehabilitation	37	904	12,402		37
Acute/Chronic Mental Illness	51*	1,633	9,450		51
Neonatal Intensive Care	37	634	11,037		37
General Long Term Care	0				
Specialized Long Term Care	0				
Long Term Acute Care	0				
Dedicated Observation	*15*		*2,045*		
TOTALS:	690	40,704	214,090		690

Source: Annual Hospital Questionnaire as submitted.
**In October 2010, the Illinois Health Facilities and Services Review Board reduced five beds from Advocate Christ Medical Center's Acute Mental Illness bed inventory.*
Source: Illinois Health Facilities Services Review Board, Update to Inventory of Hospital Services, March 19, 2008 – March 18, 211.

Advocate Hope Children's Hospital is an extension of Advocate Christ Medical Center. They operate under one license and submit one annual hospital questionnaire. The bed capacity and utilization report above reflects their combined admissions and patient days.

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 manger or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

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

SIGNATURE

Kenneth Lukhard
PRINTED NAME

President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 11 day of May

Signature of Notary

Seal

DAWN M GETZLOFF
NOTARY PUBLIC
OFFICIAL SEAL
STATE OF ILLINOIS
MY COMMISSION EXPIRES
DECEMBER 30, 2013

SIGNATURE

William Santulli
PRINTED NAME

Executive Vice President / COO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 10th day of May

Signature of Notary

Seal

"OFFICIAL SEAL"
MAUREEN F. EBERLIN
Notary Public, State of Illinois
My Commission Expires May 25, 2011

*Insert EXACT legal name of the applicant

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 manger or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

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

SIGNATURE

James H. Skogsbergh
PRINTED NAME

President and CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 11th day of May

Maureen F. Eberlin
Signature of Notary

Seal

"OFFICIAL SEAL"
MAUREEN F. EBERLIN
Notary Public, State of Illinois
My Commission Expires May 25, 2011

SIGNATURE

William Santulli
PRINTED NAME

Executive Vice President / COO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 10th day of May

Maureen F. Eberlin
Signature of Notary

Seal

"OFFICIAL SEAL"
MAUREEN F. EBERLIN
Notary Public, State of Illinois
My Commission Expires May 25, 2011

*Insert EXACT legal name of the applicant

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

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

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

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT-11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]
4. Cite the sources of the information provided as documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate.**

For projects involving modernization, describe the conditions being upgraded if any. For facility projects, include statements of age and condition and regulatory citations if any. For equipment being replaced, include repair and maintenance records.

NOTE: Information regarding the "Purpose of the Project" will be included in the State Agency Report.

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

ALTERNATIVES

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

Alternative options **must** include:

A) Proposing a project of greater or lesser scope and cost;

B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;

C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and

D) Provide the reasons why the chosen alternative was selected.

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

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

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

SECTION IV - PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE

Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

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

2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following::

   a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;

   b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;

   c. The project involves the conversion of existing space that results in excess square footage.

Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?

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

PROJECT SERVICES UTILIZATION:

This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B. **A narrative of the rationale that supports the projections must be provided.**

A table must be provided in the following format with Attachment 15.

UTILIZATION					
	DEPT./ SERVICE	*Advocate Christ Medical Center, Oak Lawn received* AL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MET STANDARD?
YEAR 1					
YEAR 2					

APPEND DOCUMENTATION AS ATTACHMENT-15, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

UNFINISHED OR SHELL SPACE:

Provide the following information:

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

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

ASSURANCES:

Submit the following:

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

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

Criterion 1110.3030 - Clinical Service Areas Other than Categories of Service

1. Applicants proposing to establish, expand and/or modernize Clinical Service Areas Other than Categories of Service must submit the following information:
2. Indicate changes by Service: Indicate # of key room changes by action(s):

Service	# Existing Key Rooms	# Proposed Key Rooms
☐		
☐		
☐		

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

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

This section is not applicable. Advocate Health and Hospitals Corporation bonds have been rated by Standard and Poor's as AA, and Fitch AA, which qualifies the applicants for the waiver.

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

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

VIII. - 1120.120 - Availability of Funds

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

_____	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
_____	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate;3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions.
_____	e)	Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
_____	f)	Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
_____	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
		TOTAL FUNDS AVAILABLE

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

IX. 1120.130 - Financial Viability

This section is not applicable. Advocate Health and Hospitals Corporation bonds have been rated by Standard and Poor's as AA, and Fitch AA, which qualifies the applicants for the waiver.

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT-40, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

Provide Data for Projects Classified as:	Category A or Category B (last three years)			Category B (Projected)
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

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

2. Variance

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

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

X. 1120.140 - Economic Feasibility

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

A. Reasonableness of Financing Arrangements **This section is not applicable. Advocate Health and Hospitals Corporation bonds have been rated by Standard and Poor's as AA, and Fitch AA, which qualifies the applicants for the waiver.**

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

1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or

2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:

A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or

B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

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

1) That the selected form of debt financing for the project will be at the lowest net cost available;

2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;

3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. **Reasonableness of Project and Related Costs**

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	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

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

APPEND DOCUMENTATION AS ATTACHMENT -42, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XI. Safety Net Impact Statement

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

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.

2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

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

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaidpatients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

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

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

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

XII. Charity Care Information

Charity Care information MUST be furnished for ALL projects.

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three audited fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

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

A table in the following format must be provided for all facilities as part of Attachment 44.

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

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

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

INDEX OF ATTACHMENTS

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

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

Applicant /Co-Applicant Identification

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

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

Type of Ownership of Applicant/Co-Applicant

- ☒ Non-profit Corporation
- ☐ For-profit Corporation
- ☐ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
- ☐ Sole Proprietorship
- ☐ Other

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

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

See Attachment 1, Exhibit 1.

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

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

Applicant /Co-Applicant Identification

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

Exact Legal Name:	Advocate Health Care Network
Address:	2025 Windsor Drive, Oak Brook, IL 60423
Name of Registered Agent:	Gail D. Hasbrouck
Name of Chief Executive Officer:	James Skogsbergh
CEO Address:	2025 Windsor Drive, Oak Brook, IL 60423
Telephone Number:	(708) 990-5008

Type of Ownership of Applicant/Co-Applicant

- ☒ Non-profit Corporation
- ☐ For-profit Corporation
- ☐ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
- ☐ Sole Proprietorship
- ☐ Other

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

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

See Attachment 1, Exhibit 2.

File Number 1004-695-5

To all to whom these Presents Shall Come, Greeting:

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

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

Authentication #: 1015101522

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

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 10TH *day of* JUNE *A.D.* 2010 .

Jesse White

SECRETARY OF STATE

File Number 1707-692-2

To all to whom these Presents Shall Come, Greeting:

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

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

Authentication #: 1016101532

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

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 10TH *day of* JUNE *A.D.* 2010 .

Jesse White

SECRETARY OF STATE

Site Ownership

[Provide this information for each applicable site]

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

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

COMMITMENT FOR TITLE INSURANCE

Chicago Title Insurance Company

Providing Title Related Services Since 1847

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

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

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

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

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

Issued By:

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

Refer Inquiries To:

(630)871-3500

CHICAGO TITLE INSURANCE COMPANY

By

Authorized Signatory

Commitment No.: 1410 008284161 UL

COMMIT 4/00 fy JG3 07/01/05

CHICAGO TITLE INSURANCE COMPANY

COMMITMENT FOR TITLE INSURANCE

SCHEDULE A

YOUR REFERENCE: ADVOCATE CHRIST HOSPITAL MEDICAL CENTER ORDER NO.: 1410 00B284161 UL

EFFECTIVE DATE: APRIL 27, 2005

1. POLICY OR POLICIES TO BE ISSUED:

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

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

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

ADVOCATE HEALTH AND HOSPITALS CORPORATION

4. MORTGAGE OR TRUST DEED TO BE INSURED:

TO COME.

ILSCHED1
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CHICAGO TITLE INSURANCE COMPANY

COMMITMENT FOR TITLE INSURANCE

SCHEDULE A (CONTINUED)

ORDER NO.: 1410 008284161 UL

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

PARCEL ONE:

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

EXCEPT FROM ABOVE THE FOLLOWING DESCRIBED PROPERTY

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

BEGINNING AT THE POINT OF INTERSECTION OF A LINE DRAWN 40.00 FEET WEST OF AND PARALLEL WITH THE EAST LINE OF SAID SOUTHWEST 1/4 WITH A LINE DRAWN 50.00 FEET NORTH OF AND PARALLEL WITH THE SOUTH LINE OF SAID SOUTHWEST 1/4; THENCE WEST 222.03 FEET ALONG A LINE 50.00 FEET NORTH OF AND PARALLEL WITH THE SOUTH LINE OF SAID SOUTHWEST 1/4, BEING ALSO THE NORTH LINE OF WEST 95TH STREET IN ACCORDANCE WITH PLAT OF DEDICATION RECORDED MAY 27, 1958 AS DOCUMENT NO. 17219540; THENCE NORTH 177.05 FEET ALONG A LINE FORMING AN ANGLE OF 89 DEGREES 54 MINUTES 37 SECONDS AS MEASURED FROM EAST TO NORTH WITH SAID NORTH LINE OF WEST 95TH STREET; THENCE EAST 24.70 FEET PARALLEL WITH SAID NORTH LINE OF WEST 95TH STREET; THENCE NORTH 72.34 FEET PARALLEL WITH THE EAST LINE OF SAID SOUTHWEST 1/4; THENCE EAST 197.28 FEET PARALLEL WITH SAID NORTH LINE OF WEST 95TH STREET TO THE WEST LINE OF SOUTH KOSTNER AVENUE, BEING A LINE 40.00 FEET WEST OF THE EAST LINE OF SAID SOUTHWEST 1/4, IN ACCORDANCE WITH THE AFORESAID PLAT OF DEDICATION; THENCE SOUTH 249.39 FEET ALONG THE WEST LINE OF SOUTH KOSTNER AVENUE TO THE HEREINABOVE DESCRIBED POINT OF BEGINNING, ALL IN COOK COUNTY, ILLINOIS.

PARCEL TWO:

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

(EXCEPT THE SOUTH 375 FEET THEREOF;

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

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

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

PARCEL THREE:

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

PARCEL FOUR:

CHICAGO TITLE INSURANCE COMPANY

COMMITMENT FOR TITLE INSURANCE
SCHEDULE A (CONTINUED)

ORDER NO.: 1410 008284161 UL

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

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The remainder of this document is located in the Appendix 1.

Operating Identity/Licensee

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

Exact Legal Name:	Advocate Health and Hospitals Corporation d/b/a Advocate Christ Medical Center
Address:	4440 West 95th Street, Oak Lawn, IL 60453-2699

☒	Non-profit Corporation	☐	Partnership		
☐	For-profit Corporation	☐	Governmental		
☐	Limited Liability Company	☐	Sole Proprietorship	☐	Other

- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.
- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**

APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

File Number 1004-695-5

To all to whom these Presents Shall Come, Greeting:

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

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

Authentication # 1024600366

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

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 6TH *day of* SEPTEMBER *A.D.* 2010 .

Jesse White

SECRETARY OF STATE

File Number 1707-692-2

To all to whom these Presents Shall Come, Greeting:

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

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

Authentication #: 1015101632

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

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 10TH *day of* JUNE *A.D.* 2010

Jesse White

SECRETARY OF STATE

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Organizational Relationships

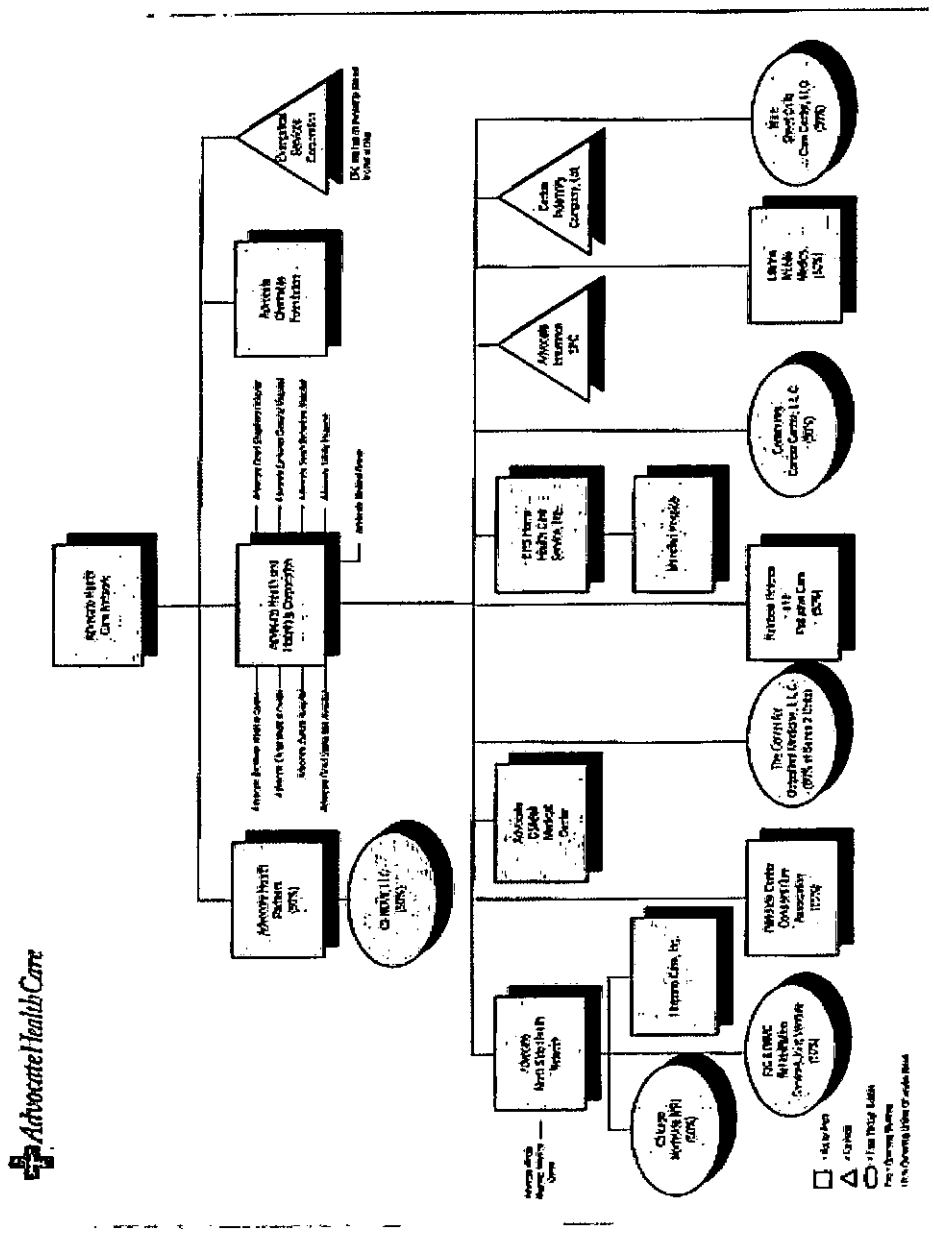
SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

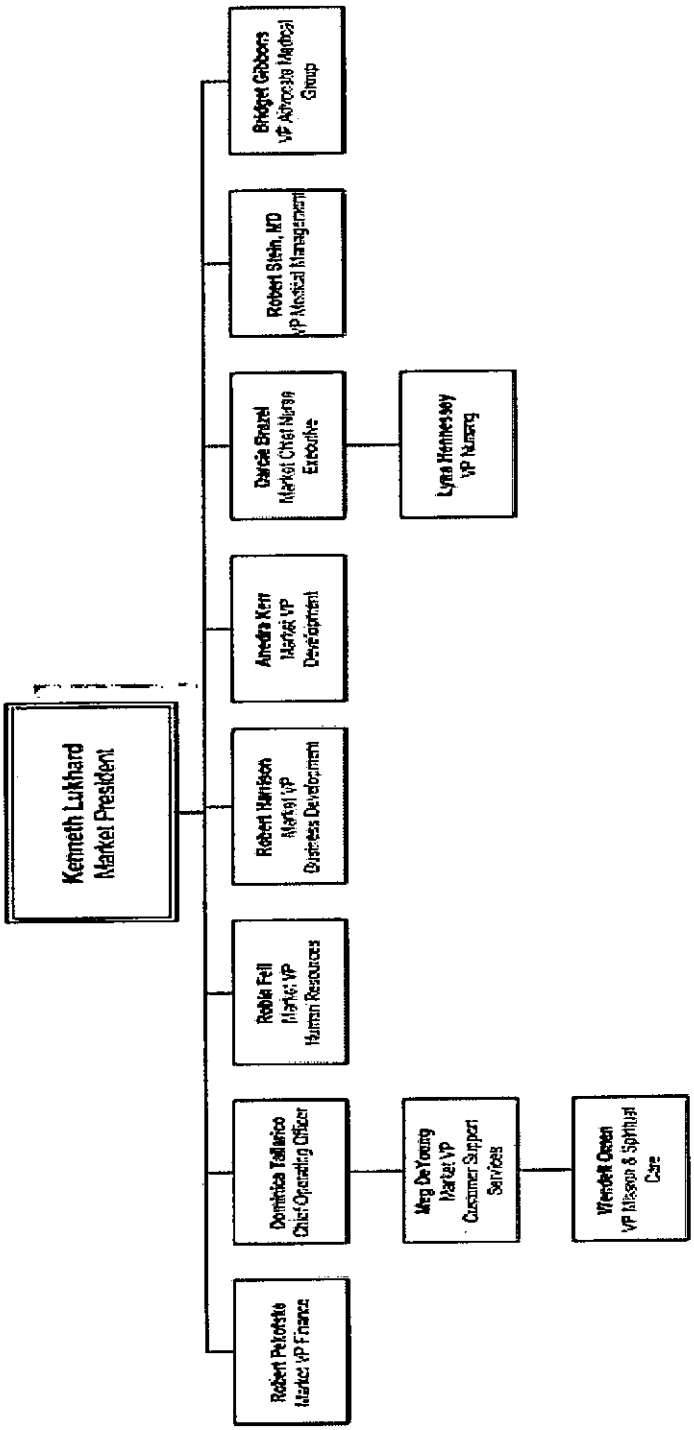
This Section must be completed for all projects

Organizational Relationships

Provide (for each co-applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.
APPEND DOCUMENTATION AS ATTACHMENT-4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Attachment 4, Exhibit 1, is an organization chart of Advocate Health Care and shows all of the relevant organizations including Advocate Health Care Network, Advocate Health and Hospitals Corporation and Advocate Christ Medical Center. Attachment 4, Exhibit 2, is an organization chart showing the leadership of Advocate Christ Medical Center.


Advocate HealthCare


Kenneth Lukhard
Market President
Bridget Gibbons
VP Advocate Medical Group
Robert Stein, MD
VP Medical Management
Darcie Brazel
Market Chief Nurse Executive
Lynn Hennessey
VP Nursing
Amelia Kerr
Market VP Development
Robert Harrison
Market VP Business Development
Robin Fell
Market VP Human Resources
Dominica Taliaferro
Chief Operating Officer
Meg DeYoung
Market VP Customer Support Services
Wendell Dixon
VP Mission & Spiritual Care
Robert Pekarske
Market VP Finance

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Flood Plain Requirements

[Refer to application instructions.]

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

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

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

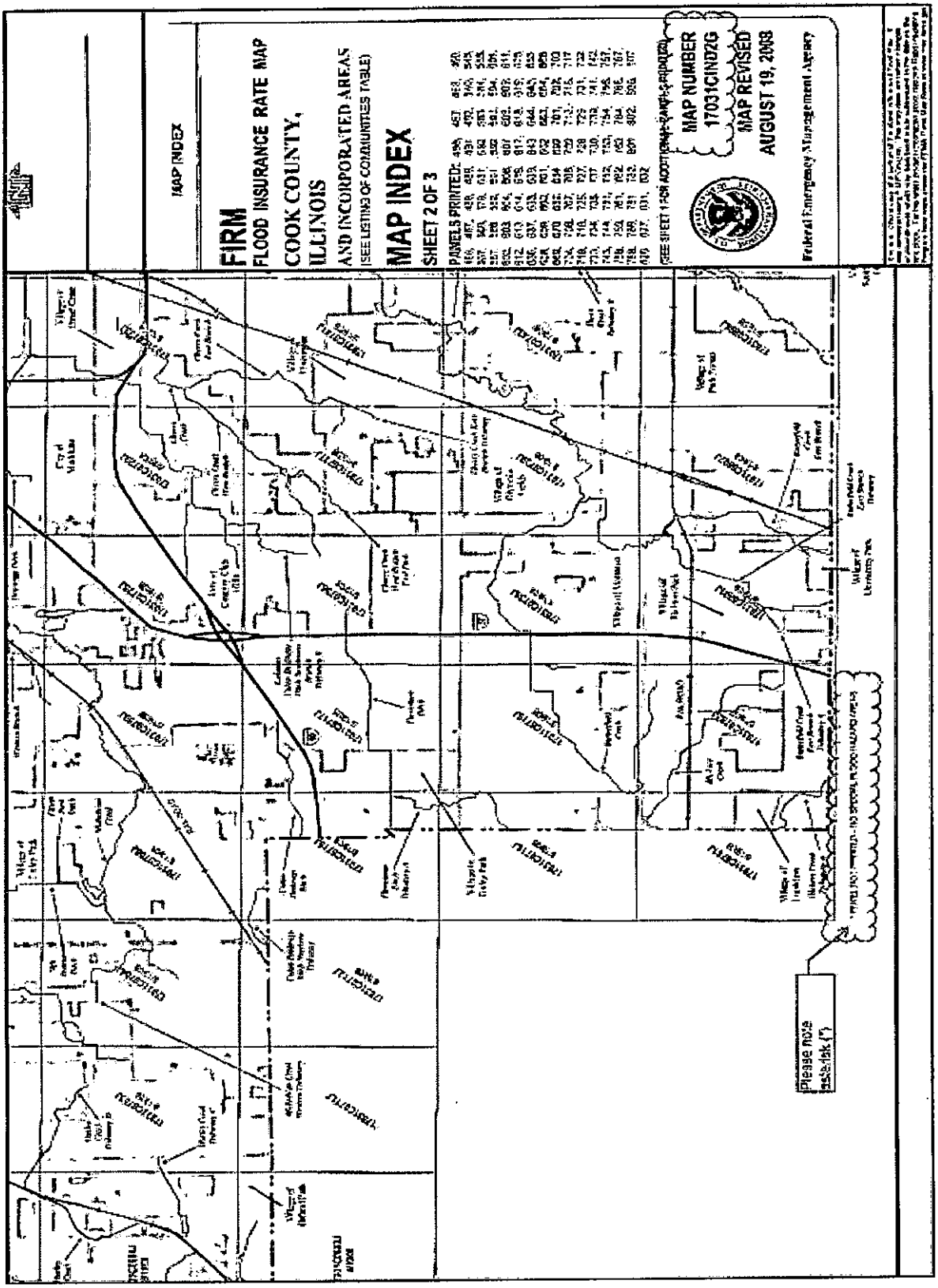
In the case of Advocate Christ Medical Center, there is no published flood map, thus the lack of documentation is the proof that this site is nowhere near a Special Flood Hazard Area.

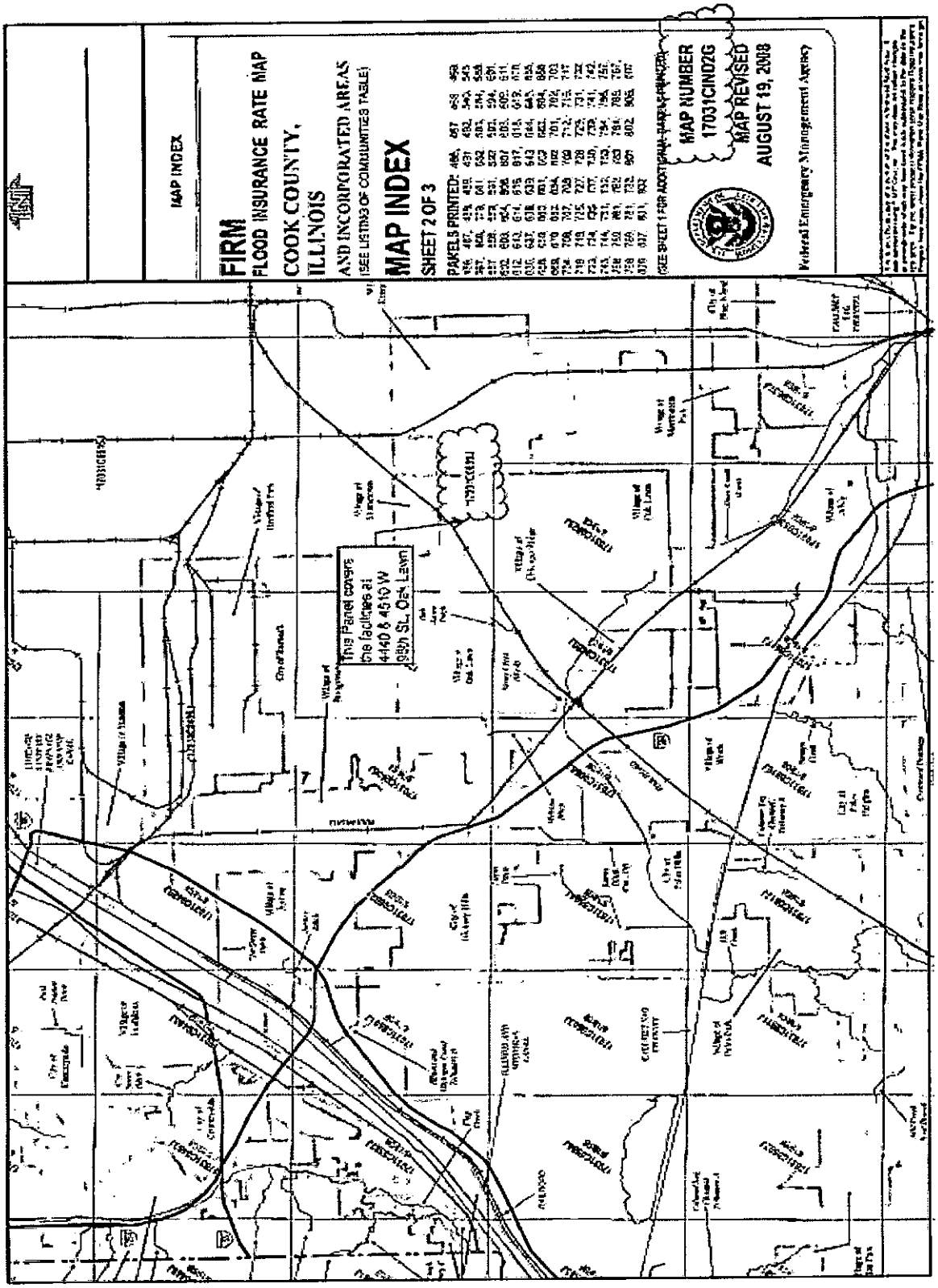
Exhibit 1, PDF (FM17031CIND2G-3.pdf) shows the Map Panel number within a red 'cloud'. This Panel Number is preceded by an asterisk. Exhibit 2 shows the meaning of the asterisk located elsewhere on the same document.

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

Attached is the last flood plain documentation Advocate Christ Medical Center has on file.

See attached Attachment 5, Exhibits 3 and 4.


MAP INDEX
FIRM
FLOOD INSURANCE RATE MAP
COOK COUNTY, ILLINOIS
AND INCORPORATED AREAS
(SEE LISTING OF COMMUNITIES TABLE)
MAP INDEX
SHEET 2 OF 3
PANELS PRINTED:
MAP NUMBER
17031CIND2G
MAP REVISED
AUGUST 19, 2008
Federal Emergency Management Agency
Please note
asterisk (*)


MAP INDEX
FIRM
FLOOD INSURANCE RATE MAP
COOK COUNTY, ILLINOIS
AND INCORPORATED AREAS
(SEE LISTING OF COMMUNITIES TABLE)
MAP INDEX
SHEET 2 OF 3
PANELS PRINTED:
(SEE SHEET 1 FOR ADDITIONAL PANELS PRINTED)
MAP NUMBER
17031CIN02G
MAP REVISED
AUGUST 19, 2008
Federal Emergency Management Agency
This Panel covers the facilities at 4440 & 4510 W 95th St, Oak Lawn

UNIVERSITY OF ILLINOIS
AT URBANA-CHAMPAIGN

Institute of Natural Resource Sustainability
Illinois State Water Survey

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

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

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

Site description of determination:
Site address: Advocate Christ Medical Center (incl. Physician's Pavilion) & Hope Children's Hospital, 4440 W. 95th St.
City, state, zip: Oak Lawn, IL 60453
County: Cook Sec¼: SE 1/4 of SW 1/4 Section: 3 T. 37 N. R. 13 E. PM: 3rd
Subject area: Parcels 24-03-318-016-0000 & -017-0000, which comprise the area bounded by S. Kilbourn Ave. on the west, S. Kostner Ave. on the east, W. 95th St. on the south, and W. 93rd St. on the north.

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

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

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

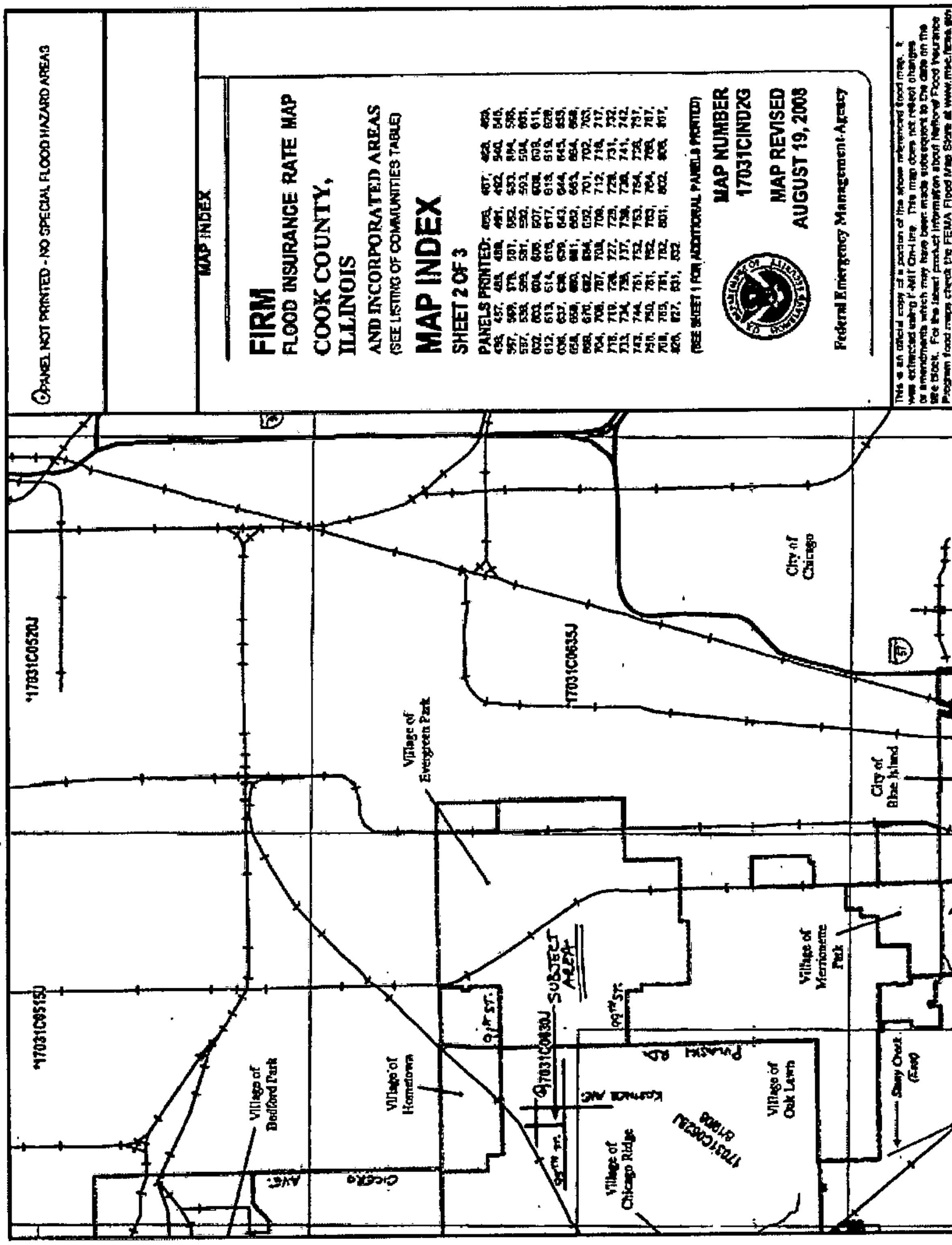
Note: This determination is based on the effective Federal Emergency Management Agency (FEMA) flood hazard reference for the subject area. This letter does not imply that the referenced property will be free from water damage. Property not in a Special Flood Hazard Area may be damaged by a flood greater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

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

William Saylor Title: ISWS Floodplain Information Specialist Date: 8/19/2008
William Saylor, CFM, ISWS, Illinois State Water Survey

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

Form rev. 2/11/2008


PANEL NOT PRINTED - NO SPECIAL FLOOD HAZARD AREAS
MAP INDEX
FIRM
FLOOD INSURANCE RATE MAP
COOK COUNTY, ILLINOIS
AND INCORPORATED AREAS
(SEE LISTING OF COMMUNITIES TABLE)
MAP INDEX
SHEET 2 OF 3
MAP NUMBER 17031CIND2G
MAP REVISED AUGUST 19, 2008
Federal Emergency Management Agency
17031C0520J
17031C0635J
17031C0515J
17031C0630J
City of Chicago
Village of Evergreen Park
City of Blue Island
Village of Merrionette Park
Village of Oak Lawn
Village of Chicago Ridge
Village of Hometown
Village of Bedford Park
SUBJECT AREA
Cicero AVE.
Pulaski Rd
Kostner AVE
Stony Creek (East)

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.
APPEND DOCUMENTATION AS ATTACHMENT-6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

APR 12 2011

Illinois Historic Preservation Agency

FAX (217) 782-8161

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

Cook County
Oak Lawn
New Construction of Ambulatory Pavilion
4440 W. 95th St.
IHPA Log #004031611

April 8, 2011

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

Dear Ms. Hood:

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

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

Please retain this letter in your files as evidence of compliance with Section 4 of the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420/1 et. seq.). This clearance remains in effect for two years from date of issuance. It does not pertain to any discovery during construction, nor is it a clearance for purposes of the Illinois Human Skeletal Remains Protection Act (20 ILCS 3440).

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

Sincerely,

Anne E. Haaker

Anne E. Haaker
Deputy State Historic
Preservation Officer

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

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must equal.

	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS			
SOURCE OF FUNDS			
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS			

NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

PROJECT COSTS AND SOURCES OF FUNDS			
USE OF FUNDS	**CLINICAL**	**NON CLINICAL**	**TOTAL**
Preplanning Costs	$ 862,500	$ 862,500	$ 1,725,000
Site Survey and Soil Investigation	$ 61,500	$ 61,500	$ 123,000
Site Preparation	$ 640,000	$ 640,000	$ 1,280,000
Off Site Work	$ 2,200,150	$ 2,200,150	$ 4,400,300
New Construction Contracts	$ 57,513,723	$ 44,301,102	$ 101,814,825
Modernization Contracts	$ -	$ 195,211	$ 195,211
Contingencies	$ 5,381,600	$ 4,228,400	$ 9,610,000
Architectural/Engineering Fees	$ 2,873,360	$ 2,257,640	$ 5,131,000
Consulting and Other Fees	$ 2,673,048	$ 2,100,252	$ 4,773,300
Movable or Other Equipment (not in construction contracts)	$ 48,000,000	$ 980,000	$ 48,980,000
Bond Issuance Expense (project related)	$ 1,184,600	$ 507,686	$ 1,692,285
Net Interest Expense During Construction (project related)	$ 7,892,946	$ 3,382,691	$ 11,275,637
Fair Market Value of Leased Space or Equipment	$ -	$ -	$ -
Other Costs To Be Capitalized	$ 6,328,560	$ 4,972,440	$ 11,301,000
Acquisition of Building or Other Property (excluding land)	$ -	$ -	$ -
TOTAL USES OF FUNDS	$ 135,611,986	$ 66,689,572	$ 202,301,558
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities			$ 66,918,722
Pledges			$ -
Gifts and Bequests			$ -
Bond Issues (project related)			$ 135,382,836
Mortgages			$ -
Leases (fair market value)			$ -
Governmental Appropriations			$ -
Grants			$ -
Other Funds and Sources			$ -
TOTAL SOURCES OF FUNDS			$ 202,301,558

On Attachment 7, Exhibit 2 is the itemization of the costs shown above.

PROJECT COSTS

Items	Cost
Pre-Planning	**$ 1,725,000**
Site and Facility Planning	380,000
Programming thru SD	1,345,000
Site survey (investigation, titles, traffic)	**$ 123,000**
Site Preparation	**$ 1,280,000**
Prep Work (Demo, clearing , grading,shoring)	600,000
Earthwork, drainage, stone, foundation prep	680,000
OFF-Site Work	**$ 4,400,300**
Site Work: Grading, Prk Lot Lights, Concrete, MWRD	1,430,000
ComEd - power extension + relocation of shop	2,100,300
Kilbourn street and traffic light	870,000
New Construction	**$ 101,814,825**
Modernization of Connector	**$ 195,211**
Contingenies	**$ 9,610,000**
Architect/Eng Fees	**$ 5,131,000**
Consulting and Other Fees	**$ 4,773,300**
Const Admin & Misc Consultants	1,390,000
A/E RFI + Operational Consultants / Misc analysis	485,000
Reimburseables/ Renderings / Misc support	425,000
MEP /Envelop, LEED Commissioning	728,000
Peer Review, Equipment planner	688,000
Miscellaneous	1,057,300
Movable / Equipment	**$ 48,980,000**
Surgical / GI	18,400,000
Sterile Processing	1,800,000
Imaging	27,800,000
Miscellaneous equipment	980,000
Bond Issuance / Finance Expense	**$ 1,692,285**
Net Interest	**$ 11,275,637**
Fair Market Value of Lease	**$ -**
Other Costs to be Capitalized	**$ 11,301,000**
FF&E - entire Amb Pavilion	2,000,000
Utilities / Taps	1,600,000
PACS Hardware / Server / Station Equipment	1,500,000
Data Infrastructure, wireless, telecom	2,080,000
Miscellaneous other costs	4,121,000
TOTAL	**$ 202,301,558**
Source of Funds	
Cash and Securities	66,918,722
Debt Financing	135,382,836
TOTAL	**$ 202,301,558**

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:

☐ None or not applicable ☒ Preliminary

☐ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): December 31, 2014

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

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

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

Not applicable.

Cost Space Requirements

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

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

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

See Attachment 9, Exhibit 1.

Cost Space Requirements							
		Department Gross Square Feet		Amount of Proposed Total Department Gross Square Feet That Is:			
Dept. / Area	Total Costs	Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
REVIEWABLE							
Surgery							
Surgery Operating Rooms	$ 34,050,124	58,697	88,045	29,348		58,697	0
Surgery Procedure Rooms	$ 7,611,790	5,871	11,798	6,718		5,080	791
Phase I Recovery (PACU)	$ 2,661,017	5,781	10,251	4,470		5,781	0
Phase II Recovery (Prep/recovery)	$ 12,454,411	9,603	32,659	23,056		9,603	0
Central Sterile Supply	$ 5,792,271	14,996	22,784	7,788		14,996	0
Ambulatory Care Services							
Cast room	$ 231,703	514	966	452		514	0
Heart Failure Clinic	$ 2,155,625	1,150	4,351	4,351		0	1,150
Fetal Diagnostics	$ 2,971,512		5,501	5,501		0	
Adult Infusion Center	$ 4,644,230	3,001	9,368	9,368		0	3,001
Neurodiagnostics	$ 613,604	1,633	2,830	1,197		1,633	
Non Invasive Cardiology	$ 1,964,138	3,774	7,739	3,965		3,774	0
Pain Center	$ 460,363	1,267	928	928		0	1,267
Pre Admission Testing	$ 406,962	2,511	3,350	839		2,511	0
Pulmonary Function	$ 386,226	831	1,611	780		831	0
Diag and Interv Rad.							
General Radiology/Fluoro	$ 9,590,210	13,182	20,621	7,439		13,182	0
Mammography	$ 384,840	1,109	1,426	317		1,109	0
Ultrasound	$ 9,063,887	6,745	14,060	7,315		6,745	0
CT & PET/CT	$ 11,805,910	8,112	16,761	8,649		8,112	0
MRI	$ 9,506,699	3,738	10,674	6,936		3,738	0
Nuclear Med./Spect. /CT	$ 10,262,430	3,703	11,184	7,481		3,703	0
Laboratory	$ 728,670	22,447	23,809	1,362		22,447	0
Pharmacy, Satellite	$ 830,257	0	1,537	1,537		0	0
Outpatient Rehab	$ 4,627,290	9,600	19,343	9,743		9,600	0
Cardiac Rehab	$ 2,407,817	1,482	6,446	4,964		1,482	0
Total Reviewable	$ 135,611,986	179,748	328,043	154,504		173,539	6,209

Source: ACMC records.

Cost Space Requirements							
		Department Gross Square Feet		Amount of Proposed Total Department Gross Square Feet That Is:			
Dept. / Area	Total Costs	Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
NON-REVIEWABLE							
Multidisciplinary Cancer, Neurosciences, Heart-Vascular Centers, and Women's Health Center, i.e. physicians' consultation offices and exam rooms	$ 13,869,036	5,865	37,431	31,566		5,865	
Lobby, Public Areas, Resource Center, Winter Garden	$ 6,280,869	9,700	22,826	13,126		9,700	0
Registration/Fin Counseling	$ 1,510,062	5,458	3,470	3,470		0	5,458
Shelled Space	$ 4,873,874	0	14,337	14,337		0	0
Administration	$ 6,610,577	4,150	20,152	16,002		4,150	0
Research/Education	$ 1,356,293	35,800	37,681	3,283		34,398	1,402
Electronic Med Rec Support	$ 191,092	5,714	6,083	369		5,714	0
Materials/EVS	$ 1,120,676	9,595	12,345	2,750		9,595	0
Circulation/ Connector/ Pneumatic Tube	$ 9,897,023	0	23,789	23,789		0	0
Modernized Connectors	$ 389,557	0	1,341		1,341	0	0
Lobby Café	$ 425,257	2,855	3,774	919		2,855	0
Retail Pharmacy	$ 373,430	0	807	807		0	0
Mechanical	19,791,826	301,775	343,846	42,071		301,775	0
Total Non-Reviewable	$ 66,689,572	380,912	527,882	152,489	1,341	374,052	6,860
TOTAL							
Reviewable & Non-Reviewable	$ 202,301,558	560,660	855,925	306,993	1,341	547,591	13,069
Total New Const & Mod. DGSF				308,334			

Source: ACMC records.

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

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

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

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT-11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

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

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

Facility	Location	License No.	Joint Commission Accreditation No.
Advocate Christ Medical Center	4440 W. 95th St. Oak Lawn, IL	1899693	7397

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

Facility	Location	License No.	Joint Commission Accreditation No.
Advocate BroMenn Medical Center	1304 Franklin Ave. Normal, IL	1756947	4482*
Advocate Condell Medical Center	801 S. Milwaukee Ave. Libertyville, IL	1756928	7372
Advocate Eureka Hospital	101 S. Major Eureka, IL	1756949	4482*
Advocate Good Samaritan Hospital	3815 Highland Ave. Downers Grove, IL	1899765	7329
Advocate Good Shepherd Hosp ital	450 W. Highway, #22 Barrington, IL	1899765	5190
Advocate Illinois Masonic Medical Center	836 W. Wellington Chicago, IL	1895997	4068
Advocate Lutheran General Hospital	1775 Dempster Park Ridge, IL	1899780	7405
Advocate South Suburban Hospital	17800 S. Kedzie Ave Hazel Crest, IL	1899779	7356
Advocate Trinity Hospital	2320 E. 93rd St. Chicago, IL	1927349	7311

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

Advocate has an ownership interest in RML. RML is the owner and operator of two not-for-profit, long-term acute care hospitals (LTACHs). RML Chicago was formerly known as Bethany Hospital.

RML Chicago	3435 W. Van Buren Chicago, IL	1756953	7360*
RML Specialty Hospital	5601 S. County Line Rd. Hinsdale, IL	1976448	7360*

*The RML facilities are accredited by the Joint Commission under the same number.

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

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

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

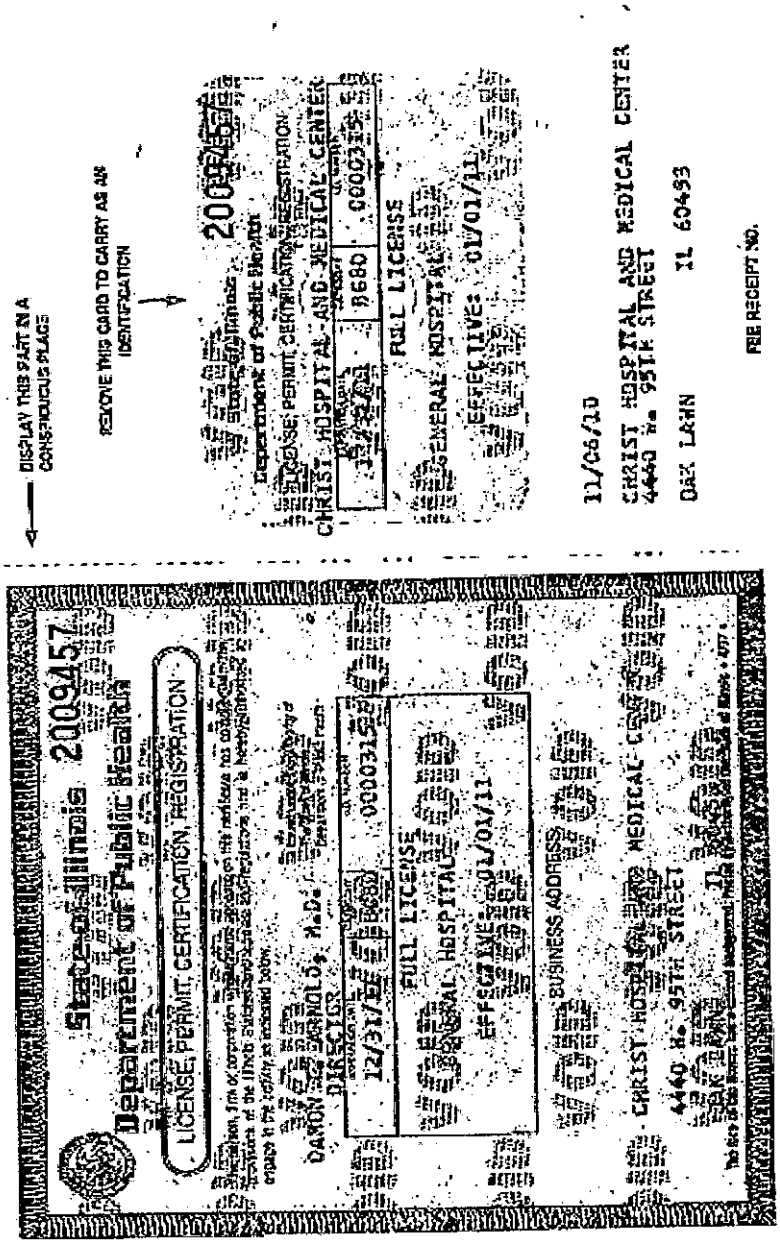
   By the signatures on this application, Advocate Health and Hospitals Corporation attests there have been no adverse actions against any facility owned and/or operated by Advocate Health and Hospitals Corporation by any regulatory agency which would affect its ability to operate as a licensed entity during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

3. **Authorization Permitting HFSRB and IDPH to Access Necessary Documentation**

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

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

   Not applicable. This is the first certificate of need filed by Advocate Christ Medical Center in 2011.


DISPLAY THIS PART IN A CONSPICUOUS PLACE
REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION
State of Illinois
Department of Public Health
LICENSE, PERMIT, CERTIFICATION, REGISTRATION
200457
CHRIST HOSPITAL AND MEDICAL CENTER
FULL LICENSE
EFFECTIVE: 01/01/11
11/06/10
4440 W. 95TH STREET
OAK LAWN IL 60453
FEE RECEIPT NO.
DIRECTOR
BUSINESS ADDRESS

Advocate Christ Medical Center

Oak Lawn, IL

has been Accredited by

The Joint Commission

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

Hospital Accreditation Program

July 31, 2010

Accreditation is customarily valid for up to 39 months.

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

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

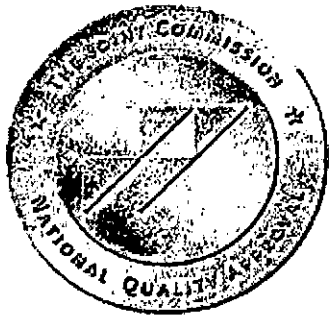
Mark Chassin, M.D.
President

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

Advocate Christ Medical Center

Oak Lawn, IL

has been Accredited by



The Joint Commission

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

Behavioral Health Care Accreditation Program

July 27, 2010

Accreditation is customarily valid for up to 39 months.

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

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

Mark Chassin, M.D.
President

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

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

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

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

READ THE REVIEW CRITERION and provide the following required information:

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]
4. Cite the sources of the information provided as documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate**.

For projects involving modernization, describe the conditions being upgraded if any. For facility projects, include statements of age and condition and regulatory citations if any. For equipment being replaced, include repair and maintenance records.

NOTE: Information regarding the "Purpose of the Project" will be included in the State Agency Report. APPEND DOCUMENTATION AS ATTACHMENT-12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

1. The Project Will Provide Health Services that Improve the Health Care or Well-Being of the Market Area Population To Be Served

Introduction

Ambulatory clinical care is at a new frontier. Years of experience delivering progressively more complicated ambulatory care, new techniques and technology including improved anesthesia have all contributed to advances that allow more and more complex care to be delivered at facilities in the outpatient setting safely yet at lower cost than comparable inpatient care.

This enhanced level of ambulatory care enables the provider to achieve priority goals of patients, physicians, and payors.

- Patients welcome having their care delivered in a patient-focused setting with a single point of access and nearby parking. They appreciate being able to schedule all their tests in a single visit at the same site. Patients with mobility issues benefit greatly without the burdens of traveling to multiple locations for testing and treatment. Outpatients also prefer not being commingled with acutely ill inpatients.
- Physicians appreciate being able to schedule their time to do procedures or read test results knowing that their patients' procedures or tests will not be delayed or postponed because of the more urgent needs of acutely ill inpatients or trauma

cases. Physicians like to satisfy their patients' expectations for an outpatient alternative to either inpatient care or outpatient care delivered in the inpatient setting.

- Payors (including governmental payors and all others) support outpatient care because it costs less to deliver than comparable inpatient care.

Advocate Christ Medical Center/Advocate Hope Children's Hospital (ACMC/AHCH, Medical Center) provided almost 350,000 outpatient care visits in 2010, approximately 85 percent of which are provided on the Medical Center's campus.

The Medical Center is proposing to develop an outpatient building, known as the Ambulatory Pavilion (Pavilion), with 308,334 DGSF of space that will house surgery, endoscopy, imaging, and institute-related clinical functions as well as medical office space to support multidisciplinary, integrated clinical care. It will indeed be a prototype of the new frontier of ambulatory care.

The proposed Ambulatory Pavilion is designed to improve the health care and the well-being of the market population to be served by providing safe, efficient ambulatory care in a setting specifically planned for the delivery of increasingly complex care in a convenient, comfortable setting, and at lower cost than comparable care delivered in the inpatient setting.

2. Definition of Planning Area

Patient Origin

Advocate Christ Medical Center (ACMC, the Medical Center) and Advocate Hope Children's Hospital (AHCH) are both tertiary/quaternary referral centers; both serve the local community as well as a very broad geographic area, especially for services that are not available at community hospitals.

Attachment 12, Exhibit 1 describes the patient origin for the Medical Center's adult inpatients and outpatients; Exhibit 2 is a map of the Medical Center's adult primary and secondary service areas. Attachment 12, Exhibit 3 describes the patient origin for AHCH's pediatric inpatients and outpatients; Exhibit 4 is a map of AHCH's pediatric primary and secondary service areas. The following are summaries of the patient origin of the adult and pediatric patients served at ACMC and AHCH. The same geographic areas are defined as the primary and secondary service areas for both entities.

Attachment 12, Table 1 compares the origin of adult inpatients and outpatients to the Medical Center. The proportion of adult inpatients is somewhat less concentrated than that of outpatients in the primary and secondary services area. Of the total, 87.0 percent of adult inpatients are from the service area, while 88.6 percent of outpatients are from the service area. Of the adult inpatients, 12.9 percent are from other Illinois areas and Out of State; 11.3 percent of the outpatients are from these areas. The strong correlation of the inpatient and outpatient origin attests to the complexity of the outpatient services at the Medical Center.

Attachment 12, Table 1
Adult Patient Origin, 2010

Area	Inpatient		Outpatient	
	Patients	Percent of Total	Patients	Percent of Total
Primary Service Area	25,913	73.3	146,903	76.6
Secondary Service Area	4,862	13.7	23,056	12.0
Other Illinois	4,073	11.5	20,036	10.4
Other States	504	1.4	1,765	0.9
All Other	15	<0.1	73	<0.1
Total	35,367	100.0	191,833	100.0

Source: ACMC records.

As shown in Attachment 12, Table 2, of the total, 82.2 percent of pediatric inpatients are from the primary and secondary service areas; these areas account for 89.3 percent of the outpatients. Other Illinois and Other States account for 17.7 percent of the inpatients and 10.7 percent of the outpatients; this demonstrates the broad regional role of Advocate Hope Children's Hospital.

Attachment 12, Table 2
Pediatric Patient Origin, 2010

Area	Inpatient		Outpatient	
	Patients	Percent of Total	Patients	Percent of Total
Primary Service Area	4,329	73.6	47,684	84.0
Secondary Service Area	506	8.6	2,996	5.3
Other Illinois	832	14.1	5,309	9.4
Other States	213	3.6	213	1.3
All Other	1	<0.1	1	<0.1
Total	5,881	100.0	56,763	100.0

Source: ACMC records.

Population and Demographics

The total population of the primary and secondary service areas of the Medical Center and AHCH is almost 1.6 million people. The pediatric population is expected to remain stable, while the 15 to 44 age cohort is expected to decline modestly. However, the percentages of population in the senior age groups, 46 to 64 and 65+, are expected to increase 1.2 and 8.4 percent, respectively. A larger percentage of seniors in the population will place additional demands on health care providers since seniors require more medical surgical services per person than do the younger population age cohorts. See Attachment 12, Exhibits 5, 6 and 7 for detailed population data for 2010 and 2019. Summary Tables 3 to 7 are included here.

Attachment 12, Table 3
Population by Age Cohort, 2010

Age Cohort	< 15	15-44	45-64	65+	Total
Primary Service Area	193,586	366,097	231,540	117,005	908,228
Secondary Service Area	162,638	282,905	161,348	73,769	680,660
Total	356,224	649,002	392,888	190,774	1,588,888

Source: Market Expert (Thomson Reuters).

Attachment 12, Table 4
Percent Distribution by Age Cohort, 2010

Age Cohort	< 15	15-44	45-64	65+	Total
Primary Service Area	21.3	40.3	25.5	12.9	100.0
Secondary Service Area	23.9	41.6	23.7	10.8	100.0
Total	22.4	40.9	24.7	12.0	100.0

Source: Market Expert (Thomson Reuters).

Attachment 12, Table 5
Population by Age Cohort, 2019

Age Cohort	<15	15-44	45-64	65+	Total
Primary Service Area	194,038	345,030	232,017	125,303	896,388
Secondary Service Area	161,809	273,486	165,647	81,421	682,363
Total	355,847	618,516	397,664	206,724	1,578,751

Source: Market Expert (Thomson Reuters).

Attachment 12, Table 6
Percent Distribution by Age Cohort, 2019

Age Cohort	< 15	15-44	45-64	65+	Total
Primary Service Area	21.6	38.5	25.9	14.0	100.00
Secondary Service Area	23.7	40.1	24.3	11.9	100.0
Total	22.5	39.2	25.2	13.1	100.0

Source: Market Expert (Thomson Reuters).

Attachment 12, Table 7
Population Change by Age Cohort, 2010 to 2019

	< 15	15-44	45-64	65+	Total
2010	356,224	649,002	392,888	190,774	1,588,888
2019	355,847	618,516	397,664	206,724	1,578,751
Percent Change	- 0.1	- 4.7	+ 1.2	+ 8.4	- 0.6

Source: Market Expert (Thomson Reuters).

Other Demographic Characteristics

Attachment 12, Tables 8 through 12 describe several key demographic characteristics of the Advocate Christ Medical Center/Advocate Hope Children's Hospital service area.

Attachment 12, Table 8 is a comparison of the racial characteristics within ACMC/AHCH's total service area (primary and secondary) to the State of Illinois and Chicago Metropolitan Statistical Area (MSA). This table shows that the proportion of minority populations within ACMC/AHCH's total service area is higher than the proportions in Illinois or the MSA.

Attachment 12, Table 8
Comparison of Racial Composition of ACMC/AHCH's
Primary and Secondary Service Areas with Illinois and Chicago Metropolitan Area

Race	Percent Primary Service Area	Percent Secondary Service Area	Percent Total Service Area	Percent Illinois	Percent MSA Area
White	50.5	26.9	40.5	63.9	53.4
Black	24.5	55.4	37.9	14.4	17.6
Hispanic	21.5	15.6	18.8	15.6	21.3
Asian & Pacific Island, Non Hispanic	1.6	0.8	1.2	4.3	5.7
All Others	1.9	1.3	1.6	1.8	1.9
Total	100.0	100.0	100.0	100.0	100.0

Source: Market Expert (Thomson Reuters).

The average household income in the Medical Center's service area is compared to Illinois on Attachment 12, Table 9. The proportion of low income households, those typically with the most challenging access to health care, is higher in the Medical Center's service area than in Illinois. The proportion of very high income households is lower in the Medical Center's service area than in all the Illinois or the Chicago MSA.

Attachment 12, Table 9
Comparison of 2010 Household Income of ACMC/AHCH's
Primary and Secondary Service Areas with Illinois and Chicago Metropolitan Area

2010 Household Income	Primary Service Area Percent of Total HH	Secondary Service Area Percent of Total HH	Total Service Area Percent of Total HH	Illinois Percent of Total HH	MSA Percent of Total HH
<$15K	10.4	17.8	13.5	10.9	9.8
$15-$25K	9.1	10.6	9.7	9.1	7.7
$25-$50K	24.2	25.4	24.7	24.3	22.0
$50-$75K	20.7	17.4	19.4	20.1	19.6
$75-$100K	14.3	11.4	13.1	13.5	14.2
Over $100K	21.3	17.4	19.5	22.0.	26.6
Total	100.0	100.0	100.0	100.0	100.0

Source: Market Expert (Thomson Reuters).

Attachment 12, Table 10 compares unemployment for the Medical Center's service area with the State and the Chicago MSA. The unemployment rate across the service area is higher than the State and MSA averages.

Attachment 12, Table 10
Comparison of Unemployment Percentages of ACMC/AHCH's
Primary and Secondary Service Areas with Illinois and Chicago Metropolitan Area

	Percent Primary Service Area	Percent Secondary Service Area	Percent Total Service Area	Percent Illinois	Percent Chicago MSA
Percent of Unemployment	8.0	12.5	9.9	7.0	7.1

Source: Market Expert (Thomson Reuters).

Attachment 12, Table 11 shows that the adult education level of the Medical Center's service area population is overall lower than Illinois or the Chicago MSA, with higher proportion of population age 25+ with less than high school or some high school and lower proportion with a college bachelor's degree or greater.

Attachment 12, Table 11
Comparison of Adult Education Level of ACMC/AHCH's
Primary and Secondary Service Areas with Illinois and Chicago Metropolitan Area

2010 Adult Education Level	Percent of Total Pop Age 25+ in Primary Service Area	Percent of Total Pop Age 25+ in Secondary Service Area	Percent of Total Pop Age 25+ in Total Service Area	Percent of Total Pop Age 25+ in Illinois	Percent of Total Pop Age 25+ in Chicago MSA
Less than High School	8.4	7.6	8.0	6.4	7.4
Some High School	9.5	12.1	10.6	7.8	7.6
High School Degree	32.4	29.0	31.2	27.9	24.5
Some College/Assoc. Degree	28.5	31.5	29.9	28.2	26.5
Bachelor's Degree or Greater	21.2	19.7	20.3	29.7	34.0
Total	100.0	100.0	100.0	100.0	100.0

Source: Market Expert (Thomson Reuters).

Attachment 12, Tables 12, 13 and 14 summarize the payor mix of the Medical Center's adult and pediatric patients compared to Illinois.

Attachment 12, Table 12
Inpatient Adult Payor Mix in Primary and Secondary Service Areas, 2010

Primary Service Area		
Insurance	**Patients**	**Percent of Total**
Medicaid	15,829	18.1
Self Pay	5,677	6.5
Managed Care	27,891	31.8
Medicare	36,907	42.1
Other	1,280	1.5
Total	87,584	100.0
Secondary Service Area		
Insurance	**Patients**	**Percent of Total**
Medicaid	19,278	27.3
Self Pay	6,209	8.8
Managed Care	17,492	24.8
Medicare	26,178	37.1
Other	1,449	2.1
Total	70,606	100.0

Source: ACMC records.

Attachment 12, Table 13
Inpatient Pediatric Payor Mix in Primary and Secondary Service Areas, 2010

Primary Service Area		
Insurance	**Patients**	**Percent of Total**
Medicaid	10,026	59.9
Self Pay	464	2.8
Private Insurance/Managed Care	6,108	36.5
Medicare	17	0.1
Other	136	0.8
Total	16,751	100.0
Secondary Service Area		
Insurance	**Patients**	**Percent of Total**
Medicaid	3,865	46.6
Self Pay	166	2.0
Private Insurance/Managed Care	4,127	49.8
Medicare	17	0.2
Other	111	1.3
Total	8,286	100.0

Source: ACMC records.

Attachment 12, Table 14
Illinois Inpatient Payor Mix 2009

Inpatient Adult Payor Mix		
Insurance	**Patients**	**Percent of Total**
Medicaid	179,800	17.5
Self Pay	68,673	6.7
Private Insurance/Managed Care	305,947	29.7
Medicare	454,800	44.2
Other	19,349	1.9
Total	1,028,569	100.0
Inpatient Pediatric Payor Mix		
Insurance	**Patients**	**Percent of Total**
Medicaid	56,181	53.1
Self Pay	3,990	3.8
Private Insurance/Managed Care	43,706	41.3
Medicare	75	0.1
Other	1,843	1.7
Total	105,795	100.0

Source: IDPH 2009 Annual Hospital Questionnaire.

At the Medical Center, Medicaid inpatient accounts for a higher proportion of payor mix than in Illinois; private insurance is somewhat higher and inpatient Medicare is somewhat lower.

3. Identify the Existing Problems/Issues

The most pressing problem or issue facing the Medical Center today is a profound lack of space.

ACMC/AHCH is a major provider of both routine and increasingly complex ambulatory care. Of the total 350,000 visits each year, about 15 percent is delivered in 4 community outpatient centers; the remaining 85 percent is delivered on the Medical Center campus in Oak Lawn.

Fifty years ago when the Medical Center first opened its doors, hospitals were designed as inpatient facilities; the majority of outpatient care was delivered in emergency departments, physicians' offices, dispensaries for the poor, and in patients' homes. Over the years, outpatient volume at the Medical Center increased; the added volume was not only in the ancillary departments (for example, surgery, endoscopy, imaging, laboratory, and rehabilitation) but also related to new programs with significant outpatient volumes (for example, Congestive Heart Failure (CHF) Clinic, Pre-Admission Testing, and Oncology Infusion Therapy); these programs all required space. As the number of outpatients increased, available departmental space remained essentially the same; to meet the increasing space demands, non-clinical spaces (storage, conference rooms and offices) were appropriated for outpatient functions.

Because spaces for outpatient services were appropriated in every corner of the hospital, way finding for outpatients became progressively more complex as patients had to navigate through the congested hospital corridors to one of many registration areas and care delivery sites. In most departments, outpatients were mixed with acutely ill inpatients. As a result, outpatients could not be assured that they would be seen at their scheduled time; in departments where inpatients and outpatients were commingled, if an emergency patient or acutely ill inpatient needed the resources that had been scheduled for an outpatient, the outpatient's case was delayed or rescheduled.

According to Kurt Salmon Associates, major teaching hospitals and academic medical centers such as ACMC/AHCH average from 2,500 to 3,000 building gross square feet (BGSF) per bed for inpatient, outpatient, teaching, and research functions. Today ACMC/AHCH has only 1,800 BGSF per bed. This deficit translates into a shortage of between 490,000 BGSF to 840,000 BGSF additional BGSF of space to even meet current industry standards.

This critical lack of space translates into the inability to care for additional outpatients who live close to ACMC/AHCH or those who have no other alternative in the south and southwest Chicago area. At a time when outpatient volume was increasing dramatically in the market, most departmental or programmatic outpatient volume increased only modestly at the Medical Center. The reason for this is very evident; there is literally no space to accommodate any more patients. The Medical Center implemented operational improvement strategies to achieve greater capacity including extending hours of operation and adding weekend hours where appropriate. The Medical Center also developed 4 off–site ambulatory centers. While these centers have met a need in their respective communities, they cannot meet the need for more complex care that must be provided on the Medical Center's campus in order to be accessible to specialized staff and to provide sophisticated technology that cannot be replicated at multiple sites. The lack of space for inpatients and outpatients also causes patient dissatisfaction issues.

The most recent Press Ganey patient survey conducted at ACMC/AHCH contains numerous comments that are indicative of this lack of space and its negative effect on patient satisfaction. The following patient comments express this concern for lack of space in the outpatient areas:

"Not enough seats for patients."

"The room is too small."

"Too much traffic."

"They should have a bigger waiting area for the family."

These are a small sampling of comments that reflect dissatisfaction with the space constraints throughout the Medical Center's outpatient chassis.

4. Sources of Information

Sources of information used in developing the certificate of need application include information from the following sources: Medical Center clinical, administrative and financial data; the Medical Center Strategic Plan: Vision 2017; as well as a recently developed Master Facility Plan and other studies by external planners, architects, and engineers. Other sources of information include national and state demographic reports; IDPH's Hospital Profiles; IHFSRB rules, State Standards and technical assistance; MapQuest; and, health care literature related to trends in outpatient care and the implications of national health care reform. The following building codes relevant in Oak Lawn were also used and include the

International Building Code, 2003; NFPA, 101, 2000; International Mechanical Code, 2004; Chicago Plumbing Code, 2003; Chicago Electrical Code, 2006; Illinois Accessibility Code, 1997; and the IDPH Hospital Licensing Act.

5. How the Project Will Address or Improve Existing Problems/Issues

Advocate Christ Medical Center/Advocate Hope Children's Hospital has matured from a community hospital to a major tertiary/quaternary medical center with expanded missions of patient care, teaching, and research. The Medical Center has continually implemented new programs and services to meet local and regional need. Because these efforts were so responsive to community need, the Medical Center has experienced continued overall growth and high occupancy despite a stable but aging service area population. Over time, to accommodate this new volume, the Medical Center added both clinical and non clinical space on the campus – Advocate Hope Children's Hospital, operating rooms, new intensive care beds, ancillary support space, a medical office building, and new parking. The Medical Center also converted beds from other categories of service to provide additional intensive care and medical surgical beds to meet patients' needs.

Even so, as noted in Section 3), *"Identify the Existing Problems"* above, today ACMC/AHCH is faced with a very serious space deficit. Patient access is being compromised just as patient satisfaction and operational efficiency are being sacrificed. Lack of space is impeding the Medical Center's development as a tertiary/quaternary referral center as well as its ability to serve the residents of south and southwest Chicago.

The proposed project will address and improve the existing space constraints by providing 308,334 DGSF of new space for ambulatory services. The proposed project will decrease the space deficiency that is causing a wide range of patient care and operational problems in the hospital. The following benefits will accrue to outpatients and inpatients when this project is completed.

<u>Benefits for Outpatients</u>

- The most pressing need at the Medical Center is additional space for ambulatory care services. The proposed project will provide 308,334 DGSF of ambulatory care space.
- The space will be located in a newly constructed building to be called the Ambulatory Pavilion (Pavilion) that will be connected to the hospital. The highest priority in the planning and design of the Pavilion has been to address the

unique requirements of routine, but more importantly, increasingly complex outpatient services.

- The new Ambulatory Pavilion will be easily accessed with a single point of entry and greatly enhanced navigational aids that will make it much easier for outpatients to find their desired clinical locations.

  The coordinator of an ambulance service wrote in her support letter the following: "The ambulance service also provides transport to outpatient facilities which includes Christ Medical Center. I have firsthand experience of the task of finding the correct department and the task of getting from one side of the facility to the other with a patient for an appointment. This is not just a challenge to the crew but an inconvenience to the patient and their family members. The family members have a very difficult time finding their family member again after they have found parking, and patients are waiting for their family members to register them so they can proceed with their appointment."

- The Pavilion also will be directly linked to the hospital via a connector that will allow for the unimpeded movement of physicians, technology, staff, or patients should an unforeseen event occur. This connector is very important to patients who undergo chemotherapy and radiation therapy as part of the same visit (Chemotherapy will be in the Ambulatory Pavilion and radiation oncology will remain in the hospital).

- The Medical Center is developing a series of institutes that will be located in the Ambulatory Pavilion. The institute space will include additional physician office space and related clinical programs. The institutes will support multidisciplinary care and clinical integration that have been proven to improve outcomes.

- The Pavilion will also provide space for medical and nursing education as well as for research.

- Much needed surgery, endoscopy and imaging capacity will be part of the Ambulatory Pavilion. All of these areas in the main hospital are operating beyond capacity and substantially over State Standards; the new outpatient space will meet the growing need for these services.

Benefits for Inpatients

- With the completion of the Ambulatory Pavilion and the relocation of outpatient volume from the main hospital departments, the following benefits will accrue to inpatients:
    - Surgery, endoscopy, and imaging facilities are all operating beyond their capacity and substantially over State Standards. The opening of additional new space and relocation of outpatient volume will relieve some of the congestion in these departments in the main hospital for inpatients and trauma cases.
    - Future expansion of the Emergency Department, cath and electrophysiology labs and interventional radiology labs can occur as outpatient departments relocated to the Ambulatory Pavilion, thereby vacating adjacent space that can be used in the future for needed expansion.
- Between 2008 and 2010, the Medical Center recruited more than 60 physicians; additional physicians are being recruited. These physicians meet current and future need for medical manpower to serve the increasing volume of patients. The Pavilion will help provide the infrastructure for these physician practices.
- In addition to the specific benefits for patients and physicians, the additional capacity resulting from new construction will better enable the Medical Center to respond to the challenges of implementing national health care reform.

6. Goals and Quantified and Measurable Objectives and Timeframes for Achieving Them

Goal

The overriding goal for the proposed Ambulatory Pavilion project is to better serve the patients who seek care at Advocate Christ Medical Center/Advocate Hope Children's Hospital by providing additional space on the campus in which to advance the high quality, complex outpatient care delivered at the Medical Center.

Objective 1

The first objective of the project is to improve outpatient care by developing an Ambulatory Pavilion that represents the new frontier of ambulatory care – the ability to care for patients with increasingly complex medical and surgical conditions in an ambulatory care setting both safely and at a lower cost than comparable inpatient care.

This objective will be accomplished with the completion of the proposed Ambulatory Pavilion which is currently planned for December 31, 2014.

Objective 2

The second objective is to relieve the excessively high utilization in many hospital departments such as surgery, endoscopy, the recovery areas, and imaging. This objective will be accomplished when outpatients are relocated from the hospital to the Ambulatory Pavilion in early 2015.

For projects involving modernization, describe the conditions being upgraded if any. For facility projects, include statements of age and condition and regulatory citations if any. For equipment being replaced, include repair and maintenance records.

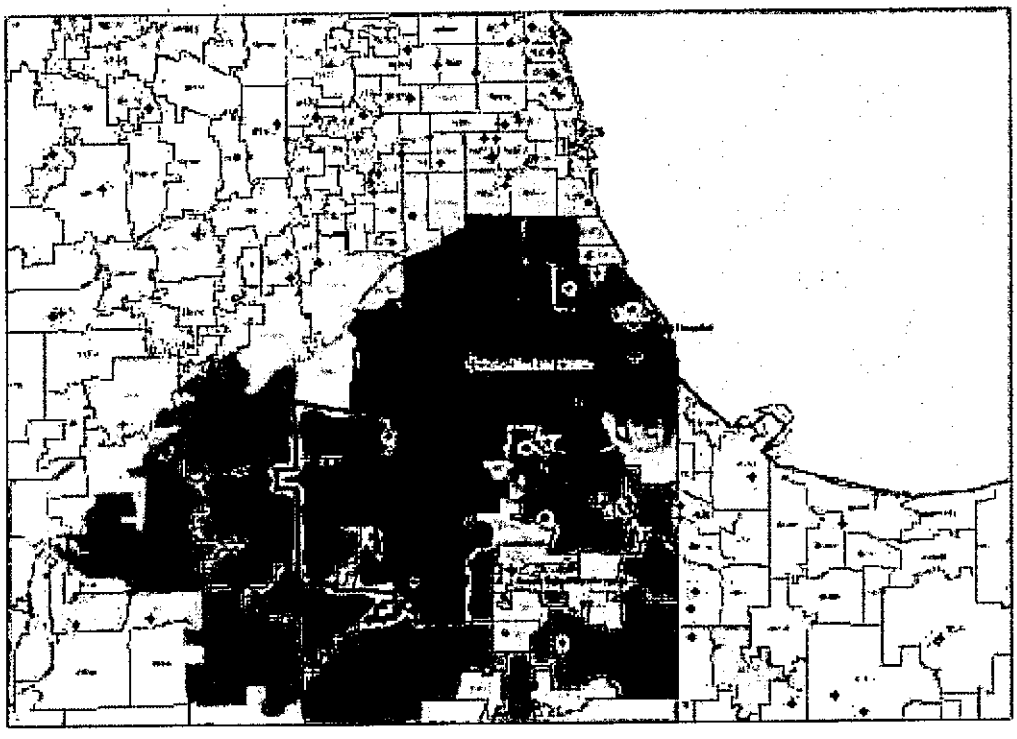
In order to provide a protected passageway between the Ambulatory Pavilion and the hospital, the current project includes the construction of a "connector." In order to complete the passageway, a wall of the hospital must be penetrated and contiguous space modernized. The penetration and modernization of adjacent space includes 1,341 DGSF of modernized space. When the new connector (new construction) and connector modernization are complete, there will be an unimpeded passageway for patients, physicians, staff, and technology between the Pavilion and the hospital.

ACMC Adult Inpatient/Outpatient Patient Origin 2010

Area	Zip Code	Community Name	Number of Patients	Cumulative Percentage of Patients
Primary Service Area (PSA)	60453	Oak Lawn	9,377	14.3
	60459	Burbank	3,400	19.5
	60652	Ashburn	3,290	24.5
	60629	Chicago Lawn	3,237	29.5
	60620	Auburn Park	3,003	34.0
	60655	Mount Greenwood	2,493	37.8
	60643	Morgan Park	2,390	41.5
	60805	Evergreen Park	2,038	44.6
	60638	Clearing	1,849	47.4
	60803	Alsip	1,800	50.2
	60415	Chicago Ridge	1,603	52.6
	60455	Bridgeview	1,591	55.0
	60462	Orland Park	1,483	57.3
	60477	Tinley Park	1,388	59.4
	60445	Midlothian	1,163	61.2
	60465	Palos Hills	1,067	62.8
	60452	Oak Forest	1,031	64.4
	60457	Hickory Hills	975	65.9
	60463	Palos Heights	905	67.3
	60632	Elsdon	894	68.6
	60636	Ogden Park	863	69.9
	60482	Worth	860	71.3
	60456	Hometown	824	72.5
	60458	Justice	814	73.8
	60467	Orland Hills	625	74.7
	60487	Tinley Park	561	75.6
	60464	Palos Park	373	76.1
PSA Total			49,897	76.1
Secondary Service Area (SSA	60628	Roseland	2,028	3.1
	60617	South Chicago	904	4.5
	60619	Grand Crossing	813	5.7
	60441	Lockport	470	6.4
	60406	Blue Island	455	7.1
	60491	Homer Glen	433	7.8
	60423	Frankfort	406	8.4
	60448	Mokena	370	9.0
	60827	Riverdale	357	9.5
	60621	Englewood	355	10.1
	60609	New City	346	10.6
	60451	New Lenox	309	11.1
	60549	South Shore	270	11.5
	60426	Harvey	267	11.9
	60439	Lemont	229	12.2
	60428	Markham	136	12.4
SSA Total			8,148	12.4
Other Illinois Total			6,878	10.5
Other States Total			584	0.9
All Other Total			28	0.0
Grand Total			65,535	100.0

Source: ACMC Records

Advocate Christ Medical Center Adult Patient Origin

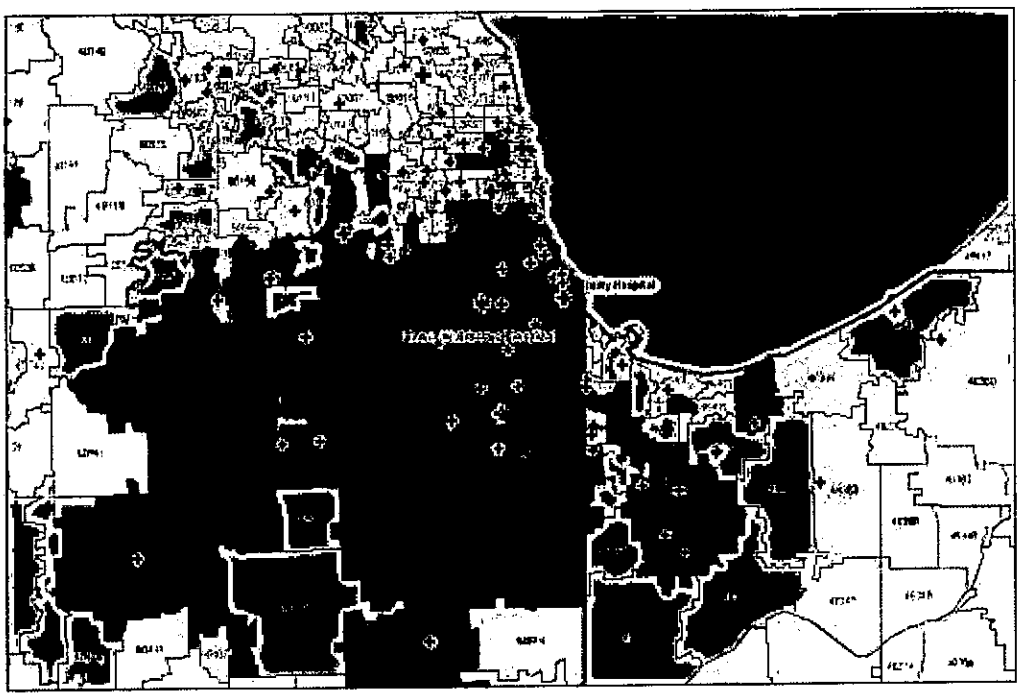


AHCH Pediatric Inpatient/Outpatient Patient Origin 2010

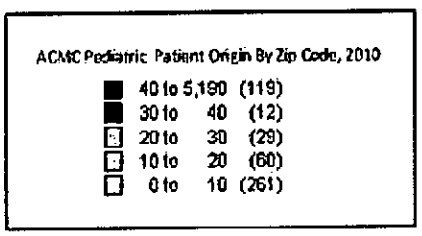
Area	Zip Code	Community Name	Number of Patients	Cumulative Percentage of Patients
Primary Service Area (PSA)	60453	Oak Lawn	5,185	12.7
	60629	Chicago Lawn	4,342	23.3
	60652	Ashburn	3,183	31.0
	60459	Burbank	2,672	37.6
	60620	Auburn Park	2,102	42.7
	60655	Mount Greenwood	1,961	47.5
	60643	Morgan Park	1,813	51.9
	60638	Clearing	1,766	56.2
	60803	Alsip	1,558	60.1
	60415	Chicago Ridge	1,477	63.7
	60455	Bridgeview	1,441	67.2
	60805	Evergreen Park	1,413	70.6
	60477	Tinley Park	1,388	74.0
	60632	Elsdon	1,321	77.3
	60462	Orland Park	1,190	80.2
	60445	Midlothian	1,180	83.0
	60452	Oak Forest	1,119	85.8
	60458	Justice	977	88.2
	60457	Hickory Hills	871	90.3
	60465	Palos Hills	853	92.4
	60482	Worth	789	94.3
	60636	Ogden Park	643	95.9
	60467	Orland Hills	507	97.1
	60456	Hometown	485	98.3
	60463	Palos Heights	472	99.4
	60464	Palos Park	226	100.0
PSA Total			40,934	100.0
Secondary Service Area (SSA	60628	Roseland	1,524	18.9
	60617	South Chicago	986	31.2
	60406	Blue Island	977	43.4
	60423	Frankfort	601	50.8
	60619	Grand Crossing	542	57.6
	60441	Lockport	478	63.5
	60448	Mokena	467	69.3
	60426	Harvey	461	75.0
	60827	Riverdale	458	80.7
	60451	New Lenox	446	86.3
	60491	Homer Glen	437	91.7
	60428	Markham	269	95.1
	60621	Englewood	262	98.3
	60439	Lemont	135	100.0
SSA Total			8,043	12.8
Other Illinois Total			12,679	20.2
Other States Total			974	1.6
All Other Total			14	0.0
Grand Total			62,644	100.0

Source: ACMC Records

Advocate Hope Children's Hospital Pediatric Primary and Secondary Service Areas



Source: ACMC Records



ACMC Service Area	ZIP Code	2010 Total Population Count	<15	15-44	45-64	65+
	60415	13,364	3,004	5,623	3,033	1,704
	60445	25,180	4,893	9,792	6,705	3,790
	60452	28,405	5,527	11,486	8,306	3,086
	60453	52,330	8,698	18,448	13,940	11,244
	60455	15,707	3,287	6,011	4,063	2,346
	60456	3,826	717	1,461	963	685
	60457	13,790	2,718	5,555	3,742	1,775
	60458	14,123	3,248	6,014	3,574	1,287
	60459	26,588	4,813	10,832	7,148	3,795
	60462	40,245	6,246	14,546	12,741	6,712
	60463	13,702	2,050	4,430	4,003	3,219
	60464	9,144	1,224	2,956	3,074	1,890
	60465	16,809	2,510	6,207	5,053	3,039
Primary Service Area	60467	26,738	5,342	9,325	8,268	3,803
	60477	39,894	7,565	15,698	11,774	4,857
	60482	10,292	1,974	4,199	2,774	1,345
	60487	27,396	5,895	11,523	8,004	1,974
	60620	76,090	16,805	30,068	18,713	10,504
	60629	109,290	28,798	49,256	22,552	8,684
	60632	87,007	23,530	40,213	16,563	6,701
	60636	45,810	12,076	19,257	9,491	4,986
	60638	53,403	10,073	20,315	13,961	9,054
	60643	52,377	10,061	20,021	14,754	7,541
	60652	38,169	8,495	15,666	9,916	4,092
	60655	27,757	5,693	11,001	7,598	3,465
	60803	22,256	4,561	9,147	5,898	2,650
	60805	18,536	3,783	7,047	4,929	2,777
Primary Service Area Total		908,228	193,586	366,097	231,540	117,005
	60406	23,991	5,943	10,505	5,374	2,169
	60423	29,712	6,721	11,910	8,253	2,828
	60426	32,227	8,753	13,641	6,602	3,231
	60428	11,954	2,782	4,918	2,752	1,502
	60439	22,986	4,572	7,998	7,127	3,289
	60441	37,909	7,802	17,770	8,868	3,469
	60448	25,786	5,568	10,926	7,123	2,169
	60451	34,284	7,959	14,464	9,042	2,819
Secondary Service Area	60491	23,924	4,995	9,791	7,113	2,025
	60609	74,592	21,773	33,784	14,024	5,011
	60617	88,263	20,836	36,408	20,621	10,398
	60619	71,735	14,643	27,000	18,337	11,755
	60621	40,233	11,290	16,619	7,958	4,366
	60628	79,101	18,181	32,195	18,466	10,259
	60649	53,293	11,875	21,879	13,180	6,359
	60827	30,670	8,945	13,097	6,508	2,120
Secondary Service Area Total		680,660	162,638	282,905	161,348	73,769
Total Service Area Total		1,588,888	356,224	649,002	392,888	190,774

Source: ACMC Records

ACMC Service Area	ZIP Code	2015 Total Population Count	<15	15-44	45-64	65+
	60415	12,840	2,895	4,992	3,220	1,733
	60445	25,059	4,883	9,055	7,042	4,079
	60452	28,307	5,615	10,733	8,304	3,655
	60453	50,932	8,760	17,224	13,509	11,439
	60455	15,780	3,398	5,738	4,124	2,520
	60456	3,539	678	1,275	975	611
	60457	13,817	2,784	5,269	3,773	1,991
	60458	14,116	3,300	5,637	3,650	1,529
	60459	25,894	4,874	10,133	6,894	3,993
	60462	40,411	6,521	14,346	12,031	7,513
	60463	13,731	2,184	4,459	3,672	3,416
	60464	9,124	1,303	2,959	2,790	2,072
	60465	16,445	2,529	5,723	4,905	3,288
Primary Service Area	60467	28,908	5,954	10,081	8,417	4,456
	60477	40,355	7,710	15,032	11,960	5,653
	60482	9,888	1,924	3,791	2,784	1,389
	60487	29,988	6,426	11,994	8,760	2,808
	60620	73,237	16,579	28,190	17,629	10,839
	60629	107,607	28,349	45,927	23,946	9,385
	60632	86,153	23,357	37,286	18,432	7,078
	60636	43,269	11,531	17,880	8,815	5,043
	60638	52,382	10,106	18,823	14,140	9,313
	60643	50,509	10,082	18,650	13,672	8,105
	60652	37,574	8,400	14,761	10,064	4,349
	60655	27,027	5,644	10,229	7,551	3,603
	60803	21,938	4,561	8,479	6,096	2,802
	60805	17,558	3,691	6,364	4,862	2,641
Primary Service Area Total		896,388	194,038	345,030	232,017	125,303
	60406	23,261	5,826	9,605	5,627	2,203
	60423	33,541	7,316	13,049	9,299	3,877
	60426	31,132	8,479	12,820	6,448	3,385
	60428	11,649	2,796	4,711	2,584	1,558
	60439	24,471	4,904	8,391	7,190	3,986
	60441	41,765	8,301	18,633	10,558	4,273
	60448	29,387	6,020	12,053	8,272	3,042
Secondary Service Area	60451	38,716	8,611	15,565	10,618	3,922
	60491	26,212	5,211	10,529	7,631	2,841
	60609	72,414	20,959	31,202	14,889	5,364
	60617	84,621	20,269	33,656	19,930	10,766
	60619	70,239	14,577	25,714	17,803	12,145
	60621	37,715	10,617	15,385	7,566	4,147
	60628	75,155	17,665	29,677	17,122	10,691
	60649	52,435	11,692	20,429	13,479	6,835
	60827	29,650	8,566	12,067	6,631	2,386
Secondary Service Area Total		682,363	161,809	273,486	165,647	81,421
Total Service Area Total		1,578,751	355,847	618,516	397,664	206,724

Source: ACMC Records

ACMC Service Area	ZIP Code	2019 Total Population Count	<15	15-44	45-64	65+
Primary Service Area	60415	11,948	2,895	4,992	3,220	1,733
	60445	24,843	4,883	9,055	7,042	4,079
	60452	28,131	5,615	10,733	8,304	3,655
	60453	48,509	8,760	17,224	13,509	11,439
	60455	15,912	3,398	5,738	4,124	2,520
	60456	3,076	678	1,275	975	611
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Source: ACMC Records

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

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

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

READ THE REVIEW CRITERION and provide the following required information:

ALTERNATIVES

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

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

Introduction

More than a decade ago, Advocate Health and Hospitals Corporation determined that the greater south and southwest Chicago area was one of the areas most in need of advanced clinical services and began the process of developing Advocate Christ Medical Center /Advocate Hope Children's Hospital (ACMC/AHCH, Medical Center) into what today is one of the major referral hospitals in the Midwest. Today, the Medical Center is a 700+-bed facility and according to the *Crain's*, November 15, 2010, is the biggest hospital in the Chicagoland (Cook, DuPage, Kane, Lake, McHenry, and Will counties) in terms of days of patient care.

Over the years, the Medical Center's adult programs continued to expand and provide a growing number of physician specialists and subspecialists, highly skilled staff, and technology to care for acutely ill and injured patients. Many of the Medical Center's adult patients are have complex needs; no other area hospital has the breadth of specialized physicians, staff, and technology that are essential for their accurate diagnosis and treatment.

For the third consecutive year, the Medical Center has been named as a top performing hospital (top 5 percent in the country) in the MIDAS+ ™ Platinum Quality Award Program. This national award is based on the Medical Center's performance in the ACS MIDAS+ National Comparative Database, a repository of performance data for more than 560 hospitals in clinical

measures of CM-HQA (Centers for Medicare and Medicaid Services and the Hospital Quality Alliance).

The Medical Center is fully accredited by The Joint Commission; it was the first hospital in the country to be accredited for Advanced Heart Failure treatment, one of the first sites to achieve recertification in the use of VADs, and also has disease specific certification for stroke.

The Medical Center's Cancer Institute was awarded a 3-year re-accreditation by the Commission on Cancer for the American College of Surgeons and received the Commission's Outstanding Achievement Award. CARF, the Commission on Accreditation on Rehabilitation, has also accredited the Medical Center's 37-bed inpatient rehabilitation unit.

The American Heart Association and the American Stroke Association recognized the Medical Center for sustained "gold award" performance in treating coronary artery disease, heart failure and stroke. Thomson-Reuters has recognized ACMC/AHCH as one of the nation's 100 top cardiovascular hospitals. The Society of Thoracic Surgeons (STS) awarded the Medical Center with a 3-Star Composite rating (recognizing that coronary bypass grafting is significantly higher than the STS mean).

The Medical Center also merited a Partner Recognition Award from Practice Greenhealth (formerly *Hospitals for a Healthy Environment)* in recognition of continuing efforts to "go green" and maintain a healthy environment.

In 1996, the Medical Center established Advocate Hope Children's Hospital (AHCH); today AHCH has 69 pediatric intensive care and general pediatric beds and 37 neonatal beds; it is the largest and only dedicated pediatric medical facility in the south and southwest Chicago suburbs. AHCH offers a full spectrum of clinical programs for children.

AHCH is a Member of the National Association of Children's Hospitals and Related Institutions and has been designated as the 10th Pediatric Critical Care Center in Illinois (the highest level of specialized pediatric and emergency care services). The Keyser Family Pediatric Cancer Center at the children's hospital is one of the largest of its kind in the Midwest. Further, AHCH is accredited by the Cystic Fibrosis Care Center. The children's hospital offers the only pediatrics rehabilitation service in the Chicago Southland. The Heart Institute for Children is internationally renowned for pioneering advances in heart care for children. AHCH is also a

member of the Children's Oncology Group, an international research organization sponsored by The National Cancer Institute.

ACMC/AHCH is a Level I Trauma Center; it is one of the busiest trauma centers in the country. It is a Point of Distribution (POD) hospital in the coordination of disaster communication for a 5-county area and is involved in bioterrorism and disaster preparedness activities both nationally and locally.

The Medical Center is a leader in breakthrough technologies, including e-ICU® intensive care monitoring, robotic daVinci Surgery System®, and is one of only a handful of centers in Illinois offering Cyberknife® technology for treating hard-to-reach tumors and other abnormalities. The Medical Center has two advanced linear accelerators and Eclipse™ 3-dimensional treatment planning and virtual simulation system for patients undergoing radiation therapy. Other important technology includes Balloon Sinuplasty™ to treat chronic sinus infections without major surgery, iE33 echocardiography instruments for 3-dimensional echo imaging, and stereotaxis technology for advanced treatment of coronary artery disease and heart arrhythmias.

In 2007, the Medical Center began the development of "institutes" as a way of integrating related clinical operations spread across several departments. Each institute has both clinical and administrative leadership. The creation of these institutes has helped strengthen the Medical Center's regional and national leadership in the treatment of heart disease, cancer and neuroscience. The goals of each of the ever-expanding number of institutes at the Medical Center are to provide excellence in patient care, research, and education and to ensure multidisciplinary care and clinical integration. This integrated, multidisciplinary approach to care has already achieved national recognition related to improved outcomes for management of chronic diseases. Advocate has learned that coordinated health care translates into healthier patients. Although these goals were established half a decade ago, they are fully consistent with the goals of the 2010 national health care reform legislation.

The Heart and Vascular Institute, for example, has been instrumental in the Medical Center's development of one of the leading cardiovascular programs in the nation. The Medical Center's program is nationally renowned for the implantation of mechanical heart pumps in patients with severe heart failure. More heart surgeries are performed at the Medical Center than any other hospital in Illinois.

Another example is the growth of the Medical Center's highly respected services encompassed in the Women's Health Center. The Medical Center is a Level III Prenatal Clinic. Women's Health includes an Obstetrics/Gynecology Clinic for local uninsured and underinsured women. It also includes a regional program for women with high risk pregnancies and their fetuses and a Fetal Diagnostics area supports the care of the more than 4,000 high risk and normal infants born at the Medical Center each year.

Since 2005, ACMC/AHCH has been recognized by the American Nurses Credentialing Center (ANCC) as a Magnet Medical Center; Magnet status represents the highest honor in nursing excellence.

Each year, the Medical Center trains more than 400 residents, 600 medical students, 800 nursing students, and other health professionals in accredited programs in a wide range of specialties. These teaching affiliations include University of Illinois Medical Center, and 12 other universities and colleges. The Medical Center also trains more than 2,500 emergency medical technicians, paramedics, and other providers of emergency services annually through the Emergency Medical Services (EMS) Academy. The Medical Center's role in training medical manpower is also consistent with the goals of national health reform.

Almost every clinical program at the Medical Center is involved in research. Clinical trials offer patients access to the very latest in care, while giving physicians and researchers the opportunity to study the effectiveness of new treatments. With the Medical Center's active participation in clinical trials, patients have access to treatments before they are more widely available. The Medical Center's researchers manage a robust portfolio of clinical trials. A significant number of the trials in progress at the Medical Center focus on treatments for cancer and cardiac-related ailments in both adult and pediatric patients.

The Caneer Institute is an example of the research programs at the Medical Center. Most of the clinical trials managed within the Cancer Institute each year are Phase III, which means that the study drug or treatment is given to a large group of patients (1,000 to 3,000) to confirm its effectiveness, monitor side effects, compare it to commonly used treatments, and collect information that will allow the drug or treatment to be used safely.

The Cancer Institute participates in studies sponsored by the National Cancer Institute through groups such as the Eastern Cooperative Oncology Group, the Radiation Therapy Oncology Group, the Gynecological Oncology Group, the National Surgical Adjuvant Breast and Bowel

Project, and the American College of Surgeons Oncology Group. In addition, the Cancer Institute participates in several other national and international cancer studies sponsored by the pharmaceutical industry.

Patient involvement in clinical trials at the Medical Center provides access to a wide range of new, experimental drugs or new treatments without having to leave the community for cancer care.

As the Medical Center continued to experience strong growth and high occupancy of its inpatient and outpatient adult and pediatric services, clinical and non clinical space on the campus became increasingly scarce. To respond to the shortage of space, the Medical Center expanded the Surgical Pavilion, developed support space, constructed a medical office building, and added parking. The Medical Center also converted other categories of service to intensive care and medical surgical beds to accommodate the high census. Even with these expansions, it became evident that incremental facility growth was no longer a feasible approach for campus development. The Medical Center's evolving patient care, education and research missions, increasing staff size, and the introduction of new technology continued to exceed the capabilities of the existing facilities; the Medical Center determined that a more far-reaching approach to campus redevelopment was needed.

The following is a discussion of the major alternatives considered by the Medical Center.

1) And 2) Identification and Documentation of Alternatives

Advocate Christ Medical Center/Advocate Hope Children's Hospital considered five fundamental alternatives. They were:

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

Alternative 2 - Develop Additional Offsite Neighborhood Outpatient Centers

Alternative 3 - Utilize Other Health Care Resources or Joint Venture with Others

Alternative 4 - Redevelop the Existing Campus with an Inpatient Tower as Phase I

Alternative 5 - Redevelop the Existing Campus with an Ambulatory Pavilion as Phase I

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

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

In December 2003, Advocate filed a certificate of need application with the Illinois Health Facilities Planning Board (IHFPB), the predecessor of the Illinois Health Facilities and Services Review Board (IHFSRB), to obtain a permit to build a 144-bed hospital on the Advocate Southwest Medical Campus. This facility was designed to complement rather than compete with intensive care, adult medical surgical, and obstetrics services at the Medical Center. All pediatric services were to remain at Advocate Hope Children's Hospital. The ancillary services in the proposed hospital were sized based on the assumption that existing Advocate outpatient services already on the Southwest campus would reduce the scope of the ancillary services that would need to be constructed as part of the hospital. The development of a new hospital in Tinley Park/Orland Park represented an alternative setting option.

The IHFPB declined the application and suggested that the Medical Center look at other alternatives, particularly redevelopment on its existing Oak Lawn campus.

- Although this alternative appeared to have many merits, the Board's decision removed it from further consideration. The Medical Center accepted the Board's direction.

Alternative 2 - Develop Additional Offsite Neighborhood Outpatient Centers

Shortly, after the proposal to build a new hospital was declined, ACMC/AHCH's leadership developed a comprehensive strategic plan called Vision 2017. It included a long-term plan to expand the inpatient and outpatient services on the Oak Lawn campus. The strategic plan also included a short-term plan to develop off-site ambulatory care centers that would relieve some of the busiest ancillary departments such as breast health, imaging, physical rehabilitation services, laboratory, and sleep disorders. The short-term plan was implemented; the Medical Center added 3 new outpatient sites – one in Oak Lawn, one in Palos Heights and another in Lockport – and now has 4 busy outpatient locations including Tinley Park. Although this alternative setting strategy was a successful interim initiative, it was rejected as the long-term solution to the pressing need for space in the hospital for the following reasons:

- While these community/local ambulatory centers met local need, they did not significantly alleviate the overcrowding at the Medical Center's Oak Lawn campus.
- The Medical Center cannot provide tertiary care at off site locations. They are too distant from the specially trained staff and sophisticated technology that is inefficient to duplicate at multiple remote locations.
- Off-site centers were not suitable for the development of the institutes and their role in providing coordinated multidisciplinary care.

Alternative 3 – Utilize Other Health Care Resources or Joint Venture with Others

Advocate Christ Medical Center/Advocate Hope Children's Hospital is a major referral center providing advanced trauma, cardiovascular, oncology, neuroscience, orthopedic, women's, children's, and surgical services. Community hospitals and academic medical centers refer patients to the Medical Center. The Medical Center seldom refers patients to other facilities. The Medical Center rejected using other health care resources for the following reasons:

- Other nearby health care resources do not have the staff or technology needed to care for the Medical Center's high risk patients.
- The Medical Center determined that the need for expansion is on the Oak Lawn campus. It is not feasible to provide tertiary/quaternary care beyond the main campus where specialized physicians, staff, and technology cannot efficiently be replicated. Other alternative sites were pursued with varying degrees of success, but none met the expressed need for ambulatory services that can serve patients with both routine and complex medical and surgical conditions.
- ACMC/AHCH supports a large graduate medical education program. These students and the continuation of the graduate medical education program depend on having patients with certain disease status present to meet the educational requirements of their respective specialties. If current and future patients at the Medical Center were transferred to other facilities, the needs of the educational program would be compromised.

The Medical Center also considered joint venturing with other area providers to meet the Medical Center's needs; joint venturing was also rejected. Unlike separate buildings dedicated to outpatients, the Ambulatory Pavilion will be operated as part of the premises licensed under

the Hospital Licensing Act. Consequently, a joint venture would need to involve a joint venture for the entire hospital – not a feasible arrangement.

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

- Collaborative arrangements with other providers include:

  ACMC/AHCH/s partnership with Advocate Trinity Hospital has allowed the Medical Center to expand the clinical institutes to the Advocate Trinity community. Expanded services include emergent PCI for STEMI patients, cardiac, Stroke Center Designation, enhanced cardiodiagnostic testing, a sleep disorders center as well as education and training for the Advocate Trinity nursing and ancillary staff.

  The Medical Center will also provide staff training and clinical oversight to the newly approved pediatric service at Advocate South Suburban Hospital.

- Collaborative arrangements to educate health care professionals include:

  The Medical Center has collaborative educational arrangements with 13 colleges and universities for the training of physicians, nurses, and other health professionals. These colleges and universities include University of Illinois Medical Center (Chicago), Chicago College of Osteopathic Medicine/Midwestern University, Loyola University, Rush University, St. Xavier University, Purdue University Calumet, Trinity Christian College, Elmhurst College, University of St. Francis, Moraine Valley Community College, and EMS Academy.

- Collaborative arrangements with community agencies include:
  - Partnership with the Museum of Science and Industry (Live…from the Heart)
  - Supporting effort with PADS (South Suburban Public Action to Deliver Shelter)
  - Supporting PASS (Domestic Violence Against Women programs)
  - Collaboration with Ronald McDonald Charities® and Frontier Construction to operate the Ronald McDonald Care Mobile.
  - Collaboration with local schools to promote careers in health care
  - Collaboration with school nurses

- Collaboration with Dawes Elementary School (with a 94 percent low income student population) to provide health services and education
- Collaboration with Oak Lawn to provide monthly screenings and education
- Collaboration with Cease Fire Illinois to reduce the incidence of violence in the community
- Support to parish nursing and other congregational health ministries
- Collaboration with several churches in the south suburbs and Chicago area to support adoption programs, child and family services, and single mothers, and
- Assistance to food pantries.

For additional detail, see Attachment 43, Safety Net Impact Statement.

- Collaborative arrangement for performance improvement and improved outcomes include:
  - American College of Cardiologists
  - Outcomes Science, American Heart Association
  - American College of Surgeons Surgical Quality Improvement Program
  - Get with the Guidelines (Stroke and Heart)
  - UNOS National registry
  - INTERMACS National Registry
  - National Quality Measures for Breast Health
  - Cancer Registry – State of Illinois and Metropolitan Chicago Breast Cancer Task Force
  - Vermont Oxford (Neonatal Outcomes)
  - Adverse Pregnancy Outcomes Reporting System (APORS)
  - Cystic Fibrosis Foundation Patient Registry
  - U.S. Immunodeficiency Network
  - ELSO (Extracorporal Life Support) Registry, and
  - COG (Children's Oncology Group)

In summary, as described in Alternatives 1, 2 and 3, the Medical Center pursued alternative site strategies – both the development of a new hospital in Tinley Park/Orland Park and the development of community-based ambulatory care centers. The Illinois Health Facilities

Planning Board declined the application for the new hospital (as well as the applications of two other hospital proposals at the same time). The community-based ambulatory care centers have been successfully implemented, but do not fill the need for the delivery of increasingly complex ambulatory care which can only be delivered on the Medical Center's campus. Because of the nature of the care being proposed for the Ambulatory Pavilion, neither the location nor the capabilities of other health care resources are sufficient to address the clinical needs of the Medical Center's many very high risk patients. The Medical Center rejected joint ventures and instead is focusing on collaborative arrangements.

Alternative 4 – Redevelop the Existing Campus with an Inpatient Tower as Phase I

The initial plan was to develop an administrative building on the campus and use the vacated space in the hospital to expand existing services. This was rejected because a limited construction project would have been insufficient to address the far-reaching facility needs on the campus. There was no doubt that a major construction project was the only feasible solution to the space shortage at the Medical Center.

In 2007, the Medical Center initiated a master facility planning process with the intent of developing a patient tower on the campus. This approach was consistent with the intent of Vision 2017. The plans for the new patient tower included both beds and ancillary services. They envisioned services in which inpatients and outpatients were commingled. Concurrently another ambulatory site for the Tinley Park campus was on the drawing board.

It was at that time that the nation's economy began to falter, and Advocate Health and Hospitals Corporation placed a capital freeze on all facility development across the system. The Medical Center's proposed ambulatory project in Tinley Park was first downsized and then abandoned; the development of the patient tower in Oak Lawn was indefinitely delayed.

With hints of an economic recovery mid-2010, the Medical Center was given the green light to restart capital planning for the campus. To ensure that the earlier plans were still appropriate, the Medical Center engaged two firms (Kurt Salmon Associates and Sg2) known for their expertise as clinical program and health care facility planners. The results of these consulting engagements were reported to Medical Center administration in the fourth quarter of 2010.

Although the firms agreed that inpatient capacity needed to be addressed, they both felt strongly that it could not be addressed until efficiency was improved. They recommended that phasing should be re-sequenced, with an initial phase being the construction of a major ambulatory facility, with a patient tower to follow.

The reasons for rejecting Alternative 4 were as follows:

- Adding more beds to the already stressed facility would further exacerbate, rather than resolve, the severe operational and space issues related to the existing high volume and inadequate capacity, and the commingling of outpatient and inpatient services.
- The most pressing need on the campus is for outpatient services.

Alternative 5 – Redevelop the Existing Campus with an Ambulatory Pavilion as Phase I

Initially, the Medical Center's leadership was surprised by the consultants' recommendation, but soon realized that their alternative approach to campus redevelopment made ultimate sense. The consultants' recommendation to first build an ambulatory building, now being called the Ambulatory Pavilion (Pavilion), would allow the Medical Center to offload the institutes and their dedicated ambulatory services; ambulatory surgery, endoscopy, and imaging; other appropriate services such as Pre-Admission Testing, Pulmonary Function and Fetal Diagnostics from the hospital or leased space. As a result of the relocation of patients, more capacity would be available for inpatients; vacated space would be designed in the context of a future development of the campus in the context of the Master Facility Plan.

Alternative 5 is the alternative of choice for the following reasons.

- Alternative 5 provides for a logical sequential development of the campus:
    - The development of an Ambulatory Pavilion allows for the immediate development of outpatient space, the most pressing need on the campus today.
    - The Ambulatory Pavilion will create a more patient-focused, patient-friendly, and efficient setting for outpatients; it will create a one-stop-shopping experience for them. Wait times and length of stay will be minimized.
    - Patient access to ambulatory services will improve; it will no longer be confusing and cumbersome. Outpatients will no longer have to navigate the congested main hospital.
    - The Pavilion will be located on the campus and connected to the hospital on some levels with connectors permitting movement of patients, physicians and other clinical support staff between the two sites. Parking with easy access is an option for the future.

- The Pavilion provides an opportunity to develop the institutes in space designed to support the multidisciplinary care and clinical integration that has been developed at ACMC/AHCH and proven to improve outcomes.
- The Pavilion provides expanded capacity to support professional education and research initiatives.
- As the result of relocating ambulatory services, the hospital departments will improve patient capacity and operational efficiencies; the relocation of the ambulatory patients will free space for current inpatients until additional capacity can be created for the hospital.
- The new ambulatory building provides more needed surgery and endoscopy capacity thus decompressing the inpatient departments and allowing them to focus on highly complex cases that are the hallmark of a tertiary/quaternary referral center.
- Space to increase a wide range of imaging modalities will be provided in the Pavilion. This will allow inpatient imaging to concentrate resources on acutely ill and trauma/emergency inpatients. Inpatients will no longer be awakened during the night to be transported to the imaging department for an exam because that was the only time the equipment was available.
- The expanded capacity will provide the infrastructure for the more than 60 physicians that have been added to the medical staff between 2008 and 2010.
- By offloading some services to the Ambulatory Pavilion, space will be vacated for the future expansion of hospital-based departments that are severely undersized including, for example, the emergency department, cardiac catheterization, and radiation oncology.
- The expanded capacity as the result of the construction of the Ambulatory Pavilion and the future modernization of vacated space in the hospital will better enable the Medical Center to respond to the challenges of implementing national health care reform.
- The construction of the Ambulatory Pavilion will add from 150 to 200 construction jobs during the duration of construction. With the current high

unemployment rate, these additional jobs are very important. (See Attachment 13, Exhibit 2)

- The Medical Center estimates that approximately 150 new associate positions will become available when the Pavilion opens. These will include, for example, positions in nursing; surgery, imaging, and enviornmental services in accordance with the Medical Center's human resources policy. These new positions will be permanent positions.

Summary of Alternatives

Description	Project Cost	Rationale
Alternative 1 – Develop a New Hospital on the Advocate Southwest Campus	$222.26 million (2003 dollars)	This alternative was abandoned because the Illinois Health Facilities Planning Board declined the certificate of need application and suggested that Advocate Christ Medical Center/Advocate Hope Children's Hospital ACMC/AHCH, Medical Center) redevelop on the Oak Lawn campus.
Alternative 2 – Develop Off-site Neighborhood Clinics	$6.95 million	The Medical Center successfully implemented this alternative and while it met local community needs it did not resolve the shortage of outpatient on the Medical Center's campus.
Alternative 3 – Partner with Other Providers or Utilize Other Health Resources	No capital cost	The Medical Center has determined that joint ventures have severe limitations on ownership since the Ambulatory Pavilion will be operated as part of the premises under the Hospital Licensure Act. Instead of joint ventures, the Medical Center is focused on the development on a wide range of collaborative arrangements to enhance access and standard of care while reducing cost. Other health care resources are not adequate to support the needs of ACMC/AHCH's acutely ill/severely injured patients. The new space needs to be on the Medical Center's campus.
Alternative 4 – Redevelop the Existing Campus with a Patient Tower as Phase I	$600+ million	Recent evaluation of campus redevelopment phasing has determined that a new patient tower will be Phase I; Phase II will occur at some undetermined future date. The conclusion of an evaluation was that adding more beds to an already stressed facility would further exacerbate rather than resolve the current severe shortage of space.

Summary of Alternatives

Description	Project Cost	Rationale
Alternative 5 – Redevelop the Existing Campus with an Ambulatory Pavilion as Phase I	$ 202,301,558	Alternative of choice for the following reasons: ▪ The Ambulatory Pavilion meets the most pressing need on campus – space for increasingly complex outpatient care. ▪ The Pavilion will be a patient-centered efficient environment for the delivery of outpatient care. Access will be simplified; waiting times and length of stay will be reduced. ▪ Will be located on the Medical Center's campus and physically connected to the hospital building allowing for movement of patients, physicians, and other staff between the two sites. ▪ Provides space specially designed for that institutes that will support multidisciplinary care and clinical integration as well as the clinical services related to the institutes. ▪ Provides expanded space to support professional education and research initiatives. ▪ Provides needed surgery and endoscopy space. ▪ Offloading of outpatient services will enhance patient capacity and operational efficiencies in the hospital. ▪ Provides space for a wide range of imaging technology. ▪ Provides the infrastructure for the more than 60 physicians that have recently been added to the staff to meet patient volumes. ▪ Vacates space in the hospital for the future expansion. ▪ Enables the Medical Center to respond to the challenges of implementing national health care reform. ▪ Adds from 150 to 200 construction jobs for the duration of the construction of the project. ▪ When the Pavilion opens approximately 150 new associate positions will become available. These will be permanent positions.

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

Introduction

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

This commitment is evident at Advocate Christ Medical Center/Advocate Hope Children's Hospital (ACMC/AHCH, Medical Center.) For example, AHCH is nationally recognized for its high standards of care. Recently, AHCH received the coveted Fire Starter Award from the Quint Studer Group. This award is given to organizations that demonstrate outcomes excellence. Similarly, ACMC has been awarded for quality outcomes. It has been named a top performing hospital (top 5 percent in the country) in the MIDAS+™ Platinum Award Program and is recognized by the American Heart Association and American Stroke Association for sustained "gold award" performance in treating coronary artery disease, heart failure, and stroke.

Two of AHHC's initiatives are described below. The first is the new accountable health care model and the second is the structure that is in place to improve quality of care.

New Accountable Health Care Model

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

Advocate Physician Partners is focused on improving health care quality and outcomes, while reducing overall cost of care – both in the inpatient and outpatient settings. This group's award winning, clinically integrated approach to patient care utilizes the best practices in evidence-based medicine, advanced technology, and quality improvement techniques. Over the past 10 years, through its clinical integration program, Advocate has learned that coordinated health care translates to healthier patients. Based on that understanding, Advocate has been working to

transform the way health care is delivered. In October 2010, Advocate announced that it was launching a benchmark care delivery system that will continue to drive collaboration among physicians, hospitals, payors, and employers. This new approach is consistent with the Accountable Care Organization (ACO) model, sets higher clinical expectations, and puts reimbursement at risk for poor outcomes.

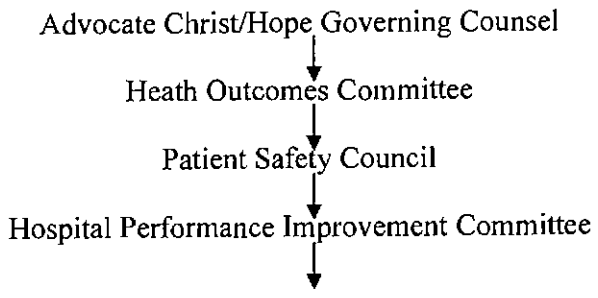
Accountable Care Organizations practice team-based care, an approach in which physicians, nurses, and specialists work together to provide coordinated care for patients. These professionals come together and agree on ways to improve care outcomes. A strong emphasis is placed on proactive measures, including prevention, identification of disease, and ongoing intervention on disease states.

The current initiative is a partnership with Blue Cross Blue Shield of Illinois. Under this arrangement, Advocate, including ACMC/AHCH, intends to reduce overall utilization by providing the most appropriate care in the most appropriate setting. It is expected that this will result in more ambulatory care, rather than inpatient care, and that overall healthcare expenditures would decline with a reduction in the intensity of the utilization. The goal of the program, called AdvocateCare, is to provide each patient with the right care at the right time in the most cost effective setting. The contract became effective January 1, 2011.

In September 2010, Washington administrative staff met with Advocate leaders to learn more about Advocate's clinical integration program and how it can be used to craft ACO regulations and benefit millions of Medicare recipients nationwide.

Established Performance Improvement Process

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



Divisional Performance Committee

↓

Department Performance Improvement Committee

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

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

The metrics used in the performance improvement process include:

- Establish organizational definitions
    - Measures of success
    - Numerator/denominator
    - Data source
- Establish baselines
- Research best practice, and
- Set target goals and monitor progress.

The Health Outcomes Committee's role is to:

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

The Hospital Performance Improvement Committee's role is to:

- Provide overall guidance for the quality structure for both clinical and non-clinical departments
- Review/approve division/department performance improvement plans
- Monitor progress of the RCA/Continuous Quality Improvement multidivisional teams, and
- Facilitate continuous compliance with regulatory requirements.

The Divisional Performance Improvement Committee's role is to:

- Review all departmental performance improvement measures/plans quarterly
- Share action planning/best practice with the team, and
- Ensure compliance with regulatory requirements specific to the Division of Pediatrics (AHCH).

The role of Department Performance is to:

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

Examples of AHCH's performance plan include:

- Patient satisfaction
- Falls
- Universal Protocol
- Documentation
- Catheter associated blood stream infection in ICU's
- Pain Assessment
- Reporting of critical tests
- Skin care

Examples of department specific indicators include:

- Appropriate abbreviations
- Chemotherapy verification procedure
- High alert medication verification

- Code blue, and
- Patient identification process

Performance Improvement in the Ambulatory Setting

The ambulatory departments of ACMC/AHCH have a data management infrastructure to collect, trend data, analyze, and share data. The infrastructure is comprised of executive leadership who oversee the development and implementation of a comprehensive and integrated performance improvement and patient safety program. The Health Outcomes Committee is the leadership body responsible for integrating, responding and directing initiatives that guide patient safety and quality to achieve optimal clinical outcomes, as well as monitoring the effectiveness of quality and patient safety initiatives. The scope of these initiatives is based on Advocate Health Care's Clinical Outcomes and Patient Safety priorities, which are outlined in the annual Performance Improvement Plan. The Director of each ambulatory department is represented on the Hospital Performance Improvement Committee. The membership is responsible for monitoring the quality and safety of care provided by both the ambulatory as well as inpatient clinical departments. Committee activity includes the ongoing assessment of key indicator measures plans as well as interventions in place to promote ongoing improvement.

Each of the ambulatory settings engages in a robust performance improvement process. Following are examples from the cardiac rehabilitation area and the department of radiology which demonstrate how the ambulatory areas within the quality infrastructure utilize data and focuses on performance improvement efforts.

Cardiac Rehabilitation

A sample of patients that completed the Early Outpatient Cardiovascular Rehabilitation (Phase II) program during 2010 participated in the department's Outcome Management Program which is a series of pre and post therapy tests used to evaluate the patient's progress and the program's overall effectiveness.

The Clinical Domain of the Outcome Management program consists of initial measures completed during the patient's orientation week and incorporated into the patient's treatment plan. Final measures are completed during the patient's last week of class. A total of 43 patients were assessed. Clinical measures include the 6 minute walk test, the Duke Activity Index, Weight and BMI (Body Mass Index). Distance walked, heart

rate and blood pressure response to exercise, and RPE are reviewed with the patient upon their completion of the program to demonstrate their improvement in exercise tolerance. Additionally, the average increase in exercise MET (metabolic equivalent) level in the six minute walk is currently used as a monthly quality improvement indicator. The BMI is calculated pre and post program and is used to show disease risk and help to develop the patient's goals during and after cardiac rehab. The Duke Activity Index measures self reported functional capacity and is used to estimate activity status and can demonstrate improvements in quality of life and exercise tolerance.

In 2010, the patient sample demonstrated a 20 percent increase from the pre-program score of 1338 to the post program score of 1602. Additionally, the patient population demonstrated a 20 percent increase in feet walked on the 6-minute walk.

The Clinical Domain consists of a number of different measures used in the program; including the use of the 6-minute walk, weight, BMI, and the Duke Activity index. Improvements were noted in all domains with the exception of the BMI. Benchmarking against evidence based practices; the team developed a series of tactics which included the development of patient education tools that addresses the specific relationship between excess weight and cardiac disease, its effect on blood lipids, glucose, and arthritis pain. The department identified weekly patient "weigh in" was inconsistent. A strategy was developed to ensure a standard date/time and documentation process was in place. The environment was modified to include a dedicated space to showcase patient events from the dietary department available to outpatients and the community at large.

CT Section of the Department of Radiology

The CT Section of the Department of Radiology has been participating in the Intravenous Contrast Extravasations National Radiology Data Registry (NRDR) sponsored by the American College of Radiology and the Society of Urological Radiology (SUR-ACR). With the advances in CT imaging technology the use of power or mechanical injectors has increased; these injectors are needed to deliver the contrast at the correct rate and volume to optimize contrast enhancement of organs and blood vessels. Due to the use of power injector the incidence of contrast extravasations has increased. (Extravasation is the escape of the contrast media from a blood vessel into surrounding tissue.) The Radiology Department has identified a benchmark for acceptable extravasations rate and

has identified best practices to reduce the rate.

The CT Section established a base line rate by collecting and submitting data for the date range 10/03/2010 to 04/01/2010, which demonstrated an extravasations rate at the national average of .07 percent (see Table 1 below). Best practice recommendations were reviewed and subsequently changes were made to IV contrast protocols which included:

- Updated CT IV worksheet to better document risk factors for extravasations
- Patients at higher risk are reviewed with the Radiologist
- Instituted IV contrast protocol setting standards for IV gauge, flow rate, and IV site
- Established protocol for using Power PICC and Power ports
- Instituted test flush of all IV prior to power injection
- Technologist stays in room at beginning of injection to check for extravasations
- All injectors pounds per square inch alarms set to automatically stop injection of PSI rate goes too high

After the changes were implemented, a second set of data was collected 08/01/2010 to 01/28/2011

Attachment 13, Table 1

Change in Extravasation Rate												
									Severity			
Report Date	Total number of extravs reported	Total IV inject	Extrav Rate	National average extrav rate	<10	10-49	50-99	>99	Minor	Moderate	Severe	Not reportable
4/16/10	48	7,204	0.70%	0.70%	4.20%	50.00%	29.20%	16.70%	89.60%	0.00%	0.00%	10.40%
2/15/11	41	7,353	0.60%	0.70%	4.90%	43.90%	41.60%	9.90%	61.00%	2.40%	0%	36.60%

The implementation of changes in protocols resulted in 7 less extravasations while there was an increase of 149 patients that received contrast. The overall extravasation rate decreased by 0.1 percent from 0.7 percent to 0.6 percent or below the national average. The Severity column titled not reportable are patients that could not be reached for complete follow up assessments, therefore the severity could not be accurately categorized.

PEPPER CONSTRUCTION

May 3, 2011

Mr. Robert Harrison
Vice President
Business Development
Advocate Christ Medical Center
4440 West 95th Street
Oak Lawn, Illinois 60453

RE: Advocate Christ Medical Center
New Ambulatory Pavilion Project

Dear Mr. Harrison:

In Pepper Construction Company's estimation, there will be approximately 150 – 200 tradespeople employed on the construction of the New Ambulatory Pavilion at Advocate Christ Medical Center. Some of the construction individuals involved throughout the project would be Superintendents, Foremen, Laborers, Project Managers, and Carpenters.

Should you have any questions, please don't hesitate to contact me.

Very truly yours,

PEPPER CONSTRUCTION COMPANY

Tim Cooper
Senior Vice President

411 Lake Zurich Road | Barrington, Illinois 60010-3141 | 847 381-2760 | FAX: 847 304-6510

SECTION IV - PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE

Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

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

2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following::

   a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;

   b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;

   c. The project involves the conversion of existing space that results in excess square footage.

Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?

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

Allocation of Waiting Space

When comparing the size of the departments on the drawings in Narrative, Exhibit 1, with the size of the departments on the various tables, the reader will notice that the size in the tables is sometime larger. That is because a portion of the waiting space has been allocated to the departments, and included in all the tables that show square feet. Waiting space is a requirement of the licensure rules for many departments so must be included in the plans. In the case of this project, there are several shared waiting rooms so a portion of that space was allocated to the nearby departments that the waiting rooms serve.

Size of the Project

The table below demonstrates the proposed project has met the State Standards for physical space for nine of the ten departments regulated regarding size.

Attachment 14, Table 1

SIZE OF PROJECT				
Dept. / Area	**Proposed DGSF**	**State Standard**	**Difference**	**Met Standard?**
Surgery Operating Rooms	88,045/40 ORs = 2,201/OR	2750 DGSF/OR	-549	Yes
Surgery Procedure Rooms	11,798/11 rooms = 1,073/room	1,100 DGSF/Proc Rm	-27	Yes
Phase I Recovery (PACU)	10,251/33 rec stations = 310/station	180 DGSF/ Recovery Station	130	No
Phase II Recovery (Prep/recovery)	32,659/82 stations = 398/station	400 DGSF/ Recovery Station	-2	Yes
General Radiology/Fluoro	20,621/18 units = 1,146/unit	1,300 DGSF/unit	-154	Yes
Mammography	1,426/5 units = 285/unit	900 DGSF/unit	-615	Yes
Ultrasound	14,060/18 units = 781/unit	900 DGSF/unit	-119	Yes
CT & PET/CT	16,761/10 units 1,676/unit	1,800 DGSF/unit	-124	Yes
MRI	10,674/6 units = 1,778/unit	1,800 DGSF/unit	-22	Yes
Nuclear Med./Spect. /CT	11,184/7 units = 1,597/unit	1,600 DGSF/unit	-3	Yes

Source: Architectural plans, ACMC plans.
These calculations are based on the total space (existing and new) and the total patient visits (inpatients and outpatients.)

Advocate Christ Medical Center plans to include in the proposed Ambulatory Pavilion a surgical service to address the more complex needs of the growing number of outpatients. That service will include post anesthesia care. The combined program with the existing and proposed Phase I Recovery (PACU) will offer a total of 33 stations. The current State standard for size, as shown in Section 1110 Appendix B, calls for:

180 DGSF/Recovery Station, or

5,940 DGSF/33 Recovery Stations

The proposed square footage of 10,251 DGSF exceeds the State Agency guidelines.

10,251 DGSF/33 Recovery Stations, or

310 DGSF/Station

There are various reasons that today's PACU must be larger than in the past. The classic recovery stations are still open bays to provide good visibility and easy access by the nursing staff. However, there is an increasing demand for private rooms to care for patients who have a known infection or for those who are so compromised that they are at greater risk for acquiring an infection. The proposed new unit will have 4 stations that are enclosed and one equipped with appropriate air pressure for isolation.

The infection control efforts to manage the risk of a contact infection of Methicillin Resistant Staph Aureus (MRSA) encourage a larger zone of contact be maintained between beds. The potential for accidental cross contact is greater when the space is confined.

The increase in the use of large equipment and more sophisticated care has resulted in more post surgical x-rays being done. The equipment is large and requires room to maneuver without exposing nearby patients to the process. More patients are on ventilators coming out of surgery and that takes room for the equipment and staff to monitor it.

The most significant factor that is affecting the size of the PACU is the new change in the IDPH Hospital Licensing Requirements. The Illinois Health and Services Review Board Code, 1110.234 a) 2) notes the following:

If the project SF is outside the Standard in Appendix B,....the applicant shall submit documentation of one or more of the following:

> *A) Additional space is mandated by government or certification agency requirements that were not in existence when the Appendix B standards were adopted.*

In the Hospital Licensing Code, Part 250.1320, effective March 4, 2011, is a revision that now permits visitors in the Phase I PACU while the patient is recovering from a surgical procedure. A copy of the new licensure requirements is included as Attachment 14, Exhibit 1.

With this significant change in the Code, it is essential to have the space available. The Code notes the importance of safeguarding the privacy of other patients and still allowing PACU staff

to give constant attention to anesthetized patients. Visitors will need seating, and in some cultures, it is typical to have several visitors at one time.

The code calls for at least one additional staff person in the PACU assigned to oversee, supervise and assist the visitors for the period of time the visitors are present.

Additionally, there is a need for better patient visibility by the nursing staff. In HealthcareBuildingIdeas.com they note:

> The trend has been to design larger bed positions approaching the size for an ICU bed with a headwall of 11-12 feet, despite the lack of change in the codes and guidelines. The Codes have continued to refer to the minimum area for each bed being on 80 square feet. The last two updates of the IAU Guidelines for the Design and Construction of Health Care Facilities added clearance around each bed that result in an average bed position of at least 120 square feet.

In view of these significant changes, it is imperative to be prepared for this operational demand for space.

E) *Collaboration with, and an annual report to, the nurse staffing committee;*

F) *Procedures for a nurse to refuse to perform or be involved in patient handling or movement that the nurse in good faith believes will expose a patient or nurse or other health care worker to an unacceptable risk of injury;*

G) *Submission of an annual report to the hospital's governing body or quality assurance committee on activities related to the identification, assessment, and development of strategies to control risk of injury to patients and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a patient; and*

H) *Consideration of the feasibility of incorporating patient handling equipment or the physical space and construction design needed to incorporate that equipment when developing architectural plans for construction or remodeling of a hospital or unit of a hospital in which patient handling and movement occurs.* (Section 6.25 of the Act)~~Patient safety.~~

8) Nursing role in other hospital services, including but not limited to such services as dietary, pharmacy and housekeeping.

9) Emotional and attitudinal support. (Refer to Section 250.260(~~b~~)(1).)

d) A nursing procedure manual shall be developed and copies shall be available on the patient care units, to the nursing staff and to other services and departments of the hospital, including members of the medical staff and students.

e) The procedure manual shall provide a ready reference on nursing procedures and a basis for standardization of procedures and equipment in the hospital.

(Source: Amended at 35 Ill. Reg. 4556, effective March 4, 2011)

SUBPART J: SURGICAL AND RECOVERY ROOM SERVICES

Section 250.1320 Postanesthesia Care Units~~Postoperative Recovery Facilities~~

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

a) Provision and use of Phase I Postanesthesia Care Unit (Phase I PACU)~~postoperative recovery facilities~~

1) For the purposes of this Section, Phase I of postanesthesia care is the phase immediately following surgery, usually in a recovery room, after which the patient is returned to his or her room.

2)~~1)~~ Postanesthesia care unitsPostoperative recovery facilities shall be provided by all hospitals in which surgery is performed. They shall be in a separate room where patients who have undergone surgical procedures can be immediately observed and receive specialized care by selected and trained personnel, and where, when necessary, prompt emergency care can be initiated.

3)~~2)~~ The services of the Phase I PACU~~postoperative recovery room~~ may be used~~utilized~~ for postpartum care if the delivery room or place of delivery is in proximity to the Phase I PACU~~postoperative recovery room~~. Only clean (non-infected or non-infectious) postpartum patients may be admitted to the Phase I PACU~~postoperative recovery room~~ and may, after appropriate observation, be returned to the maternity department.

b) Personnel

1) Physician
A physician shall be responsible for the conduct of the Phase I PACU~~recovery room~~, for the training of Phase I PACU~~recovery room~~ personnel, and for the establishment of admission, ~~and~~ discharge, and emergency policies and procedures.

2) Nurse

A) A registered nurse who has education and experience in Phase I postanesthesia~~postoperative recovery room~~ care shall supervise all personnel performing nursing service functions.

B) A registered nurse shall be in attendance at all times when patients are in the Phase I PACU~~recovery room~~.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

C) There shall be sufficient nursing personnel to provide the specialized care required for the postsurgical~~post-surgical~~ patient. It is recommended that a ratio of one nursing personnel to two~~three~~ patients be maintained at all times.

D) Nursing personnel shall be assigned permanently to the Phase I PACU~~postoperative recovery room~~ when patients are present.

e) Practices for operation of the Phase I PACU~~postoperative recovery rooms~~

1) Only clean surgical cases shall be admitted to the Phase I PACU~~postoperative recovery room~~.

2) Contaminated cases shall be returned to the isolation room or a private room. Contaminated cases may be admitted to the Phase I PACU when~~When~~ a separate isolation facility is within or adjacent to the Phase I PACU~~postoperative recovery room, contaminated cases may be admitted to it~~.

3) A member of the medical staff shall provide initial orders for the care of each patient upon admission.

4) A member of the medical staff shall be responsible for the patient's discharge from the Phase I PACU~~recovery room~~.

5) Anesthetized patients shall be constantly attended. Side rails shall be attached to movable carts and beds and raised above mattress level when occupied by anesthetized patients. Cribs shall be provided for the anesthetized or postsurgical~~post-surgical~~ child.

6) Written policies and procedures, which shall beare reviewed regularly and revised as necessary, shall be established.

7) A complete orientation program and continuing in-service education program shall be provided for all personnel assigned to the Phase I PACU~~recovery room~~.

8) Personnel with communicable diseases shall be excluded from the Phase I PACU~~recovery room~~.

9) VisitorsNo visitors shall be permitted in the Phase I PACU ifpostoperative recovery room, except in the case where a hospital has adopted a policy, approved through the Governing Board, that allows for visitation in the Phase I PACU while the patient isa parent or guardian, or other individual selected by a child's parent or guardian, of a child 12 years of age or younger to be present with the child in recovering from a surgical procedure. Before allowing individuals to be present in the Phase I PACUrecovery area with their child, the hospital shall have a policy in place that includes at least the following:

A) Written consent of an adult patient;both the parent, guardian, or legal representative of a minor or a mentally disabled adult; orother individual and the physician performing the surgery;

B) Notation in the patient's medical record of the presence of additional visitorspersons in the Phase I PACUpostoperative recovery room during recovery of the patientchild from a surgical procedure;

C) Application of safeguards against the introduction of infection or other hazards by the visitor,parent, guardian or other individual including orientation, education and training of the person, preferably prior to the performance of the procedure but at least prior to visitation; this shall include, at minimum, specifics regarding the procedure and recovery, what can be expected, and basic infection control practices expected of the visitorperson;

D) Provision of at least one additional staff person in the Phase I PACUrecovery room assigned to oversee, supervise and assist the visitorsparent, guardian or other designated individual for the period of time the visitors areparent, guardian or designated individual is present;

E) Provision of safeguards to ensure the privacy of other patients who may be recovering from surgical procedures, which may include separate rooms or some other type of separation for recovery of patientschildren who would have a visitorparent present. Privacy safeguards shall allow Phase I PACU staff to provideWhatever

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NOTICE OF ADOPTED AMENDMENTS

~~method is chosen must allow~~ for constant attention ~~by~~ of anesthetized patients ~~by recovery room staff~~; and

f) If, at any point during the recovery of the ~~minor~~ patient, Phase I PACU ~~is determined by the recovery room~~ personnel determine that the ~~visitor~~ parent, guardian or other individual poses a threat to the safe, therapeutic recovery of the patient, personnel ~~he or she~~ may require the ~~visitor~~ parent, guardian or other individual to leave the Phase I PACU ~~recovery room~~.

d) Drugs, supplies and equipment
Drugs, supplies and equipment shall be immediately and continually accessible in the Phase I PACU ~~unit for postoperative care~~, including emergencies. These shall include cardiac-respiratory monitoring and resuscitation materials.

e) The Phase I PACU ~~post-operative recovery facility~~ shall contain and provide for a drug distribution station, including a secure area, adequate hand-washing ~~and washing~~ facilities, charting and dictating area, soiled utility area with bedpan flushing device, and adequate storage space for supplies and equipment.

(Source: Amended at 35 Ill. Reg. 4556, effective March 4, 2011)

Size of the Ambulatory Care Departments

There are nine clinical service areas planned to go in the proposed Ambulatory Pavilion. Five of the departments will continue to have operations in the hospital, in addition to the new locations for outpatients. The size of the departments varies greatly, depending on the program, the required equipment, support space needed, and the length of time of the patient visit.

The State Standard is 2,000 visits per year per 800 GSF for Ambulatory Care Services. According to the rules, the term ambulatory care means medical care including the diagnosis, observation, treatment, or rehabilitation that is provided on an outpatient basis. Ambulatory care includes simple diagnostic procedures such as blood tests or well-baby visits; they also include more complex procedures such as oncology infusion treatments and CHF Clinic visits. Since the guideline appears to cover a wide range of ambulatory care that is organized as a service, time per visit varies widely. The time for a blood test could be 5 minutes or less, while more complex ambulatory visits could take several hours.

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

250 days per year x 7.5 hours per day x 80 percent occupancy = 1,500 hours of surgery per room per year

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

1,500 hours per room ÷ 2,000 visits per room = 0.75 hours or 45 minutes per visit

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

Congestive Heart Failure Clinic

For some departments, the visit was much longer than the calculated 45 minutes. A review of the Hospital records showed the average CHF patient's treatment time to be 3.8 hours or 5.1 times the 45 minute average. See Attachment 37, C-7 for details on this department's unique demand. The total number of visits was then multiplied by 5.1 to get the equivalent visits.

7,172 x 5.1 = 36,577 equivalent visits

Neurodiagnostics

A study of the average time of a visit to Neurodiagnostics found 1.83 hours/exam or 110 minutes/exam. Using the standard described above, a Neurodiagnostics patient visit is 2.4 times the average ambulatory care visit. See Attachment 37, C-10 for the details. When calculated, the equivalent visit was:

4,378 x 2.4 = 10,507 equivalent visits.

Pulmonary Function

This department's records show an average pulmonary function visit takes 1.5 hours, including set-up and clean-up of the equipment. Compared to the standard 45 minute visit, these patients

are in the department twice as long. See Attachment 37, C.14 for more on this service. The impact of this treatment time per patient is:

2,291 visits x 2.0 = 4,582 equivalent visits

Attachment 14, Table 2

SIZE OF AMBULATORY CARE DEPARTMENTS				
Dept. / Area	**Proposed DGSF**	**State Standard**	**Difference**	**Met Standard**
Cast Room	966 gsf / 6,223 visits = 310 gsf/2,000 visits	800 gsf/2000 visits	-490	Yes
Heart Failure Clinic	4,351 gsf / 36,577 equivalent visits[1] = 242 gsf/2,000 visits	800 gsf/2000 visits	-558	Yes
Fetal Diagnostics	5,501 gsf / 23,974 visits 458 gsf/2,000 visits	800 gsf/2000 visits	-342	Yes
Adult Infusion Center	9,368 gsf / 31,650 visits 592 gsf/2,000 visits	800 gsf/2000 visits	-208	Yes
Neurodiagnostics	2,830 gsf / 10,507 equivalent visits = 544gsf/2,000 visits	800 gsf/2000 visits	-256	Yes
Non-Invasive Cardiology	7,739 gsf / 90,636 visits 171 gsf/2,000 visits	800 gsf/2000 visits	-629	Yes
Pain Center	928 gsf / 4,848 visits = 386 gsf/2,000 visits	800 gsf/2000 visits	-397	Yes
Pre-Admission Testing	3,350gsf / 11,831 visits 567 gsf/2,000 visits	800 gsf/2000 visits	-233	Yes
Pulmonary Function	1,611 gsf / 4,582 equivalent visits = 700 gsf/2,000 visits	800 gsf/2000 visits	-100	Yes

Source: ACMC records.
These calculations are based on the total space (existing and new) and the total patient visits (inpatients and outpatients.)

Size of the Additional Departments

The size of the other departments that are not defined in Appendix B has been guided by the American Institute of Architects, Academy of Architecture for Health, a noted resource and authority. The *Guidelines for Design and Construction of Health Care Facilities*, 2006 edition, was referenced in the early planning phase. The 2010 edition has recently been released, with updates to selected sections.

The following are the clinical service areas not listed in Appendix B and the rationale used to determine their gross square footage is necessary and appropriate.

Attachment 14, Table 3

SIZE OF ADDITIONAL CLINICAL DEPARTMENTS		
Dept. / Area	**Proposed DGSF**	**Basis for Size**
Laboratory	23,809 gsf / 2,063,989 tests	The size was determined by the program, with a review of the drawing and specimen collection stations needed, and the number of staff. The new Lab will only be 1,362 gsf. The remaining space is the main laboratory located in the Hospital. See Attachment 37, F.21 for details.
Pharmacy, Satellite	1,537gsf / 31,650 infusion patients	This service will be located in the Cancer Institute and will prepare the infusions and other meds for the oncology patients. See Attachment 37, G.22 for details.
Outpatient Rehab	19,343 gsf / 244,864 visits	199,001 adult patients are expected, the remaining 19,282 are pediatric patients. 9,700 gsf of the department will remain in the Hospital to see the inpatients. The pieces of rehab equipment and number of treatment areas to accommodate the patient volume were the basis for the size. See Attachment 327, H.23 for details.
Cardiac Rehab	6,446 gsf /16,320 visits	75% of this service is outpatient. Similarly, 77% of the department's space will be in the Ambulatory Pavilion as a part of the Heart and Vascular Institute. Equipment, treatment areas and staff were the factors in determining size. See Attachment 37, H.24 for details.

Source: ACMC records.
These calculations are based on the total space (existing and new) and the total patient visits (inpatients and outpatients.)

Size of Non Clinical Departments/Areas

The size of the Multidisciplinary Centers (physicians' office areas) (31,566 DGSF) was determined by the patient volume, the number of physicians and professional staff expected, and the number of exam and support rooms required.

The area of the Lobby, Public Area, Resource Center, and Winter Garden (13,126 DGSF) was determined by the volume of patients, visitors, and staff moving through the area.

Registration and Financial Counseling size (3,470 DGSF) is based on the volume of patients expected to register on site. Patients pre-registered will go directly to the department for their scheduled visit.

The Shell Space was added in a block of sufficient size and location (14,337 DGSF) to accommodate the growth of the Institutes and other programs.

Administration, Research, and Education size (19,285 DGSF) and location were based on the support to be provided to the departments, and the staff that would use the spaces.

The Electronic Medical Record Support space (369 DGSF) will accommodate the computer system to manage the new electronic health record system.

Materials Management and EVS are sized (2,650 DGSF) to provide receiving, breakdown, storage and movement of supplies through the Pavilion and to provide supplies and cleaning support located throughout the building.

Circulation/Connectors/Pneumatic Tube are sized (23,789 DGSF) to serve as the connections and walkways outside the departments.

The Modernized Connector (1,341 DGSF) was sized to connect the new Pavilion back to the existing hospital.

The Lobby Café (191 DGSF) was sized to allow for food sales and for guests to have a place to sit while enjoying the food.

The Retail Pharmacy was sized (807 DGSF) for a walk-in customer base, with limited display space.

The Mechanical space was sized (42,071 DGSF) by the engineers to accommodate the HVAC, electrical systems, medical gasses equipment, emergency generators, auxiliary equipment, and operational support needed.

HDR ONE COMPANY Many Solutions

May 10, 2011

Mr. Scott Nelson
Director
Strategy, Planning and Design
Planning, Design and Construction
Advocate Health Care
2025 Windsor Drive
Oak Brook, IL 60523

Re: New Ambulatory Pavilion
Advocate Christ Medical Center
Oak Lawn, Illinois

Scott,

Per your request, HDR has evaluated the probable construction cost per square foot averages for the proposed Amulatory Pavilion compared against average costs for this type of building. The scope, program and site for the proposed Ambulatory Pavilion project will incur additional costs not normally anticipated in average costs per square foot for similar types of buildings for the provision of outpatient services.

Below is an outline of items that are potentially premium costs related to a high rise building on a constraned site, with a large portion of the program devoted to outpateint treatment facilities such as surgery, endoscopy and imaging.

Structural items:

1. High-rise construction results in some cost premium for:
   a. Caisson foundations – heavier loads drive the need for deep foundation system which is more expensive.
   b. Higher wind loads result in some additional costs to the frame.
   c. Seismic loading on a high-rise structures and this building's Seismic Design Category results in a higher frame cost than shorter structures or structures in some other locations.
2. Imaging equipment must be located on supported floors which increases the cost of the frame and foundations compared to more typical slab on grade installations.
3. Larger building volume, stacking requirements and site constraints drive the need to place mechanical units on a supported floor which increases frame and foundation loads.
4. Locations of OR's on supported floors results in potential vibration and acoustic issues that can influence the thickness of slab required and thus influences frame cost.

General Architectural items:

- Type 1A Construction allows the building to be "Unlimited Area" and unlimited height. It also allows it to be an addition to the existing campus. If it were Type 1B, we would need a 3-HR fire wall to create a separate building. – additional fire proofing.
- Additional elevators are required for multistory buildings. More stories = more elevators/ SF.
- High Rise construction (over 75-FT above the lowest level of fire dept. access) adds several architectural requirements in addition to the structural requirements. A Fire Command Center must be provided, exit stair and elevator enclosures must have increased structural integrity, exit stairs must be pressurized, Luminescent egress path markings must be provided at stairs and stairs and elevators must provide for fire service access.
- Newest Energy Efficient Envelope requirements of ASHRAE 90.1 and IECC, 2009 require additional insulation materials in exterior walls, below grade walls, below slab on grade floor and also require higher performing fenestration. Additional layers of building enclosure materials and sealant are required to reduce air infiltration. Building envelope performance is also enhanced beyond a typical office building to allow for the high humidity environment of the Ambulatory Health Care uses in the building.
- New IBC Ambulatory Health Care use within the Group B business occupancy requires that the building be divided into smoke compartments, travel distance is limited to 150-FT from a room door to an exit, door closers must release with actuation of the fire alarm.

Architectural items due to features of Ambulatory Pavilion:

- 2-story spaces at Lobby and Winter Garden.
- Ground level entrance requires site work ramps, stairs and retaining walls.
- Horizontal exit required at Ambulatory Health Care floors.
- 5th floor location of Imaging equipment increases complexity of equipment installation.
- Extensive use of glass on the south façade.
- High ratio of D&T space relative to Clinic or Medical Office type Space. Significant Imaging, Surgery and Endoscopy departments is +/- XXX% of the overall building area.
- Desire to attain LEED Certification.
- Mechanical systems on interstitial floor (Not in a typically less costly penthouse location with simple screen wall)

Site items:

- Sub surface storm water detention beneath new entry drive/drop-off
- Complex ComEd underground transformer power distribution to the building

Mechanical Systems Items:

- High rise mechanical implications:
  1. Stair pressurization systems
  2. Lengthy basement to roof boiler stack

3. Lengthy basement to roof cooling tower water piping
4. Rooftop cooling tower screening requirement
5. High duct shaft construction costs and loss of associated usable floor square feet area
6. Remote MRI cryogen vent location and remote MRI cooling equipment location availability
7. Fire protection pressure controls
8. Domestic water pressure controls
9. High roof drainage system costs

- Mechanical building site constraints
  1. Existing adjacent building cooling tower relocation to new building roof
  2. Emergency generator outdoor remote fuel tank located far from the indoor equipment
  3. Oxygen piping to remote source equipment located very far from the new building site
  4. Lack of space for exhaust and outdoor air intakes at lower building levels resulting in lengthy duct systems.
  5. Large and tall southern building exposure increases mechanical cooling requirements
- Mechanical green initiatives/sustainable design elements
  1. High efficiency chiller system with high cost variable speed chiller drives
  2. High efficiency hot water boiler system including high boiler equipment costs, high stainless steel material costs, and high heating equipment costs to obtain low temperature condensing return water temperatures
  3. Exhaust heat reclaim equipment
  4. Energy meters (natural gas, steam, heating water and chilled water)
  5. Air-conditioning condensate collection system
  6. Cooling tower heat reclaim system for domestic water pre-heat
  7. Complete perimeter heating system to allow ventilation fans nighttime shutdown
  8. Free cooling process chiller systems provisions for 24/7 year round cooling loads associated with data rooms, imaging MRI equipment and oncology pharmacy.
- Fully ducted return air systems for improved indoor air circulation, privacy, dust control and local electrical code compliance (City of Chicago Electrical Code).
- Medical gas alarm systems tie into existing facility support areas located a far distance in the adjacent existing building and with Level 1 reporting requirements due to existing source equipment tie.
- Temperature Control system costs for connection and communication with the existing building automation system and building maintenance staff.
- Entrance lobby smoke control system

<u>Electrical System items:</u>

- High-rise code requirements which increases fire alarm costs as well as Chicago Code Grounding issues (i.e. Hogen).
- New primary 12 KV electrical service for 330,000 sf bldg.
- Complexity of obtaining service from ComEd due to lack of capacity of existing systems.

- Service improvements for the betterment of the campus regarding future work
- Possible issues with Village concerns over utility poles
- UPS for diagnostic equipment
- Lightning protection
- Seismic support for electrical equipment
- LEED items such as lighting constrains, controls and monitoring

Construction Items:

- Tight site logistics GC premium / 95th Street
- Excavation and haul-away of existing site (imbalanced cut and fill)
- No Lay- Down area – multiple deliveries
- Metropolitan Water Reclamation District – meet new site detention standards
- Non-closure of Kilbourn due to ED ambulance route
- Sheet piling for proximity to existing South Bed Tower

Sincerely,

MARK BALAU
AIA, RCARD, LEED AP | Vice President & Senior Project Manager

HDR/architecture.com | 773.380.7957 | fax 773.380.7979 | mark.balau@hdrinc.com
HDR Architecture, Inc. | 8550 W. Bryn Mawr Ave. Suite 500 | Chicago, IL 60631-3721

Cc:

SECTION IV - PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE

Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space

PROJECT SERVICES UTILIZATION:

This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B. **A narrative of the rationale that supports the projections must be provided.**

A table must be provided in the following format with Attachment 15.

UTILIZATION					
	DEPT./ SERVICE	*Advocate Christ Medical Center, Oak Lawn received* AL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MET STANDARD?
YEAR 1					
YEAR 2					

APPEND DOCUMENTATION AS ATTACHMENT-15, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Attachment 15, Exhibit 1, documents that the services in the Ambulatory Pavilion being proposed by Advocate Christ Medical Center / Advocate Hope Children's Hospital meet or exceed the utilization standards specified in 1110 Appendix B.

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

Projected Services Utilization						
Department/ Service	Historical Utilization		Projected Utilization 2016	State Standard	Number Requested	Met Standard?
	2009	2010				
A.1 Surgery Operating Room (Class C)	47,314 hours	50,534 hours	71,936 hours	71,936 hours ÷ 1,500 = 48 – 49	40	Yes
A.2 Surgery Procedure Room (Class B)	11,274 hours	13,273 hours	21,056 hours	21,056 hours ÷ 1,500 = 14	11	Yes
C.6 Cast Room	4,624 visits	4,876 visits	6,223 visits	6,223 visits ÷ 2,000 = 3	2	Yes
C.7 CHF Clinic	5,452 visits	5,831 visits	27,254 hours	27,254 hours ÷ 1,500 = 19	15	Yes
C.8 Fetal Diagnostics	15,607 visits	17,145 visits	23,974 visits	23,974 visits ÷ 2,000 = 12	10	Yes
C.9 Infusion Center (Adult)	12,533 visits	15,678 visits	56,970 hours	56,970 hours ÷ 1,500 = 38	24	Yes
C.10 Neurodiagnostics	4,113 visits	3,970 visits	4,242 visits	7,763 hours ÷ 1,500 = 6	6	Yes
C.11 Non-Invasive Cardiology	10,488 visits	12,077 visits	15,142 visits	15,142 visits ÷ 2,000 = 8	6	Yes
C.12 Pain Management Center	4,522 visits	4,114 visits	4,658 visits	4,658 visits ÷ 2,000 = 3	1	Yes
C.13 Pr-Admission Testing	4,735 visits	4,949 visits	5,206 visits	5,206 visits ÷ 2,000 = 3	1	Yes
C.14 Pulmonary Function	1,777 visits	1,774 visits	1,954 visits	2,931 hours ÷ 1,500 = 2	2	Yes
D.15 General Radiology and Fluoroscopy	155,285 procedures	157,255 procedures	165,006 procedures	165,006 visits ÷ 8,000 = 21	18	Yes
D.16 Mammography	17,788 visits	17,732 visits	29,599 visits	29,599 visits ÷ 5,000 = 6	5	Yes
D.17 Ultrasound	35,052 visits	36,644 visits	43,890 on campus visits	43,890 visits on campus ÷ 3,100 = 15	15[1]	Yes
D.18 CT & PET/CT	59,338 visits	58,626 visits	65,043 visits	65,043 visits ÷ 7,000 = 10	10	Yes
D.19 MRI	10,717 visits	12,877 visits	15,323 visits	15,323 visits ÷ 2,500 = 7	6	Yes
D.20 Nuclear Medicine/SPECT /CT	14,378 visits	13,860 visits	12,924 visits	12,924 visits ÷ 2,000 = 7	7	Yes

Projected Services Utilization						
Department/ Service	Historical Utilization		Projected Utilization 2016	State Standard	Number Requested	Met Standard?
	2009	2010				
H.23 Outpatient Rehabilitation	46,204 modules/ 18,482 visits	42,358 modules/ 16,934 visits	84,455 modules/ 33,923 visits	33,923 visits ÷ 2,000 = 17	16	Yes
H.24 Cardiac Rehabilitation	12,183 visits	12,162 visits	12,989 visits	12,989 visits ÷ 2,000 = 7	1	Yes

Source: ACMC records.
[1]3 additional ultrasound units are located off campus.

UNFINISHED OR SHELL SPACE:

Provide the following information:

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

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

1. and 2. Total Gross Square Footage and Anticipated Use of the Proposed "Shell Space"

1. Total gross square footage of the proposed shell space;

2. The anticipated use of the shell space, specifying the proposed GSF to be allocated to each department, area or function;

As described in greater detail in Attachments 12 and 13, there is a severe shortage of space for both outpatient and inpatient services on the Oak Lawn campus of Advocate Christ Medical Center/Advocate Hope Children's Hospital (ACMC/AHCH, Medical Center). To address this space shortfall, the Medical Center is embarking on a multi-year master facilities planning process to redevelop the campus. The first phase of this redevelopment is the construction of an ambulatory care building; it is now being called the Ambulatory Pavilion (Pavilion) and is the subject of this application. The second major phase will be the construction of a patient tower and expansion of Advocate Hope Children's Hospital that will include both beds and ancillary services; this patient tower will further decompress both the highly utilized inpatient units and the very sophisticated ancillary services used by both inpatients and outpatients at the Medical Center.

Although the Medical Center considered building the patient tower first, this phasing was re-sequenced for several reasons and the Ambulatory Pavilion is the initial phase. First, the most pressing need for space on the campus today is for outpatient services. Second, adding inpatient capacity and the attendant demand for ancillary support would further exacerbate, rather than resolve, the severe operational and space issues related to the current high volumes and inadequate capacity.

The Ambulatory Pavilion will provide 308,334 DGSF and 326,031 BGSF of new space and will allow the Medical Center to relocate the institutes and their dedicated ambulatory services; ambulatory surgery, endoscopy, and imaging; as well as other appropriate outpatient services from the main hospital building. By relocating outpatient volume from the hospital to the Ambulatory Pavilion, the current hospital departments will be better able to accommodate inpatient volume until a patient tower can be developed.

The Proposed Ambulatory Pavilion Will Contain 14,337 DGSF of Shell Space

The Medical Center expects to file a certificate of need for a patient tower in the future. Because of the space constraints in the existing patient tower, 14,337 DGSF of space in the Ambulatory Pavilion will be shelled and used as a staging area during the construction of the patient tower. At the completion of the patient tower, the Medical Center currently expects the shell space to be built out and used for the expansion of the multidisciplinary institutes.

At the Completion of the Ambulatory Pavilion Project, the Hospital Will Have Approximately 23,799 DGSF of Vacated Space

The following matrix summarizes the space that will be vacated in the hospital when services are relocated to the Ambulatory Pavilion.

Attachment 16, Table 1
Vacated Space at the Completion of the Ambulatory Pavilion

Area/ Department	Current Location	DGSF Being Vacated
Infusion Therapy (Adult)	Ground Floor	3,001
Endoscopy	First Floor	791
Congestive Heart Failure		1,150
Pain Center		1,267
Outpatient Registration/Financial Counseling		5,458
Research/Education	NOB (North Office Building)	1,402
Total Hospital		13,069
Area/Department	**Current Location**	**DGSF Being Vacated**
Fetal Diagnostics	POB (Physician Office Building)	900
Institutes		9,830
Total Professional Office Building		10,730

Source: ACMC records.

The modernization of the vacated hospital space is not part of this project. For the purposes of this application, the Medical Center is addressing the vacated space in order to provide a comprehensive depiction of the campus redevelopment plans.

Of the total vacated space, 10,730 DGSF is in a professional office building on the campus. This building is not owned by the Medical Center; the vacated space is leased space.

The remainder of the space is in multiple locations in the hospital. The anticipated reuse of the vacated space has not been determined. The highest and best use of the space will be addressed during the design of the second phase of the campus redevelopment, the proposed patient tower. The actual modernization of the vacated space may be completed as part of the patient tower project or as a separate project to be completed after the patient tower is designed, but before the certificate of need application for the patient tower is filed.

3. **Reason Shell Space Is Being Constructed**

3. Evidence that the shell space is being constructed due to
a. Requirements of governmental or certification agencies; or
b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.

Reason Shell Space Is Being Constructed in the Ambulatory Pavilion.

There will be 14,337 DGSF of shell space on the first floor of the Ambulatory Pavilion when it is complete in December 2014. The Medical Center has short-and long-term plans for this space. At the time the patient tower is constructed, space will be needed for staging certain departments/areas. The shell space will be used for that purpose. When the space is no

longer needed as staging space, the Medical Center currently expects it will be finished as expansion space for the multidisciplinary institutes.

Current site constraints do not allow the expansion of the Ambulatory Pavilion in the future. Hence any expansion would be at another location and defeat the goals of multidisciplinary/ coordinated care, the care delivery approach that has proven to improve outcomes, and reduce costs. Therefore, it is not only more cost effective to build the space now, it is operationally sound.

Reason Vacated Space Is Not Being Modernization the Hospital

As noted above, there will be approximately 13,069 DGSF of space vacated in the hospital when services are moved to the Ambulatory Pavilion. This space is scattered on several levels of the building and some is interspersed through dedicated inpatient areas. The reuse of the vacated space has not been determined; the ultimate use of the space will be contingent on a determination of the highest need and best uses for the space in the context of the Master Facilities Plan.

4. Historical and Projected Utilization

4. Provide:

a. Historical utilization for the area for the latest five-year period for which data are available; and

b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

Historical and Projected Utilization of Shell Space in the Ambulatory Pavilion

Current planning suggests that the shell space in the Ambulatory Pavilion will ultimately be used for the future expansion of the multidisciplinary institutes. This space will include medical office space where physicians can see patients and consult with their colleagues. This is non clinical space and there are no historical or projected volumes.

Historical and Projected Utilization of Vacated Space in the Hospital

The reuse of the 13,069 DGSF of vacated space in the hospital has not been determined; the ultimate use of the space will be contingent on determining the highest need and best use of the space in the context of the Master Facilities Plan. Since the departments that will be relocated to or expanded into the vacated space are unknown at the present time, neither

historical nor projected volumes can be provided. The actual modernization of the vacated space may be completed as part of the patient tower project or it may be one or more projects to be completed after the patient tower is designed, but before the certificate of need application for the patient tower is filed.

As verified in Attachment 17, the Medical Center will submit one or more certificates of need for the reuse of the shell space regardless of the capital thresholds in effect at the time or the categories of service or clinical service areas involved.

SECTION IV – PROJECT SCOPE, UTLIZATION, AND UNFINISHED/SHELL SPACE

Criterion 1110.234 – Project Scope, Utilization, and Unfinished/Shell Space

ASSURANCES:

Submit the following:

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

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

The requested assurance letter is appended as Attachment 17, Exhibit 1.

Advocate
Christ Medical Center
Hope Children's Hospital

4440 West 95th Street || Oak Lawn, IL 60453 || T 708.684.8000 || advocatehealth.com

May 11, 2011

Mr. Dale Galassie
Chairman
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

Dear Mr. Galassie:

The purpose of this letter is to assure the Illinois Health Facilities and Services Review Board (IHFSRB) that Advocate Health Care Network and Advocate Health and Hospitals Corporation d/b/a Advocate Christ Medical Center/Advocate Hope Children's Hospital (ACMC/AHCH, the Medical Center) will submit one or more certificate of need applications to build out the proposed shell space in the Ambulatory Pavilion, regardless of the capital thresholds in effect at the time or the categories of service involved.

The build out of the shell space will occur when it is no longer needed for construction phasing and the currently available multidisciplinary institute space is fully utilized. The timing of the build out of the shell space and the modernization of the vacated space will depend on capital approvals for the projects from Advocate Health and Hospitals Corporation. The anticipated date when the shell space will become operational will depend on certificate of need approvals and construction duration. It is our expectation that one or more certificates of need will be filed prior to the future approval and construction of a patient tower.

We must plan for the highest and best use of all space and the most prudent use of scarce capital spread throughout the Advocate Health Care system.

Sincerely,

Kenneth Lukhard
President, Advocate Christ Medical Center/Advocate Hope Children's Hospital

Cc: Ms. Courtney Avery, Administrator
Mr. Mike Constantino, Supervisor of Project Review Section

Criterion 1110.3030 - Clinical Service Areas Other than Categories of Service

1. Applicants proposing to establish, expand and/or modernize Clinical Service Areas Other than Categories of Service must submit the following information:
2. Indicate changes by Service: Indicate # of key room changes by action(s):

Attachment 37

Service	# Existing Key Rooms	# Proposed Key Rooms
☒ Surgery Operating Rooms (Class C)	26	40
☒ Surgery Procedure Rooms (Class B)	5	11
☒ Phase I Recovery (PACU)	19	33
☒ Phase II Recovery (Prep/Recovery)	16	82
☒ General Radiology/Fluoroscopy	11	18
☒ Mammography	5	5
☒ Ultrasound	11	18
☒ CT & PET/CT	6	10
☒ MRI	4	6
☒ Nuclear Medicine	5	7

Also see text.

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

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

APPEND DOCUMENTATION AS ATTACHMENT-37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Background

Although Christ Hospital (now Advocate Christ Medical Center/Advocate Hope Children's Hospital) opened in 1961, the facility planning model for the hospital relied on clinical care experience from the 1950s. The hospital of the 1950s was essentially an inpatient facility with ancillary support facilities sized to meet the needs of the inpatients. Outpatient activity was delivered in hospital emergency departments, in physicians' offices, in dispensaries for the poor, or in patients' homes.

Based on the 1950's model, the design of the Medical Center's original facility did not take into account either today's standards for inpatient care or the high volume of outpatient care that would be delivered in either traditional ancillary departments or in clinics. Consequently, the size and functionality of most of the Medical Center's facilities are obsolete.

Over the last 50 years, and especially over the last 20 years, the Medical Center matured from a community hospital to a major tertiary/quaternary referral center with expanded missions of patient care, teaching, and research. Today similar teaching hospitals/academic medical centers have about 50 percent more square footage per bed; hence, the Medical Center's facilities are very small when compared to contemporary national planning guidelines. The issues related to inadequate size have been compounded by the fact that medicine is always changing; more and more care is being delivered in the outpatient setting now than in the past. For example, today, 70 percent of all imaging and 60 percent of all surgery procedures provided in Illinois hospitals are for outpatients, according to the State's summary of 2009 Annual Hospital Questionnaire data.

Today, the limited available space at the Medical Center is assigned to inpatient, outpatient and inpatient/outpatient functions. The inpatient space is undersized. The ancillary departments (for example, surgery and imaging) are also undersized; inpatients and outpatients are commingled. Space for clinics and physician offices as well as education and research is also extremely limited. There is no space for the expansion of existing services, for the development of new services, or to respond to new challenges facing health care providers, including national health care reform.

To resolve the space shortage, the Medical Center first considered building an inpatient tower and moving administrative functions out of the Hospital. The plan changed when it became apparent that the current commingling of inpatient and outpatient populations was adversely affecting patient satisfaction, throughput, and efficiency and that the first priority on the campus must be to develop ambulatory space. This new space would be designed to address both the demand for routine as well as complex outpatient services. The greater Oak Lawn community looks to the Medical Center for routine care; the broader referral community looks to the Medical Center for complex services that are not available in community hospitals and that are especially difficult and expensive to replicate on remote sites.

This realization led to the conclusion that a phased approach to campus redevelopment would be necessary in order to provide adequate and appropriate space to meet community and referral needs and second, to decompress the current hospital building – for both the inpatient and outpatient services that will remain in the current facility. It is important to note, the development of the new building, called the Ambulatory Pavilion (Pavilion), does not preclude the need to construct a patient tower in the future. Most of the Medical Center's patients are acutely ill or seriously injured. While they may benefit from pre-admission and post discharge services such as outpatient rehabilitation or the CHF Clinic, they will continue to require inpatient care.

Ambulatory Care – The New Frontier of Health Care

Between 1965 and 2008, per capita annual inpatient utilization nationally decreased from 1,174 patient days per 1,000 population to 551 days per 1,000 population, or by 53 percent. This steep decline was the result of a decreasing rate of inpatient admissions per 1,000 population, and more importantly, decreasing average length of stay. This reduced inpatient utilization reflected, to a great degree, the implementation of prospective payment for Medicare recipients in the 1980s. Prospective payment encouraged shorter length of stays. The improvements in patient management that were developed initially for Medicare patients were soon used for all patients regardless of payor.

The amount of health care provided in the U.S., however, did not decline. Instead, it moved from the inpatient to the outpatient setting – to hospital-based departments and clinics, to freestanding ambulatory centers owned and operated by hospitals and other providers, and to physician offices. In fact, hospital-based outpatient visits almost doubled between 1988 (post implementation of prospective payment) and 2008, or from about 1,100 visits per 1,000 population to almost 2,200 visits per 1,000 population. There was also strong growth in ambulatory surgery treatment centers, dialysis centers, urgent care centers, and physician office-based services, especially when reimbursement was attractive. Outpatient services often precluded the need to admit patients and reduced length of stay.

By 2010, the Medical Center reported 345,000 outpatient visits with 85 percent of them occurring on the campus and the remaining 15 percent in community outpatient centers operated by the Medical Center. On an average day, there are 1,000 outpatients on the Medical Center's

campus; the outpatients place acute stress not only on the existing facilities and technology, but also on the staff.

Among the major factors that will contribute to more health care being delivered in the outpatient setting in the future are population aging and evolving clinical technology and techniques.

- Life expectancy in the United States continues to increase. According to the Centers of Disease Control, in 2007 American men could expect to live 3.5 years longer and women 1.6 years longer than they did in 1990. Mortality from heart disease, stroke and cancer continues to decline. Infant mortality, a major component in overall life expectance, declined through 2001 and then stabilized.

  Longer life spans come with an increase in the prevalence of chronic diseases and conditions associated with aging. As the Baby Boomers move into the 65+ age cohort, they will drive an increase in health care utilization.

- Technology and new enhancements in care delivery (fewer invasive surgical techniques, treatment protocols, and earlier detection) will enable procedures to move out of the hospital and prevent hospitalizations.

- Outpatient utilization will continue to increase over the next decade as patients prefer to obtain their care in the outpatient setting, whenever possible.

Implications of National Health Care Reform

Advocate Christ Medical Center/Advocate Hope Children's Hospital (ACMC/AHCH, Medical Center) recognized the benefits of outpatient care more than a decade ago and has been continually adding programs and improving outpatient flow (in spite of limited space). The goals of the Medical Center are similar to the goals of the national health care legislation passed in 2010. The Medical Center's innovative approaches to providing safe and efficient care in the outpatient setting are fully consistent with the broader purposes of the legislation – to increase access, to enhance quality, and to reduce cost.

Health care experts are predicting an overall increase of from 20 to 30 percent in outpatient volume over the next decade, with more complex surgery, endoscopic screenings and interventions, and most imaging procedures leading the way. Precluding potentially avoidable admissions and improved management of chronic disease will also contribute to strengthening

outpatient demand. Reimbursement incentives will further shift patients to the hospital – based outpatient setting.

Justifying Outpatient Volume in the Proposed Ambulatory Pavilion

The purpose of Attachment 37 is to document the need for the clinical services to be provided in the Ambulatory Pavilion.

The Medical Center has imaging services on the campus and at two offsite locations, the Center for Breast Health in Oak Lawn and the Lockport Outpatient Center.

These services are not interchangeable with the services on the campus. The Center for Breast Health's mammography and ultrasound equipment can be used only for the diagnosis and treatment of breast disease. The Lockport services including mammography, ultrasound, general radiology, CT, and MRI are 40 minutes travel time from Oak Lawn and were developed for the residents of the greater Lockport community. The first full year of operation of Lockport was 2010. Residents from the Oak Lawn community and communities to the north and east do not want to travel 40 minutes or more for an imaging procedure.

The service area radius for an outpatient center is usually about 5 miles. Even so, in accordance with the CON, the number of units, volumes and square footages related to the Center for Breast Health and Lockport are included in the justification of project. The Medical Center has segregated the activity on the campus from the offsite activity to highlight the need for expansion on campus.

The State Agency recognizes several approaches to documenting need. These include:

1. Current Volume. In each of the following sections of Attachment 37, the most recent 3 years of volume is provided.

   Current volume is just one way to justify key rooms – both for those that have State Standards and those that do not.

2. Necessary Expansion. The CON rules recognize that factors other than current volume drive the need for future key rooms. In this application, the Medical Center has provided CAGR (compounding annual growth rate) trends based on the available historical years of data and extended to 2019. The State Agency considers projections for as many years as historical volume is provided. The projected volume is also shown on Attachment 37, Exhibit 1. The CAGR trend lines account for

growth and aging of the population and for the availability of new technology or techniques adopted because they improve diagnosis and treatment. It would not be prudent to invest almost $200 million in a facility that would be undersized and outdated the year that it opened. The project is targeted for occupancy by the end of 2014; the projections are focused on 2016 (2 years after project completion) and 2019 (5 years after project completion).

The Medical Center believes that the CAGR trend lines are very conservative in terms of projected outpatient volumes. Because of space limitations and the Medical Center's tertiary/quaternary mission, many outpatient services have not been able to accommodate need and have shown little volume increases in recent years. In these instances, the CAGR trend line underestimates the true potential future volume.

As noted above, the historical imaging volumes include the Center for Breast Health and Lockport Outpatient Center. Lockport has completed only one year of operation. To be conservative, when the Medical Center prepared CAGR trend lines for the imaging services with a unit at Lockport, the 2010 volume was held constant to 2019. Since this is start up volume only, this results in the underestimation of need for these imaging services.

Even with these limitations of the CAGR method, the Medical Center did not adjust the projections. Rather, where appropriate, the Medical Center clarified the implications of the trends.

3. Implications of National Health Care Reform. State Staff asked the applicant to consider the implications of national health care reform when projecting utilization in the application. In each justification, the applicant has described the elements of national health care reform that may be impacted by that service. In addition, the applicant conservatively expanded the CAGR trend lines by only 15 percent to account for national health care reform. This is a conservative factor since most health care experts are projecting a 20 to 30 percent expansion of outpatient utilization related to the implementation of this 2010 federal legislation. The Medical Center is applying this lower factor to account for instances where national health care may have some offsetting effects. The Medical Center did not rely on this national health reform factor to justify services or equipment.

None of the projections assume an increase in market share.

Summary

The Ambulatory Pavilion being proposed will be able to accommodate more complex outpatient care and the increasing demand for these services.

The following sections justify the need for each of the services in the project. Each service either meets or exceeds State Standards.

Attachment 37, Exhibit 2 is a list of the clinical service areas and non clinical areas that are included in the project. Throughout the application all justifications and schedules use this order.

Current and Projected Utilization of Ambulatory Care Services

Current and Projected Utilization of Ambulatory Care Services

Procedure		2002	2003	2004	2005	2006	2007	2008	2009	2010
Surgery										
Surgery Operating Rooms Total		na	33,485	32,669	31,842	32,207	24,415	35,053	47,314	50,534
(Procedure Hours)	*Inpatient*	na	22,265	22,257	22,269	22,760	17,956	24,221	31,898	34,118
	Outpatient	na	11,220	10,412	9,573	9,447	6,459	10,832	15,416	16,416
Surgery Procedure Rooms/Endoscopy (Class B) Total		na	na	na	na	9,915	10,919	11,334	11,274	13,273
	Inpatient	na	na	na	na	3,765	4,054	3,884	3,827	4,305
	Outpatient	na	na	na	na	6,150	6,865	7,450	7,447	8,968
Ambulatory Care Services										
Cast Room Total		3,522	873	914	2,996	2,716	3,207	4,557	4,624	4,876
	Inpatient	na	na	na	na	na	na	na	na	na
	Outpatient	3,522	873	914	2,996	2,716	3,207	4,557	4,624	4,876
CHF Clinic Total		4,425	4,735	4,670	4,707	4,785	5,003	5,163	5,452	5,831
	Inpatient	na	na	na	na	na	na	na	na	na
	Outpatient	4,425	4,735	4,670	4,707	4,785	5,003	5,163	5,452	5,831
Fetal Diagnostics Total		na	11,767	17,263	17,330	14,692	15,457	15,693	15,607	17,145
(Ultrasound + NST)	*Inpatient*	na	na	na	na	na	na	na	na	na
	Outpatient	na	11,767	17,263	17,330	14,692	15,457	15,693	15,607	17,145
Fetal Diagnostics (Ultrasound) Total		na	7,570	10,729	11,654	10,099	11,821	11,905	11,850	12,066
	Inpatient	na	na	na	na	na	na	na	na	na
	Outpatient	na	7,570	10,729	11,654	10,099	11,821	11,905	11,850	12,066
Fetal Diagnostics (NST) Total		na	4,197	6,534	5,676	4,593	3,636	3,788	3,757	5,079
	Inpatient	na	na	na	na	na	na	na	na	na
	Outpatient	na	4,197	6,534	5,676	4,593	3,636	3,788	3,757	5,079
Infusion Center - Adult Total (Oncology)		na	na	na	8,731	10,320	11,671	11,195	12,533	15,678
	Inpatient	na	na	na	na	na	na	na	na	na
	Outpatient	na	na	na	8,731	10,320	11,671	11,195	12,533	15,678
Neurodiagnostic Total		na	na	na	na	3,886	4,114	3,978	4,167	3,970
(EEG + EMG + Sleep Studies)	*Inpatient*	na	na	na	na	1,798	2,055	1,954	2,007	1,962
	Outpatient	na	na	na	na	2,088	2,059	2,024	2,591	2,374
EEG Total		na	na	na	na	2,750	3,032	3,004	3,085	3,045
	Inpatient	na	na	na	na	1,680	1,901	1,846	1,885	1,837
	Outpatient	na	na	na	na	1,070	1,131	1,158	1,200	1,208
EMG Total		na	na	na	na	1,136	1,082	974	1,082	925
	Inpatient	na	na	na	na	118	154	108	122	125
	Outpatient	na	na	na	na	1,018	928	866	960	800
Sleep Studies Total		na	na	na	na	na	na	na	431	366
	Inpatient	na	na	na	na	na	na	na	na	na
	Outpatient	na	na	na	na	na	na	na	431	366
Noninvasive Cardiology Total		na	na	na	na	77,646	77,988	79,117	79,756	81,580
(EKG+ECHO+Stress Testing)	*Inpatient*	na	na	na	na	67,014	67,220	67,552	68,896	69,166
	Outpatient	na	na	na	na	10,632	10,768	11,565	10,860	12,414
EKG-Holter/Event Monitoring Total		na	na	na	na	60,384	60,803	61,192	61,717	63,229
	Inpatient	na	na	na	na	53,653	54,024	54,357	55,080	56,398
Outpatient Staying at Hospital		na	na	na	na	na	na	na	na	na
Outpatient Moving to Ambulatory Pavilion		na	na	na	na	6,731	6,779	6,835	6,637	6,831
Total Outpatient		na	na	na	na	6,731	6,779	6,835	6,637	6,831
ECHO and Tee Total		na	na	na	10,337	11,138	11,186	11,934	12,375	13,252
Inpatient		na	na	na	8,654	9,386	9,455	10,098	10,395	10,669
Outpatient Staying at Hospital		na	na	na	190	174	176	209	248	289
Outpatient Moving to Ambulatory Pavilion		na	na	na	1,493	1,578	1,555	1,627	1,732	2,294
Total Outpatient		na	na	na	1,683	1,752	1,731	1,836	1,980	2,583
Stress Testing Total		na	na	na	6,297	6,124	5,999	5,991	6,664	5,099
Inpatient		na	na	na	4,092	3,975	3,741	3,097	3,421	2,099
Outpatient Staying at Hospital		na	na	na	59	56	64	80	124	108
Outpatient Moving to Ambulatory Pavilion		na	na	na	2,146	2,093	2,194	2,814	2,119	2,892
Total Outpatient		na	na	na	2,205	2,149	2,258	2,894	2,243	3,000

Current and Projected Utilization of Ambulatory Care Services

Procedure		2011	2012	2013	2014	2015	2016	2017	2018	2019
Surgery										
Surgery Operating Rooms Total		53,596	56,844	60,290	63,945	67,823	71,936	76,299	80,928	85,839
(Procedure Hours)	*Inpatient*	36,263	38,543	40,966	43,542	46,279	49,189	52,281	55,568	59,062
	Outpatient	17,333	18,302	19,324	20,404	21,544	22,747	24,018	25,360	26,777
Surgery Procedure Rooms/Endoscopy (Class B) Total		14,307	15,433	16,661	18,000	19,461	21,055	22,796	24,698	26,775
	Inpatient	4,452	4,603	4,760	4,922	5,090	5,264	5,443	5,628	5,820
	Outpatient	9,855	10,829	11,900	13,077	14,370	15,792	17,353	19,069	20,955
Ambulatory Care Services										
Cast Room Total		5,078	5,289	5,509	5,737	5,975	6,223	6,482	6,751	7,031
	Inpatient	na	na	na	na	na	na	na	na	na
	Outpatient	5,078	5,289	5,509	5,737	5,975	6,223	6,482	6,751	7,031
CHF Clinic Total		6,036	6,247	6,467	6,694	6,928	7,172	7,423	7,684	7,953
	Inpatient	na	na	na	na	na	na	na	na	na
	Outpatient	6,036	6,247	6,467	6,694	6,928	7,172	7,423	7,684	7,953
Fetal DiagnosticsTotal		18,116	19,149	20,246	21,413	22,654	23,974	25,379	26,873	28,463
(Ultrasound + NST)	*Inpatient*	na	na	na	na	na	na	na	na	na
	Outpatient	18,116	19,149	20,246	21,413	22,654	23,974	25,379	26,873	28,463
Fetal Diagnostics (Ultrasound) Total		12,897	13,785	14,734	15,749	16,834	17,993	19,232	20,557	21,972
	Inpatient	na	na	na	na	na	na	na	na	na
	Outpatient	12,897	13,785	14,734	15,749	16,834	17,993	19,232	20,557	21,972
Fetal Diagnostics (NST) Total		5,219	5,363	5,512	5,664	5,820	5,981	6,146	6,316	6,491
	Inpatient	na	na	na	na	na	na	na	na	na
	Outpatient	5,219	5,363	5,512	5,664	5,820	5,981	6,146	6,316	6,491
Infusion Center - Adult Total (Oncology)		17,625	19,815	22,276	25,042	28,153	31,650	35,581	40,000	44,969
	Inpatient	na	na	na	na	na	na	na	na	na
	Outpatient	17,625	19,815	22,276	25,042	28,153	31,650	35,581	40,000	44,969
Neurodiagnostic Total		4,315	4,306	4,310	4,324	4,348	4,380	4,421	4,469	4,525
(EEG + EMG + Sleep Studies)	*Inpatient*	2,005	2,050	2,095	2,141	2,188	2,237	2,286	2,337	2,388
	Outpatient	2,309	2,257	2,215	2,183	2,159	2,144	2,135	2,133	2,136
EEG Total		3,124	3,204	3,287	3,372	3,460	3,550	3,642	3,736	3,833
	Inpatient	1,878	1,921	1,964	2,009	2,054	2,100	2,148	2,196	2,246
	Outpatient	1,245	1,284	1,323	1,364	1,406	1,449	1,494	1,540	1,587
EMG Total		880	838	798	761	726	694	663	634	607
	Inpatient	127	129	131	132	134	136	138	140	142
	Outpatient	753	709	668	629	592	557	525	494	465
Sleep Studies Total		311	264	224	190	162	137	117	99	84
	Inpatient	na	na	na	na	na	na	na	na	na
	Outpatient	311	264	224	190	162	137	117	99	84
Noninvasive Cardiology Total		82,854	84,221	85,681	87,236	88,886	90,636	92,489	94,449	96,522
(EKG+ECHO+Stress Testing)	*Inpatient*	69,959	70,805	71,700	72,641	73,626	74,653	75,719	76,823	77,964
	Outpatient	12,895	13,416	13,981	14,594	15,260	15,983	16,770	17,626	18,558
EKG-Holter/Event Monitoring Total		63,962	64,704	65,456	66,216	66,986	67,765	68,554	69,352	70,160
	Inpatient	57,106	57,823	58,549	59,283	60,028	60,781	61,544	62,317	63,099
	Outpatient Staying at Hospital	na	na	na	na	na	na	na	na	na
	Outpatient Moving to Ambulatory Pavilion	6,856	6,882	6,907	6,932	6,958	6,984	7,010	7,035	7,061
	Total Outpatient	6,856	6,882	6,907	6,932	6,958	6,984	7,010	7,035	7,061
ECHO and Tee Total		13,863	14,513	15,205	15,942	16,729	17,569	18,468	19,430	20,462
	Inpatient	11,016	11,375	11,745	12,127	12,522	12,930	13,351	13,785	14,234
	Outpatient Staying at Hospital	328	372	423	480	545	619	702	797	905
	Outpatient Moving to Ambulatory Pavilion	2,519	2,766	3,037	3,335	3,662	4,021	4,415	4,848	5,323
	Total Outpatient	2,847	3,138	3,460	3,815	4,207	4,640	5,117	5,645	6,228
Stress Testing Total		5,028	5,003	5,020	5,077	5,172	5,302	5,467	5,667	5,900
	Inpatient	1,837	1,607	1,406	1,230	1,077	942	824	721	631
	Outpatient Staying at Hospital	122	138	155	175	198	223	252	284	321
	Outpatient Moving to Ambulatory Pavilion	3,070	3,259	3,459	3,672	3,897	4,137	4,391	4,661	4,948
	Total Outpatient	3,192	3,396	3,614	3,847	4,095	4,360	4,643	4,945	5,269

Current and Projected Utilization of Ambulatory Care Services

Procedure	2002	2003	2004	2005	2006	2007	2008	2009	2010
Pain Center Visits Total	3,548	4,041	4,031	3,930	3,969	4,588	4,775	4,649	4,230
Inpatient	60	171	123	100	97	220	252	127	116
Outpatient	3,486	3,870	3,908	3,830	3,872	4,368	4,523	4,522	4,114
Pre Admission Total**	na	na	4,704	4,331	4,210	3,903	4,378	4,735	4,949
Inpatient	na	na	na	na	na	na	na	na	na
Outpatient	na	na	4,704	4,331	4,210	3,903	4,378	4,735	4,949
Pulmonary Function Visits Total	1,979	2,150	2,072	2,197	2,140	2,202	2,115	2,235	2,144
Inpatient	420	404	391	352	352	419	466	458	370
Outpatient	1,559	1,746	1,681	1,845	1,788	1,783	1,649	1,777	1,774
Diagnostic and Interventional Radiology/Imaging by Modality									
Radiology/Fluoroscopy Total (Campus + Lockport)	148,574	152,385	141,601	136,488	142,847	140,552	150,687	155,285	157,255
Campus Total	148,574	152,385	141,601	136,488	142,847	140,552	150,687	155,285	156,682
Inpatient	86,262	86,788	81,817	83,264	87,605	87,504	96,516	90,277	97,542
Outpatient	62,312	65,597	59,784	53,224	55,242	53,048	54,171	65,008	59,140
Lockport Total	na	na	na	na	na	na	na	na	573
Inpatient	na	na	na	na	na	na	na	na	na
Outpatient	na	na	na	na	na	na	na	na	573
Campus + Lockport Total	148,574	152,385	141,601	136,488	142,847	140,552	150,687	155,285	157,255
Inpatient	86,262	86,788	81,817	83,264	87,605	87,504	96,516	90,277	97,542
Outpatient	62,312	65,597	59,784	53,224	55,242	53,048	54,171	65,008	59,713
Radiology Total	141,032	144,824	134,810	129,533	136,311	133,456	142,398	146,728	150,203
Inpatient	80,879	81,532	77,028	78,268	82,178	82,375	90,388	84,288	93,285
Outpatient	60,153	63,292	57,782	51,265	53,133	51,081	52,010	62,440	56,345
Lockport Outpatient	na	na	na	na	na	na	na	na	573
Fluoroscopy Total	7,542	7,561	6,791	6,955	7,536	7,096	8,289	8,557	7,052
Inpatient	5,383	5,256	4,789	4,996	5,427	5,129	6,128	5,989	4,257
Outpatient	2,159	2,305	2,002	1,959	2,109	1,967	2,161	2,568	2,795
Mammography Total (Campus + Lockport + Breast Health)	15,885	18,518	17,395	17,749	31,129	30,752	15,432	17,788	17,732
Campus Visits/Procedures Total	15,885	18,518	17,395	17,749	31,129	30,752	66	na	na
Inpatient	90	79	147	99	138	108	66	na	na
Outpatient	15,795	18,439	17,248	17,650	30,991	30,644	na	na	na
Lockport Total	na	na	na	na	na	na	na	na	273
Inpatient	na	na	na	na	na	na	na	na	na
Outpatient	na	na	na	na	na	na	na	na	273
Breast Health Total	na	na	na	na	na	13,471	15,366	17,788	17,459
Inpatient	na	na	na	na	na	na	na	na	na
Outpatient	na	na	na	na	na	13,471	15,366	17,788	17,459
Campus + Lockport + Breast Health Total	15,885	18,518	17,395	17,749	31,129	30,752	15,432	17,788	17,732
Inpatient	90	79	147	99	138	108	66	na	na
Outpatient	15,795	18,439	17,248	17,650	30,991	44,115	15,366	17,788	17,732
Ultrasound Total (Campus + Lockport)	24,348	24,777	25,413	27,091	28,554	30,283	33,052	37,194	38,641
Campus Visits/Procedures Total	24,348	24,777	25,413	27,091	28,554	30,283	31,208	35,052	34,095
Inpatient	11,594	11,191	11,742	12,384	13,037	14,449	15,437	14,391	16,323
Outpatient	12,754	13,586	13,671	14,707	15,517	15,834	15,771	20,661	17,772
Lockport Total	na	na	na	na	na	na	na	na	576
Inpatient	na	na	na	na	na	na	na	na	na
Outpatient	na	na	na	na	na	na	na	na	576
Campus and Lockport Total	24,348	24,777	25,413	27,091	28,554	30,283	31,208	35,052	34,671
Inpatient	11,594	11,191	11,742	12,384	13,037	14,449	15,437	14,391	16,323
Outpatient	12,754	13,586	13,671	14,707	15,517	15,834	15,771	20,661	18,348
Ultrasound Breast Health Total	na	na	na	na	na	1,506	1,844	2,142	1,970
Inpatient	na	na	na	na	na	na	na	na	na
Outpatient	na	na	na	na	na	1,506	1,844	2,142	1,970
CT and PET/CT Total	51,436	42,602	45,741	52,164	52,540	56,916	55,430	59,338	58,626
(Visits) *Inpatient*	25,944	21,403	23,317	27,098	27,324	29,986	30,121	27,914	31,296
Outpatient	25,492	21,199	22,424	25,066	25,216	26,930	25,309	31,424	27,121
Lockport Outpatient	na	na	na	na	na	na	na	na	209

** Preadmission volumes were estimated to be 50% of Surgical Operating Rooms volumes.

Current and Projected Utilization of Ambulatory Care Services

Procedure	2011	2012	2013	2014	2015	2016	2017	2018	2019
Pain Center Visits Total	**4,326**	**4,425**	**4,526**	**4,631**	**4,738**	**4,848**	**4,962**	**5,079**	**5,200**
Inpatient	126	137	149	161	175	190	207	224	244
Outpatient	4,200	4,288	4,378	4,469	4,563	4,658	4,756	4,855	4,957
Pre Admission Total*	**4,990**	**5,033**	**5,075**	**5,119**	**5,162**	**5,206**	**5,250**	**5,294**	**5,339**
Inpatient	na	na	na	na	na	na	na	na	na
Outpatient	4,990	5,033	5,075	5,119	5,162	5,206	5,250	5,294	5,339
Pulmonary Function Visits Total	**2,167**	**2,181**	**2,215**	**2,240**	**2,265**	**2,291**	**2,317**	**2,345**	**2,372**
Inpatient	364	358	353	347	342	336	331	326	321
Outpatient	1,803	1,832	1,862	1,892	1,923	1,954	1,986	2,019	2,052
Diagnostic and Interventional Radiology/Imaging by Modality									
Radiology/Fluoroscopy Total (Campus + Lockport)	**158,444**	**159,673**	**160,944**	**162,256**	**163,610**	**165,006**	**166,446**	**167,930**	**169,458**
Campus Total	157,871	159,100	160,371	161,683	163,037	164,433	165,873	167,357	168,885
Inpatient	99,098	100,688	102,311	103,970	105,664	107,393	109,158	110,960	112,800
Outpatient	58,773	58,413	58,059	57,713	57,373	57,040	56,715	56,396	56,085
Lockport Total	573	573	573	573	573	573	573	573	573
Inpatient	na	na	na	na	na	na	na	na	na
Outpatient	573	573	573	573	573	573	573	573	573
Campus + Lockport Total	158,444	159,673	160,944	162,256	163,610	165,006	166,446	167,930	169,458
Inpatient	99,098	100,688	102,311	103,970	105,664	107,393	109,158	110,960	112,800
Outpatient	59,346	58,986	58,632	58,286	57,948	57,613	57,288	56,969	56,658
Radiology Total	**151,423**	**152,677**	**153,966**	**155,290**	**156,649**	**158,044**	**159,476**	**160,945**	**162,452**
Inpatient	94,964	96,673	98,413	100,184	101,987	103,823	105,692	107,594	109,530
Outpatient	55,886	55,431	54,980	54,532	54,088	53,648	53,211	52,778	52,348
Lockport Outpatient	573	573	573	573	573	573	573	573	573
Fluoroscopy Total	**7,021**	**6,996**	**6,978**	**6,966**	**6,961**	**6,962**	**6,970**	**6,985**	**7,006**
Inpatient	4,134	4,014	3,898	3,786	3,676	3,570	3,467	3,367	3,269
Outpatient	2,887	2,981	3,079	3,180	3,284	3,392	3,503	3,618	3,737
Mammography Total (Campus + Lockport + Breast Health)	**19,308**	**21,027**	**22,901**	**24,944**	**27,171**	**29,599**	**32,247**	**35,134**	**38,281**
Campus Visits/Procedures Total	na	na	na	na	na	na	na	na	na
Inpatient	na	na	na	na	na	na	na	na	na
Outpatient	na	na	na	na	na	na	na	na	na
Lockport Total	273	273	273	273	273	273	273	273	273
Inpatient	na	na	na	na	na	na	na	na	na
Outpatient	273	273	273	273	273	273	273	273	273
Breast Health Total	19,035	20,754	22,628	24,671	26,898	29,326	31,974	34,861	38,008
Inpatient	na	na	na	na	na	na	na	na	na
Outpatient	19,035	20,754	22,628	24,671	26,898	29,326	31,974	34,861	38,008
Campus + Lockport + Breast Health Total	19,308	21,027	22,901	24,944	27,171	29,599	32,247	35,134	38,281
Inpatient	na	na	na	na	na	na	na	na	na
Outpatient	19,308	21,027	22,901	24,944	27,171	29,599	32,247	35,134	38,281
Ultrasound Total (Campus + Lockport)	**36,137**	**37,665**	**39,260**	**40,923**	**42,657**	**44,466**	**46,353**	**48,321**	**50,374**
Campus Visits/Procedures Total	35,561	37,089	38,684	40,347	42,081	43,890	45,777	47,745	49,798
Inpatient	17,036	17,780	18,557	19,368	20,214	21,097	22,019	22,981	23,985
Outpatient	18,525	19,309	20,127	20,979	21,867	22,793	23,758	24,764	25,813
Lockport Total	576	576	576	576	576	576	576	576	576
Inpatient	na	na	na	na	na	na	na	na	na
Outpatient	576	576	576	576	576	576	576	576	576
Campus and Lockport Total	36,137	37,665	39,260	40,923	42,657	44,466	46,353	48,321	50,374
Inpatient	17,036	17,780	18,557	19,368	20,214	21,097	22,019	22,981	23,985
Outpatient	19,101	19,885	20,703	21,555	22,443	23,369	24,334	25,340	26,389
Ultrasound Breast Health Total	2,155	2,356	2,577	2,818	3,082	3,371	3,687	4,032	4,410
Inpatient	na	na	na	na	na	na	na	na	na
Outpatient	2,155	2,356	2,577	2,818	3,082	3,371	3,687	4,032	4,410
CT and PET/CT Total	**59,579**	**60,552**	**61,544**	**62,556**	**63,589**	**64,643**	**65,718**	**66,815**	**67,935**
(Visits) Inpatient	32,038	32,798	33,576	34,373	35,188	36,023	36,877	37,752	38,648
Outpatient	27,332	27,544	27,758	27,974	28,192	28,411	28,632	28,854	29,078
Lockport Outpatient	209	209	209	209	209	209	209	209	209

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Current and Projected Utilization of Ambulatory Care Services

Procedure		2002	2003	2004	2005	2006	2007	2008	2009	2010
MRI + Mobile MRI Total		**8,431**	**7,445**	**7,663**	**9,356**	**9,641**	**9,962**	**10,687**	**10,717**	**12,877**
	Inpatient	4,267	4,098	4,518	4,535	4,611	4,782	5,234	4,716	5,860
	Outpatient	4,164	3,347	3,145	4,821	5,030	5,180	5,453	6,001	7,017
MRI Total		**8,431**	**7,445**	**7,663**	**9,356**	**9,641**	**9,962**	**10,687**	**10,717**	**11,314**
	Inpatient	4,267	4,098	4,518	4,535	4,611	4,782	5,234	4,716	5,860
	Outpatient	4,164	3,347	3,145	4,821	5,030	5,180	5,453	6,001	5,133
	Lockport Outpatient	na	na	na	na	na	na	na	na	321
Mobile MRI Total		**na**	**na**	**na**	**na**	**na**	**na**	**na**	**na**	**1,563**
	Inpatient	na	na	na	na	na	na	na	na	na
	Outpatient	na	na	na	na	na	na	na	na	1,563
Nuclear Medicine/SPECT/CT Visits Total		**15,286**	**16,373**	**17,490**	**15,752**	**15,535**	**15,311**	**14,359**	**14,378**	**13,860**
	Inpatient	9,086	9,517	9,816	9,425	9,425	9,694	8,787	7,821	7,740
	Outpatient	6,200	6,855	7,674	6,327	6,110	5,617	5,572	6,557	6,120
Laboratory										
Laboratory Total		**1,414,453**	**1,624,399**	**425,299**	**1,620,467**	**1,687,036**	**1,760,926**	**1,798,474**	**1,729,371**	**1,753,759**
	Inpatient	995,087	1,157,541	na	1,186,222	1,202,630	1,277,466	1,322,650	1,260,495	1,273,468
	Outpatient	419,366	466,858	425,299	434,245	484,406	483,460	475,824	468,876	480,291
Rehab										
Rehab Total		**193,404**	**253,592**	**225,235**	**204,373**	**218,028**	**226,061**	**217,156**	**211,483**	**209,342**
(Adult + Pediatric)	*Inpatient*	144,505	191,849	160,892	155,977	166,126	169,281	165,752	165,279	166,984
	Outpatient	48,899	61,743	64,343	48,396	51,902	56,780	51,404	46,204	42,358
Adult Total		**146,101**	**215,028**	**186,583**	**172,400**	**190,194**	**195,086**	**192,762**	**190,806**	**187,175**
	Inpatient	132,262	180,764	151,062	143,223	158,543	159,941	156,173	156,095	158,108
	Outpatient	13,839	34,264	35,521	29,177	31,651	35,145	36,589	34,711	29,067
Pediatric Total		**47,303**	**38,564**	**38,652**	**31,973**	**27,834**	**30,975**	**24,394**	**20,677**	**22,167**
	Inpatient	12,243	11,085	9,830	12,754	7,583	9,340	9,579	9,184	8,876
	Outpatient	35,060	27,479	28,822	19,219	20,251	21,635	14,815	11,493	13,291
Cardiac Rehab Total		**na**	**na**	**na**	**14,909**	**14,857**	**14,872**	**15,464**	**15,738**	**15,528**
	Inpatient	na	na	na	3,396	3,445	3,933	3,605	3,555	3,366
	Outpatient	na	na	na	11,513	11,412	10,939	11,859	12,183	12,162
Overall Total										
	Inpatient Total									
	Outpatient Total									

Current and Projected Utilization of Ambulatory Care Services

Procedure		2011	2012	2013	2014	2015	2016	2017	2018	2019
MRI + Mobile MRI Total		**13,250**	**13,636**	**14,036**	**14,450**	**14,879**	**15,323**	**15,783**	**16,259**	**16,752**
	Inpatient	6,097	6,344	6,600	6,867	7,145	7,434	7,735	8,048	8,373
	Outpatient	7,153	7,293	7,436	7,583	7,734	7,889	8,048	8,211	8,379
MRI Total		**11,687**	**12,073**	**12,473**	**12,887**	**13,316**	**13,760**	**14,220**	**14,696**	**15,189**
	Inpatient	6,097	6,344	6,600	6,867	7,145	7,434	7,735	8,048	8,373
	Outpatient	5,269	5,409	5,552	5,699	5,850	6,005	6,164	6,327	6,495
	Lockport Outpatient	321	321	321	321	321	321	321	321	321
Mobile MRI Total		**1,563**	**1,563**	**1,563**	**1,563**	**1,563**	**1,563**	**1,563**	**1,563**	**1,563**
	Inpatient	na	na	na	na	na	na	na	na	na
	Outpatient	1,563	1,563	1,563	1,563	1,563	1,563	1,563	1,563	1,563
Nuclear Medicine Visits Total		**13,696**	**13,536**	**13,379**	**13,224**	**13,073**	**12,924**	**12,778**	**12,634**	**12,494**
	Inpatient	7,587	7,436	7,289	7,144	7,002	6,864	6,727	6,594	6,463
	Outpatient	6,110	6,100	6,090	6,080	6,071	6,061	6,051	6,041	6,031
Laboratory										
Laboratory Total		**1,801,850**	**1,851,329**	**1,902,240**	**1,954,623**	**2,008,525**	**2,063,989**	**2,121,063**	**2,179,795**	**2,240,234**
	Inpatient	1,313,345	1,354,471	1,396,885	1,440,627	1,485,739	1,532,263	1,580,244	1,629,728	1,680,761
	Outpatient	488,504	496,858	505,355	513,996	522,786	531,726	540,819	550,067	559,474
Rehab										
Rehab Total		**213,867**	**218,935**	**224,553**	**230,734**	**237,497**	**244,864**	**252,864**	**261,530**	**270,900**
(Adult + Pediatric)	*Inpatient*	170,202	173,513	176,921	180,425	184,028	187,730	191,533	195,440	199,451
	Outpatient	43,666	45,421	47,632	50,309	53,469	57,135	61,331	66,090	71,449
Adult Total		**183,175**	**193,581**	**193,581**	**195,614**	**197,646**	**199,001**	**199,679**	**200,018**	**200,356**
	Inpatient	161,675	165,323	169,053	172,867	176,768	180,756	184,834	189,005	193,269
	Outpatient	31,892	34,992	38,394	42,126	46,221	50,713	55,643	61,051	66,986
Pediatric Total		**19,282**	**19,282**	**19,282**	**19,282**	**19,282**	**19,282**	**19,282**	**19,282**	**19,282**
	Inpatient	8,526	8,190	7,868	7,558	7,260	6,974	6,699	6,435	6,181
	Outpatient	11,773	10,429	9,238	8,183	7,249	6,421	5,688	5,039	4,463
Cardiac Rehab Total		**15,656**	**15,786**	**15,917**	**16,050**	**16,184**	**16,320**	**16,457**	**16,596**	**16,736**
	Inpatient	3,360	3,354	3,348	3,342	3,336	3,330	3,324	3,319	3,313
	Outpatient	12,296	12,432	12,569	12,707	12,848	12,989	13,133	13,277	13,424
Overall Total										
	Inpatient Total									
	Outpatient Total									

Lists of Clinical and Non Clinical Departments and Areas

CLINICAL SERVICE AREAS

A. Surgery

1. Surgery Operating Rooms (Class C)
2. Surgery Procedure Rooms/Endoscopy (Class B)
3. Phase I Recovery (PACU)
4. Phase II Recovery (Prep/recovery)
5. Central Sterile Processing and Supply

C. Ambulatory Care Services (Organized as a Service)

6. Cast Room
7. CHF Clinic
8. Fetal Diagnostics
9. Infusion Center (Adult)
10. Neurodiagnostics
11. Non-Invasive Cardiology
12. Pain Center
13. Pre-Admission Testing
14. Pulmonary Function

D. Diagnostic and Interventional Radiology/Imaging by Modality (excludes portables, mobile equipment utilization)

15. General Radiology and Fluoroscopy/Tomography/Other X-ray Procedures
16. Mammography
17. Ultrasound
18. CT, PET/CT
19. MRI
20. Nuclear Medicine/SPECT/ CT

F. Laboratory

21. Laboratory

G. Pharmacy

22. Pharmacy

H. OT/PT

23. Outpatient Rehabilitation
24. Cardiac Rehabilitation

NON CLINICAL SERVICE AREAS

(25. through 29. deliberately unused)

30. Institutes and Physician Offices
31. Lobby, Public Areas, Resource Center, and Winter Garden
32. Registration including Financial Counseling
33. Shell Space
34. Administration
35. Research/Education
36. Electronic Medical Record Support
37. Materials Management /EVS
38. Circulation, Connector, Pneumatic Tube System
39. Lobby Café
40. Retail Pharmacy
41. Mechanicals and Interstitial Spaces

Clinical Service Area –
Surgery Operating Rooms (Class C)

Clinical List Designation A.1

c) Service Modernization

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

1) Deteriorated Equipment of Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

NA. The proposed project will not replace surgery operating rooms or equipment that has deteriorated. The project will add 14 needed operating rooms on Level 3 of the proposed Ambulatory Pavilion (Pavilion) at Advocate Christ Medical Center/Advocate Hope Children's Hospital (ACMC/AHCH, Medical Center).

2) Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

Today, all adult and pediatric surgery at the Medical Center is performed in the surgical suite in the main hospital.

In October 2003, the Illinois Health Facilities Planning Board approved the Medical Center's application to construct a 4-level addition to the existing surgery pavilion; the addition included space for surgery, central sterile processing and supply, and intensive care beds. The permit (#03-035) increased the number of operating rooms from 21 to 26. The additional operating rooms opened in 2007. (During 2007, utilization was depressed because of the construction.) In that certificate of need application, the Medical Center justified the need for 30 rooms, however only 26 were requested. As shown on Attachment 37, A.1., Table 1, the 26 operating rooms were operating in excess of the

2010, these rooms operated at an average of 1,944 hours per room, or 29.6 percent higher than the State Standard of 1,500 hours per room than the State Standard of 1,500 hours per room.

To meet the increasing hours of surgery, the Medical Center extended weekday hours and added Saturday hours. Surgery teams were developed with special skills for each specialty to increase patient capacity and patient satisfaction.

Attachment 37, A.1, Table 1
Historical Utilization of Surgery at ACMC/AHCH, 2006 to 2010

Year	2006	2007	2008	2009	2010	Percent Change 2008-2010
IP Hours	22,760	17,956	24,221	31,898	34,118	40.9
OP Hours	9,447	6,459	10,832	15,416	16,416	51.6
Total Hours	32,207	24,415	35,053	47,314	50,534	44.2
Percent OP Hours	29.3	26.5	30.9	32.6	32.5	+1.6
Number of Operating Rooms	19	26	26	26	26	--
Hours per Room	1,696	939	1,349	1,820	1,944	+44.1
Percent over State Standard	+13.0	--	--	+21.3	+ 29.6	--

Source: ACMC records.

Demand for surgical services is expected to increase from 20 to 30 percent nationally over the next decade, according to industry experts. Strong growth in surgical services is also expected at the Medical Center for the following reasons:

- The Medical Center is the only Level I Trauma Center (the highest designation) in the southwest Chicago area and the largest in Illinois, reporting almost 86,000 visits in 2010. The demand for trauma services is expected to increase; trauma patients often require immediate access to an operating room.
- During 2008 and 2009, the Medical Center recruited 19 general and sub-specialist surgeons to the medical staff; an additional 6 surgeons were recruited in 2010. These practices are all ramping up and will further increase need for surgical capacity. Many of the Medical Center's physicians have expressed a preference for an ambulatory surgery option because it allows for improved efficiencies and available block time.

- The Medical Center is also adding new programs that have a major surgical component. These include complex neurological, orthopedic, oncological, and thoracic procedures and will require more capacity in the inpatient surgical suite. Capacity for these cases will become available when outpatient surgery cases are relocated to the Ambulatory Pavilion.

The accelerating trend toward outpatient surgery is an important change in industry standards. Outpatient surgery typically accounts for about 60 percent of all surgery cases performed in Illinois hospitals. Outpatient surgery accounts for 32 percent of the cases at ACMC/AHCH. In a tertiary/quaternary medical center such as ACMC/AHCH, trauma and other emergency surgical cases take precedence over elective outpatient cases. Consequently, outpatient cases are frequently delayed and may even be rescheduled.

The Medical Center is proposing to add 14 outpatient operating rooms in the Ambulatory Pavilion so that future ambulatory surgery growth can occur. Growth in outpatient surgical hours is expected to be primarily in the specialties of general surgery, women's services, otolaryngology, ophthalmology, orthopedics, urology, and plastic-reconstructive surgery. These are all established specialties at the Medical Center with expected strong growth.

A final change in industry standards is national health care reform. The newly insured population will have improved access to health care. This is expected to result in the discovery of more undiagnosed conditions that will require surgery. There will be incentive to treat "preventable hospital admissions" on an outpatient basis. Some surgical procedures currently provided in the inpatient setting will migrate to the outpatient setting; this will also prevent hospital admissions.

3) Utilization

A) Major Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

NA. There is no surgery equipment in this project that meets or exceeds the major medical equipment threshold.

B) Service or Facility

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

In Section c) 2) above, ACMC/AHCH showed how the utilization of the Medical Center's current operating room complement is substantially over State Standards and described changes in industry standards that will influence growth in surgery in the future.

The following calculations were used to determine future need.

Current Utilization

Current utilization justifies the need for 34 operating rooms. The Medical Center currently has only 26 rooms. The State Standard is 1,500 hours per room per year.

50,534 hours ÷ 1,500 hours per room = 34 operating rooms

Projected Utilization

To anticipate future demand, the Medical Center prepared CAGR trend lines/projections based on utilization trends from 2003 to 2010; 2003 is the base year for the surgical projection because the 2002 data are not reliable. The trend line was extended to 2019. The growth suggests the need for 49 operating rooms by 2016 and 58 operating rooms by 2019.

Attachment 37, A.1, Table 2
CAGR Projected Surgery Hours, 2016 and 2019

Year	2010	2016 Second Full Year of Operation	Percent Change 2010 to 2016	Number of Rooms Justified in 2016	2019 Fifth Full Year of Operation	Number of Rooms Justified in 2019
IP Hours	34,118	49,189	+44.2	33	59,062	40
OP Hours	16,416	22,747	+38.6	16	26,777	18
Total Hours	50,534	71,936	+42.4	48 to 49	85,839	58

Source: ACMC records.

Impact of Health Care Reform

The Medical Center then conservatively applied a 15 percent growth factor to account for the implementation of national health care reform legislation. This factor increases total projected volume and the need for as many as 58 rooms in 2016.

2016

85,839 hours x 1.15 national health care reform factor = 98,715 hours

98,715 hours ÷ 1,500 hours per room = 66 rooms

ACMC/AHCH Has Justified the Need for 40 Operating Rooms

To be conservative, the Medical Center is requesting only 40 operating rooms; these include the 26 existing rooms in the main hospital and 14 additional rooms in the Ambulatory Pavilion. By shifting appropriate cases to the outpatient setting, the Medical Center will be able to dedicate at least one room in the hospital for robotic surgery, and one room will be available for trauma cases.

By 2016, the second full year of operation for the Ambulatory Pavilion, the 26 existing and the 14 additional operating rooms will be operating above the State Standard.

71,936 hours ÷ 40 rooms = 1,799 hours per room

1,799 hours per room > State Standard of 1,500 hours per room

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

NA. There is a State Standard for Surgery Operating Rooms (Class C); ACMC/AHCH's projected volume exceeds the State Standard by the second full year of operation.

c) Service Modernization

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

1) Deteriorated Equipment of Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

NA. The proposed project will not replace facilities or equipment that has deteriorated. The project will add 8 endoscopy rooms in the proposed Ambulatory Pavilion (Pavilion), and reduce from 5 to 3 the number of rooms in the main hospital at Advocate Christ Medical Center/Advocate Hope Children's Hospital (ACMC/AHCH/Medical Center).

2) Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

Using an instrument called an endoscope that has a tiny camera attached to a long thin tube; a physician moves the camera through a body passage to see inside the body. There are many types of endoscopy procedures; gastroenterology procedures (of the esophagus, stomach, and large intestine) and bronchoscopy procedures (of the throat, larynx, trachea and lungs) are performed in the Medical Center's endoscopy rooms. Sometimes endoscopes are used for surgical procedures (therapeutic endoscopy), such as removing polyps from the colon.

Nationally, the diagnosis and treatment of gastrointestinal and bronchial disorders are moving to the outpatient setting. The experience of Advocate Christ Medical Center/Advocate Hope Children's Hospital has mirrored the national trends with 68

percent of endoscopy hours being outpatient.

All adult and pediatric endoscopic and bronchial procedures at the Medical Center are currently performed in 5 endoscopy rooms in the main hospital; this complement will be reduced to 3 rooms when the Ambulatory Pavilion opens.

In 2010, the 5 existing endoscopy rooms operated at an average of 2,655 hours per room or 77 percent higher than the State Standard. The Medical Center cannot serve any additional endoscopy patients until capacity is expanded.

Attachment 37, A.2, Table 1
Historical Utilization of Endoscopy at ACMC/AHCH, 2008 to 2010

Year	2008	2009	2010	Percent Change 2008-2010
IP Hours	3,884	3,827	4,305	+10.8
OP Hours	7,450	7,447	8,968	+20.4
Total Hours	11,334	11,274	13,273	+17.1
Percent OP Hours	65.7	66.1	67.6	+1.9
Number of Endoscopy Rooms	5	5	5	--
Hours per Room	2,267	2,255	2,655	+17.1
Percent over State Standard	+51.1	+50.3	+77.0	+25.9

Source: ACMC records.

In the field of endoscopy, several important changes in industry standards are occurring; industry experts expect these changes to increase endoscopy volume substantially over the next decade, with an expected 50 percent growth in outpatient volume and a 15 percent increase overall. The first set of changes relates to technology, the second to reimbursement.

Changes in industry standards relating to technology include new applications of established procedures, emerging technologies capable of identifying gastric disease at earlier stages, new minimally invasive techniques, and expanding new therapeutic options.

The second major change in industry standards relates to reimbursement. The provisions of the 2010 health reform legislation will increase the volume of colon screening for cancer. While this provision initially only affects Medicare recipients, eventually all health plans must include these diagnostic screenings with no co-

payment. Improved coverage for colorectal screenings is especially important to historically underserved populations that have a higher incidence of colorectal cancer. Early screenings and the removal of pre-cancerous polyps will prevent admissions.

3) Utilization

A) Major Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

NA There is no endoscopic equipment in this project that meets or exceeds the major medical equipment threshold.

B) Service or Facility

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

In Section c) 2) above, ACMC/AHCH first showed that the Medical Center's endoscopy rooms are operating at volumes substantially over the State Standard and second, described changes in industry standards that will influence growth in endoscopy volume in the future.

The following calculations were used to determine future need. The State Standard for surgery procedure rooms is 1,500 hours per room.

Current Utilization

Current utilization of the existing 5 endoscopy rooms justifies the need for 9 procedure/endoscopy rooms. The Medical Center currently has only 5 rooms.

13,273 hours ÷1,500 hours per room = 9 rooms

Projected Utilization

In order to project future demand, the Medical Center prepared CAGR trend lines based on the utilization trends from 2006 to 2010. 2006 is the base year for the projection because earlier data is not reliable. The trend lines were extended to

2019. Combined inpatient and outpatient growth suggests the need for 14 endoscopy rooms by 2016 and 18 endoscopy rooms by 2019.

Attachment 37, A.2, Table 2
CAGR Projected Endoscopy Hours, 2016 and 2019

Year	2010	2016 Second Full Year of Operation	Percent Change 2010 to 2016	Number of Rooms Justified by 2016	2019 Fifth Full Year of Operation	Number of Rooms Justified by 2019
IP Hours	4,305	5,264	+22.3	4	5,820	4
OP Hours	8,968	15,792	+76.1	11	20,955	14
Total	13,273	21,056	+58.6	14 to 15	26,775	18

Source: ACMC records.

Impact of National Health Care Reform

The Medical Center then conservatively applied a 15 percent growth factor to account for the implementation of the national health care reform legislation. This factor increases total projected volume to 24,215 hours, or the need for 17 rooms in 2016.

2016

21,056 hours x 1.15 national health care reform factor = 24,215 hours

24,215 hours ÷ 1,500 hours per room = 17 rooms

ACMC/AHCH Has Justified the Need for 11 Endoscopy Rooms

To be conservative, the Medical Center is requesting only 11 endoscopy rooms; this reflects the reduction of rooms in the main hospital from 5 to 3 and the addition of 8 rooms in the Ambulatory Pavilion.

In 2016, the second full year of operation of the Ambulatory Pavilion the 3 rooms remaining in the hospital and the 8 new rooms will be operating above the State Standard.

21,056 hours ÷ 11 rooms = 1,914 hours per room

1,914 hours per room > State Standard of 1,500 hours per room

The number of endoscopy hours is projected to continue to increase after 2016.

Additional growth will further increase the number of hours per room.

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

NA. There is a State Standard for Surgery Procedure Rooms (Class B); ACMC/AHCH's projected volume exceeds the State Standard by the second full year of operation.

c) Service Modernization

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

1) Deteriorated Equipment of Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

NA. The proposed project will not replace facilities or equipment that has deteriorated. The project will add 14 Phase I Recovery (PACU) stations on Level 3 of the proposed Ambulatory Pavilion (Pavilion) adjacent to the Surgery Operating Rooms (Class C)

2) Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

In section A. 1, Surgery Operating Rooms (Class C), Advocate Christ Medical Center/Advocate Hope Children's Hospital (ACMC/AHCH, Medical Center) justified the need for 14 operating rooms in the Ambulatory Pavilion. The Phase I Recovery (PACU) stations are needed to support these operating rooms.

A) Major Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

NA. There is no Phase I Recovery (PACU) equipment in this project that meets or exceeds the major medical equipment threshold.

B) Service or Facility

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

There is no State Standard for utilization of Phase I Recovery (PACU) stations.

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

IDPH Hospital Code Section 250.2440 Need for Recovery Positions requires a minimum of one post-operative recovery room for each operating room. ACMC/AHCH is requesting 14 surgery operating rooms and is proposing to provide 14 Phase I Recovery (PACU) stations. Hence the proposed PACU space in the Ambulatory Building will meet the IDPH code requirement.

14 Phase I Recovery (PACU) stations = 14 operating rooms

ACMC/AHCH Has Justified the Need for 14 Phase I Recovery (PACU) Stations

The Medical Center has justified the need for 14 Phase I Recovery (PACU) stations as required by IDPH Hospital Code.

14 proposed Phase I Recovery (Prcp/Recovery) stations =
14 Phase I Recovery/PACU stations
required by IDPH Hospital Code

Clinical Service Area –
Phase II Recovery (Prep/recovery)

Clinical List Designation A. 4

c) Service Modernization
The applicant shall document that the proposed project meets one of the following:

1) Deteriorated Equipment of Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

The proposed project will not replace facilities or equipment that has deteriorated.

The project will add 66 Phase II Recovery (Prep/recovery) stations in the proposed Ambulatory Pavilion (Pavilion).

2) Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

In Section A.1, Surgery Operating Rooms (Class C) and Section A.2, Surgery Procedure Rooms (Class B), Advocate Christ Medical Center/Advocate Hope Children's Hospital (ACMC/AHCH, Medical Center) justified the need for 40 operating rooms and 11 surgery procedure rooms, of the total; 14 operating room and 8 procedure rooms will be in the Pavilion. The Phase II Recovery (Prep/recovery) stations are needed to support these operating and procedure rooms.

A) Major Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

NA. There is no Phase II Recovery equipment in this project that meets or exceeds the major medical equipment threshold.

B) Service or Facility

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

There is no State Standard for utilization of Phase II Recovery (Prep/recovery) stations.

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

The Medical Center is proposing to add 66 Phase II Recovery (Prep/recovery) stations.

IDPH Hospital Code Section 250.2440 i) 5) B) requires a minimum of 4 recovery stations for a surgery operating room. As noted in A.2 and A.3, the Medical Center is proposing to have 14 surgery operating rooms and 14 Phase I Reeovery (Prep/recovery) stations. To meet the code requirement, the Medical Center must provide 3 Phase II Recovery (Prep/recovery) stations for each of the 14 surgery operating rooms or 42 stations.

The Code also requires that each surgery procedure room also have 3 Phase II Recovery (Prep/recovery) stations. The Pavilion will house 8 surgery procedure / endoscopy rooms; they will require an additional 24 Phase II Recovery stations. The complements of surgery operating room and surgery procedure rooms require 66 Phase II Recovery (Prep/recovery) stations.

42 Phase II Recovery stations for 14 Surgery Operating Rooms +
24 Phase II Recovery stations for 8 Surgery Procedure Rooms =
66 total Phase II Recovery stations.

ACMC/AHCH Has Justified the Need for 66 Phase II Recovery (Prep/Recovery) Stations

The Medical Center has justified the need for 66 Phase II Recovery (Prep/recovery) stations as required by IDPH Hospital Code.

66 proposed Phase II Recovery (Prep/Recovery) =
66 Phase II Recovery (Prep/Recovery) required by IDPH Hospital Code

Clinical Service Area -
Central Sterile Processing and Supply

Clinical List Designation A.5

c) Service Modernization

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

1) Deteriorated Equipment of Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

The proposed project will not replace facilities or equipment that has deteriorated. The project will develop new space for central sterile processing and supply in the proposed Ambulatory Pavilion (Pavilion).

2) Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

In sections A.1 Surgery Operating Rooms), and A.2 Surgery Procedure/Endoscopy Rooms, Advocate Christ Medical Center/Advocate Hope Children's Hospital (ACMC/AHCH, Medical Center) justified the need for 14 operating rooms and 8 endoscopy rooms in the Ambulatory Pavilion. The central sterile processing and supply area is needed to support these functions. Central sterile processing and supply in the hospital is operating at capacity and cannot accommodate any additional volume.

A) Major Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

NA. There is no central sterile processing and supply equipment in this project

that meets or exceeds the major medical equipment threshold.

B) Service or Facility

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

There is no State Standard for utilization of Central Sterile Processing and Supply.

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

The proposed Ambulatory Pavilion is projected to have approximately 100 surgery and endoscopy patients per day by 2016, the second full year of operation. Each of these cases will require sterile supplies and equipment.

Key sterile processing functions include receiving and break out, and storage areas for surgery and endoscopy supplies. Soiled surgical equipment and scopes will be processed through decontamination and sterilization and then moved to sterile storage. Case carts will also be cleaned and stored until needed. Trays will be assembled with supplies and equipment, sterilized, loaded on clean carts, and moved to surgery and endoscopy via a clean elevator. Used equipment and trays will be returned to sterile processing area via a soiled elevator; soiled case carts and equipment will be held until they are again routed through the cleaning process.

These functions are all essential to support the projected volumes for surgery and endoscopy in the Ambulatory Pavilion.

ACMC/AHCH Has Justified the Need for a Central Sterile Processing and Supply Area

The Medical Center has demonstrated that the proposed central sterile processing and supply area is essential to support primarily the surgery and endoscopy areas in the Ambulatory Pavilion.

Clinical Service Area – Cast Room

Clinical List Designation C.6

c) Service Modernization
The applicant shall document that the proposed project meets one of the following:

4) Deteriorated Equipment of Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

NA. The proposed project will not result in the replacement of facilities that have deteriorated and need replacement. The purpose of the cast room addition is to have adequate capacity and to improve access for patients in the Ambulatory Pavilion (Pavilion).

5) Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

An orthopedic cast is a shell, frequently made of plaster, encasing a limb or limbs (and in some cases, large portions of a body) to hold broken bones in place until healing is confirmed. Today, some casts are made of synthetic materials – often knitted fiberglass bandages impregnated with polyurethane; fiberglass casts are light, durable, and resistant to water.

The orthopedic surgeons at the Advocate Christ Medical Center/Advocate Hope Children's Hospital (ACMC/AHCH, Medical Center) will use the 1 proposed cast room in the Pavilion to apply or remove casts for both adult and pediatric patients. A second cast room already exists in the Emergency Department.

Attachment 37, C.6, Table 1
Historieal Utilization of the Cast Room at ACMC/AHCH

Year	2008	2009	2010	Percent Change 2008-2010
IP Visits	--	--	--	
OP Visits	4,557	4,624	4,876	+ 7.0
Total Visits	4,557	4,624	4,876	+ 7.0
Percent OP Visits	100.0	100.0	100.0	--
Number of Units Justified	2	2	2	--

Source: ACMC records.

The utilization of the cast rooms between 2008 and 2010 showed a 7.0 percent increase. Having a cast room in close proximity to the radiology department makes it easier to diagnose and treat patients needing a cast. It will also be more convenient for patients who may have difficulty ambulating since the cast room will be on the first level of the Ambulatory Pavilion with ready access to parking.

6) Utilization

A) Major Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

NA. There is no cast room equipment in this project that meets or exceeds the major medical equipment threshold.

B) Service or Facility

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

A description of the increase in cast room utilization at the Medical Center between 2008 and 2010 and the benefits of having the proposed cast rooms in the Ambulatory Pavilion are described in Section c) 2) above.

The cast room is considered by the HFSRB rules to be an Ambulatory Care Service; the State Standard for Ambulatory Care Services is 2,000 visits per room.

The following calculations were used to determine future need.

Current Need

Current volume justifies the need for 3 cast rooms.

4,876 visits ÷ 2,000 visits per room = 3 rooms

Projected Utilization

To better understand future demand based on the aging of the population and innovations in orthopedics, the Medical Center prepared a CAGR trend line based on cast room utilization from 2002 to 2010 and extended it to 2019. The trend line suggests the need for as many as 4 cast rooms by the second year of operation.

Attachment 37, C. 6, Table 2
CAGR Projected Cast Room Procedures, 2016 and 2019

	2010	2016 Second Full Year of Operation	Percent Change 2010 to 2016	Number of Rooms Justified in 2016	2019 Fifth Full Year of Operation	Number of Rooms Justified in 2019
IP Visits	-	-	-	-	-	-
OP Visits	4,876	6,223	27.6	4	7,031	4
Total Visits	4,876	6,223	27.6	4	7,031	4

Source: ACMC records.

Impact of National Health Care Reform Legislation

Next, the Medical Center conservatively applied a 15 percent growth factor to account for the implementation of national health care reform legislation. This factor also justifies the need for 4 cast rooms in 2016.

2016

6,223 cast room visits x 1.15 national health care reform factor = 7,156 cast room visits

7,156 visits ÷ 2,000 visits per room = 4 cast rooms

ACMC/AHCH Has Justified the Need for 2 Cast Rooms

The Medical Center is proposing to have 1 cast room in the Ambulatory Pavilion; there will be a second cast room in the hospital's Emergency Department. By 2016, the second full year of operation of the Ambulatory Pavilion, the 2 cast rooms at the Medical Center will exceed the State Standard for Ambulatory Care

Services.

6,223 visits ÷ 2 cast rooms = 3,112 visits per room

3,112 visits per room > State Standard of 2,000 visits per room

The demand for cast room capacity is expected to continue to increase after 2016, further increasing the number of visits per room.

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

Cast rooms are an Ambulatory Care Service. There is a State Standard for Ambulatory Care Services. ACMC/AHCH's volume currently exceeds the State Standard.

4,876 visits ÷ 2 cast rooms = 2,438 visits per room

2,438 visits per room > State Standard of 2,000 visits per room

Clinical Service Area – CHF Clinic

Clinical List Designation – C.7

c) Service Modernization
The applicant shall document that the proposed project meets one of the following:

1) Deteriorated Equipment of Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

NA. Advocate Christ Medical Center/Advocate Hope Children's Hospital (ACMC/AHCH, Medical Center) is proposing to move the Congestive Heart Failure (CHF) Clinic into the Heart and Vascular Institute on Level 6 of the Ambulatory Pavilion (Pavilion). This re-location will not result in the replacement of facilities that have deteriorated.

2) Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

Necessary Expansion

Advocate Christ Medical Center/Advocate Hope Children's is one of the most comprehensive providers of cardiovascular services in Illinois and is nationally renowned for its use of innovative technologies and advanced procedures in the treatment of both adult and pediatric heart disease, heart failure, and stroke. ACMC/AHCH is recognized by the American Heart Association and the American Stroke Associates for sustained "gold award performance" in treating coronary artery disease, heart failure, and stroke.

Congestive Heart Failure (CHF) occurs when the heart is not pumping as well as it should to deliver oxygen-rich blood to the body's cells and ultimately results in the buildup of fluid in the lungs and other body tissues. CHF can significantly affect a person's ability to function in daily life.

According to the American Heart Association, people age 40 and over have a 1 in 5 chance of developing CHF. More and more cases of CHF are diagnosed each year – partly because people are living longer and surviving heart attacks as well as other medical conditions that put them at risk for CHF. Today, CHF is the leading cause of hospitalization among Americans. Because of inadequate treatment, discharge guidance, and follow up after an inpatient CHF event, many patients experience clinical deterioration and re-hospitalization.

Quality indicators and financial pressures will shift much of the CHF care from the inpatient to the outpatient setting. Health care leaders are forecasting a 40 percent decline in CHF admissions nationally and a concurrent increase in outpatient care. More than 16 years ago, in January 1995, the Medical Center opened a CHF Clinic to improve the lives of CHF patients and to save costs. Early stage CHF treatment at the Clinic includes life style changes, medicine, transcatheter intervention, and surgery. In the most severe cases of CHF or end stage heart failure, treatment may include the implantation of mechanical assist devices or even heart transplantation.

The Clinic's comprehensive program for CHF patients was designed to reinforce the patient's prescribed medication and treatment plan and break the typical cycle of repeat hospitalization. Through this program, the patient gains a better quality of life with improved function and fewer days spent in the hospital.

Some of the services provided by the CHF Clinic include:

- Education about heart failure, medications, and dietary restrictions
- Close surveillance and monitoring through ongoing patient assessment, evaluation, and lab analysis
- Adjustment and titration of CHF medications
- Anticoagulation monitoring

- Ongoing communication with the Clinic's staff as well as with the patient's primary care physician, cardiologist, and other specialists
- Acute outpatient therapies for patients who have worsening symptoms including IV diuretics
- Phone call follow up and support
- Ability to see patients urgently who have sudden changes in symptoms
- Influenza and pneumococcal immunizations, and
- Follow up with patients receiving biventricular devices.

The implementation of national health care reform, a change in industry standards, is expected to further increase the use of the Medical Center's CHF Clinic services because they have proven to better manage the disease process, improve individual health status, as well as reduce hospital admissions and readmission through disease monitoring and care protocols.

Attachment 37, C. 7, Table 1
Historical Utilization of the CHF Clinic at ACMC/AHCH

Year	2008	2009	2010	Percent Change 2008 to 2010
IP Visits	--	--	--	--
OP Visits	5,163	5,452	5,831	+12.9
Total Visits	5,163	5,452	5,831	+12.9
Percent OP Visits	100.0	100.0	100.0	100.0

Source: ACMC records.

The Medical Center's ability to accept additional CHF patients is currently limited by the 9 available treatment stations. In an interim development, the Medical Center is adding 3 stations to bring the total to 12 stations until the Ambulatory Pavilion opens. The new CHF Clinic in the Pavilion will have 15 treatment stations.

3) Utilization

C) Major Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

NA. There is no congestive heart failure equipment in this project that meets or exceeds the major medical equipment threshold.

D) Service or Facility

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

A description of the innovative CHF Clinic program at the Medical Center and the positive outlook for CHF visits under national health care reform are described in Section c) 2).

The State Standard is 2,000 visits per year per "room" for Ambulatory Care Services. According to the rules, the term ambulatory care means medical care including the diagnosis, observation, treatment, or rehabilitation that is provided on an outpatient basis. Ambulatory care includes simple diagnostic procedures such as blood tests or well-baby visits; they also include more complex procedures such as oncology infusion treatments and CHF Clinic visits. Since the guideline appears to cover a wide range of ambulatory care that is organized as a service, time per visit varies widely. The time for a blood test could be 5 minutes or less, while more complex ambulatory visits could take several hours.

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

250 days per year x 7.5 hours per day x 80 percent occupancy = 1,500 hours of surgery per room per year

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

1,500 hours per room ÷ 2,000 visits per room = 0.75 hours or 45 minutes per visit

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

The following calculations were used to determine current and future need for CHF treatment stations.

Current Utilization

The Medical Center determined that the average treatment time for a CHF patient is 3.8 hours or more than 5 times longer than the 45 minute State Standard.

3.8 hours x 60 = 228 minutes ÷ 45 minutes =
5.1 times longer than the State Standard visit time

Based on current treatment time, the Medical Center's current volume justifies 15 treatment stations.

5,831 visits x 3.8 hours per treatment = 22,158 treatment hours

22,158 treatment hours ÷ 1,500 hours per treatment station =
15 treatment stations.

Projected Utilization

To anticipate future demand based on the aging of the population and clinical innovations in the delivery of CHF care, the Medical Center prepared a CAGR trend line based on CHF Clinic utilization from 2002 to 2010 and extended it to 2019. Projected visits were converted to hours using 3.8 hour per visit. The trend line, adjusted by hours per visit, suggests the need for as many as 19 treatment stations by 2016.

Attachment 37, C.7, Table 2
CAGR Projected CHF Clinic Visits, 2016 and 2019

Year	2010	2016 Second Full Year of Operation	Percent Change 2010 to 2016	Number of Treatment Stations Justified in 2016	2019 Fifth Full Year of Operation	Number of Treatment Stations Justified in 2019
IP Visits	-	-	-	-	-	-
OP Visits	5,831	7,172	+23.0	19	7,953	21
Total Visits	5,831	7,172	+23.0	19	7,953	21

Source: ACMC records.

2016

7,172 visits x 3.8 hours per visit = 27,254 total hours

27,254 total hours ÷ 1,500 hours per treatment station = 19 treatment stations

2019

7,953 visits x 3.8 hours per visit = 30,222 total hours

30,222 total hours ÷ 1,500 hours per treatment station = 21 treatment stations

Impact of National Health Care Reform Legislation

Finally, the Medical Center conservatively applied a 15 percent growth factor to account for the implementation of national health care reform legislation. This factor increases the projected need for CHF treatment stations to as many as 21 by 2016.

2016

7,172 visits x 1.15 = 8,248 visits

8,248 visits x 3.8 hours per visit = 31,342 hours

31,342 hours ÷ 1,500 hours per treatment station = 21 treatment stations

ACMC/AHCH Has Justified the Need for 15 CHF Clinic Treatment Stations

Although more treatment stations have been justified, the Medical Center is conservatively requesting only 15 stations; these will all be located in the Heart and Vascular Institute on the sixth floor of the Ambulatory Pavilion.

By the second full year of operation of the Ambulatory Pavilion, the total complement of 15 treatment stations will be operating above the State Standard.

27,254 hours ÷ 15 stations = 1,816 hours per station

1,816 hours per station > State Standard of 1,500 hours per station

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

There is a State Standard for Ambulatory Care Services. ACMC/AHCH's current CHF Clinic utilization justifies 15 treatment stations.

5,831 visits x 3.8 hours per visit = 22,158 treatment hours

22,158 treatment hours ÷ 1,500 hours per treatment station = 15 stations.

Clinical Service Area – Fetal Diagnostics

Clinical List Designation – C.8

c) Service Modernization
The applicant shall document that the proposed project meets one of the following:

1) Deteriorated Equipment of Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

NA. Fetal Diagnostics is currently located in the professional office building on the campus of Advocate Christ Medical Center/Advocate Hope Children's Hospital (ACMC/AHCH, Medical Center). The Medical Center leases space in the professional office building for several services including Fetal Diagnostics. Fetal Diagnostics will be relocated to the Ambulatory Pavilion

2) Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

Advocate Christ Medical Center is a Level III Perinatal Center and cares for more than 4,000 normal and high risk mothers and babies each year.

An important aspect of the perinatal program is prenatal testing or fetal diagnostics. These tests diagnose genetic, medical and obstetrical conditions. Among the prenatal tests that are performed and read by the Maternal and Fetal Medicine specialists at the Medical Center are:

- Prenatal ultrasound
    - Ultrasound uses sound waves to produce an image of the fetus inside the womb. Common reasons for having ultrasound include:

- Determining the age and sex of the fetus
- Evaluating the anatomy, blood flow, and size of the fetus
- Diagnosing multiple births
- Checking for the fetus' position in the womb
- Determining the cause of bleeding during pregnancy
- As guidance for chorionic villus sampling (CVS), and
- As guidance for amniocentesis sampling.
    - Using ultrasound to see the position of the baby, the doctor guides a thin needle through the mother's abdominal wall and into the sac surrounding the fetus. A small amount of fluid is removed for analysis to diagnose large chromosomal abnormalities such as Down syndrome

- Non Stress Test (NST)
    - An NST is a means of monitoring the fetal heart with an external transducer. The tracing is observed for fetal heart rate associated with fetal movement.
- Genetic counseling and diabetes education

The ultrasound units in Fetal Diagnostics are only available for obstetrical exams. They are specifically programmed for obstetrical applications; this programming is a very complicated process. The ultrasound tests are performed and read by Maternal and Fetal Medicine specialists; not by radiologists. The Maternal and Fetal Medicine specialists are assisted by specially trained sonographers who are certified by the American Registry of Diagnostic Medical Sonographers.

Attachment 37, C. 8 Table 1
Historical Utilization of Fetal Diagnostics at ACMC/AHCH

Year	2008	2009	2010	Percent Change 2008-2010
IP Visits	--	--	--	--
OP Visits	15,693	15,607	17,145	+9.3
Total Visits	15,693	15,607	17,145	+9.3
Percent OP Visits	100.0	100.0	100.0	--
Number of Rooms Justified	11	11	12	+9.1

Source: ACMC records.

The Fetal Diagnostic service has recorded 9.3 percent growth between 2008 and 2010. This reflects the number of high risk pregnancies in the referral area served by the Medical Center and the ability to diagnose in utero conditions early in a pregnancy and treat them aggressively for improved outcomes. An important member of the Fetal Diagnostics staff is the diabetic educator. She is key in helping diabetic mothers control their disease as soon as the mother has an indication that her diabetic condition is abnormal. This role in prevention of serious diabetic complications prevents admissions.

National health care reform encourages disease prevention, early diagnosis, and potentially early intervention to minimize more acute and costly treatment protocols. Fetal Diagnostics at the Medical Center will enhance prenatal care, reduce premature births, and low birth weight babies which drive the demand for costly neonatal care.

3) Utilization

A) Major Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

NA. There is no fetal diagnostic equipment in this project that meets or exceeds the major medical equipment threshold.

B) Service or Facility

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

A description of recent utilization of Fetal Diagnostics at the Medical Center and how the services complement the goals of national health care reform are described in Section c) 2).

Fetal Diagnostics is an Ambulatory Care Service; the State Standard for Ambulatory Care Services is 2,000 visits per room.

The following calculations were used to quantify the number of rooms being justified for Fetal Diagnostics.

Current Need

Current utilization of Fetal Diagnostics justifies the need for 9 rooms

17,145 visits ÷ 2,000 visits per room = 9 rooms

Projected Utilization

To estimate future volume of Fetal Diagnostics, the Medical Center prepared a CAGR trend line based on historical data and extended the trend line to 2019. The CAGR trend line suggests that by 2019 the Medical Center could need as many as 15 Fetal Diagnostic rooms.

Attachment 37, C. 8, Table 2
CAGR Projected Fetal Diagnostics Visits, 2016 and 2019

Year	2010	2016 Second Full Year of Operation	Percent Change 2010 to 2016	Number of Rooms Justified in 2016	2019 Fifth Full Year of Operation	Number of Rooms Justified in 2019
IP Visits	-	-	-	-	-	-
OP Visits	17,145	23,974	39.8	12	28,463	15
Total Visits	17,145	23,974	39.8	12	28,463	15

Source: ACMC records.

Impact of National Health Care Reform

As a third test of projected need, the Medical Center applied a 15 percent growth factor to account for the implementation of the national health care reform legislation. This factor increases total projected need to 14 Fetal Diagnostic rooms in 2016.

2016

23,974 visits x 1.15 national health care reform factor = 27,571 visits

27,571 visits ÷2,000 visits per room = 14 rooms

ACMC/AHCH Has Justified the Need for 10 Fetal Diagnostic Rooms

The Medical Center is requesting 10 rooms in Fetal Diagnostics; the 10-room complement will include 7 ultrasound rooms, 2 procedure rooms, and 1 NST monitoring room.

By 2016, the Medical Center expects Fetal Diagnostics to record, 2,398 visits per room or more than the State Standard.

23,974 visits ÷ 10 rooms = 2,398 visits per room

2,398 visits per room > the State Standard of 2,000 visits per room

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

HFSRB considers Fetal Diagnostics to be an Ambulatory Care Service. ACMC/AHCH will exceed the State Standard for Ambulatory Care Services by the second full year of utilization.

Clinical Service Area – Infusion Center (Adult)

Clinical List Designation – C.9

c) Service Modernization
The applicant shall document that the proposed project meets one of the following:

1) Deteriorated Equipment of Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

NA. The proposed project will not result in the replacement of equipment or facilities that have deteriorated or need replacement. The Infusion Center at Advocate Christ Medical Center/Advocate Hope Children's Hospital (ACMC/AHCH, Medical Center) is being relocated to the Ambulatory Pavilion (Pavilion) because the current space is inadequate to support the current and projected number of adult infusion therapy patients.

2) Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

Medical infusion therapy, sometimes called medical oncology or chemotherapy, involves using drugs to destroy cancer cells. A medical infusion therapy patient typically receives a combination of drugs at each treatment. Most of these drugs are given using intravenous (IV) therapy. Surgery and radiation therapy may be used in conjunction with chemotherapy treatments The Ambulatory Pavilion will be connected to the hospital so that patients receiving both chemotherapy and radiation therapy on the same visit can move safely between the two treatment sites.

The Medical Center provides a comprehensive cancer program including patient care, education, and research. The oncologic clinical trials being used at the Medical

Center are managed by government agencies, educational institutions, and private organizations, including pharmaceutical companies, to evaluate the effectiveness of new treatments and therapies. The Medical Center is currently engaged in 12 cancer-related clinical trials.

The cancer program at ACMC/AHCH is led by sub-specialist oncology surgeons, radiation oncologists, and medical oncologists. The medical oncologists plan and administer the chemotherapy treatment protocols and most of the research protocols. In addition to chemotherapy, the staff administers blood transfusions, hormonal therapy, immune therapy, and newer targeted therapies.

A change in an industry's standard of care is apheresis. The Medical Center also provides apheresis; during apheresis, blood is removed from the patient and circulated through a cell separator that removes stem cells and allows the rest of the blood to flow back into the blood stream. It usually takes several sessions of 2 to 4 hours each to get enough stem cells. The stem cells are frozen. Within a few days after a patient receives a high dose chemotherapy treatment, the stored stem cells are warmed in a bath and administered to the patient. The stem cells travel to the bone marrow where they begin to produce healthy new blood cells. This is called "autologous stem cell transplant" and it has revolutionized myeloma treatment.

Attachment 37, C. 9, Table 1
Historical Utilization of Adult Infusion Therapy at ACMC/AHCH

Year	2008	2009	2010	Percent Change 2008 – 2010
IP Visits	-	-	-	-
OP Visits	11,195	12,533	15,678	+40.0
Total Visits	11,195	12,533	15,678	+40.0
Percent Outpatient	100.0	100.0	100.0	-

Source: ACMC records.

Historically all chemotherapy patients were treated in an inpatient environment; contemporary care delivery models have demonstrated the efficacy of providing these treatments in an outpatient setting. Today, about 80 percent of all chemotherapy visits

at the Medical Center are outpatient. This is another important change in the standard of care.

Outpatient visits for chemotherapy and related services at the Medical Center increased 40 percent between 2008 and 2010, to some degree because some chemotherapy is moving to the hospital from physician offices. Demand for cancer services is expected to increase further as the population ages and new, more effective drugs become available.

Health care reform initiatives are expected to further increase infusion center utilization in order to reduce readmissions and to improve disease management based on applicable infusion therapy protocols.

3) Utilization

A) Major Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

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

B) Service or Facility

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

The Infusion Center is an Ambulatory Care Service; the State Standard for Ambulatory Care Services is 2,000 visits per room.

The following calculations were used to quantify a range of future need for the Infusion Center.

As detailed in Attachment 37, C.7 CHF Clinic, the Medical Center determined that the average treatment time proposed by the State Standard for Ambulatory Care Services is 45 minutes.

Next, the Medical Center determined that the average treatment time for an infusion therapy/transfusion/apheresis patient visit is 2.8 hours. This is 3.7 times longer than the State Standard.

2.8 hours x 60 minutes per hours = 168 minutes ÷ 45 minutes
State Standard = 3.7 times longer than the State Standard

The following calculations were used to quantify the number of rooms to be justified for the Infusion Center.

Current Need

Based on current average treatment time, the Medical Center determined that current utilization would justify 30 treatment stations.

15,678 visits x 2.8 hours per visit = 43,899 treatment hours

43,899 treatment hours ÷ 1,500 hours per treatment station = 30 treatment stations

Projected Utilization

The Medical Center also prepared a CAGR trend line based on data from 2005 to 2010; 2005 was used as the base year because it was determined that earlier data was not complete. The CAGR trend line was extended to 2019 in order to determine the effect of expected changes in the market on future infusion therapy visits. The projected volume for 2016 and 2019 were converted to total treatment hours.

At the present time, a chemotherapy outpatient visit includes the following steps. The patient is assigned to a treatment chair; blood is drawn and sent to the lab. While waiting for the laboratory results, vital signs are taken. If the patient's white cell count is too low, the patient is rescheduled. If the white cell count is satisfactory, staff contacts the pharmacy to mix the chemotherapy. (This all takes place while the patient is in the treatment chair because the current department does not have a waiting room.) Only then is the IV started, the pre-treatment medications administered, and the infusion completed. Time is also required to

set up and clean up the station. The average time to complete a treatment is 2.8 hours.

In the new Ambulatory Pavilion space, the process will be more efficient and will result in better utilization of the treatment stations. For example, the new space has blood drawing cubicles and a small lab, primarily to run CBCs (complete blood counts). It is not until the test results are available, that the patient is cleared for an infusion therapy treatment, and the chemotherapy mixed that the patient is escorted to a treatment chair. Because of this more efficient process, average "chair time" in the Pavilion has been calculated to be only 1.8 hours.

This revised treatment time has been used to calculate the number of treatment stations that will be needed.

Attachment 37, C. 9, Table 2
CAGR Projected Infusion Therapy Visits, 2016 and 2019

Year	2010	2016 Second Full Year of Operation	Percent Change 2010 to 2016	Number of Stations Justified in 2016	2019 Fifth Full Year of Operation	Number of Stations Justified in 2019
IP Visits	-	-	-	-	-	-
OP Visits	15,678	31,650	+101.9	38	44,969	54
Total Visits	15,678	31,650	+101.9	38	44,969	54

Source: ACMC records.

2016

31,650 visits x 1.8 hours per visit = 56,970 total hours

56,970 total hours ÷ 1,500 hours per treatment station = 38 treatment stations

2019

44,969 visits x 1.8 hours per visit = 80,945 treatment hours

80,945 hours ÷ 1,500 hours per treatment station = 54 treatment stations

Impact of National Health Care Reform

The Medical Center then applied a 15 percent growth factor to account for the implementation of national health care reform. This factor increased total visits and treatment stations.

2016

56,970 treatment hours x 1.15 national health care reform factor = 65,516 treatment hours

65,516 treatment hours ÷1,500 hours per chair = 44 treatment stations

ACMC/AHCH Has Justified the Need for 24 Infusion Therapy Treatment Chairs

The Medical Center is proposing to develop 24 treatment chairs; of these 20 will be in an open infusion area and 4 will be in private infusion rooms. The infusion therapy area will be part of the Cancer Institute at Level 8 of the Ambulatory Pavilion.

By 2016, the Ambulatory Pavilion's second full year of operation, the 24 infusion treatment chairs will be operating above the State Standard.

56,970 hours ÷ 24 treatment chairs = 2,374 hours per treatment chair

2,374 hours per treatment station > State Standard of 1,500 hours per treatment chair

The Medical Center is confident that the projected volume can be accommodated in 24 treatment chairs because the hours of operation of the Infusion Center are considerably longer than the 7.5 hours a day, 250 days per year used in the State Standard. Infusion Therapy's regularly scheduled hours are Monday and Friday 8 am to 5 pm; Tuesday through Thursday 8 am to 7 pm; and Saturday and Sunday 8 am to 11:30 am. If visits exceed capacity, hours are extended. Further, the Medical Center expects the infusion therapy area to function at more than the State Standard's 80 percent occupancy.

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

Infusion Therapy is considered by the HFSRB rules to be an Ambulatory Care Service. ACMC/AHCH exceeds the State Standard for Ambulatory Care Service utilization by 2016.

c) Service Modernization
The applicant shall document that the proposed project meets one of the following:

1) Deteriorated Equipment of Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

NA. The proposed project will not result in the replacement of equipment or facilities that have deteriorated or need replacement at Advocate Christ Medical Center/Advocate Hope Children's Hospital (ACMC/AHCH, Medical Center).

2) Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

Two primary services are included in Neurodiagnostics; they are EEG and EMG.

The sleep disorders lab is also located in this area.

An electroencephalogram (EEG) is a test to detect problems in the electrical activity in the brain. An EEG is used to diagnose certain conditions such as:

- Epilepsy
- Problems related to loss of consciousness
- Sleep disorders, and other
- Physical and mental problems.

An electromyogram (EMG) is a test that checks the health of the nerves that control the muscles. EMGs are most often done for the following reasons:

- To diagnose the source of pain, numbness, tingling, weakness or cramping in the muscles or nerves
- To differentiate between true muscle weakness and limitations due to pain

- To determine if muscles are working properly, and
- To differentiate between muscular conditions and dysfunction due to nerve disorders.

Sleep disorders are common and increasing in the U.S.; about 30 million Americans suffer from sleep disorders which if left untreated can cause health-related problems including heart attacks, strokes and congestive heart failure and can contribute to the severity of other diseases. Nearly 100 sleep/wake disorders have been identified including insomnia, REM sleep disorder, snoring, sleep apnea, sleep deprivation, hypersomnia, and restless legs syndrome. Both overnight and day sleep studies are used to diagnose sleep disorders.

The Medical Center has developed a Neuroscience Institute. Among the major programs that are housed in this institute are the Primary Stroke Center, which is accredited by Joint Commission and treats more stroke patients than any other stroke center in the Chicago area. The Medical Center has been designated as a National Multiple Sclerosis treatment center, and the physicians are also noted for the treatment of head and spine traumas. EEGs and EMGs are essential in the diagnosis of neurological disorders.

At the conclusion of the proposed Ambulatory Pavilion (Pavilion), the Medical Center will maintain two neurodiagnostic areas – one for inpatient EEGs and EMGs as well as the outpatient sleep studies in the hospital and another for outpatients in the Pavilion. The Center currently uses 4 rooms. Of these, one is leased and one is a dedicated sleep lab. (Although technically doing outpatient tests, the sleep lab will remain in the hospital; this is for patient and staff safety.) Therefore there are only 2 hospital rooms routinely available for EEG and EMG tests. The Medical Center is proposing to add 4 interchangeable rooms for EEGs and EMGs in the Ambulatory Pavilion; at the completion of the Pavilion project, there will be 6 rooms for EEGs and EMGs.

In the last 2 years, the volume of EEGs and EMGs at Advocate Christ Medical Center has remained stable.

The sleep lab volume declined between 2009 and 2010; however, annualized first quarter 2010 shows a strong recovery.

Attachment 37, C. 10 Table 1
Historical Utilization of **Neurodiagnostics (EEG and EMG) at ACMC/AHCH**

Year	2008	2009	2010	Percent Change 2008 – 2010
IP Visits	1,954	2,007	1,962	+0.4
OP Visits	2,024	2,160	2,008	-0.8
Total Visits	3,978	4,167	3,970	-
Percent OP EEG/EKG Visits	50.9	51.8	46.3	-0.3
Sleep Visits	-	431	366	-

Source: ACMC records.

Utilization of neurodiagnostic services can be expected to increase with the aging of the population and increasing prevalence in neurological disorders. The volumes of services that provide early diagnosis and prevent admissions and readmissions should increase in the era of national health care reform.

Utilization

A) Major Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

NA. There is no EEG or EMG equipment in this project that meets or exceeds the major medical equipment threshold.

B) Service or Facility

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

An overview of the importance of EEGs and EMGs, along with recent utilization of these studies, are described in Section c) 2).

Neurodiagnostics is an Ambulatory Care Service; the State Standard for Ambulatory Care Services is 2,000 visits per room.

The following calculations were used to quantify a range of future need for Neurodiagnostics. (Since sleep studies are of such a long duration [at least 9 hours], the Medical Center has assumed that the existing room in the hospital would continue to be dedicated to sleep studies.)

As described in Attachment C. 7, CHF Clinic, the Medical Center used two factors – hours of time per room and number of visits per room to determine that the average time proposed by the State Standard is 45 minutes.

Next the Medical Center determined that the average time for EEGs and EMGs is 110 minutes or 1.83 hours including procedure time, clean up, and set up times. This is 2.4 times longer than the State Standard of 45 minutes.

110 minutes average EEG/EMG time ÷ 45 minutes State Standard
= 2.4 times longer than the State Standard

The following calculations were used to quantify the number of rooms to be justified for EEG and EMG visits.

Current Need

Based on current average time for EEGs and EMGs, the Medical Center determined that current utilization would justify 5 rooms for EEGs and EMGs.

3,970 EEG/EMG visits x 1.83 hours per study = 7,261 EEG/EMG hours

7,261 EEG/EMG hours ÷ 1,500 hours per room = 5 rooms

Projected Utilization

Next the Medical Center prepared CAGR trend lines based on EEG/EMG data from 2002 to 2010. The CAGR line was then extended to 2019 in order to determine the effect of expected changes in the market on future EEG/EMG

visits. The CAGR trend suggests that by 2019, the Medical Center could provide as many as 4,440 EEG/EKG visits.

The projected volumes for 2016 and 2019 were then converted to total study hours.

2016

4,242 EEG/EMG visits x 1.83 hours per exam = 7,763 EEG/EMG hours

7,763 EEG/EMG hours ÷1,500 hours per room = 6 rooms

2019

4,440 EEG/EMG visits x 1.83 hours per exam = 8,126 EEG/EMG hours

8,126 EEG/EMG hours ÷1,500 hours per room = 6 rooms

Attachment 37, C. 10, Table 2
CAGR Projected Neurodiagnostics Volume, 2016 and 2019

Year	2010	2016 Second Full Year of Operation	Percent Change 2010 to 2016	Number of Rooms Justified in 2016	2019 Fifth Full Year of Operation	Number of Rooms Justified in 2019
Inpatient Visits	1,962	2,236	+14.0	-	2,388	-
Outpatient Visits	2,008	2,006	+70.1	-	2,052	-
Total Visits	3,970	4,242	+6.9	6	4,440	6
Sleep Visits	366	136	-62.8	-	84	-

Source: ACMC records.

Impact of National Health Care Reform

The Medical Center applied a 15 percent growth factor to account for the implementation of national health care reform. This factor increased the number of studies, however, the number of needed EEG/EMG rooms remained the same.

2016

7,763 EEG/EMG hours x 1.15 national health reform factor
= 8,928 EEG/EMG hours

8,928 EEG/EMG hours ÷ 1,500 hours per room = 6 rooms

ACMC/AHCH Has Justified the Need for 6 Neurodiagnostics Rooms

The Medical Center is proposing to have 6 neurodiagnostic rooms.

Two existing rooms will be available in the hospital to conduct inpatient studies. There will be 4 rooms in the Ambulatory Pavilion for outpatient studies for a total 6 rooms. The Medical Center has justified 6 EEG/EMG rooms. There is no change related to the existing sleep disorder lab.

7,763 hours ÷ 6 rooms = 1,294 hours per room

1,294 hours per room = 86.3 percent State Standard 1,500 hours per room

It is noteworthy that the projected sleep lab studies understate future volume. During the first quarter of 2011, the sleep lab reported 100 visits or an annualized rate of 400 visits for the year. Data from 2010 appears to be an anomaly and unrealistically depressed the CAGR projection. Based on 2009 and expected 2011 volume, sleep lab utilization justifies 3 rooms; there will continue to be one sleep lab in the hospital.

2009

431 visits x 9 hours per visit = 3,879 hours

3,879 hours ÷ 1,500 hours per room = 3 rooms

2011 (Annualized)

400 visits x 9 hours per visit = 3,600 hours

3,600 hours ÷ 1,500 hours per room = 3 rooms

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

Neurodiagnostics is considered to be an Ambulatory Care Service by the HFSRB rules. ACMC/AHCH will meet the State Standard for Ambulatory Care Service utilization by 2016.

c) Service Modernization
The applicant shall document that the proposed project meets one of the following:

1) Deteriorated Equipment of Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

NA. The proposed project will not result in the replacement of equipment or facilities that have deteriorated or need replacement.

2) Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

Advocate Christ Medical Center and Advocate Hope Children's Hospital (ACMC/AHCH, Medical Center) provide nationally renowned programs for the diagnosis and treatment of heart disease in children and adults. The Medical Center provides both invasive and noninvasive diagnostic cardiology services. At the completion of the proposed construction of an Ambulatory Pavilion (Pavilion), the noninvasive cardiology services will be physically located in both the main hospital for inpatients and the Pavilion for outpatients.

Attachment 37, C.11, Table 1
Historical Utilization (Visits) of Non-Invasive Cardiology Services at ACMC/AHCH

Year	2008	2009	2010	Percent Change 2008-2010
IP				
Echo and TEE	10,098	10,395	10,669	
Stress Testing	3,097	3,421	2,099	
EKG/Holter/Event Monitoring	54,357	55,080	56,398	
Total	67,552	68,896	69,166	+2.4
OP Remaining in the Hospital				
Echo and TEE	209	248	289	
Stress Testing	80	124	108	
EKG/Holter/Event Monitoring	-	-	-	
Total	289	372	397	+37.4
OP Moving to the Ambulatory Pavilion				
Echo and TEE	1,627	1,732	2,294	
Stress Testing	2,814	2,119	2,892	
EKG/Holter/Event Monitoring	6,835	6,637	6,831	
Total	11,276	10,488	12,077	+6.6
Total				
Echo and TEE	11,934	12,375	13,252	+11.0
Stress Testing	5,991	5,664	5,099	-14.9
EKG/Holter/Event Monitoring	61,192	61,717	63,229	+3.3
Total	79,117	79,756	81,580	+3.1

Source: ACMC records.

The Medical Center assessed the current non-invasive cardiology volume to determine which patients would continue to use the inpatient non-invasive cardiology department and which ones could be moved to the Pavilion. As shown on the above table, inpatients will use the hospital-based services. While most outpatients will use the non-invasive cardiology services in the Pavilion, a few will use the hospital. These patients will use specific equipment available only in the hospital, such as the CPX cardiopulmonary unit, because it would be too expensive to duplicate.

Many physicians have non-invasive cardiology modalities in their offices. For at least two reasons, some of the volume currently seen in the physician offices will most likely return as outpatient volume to the hospital. First, several local cardiologists have elected to become Advocate-employed physicians and have ceased to maintain the

services in their offices. Second, other physicians have determined that current reimbursement policies no longer make it attractive to provide these services.

In the Pavilion, the program will be part of the Heart and Vascular Institute on the sixth level and include the following modalities – Echo/TEE, Stress Testing, and EKG and Holter/Event Monitoring.

- Echo (cardiography) and TEE (transesophageal echocardiography) uses sound waves to produce an image of the heart. The tests show the size, shape, and movement of the heart; the condition of the aorta; the action of the heart valves; and, blood flow through the heart.
- Stress Testing (includes routine, stress echo, nuclear, and CPX) allows the physician to see the wall motion of the heart's pumping chambers before and after exercise. The test can show if areas of the heart muscle are not getting enough oxygen-rich blood.
- EKG/Holter/Event Monitoring. EKG is used to determine the electrical activity of the heartbeat including heart rhythm, size, and function of the heart chambers and heart muscle. During Holter/Event Monitoring, the patient wears a monitoring device that provides a constant reading of heart rate and rhythm for a 24-hour period or longer.

Health reform proposes to reduce/manage costs through prevention, thereby reducing acute care episodes and hospital inpatient admissions. Cardiovascular and heart disease are chronic conditions and have increasing prevalence due to life style factors and an aging population. Non-invasive cardiology technology used to screen and monitor population is expected to result in early diagnosis and treatment in the ambulatory setting, thereby reducing admissions, improving overall quality of life, and reducing cost based on applicable clinical practice guidelines.

3) Utilization

A) Major Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

NA. There is no non-invasive cardiology equipment in this project that meets or exceeds the major medical equipment threshold.

B) Service or Facility

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

Utilization of inpatient and outpatient non invasive diagnostic services as well as the implications for future utilization under national health care reform are described in Section c) 2).

The following calculations were used to quantify the range of future need for non-invasive cardiology visits in the Ambulatory Pavilion. Non-Invasive Cardiology is an Ambulatory Care Service; the State Standard for Ambulatory Care Services is 2,000 visits per key room.

Current Need

In 2010, the volume that would have occurred in the Ambulatory Pavilion justifies 2 Echo/TEE units, 2 Stress Testing units, and as many as 4 EKG/Holter/Event Monitoring units.

Attachment 37, C. 11, Table 2
Number of Non Invasive Cardiology Units Based on Current Utilization

Modality	2010 Volume	Number of Units Justified at 2,000 Visits per Unit
Echo and TEE	2,294	2
Stress Testing	2,892	2
EKG/Holter/Event Monitoring	6,831	4
Total	12,017	6 to 8

Source: ACMC records.

Projected Utilization

It would not be prudent to build and equip Non-Invasive Cardiology in the Ambulatory Pavilion without considering future demand. To anticipate future demand, the Medical Center prepared CAGR trend lines based on non-invasive cardiology utilization from

2005 to 2010 and extended them to 2019. The trend lines suggest that the Medical Center would need 2 Echo/TEE and 3 Stress Testing units and 4 EKG/Holter/Event Monitoring units by 2016 in the Pavilion.

Attachment 37, C. 11, Table 3
CAGR Projected Outpatient Non-Invasive Cardiology Procedures in the Ambulatory Pavilion

	2010	2016 Second Full Year of Operation	Percent Change 2010 to 2016	Number of Units Justified in 2016	2019 Fifth Full Year of Operation	Number of Units Justified in 2019
Echo/TEE	2,294	4,021	+75.2	2	5,323	3
Stress Testing	2,892	4,137	+43.0	3	4,948	3
EKG/Holter/Event Monitoring	6,831	6,984	+ 2.2	4	7,061	4
Total	12,017	15,142	+26.0	8 to 9	17,332	9 to 10

Source: ACMC records.

Impact of National Health Care Reform Legislation

As a third step in determining future need, the Medical Center applied a 15 percent growth factor to account for the implementation of the national health care reform legislation. This factor shows a projected need for 3 Echo/TEE, 3 Stress Testing units, and 4 EKG/Holter/Event Monitoring units by 2016.

2016 – Echo/TEE

4,021 visits x 1.15 national health care factor = 4,625 visits
4,625 visits ÷ 2,000 visits per unit = 3 units

2016 – Stress Testing

4,137 visits x 1.15 national health reform factor = 4,758 visits
4,758 visits ÷ 2,000 visits per unit = 3 units

2016 – EKG//Holter/Event Monitoring

6,984 visits x 1.15 national health reform factor = 8,032 visits
8,032 visits ÷ 2,000 visits per unit = 4 units

ACMC/AHCH Has Justified the Need for Non Invasive Cardiology Equipment

The Medical Center has justified the need for as many as many as 2 Echo/TEE units, 3 Stress Testing and 4 EKG/Holter/Event Monitoring units but is requesting only 6 units, two of each.

By 2016, the second full year of operation of the Ambulatory Pavilion, the total complement of Non-Invasive Cardiology units will be operating at or above the State Standard.

Echo/TEE

4,021 visits ÷ 2 units = 2,011 visits per unit

2,011 visits per unit > State Standard of 2,000 visits per unit

Stress Testing

4,137 visits ÷ 2 units = 2,069 visits per unit

2,069 visits per unit > State Standard of 2,000 visits per unit

EKG/Holter/Event Monitoring

6,984 visits ÷ 2 units = 3,492 visits per unit

3,492 visits per unit > State Standard of 2,000 visits per unit

The demand for non-invasive cardiology visits is expected to continue to increase after 2016; increased procedures will increase the number of visits per unit.

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

There is a State Standard for Ambulatory Care Services. ACMC/AHCH will exceed the State Standard for Non-Invasive Cardiology by 2016.

c) Service Modernization
The applicant shall document that the proposed project meets one of the following:

1) Deteriorated Equipment of Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

NA. The proposed project will not result in the replacement of equipment or facilities that have deteriorated or need replacement at Advocate Christ Medical Center/Advocate Hope Children's Hospital (ACMC/AHCH, Medical Center).

2) Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

Pain is a complicated, often debilitating medical problem that can have profound effects on all aspects of a patient's life. The Medical Center offers a comprehensive range of services for patients suffering from acute or chronic pain. The goal of the Medical Center's Pain Management Center is to return patients to their maximum level of functioning and to improve their independence, comfort, and quality of life.

The Pain Management Center physicians have the expertise to treat and manage numerous types of acute and chronic pain including back pain, neuropathic (nerve) pain, cancer pain, musculoskeletal/rheumatologic pain, post injury pain, and surgical pain.

The physicians use the most current pain management techniques including:

- Lumbar and cervical epidural injection
- Trigger point injection
- Facet joint injection
- Radiofrequency ablation
- Spinal cord stimulator
- Implantable pump therapy
- Medical management, and
- Psychotherapy and counseling.

Attachment 37, C.12, Table 1
Historical Utilization of the Pain Center at ACMC/AHCH

Year	2008	2009	2010	Percent Change 2008-2010
IP Visits	252	127	116	-54.0
OP Visits	4,523	4,522	4,114	-9.0
Total Visits	4,775	4,649	4,230	-11.4
Percent OP Visits	94.7	97.3	97.3	+2.6
Number of Key Rooms	1	1	1	-
Visits per Key Room	4,523	4,522	4,114	-9.0
Percent over State Standard	+126.2	+126.1	+105.7	-20.5

Source: ACMC records.

The senior population, those 40 and over, are the primary users of the Pain Management Center; this population cohort is expected to increase over the next decade.

Under national health care reform, utilization of the Pain Management Center is expected to increase in response to chronic disease management protocols, improvement in community health status initiatives, improving quality of life, aging population, the chronicity of disease associated with pain, and the movement to reduce hospital admissions and readmissions. The better a disease process is managed in the outpatient setting, the better the potential is for lower utilization of inpatient services.

3) Utilization

A) Major Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

NA. There is no pain management equipment in this project that meets or exceeds the major medical equipment threshold.

B) Service or Facility

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

A profile of the Pain Management Center's historical utilization and the implications for future utilization under national health care reform are described in Section c) 2).

The Pain Management Center is an Ambulatory Care Service; the State Standard for Ambulatory Care Services is 2,000 visits per room. The key room in the Pain Management Center is where physicians inject pain blocking drugs via epidural injections, nerve blocks, and facet injections. Image guiding technology, a C-arm, is used for visualization to ensure accurate and safe injections.

The following calculations were used to quantify a range of future need for the Pain Center.

Current Need

Current outpatient utilization of the Pain Center justifies the need for 3 injection rooms.

4,114 outpatient visits ÷ 2,000 visits per room = 3 injection rooms

Projected Utilization

To estimate future utilization, the Medical Center prepared CAGR trend lines based on 10 years of historical data and extended to 2019 in order to determine

the impact of growth and aging on future Pain Management Center utilization. The CAGR trend line suggests that by 2019, the Medical Center could need as many as 3 injection rooms.

Attachment 37, C. 12 Table 2
CAGR Projected Pain Center Visits, 2016 and 2019

Year	2010	2016 Second Full Year of Operation	Percent Change 2010 to 2016	Number of Rooms Justified in 2016	2019 Fifth Full Year of Operation	Number of Rooms Justified in 2019
IP Visits	116	190	+63.8	<1	244	<1
OP Visits	4,114	4,658	+13.2	3	4,957	3
Total Visits	4,230	4,848	+14.6	3	5,200	3

Source: ACMC records.

ACMC/AHCH is proposing to develop 1 injection room in the Pain Center. One injection room can support current and projected volume because the patient is only in the injection room for a short time.

Impact of National Health Care Reform

The Medical Center then applied a 15 percent growth factor to account for the implementation of national health care reform. This factor increase total projected volume; however, the number of needed injection rooms remained at 3 for both 2016.

2016

4,658 visits x 1.15 national health care reform factor = 5,357 visits

5,357 visits ÷2,000 visits per key room = 3 rooms

ACMC/AHCH Has Justified the Need for 1 Pain Management Center Injection Room.

Although 3 injection rooms have been justified for the Pain Management Center, ACMC/AHCH is requesting only 1 room. One injection room can support current and projected volume because the patient is only in the injection room for a short time. This room will be part of the Neurosciences Institute on Level 7 of the Ambulatory Pavilion.

By 2016, the second full year of operation of the Ambulatory Pavilion, the injection room in the Pain Center will be operating above the State Standard.

4,658 visits per injection room > State Standard of 2,000 visits per key room

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

The Pain Center is considered by the HFSRB rules to be an Ambulatory Care Service. ACMC/AHCH utilization currently exceeds the State Standard for Pain Management Center/Ambulatory Care Service utilization.

2010

4,414 visits per room > State Standard of 2,000 visits per room

c) Service Modernization
The applicant shall document that the proposed project meets one of the following:

1) Deteriorated Equipment of Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

NA. The proposed project will not result in the replacement of equipment or facilities that have deteriorated and need replacement.

2) Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

Pre-admission testing is an effective way to shorten length of stay for elective inpatients and for expediting the care of many outpatients.

Some patients visit pre-admission testing at Advocate Christ Medical Center/Advocate Hope Children's Hospital (ACMC/AHCH, Medical Center) a few days before their scheduled admission, complex diagnostic test, or procedure. At that time, most required pre-admission tests and consultations are completed. The pre-admission nurses use the pre-admission testing area to conduct pre-procedure training as well as patient and family education.

Other patients avail themselves of an electronic pre-admission option that the Medical Center provides. These patients receive a follow-up call from anesthesia and a pre-admission nurse prior to their visit to one of the Medical Center services.

At the completion of the Ambulatory Pavilion (Pavilion), there will be two pre-admission testing areas at the Medical Center – one for inpatients and the other for

outpatients. The testing area in the Pavilion will be used primarily by ambulatory surgery patients.

Attachment 37, C.13 Table 1
Historical Utilization of Pre-Admission Testing at ACMC/AHCH, 2008 to 2010

Year	2008	2009	2010	Percent Change 2008-2010
IP Visits	-	-	-	-
OP Visits	4,378	4,735	4,949	+13.0
Total Visits	4,378	4,735	4,949	+13.0

Source: ACMC records.

As shown on the above table, the number outpatients who benefit from pre-admission testing is increasing.

The proposed new pre-admission testing area will be located in the Pavilion on Level 1. It will be conveniently located near the main entrance of the building as well as the ancillary services typically needed in conjunction with pre-admission testing, including laboratory, radiology, and pulmonary function. Pre-admission testing will be readily accessible and convenient for patients in the Pavilion; it will be "one-stop shopping."

The national health reform legislation supports initiatives that reduce unnecessary inpatient utilization. If a patient requires hospitalization, pre-admission testing reduces length of stay because tests are provided on an outpatient basis before admission. Shorter inpatient stays reduce the cost of care.

3) Utilization

A) Major Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

NA. There is no pre-admission testing equipment in this project that meets or exceeds the major medical equipment threshold.

B) Service or Facility

Projects involving the modernization of a service or facility shall meet or exceed the utilization standards for the service, as specified in Appendix B. The number

of key rooms being modernized shall not exceed the number justified by historical utilization rates for each of the latest two years, unless additional key rooms can be justified per subsection c) 2) Necessary Expansion.

A description of the utilization of the outpatient pre-admission testing services at the Medical Center and the implications of national health care reform on this service are discussed in Section c) 2).

According to the HFSRB rules, Pre-Admission Testing is an Ambulatory Care Service; the State Standard for Ambulatory Care Services is 2,000 visits per room.

The following calculations were used to quantify a range of future need for pre-admission testing.

Current Need

Current outpatient utilization of pre-admission testing services justifies the need for 3 testing rooms.

4,949 outpatient visits ÷ 2,000 visits per room = 3 testing rooms

Projected Utilization

To determine the impact of expected demographic changes and growth of the outpatient services, especially those that will be housed in the Ambulatory Pavilion such as outpatient surgery, the Medical Center prepared CAGR trend lines based on historical data from 2003 to 2010 and extended the trend lines to 2019. These CAGR trend lines suggest that by 2019, the Medical Center can still justify 3 testing rooms.

Attachment 37, C. 13, Table 2
CAGR Projected Pre-Admission Testing Visits, 2016 and 2019

	2010	2016 First Full Year of Operation	Percent Change 2010 to 2016	Number of Rooms Justified in 2016	2019 Fifth Full Year of Operation	Number of Rooms Justified in 2019
IP Visits	NA	NA	NA	-	NA	-
Outpatient Visits	4,949	5,206	+5.2	3	5,339	3
Total Visits	4,949	5,206	+5.2	3	5,339	3

Source: ACMC records.

Impact of National Health Care Reform

The Medical Center then conservatively applied a 15 percent growth factor to account for the implementation of national health care reform. This factor increased total visits. Three rooms will continue to accommodate 2016 visits.

2016

5,206 outpatient visits x 1.15 national health care reform = 5,987 visits

5,987 outpatient visits ÷ 2,000 visits per room = 3 rooms

ACMC/AHCH Has Justified the Need for 1 Pre-Admission Testing Room

Although as many as 3 pre-admission testing rooms have been justified, the Medical Center is requesting only 1 testing room. The Medical Center will be able to deliver the proposed volume of pre-admission testing services in this smaller area because laboratory, imaging and pulmonary function do not have to be replicated; these services are all proximally located to the pre-admission testing area. Further, it is expected that increasing utilization of the electronic pre-admission testing option will further decrease the number of pre-admission testing visits.

By 2016, the second full year of operation of the Ambulatory Pavilion, the key room in Pre-admission Testing will be operating above the State Standard.

5,206 visits per testing room > State Standard of 2,000 visits per room

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

Pre-Admission Testing is considered by HFSRB rules to be an Ambulatory Care Service. The Medical Center's current utilization exceeds the State Standard for Ambulatory Care Service utilization.

2010

4,949 visits ÷ 1 = 4,949 visits per room

4,949 visits per room > State Standard of 2,000 visits per room

Clinical Service Area –
Pulmonary Function Lab

Clinical List Designation – C.14

c) Service Modernization
The applicant shall document that the proposed project meets one of the following:

1) Deteriorated Equipment of Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

NA. The proposed project will not result in the replacement of equipment or facilities that have deteriorated or need replacement.

2) Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

Pulmonary function tests measure how well the lungs take in and release air as well as how well they move gases such as oxygen from the atmosphere into the body's circulation. Both pediatric and adult patients use Pulmonary Function Testing at Advocate Christ Medical Center/ Advocate Hope Children's Hospital (ACMC/AHCH, Medical Center).

Pulmonary function tests are used for:

- Screening for the existence of lung disease
- Determining a patient's condition prior to surgery to assess the risk of respiratory complications after surgery
- Evaluating the ability of a patient to wean from a ventilator, and
- Assessing the progression of lung disease and the effectiveness of treatment.

Among the diseases that are evaluated, diagnosed, and treated based on pulmonary function test results are asthma, bronchitis, COPD (chronic obstructive pulmonary disease), cystic fibrosis, emphysema, fungal infections of the lung, lung cancer, pneumonia, pulmonary sleep disorders, shortness of breath, and tuberculosis. Advocate Hope Children's Hospital is a Cystic Fibrosis Care Center and pulmonary functions testing is very important to this program.

Attachment 37, C.14, Table 1
Historical Utilization of Pulmonary Function at ACMC/AHCH

Year	2008	2009	2010	Percent Change 2008-2010
IP Visits	466	458	370	-20.6
OP Visits	1,649	1,777	1,774	+ 7.6
Total Visits	2,115	2,235	2,144	+ 1.3
Percent OP Visits	78.0	76.1	83.9	+ 5.9

Source: ACMC records.

Inpatients will continue to use the existing pulmonary function lab in the hospital. Outpatients will use the pulmonary function lab in the Ambulatory Pavilion.

Among the reasons for the proposed location, size, and number of pulmonary function labs in the Ambulatory Pavilion relate to the limitations of the current lab which is located on the ground floor of the hospital.

- Many patients coming to the Medical Center for pulmonary function tests are compromised by their breathing and in many cases on portable oxygen tanks; they have difficulty walking to the current pulmonary function lab location.
- Pulmonary function therapists deliver a drug called methylcholine as part of testing; this medication actually causes a reaction to positively determine if the patient is asthmatic. However, with the very limited space in the current lab, the staff delivering the medication and the patients immediately outside the door of the lab are potentially jeopardized. Staff uses a dosimeter which reduces the amount of aerosol deposited into the air to minimize this problem.
- The therapists also perform an indirect calorimetry test. This test requires the patient to be in a reclined (almost flat) position for testing. The current labs

cannot accommodate a reclining patient bed/chair/cart to allow the patient to lie down. As a result, the therapist must locate a space in another area with a bed/chair/cart that can be used for an hour to perform the test.

- Since the lab is not big enough to accommodate a patient on a cart, if the patient cannot come to the lab in a wheelchair, the therapists must take a portable bedside spirometer to them. This devise is not as inclusive as the permanent spirometers in the lab and cannot provide all of the results that the physicians order.
- When a large wheelchair adult or pediatric patient is accompanied by a parent or companion, the lab is so small that the test must be performed with the lab door open to compensate for the current lack of space. This compromises patient privacy.
- Outpatients coming to the lab for blood gas testing must have their blood drawn in the waiting area. This also compromises patient privacy.
- Advocate Hope Children's Hospital is a cystic fibrosis center. For infection control, the Cystic Fibrosis Foundation standards have very stringent guidelines for maintaining the condition of the lab. With little or no room in the pulmonary function department except for the labs, file cabinets and desks for charting are located within the lab. Consequently, staff is required to wipe down the file cabinets, and desks in addition to the equipment between each patient visit.
- According to American Thoracic Society standards, when the therapists administer the 6-minute walk test, the patient must be able to walk in an area that is 100 feet long with no turns or stairs, except at the 100 foot mark. The current lab location makes compliance with this requirement very challenging.
- Currently, there is no available program option to obtain pulmonary function tests electronically. As a result, all test results are maintained in the lab in hard copy form so the physicians reading test results can have previous tests results available for comparison. This is cumbersome and space consuming.
- Physicians are purchasing portable spirometers for testing in their offices. This has resulted in some tests moving from the hospital to the physicians' offices. (In

the future, these tests may also return to the hospital if reimbursement policies change.) However, the lab staff is now performing more time-consuming, complex tests that require a body box to be in each lab; the more complex tests also require more time. Most pulmonary function tests are now taking 1 to 2 hours to complete. Further, pediatric tests also take more time in order to get good results. The lab has extended its hours of operation to accommodate this change in practice.

National health care reform initiatives targeting preventive medical services, chronic conditions/disease management, as well as focusing on cardiovascular health, will increase the demand for diagnostic and therapeutic pulmonary function services. These services will also help reduce respiratory disease-related acute admissions such as COPD by treating patients on an outpatient basis. Pulmonary function services also complement the diagnosis and treatment of cardiovascular disease and lung cancer which will also assist in managing such clinical conditions and improve quality based on emerging clinical practice guidelines.

3) Utilization

A) Major Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

NA. There is no pulmonary function equipment in this project that meets or exceeds the major medical equipment threshold.

B) Service or Facility

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

A description of the utilization of the Pulmonary Function Labs at the Medical Center and the positive implications for this service under national health care reform are described in Section 2) c).

Pulmonary Function Labs are considered an Ambulatory Care Service; the State Standard for Ambulatory Care Services is 2,000 visits per room.

The following calculations were used to determine current and future need for Pulmonary Function labs.

Current Need

1,774 visits ÷ 2,000 visits per unit = 1 pulmonary function labs

Although the current utilization of the pulmonary function labs justifies 1 lab, it does not fully demonstrate the amount of care that will be provided. The Medical Center has determined that the State Standard is based on 45 minutes per visit or 1,500 hours per room. An average pulmonary function visit including set up and clean up time is 1.5 hours (90 minutes), twice as long as the State Standard would suggest. Based on this time, the pulmonary function outpatient utilization could support 2 rooms

1,774 visits x 1.5 hours per visit = 2,661 hours

2,661 hours ÷ 1,500 hours per lab = 2 labs

Projected Utilization

To ascertain the impact of population growth and aging as well as future new technology and applications of existing technology on future pulmonary function utilization, the Medical Center prepared a CAGR trend line analyses based on 10 years of historical data and extended to 2019. The CAGR trend line suggests that by 2016 the Medical Center will experience a 15.7 percent growth in visits (especially more complex visits), the result of the growth and aging of the population offset by less complex tests possibly migrating to physician offices, if reimbursement continues to be favorable.

Attachment 37, C.14, Table 2
CAGR Projected Pulmonary Function Visits, 2016 and 2019

Year	2010	2016 Second Full Year of Operation	Percent Change 2010 to 2016	Number of Units Justified in 2016	2019 Fifth Full Year of Operation	Number of Units Justified in 2019
IP Visits	370	336	-13.2	<1	321	<1
OP Visits	1,774	1,954	+15.7	1	2,051	2
Total Visits	2,144	2,291	+10.7	2	2,372	2

Source: ACMC records.

The outpatient trend line continues to show the need for 1 pulmonary function lab by 2016, but again it does not fully demonstrate the amount of care that will be provided. By applying the same formula to the 2016 projected volume, the need for 2 outpatient labs is justified.

1,954 outpatient visits x 1.5 hours per visits = 2,931 hours

2,931 hours ÷ 1,500 hours per lab = 2 outpatient labs

Impact of National Health Care Reform

In order to account for the implementation of national health care reform, the Medical Center applied a 15 percent growth factor to the projected pulmonary function volumes. This factor increased total projected outpatient visits; it continues to show a need for 2 labs.

2016

1,954 outpatient visits x 1.15 national health care reform factor = 2,247 visits

1,954 outpatient visits x 1.5 hours per visit = 2,931 hours

2,931 hours ÷1,500 hours per lab = 2 labs

ACMC/AHCH Has Justified the Need for 2 Pulmonary Function Labs

Current utilization, conservative CAGR projections, adjustments for care time, and the impact of national health care reform all confirm the need for 2 pulmonary function labs in the Ambulatory Pavilion. ACMC/AHCH is proposing to develop 2 labs in the Pavilion on the first floor adjacent to Pre-admission Testing and the Laboratory Drawing area.

By 2016, the second full year of operation of the Ambulatory Pavilion, the

Standard of 1,500 hours per lab.

2,931 hours ÷ 2 labs = 1,466 hours per lab

1,466 hours per lab = 1,500 hours per lab

1,466 hours = 97.7 percent of State Standard of 1,500 hours per lab

The proposed 2 outpatient labs are justified by the 2016 projected volume.

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

For purposes of certificate of need review, pulmonary function testing is considered an Ambulatory Care Service that has a State Standard of 2,000 visits or 1,500 hours per room. The Medical Center has justified the 2 outpatient pulmonary function labs being proposed.

Current and Projected Location of Imaging Equipment by Type and Number of Units

Advocate Christ Medical Center/Advocate Hope Children's Hospital currently has imaging equipment in 3 locations – the campus, Lockport Outpatient Center and the Center for Breast Health. At the completion of the proposed Ambulatory Pavilion (Pavilion) there will be imaging in 4 locations – the 3 mentioned above as well as the Pavilion. The following is a summary of the current and proposed imaging equipment locations and the number of units by type at each location.

Current and Projected Location of Imaging Equipment by Type and Number of Units									
Modality	Current				Proposed				
		Off-Site		Total			Off-Site		
	Campus	Lockport	Center for Breast Health		Campus	Ambulatory Pavilion	Lockport	Center for Breast Health	Total
General Rad/Fluoro	10	1	-	11	10	7	1		18
Mammography	1 For needle localization	1	3	5	-	1 For needle localization	1	3	5
Ultrasound	8	1	2	11	8	7	1	2	18
CT & PET CT	5	1	-	6	5	4 Including one CT & PET/CT	1	-	10
MRI	3 Including 1 mobile that will be retired	1	-	4	2	3	1	-	6
Nuclear Med	5 2 will be retired	-	-	5	3	4 Including one SPECT/CT	-	-	7

Clinical Service Area –
General Radiology and Fluoroscopy

Clinical List Designation D.15

c) Service Modernization
The applicant shall document that the proposed project meets one of the following:

7) Deteriorated Equipment of Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

The proposed project will not replace facilities or equipment that has deteriorated. The project will add 6 general radiology units and 1 fluoroscopy unit for a total of 7 units in the proposed Ambulatory Pavilion.

8) Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

Advocate Christ Medical Center/Advocate Hope Children's Hospital (ACMC/AHCH, Medical Center) operates 11 general radiology and fluoroscopy units. Of the total, 10 are on the campus; of these, 9 are in the hospital's main imaging department and 1 is in Advocate Hope Children's Hospital (AHCH); the AHCH unit is dedicated to pediatric patients.

There is also one contracted unit at the new Lockport Outpatient Center. While this unit is part of the Medical Center's total complement of general radiology/fluoroscopy units, it is 40 minutes travel time from the main campus in Oak Lawn and serves the local Lockport area; its capacity is not interchangeable with the main campus because of the long travel time. The first full year for the Lockport unit was 2010; volume met targeted levels.

The Medical Center reports general radiology and fluoroscopy procedures together on the Annual Hospital Questionnaire (IDPH). The fluoroscopy units are used for general radiology as well as fluoroscopy.

Between 2008 and 2010, the Medical Center's general radiology/fluoroscopy procedures increased 4.0 percent or by almost 6,000 procedures. This continuing increase in volume is quite remarkable for at least two reasons. First, the utilization of the existing units on the Medical Center's campus is almost twice the State Standard. To accomplish this remarkable utilization; some units are staffed 24 hours a day; inpatients may be transported to the Radiology Department in the middle of the night to have an exam performed because this is the only time equipment is available. Second, the growth was occurring during a period when radiology units were opening in physicians' offices throughout the Medical Center's service area.

Attachment 37, D. 15, Table 1
Historical Utilization of General Radiology/Fluoroscopy at ACMC/AHCH, 2008 to 2010

			Campus Only Without Lockport		Campus and Lockport	
Year	2008	2009	2010	Percent Change 2008-2010	2010	Percent Change 2008-2010
IP Procedures	96,516	90,277	97,542	+1.1	97,542	+1.1
OP Procedures	54,171	65,008	59,140	+9.2	59,713	-
Total Procedures	150,687	155,285	156,682	+4.0	157,255	+4.0
Percent OP Procedures	35.9	41.9	37.7	+1.8	38.0	+2.1
Number of Units	10	10	10	-	11	+1
Procedures per Unit	15,069	15,529	15,669	-	14,296	-
Percent over State Standard	+88.4	+94.1	+95.9	-	+78.7	-

Source: ACMC records.

The ultimate impact of the passage of national health care reform legislation on general radiology and fluoroscopy volumes is not clear. The Commonwealth of Massachusetts is being used to gauge the potential impact of national health care reform because Massachusetts has already mandated health insurance for all residents. In Massachusetts, the first departments to experience additional volume were the emergency departments. Since ACMC/AHCH has a very busy Level I Trauma Center, the Medical Center could experience a surge in emergency volume. Emergency visits

often require radiology procedures; hence, implementation of national health care reform could increase demand for general radiology/fluoroscopy procedures.

Bundled payments may foster using more advanced imaging modalities earlier in the diagnostic process in order to determine a definitive diagnosis sooner than evolving a diagnosis through a series of less definitive modalities; however, this approach has not proven to be cost effective in the past.

9) Utilization

F) Major Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

NA. There is no general radiology/fluoroscopy equipment in this project that meets or exceeds the major medical equipment threshold.

G) Service or Facility

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

In Section c) 2) above, ACMC/AHCH showed how the utilization of the Medical Center's existing general radiology/fluoroscopy equipment is substantially higher than State Standards and described changes in industry standards that will influence future general radiology/fluoroscopy volume in the future.

The State Standard for general radiology is 8,000 procedures per unit. The State Standard for fluoroscopy/tomography/other X-ray procedures is less, or 6,500 procedures per unit. Even though the Medical Center has both general radiology and fluoroscopy units, the fluoroscopy units are used for both general radiology and fluoroscopy procedures. Therefore, ACMC/AHCH used the more conservative utilization target, or 8,000 procedures per unit to justify the number of units being requested. Hence, all of the following calculations that were used to determine future need are conservative.

Current Utilization

Current utilization of the Medical Center's radiology/fluoroscopy units at the Medical Center justifies the need for at least 20 general radiology/fluoroscopy units; the Medical Center has 11 units including onsite and offsite installations.

Campus Only without Lockport

156,682 total procedures ÷ 8,000 procedures = 20 units

Campus and Lockport

157,255 total procedures ÷ 8,000 procedures = 20 units

Projected Utilization

To anticipate future demand, the Medical Center prepared CAGR trend lines based on utilization trends from 2002 to 2010 data extended to 2019.

This methodology suggests the need for 21 units by 2016 and 22 units by 2019 on the Medical Center's campus.

Attachment 37, D. 15, Table 2
CAGR Projected General Radiology/Fluoroscopy Procedures
Campus Only, excluding Lockport
2016 and 2019

Year	2010	2016 Second Full Year of Operation	Percent Change 2010 to 2016	Number of Rooms Justified in 2016	2019 Fifth Full Year of Operation	Number of Rooms Justified in 2019
IP Procedures	97,542	107,393	+10.1	14	112,800	15
OP Procedures	59,140	57,040	-3.6	8	56,085	7
Total Procedures	156,682	164,433	+4.9	21 - 22	168,885	22

Source: ACMC records.

Attachment 37, D. 15, Table 3
CAGR Projected General Radiology/Fluoroscopy Procedures, including Lockport
2016 and 2019

Year	2010	2016 Second Full Year of Operation	Percent Change 2010 to 2016	Number of Rooms Justified in 2016	2019 Fifth Full Year of Operation	Number of Rooms Justified in 2019
IP Procedures	97,542	107,393	+10.1	14	112,800	15
OP Procedures	59,713	57,613	-0.5	8	56,658	7
Total Procedures	157,255	165,006	+4.9	21 - 22	169,458	22 to 23

Source: ACMC records.

Impact of Health Care Reform

In addition to current volume and CAGR trend lines, the Medical Center conservatively applied a 15 percent growth factor in account for the implementation of the national health care reform legislation. This factor increased projected need for 24 units on the campus and 25 total units by 2016.

2016 Excluding Lockport

164,433 general radiology/fluoroscopy procedures x 1.15 national health care reform factors = 189,098 procedures

189,098 procedures ÷ 8,000 procedures per unit = 24 units

2016 Including Lockport

165,006 general radiology/fluoroscopy procedures x 1.15 national health care reform factors = 189,757 procedures

189,757 procedures ÷ 8,000 procedures per unit = 25 units

ACMC/AHCH Has Justified the Need for 18 General Radiology/Fluoroscopy Units

To be conservative, the Medical Center is requesting 18 general radiology/ fluoroscopy units. Of these 10 will be on campus (9 in the hospital and 1 in Hope), 7 will be in the Ambulatory Pavilion, and 1 will be in Lockport.

By 2016, the second full year of operation of the Ambulatory Pavilion, the general radiology/fluoroscopy units will exceed the State Standard.

2016 Units on Campus

164,433 total procedures ÷ 17 units = 9,673 procedures per unit

9,673 procedures per unit > State Standard of 8,000 units per procedure

2019 Total Units Including Lockport

165,006 total procedures ÷ 18 units = 9,167 procedures per unit

9,167 procedures per unit > State Standard of 8,000 units per procedure

Based on projections to 2019, these volumes will continue to increase.

ACMC/AHCH's current volume exceeds the State Standard for general radiology procedures.

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

NA. There is a State Standard for general radiology/fluoroscopy units. The Medical Center's current utilization justifies the proposed 18 units.

2010 Units on Campus

156,682 procedures ÷ 17 proposed units on campus = 9,217 procedures per unit

9,217 procedures > State Standard of 8,000 procedures per unit

2010 Total Units Including Lockport

157,255 procedures ÷ 18 proposed units on campus = 8,737 procedures per unit

8,737 procedures > State Standard of 8,000 procedures per unit

Clinical Service Area – Mammography

Clinical List Designation – D.16

c) Service Modernization

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

1) Deteriorated Equipment of Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

The proposed project will replace one mammography unit that has deteriorated. It is obsolete and is no longer certified by MQSA to do mammograms. This unit is used only for localizations prior to breast surgery. It is currently located in the hospital's imaging department. It will be replaced by a new unit in the Ambulatory Pavilion that will be located near surgery.

2) Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

Breast cancer is a major focus of the Cancer Institute at Advocate Christ Medical Center/Advocate Hope Children's Hospital (ACMC/AHCH, Medical Center). Of the total cancer cases at the Medical Center, 36 percent are breast cancer, compared to 26 percent nationally. Mammography is an essential modality in the diagnosis and treatment of breast cancer.

A mammogram is an x-ray picture of the breast. Mammography can be used to check for breast cancer in women who have no signs or symptoms of disease; it is also used to evaluate women who have symptoms of non-cancerous breast disease. These mammograms are called screening mammograms and usually involve two images of each breast.

Mammograms can also be used to check for breast cancer after a lump or other sign or symptom of breast disease has been found; these are called diagnostic mammograms. Diagnostic mammograms can also be used to evaluate changes found during a screening mammogram or to view breast tissue. Diagnostic mammograms take longer than screening mammograms because more x-rays are needed to obtain views of the breast from many different angles. There are two fundamental types of mammography units - conventional (where the images are stored on film) and digital (where images are stored as a computer file). Digital mammography offers the following advantages over conventional mammography:

- Health care providers can share image files electronically, making long-distance consultations between radiologists and breast surgeons easier
- Subtle differences between normal and abnormal tissues may be more easily noted, and
- Fewer repeat images may be needed, reducing the exposure to radiation.

If the cause of an irregularity cannot be determined with sufficient certainty, a biopsy is performed. If the patient requires surgery, the physician performs a needle localization to mark the site of the surgery. The patient is positioned on her abdomen on a special table. The breast is placed through an opening on a table, compressed and a mammogram is performed. This allows the physician to locate the suspicious areas. The physician will then numb the breast tissue with a local anesthetic, place a fine wire into the area of the lesion and tape the wire to the breast. The patient is then moved to surgery where the surgeon removes the suspicious area.

Today the Medical Center has 4 digital screening and diagnostic mammography units. They are all off site; 3 are at the Center for Breast Health and 1 is located in the Lockport Outpatient Center. The Lockport unit has not reached its second full year of utilization. The breast surgeons perform breast biopsies at the Center for Breast Health; they do needle localizations at the hospital. When the Ambulatory Pavilion is ready for occupancy, the breast surgeons will relocate their practices to the Cancer Institute in the Pavilion. They will perform needle localizations and breast surgery at the Pavilion. The unit used for needle localizations at the hospital is old and is no

longer certified by the MQSA; it is being replaced. Since it is not feasible to move the patient any distance with the wire in her breast because it can easily move or become dislodged and ultimately complicate the surgery. Therefore, it is necessary to purchase a new unit for needle localizations and locate it in the Ambulatory Pavilion. Again, this unit will not be used for screening or diagnostic mammograms.

The Center is currently in the process of applying for designation as a Breast Imaging Center of Excellence by the American College of Radiology, signifying that it meets the highest standards of the radiation profession.

Attachment 37, D.16, Table 1
Historical Utilization of Mammography at ACMC/AHCH, 2008 to 2010
All mammography units are located off-site.

Year	2008	2009	2010	Percent Change 2008-2010
IP Visits	66	-	-	-
OP Visits[2]	15,366	17,788	17,732	-29.6
Total Visits[1]	15,433	17,788	17,732	-29.6
Percent OP Visits	99.6	100.0	100.0	-0.4
Number of Units	3	3	4	+1
Visits per Unit	5,144	5,930	4,433	-13.8
Percent over/under State Standard	+2.9	+ 18.6	-8.7	-5.8

Source: ACMC records.

1. By early 2008, all mammography services had been moved off-site to the Center for Breast Health; the fourth unit was added in Lockport, its first full year of utilization was 2010.
2. The 2008 data reflects mammograms. The higher 2008 number in the AHQ includes both mammograms and CADs.

The State Standard for mammography is 5,000 units per visit.

In November 2009, the United States Preventative Services Task Force released new guidelines that recommended that most women start regular breast cancer screening at age 50, not 40 as had been previously recommended by this same Task Force. The implications of this recommendation are reflected in the stable utilization of the mammography units at the Center for Breast Health between 2009 and 2010. However, year-to-date data suggests that volume will increase to more than 19,000 exams in 2011.

Preventing disease as well as detecting and managing chronic disease are among the national health care reform goals. Health care experts expect that health care reform initiatives will increase the mammography screening rate, thereby identifying cancer

earlier and reducing acute treatment protocols including hospital admissions and surgical intervention. Today, approximately one-third of breast cancer cases in the United States are diagnosed at a later disease stage making treatment more difficult and expensive. Breast cancer screening, needle biopsies, and breast surgery will improve quality, reduce complicated treatment protocols, and better manage limited health care resources.

3) Utilization

C) Major Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

NA. There is no mammography equipment in this project that meets or exceeds the major medical equipment threshold.

D) Service or Facility

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

A profile of historical utilization of mammography and the implications for future utilization under national health care reform are described in Section c) 2).

The following calculations were used to determine future need. The State Standard for mammography units is 5,000 visits per unit.

Current Utilization

Current utilization of the Medical Center's 4 offsite mammography units justifies the need for 4 units.

17, 732 visits ÷ 5,000 visits per unit = 4 units

This calculation does not take into account the fact the Lockport unit's first year of operation of 2010.

Projected Utilization

To anticipate future demand, the Medical Center prepared a CAGR trend line based on utilization trends from 2002 to 2010 and extended to 2019. The projected growth suggests the need for 6 mammography units by 2016.

29,599 visits ÷ 5,000 visits per units = 6 units

Attachment 37, D. 16, Table 2
CAGR Projected Mammography Visits, 2016 and 2019

Year	2010	2016 Second Full Year of Operation	Percent Change 2010 to 2016	Number of Rooms Justified by 2016 [1]	2019 Fifth Full Year of Operation	Number of Rooms Justified by 2019
IP Visits	-	-	-	-	-	-
OP Visits	17,732	29,599	+66.9	6	38,281	8
Total Visits	17,732	29,599	+66.9	6	38,281	8

Source: ACMC records.
[1]. This does not include the mammography unit at the Ambulatory Pavilion which will not be used for screening and diagnostic mammograms.

Impact of National Health Care Reform

The Medical Center then conservatively applied a 15 percent growth factor to account for the implementation of national health care reform legislation. This factor increases projected 2016 volume to 34,039 visits or the need for 7 units.

2016

29,599 visits x 1.15 national health care reform factor = 34,039 visits

34,039 visits ÷ 5,000 visits per unit = 7 units

ACMC/AHCH Has Justified the Need for 5 Mammography Units

The CAGR and national health care reform projections understate future demand for mammography units. Of the Medical Center's current complement of 4 units, one has not reached its second full year of utilization and volume in the projection is held constant at the 2010 level. It therefore unrealistically diminishes the trend line. The additional mammography unit in the Ambulatory Pavilion is for patient safety; it would be unsafe to prepare a woman for a needle biopsy and then require her to move several city blocks to the location where the

biopsy would be performed. It will not be used for screening and diagnostic mammograms.

2016

29,599 visits ÷ 4 units = 7,400 visits per unit

7,400 visits per unit > State Standard of 5,000 visits per unit

29,599 visits ÷ 5 units = 5,920 visits per unit

5,920 visits per unit > State Standard of 5,000 visits per unit

Even if the special unit for needle localizations is included, the 5 units will still operate at more than 5,000 visits per unit.

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

There is a State Standard for mammography units. ACMC/AHCH exceeds the State Standard for mammography services by the second year of utilization.

Clinical Service Area – Ultrasound

Clinical List Designation – D.17

c) Service Modernization

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

1) Deteriorated Equipment of Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

NA. The proposed project will not replace facilities or equipment that has deteriorated. The project will add 7 ultrasound units on the first floor of the Ambulatory Pavilion that is being proposed by Advocate Christ Medical Center/Advocate Hope Children's Hospital (ACMC/AHCH, the Medical Center).

2) Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

Ultrasound technology is a diagnostic imaging technique used to visualize subcutaneous body structures including tendons, muscles, breast and internal organs for possible pathology and lesions. Ultrasound is also used to guide interventional procedures and has applications in cancer, urology, and cataract treatment.

Ultrasound is an essential diagnostic and therapeutic modality for many of the disciplines that will be housed in the Ambulatory Pavilion including cardiovascular medicine, neuroscience, cancer, women's services, orthopedics, gastroenterology, and neurology.

Advocate Christ Medical Center/Advocate Hope Children's Hospital (ACMC/AHCH, Medical Center, AHCH) currently operates 11 ultrasound units. Of these 8 are at the Medical Center; there is 1 in AHCH dedicated to pediatrics; the 7 others are in the main radiology/imaging suite. When needed, 1 of the 7 from the radiology suite is

moved to the Emergency Department; however, it is considered a fixed unit. The Medical Center also operates 1 general ultrasound unit in Lockport that has not reached its second full year of operation. The Medical Center also operates 2 units at the Center for Breast Health; these units are equipped with special breast transducers and software; they are very specialized and cannot be used for general ultrasound examinations.

Attachment 37, D.17, Table 1
Historical Utilization of Ultrasound at ACMC/AHCH, 2008 to 2010

			Campus Only	Campus Lockport		Center for Breast Health				
	2008	2009	2010	2010	Percent Change 2008-2010	2008	2009	2010	Total 2010	Percent Change 2008-2010
IP Visits	15,437	14,391	16,323	16,323	+5.7	-	-	-	16,323	+5.7
OP Visits	15,711	20,661	17,772	18,348	+16.3	1,844	2,142	1,970	20,318	+29.3
Total Visits	31,208	35,052	34,095	34,671	+11.1	1,844	2,142	1,970	36,651	+17.4
Percent OP Visits	50.5	58.9	52.1	52.9	+2.4	100.0	100.0	100.0	55.5	55.5
Number of Units	8	8	8	9	+1	2	2	2	11	+3
Visits per Unit	3,901	4,382	4,262	3,853	-1.2	922	1,072	985	3,331	-14.6
Percent Over State Standard	+25.8	+41.4	+37.5	+24.5	-1.3-	-70.3	-65.4	-68.2	+7.5	-18.3

Source: ACMC records.

The 8 ultrasound units at the Medical Center are very busy. The current backlog for scheduling adult outpatients averages 3 to 5 days. The current backlog for pediatric outpatients is 2 weeks.

Ultrasound is a cost effective modality; its use is likely to increase as national health care reform is implemented.

3) Utilization

A) Major Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

NA. There is no ultrasound equipment in this project that meets or exceeds the major medical equipment threshold

B) Service or Facility

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

A description of the increasing utilization of the ultrasound units at the Medical Center and the favorable outlook for ultrasound under national health care reform are described in Section c) 2).

The following calculations were used to determine future need. The State Standard for Ultrasound utilization is 3,100 visits per year.

Current Need

Current utilization justifies the need for 12 ultrasound units.

2010 General Ultrasound

34,671 visits ÷ 3,100 visits per unit = 12 units

2010 All Ultrasound

36,641 visits ÷ 3,100 visits per unit = 12 units

The 2 units at the Center for Breast Health are special purpose units; the 8 units at the hospital and the 1 unit at Lockport are general ultrasound units. Even so, the unit in Lockport is not interchangeable with the units at the hospital. The Lockport unit is 40 minutes travel time from the campus; it serves the greater Lockport area and is too far for Oak Lawn area residents to travel for this exam. Even so, it was included in the data.

Projected Utilization

To anticipate future demand for ultrasound equipment, the Medical Center prepared CAGR trend lines based on ultrasound utilization between 2002 and 2010

and extended to 2019. The trend lines suggest the need for 18 ultrasound units by 2019.

Attachment 37, D. 17, Table 2
CAGR Projected Ultrasound Visits, Campus, Lockport, and the Center for Breast Health
2016 and 2019

Year	2010	2016 Second Full Year of Operation	Percent Change 2010 to 2016	Number of Units Justified in 2016	2019 Fifth Full Year of Operation	Number of Units Justified by 2019
IP Visits	16,323	21,097	+29.2	7	23,985	8
OP Visits	18,348	26,740	+45.7	9	30,808	10
Total Visits	34,671	47,837	+38.0	16	54,793	18

Source: ACMC records.

Impact of Health Care Reform

Finally, the Medical Center applied a 15 percent growth factor to account for the implementation of the national health care reform legislation. This factor increases total projected need for 17 units on the campus and 18 total units.

2016 Campus Only

43,890 visits x 1.15 national health care reform factor = 50,474 visits

50,474 visits ÷ 3,100 visits per unit = 17 units

2016 Total

47,837 visits x 1.15 national health care reform factor = 55,013 visits

55,013 visits ÷3,100 visits per unit = 18 units

ACMC/AHCH Has Justified the Need for 18 Ultrasound Units

The general ultrasound units on the campus are very busy. In fact, in 2010, they operated at 4,262 visits per unit or 37.5 percent higher than the State Standard of 3,100 visits per unit. Current campus utilization justifies the need for 11 units.

The Medical Center has 3 other ultrasound units. There is a new general ultrasound unit in Lockport; it has not reached its second full year of operation. As noted in the introduction, the 2010 Lockport utilization was held constant throughout the projection period, understating the 2016 and future projected utilization of this unit as well as the utilization for the Medical Center's total complement of ultrasound units. This unit is 40 minutes travel time from the

campus and not a reasonable alternative for Oak Lawn area residents. There are also 2 special breast ultrasound units at the Center for Breast Health. By 2016, they are projected to have 3,371 visits or enough to meet the State Standard. However, these are not general ultrasound units and are not interchangeable with the general ultrasound units on the campus.

2016 projected volume on campus justifies 15 ultrasound units.

43,890 visits ÷ 3,100 visit per units = 15 units.

The Medical Center is proposing 15 units on the campus; of these, the 8 existing units would remain in the hospital and 7 units new units would be placed in the Ambulatory Pavilion.

By 2016, there are no plans to add ultrasound units either in Lockport or the Center for Breast Health even though the utilization of these units is projected to continue to increase. Projections suggest that the Center for Breast Health will meet the State Standard by 2016 and the unit at Lockport is expected to reach 1,942 visits by 2016 according to the CON justifying this unit (Permit #08-012); the unit was approved based on the-then State Standard of 2,000 ultrasound visits per unit.

Based on this analysis, the Medical Center can justify 18 ultrasound units including 15 on the campus and the existing 3 units at the Center for Breast Health and Lockport.

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

There is a State Standard for ultrasound. ACMC/AHCH meets the State Standard.

Clinical Service Area –
CT & PET/CT

Clinical List Designation D.18

c) Service Modernization
The applicant shall document that the proposed project meets one of the following:

1) Deteriorated Equipment of Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

NA. The proposed Ambulatory Pavilion (Pavilion) at Advocate Christ Medical Center/Advocate Hope Children's Hospital (ACMC/AHCH, the Medical Center) will not replace facilities or equipment that has deteriorated. The project will add 4 CT scanners in the Ambulatory Pavilion, one of which will have PET scanning capability.

2) Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

Computerized tomography (CT) and Positron Emission Tomography (PET) are essential imaging modalities at the Medical Center.

CT has several advantages over general radiography. With CT, a physician is able to generate a three-dimensional image of the area being studied. CT eliminates the superimposition of images or structures outside the area of interest. Further, because of its inherent high resolution, very tiny differences between tissues can be distinguished. Finally, images can be viewed in the axial, coronal, or sagittal planes, depending on the diagnostic task.

Positron Emission Tomography (PET) scanning involves administering a radioactive substance to the patient; the radioactivity localizes in the appropriate areas of the

body and is detected by the scanner. Different colors or degrees of brightness on the PET image represent different levels of tissue or organ function. PET scans are used most often to detect cancer, to stage treatment, and to monitor the effectiveness of the treatment. PET scans of the heart are used to monitor blood flow to the heart muscle, evaluate signs of coronary artery disease, and to differentiate nonfunctioning heart muscle that would benefit from angioplasty or heart surgery. PET scans of the brain are used to evaluate patients who have memory disorders and to identify suspected brain tumors.

When diagnosing with separate CT and PET scans, it is difficult for physicians to interpret the results because the scans are taken at a different times and locations and the patient's body position changes from one scan to the next. The combination of PET/CT provides physicians a more complete picture of what is occurring in the body, both anatomically and metabolically because the results of PET and CT scans are "fused" together; the combined images provide more complete information. Both scans can be done at the same time on a PET/CT. The PET/CT system provides exceptional quality and accuracy of diagnostic information.

At the present time, the Medical Center does not have PET capability.

In the Annual Questionnaire, hospitals are required to provide CT exams/procedures. The CON State Standard is visits based. The Medical Center has used visits throughout this justification. The State Standard is 7,000 visits per CT scanner.

Attachment 37 D.18 Table 1
Historical Utilization of CT Visits at ACMC/AHCH

	Campus Only				Campus and Lockport[1]	
	2008	2009	2010	Percent Change 2008 - 2010		Percent Change 2008 - 2010
IP Visits	30,121	27,914	31,296	+3.9	31,296	+ 3.9
OP Visits	25,309	31,424	27,121	+7.2	27,330	+8.0
Total Visits	55,430	59,338	58,417	+ 5.4	58,626	+5.7
Percent OP Visits	45.7	53.0	46.4	+0.7	46.6	+0.9
Number of Units	5	5	5	-	6	+ 1
Visits per Unit	11,086	11,868	11,684	+ 5.4	9,771	- 12.2
Percent over State Standard	58.4	69.5	66.9	+ 8.5	39.6	- 18.8

Source: ACMC records.
1. ACMC added one CT scanner at the Lockport Outpatient Center in 2010.

The CT scanner at Lockport has not reached its second full year of utilization. Lockport is 40 minutes travel time from the Medical Center; residents from the greater Oak Lawn community prefer to have their care at the Medical Center. The Lockport Outpatient Center was established to serve the greater Lockport area.

The 5 CT scanners at the Medical Center campus reported 58,417 visits or 11,684 visits per scanner in 2010; this is 66.9 percent over the State Standard. Even so, the Medical Center achieved 5.4 percent growth over the last 2 years.

Projected PET Utilization

The Medical Center has no record of the number of PET referrals; these referrals are made directly by the physicians. To determine the number of PET scans that could be anticipated; the Medical Center researched several PET need determination methodologies and used one published by the State of Georgia (111-2-2-.41 *Specific Review Criteria for Positron Emission Tomography Units,* effective June 2, 2008. Full text available at http://www.georgia.gov/vgn/images/portal/cit_1210/52/9/892827338-1-07-Proposed_2007_PET_Component_Plan.pdf. The Georgia PET methodology is as follows:

1. Calculate the projected incidence of cancer in a geographic area.
2. Multiply the projected incidence of cancer by 50 percent to determine the projected number of patients diagnosed with cancer who might benefit from a scan.
3. Multiply the number of cancer patients who might benefit from a PET scan by 1.4 to accommodate for non-oncologic patients and follow up scans for oncology patients in the projected need for services.

The Medical Center applied this methodology as follows:

1. The Medical Center obtained age specific cancer incidence rates by age group from the National Cancer Institute's Seer Data Base and applied the rates to 2011 population of the ACMC/AHCH primary and secondary service areas. Based on this calculation, the total incidence of cancer in the Medical Center's total service area is 8,213 cases. This estimate is conservative because it does not include population beyond the primary and secondary service areas.
2. The Medical Center then multiplied the total incidence of cancer by 50 percent to determine the number of these cancer patients who would benefit from a PET scan. Fifty percent of 8,213 cases equals 4,107 cases.
3. Next the Medical Center multiplied the number of cancer cases that would benefit from a PET scan x 1.4 to accommodate non-oncologic and follow-up scans and determined the area's potential need for PET scans to be 5,750 scans.
4. Finally, since there are other PET providers in the Medical Center's service area, the Medical Center adjusted the total area scans by the Medical Center's current market share in the total service area, or 14.1 percent. Total scans x 14.1 percent resulted in a potential demand of 811 PET scans.

Having determined the calculated potential for its market, the Medical Center reviewed the 2010 experience of other Advocate hospitals with PET scanning capability, especially Advocate Condell (354 scans), Advocate Good Samaritan (456 scans), Advocate Lutheran General (414 scans), and Advocate Illinois Masonic (326 scans). Based on both the Georgia methodology and the current experience of Advocate hospitals providing PET scanning capabilities, the Medical Center projected that start-up volume would be 400 visits.

The ability to fuse CT and PET scans is a significant change in industry standard. Growth and aging of the population are expected to increase demand for CT and PET/CT scans because of the higher incidence of cancer, heart disease, Alzheimer's and other diseases in the more senior population and the improved capability of the CT and PET/CT.

Among the goals of national healthcare reform are preventing and managing certain chronic diseases such as vascular, heart, cancer, and neurological disorders. CT and PET/CT technology is best suited to cost effectively and efficiently diagnose and monitor these disease processes. Increased utilization is expected to improve care quality and respond to the increasing disease prevalence in the aging population.

3) Utilization

A) Major Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

NA. There is no CT and PET/CT equipment in this project that meets or exceeds the major medical equipment threshold.

B) Service or Facility

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

A description of the historical utilization of the CT scanners at the Medical Center and at Lockport, a projection of future PET scans, as well as the optimistic outlook for CT scanning under national care reform are described in Section c) 2).

ACMC/AHCH currently has 5 CT scanners on the campus and one in Lockport for a total of 6. The Medical Center is proposing to add 4 CT scanners in the Ambulatory Pavilion bringing the total to 9 on campus, one of which will have PET scanning capabilities. There will be no changes in the numbers in scanners in Lockport.

The State Standard for CT is 7,000 visits per year. The State Standard for PET is 3,600 visits per year. Even though the Medical Center is proposing to have one CT unit with PET capability, the Medical Center used the more conservative utilization target, or 7,000 visits per year per unit. Hence the following calculations used to determine future need are conservative.

Current Need

Current CT only visits justify the need for 9 CT scanners

Campus

58,417 campus visits ÷ 7,000 visits per CT scanner =
9 scanners on campus

Campus and Lockport

58,626 total visits ÷ 7,000 visits per CT scanner = 9 total scanners

Extremely high utilization of the CT scanners on the Medical Center's campus has resulted in limited growth.

Projected Utilization

To determine future visits based on aging of the population and increasing applications for CT, the Medical Center prepared CAGR trend lines based

on CT utilization from 2002 to 2010 and extended the trend lines to 2019. The trend lines suggest the need for at least 10 CT units by 2016.

Attachment 37 D.18 Table 2
Current and Project Utilization and Total Number of Units Justified

Year	2010	2016 Second Full Year of Operation	Percent Change 2010 to 2016	Number of Units Justified in 2016	2019 Fifth Full Year of Operation	Number of Units Justified in 2019
IP CT Visits	31,296	36,0023	+ 15.1	5	38,648	6
OP CT Visits	27,330	28,620	+ 4.7	5	29,287	4
Total CT Visits	58,626	64,643	+ 10.3	10	67,935	10
Est. PET Visits		400			400	
Total CT & PET/CT Visits	58,626	65,043	+ 10.9	10	68,335	10

Source: ACMC records.

Impact of National Health Care Reform

Based on the expected impact of national health care reform on CT and PET/CT, the Medical Center conservatively applied a 15 percent growth factor to account for the implementation of this legislation. This factor increases the projected need for as many as 11 units in 2016.

2016

65,043 visits x 1.15 national health care reform factor = 74,800 visits

74,800 visits ÷7,000 visits per unit = 11 units

ACMC/AHCH Has Justified the Need for 10 CT Scanners including 1 with PET Scanning Capabilities

Although as many as 11 CT and PET/CT scanners have been justified, the Medical Center is requesting 10 units. These will include the existing 5 units in the hospital, 4 in the Ambulatory Pavilion for a total of 9 on the campus plus 1 at the Lockport Outpatient Center. The Medical Center expects to achieve higher throughput than the State Standard.

By 2016, the second full year of operation of the Ambulatory Pavilion, the complement of CT and PET/CT units on the campus will exceed the State Standard.

Campus

65,043 total visits – 209 visits at Lockport = 64,834 visits on campus

64,834 visits on campus ÷ 9 units on campus = 7,204 visits per unit

7,204 visits per unit > 7,000 visits per unit

The lower visits per unit rate for all units reflects that Lockport volume was held at 209 visits throughout the projection period in the CAGR projections since there was only one year of data. As a result of this, the total projected volume is understated.

Total

65,043 visits ÷ 10 units = 6,504 visits per unit

6,504 visits per unit = 92.9 percent of 7,000 visits per unit

Continued growth in demand beyond 2016 is expected.

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

There is a State Standard for CT and for PET. ACMC/AHCH will meet the State Standard by the second full year of operation.

Clinical Service Area –
Magnetic Resonance Imaging (MRI)

Clinical List Designation – D.19

c) Service Modernization

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

1) Deteriorated Equipment of Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

In January 2010, Advocate Christ Medical Center/Advocate Hope Children's Hospital (ACMC/AHCH, Medical Center) contracted for mobile outpatient magnetic resonance imaging (MRI) services to supplement the capacity of the existing 2 fixed units on campus. Although the mobile services are meeting an immediate clinical need, this alternative is not a satisfactory solution to providing MRI services over the longer term. The unit is unattractive and remote from parking. Many outpatients prefer to wait until they can schedule an exam on the hospital equipment. The Medical Center is proposing to install 3 MRI units in the Ambulatory Pavilion. At the time the Ambulatory Pavilion opens, the Medical Center will have 6 MRIs; of these, 2 will be in the hospital, 3 will be in the Ambulatory Pavilion, and 1 will be in Lockport. The contract for the mobile unit will be terminated.

2) Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

MRI is one of the most useful imaging tools in the diagnosis of a wide variety of diseases and injuries. MRI provides the most detailed images of soft tissues such as

the brain, eyes, and inner ear; of organs such as the heart, liver, and pancreas; of the female reproductive system; as well as of joints, ligaments, and cartilage. It is also useful to provide real time images of the heart and circulatory system.

Until 2010, the Medical Center had only 2 MRI units; the number of procedures per unit in 2008 and 2009 was more than twice the State Standard of 2,500 procedures per unit per year. Utilization was capped by lack of capacity. In January 2010, the Medical Center contracted for a mobile MRI unit. As expected, as soon as the third unit became available, utilization increased reflecting how important MRI capability is to the institutes and other clinical services at the Medical Center. The MRI unit in Lockport also reported utilization for the first full year of utilization; since this unit has not reached the second full year of operation, its ramp-up utilization depressed the procedures for the total MRI complement.

Several operational issues affect the utilization of the MRI units. For example, the mobile unit has fixed hours of operation and limited staff coverage to provide contrast enhanced exams. Further, one of the hospital-based MRI units is used to conduct pediatric MRI scans. Since these scans typically require general anesthesia, they take longer than an average adult scan; one scanner is dedicated 4 days a week to pediatric scans.

Attachment 37, D. 19 Table 1
Historical Utilization of MRI at ACMC/AHCH, 2008 to 2010

			Campus Only		Campus and Lockport	
Year	2008	2009	2010	Percent Change 2008-2010	2010	Percent Change 2008-2010
Number of Fixed Units	2	2	2		3	
Number of Mobile Units	-	-	1		1	
Total Number of Units	2	2	3	+1	4	+2
Fixed IP Procedures	5,234	4,716	5,860	+12.0	5,860	+12.0
Fixed OP Procedures	5,453	6,001	5,133	-5.9	5,454	-0.0
Total Fixed Procedures	10,687	10,717	10,993	+2.9	11,314	+6.1
Mobile OP Procedures	-	-	1,563	-	1,563	-
Total OP Procedures	5,453	6,001	6,696	+22.8	7,017	+28.7
Total Procedures	10,687	10,717	12,556	+17.5	12,877	+29.7
Percent OP Procedures	51.0	56.0	53.3	+2.3-	54.5	+3.5
Procedures per Unit	5,344	5,359	4,185	-21.7	3,229	-39.7
Percent over State Standard	113.8	114.4	67.4	46.4	28.8	-85.0

Source: ACMC records.

Demand for advanced imaging procedures such as MRI and CT is expected to increase at a faster rate than that of general radiology and fluoroscopy. Industry experts expect MRI volume to increase 50 percent nationally over the next decade. Because of the high case mix (acuity) of the patients at the Medical Center, the increase in MRI demand at the Medical Center could outpace average market growth.

The implementation of the national health care reform is expected to have a positive impact on MRI utilization. Early diagnosis and associated treatment for select disease conditions will foster ambulatory treatment protocols and reduce acute admissions consistent with underlying health reform initiatives.

3) Utilization

A) Major Medical Equipment
Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

NA. There is no MRI equipment in this project that meets or exceeds the major medical equipment threshold.

B) Service or Facility

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

A description of the utilization of the MRI units at the Medical Center and the encouraging outlook for MRI under national health reform are described in Section c) 2).

The following calculations were used to determine future need. The State Standard for MRI is 2,500 procedures per unit.

Current Utilization

Current utilization of the 3 MRI units on the Medical Center campus justifies the need for 5 MRI units.

12,556 procedures ÷ 2,500 procedures per unit = 5 MRI units

The Lockport unit's first full year of utilization was 2010. This unit is community based and remote (40 minutes travel time) from the Medical Center's Oak Lawn campus and the local population that rely on the Medical Center's facilities. The utilization of the 4 total MRIs operated by the Medical Center justifies the need for 6 MRI units.

12,877 procedures ÷ 2,500 procedures per unit = 6 MRI units

Projected Utilization

It would be imprudent to build and equip the Ambulatory Pavilion to accommodate only today's MRI requirements on the campus. To anticipate future demand based on growth and aging and clinical innovations such as increasing demand by stroke patients, the Medical Center prepared CAGR trend lines based on MRI utilization

from 2002 to 2010 and extended them to 2019. The trend lines suggest the need for at least 7 MRI units by 2016 and 8 MRI units by 2019.

Attachment 37, D. 19, Table 2
CAGR Projected MRI Procedures,
including Lockport 2016 and 2019

	2010	2016 Second Full Year of Operation	Percent Change 2010 to 2016	Number of Units Justified in 2016	2019 Fifth Full Year of Operation	Number of Units Justified in 2019
IP Procedures	5,860	7,434	+26.9	3	8,373	4
OP Procedures	7,017	7,889	+12.4	3	8,379	4
Total Procedures	12,877	15,323	19.0	6	16,752	7 to 8

Source: ACMC records.

Attachment 37, D. 19, Table 3
CAGR Projected MRI Procedures,
excluding Lockport, 2016 and 2019

	2010	2016 Second Full Year of Operation	Percent Change 2010 to 2016	Number of Units Justified in 2016	2019 Fifth Full Year of Operation	Number of Units Justified in 2019
IP Procedures	5,860	7,434	+26.9	3	8,373	4
OP Procedures	6,696	7,568	+13.0	3	8,048	4
Total Procedures	12,556	15,002	+19.5	6	16,431	7 to 8

Source: ACMC records.

Impact of National Health Care Reform Legislation

Finally, the Medical Center conservatively applied a 15 percent growth factor to account for the implementation of the national health care reform legislation. This factor confirmed total project need for 7 MRI units by 2016.

2016 Campus

15,002 MRI procedures x 1.15 national health care reform factor = 17,253 procedures

17,253 Procedures ÷ 2,500 procedures per unit = 7 MRI units

ACMC/AHCH Has Justified the Need for 6 MRI Units

Although the Medical Center justified the need for as many as 7 MRI units on the campus; it is only requesting only 6 units. These will include 2 in the hospital, 3 in the Ambulatory Pavilion and 1 in Lockport. The unit in Lockport will continue to serve residents of Lockport and other nearby communities. The Medical Center assumed that inpatients would use the 2 MRI units in the hospital and that scheduling would be flexible to account for emergency and trauma cases. The Medical Center also assumed that the 3 newer MRI units that will be installed in the Ambulatory Pavilion could support higher throughput than the existing units in the hospital. The 3 MRI units proposed for the Ambulatory Pavilion will be located on Level 5.

By 2016, the second full year of operation of the Ambulatory Pavilion, the total complement of 5 units at the Medical Center will be operating above the State Standard.

2016 Campus

15,002 procedures ÷ 5 units = 3,001 procedures per unit

3,001 procedures per MRI per year > State Standard of 2,500 procedures per year

The same year, the total complement of 6 units (5 at the hospital and 1 in Lockport) will also be operating at the State Standard.

2016 Total

15,323 procedures ÷ 6 units = 2,553 procedures per unit

2,553 procedures per MRI per year > State Standard of 2,500 procedures per year

The demand for MRI procedures is expected to continue to increase after 2016; increased procedures will increase the number of visits per unit.

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

There is a State Standard for MRI. ACMC/AHCH will exceed the State Standard by the second full year of operation.

Clinical Service Area – Nuclear Medicine

Clinical List Designation D.20

c) Service Modernization

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

1) Deteriorated Equipment of Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

The proposed project will not result in the replacement of facilities that have deteriorated and need replacement. However, 2 of the existing nuclear medicine units at Advocate Christ Medical Center/Advocate Hope Children's Hospital (ACMC/AHCH, Medical Center) are obsolete and will be retired when the proposed Ambulatory Pavilion (Pavilion) opens. There will be a total of 7 nuclear medicine units at that time; these include 3 remaining existing Gamma SPECT cameras in the hospital as well as 3 Gamma SPECT cameras and 1 Gamma SPECT/CT camera in the Pavilion.

2) Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

Nuclear scanning uses radiation to help physicians evaluate the physiology and function as well as anatomical features and to detect disease, inflammation, or infection throughout the body. When a nuclear scan is performed, the patient drinks, inhales, or is injected with a radiopharmaceutical – a drug that contains a weak dose of radiation to trace the disease's path. A special camera is then used to provide images of the area being examined.

Attachment 37, D. 20, Table 1
Historical Utilization of Nuclear Medicine at ACMC/AHCH, 2008 to 2010

Year	2008	2009	2010	Percent Change 2008-2010
IP Visits	8,787	7,821	7,740	-11.9
OP Visits	5,572	6,557	6,120	+9.8
Total Visits	14,359	14,378	13,860	-3.5
Percent OP Visits	38.8	45.6	44.2	+5.4
Number of Units	5	5	5	--
Visits per Unit	2,872	2,876	2,772	-3.5
Percent over State Standard	+43.6	+43.8	+38.6	-5.0

Source: ACMC records.

Note: The AHQ requires that procedures or exams be reported for nuclear medicine. However, the State Standard for justifying nuclear medicine units is for visits. The values used throughout this section are visits.

Over the last 2 years, the Gamma cameras at the Medical Center have been operating on average about 40 percent over the State Standard; this high utilization limits growth. Further, 2 of the units are obsolete.

An important change in industry standards is the introduction of SPECT/CT. This technology enables both single photon emission computed tomography (SPECT) and computed tomography (CT) images to be taken in one imaging session; the SPECT provides functional data collected from multiple views and reconstruction images while the CT provides anatomical mapping or localization. These images are inherently registered or fused. CT attenuation correction also may be used to correct the fused image to remove attenuation artifacts.

SPECT/CT is becoming the preferred method for imaging many types of disease processes. Health care experts project substantial growth in SPECT/CT imaging. Patients seen in the Heart and Vascular and Cancer Institutes have special needs for this new technology. For example, SPECT/CT enables the precise localization of an abnormal ischemic segment of a blood vessel that delivers blood flow to the heart. SPECT/CT also allows for more accurate tumor localization, especially for patients with tumors of the brain and nervous system; the gastrointestinal system; the

gynecologic system; head and neck; lung and bronchial system; and, the urological system. At the present time, the Medical Center does not have SPECT/CT capability.

Another important change in industry standards is the application of SPECT/CT in the "thyroid uptake" scans. A thyroid uptake scan helps evaluate the function of the thyroid, a gland in the neck that controls metabolism, the chemical process that regulates the rate at which the body functions. The patient is given radioactive iodine (radiotracer) and then scheduled for the thyroid uptake exam from 6 to 24 hours later. During the procedure, the patient sits in a chair while a probe is placed over the thyroid gland in the neck. This small probe is capable of detecting and measuring the gamma rays emitted from the radiotracer that have accumulated in the thyroid gland. This information is not available using other imaging procedures. The thyroid uptake is less traumatic than exploratory surgery.

Another important change in industry standards is the implementation of national health care reform. As the result of this legislation, industry experts expect nuclear medicine utilization to increase, especially SPECT/CT because it is capable of improving diagnostic accuracy. By developing a more accurate diagnosis early in the disease process, overall cost is contained and acute inpatient admissions avoided – both health reform goals. Primary areas of growth in nuclear imaging are expected to be in cardiac, neurologic, orthopedic, and renal services.

A) Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

NA. There is no nuclear medicine equipment in this project that meets or exceeds the major medical equipment threshold.

B) Service or Facility

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

In Section c) 2) above, ACMC/AHCH showed how the utilization of the Medical Center's nuclear medicine cameras is substantially over State Standards and described changes in industry standards that will influence growth in nuclear medicine in the future, including the addition of SPECT/CT and national health care reform.

The following calculations were used to determine future need. The State Standard for nuclear medicine is 2,000 visits per unit.

Current Utilization

Current volume justifies the need for 7 Gamma SPECT/SPECT/CT cameras.

13,860 nuclear medicine visits ÷ 2,000 visits per camera =
7 Gamma SPECT/SPECT/CT cameras

Projected Utilization

To anticipate future demand based on growth and aging and clinical innovations including the introduction of SPECT/CT, the Medical Center prepared CAGR trend lines based on nuclear medicine visits from 2002 to 2010 and extended to 2019. These trend lines suggest the need for at least 7 nuclear scanning cameras. These projections are very conservative. The Medical Center currently does not have SPECT/CT capability; hence, there is no SPECT/CT volume considered in the historical trend line or in the projection.

Based on a review of the current mix of nuclear medicine visits, the nuclear medicine physicians expect that 50 percent of the visits to the SPECT/CT will be exchanges for current SPECT visits because they will be better served on the SPECT/CT. They expect the other 50 percent will be new volume of tests that currently are not being performed at the Medical Center.

Attachment 37, D. 20, Table 2
CAGR Projected Nuclear Medicine Visits, 2016 and 2019

Year	2010	2016 Second Full Year of Operation	Percent Change 2010 to 2016	Number of Rooms Justified in 2016	2019 Fifth Full Year of Operation	Number of Rooms Justified In 2019
IP Visits	7,740	6,863	-11.3	4	6,463	4
OP Visits	6,120	6,061	-1.0	3	6,031	3
Total Visits	13,860	12,924	-6.8	7	12,494	7

Source: ACMC records.

In recent years, some cardiologists have acquired nuclear medicine capability for their offices. As reimbursement declines, the scans being performed in physician offices may return to the hospital.

Impact of Health Care Reform

The Medical Center then conservatively applied a 15 percent growth factor to account for the implementation of national health care reform legislation. This factor increases total need for nuclear medicine cameras and a Gamma/CT to 8 units.

2016

12,924 nuclear medicine visits x 1.15 national health care reform factor = 14,863 visits

14,863 visits ÷2,000 visits per unit = 8 units

ACMC/AHCH Has Justified the Need for a Total of 7 Nuclear Medicine Gamma SPECT and Gamma SPECT/CT Cameras

To be conservative, the Medical Center is requesting 7 SPECT cameras and 1 SPECT/CT, or a total of 7 nuclear medicine units, 3 will be located in the hospital and 4 units will be located on Level 5 of the Ambulatory Pavilion.

By 2016, the second full year of operation of the Ambulatory Pavilion, the 7 units will be operating at 92.3 percent of the State Agency Standard.

12,924 visits ÷ 7 units = 1,846 visits per unit

This volume does not include the new SPECT/CT visits or the return of physician office visits. New SPECT/CT volume is expected to be between 1,800 and 2,000 visits per year. Of these 50 percent are expected to be new visits, or from 900 to 1,000 new visits.

If these visits are added to the projected 2016 volume, which doesn't account for these visits, the number of visits would approach 98.8 percent of the State Standard by 2016.

12,924 visits ÷ 1,000 new SPECT/CT visits = 12,924 visits

12,924 visits ÷ 7 cameras = 1,990 visits per camera
or 99.5 percent of the State Standard

Even this number is conservative because it does not include a factor for physician office visits that may return to the hospital.

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

NA. There is a State Standard for nuclear medicine. ACMC/AHCH's projected volume is consistent with the State Standard by the second full year of operation.

Clinical Service Area – Laboratory

Clinical List Designation F.21

c) Service Modernization

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

1) Deteriorated Equipment of Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

NA. The proposed development of laboratory space in the proposed Ambulatory Pavilion (Pavilion) on the campus of Advocate Christ Medical Center/Advocate Hope Children's Hospital (ACMC/AHCH, Medical Center) will not result in the replacement of equipment or facilities that have deteriorated and need replacement.

2) Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

The first level of the Ambulatory Pavilion will house a Pre-Admission Testing area. It will be located on the same level as radiology, pulmonary function and laboratory, all services that may be needed as part of a pre-admission testing visit.

The laboratory area will be a specimen collection area only. There will be 8 phlebotomy collection chairs – 4 for adults and 4 for children and 4 toilets with pass throughs – 2 for adults and 2 for children for a total of 12 specimen collection stations.

The area will be used by patients whose physicians are in the Pavilion as well as by walk-in patients who have physician orders for a laboratory test and that requires a specimen. The Medical Center is planning for 50 percent of the outpatient surgical patients to take advantage of this specimen collection area. The number of patients with physician orders has not been quantified.

The samples collected at the Level 1 specimen collection area will be transported by the pneumatic tube system to the main laboratory where they will be processed. The results will be returned to pre-admission testing or the physician using computers.

Attachment 37, F. 21 Table 1
Historical Utilization of Laboratory at ACMC/AHCH

Year	2008	2009	2010	Percent Change 2008-2010
IP Studies	1,322,650	1,260,495	1,273,468	-3.7
OP Studies	475,824	468,876	480,291	+0.9
Total Studies	1,798,474	1,729,371	1,753,759	-2.5
Percent OP Studies	26.5	27.1	27.4	+0.9

Source: ACMC records.

The purpose of Table 1 is to demonstrate that the Medical Center has a very active laboratory that is capable of meeting the needs of outpatients using the pre-admission testing service or of others coming to the Ambulatory Pavilion to have a physician's order filled.

To the degree that healthcare reform will provide care to additional covered lives and encourage preventive health services, most health care observers expect laboratory services to remain constant or increase slightly as access increases; growth will be limited by the mandate to manage health care resources and coordinate care.

A) Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

NA. There is no laboratory equipment in this project that meets or exceeds the major medical equipment threshold.

B) Service or Facility

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

There are no State Standards for laboratory utilization.

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

To determine how many specimen collections stations would be needed in 2016, the second full year of operation of the Ambulatory Pavilion, the Medical Center assumed that by 2016 that outpatient visits to the campus would increase by 10 percent from 300,390 in 2010.

300,390 outpatient visits x 1.10 percent increase = 330,429 outpatient visits

Next the Medical Center assumed that 40 percent of the visits would seek laboratory services at the Ambulatory Pavilion.

330,429 outpatient visits x 40 percent = 132,172 visits

The Medical Center further assumed that 10 percent of the patients accessing the laboratory specimen collection area would be walk-ins.

132,172 visits x 1.10 percent increase = 145,390 total visits

To determine the capacity that the lab would need to support this volume, the Medical Center first assumed that 6 visits could be accommodated per hour at each station and that the laboratory would operate 8 hours a day and 300 days a year.

6 visits x 8 hours x 300 days = 14,400 visits per collection station per year

145,390 visits ÷ 14,400 visits per stations = 11 stations

Finally, the Medical Center took into consideration that many tests would be fasting tests and that volume would not occur evenly across the day, but would be greater in the early hours. For that reason, the Medical Center is requesting 12 specimen collection stations.

ACMC/AHCH Has Justified the Need for a 12 Specimen Collection Stations

The Medical Center is proposing to develop 12 specimen collection stations in a satellite specimen collection area on Level 1 of the Ambulatory Pavilion.

By 2016, the 12 specimen collection stations will be operating at 11,015 visits per

station per year. If the guideline for Ambulatory Care Services is used, the Medical Center can justify 12 specimen collection areas.

132,172 visits ÷ 12 specimen collection stations =

11,015 visits per station per year

11,015 visits per station > State Standard of 2,000 visits per station

Clinical Service Area – Pharmacy

Clinical List Designation G.22

c) Service Modernization
The applicant shall document that the proposed project meets one of the following:

1) Deteriorated Equipment of Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

NA. The addition of satellite pharmacy space in the Ambulatory Pavilion (Pavilion) at the Advocate Christ Medical Center/Advocate Hope Children's Hospital (ACMC/AHCH, Medical Center) will not result in the replacement of equipment or facilities that have deteriorated and need replacement.

2) Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

The proposed satellite pharmacy will be located adjacent to the Infusion Center in the Cancer Institute on Level 8 of the Ambulatory Pavilion.

The drugs that are used for medical oncology treatments and for oncology clinical trials must be compounded immediately prior to treatment. The drugs must be prepared by skilled pharmacists in dedicated space with special exhaust hoods. The pharmacy in the Pavilion will have 3 hoods in which to prepare the drug mixtures as well as secure storage for clinical trial drugs and refrigerator/freezer storage for other drugs.

The chemotherapy drugs cannot be prepared in the main pharmacy and transported to the Ambulatory Pavilion because they could cause a safety hazard. These potent chemotherapy drugs could cause harm if they were to be spilled.

The satellite pharmacy will also provide drugs for surgery and the CHF Clinic in addition to the chemotherapy preparation area.

A) Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

NA. There is no pharmacy equipment in this project that meets or exceeds the major medical equipment threshold.

B) Service or Facility

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

There are no State Standards for pharmacy volume.

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

The demand for pharmacy services is directly related to the proposed number of medical infusion/chemotherapy treatments. As shown below, adult infusion therapy is projected to have very strong growth as innovative and more effective chemotherapy agents become available and allow more treatments to move the outpatient setting.

Attachment 37, G.22, Table 1
Current and Projected Adult Infusion Therapy Visits, 2010 and 2016

Year	2010	2016	Percent Change
IP Visits	--		
OP Visits	15,678	31,650	+101.9
Total Visits	15,678	31,650	+101.9

Source: ACMC records.

Today, the Infusion Center treats about 50 patients a day; by the second full year of operation of the Ambulatory Pavilion, that number is projected to double. Having the

drugs prepared near the stations where they are administered also reduces wait time for patients. Patients appreciate shorter wait times between results reporting on blood work and the administration of chemotherapy drugs; the shorter wait times also increase the utilization of the chemotherapy chairs.

ACMC/AHCH Has Justified the Need for a Satellite Pharmacy in the Ambulatory Pavilion

To ensure the safety of other patients, visitors and staff and to reduce wait times and concurrently increase patient satisfaction and area productivity, it is essential to have a satellite pharmacy. The pharmacy will also support other services in the Ambulatory Pavilion including surgery and the CHF Clinic.

c) Service Modernization

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

1) Deteriorated Equipment of Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

NA. The proposed project will not result in the replacement of equipment or facilities that have deteriorated or need replacement.

2) Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

Advocate Christ Medical Center/Advocate Hope Children's Hospital (ACMC/AHCH, Medical Center) provides inpatient and outpatient rehabilitation services for pediatric and adult patients. The rehabilitation services include physical therapy, occupational therapy, speech therapy, audiology, wound therapy, and occupational health/Workman's Compensation-related rehabilitation.

Patients utilize the Medical Center's rehabilitation services to regain their strength and physical capabilities and rebuild their lives following a significant injury or illness. Rehabilitation services are provided by multidisciplinary teams of physiatrists and therapists who design and coordinate treatment plans to maximize the functional capabilities of the patients and reintegrate them into the community.

The Medical Center has a 37-bed inpatient rehabilitation unit that reported over 90 percent occupancy in 2010. Many cardiac, oncology and orthopedic inpatients are seen

as outpatients in the therapy areas following their inpatient rehabilitation care. Other patients begin rehabilitation regimens as outpatients.

Space for rehabilitation services is very limited on the Oak Lawn campus. As demand for rehabilitation therapy increased, the Medical Center developed satellite outpatient rehabilitation centers. Each of these was designed to serve a local area with a 5-mile radius from the site. Today there are busy outpatient rehabilitation services in Tinley Park, Palos Heights and Lockport.

Attachment 37, H. 23, Table 1
Utilization of 15 Minute Treatment Modules of Services ACMC/AHCH Outpatient Rehabilitation Services, 2010

Location	IP Modules		OP Modules		Distance from Oak Lawn Campus	
	2009	2010	2009	2010	Distance in Miles	Travel Time in Minutes
ACMC-Adult	156,095	158,108	34,711	29,067	-	-
AHCH-Pediatric	9,386	8,604	11,493	13,291	-	-
Tinley Park	-	-	7,609	11,999	7.02	17
Palos Heights	-	-	37,427	35,799	15.97	32
Lockport	-	-	-	8,331	21.66	40
Total OP in Satellite Locations	-	-	45,036	56,129	-	-

Source: ACMC records.

In 2010, the Medical Center, Tinley Park and Palos Heights operated at capacity; they had waiting lists, especially for children. The Lockport facility was projected to have 9,481 treatment modules by 2012; it reached 87.9 percent of that projection during its first full year of operation and is expected to be at capacity by the time the Ambulatory Pavilion opens.

Even with the strong increase in volume at the satellite facilities, volume at the Oak Lawn campus remained strong. As outpatient volume shifted to the satellite facilities, it was replaced by additional inpatient volume. Even with the community-based outpatient centers, outpatient capacity will always be needed at the Oak Lawn campus for at least two reasons. First, more specialized outpatient care is provided at the

Medical Center. Second, the Medical Center serves its own local community (those within 5 miles of the site), and especially those residing north and east of the hospital.

Rehabilitation patients often prefer to use an outpatient rehabilitation service that are located in their community, one that is easy to access and has convenient, ample parking near the entrance to the facility. Convenient access encourages compliance with rehabilitation treatment regimens; compliance improves outcomes.

Outpatient rehabilitation utilization is counted in terms of modules, or 15 minute blocks of rehabilitation activities.

Attachment 37, H. 26 Table 2
Utilization of 15 Minute Treatment Modules of
Outpatient Rehabilitation Services at ACMC/AHCH

Year	2008	2009	2010	Percent Change 2008-2010
Adult IP Modules	156,173	156,095	158,108	+1.2
Adult OP Modules	36,589	34,711	29,067	-20.6
Total Adult Modules	192,762	190,806	187,175	-2.9
Pediatric IP Modules	9,579	9,184	8,876	-4.1
Pediatric OP Modules	14,815	11,493	13,291	-10.6
Total Pediatric Modules	24,394	20,677	22,167	-9.1
Total OP Modules at ACMC/AHCH	51,514	46,204	42,358	-17.8
Total OP Modules at Satellite Locations	NA	45,036	56,129	--
Total OP Modules	51,514	91,240	98,487	+91.2

Source: ACMC records.

Although outpatient rehabilitation utilization is modestly declining at the Medical Center, total outpatient rehabilitation modules at the Medical Center's community rehabilitation facilities have increased 24.6 percent between 2009 and 2010. The outpatient rehabilitation sites are all operating at capacity except Lockport; if current trends continue, Lockport will also be at capacity by 2016, the second full year of operation of the Pavilion. Additional capacity is needed; the best location to provide that capacity is the Ambulatory Pavilion. The Oak Lawn location will serve service

area residents to the north and east of the hospital; the other outpatient sites are to the south and west. Further, by shifting outpatient volume to the Pavilion, the existing rehabilitation space will be able to better accommodate the high volume of inpatients.

Some industry experts expect adult and pediatric rehabilitation services to grow more than 30 percent over the next decade. Several factors will drive the increase including aging population, increasing obesity, as well as the improving survivability rate of complex pediatric diseases, stroke, and other chronic diseases. Technology will also affect the demand for rehabilitation services. For example, partial joint replacement will reduce the number of joint procedures requiring inpatient rehabilitation, returning military will require rehabilitation and prosthetics care, and obesity will increase the duration of outpatient rehabilitation. To some degree, stem cell and gene therapy may decelerate the progression of degenerative diseases and may offset some of the growth factors.

The implementation of national health care reform will place additional demands on rehabilitation services, and especially outpatient services. Appropriate outpatient rehabilitation services can preclude hospital admissions for acute musculoskeletal conditions, thereby reducing surgeries and the cost of an inpatient stay. In addition, post-acute outpatient rehabilitation can reduce average length of stay and readmissions.

3) Utilization

A) Major Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

NA. There is no rehabilitation equipment in this project that meets or exceeds the major medical equipment threshold.

B) Service or Facility

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

There is no State Standard for utilization of outpatient rehabilitation services. Outpatient rehabilitation is considered an Ambulatory Care Service; there is a State Standard for Ambulatory Care Services and it is 2,000 visits per unit.

Current utilization of inpatient and outpatient rehabilitation services as well as the implementation of future utilization under national health care reform are described in Section 2) c).

The following calculations were used to quantify the range of future need for outpatient rehabilitation services.

Current Utilization

Between 2008 and 2010, the Medical Center provided outpatient rehabilitation services at multiple sites; in total, these sites reported a 91.2 percent increase in utilization. Four of the sites operated at capacity and the fifth has achieved 87.9 percent occupancy in its first full year of operation. Current utilization supports the expansion of outpatient rehabilitation services. The most appropriate site to expand these services is in the Ambulatory Pavilion because it will meet the needs of the local patients (those within 5 miles of the Medical Center and especially to the east and north of the site) as well as those with needs requiring complex rehabilitation care. Further expansion to the Pavilion will relieve capacity constraints for inpatients.

Projected Need

The Medical Center prepared CAGR (compound average growth rate) trend lines based on 10 years of historical data and extended to 2019 in order to determine the impact of growth and aging on future outpatient rehabilitation utilization. The CAGR trend line suggests that by 2016 the Medical Center could expect as many as 57,134 adult and pediatric outpatient modules of service.

Rehabilitation modules are converted to visits using a factor of 2.5 modules per visit. The number of projected modules converts to 22,854 visits.

$$57{,}134 \text{ modules} \div 2.5 = 22{,}854 \text{ visits}$$

Attachment 37, H. 23, Table 3
CAGR Projected Outpatient Rehabilitation Modules, 2016 and 2019

Year	2010	2016 Second Full Year of Utilization	Percent Change 2010 to 2016	Number of Rooms Justified 2016	2019 Fifth Full Year of Utilization	Number of Rooms Justified in 2009
IP Modules/Visits	164,984/ 65,994	187,730/ 75,092	+13.8	38	199,450/ 79,780	40
OP Modules/Visits	42,358/ 16,943	57,134/ 22,854	+34.9	12	71,449/ 28,580	15
Total Modules/Visits	207,342/ 82,937	244,864/ 97,947	+18.1	49 to 50	270,899/ 108,360	55

Source: ACMC records.

However, projected volume based on historical experience substantially underestimates the need for outpatient rehabilitation services when the space in the Ambulatory Pavilion becomes available. These additional outpatient rehabilitation services include the following:

1. Adult Speech Therapy

   The Medical Center is a Primary Stroke Center and one of the largest stroke programs in Illinois.

   Many stroke patients need extensive speech therapy. Currently the speech therapy space is shared by inpatients and outpatients. The amount of space allocated for outpatient speech therapy is inadequate to meet current need.

   Adult outpatient speech therapy typically has a waiting list of from 18 to 20 patients; the delay in serving these patients is usually from 4 to 6 weeks.

   With adequate capacity in the Ambulatory Pavilion, the Medical Center expects to accommodate approximately 1,420 additional modules of service, or the equivalent of 1,420 total annual visits.

2. Physical Therapy and Occupational Therapy

   Outpatient physical therapy and occupational therapy space is extremely limited and shared with inpatient unit physical therapy (PT) and occupational therapy

(OT). Because of the shared limited space, the area can only support single pieces of equipment such as stairs and parallel bars. Because of these limitations, many outpatients forego a complete rehabilitation course of treatment due to waiting for equipment to become available during treatment sessions. In the Pavilion, there will be adequate equipment and the Medical Center projected approximately 6,084 additional physical therapy modules, or the equivalent of 2,434 visits.

3. Lymphedema Care

Lymphedema refers to a swelling that generally occurs in a patient's arms or legs. Lymphedema is caused by a blockage in the lymphatic system, an important part of the immune and circulatory systems. The blockage prevents lymph fluid from draining, and as the fluid builds up, the swelling continues. The swelling is very painful and limits functional ability and safety of the patient. Cancer patients often experience lymphedema.

Although there is no cure for lymphedema, treatment focuses on reducing the swelling and controlling the pain. A physical therapist uses manual lymphatic drainage techniques to drain fluid out of the limb followed by specialized wrapping to maintain the decreased swelling.

The Medical Center has advanced cancer programs for adults and children. Many of these patients benefit from the support of physical therapists to provide manual lymphatic drainage, wrapping, teaching of wrapping, and care of the limb. Ultimately the therapist recommends a compression garment when the circumference of the limb is at a functional level.

At the present time, there are many lymphedema patients that would benefit from additional rehabilitation care, with from 10 to 13 patients waiting for services. The delay in servicing these patients is 6 to 8 weeks or more. The current limited space which is shared with other therapy patients does not permit the therapists treatment space to see additional patients as the treatment sessions for these patients are from 60 to 90 minutes.

At the opening of the Ambulatory Pavilion there will be adequate space to treat lymphedema patients. Projected unmet need translates into approximately 9,252 additional physical therapy modules, or the equivalent of 3,100 visits.

4. Adult Physical and Occupational therapy Evaluations

Outpatient PT and OT services do not have adequate space for evaluation of patients. The physical therapy area is shared with inpatient physical therapy; the occupational therapy area has a single table to provide evaluation and treatment. The current limited space has patients waiting
3 weeks for a therapy evaluation due to the facility constraints.

In the Ambulatory Pavilion patients will get a physical or occupational therapy evaluation within the week of the patient calling for services, providing timely and necessary services for patients who have had rehabilitation or surgeries in the hospital. These additional evaluations will provide 5,250 additional treatment modules, or the equivalent of 1,500 visits.

5. Pediatric Sensory Care

Pediatric sensory therapeutic interventions will be a new service for outpatient rehabilitation. Often babies born prematurely have severely delayed sensory systems; these children have difficulty functioning well in a normal environment. Therapists use techniques with these children to align the sensory system during a treatment session and subsequently facilitate other treatment objectives. Also, the sensory room will be utilized in the occupational therapy treatment for autistic children.

The physicians at Advocate Christ Medical Center deliver more than 4,000 normal and high risk infants each year. Not only infants from the ACMC/AHCH program, but also babies born at other regional facilities have delayed sensory systems. In the Pavilion outpatient rehabilitation space, there will be a special "Pediatric Sensory Room" with the quiet environment and special equipment to restore these children to a more normal lifestyle. Discussions with the Medical Center's neonatologists suggest that outpatient rehabilitation will receive referrals for about 75 of these children each year.

These children will require approximately 3,600 modules of care over the course of their therapy. This converts to 900 visits.

6. Pediatric Speech Therapy.

Advocate Hope Children's Hospital and the physicians at Advocate Christ Medical Center provide inpatient care for almost 3,500 children each year. Many premature children or children with other impairments are referred to pediatric speech therapy for swallowing evaluations and treatment services. In 2011, the State changed the early intervention program and children requiring swallowing therapy are no longer seen in the home for speech therapy services if they have a feeding tube. These children often need speech therapy services to work with the family on improving and facilitating swallowing in the future and to eventually removing the tube and/or improving quality of life with oral feeding.

The current pediatric speech therapy space is limited to 7 patients per day. The number of parents needing these services far exceeds this visit number. The department has 20 to 30 patients waiting for 8 to 12 weeks for appointments.

At the opening of the Ambulatory Pavilion it will have adequate space to treat pediatric speech patients; the projected unmet need translates into approximately 1,715 additional speech therapy modules, or the equivalent of 1,715 visits.

In summary, the expanded space for Outpatient Rehabilitation in the Ambulatory Pavilion will allow the department to provide 11,069 additional visits that are not accounted for in the initial CAGR projection.

Service	Modules	Additional Visits
Adult Speech Therapy	1,420	1,420
Physical Therapy and Occupational Therapy	6,084	2,434
Lymphedema Care	9,252	3,100
Adult Physical Therapy and Occupational Evaluation	5,250	1,500
Pediatric Sensory Care	3,600	900
Pediatric Speech Therapy	1,715	1,175
Total	**27,321**	**11,069**

Total volume based on current experience as well as additional visits that are not accounted for in the initial projection is 33,923 visits.

22,854 base line projected visits + 11,069 additional visits = 33,923 visits

Impact of National Health Care Reform

The Medical Center then conservatively applied a 15 percent growth factor to account for the implementation of national health care reform legislation. This calculation increases potential visits to 39,012 visits by 2016.

2016 Outpatient Rehabilitation

33,923 visits x 1.15 = 39,012 visits

ACMC/AHCH Has Justified the Need for 16 Outpatient Rehabilitation Rooms

The Medical Center is proposing to build 16 outpatient rehabilitation rooms including 4 private therapy rooms, 3 gyms for physical therapy, 3 occupational therapy rooms, 4 speech and language therapy rooms, 1 pediatric sensory room, and 1 audiology room.

Current and new volume will be 33,923 visits by the end of the second year of operation of the Ambulatory Pavilion. Outpatient Rehabilitation is an Ambulatory Care Service with a target utilization of 2,000 visits per room.

33,923 outpatient rehabilitation visits ÷ 2,000 visits per room = 17 rooms

17 justified rooms > 16 proposed rooms

On average, each of the proposed rooms will operate at 2,120 visits per room

33,923 visits ÷ 16 rooms = 2,120 visits per room

2,120 visits per room > State Standard of 2,000 visits per room

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

There is a State Standard for Ambulatory Care Services; ACMC/AHCH will exceed the Standard by the second full year of operation.

Clinical Service Area – Cardiac Rehabilitation

Clinical List Designation H.24

c) Service Modernization
The applicant shall document that the proposed project meets one of the following:

4) Deteriorated Equipment of Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

NA. The proposed project will not result in the replacement of equipment or facilities that have deteriorated or need replacement. Today, the adult cardiac/pulmonary rehabilitation program at Advocate Christ Medical Center/Advocate Hope Children's Hospital (ACMC/AHCH, Medical Center) is severely undersized. The exercise gym is too small to support current volume. The current Cardiac Rehabilitation area is located adjacent to the Emergency Department. After outpatients are relocated to the Ambulatory Pavilion, the existing area will continue to be used for inpatients.

4) Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

Both cardiac and pulmonary rehabilitation services are part of Cardiac Rehabilitation at the Medical Center. The Cardiac Rehabilitation staff members are experienced in caring for people who have a history of cardiovascular or pulmonary disease as well as those who are at risk for developing these conditions.

Cardiac rehabilitation is an essential aspect in the continuum of care provided in the Medical Center's Heart and Vascular Institute.

The goals of cardiac and pulmonary rehabilitation are to:

- Increase the patients' lifespans

- Improve quality of life
- Help patients adjust physically and psychologically to heart or pulmonary illness
- Improve exercise tolerance
- Reduce cardiac or pulmonary symptoms
- Reduce cardiac or pulmonary risk factors to help prevent future cardiac events or the progression of pulmonary disease
- Provide education and counseling to improve the patients' understanding of their condition, and
- Provide guidance on return to work, when appropriate.

Physicians recommend cardiac or pulmonary rehabilitation for patients who had angioplasty, heart attack, congestive heart failure, heart surgery, asthma, bronchiectasis, chronic bronchitis, chronic lung disease, cystic fibrosis, emphysema, occupational/environmental lung disease, respiratory failure, and sarcoidosis.

Cardiac or pulmonary rehabilitation usually begins after the patient has suffered a major cardiac or pulmonary event and while the patient is still hospitalized (Phase I). Inpatient cardiac rehabilitation is most commonly delivered in the patient's room. Bedside activity as well as patient and family education can take place there while more progressive ambulation can be carried out in adjacent hallways. The Phase I patients are telemetry monitored to assess response to activity progression. Phases II and III continue with monitored programs in the outpatient setting until home maintenance programs can be safely followed. Both the American Heart Association and the American College of Cardiology strongly recommend cardiac rehabilitation programs.

Attachment 37, H.24 Table 1
Historical Utilization of Adult Cardiac Rehabilitation
at ACMC/AHCH

Year	2008	2009	2010	Percent Change 2008-2010
IP Visits	3,605	3,555	3,366	-6.6
OP Visits	11,859	12,183	12,162	+2.6
Total Visits	15,872	15,738	15,538	-2.1
Percent OP Visits	74.7	77.4	78.3	+3.6

Source: ACMC records.

As shown in Attachment 37, H.24, Table 1, the essentially stable utilization of outpatient cardiac rehabilitation services reflects the extremely limited space available in which to provide this service. For example, in the current location, the circulation space between the pieces of equipment is not adequate. The severe space limitation results in access being denied to patients who would benefit from the program. To be able to optimize the use of the space, Cardiac Rehabilitation now operates 6 days a week. Further, Advocate developed a satellite cardiac rehabilitation center in Palos Heights to service that community and relieve space on the Medical Center campus.

Cardiac and pulmonary rehabilitation have demonstrated their efficacy in improving heart and lung function thereby reducing readmission rates, and individual health status. These outcomes improve quality of life and reduce chronic-disease related health costs. As such, the continued shift from inpatient to outpatient rehabilitation and more patients being referred to this program will translate into an increase in cardiac and pulmonary rehabilitation visits as national health care reform is implemented.

Utilization

A) Major Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

NA. There is no cardiac rehabilitation equipment in this project that meets or exceeds the major medical equipment threshold.

B) Service or Facility

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

Utilization of inpatient and outpatient cardiac/pulmonary rehabilitation services as well as the implications for future utilization under national health care reform are described in Section c) 2).

The following calculations were used to quantify the range of future need for cardiac and pulmonary rehabilitation visits. Cardiac Rehabilitation is an Ambulatory Care Service; the State Standard for Ambulatory Care Services is 2,000 visits per key room. The key room in Cardiac Rehabilitation is the gym.

Current Need

If the State Standard for Ambulatory Care Services is used, the current outpatient utilization of Cardiac Rehabilitation (including both cardiac and pulmonary patients) justifies the need for 7 rooms. The Medical Center is proposing to develop only one large gym in the Pavilion.

12,162 outpatient visits ÷ 2,000 visits per room = 7 gyms/exercise rooms

Projected Utilization

Current utilization of Cardiac Rehabilitation justifies the proposed gym. Even so, the Medical Center prepared CAGR trend lines based on 10 years of historical data and extended to 2019 in order to determine the impact of aging and increasing incidence of heart and lung disease as well as the continued development of the Heart and Vascular Institute. The outpatient trend line suggests that by 2016, the Medical Center could anticipate at least 12,989 cardiac and pulmonary outpatient rehab visits. These visits would be accommodated in the proposed new gym.

Attachment 37 H. 24, Table 2
CAGR Projected Cardiac Rehabilitation Visits, 2016 and 2019

Year	2010	2016 Second Full Year of Utilization	Percent Change 2010 to 2016	Number of Rooms Justified in 2016	2019 Fifth Full Year of Utilization	Number of Rooms Justified in 2019
Inpatient Visits	3,366	3,330	- 1.6	2	3,313	2
Outpatient Visits	12,162	12,989	+10.4	7	13,424	7
Total Visits	16,538	16,320	+1.2	9	16,736	9

Source: ACMC records.

Impact of National Health Care Reform

Finally, the Medical Center applied a 15 percent growth factor to account for the implementation of national health care reform. This factor increased outpatient projected volume to 12,989 visits and 16,320 total visits in 2016.

2016 Outpatient

12,989 visits x 1.15 national health care reform factor = 14,938 visits

14,938 visits ÷2,000 visits per room = 8 rooms

ACMC/AHCH Has Justified the Need for 1 Cardiac/Pulmonary Room

Although the State Standard would allow many rooms, the reality of cardiac/pulmonary rehabilitation is that all the visits will occur in 1 gym, a large gym with exercise equipment. The current cardiac rehabilitation area can only support 15 pieces of exercise equipment; the proposed new gym will be able to support 25. Cardiac Rehabilitation will be located on Level 6, the Heart and Vascular Institute.

By 2016, the second full year of operation of the Ambulatory Pavilion, the gym in Cardiac Rehabilitation will be operating above the State Standard.

2016 Outpatient

12,989 outpatient visits ÷ 1 gym = 12,989 visits per gym

12,989 visits per gym > State Standard of 2,000 visits per room

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

There is no State Standard for Cardiac Rehabilitation; there is a State Standard for Ambulatory Care Services. ACMC/AHCH currently exceeds the State Standard.

Non-Clinical Service Areas

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

30. Institutes & Physician Offices

The hallmark of the Ambulatory Pavilion is that it will be the home of three major institutes, where physicians are supported by multidisciplinary teams of professionals to provide diagnosis and treatment. The physicians' offices are presently in multiple locations throughout the hospital. The patient must find the physician and then find the diagnostic services and the places where treatment can be given. Through this Ambulatory Pavilion project, the physicians will be located near the key diagnostic services and therapies essential to their programs of care. There are over 300 physicians plus residents and medical students who will see patients. The patients will then have access to their physician and to the patients' services, all in one location. This model of care is more efficient for the patient and for all of the people providing their care.

The Heart and Vascular Institute at the Medical Center offers a full spectrum cardiovascular program to Illinois residents, including preventive, diagnostic, interventional, surgical, and transplant services. It is one of four programs in Illinois with an advanced certification in ventricular assist deice, and one of two programs with an advanced certification in heart failure from The Joint Commission. ACMC/AHCH performs more heart surgeries on adults and children than any other hospital in northern Illinois and the most open heart surgeries than any other hospital in Illinois.

Physicians in the Heart and Vascular Institute represent the first team in the United States to implant a HeartMate II® ventricular assist device (VAD), offering another option to advanced stage heart patients who do not respond to conventional therapy. It also features the first team in Illinois to perform robotic mitral valve repair surgery.

The nationally renowned team of cardiologists, cardiovascular surgeons, advanced practice nurses, interventionalists, psychologists, dietitians,

pharmacists, and physical and occupational therapist bring an interdisciplinary approach to treating all aspects of cardiac care.

The Neuroscience Institute at the Medical Center integrates a full array of treatments and expertise to address the many dimensions of neurologic care for adults and children. The physicians and their multidisciplinary team of professionals will be located on the seventh floor near the clinical services of Outpatient Rehabilitation, the Pain Center, and Neurodiagnostics.

Their accredited primary stroke center treats more patients than anywhere else in the Chicago area. The multiple sclerosis program at Advocate Christ Medical Center is one of eight in Illinois designated as a National Multiple Sclerosis Society treatment center. The physicians are noted for caring for head and spine traumas.

The Cancer Institute at the Medical Center provides the most advanced diagnostic and treatment options for the full range of routine or complex cancers. The oncologists and other oncology specialists, along with their multidisciplinary team of professionals, will be in a Center on the eighth floor near the clinical services of Adult Infusion and a Satellite Pharmacy. The team will also have easy access to the research and education components.

The physicians have a longstanding reputation in the Chicagoland area for seeing and treating newly diagnosed lung cancers and among the biggest programs in Illinois for breast and pediatric cancers. The Medical Center has earned designation as a cancer teaching hospital by the American College of Surgeons, the highest-possible designation for a non-university program. There is a strong commitment to preventing cancer before it even begins, with dedicated programs for cancer screening and educational programs.

The Women's Center addresses women's health care needs across the life span. Its role is to educate women about the state-of-the-art options available. The Women's Center has specialists in obstetrics, gynecology, high risk obstetrics, gyne-oncology, and maternal fetal medicine to address the wellness concerns of women and their families. They will reside on the Ground level of the Ambulatory Pavilion near the clinical services of Fetal Diagnostics.

Their obstetrician/gynecologists conduct annual exams and help a patient plan her pregnancy and delivery. Sometimes, help is needed to start a family. The Women's Center is staffed with reproductive endocrinologists and other specialists in the areas of prenatal testing, high risk pregnancy and genetic counseling to give nature a helping hand. More than 4,000 families choose ACMC/AHCH each year as the place to have their babies - second in the Chicagoland area

31. Lobby, Public Areas, Resource Center, & Winter Garden

These locations in the Ambulatory Pavilion make it easier for patients and those accompanying them to enter and find accommodations. This category of space includes comfortable waiting areas and nearby toilets. The Resource Center will be a location where a patient can find material related to health and life style. The Winter Garden is a location with windows and comfortable seating to enjoy a nice view while waiting for an appointment or between treatments.

32. Registration and Financial Counseling

Registration will be located throughout the building on each level. The site on the Ground level is where a patient will establish a record if they are coming for their first visit to the Ambulatory Pavilion. Thereafter, with pre-registration, a patient can go directly to the department where he is going to receive care, and check in there. With all the complexities of insurance, Medicare, and Medicaid, there will be financial counselors available to help a patient or family.

33. Shell Space

The need for future growth of the ambulatory services was apparent as planning was done. To accommodate that growth in the most cost effective way involves building space today with this project, and shelling it to be ready for the build out when the demand and the specific programs are better known. During the construction phases in the next building project, the space will be used for staging. More detail is shown in Attachment 16.

34. Administration

Areas designated as Administration are in various locations throughout the Ambulatory Pavilion, where management will be located to direct and support

operations. The work entails directing staffing, resource management, process management, and strategic planning.

35. Research and Education

The Institutes currently conduct a significant amount of medical research and education. The space to house the researchers, their technical staff, and the systems to support them have been specifically designated in the Heart and Vascular Institute and the Cancer Institute. As referenced in the rest of the application, this is a teaching hospital with 400 residents, 600 medicals students, 800 nursing students, and over 2,000 emergency medical technician students. The need for research and teaching space is critical for those programs. There are numerous clinical trials underway that are managed by government agencies, educational institutions, private corporations, and pharmaceutical companies to evaluate the effectiveness of new therapies and medications.

36. Electronic Medical Record Support

This area will house the computer system that will control the electronic aspect of the medical record. This initiative is linked to Health Reform and will make it much easier for a patient to access, understand, and manage his own health information.

37. Materials and Environmental Services

The EVS areas support the departments near them, primarily for linens, supplies, cleaning, and maintenance of the area. Materials Management will be responsible for receiving, breakdown, storage and movement of supplies through the Ambulatory Pavilion.

38. Circulation/Connector/Pneumatic Tube

These sections of the building are the passageways that help move people through the Ambulatory Pavilion to get to the departments. The stairs are part of the circulation area. A connection from the Ambulatory Pavilion to the existing hospital will permit the unimpeded movement of patients, physicians, and other clinical support staff between the two sites. The pneumatic tube system is an essential mover of paper and small items, saving the staff untold hours of walking to make a delivery several floors away.

At the point where the connector enters into the existing hospital, there will be some modernization work done to open up a passageway and leave the area with a good traffic flow.

39. Lobby Café

This area is a welcoming place where patients and guests can stop to get a quick meal or refreshment. It is on the Ground level next to a large lobby. There will not be any cooking at this site so a kitchen will not be needed. Fresh salads, sandwiches, soups, and desserts will be available to patrons, along with a friendly place to sit and enjoy the food.

40. Retail Pharmacy

There will be a retail pharmacy available on the second floor. This will provide convenience for the patients who want to pick up their prescription before leaving the Ambulatory Pavilion. This is a new service for Advocate Christ Medical Center and will likely be a benefit for employees as well as patients.

41. Mechanical and Interstitial Spaces

The mechanical support for the whole building will come from the areas designated as mechanical. About 40 percent of the Ground level and the entire Fourth level will be devoted to mechanical use. That includes the heating, ventilation, and cooling systems as well as the vacuum and vertical systems. The efficiency of operating the building is linked to the quality of the mechanical systems installed, operated and maintained.

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

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

VIII. - 1120.120 - Availability of Funds **This section is not applicable. Advocate Health and Hospitals Corporation bonds have been rated by Fitch as AA, and by Standard and Poor's as AA which qualifies the applicants for the waiver**

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

_____	a) Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b) Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c) Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
_____	d) Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions.
_____	e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
_____	f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
_____	g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
	TOTAL FUNDS AVAILABLE

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

FitchRatings

FITCH AFFIRMS ADVOCATE HEALTH CARE'S (IL) RATINGS AT 'AA/F1+'; OUTLOOK STABLE

Fitch Ratings-Chicago-01 February 2011: Fitch Ratings, as part of its ongoing surveillance effort, has affirmed its 'AA' ratings on approximately $995.4 million revenue bonds issued through the Illinois Health Facilities Authority and the Illinois Finance Authority on behalf of Advocate Health Care Network (Advocate).

In addition, Fitch affirms its 'F1+' short-term ratings on the following bonds based on self liquidity provided by Advocate:

--$43,225,000 Illinois Finance Authority revenue bonds, series 2008A-2;
--$51,140,000 Illinois Finance Authority revenue bonds, series 2008A-1;
--$51,145,000 Illinois Finance Authority revenue bonds, series 2008A-3;
--$27,695,000 Illinois Health Facilities Authority revenue bonds, series 2003C.

The Rating Outlook is Stable.

RATING RATIONALE:
--Advocate's modest debt burden combined with strong operating profitability has resulted in very strong coverage of maximum annual debt service (MADS) of 7.4 times (x) and 6.4x in 2009 and 2008, respectively.
--Advocate has substantial balance sheet strength with liquidity indicators (255 days cash on hand [DCOH], 42.9x cushion ratio and 258% cash to long-term debt) that handily exceed Fitch's 2009 'AA' category medians.
--Advocate Health Network is the largest healthcare provider in the State of Illinois and maintains a leading market share that is more than double its nearest competitor in the highly competitive Chicago metropolitan area.
--Advocate's integrated delivery approach includes employed and aligned physician staff which allows for effective managed contracting.

OUTLOOK:
--Advocate's leading market position combined with its employed and aligned medical staff is expected to sustain historical operating performance over the outlook period.

SECURITY:
The bonds are secured by a pledge of gross revenues of the obligated group, and a debt service reserve fund on the series 1993C bonds.

CREDIT SUMMARY:
The 'AA' rating reflects Advocate's low debt burden and strong operating profitability, robust liquidity position, a leading market position in the Chicago metropolitan area and the benefits of its aligned medical staff. Advocate's debt burden remains among the lightest in Fitch's health care portfolio. In 2009, MADS as percentage of revenues was just 1.5% and debt equated to 2.0x EBITDA; both of which are lighter than the 'AA' category medians of 2.6% and 3.4x, respectively. Advocate's historical operating profitability has been solid and compares favorably to similar 'AA' category providers. In 2008 and 2009, Advocate generated operating EBITDA margins of 10.7% and 9.5%, respectively. Through the nine-months ended Sept. 30, 2010, Advocate generated $384 million of operating EBITDA on total revenues of $3.38 billion or an 11.4% margin. Advocate's solid profitability combined with its light debt burden results in robust MADS coverage of 7.4x and 6.4x in 2009 and 2008, respectively.

At Sept. 30, 2010, Advocate's unrestricted cash and investments totaled $2.66 billion, which is improved from $2.19 billion at Dec. 31, 2009. Liquidity metrics at Sept 30, are very strong with

255 DCOH, a cushion ratio of 42.9x and cash and investments equating to 258% of long-term debt; all of which handily exceed the respective 'AA' category medians of 214.7, 19.6x and 149.9%.

Advocate continues to be the market-share leader in the six-county Chicago metropolitan area with a 15.4% market share through June 30, 2010 compared with its closest competitor, Resurrection Healthcare (rated 'BBB+' by Fitch), with a 6.8% market share. Advocate has eight acute care hospitals located in and around the city of Chicago, forming a ring around the city. Advocate's flagship facilities (Advocate Christ Medical Center, Advocate Lutheran General Hospital, Advocate Good Shepherd and Advocate Good Samaritan) are located in desirable suburban locations and maintain leading market-share positions in their service areas. Furthermore, Advocate has created a highly aligned medical staff through its 775+ employed physician FTEs and its 3,400 member physician-hospital organization (PHO). Fitch views Advocate's physician alignment favorably as it allows for greater care coordination and more effective managed care contracting.

Fitch's main credit concern revolves around the highly competitive service area in Chicago and the poor political and legal environment in Illinois. Although Advocate is the overall market-share leader in Illinois, the system has formidable competition from an array of academic medical centers such as Northwestern Memorial Hospital, the University of Chicago Hospitals and Rush University Medical Center (rated 'A-' by Fitch), as well as several suburban community medical centers such as Central DuPage Hospital (rated 'AA' by Fitch), Northwest Community Hospital and Evanston Northwestern Hospital. Each of these competing hospitals has expansion projects currently underway. Advocate's service area is one of the least favorable political and medical malpractice environments in the nation for health care providers. Due to its size relative to others in the market, Fitch believes Advocate may be subject to greater scrutiny by political interests and regulatory agencies in Springfield, IL.

The 'F1+' rating reflects the strength of Advocate's cash and investment position to pay the cost of a mandatory tender on the series 2003C and 2008A-1, 2008A-2 and 2008A-3 multi-annual put bonds. At Dec. 31, 2010, Advocate's eligible cash and investment position available for same-day settlement (see Fitch's report 'Criteria for Assigning Short Term Ratings Based on Internal Liquidity' dated Dec. 29, 2009) would cover the cost of the maximum mandatory put on any given date well in excess of Fitch's criteria of 1.25x. Advocate has provided Fitch an internal procedures letter outlining the procedures to meet any un-remarketed puts. In addition, Advocate provides monthly liquidity reports to Fitch to monitor the sufficiency of Advocate's cash and investment position relative to its mandatory put exposure.

The Stable Outlook reflects Advocate's leading market position combined with its employed and aligned medical staff that is expected to sustain historical operating performance over the outlook period. Advocate's substantial liquidity provides a large cushion against any changes in reimbursement and operations.

Advocate is counter-party to three floating to fixed rate swaps with a total notional value of $326.3 million. The market to market on the swaps at Dec. 31, 2010 was approximately negative $44.1 million with required collateral posting of roughly $15.1 million.

Advocate is an integrated health care system composed of 10 acute care hospitals, two integrated children's hospitals, a home health agency and over 200 sites located throughout the Chicago metropolitan area and in Bloomington, IL. Total revenues in fiscal 2009 were $4.07 billion. Advocate's disclosure is outstanding and includes annual audited financial statements as well as quarterly unaudited balance sheet, income statement, cash flow statement, an extensive MD&A, and utilization statistics. The information is submitted to the nationally recognized municipal securities information repositories. In addition, management holds quarterly calls with rating agencies and annual calls with investors.

Contact:
Primary Analyst
Jim LeBuhn
Senior Director
+1-312-368-2059

Fitch, Inc.
70 W. Madison Street
Chicago, IL 60602

Secondary Analyst
Emily Wadhwani
Associate Director
+1-312-368-3347

Committee Chairperson
Emily Wong
Senior Director
+1-212-908-0651

Media Relations: Cindy Stoller, New York, Tel: +1 212 908 0526, Email: cindy.stoller@fitchratings.com.

Additional information is available at 'www.fitchratings.com'

This action was informed by sources of information identified in the Revenue-Supported Rating Criteria.

Applicable Criteria and Related Research:
--'Revenue-Supported Rating Criteria', dated 08 Oct. 2010.
--'Nonprofit Hospitals and Health Systems Rating Criteria', dated 29 Dec. 2009.
--'Criteria for Assigning Short Term Ratings Based on Internal Liquidity', dated 29 Dec. 2009.

For information on Build America Bonds, visit www.fitchratings.com/BABs.

Applicable Criteria and Related Research:
Revenue-Supported Rating Criteria
http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=564565
Nonprofit Hospitals and Health Systems Rating Criteria
http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=493186
Criteria for Assigning Short-Term Ratings Based on Internal Liquidity
http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=493176

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March 24, 2011

Illinois Finance Authority Advocate Health Care Network; System

Primary Credit Analyst:
Brian T Williamson, Chicago (1) 312-233-7009; brian_williamson@standardandpoors.com

Secondary Contact:
Suzie Desai, Chicago (1) 312-233-7046; suzie_desai@standardandpoors.com

Table Of Contents

Illinois Finance Authority
Advocate Health Care Network; System

Credit Profile

Illinois Fin Auth, Illinois
Advocate Hlth Care Network, Illinois
Illinois Finance Authority (Advocate Health Care Network)
Long Term Rating AA/Stable Affirmed

Rationale

Standard & Poor's Ratings Services affirmed its 'AA' long-term ratings and, where applicable, 'AA/A-1+' and 'AA/A-1' ratings on various series of bonds issued by the Illinois Finance Authority on behalf of Advocate Health Care Network (AHCN).

The 'A-1+' short-term component of the rating on the series 2003A 2003C, 2008A-1, 2008A-2, 2008A-3, and 2008C-3B bonds reflects the credit strength inherent in the 'AA' long-term rating on AHCN and the sufficiency of AHCN's unrestricted assets in providing liquidity support for the aforementioned bonds. Standard & Poor's Fund Ratings and Evaluations Group assesses the liquidity of AHCN's unrestricted investment portfolio to determine the adequacy and availability of these funds to guarantee the timely purchase of the bonds tendered in the event of a failed remarketing. Standard & Poor's monitors the liquidity and sufficiency of AHCN's investment portfolio on a monthly basis.

The 'A-1+' short-term component of the ratings on the issuer's series 2008C-1, 2008C-2A, and 2008C-2B bonds and the 'A-1' short-term component of the rating on the series 2008C-3A bonds reflect the standby bond purchase agreement (SBPA) in effect from various financial institutions (see the "Basis For Short-Term Ratings" section).

The 'AA' long-term ratings reflect AHCN's strength as Chicago's largest health system, with total operating revenue of $4.5 billion in 2010 and a balance sheet with $6.7 billion of total assets. Total long-term debt in 2010 was $1.041 billion. This includes debt classified on the audited financial statements as current liability subject to short-term remarketing agreements, which Standard & Poor's treats as long-term debt for the purpose of our debt-related ratios.

The 'AA' long-term ratings further reflect AHCN's:

- Continued leading 15.6% market share through the first nine months of 2010, driven by increased utilization at most of its hospitals;
- Position as Chicago's largest and most successfully integrated health delivery system, with approximately 3,400 licensed beds and more than 5,400 physicians on the active staff of its hospitals, 3,400 of whom are affiliated with Advocate Health Partners, a managed-care contracting affiliate of AHCN;
- Good financial profile, with a 7.4%% operating margin for fiscal 2010;
- Strong 13.7x debt service coverage ratio for fiscal 2010; and
- Good 23.3% leverage and liquidity of 250 days' cash on hand at Dec. 31, 2010.

AHCN's challenges include very strong competition in the greater Chicago market and the contemplated issuance of new debt in fiscal 2011. We will review the rating once plans are finalized, but there is currently room at the existing rating for the issuance of new debt.

AHCN provides a continuum of care through its 10 general acute-care hospitals and two integrated children's hospitals, with approximately 3,300 licensed beds, primary and specialty physician services, outpatient centers, physician office buildings, home health, and hospice care throughout the metropolitan Chicago area and central Illinois. AHCN has approximately 5,400 physicians on staff. Through a long-term academic and teaching affiliation with the University of Illinois at Chicago Health Sciences Center, AHCN trains more resident physicians than any non-university teaching hospital in Illinois. We also note that in 2010, Advocate Good Samaritan Hospital was one of seven organizations to receive the Malcolm Baldridge National Quality award. In January 2011, SDI Health ranked AHCN 10th among the nation's top 100 integrated health care networks. (The SDI IHN Rating System rates local and regional, non-specialty integrated healthcare networks on their performance and degree of integration.)

During fiscal 2010, AHCN saw its admission increase by 9.1%, primarily from the acquisition of BroMenn in late fiscal 2009. However, if we disregard the admissions for BroMenn, AHCN's utilization was still up by 2.2% because of growth in its south suburban Chicago market and continued growth at Advocate Condell Medical Center.

AHCN's operating margin continued to be strong in fiscal 2010. For the year, AHCN posted an operating margin of 7.4% compared with 6.1% for fiscal 2009. Management states that the strong operations resulted from the addition of BroMenn and improved utilization at its previously owned and operated facilities along with slower growth in its expense base rose. Management has continued its focus on expenses and saw the expense base, excluding BroMenn, increase by 1% for fiscal 2010. For fiscal 2011, AHCN is budgeting for softer operations with a margin of 3.8% for the year. With the strong operations, solid investment income, and low 1.3% debt burden, AHCN posted maximum annual debt service coverage of 13.7x, which is strong for the rating.

We consider AHCN's balance sheet strengthening for the rating. At Dec. 31, 2010, leverage was 23.3%, cash to debt was 261%, cash to puttable debt was 422.5%, and liquidity was 250 days. During fiscal 2011, AHCN expects to issue $100 million of new debt. During fiscal 2010, ACHN held off on issuing new debt outside of the BroMenn transaction that closed in early 2010. We will review the new issuance at a later date. However, Standard & Poor's believes that the rating has some room for debt issuance.

Standard & Poor's issued AHCN a Debt Derivative Profile (DDP) overall score of '1.5' on a four-point scale, with '1' representing the lowest risk. The overall score of '1.5' reflects our belief that these swaps carry very low risk of creating any financial loss due to collateralization or early termination from credit or economic reasons. As of Dec. 31, 2010, AHCN had $28 million of collateral posted.

Outlook

The stable outlook reflects AHCN's market leadership, extensive physician network, and solid financial profile. Any consideration of a higher rating would be tied to review of the contemplated debt issuance and the continued strong operations and maintenance of the balance sheet. If patient volumes come under pressure because of increased competition, profitability declines, decreased liquidity, or substantially increased debt leverage, we could lower the rating.

Basis For Short-Term Ratings

The short-term component of the ratings assigned represents the likelihood of payment of tenders and reflects liquidity facilities that will cover all of the bond series.

The providers of the liquidity facilities are as follows:

- Series 2008C-1: JPMorgan Chase Bank (A-1+)
- Series 2008C-2A: Northern Trust Co. (A-1+)
- Series 2008C-2B: Northern Trust
- Series 2008C-3A: Bank of America (A-1)

The liquidity facilities, which are part of the SBPA, shall provide coverage for principal and 37 days' interest at the maximum rate of 12% for the purchase price of bonds that are not successfully remarketed. The SBPA is scheduled to terminate on Aug. 20, 2013, unless extended or terminated according to its terms.

The bonds will initially bear interest in the weekly rate mode, but upon mandatory tender may be converted to bear interest in daily, long-term, bond-interest-term, or auction-rate modes. The initial liquidity facility will enhance bonds in the daily and weekly rate modes, and during these modes bondholders may optionally tender bonds upon delivering appropriate notice.

The bonds are subject to mandatory tender upon the following occurrences:

- On the day following the last day of the bond interest term;
- On the date that bonds are converted to another mode;
- The fifth business day preceding the expiration or termination of the SBPA;
- The effective date of a liquidity facility; and
- The fifth business day preceding the date of termination as a result of the trustee's receipt of a notice termination event has occurred under the SBPA.

The SBPA provider's obligations to purchase unremarketed tendered bonds will be terminated without notice to the bondholders upon the occurrence of various events in the SBPA, which include, but are not limited to, a lowering of the obligor rating to less than 'BBB-'. Upon this occurrence, the obligor will be responsible for providing payment for the tendered bonds. Additionally, the bonds may be called due to optional or mandatory redemption as fully outlined in the bond documents.

Related Criteria And Research

- USPF Criteria: Not-For-Profit Health Care, June 14, 2007
- General Criteria: Methodology: The Interaction Of Bond Insurance And Credit Ratings, Aug. 24, 2009
- USPF Criteria: Municipal Swaps, June 27, 2007
- USPF Criteria: Debt Derivative Profile Scores, March 27, 2006

Ratings Detail (As Of March 24, 2011)

Illinois Fin Auth, Illinois
Advocate Hlth Care Network, Illinois

Ratings Detail (As Of March 24, 2011) **(cont.)**		
Illinois Finance Authority (Advocate Health Care Network)		
Long Term Rating	AA/A-1+/Stable	Affirmed
Illinois Finance Authority (Advocate Health Care Network) hosp VRDB ser 2008C-1		
Long Term Rating	AA/A-1+/Stable	Affirmed
Illinois Finance Authority (Advocate Health Care Network) hosp VRDB ser 2008C-2A		
Long Term Rating	AA/A-1+/Stable	Affirmed
Illinois Finance Authority (Advocate Health Care Network) hosp VRDB ser 2008C-2B		
Long Term Rating	AA/A-1+/Stable	Affirmed
Illinois Finance Authority (Advocate Health Care Network) hosp VRDB ser 2008C-3A		
Long Term Rating	AA/A-1/Stable	Affirmed
Illinois Finance Authority (Advocate Health Care Network) hosp VRDB ser 2008C-3B		
Long Term Rating	AA/A-1+/Stable	Upgraded

IX. 1120.130 - Financial Viability

This section is not applicable. Advocate Health and Hospitals Corporation bonds have been rated by Standard and Poor's as AA, and Fitch AA, which qualifies the applicants for the waiver.

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT-40, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

Provide Data for Projects Classified as:	Category A or Category B (last three years)			Category B (Projected)
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

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

2. Variance

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

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

X. 1120.140 - Economic Feasibility

This section is applicable to all projects subject to Part 1120. Part A of this section is not applicable. Advocate Health and Hospitals Corporation bonds have been rated by Fitch as AA, and by Standard and Poor's as AA which qualifies the applicants for the waiver

A. Reasonableness of Financing Arrangements

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

1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or

2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:

   A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or

   B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

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

1) That the selected form of debt financing for the project will be at the lowest net cost available;

2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;

3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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).

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

APPEND DOCUMENTATION AS ATTACHMENT -42, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

A letter attesting to the conditions of debt financing follows:

Advocate
Christ Medical Center
Hope Children's Hospital

4440 West 95th Street || Oak Lawn, IL 60453 || T 708.684.8000 || advocatehealth.com

May 11, 2011

Mr. Dale Galassie, Chairman
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

Dear Mr. Galassie:

This letter is to attest to the fact that the selected form of debt financing for the proposed Advocate Christ Medical Center Ambulatory Pavilion project will be at the lowest net cost available, or if a more costly form of financing is selected, that form is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional debt, term financing costs, and other factors.

Sincerely,

Kenneth Lukhard
President, Advocate Christ Medical Center/Advocate Hope Children's Hospital

Subscribed and sworn before me this 11th day of May 2011.

NOTARY PUBLIC OFFICIAL SEAL STATE OF ILLINOIS
DAWN M GETZLOFF
MY COMMISSION EXPIRES
DECEMBER 30, 2013

Projected Operating Costs

	Year 2016	Cost per equivalent patient day
Operating Expenses	$ 27,207,000	$ 92.83

Total Effect of the Project on Capital Costs

	Year 2016	Cost per equivalent patient day
Capital Costs	$ 20,214,000	$ 68.97

Cost & Gross Square Feet by Department or Service									
	A	B	C	D	E	F	G	H	
Dept. / Area	Cost/Sq Ft		Gross Sq Ft		Gross Sq Ft		Const. $	Mod. $	Total Cost
	New	Mod	New	Circ	Mod.	Circ.	A x C	B x E	G+H
CLINICAL									
Surgery									
Surgery Operating Rooms	$ 455.24		29,348	15%			$ 13,360,327		$ 13,360,327
Surgery Procedure Rooms	$ 428.06		6,718	15%			$ 2,875,724		$ 2,875,724
Phase I Recovery (PACU)	$ 400.50		4,470	15%			$ 1,790,235		$ 1,790,235
Phase II Recovery (Prep/recovery)	$ 345.38		23,056	15%			$ 7,962,970		$ 7,962,970
Central Sterile Supply	$ 317.81		7,788	15%			$ 2,475,124		$ 2,475,124
Ambulatory Care Serv									
Cast room	$ 317.81		452	15%			$ 143,651		$ 143,651
Heart Failure Clinic	$ 300.63		4,351	15%			$ 1,308,025		$ 1,308,025
Fetal Diagnostics	$ 345.37		5,501	15%			$ 1,899,886		$ 1,899,886
Adult Infusion Center	$ 300.95		9,368	15%			$ 2,819,290		$ 2,819,290
Neurodiagnostics	$ 317.81		1,197	15%			$ 380,422		$ 380,422
Non Invasive Cardiology	$ 300.56		3,965	15%			$ 1,191,733		$ 1,191,733
Pain Center	$ 301.27		928	15%			$ 279,583		$ 279,583
Pre Admission Testing	$ 290.25		839	15%			$ 243,520		$ 243,520
Pulmonary Function	$ 300.36		780	15%			$ 234,278		$ 234,278
Diag and Interv Rad.									
General Radiology/Fluoro	$ 365.42		7,439	15%			$ 2,718,385		$ 2,718,385
Mammography	$ 290.25		317	15%			$ 92,009		$ 92,009
Ultrasound	$ 315.33		7,315	15%			$ 2,306,607		$ 2,306,607
CT & PET/CT	$ 441.25		8,649	15%			$ 3,816,339		$ 3,816,339
MRI	$ 446.87		6,936	15%			$ 3,099,523		$ 3,099,523
Nuclear Med./Spect. /CT	$ 448.04		7,481	15%			$ 3,351,807		$ 3,351,807
Laboratory	$ 340.19		1362	15%			$ 463,345		$ 463,345
Pharmacy, Satellite	$ 345.37		1537	15%			$ 530,841		$ 530,841
Outpatient Rehab	$ 280.13		9743	15%			$ 2,729,298		$ 2,729,298
Cardiac Rehab	$ 290.25		4964	15%			$ 1,440,801		$ 1,440,801
Total Clinical	$ 372.25	0	154,504		0		$ 57,513,723	0	$ 57,513,723
Clin Contingency									$ 5,381,600
Total Clin Const + Contingency									$ 62,895,323
Clinical Const. + Contingency/DGSF									$407.08

Source: ACMC records.

Cost & Gross Square Feet by Department or Service (cont.)

Cost & Gross Square Feet by Department or Service									
	A	B	C	D	E	F	G	H	
Dept. / Area	Cost/Sq Ft		Gross Sq Ft		Gross Sq Ft		Const. $	Mod. $	Total Cost
	New	Mod	New	Circ	Mod.	Circ.	A x C	B x E	G+H
NON CLINICAL									
Multidisciplinary Cancer, Neurosciences, Heart-Vascular Centers, and Women's Health Center, i.e. physicians' consultation offices and exam rooms	$ 294.44		31,566	15%			$ 9,294,299		$ 9,294,299
Lobby, Public Areas, Resource Center, Winter Garden	$ 333.58		13,126	25%			$ 4,378,569		$ 4,378,569
Registration/ Financial Counseling	$ 290.25		3,470	15%			$ 1,007,168		$ 1,007,168
Shelled Space	$ 202.05		14,337				$ 2,896,792		$ 2,896,792
Administration	$ 268.18		16,002	15%			$ 4,291,469		$ 4,291,469
Research/Education	$ 268.20		3,283	15%			$ 880,501		$ 880,501
Electronic Med Rec Support	$ 372.94		369	15%			$ 137,614		$ 137,614
Materials/EVS	$ 262.59		2,750	15%			$ 722,129		$ 722,129
Circulation/ Connector/ Pneumatic Tube	$ 271.11		23,789	95%			$ 6,449,376		$ 6,449,376
Modernized Connectors	0	$ 145.57	0		1,341	100%		$ 195,211	$ 195,211
Lobby Café	$ 317.81		919	15%			$ 292,070		$ 292,070
Retail Pharmacy	$ 317.81		807	15%			$ 256,475		$ 256,475
Mechanical	$ 325.51		42,071	15%			$ 13,694,640		$ 13,694,640
Total Non Clinical	$ 289.26	$ 145.57	152,489		1,341		$ 44,301,102	$ 195,211	$ 44,496,313
Non Clin Contingency									$ 4,228,400
Total Non Clin Const + Contingency									$ 48,724,713
Non Clin Const. + Conting/DGSF									$316.74
Total Construction Cost			306,993		1,341		$ 101,814,825	$ 195,211	$ 102,010,036
Total DGSF			308,334						
Contingency									$ 9,610,000
Total Construction + Contingency									$ 111,620,036
Total Const. + Contingency/DGSF									$362.01

Source: ACMC records.

Comparison of Project Cost to Adjusted State Standard

The Rules allow for a complex project to be evaluated and the costs weighted by the complexity of the departments. The Standard Cost is obtained from R.S. Means and is unique for the geographic area. In the case of this project, the R.S. Means standard cost for construction is $370/GSF. The Rules allow a 3%/year inflation factor to be applied. The following is an excerpt from the Rules:

Section 1120.APPENDIX A Financial and Economic Review Standards

A) Reasonableness of Project and Related Costs Standards

8. Cost Complexity Index (to be applied to hospital projects only)

The mix of service areas or departments for new construction and modernization will be adjusted by the following Cost Complexity Index:

	Service Areas\Departments	Complexity Ratios
1.	Acute Care Beds	1.07
2.	ICU Beds	1.21
3.	Diagnostic And Therapeutic (High)	1.23
4.	Diagnostic And Therapeutic (Medium)	1.11
5.	Diagnostic And Therapeutic (Low)	0.97
6.	Clinical Storage, Processing And Distribution	0.95
7.	Administrative	0.79
8.	Non-Clinical Storage, Processing And Distribution	0.72
9.	Public/Amenities	0.95
10.	Building Components	0.73

Source: JCAR Administrative Code, Section 1120.APPENDIX A

For purposes of the Cost Complexity Index table only, the following definitions apply:

1. "Acute Care Beds" – bed-related clinical service areas including departments/service areas such as, but not limited to, medical-surgical bed units, labor delivery recovery or labor delivery recovery postpartum units, obstetrics nursing bed units, newborn nursery units, rehabilitation bed units, pediatrics bed units, acute mental illness bed units, long-term care acute bed units, skilled nursing units and other related service areas.

2. "ICU Beds" – intensive care bed unit clinical service areas including departments/service areas such as, but not limited to, medical intensive care, surgical intensive care, burn

intensive care, pediatric intensive care, neonatal intensive care units and other related service areas.

3. "Diagnostics and Treatment High Resource Intensive" – clinical service areas including departments/service areas such as diagnostic and imaging radiology with fixed equipment like MRI, nuclear medicine, cardiac catheterization, interventional radiology, surgery, vascular laboratory, radiation oncology, operating rooms (Class C), C-section and other related service areas.

4. "Diagnostics and Treatment Medium Resource Intensive" – clinical service areas including departments/service areas such as, but not limited to, emergency department, Phase II recovery, clinical laboratory, surgical procedure rooms (Class B), gastro-intestinal laboratory procedures, observation rooms and other related service areas.

5. "Diagnostics and Treatment Low Resource Intensive" – clinical service areas including departments/service areas such as, but not limited to, pharmacy, neuro-diagnostics, PT/OT/speech, respiratory therapy, cardiac rehabilitation, cardiac diagnostics, in-patient dialysis, express testing, infusion/transfusion, partial hospital program (outpatient treatment) and other examination room related service areas.

6. "Clinical Storage, Processing and Distribution" – clinical service areas including, but not limited to, central sterile processing, pharmacy, biomedical engineering, autopsy, morgue and other related service areas.

7. "Administrative" – non-clinical service areas or office-based departments/service areas including, but not limited to, administration/business office, medical library, medical records, human resources, marketing, meeting rooms, family services, registration, admissions, on-call rooms, patient resource coordination center, care management, emergency medical service offices, security, volunteer services, information systems, foundation office and accounting and other related service areas.

8. "Non-Clinical Storage, Processing and Distribution" – non-clinical service areas including departments/service areas such as, but not limited to, storage, helicopter pads, employee facilities, materials management (offices and warehouses), linen holding, housekeeping, shop, ambulance garage, print shop/copy room, maintenance, kitchen/food services, transportation and other related service areas.

9. "Public/Amenities" – non-clinical service areas including, but not limited to, lobbies, vertical circulation, reception, gift shop, community meeting rooms and other related service areas.

10 "Building Components" – non-clinical service area components or grossing factors including, but not limited to, exterior walls, HVAC, parking garages, boiler plant and other related service areas.

Note: Although not in the Rules, the complexity factor of 0.5 was applied to the Shell Space, based on discussion and advice from the Health Facilities and Services Review Board staff.

The table on the following pages was prepared to demonstrate the application of the Cost Complexity Index to this project. By using the complexity factors and two years of inflation, the total adjusted standard cost for this project would be $383/DGSF. The actual construction cost plus contingency is $362/DGSF, or $21/DGSF under the expected adjusted State Standard.

Comparison of State Adjusted Standard Cost to Proposed Project Cost using Complexity Factors

Dept. / Area	Construction Cost	New Const. DGSF	Modernized DGSF	Construction Costs/DGSF	Complexity Factor (Project)	$370 adj for complexity (Project)	$ Adj for 1 yr inflation at 3% (Project)	$ Adj for 1 yr inflation at 3% (Project)	Adjusted Std Cost (Project)	Proposed Cost + Contingency	% difference
CLINICAL						$370	1.03	1.03			
Surgery											
Surgery Operating Rooms	$ 13,360,327	29,348		$ 455.24	1.23	$455.10	$468.75	$482.82	$14,169,672	$14,610,462	3.1%
Surgery Procedure Rooms	$ 2,875,724	6,718		$ 428.06	1.11	$410.70	$423.02	$435.71	$2,927,111	$3,144,808	7.4%
Phase I Recovery (PACU)	$ 1,790,235	4,470		$ 400.50	1.11	$410.70	$423.02	$435.71	$1,947,631	$1,957,749	0.5%
Phase II Recovery (Prep/recovery)	$ 7,962,970	23,056		$ 345.38	1.11	$410.70	$423.02	$435.71	$10,045,767	$8,708,071	-13.3%
Central Sterile Supply	$ 2,475,124	7,788		$ 317.81	0.95	$351.50	$362.05	$372.91	$2,904,195	$2,706,723	-6.8%
Ambulatory Care Serv											
Cast room	$ 143,651	452		$ 317.81	1.11	$410.70	$423.02	$435.71	$196,942	$157,093	-20.2%
Heart Failure Clinic	$ 1,308,025	4,351		$ 300.63	0.97	$358.90	$369.67	$380.76	$1,656,674	$1,430,418	-13.7%
Fetal Diagnostics	$ 1,899,886	5,501		$ 345.37	1.23	$455.10	$468.75	$482.82	$2,655,969	$2,077,660	-21.8%
Adult Infusion Center	$ 2,819,290	9,368		$ 300.95	0.97	$358.90	$369.67	$380.76	$3,566,932	$3,083,093	-13.6%
Neurodiagnostics	$ 380,422	1,197		$ 317.81	1.11	$410.70	$423.02	$435.71	$521,547	$416,018	-20.2%
Non Invasive Cardiology	$ 1,191,733	3,965		$ 300.56	0.97	$358.90	$369.67	$380.76	$1,509,702	$1,303,244	-13.7%
Pain Center	$ 279,583	928		$ 301.27	0.97	$358.90	$369.67	$380.76	$353,343	$305,744	-13.5%
Pre Admission Testing	$ 243,520	839		$ 290.25	0.97	$358.90	$369.67	$380.76	$319,455	$266,306	-16.6%
Pulmonary Function	$ 234,278	780		$ 300.36	0.97	$358.90	$369.67	$380.76	$296,990	$256,200	-13.7%
Diag and Interv Rad.											
General Radiology/Fluoro	$ 2,718,385	7,439		$ 365.42	1.23	$455.10	$468.75	$482.82	$3,591,665	$2,972,746	-17.2%
Mammography	$ 92,009	317		$ 290.25	1.23	$455.10	$468.75	$482.82	$153,053	$100,618	-34.3%
Ultrasound	$ 2,306,607	7,315		$ 315.33	1.23	$455.10	$468.75	$482.82	$3,531,796	$2,522,438	-28.6%
CT & PET/CT	$ 3,816,339	8,649		$ 441.25	1.23	$455.10	$468.75	$482.82	$4,175,872	$4,173,437	-0.1%
MRI	$ 3,099,523	6,936		$ 446.87	1.23	$455.10	$468.75	$482.82	$3,348,809	$3,389,548	1.2%
Nuclear Med./Spect. /CT	$ 3,351,807	7,481		$ 448.04	1.23	$455.10	$468.75	$482.82	$3,611,943	$3,665,438	1.5%
Laboratory	$ 463,345	1,362		$ 340.19	1.11	$410.70	$423.02	$435.71	$593,439	$506,701	-14.6%
Pharmacy, Satellite	$ 530,841	1,537		$ 345.37	0.97	$358.90	$369.67	$380.76	$585,224	$580,512	-0.8%
Outpatient Rehab	$ 2,729,298	9,743		$ 280.13	0.97	$358.90	$369.67	$380.76	$3,709,716	$2,984,680	-19.5%
Cardiac Rehab	$ 1,440,801	4,964		$ 290.25	0.97	$358.90	$369.67	$380.76	$1,890,078	$1,575,618	-16.6%
Total Clinical	$ 57,513,723	154,504		$ 372.25					68,263,522	62,895,322	-7.9%

Comparison of State Adjusted Standard Cost to Proposed Project Cost using Complexity Factors

					Project						
Dept. / Area	Construction Cost	New Const. DGSF	Modernized DGSF	Construction Costs/DGSF	Complexity Factor	$370 adj for complexity	$ Adj for 1 yr inflation at 3%	$ Adj for 1 yr inflation at 3%	Adjusted Std Cost	Proposed Cost + Contingency	% difference
NON CLINICAL											
Multidisciplinary Cancer, Neurosciences, Heart-Vascular Centers, and Women's Health Center,	$ 9,294,299	31,566		$ 294.44	0.97	$358.90	$369.67	$380.76	$12,018,976	$10,177,519	-15.3%
Lobby, Public Areas, Resource Center, Winter Garden	$ 4,378,569	13,126		$ 333.58	0.95	$351.50	$362.05	$372.91	$4,894,769	$4,794,656	-2.0%
Registration/Financial Counseling	$ 1,007,168	3,470		$ 290.25	0.79	$292.30	$301.07	$310.10	$1,076,051	$1,102,877	2.5%
Shell Space	$ 2,896,792	14,337		$ 202.05	0.50	$185.00	$190.55	$196.27	$2,813,873	$3,172,069	12.7%
Administration	$ 4,291,469	16,002		$ 268.18	0.79	$292.30	$301.07	$310.10	$4,962,237	$4,699,279	-5.3%
Research/Education	$ 880,501	3,283		$ 268.20	0.79	$292.30	$301.07	$310.10	$1,018,062	$964,173	-5.3%
Electronic Med Rec Support	$ 137,614	369		$ 372.94	0.79	$292.30	$301.07	$310.10	$114,427	$150,691	31.7%
Materials/EVS	$ 722,129	2,750		$ 262.59	0.72	$266.40	$274.39	$282.62	$777,215	$790,752	1.7%
New Circulation/ Connector/ Pneumatic Tube	$ 6,449,376	23,789		$ 271.11	0.95	$351.50	$362.05	$372.91	$8,871,069	$7,062,248	-20.4%
Modernized Connectors	$ 195,211		1,341	$ 145.57	0.95	$351.50	$362.05	$372.91	$500,067	$213,762	-57.3%
Lobby Café	$ 292,070	919		$ 317.81	0.72	$266.40	$274.39	$282.62	$259,731	$319,825	23.1%
Retail Pharmacy	$ 256,475	807		$ 317.81	0.72	$266.40	$274.39	$282.62	$228,077	$280,847	23.1%
Mechanical	$ 13,694,640	42,071		$ 325.51	0.73	$270.10	$278.20	$286.55	$12,055,407	$14,996,016	24.4%
Total Non-clinical	$ 44,496,313	152,489	1,341	$ 289.26					$49,589,962	$48,724,714	-1.7%
TOTAL											
Total Clinical + Non Clinical	$ 102,010,036	306,993	1,341								
Contingency	$ 9,610,000										
Total New Const & Mod.+Conting.	$ 111,620,036	308,334							$117,853,484	$111,620,036	-5.3%
Total New Const & Mod./DGSF	$362.01								$382.23	$362.01	-5.3%

XI. Safety Net Impact Statement

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

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.

2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

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

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaidpatients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

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

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

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

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

20 ILCS 3960 Sec. 5.4 requires that certificate of need applicants provide a Safety Net Impact Statement. The Section reads as follows:

(a) General review criteria shall include a requirement that all health care facilities, with the exception of skilled and intermediate long-term care facilities licensed under the Nursing Home Care Act, provide a Safety Net Impact Statement, which shall be filed with an application for a substantive project or when the application proposes to discontinue a category of service.

No response required.

(b) For the purposes of this Section, "safety net services" are services provided by health care providers or organizations that deliver health care services to persons with barriers to mainstream health care due to lack of insurance, inability to pay, special needs, ethnic or cultural characteristics, or geographic isolation. Safety net service providers include, but are not limited to, hospitals and private practice physicians that provide charity care, school-based health centers, migrant health clinics, rural health clinics, federally qualified health centers, community health centers, public health departments, and community mental health centers.

No response required.

(c) As developed by the applicant, a Safety Net Impact Statement shall describe all of the following:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.

Advocate Health and Hospitals Corporation, as a system, has a history of providing quality care to over a million patients annually. In addition, Advocate provides essential community services and programs to patients, families, and communities. It is significant to note that in 2010 Advocate Christ Medical Center and Advocate Hope Children's Hospital (ACMC/AHCH, the Medical Center) delivered 40,477 days of inpatient care to Medicaid patients, putting it in the top ten hospitals in Illinois providing that focus, according to COMPdata records. The proposed ACMC/AHCH Ambulatory Pavilion will have a positive impact on safety net services. The Ambulatory Pavilion will be expanding capacity and thus making more accessible the services it has historically provided to the region, including a growing number of patients with financial barriers to healthcare, special needs, or other limitations.

As an example of the safety net services provided, ACMC/AHCH in partnership with the Ronald McDonald House Charities (RMHC), and Frontier Construction operates Ronald McDonald Care Mobile®. This is a 40-foot, mobile pediatric medical clinic with a clinical staff that provides free health care services to children in underserved areas of Chicago and surrounding communities. Services include (but are not limited to) school physicals, immunizations, asthma care, health screenings, prenatal instruction and education, and well-baby care throughout the community. In 2010, the Ronald McDonald Care Mobile® team served nearly 2,000 children and administered over 2,300 vaccines and 1,738 physicals. Their goal is to find a "medical home" for all the children who visit the Care Mobile. As ACMC/AHCH's partner, RMHC provides limited financial support of the Care Mobile's annual operating budget.

2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

The Medical Center's development of an Ambulatory Pavilion should not affect any other facilities' ability to cross-subsidize other safety net services. The patients expected to use the services in the Ambulatory Pavilion, historically, have been served by ACMC and its associated facility for children, AHCH.

3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Not applicable.

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

1. For the three fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

The Medical Center certifies that the following charity care and community benefits information is accurate and complete and in accordance with the Illinois Community Benefits Act, and certifies the amount of care provided to Medicaid patients is consistent with the information published in the Annual Hospital Profile.

Attachment 43, Table 1

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**Year 2007**	**Year 2008**	**Year 2009**
Inpatient	184	307	360
Outpatient	391	655	1,069
Total	575	962	1,429
Charity (cost In dollars)			
Inpatient	$ 3,826,700	$ 4,255,000	$ 7,731,100
Outpatient	$ 328,500	$ 432,800	$ 1,397,900
Total	$ 4,155,200	$ 4,687,800	$ 9,129,000
MEDICAID			
Medicaid (# of patients)	**Year 2007**	**Year 2008**	**Year2009**
Inpatient	7,221	7,651	7,969
Outpatient	68,133	67,426	76,306
Total	75,354	75,077	84,275
Medicaid (revenue)[1]			
Inpatient	$ 95,669,000	99,445,000	$ 75,262,244
Outpatient	$ 9,208,000	5,874,000	5,823,286
Total	$ 104,877,000	$ 105,319,000	$ 81,085,530

Source: Annual Hospital Questionnaire
[1] In 2009, Medicaid Revenue of $81,085,530 erroneously excluded the Proceeds from the Medicaid Assessment ($33,274,000).

3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

In 2009, the Advocate system provided more than $462 million in charitable care and services. This represents an $89 million increase over 2008.

Advocate's community benefits investment allows it to meet the health and wellness needs of its communities and expands access to care. In addition to $48.4 million in free and charity care for the uninsured and underinsured, Advocate supplied more than $274 million in care without full reimbursement from Medicare and Medicaid or other government-sponsored programs.

In addition to free and subsidized care, and in alignment with its Magnet Status, ACMC/AHCH also offers programs and services that respond to communities' unique healthcare needs. The

hospital sponsors community outreach efforts to address the health and welfare needs of the communities it serves. Outreach efforts include health and disease prevention programs such as health fairs and free health screenings; free medical clinics for underserved patients; support groups; homeless shelters, school supply drives, coat drives, Treats for Troops, food drives for local food pantries, and school-based health centers. These include health and wellness screenings, behavior health services, and school-based health care. Also provided are language-assistance services, interpreters and non-English educational materials.

Blood pressure screenings are provided monthly as part of ACMC/AHCH's participation in the Oak Lawn Community Partnership. Those screenings are performed in conjunction with the Oak Lawn firefighters. The Medical Center provided portable, 12-lead EKG monitors for the ambulances in the Chicago suburbs of Oak Lawn and Burbank and trained paramedics in their use. ACMC/AHCH provides staff for "Ask the Pharmacist" offered twice a year, as well as "Ask the Cardiac RN", and "Ask the Diabetes Educator." Hearing screenings are offered by the Medical Center's audiologists three times a year.

During Prostate Cancer Awareness month and Skin Cancer Awareness Month, free screenings are offered to the community. During Colon Cancer Awareness Month, at-home test kits are distributed, and are read at the laboratory free of charge.

The Medical Center partners with the American Cancer Society through a sponsorship of the Southland region's seven Relay for Life events. The Medical Center is also a presenting sponsor of the Orland Park "Making Strides Against Breast Cancer." Both events are significant fundraisers for American Cancer Society in the region. In the coming year, the American Cancer Society will be providing a Patient Services Navigator for outpatients receiving cancer-related services.

Advocate Health Care also supports the American Heart Association. In 2010, Advocate Health Care was a major corporate fundraiser for the 2010 Heart Walk, raising over $350,000. Associates at the Medical Center kicked off the heart walk fundraising campaign with a captain's breakfast in July. Fundraising and heart walk activities included raffles, bake sales, contests and collecting spare change in the cafeteria. ACMC/AHCH registered 43 teams and 423 walkers. Funds raised will support the American Heart Association's educational programs and research to further improve heart care.

Chicago area's South Suburban Public Action to Deliver Shelters (P.A.D.S. Homeless Shelters) are supported by ACMC/AHCH with free laundry service. These shelters are held in a different local church each night of the week. The Medical Center solicits volunteers for shelter help every year.

There is a history of collaboration with the Chicago-based outreach program, CeaseFire, to help reduce the incidence of violence in the community.

ACMC/AHCH partnered with the Ronald McDonald House Charities® of Chicagoland and Northwest Indiana (RMHC) in the opening of a 16-bed Ronald McDonald House in Oak Lawn for families of children being treated at Hope Children's Hospital. In cooperation with RMHC, the Medical Center also provides Happy Hearts and Homes, a nine-week parenting program for at-risk, first-time parents.

The Advocate Physicians Partners has established a Clinical Integration Program with new initiatives to address diabetes, asthma, coronary artery disease and congestive health failure. This model, which includes training for small independent practices and their practice managers, is gaining support. The community continues to benefit from more coordinated care, and improved outcomes.

In addition to patient care services, ACMC/AHCH is involved in hospital-based education by providing resident training programs in Anesthesiology, Cardiology, Family Medicine, Emergency Medicine, Pediatrics, Pediatric Cardiology, and Surgery to train physicians in these specialties. The Medical Center is also affiliated with multiple schools of nursing and provides clinical experiences to hundreds of nurses, radiology technicians, physical therapists, and a host of others to meet the growing need for skilled health care professionals.

The hospital trains more than 2,500 emergency medical technicians, paramedics and other providers of emergency care each year through the Emergency Medical Services (EMS) Academy — one of the largest EMS training programs in Illinois.

ACMC/AHCH has gone the extra mile by providing Medic Training for the Illinois Army National Guard to prepare them for deployment to Iraq and Afghanistan. The medics shadowed trauma surgeons who conducted the initial evaluation of injured patients, performed surgeries on gunshot and stabbing victims, all with the goal to give the medics experience they will need to provide quick and creative action in combat support hospitals.

The Medical Center has also partnered with the Village of Oak Lawn to get 1,300 high school students and their teachers certified in specialized first aid skills including resuscitation procedures, use of automatic defibrillators, immobilization of trauma victims, and control of bleeding.

Live...from the Heart is a joint project between the Museum of Science and Industry in Chicago and ACMC/AHCH. This is a videoconference – based education program that offers high school aged students and teachers a dramatic exploration of the human heart. Through a live, two-way, closed circuit feed, participants watch open heart surgery – typically coronary artery bypass surgery – being performed at the Medical Center. Throughout the procedure, participants are able to interact with all members of the cardiovascular surgery team to elicit information and ask questions. The presentation, while somewhat variable each week, aims to cover the following topics during the program: heart disease risk and prevention, diagnostic procedures leading up to heart surgery, the evolution and future of heart surgery, professional careers and opportunities in health sciences.

This innovative program reaches nearly 5,000 students annually throughout the US and Canada. The program takes students through the pre-surgical disease process, diagnosis, consent process, through the actual live surgery with opportunities to pose questions to the surgeon during the procedure, and post-op risk reduction and prevention. With the use of advanced technology and science education, ACMC/AHCH is reaching the next generation of health care providers. Since the opening of the program in 2002 – through the 2009-2010 school year, over 20,000 individuals have participated in the program.

Since 2004, AHCH has had a standing partnership with Dawes Elementary School in Chicago (94 percent low-income student population) to provide health services through the Ronald McDonald Care Mobile, health education seminars for parents and students, mentoring, health fairs and fundraising support through the hospital's annual employee giving campaign.

For the past 11 years, AHCH has sponsored a free half-day conference for school nurses from the Chicago Public Schools and suburban area featuring the latest in medical information, treatment, and ways to improve student compliance with medical treatment. School nurses representing over 50,000 students also receive a monthly email health tips publication from the hospital, which they are encouraged to share with their school community.

Clinical staff regularly visits area high schools to discuss careers in health care.

Advocate is also engaged in multiple research projects that will result in new techniques, drugs, and devices to improve the health and well-being of patients everywhere. ACMC/AHCH provides care and rehabilitation services for children with developmental disabilities, sleep disorders, allergies and asthma. Its outpatient pediatric cancer program is the largest in the Midwest. The Medical Center is also home the Heart Institute for Children, a national center for research and development and the largest pediatric cardiology program in the Midwest.

XII. Charity Care Information

Charity Care information MUST be furnished for ALL projects.

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three audited fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

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

A table in the following format must be provided for all facilities as part of Attachment 44.

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

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

XII. Charity Care Information

Charity Care information MUST be furnished for ALL projects.

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three audited fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payor source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

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

Advocate Health and Hospitals Corporation, d/b/a Advocate Christ Medical Center, provided the following charity care.

Attachment 44, Table 1

Charity Care			
	Year 2007	Year 2008	Year 2009
Net Patient Revenue	$ 774,188,000	$ 829,112,000	$ 871,478,000
Amount of Charity Care (charges)	$ 15,579,000	$ 20,599,000	$ 32,556,000
Cost of Charity Care	$ 4,155,200	$ 4,687,800	$ 9,129,000
Charity Care as percent of total net patient revenue	0.5%	0.6%	1.0%

Source: Annual Hospital Questionnaire and hospital records.

Appendices

The following pages include:

Appendix 1: The rest of the documents from Attachment 2, Exhibit 1, showing ownership of the site.

Appendix 2: Additional support letters.

CHICAGO TITLE INSURANCE COMPANY
COMMITMENT FOR TITLE INSURANCE
SCHEDULE B

ORDER NO.: 1410 000284161 HL

3. WE SHOULD BE FURNISHED A PROPERLY EXECUTED ALTA STATEMENT.

2. NOTE FOR INFORMATION: THE COVERAGE AFFORDED BY THIS COMMITMENT AND ANY POLICY ISSUED PURSUANT HERETO SHALL NOT COMMENCE PRIOR TO THE DATE ON WHICH ALL CHARGES PROPERLY BILLED BY THE COMPANY HAVE BEEN FULLY PAID.

A 3.

1. TAXES FOR THE YEAR(S) 2004 AND 2005
2005 TAXES ARE NOT YET DUE OR PAYABLE.

1A. NOTE: 2004 FIRST INSTALLMENT WAS DUE MARCH 01, 2005
NOTE: 2004 FINAL INSTALLMENT NOT YET DUE OR PAYABLE

PERM TAX#	PCL	YEAR	1ST INST	STAT
10-30-400-013-0000	1 OF 3	2004	$21,709.87	PAID
24-03-318-016-0000	2 OF 3	2004	NOT BILLED	
24-03-400-026-0000	3 OF 3	2004	NOT BILLED	

PERM TAX# 24-03-318-016-0000 PCL 2 OF 3 VOLUME 127

3A THE GENERAL TAXES AS SHOWN BELOW ARE MARKED EXEMPT ON THE

COLLECTOR'S WARRANTS.

YEAR(S)- 2003 AND PRIOR

UNLESS SATISFACTORY EVIDENCE IS SUBMITTED TO SUBSTANTIATE SAID

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CHICAGO TITLE INSURANCE COMPANY

COMMITMENT FOR TITLE INSURANCE
SCHEDULE B (CONTINUED)

ORDER NO.: 1410 008284161 UL

EXEMPTION OUR POLICY, IF AND WHEN ISSUED, WILL BE SUBJECT TO SAID TAXES.

PERM TAX# 24-03-400-026-0000 PCL 3 OF 3 VOLUME 127

3B THE GENERAL TAXES AS SHOWN BELOW ARE MARKED EXEMPT ON THE COLLECTOR'S WARRANTS.

YEAR(S): 2003 AND PRIOR

UNLESS SATISFACTORY EVIDENCE IS SUBMITTED TO SUBSTANTIATE SAID EXEMPTION OUR POLICY, IF AND WHEN ISSUED, WILL BE SUBJECT TO SAID TAXES.

B 4. BECAUSE OF PROCEDURES INSTITUTED BY THE COOK COUNTY TREASURER, THE COMPANY REQUESTS THAT ORIGINAL TAX BILLS BE FURNISHED WHENEVER THE COMPANY IS REQUESTED TO PAY TAXES. IF ORIGINAL TAX BILLS ARE NOT FURNISHED, THE COMPANY WILL COLLECT ADDITIONAL FEES FOR EACH TAX NUMBER TO PAY CHARGES IMPOSED BY THE COOK COUNTY TREASURER FOR THE PRODUCTION OF DUPLICATE TAX BILLS. FURTHER, BECAUSE OF DELAYS BY THE COOK COUNTY TREASURER IN PRODUCING DUPLICATE TAX BILLS, THE COMPANY WILL HOLD BACK FROM CLOSING ADDITIONAL FUNDS TO PAY INTEREST THAT WILL ACCRUE BECAUSE OF THE TREASURER'S PROCEDURES.

AC 5. MECHANICS LIEN CLAIM IN FAVOR OF CORSETTI STRUCTURAL STEEL, INC., A CORPORATION OF DELAWARE AGAINST PEPPER CONSTRUCTION, CONTRACTOR AND ADVOCATE HEALTH AND HOSPITALS CORPORATION FORMERLY KNOWN AS EVANGELICAL HOSPITALS CORPORATION, OWNER, RECORDED JANUARY 7, 2004 AS DOCUMENT NUMBER 0400746080 IN THE AMOUNT OF $102,643.16.

(AFFECTS PARCEL ONE)

(MODIFICATION 120 ENDORSEMENT APPROVED)

AB 6. PURSUANT TO YOUR REQUEST THAT WE INSURE A MORTGAGE SECURING REIMBURSEMENT PURSUANT TO AN INDUSTRIAL REVENUE BOND CONTEMPLATED FOR THE DESCRIBED PREMISES, WE SHOULD BE FURNISHED THE FOLLOWING DOCUMENTATION PRIOR TO CLOSING:

1. A BOND COUNSEL'S OPINION LETTER UPON WHICH WE MAY RELY THAT REFLECTS AN EXAMINATION HAS BEEN MADE OF THE BOND ISSUE AND USE OF THE PROCEEDS THEREOF, AND THE PERTINENT REGULATORY AND STATUTORY AUTHORITY AND OTHER DOCUMENTATION NECESSARY FOR THE VALIDITY OF THE BOND ISSUE.

2. A LEGAL OPINION LETTER FROM BORROWER'S COUNSEL UPON WHICH WE MAY RELY THAT THE MORTGAGE EVIDENCING THE BOND ISSUE AND ASSIGNMENT TO AN INSTITUTIONAL LENDER WILL CREATE A FIRST LIEN; IS PROPER; IS EXEMPT FROM SECURITIES LAWS; AND THAT OTHER CONDITIONS HAVE BEEN MET FOR THE ISSUER AND OTHER PARTIES TO

CHICAGO TITLE INSURANCE COMPANY

COMMITMENT FOR TITLE INSURANCE

SCHEDULE B (CONTINUED)

ORDER NO.: 1410 008284161 UL

ESTABLISH AN ENFORCEABLE LIEN.

3. IF THERE WILL BE A LEASE AGREEMENT MADE AS SECURITY FOR THE BOND, WE SHOULD HAVE OPINION OF THE LESSEE'S LEGAL COUNSEL THAT THE DOCUMENTS WHEN EXECUTED WILL BE BINDING AND ENFORCEABLE.

4. IF THE PROCEEDS OF THE BOND ARE TO BE USED FOR THE CONSTRUCTION OF IMPROVEMENTS ON THE LAND AND THE BOND PROCEEDS WILL BE ADMINISTERED THROUGH A DISBURSING AGENT, WE SHOULD BE NOTIFIED OF THAT FACT AND THIS REPORT IS SUBJECT TO ADDITIONAL EXCEPTIONS AS MAY BE DEEMED NECESSARY.

C 7. MUNICIPAL REAL ESTATE TRANSFER TAX STAMPS (OR PROOF OF EXEMPTION) MUST ACCOMPANY ANY CONVEYANCE AND CERTAIN OTHER TRANSFERS OF PROPERTY LOCATED IN OAK LAWN. PLEASE CONTACT SAID MUNICIPALITY PRIOR TO CLOSING FOR ITS SPECIFIC REQUIREMENTS, WHICH MAY INCLUDE THE PAYMENT OF FEES, AN INSPECTION OR OTHER APPROVALS.

(AFFECTS PARCEL ONE)

AA 8. MUNICIPAL REAL ESTATE TRANSFER TAX STAMPS (OR PROOF OF EXEMPTION) MUST ACCOMPANY ANY CONVEYANCE AND CERTAIN OTHER TRANSFERS OF PROPERTY LOCATED IN NILES. PLEASE CONTACT SAID MUNICIPALITY PRIOR TO CLOSING FOR ITS SPECIFIC REQUIREMENTS, WHICH MAY INCLUDE THE PAYMENT OF FEES, AN INSPECTION OR OTHER APPROVALS.

(AFFECTS PARCEL 4)

V 9. RIGHTS OF THE UNITED STATES OF AMERICA TO RECOVER ANY PUBLIC FUNDS ADVANCED UNDER THE PROVISIONS OF ONE OR MORE OF THE VARIOUS FEDERAL STATUTES RELATING TO HEALTH CARE.

W 10. WE SHOULD BE FURNISHED A CERTIFIED COPY OF THE DIRECTORS' RESOLUTIONS AUTHORIZING THE CONVEYANCE OR MORTGAGE TO BE INSURED. SAID RESOLUTIONS SHOULD EVIDENCE THE AUTHORITY OF THE PERSONS EXECUTING THE CONVEYANCE OR MORTGAGE. IF THEY DO NOT, A CERTIFIED COPY OF THE CORPORATE BY-LAWS ALSO SHOULD BE FURNISHED.

IF SAID CONVEYANCE OR MORTGAGE COMPRISES ALL OR SUBSTANTIALLY ALL THE CORPORATION'S ASSETS, WE ALSO SHOULD BE FURNISHED A CERTIFIED COPY OF THE SHAREHOLDER/MEMBER RESOLUTIONS WHICH AUTHORIZE SAID CONVEYANCE OR MORTGAGE. THIS COMMITMENT IS SUBJECT TO SUCH FURTHER EXCEPTIONS, IF ANY, AS MAY BE DEEMED NECESSARY AFTER OUR REVIEW OF THESE MATERIALS.

O 11. EXISTING UNRECORDED LEASES AND ALL RIGHTS THEREUNDER OF THE LESSEES AND OF ANY PERSON OR PARTY CLAIMING BY, THROUGH OR UNDER THE LESSEES.

E 12. WE SHOULD BE FURNISHED A STATEMENT THAT THERE IS NO PROPERTY MANAGER EMPLOYED TO MANAGE THE LAND, OR, IN THE ALTERNATIVE, A FINAL LIEN WAIVER FROM ANY SUCH PROPERTY MANAGER.

F 13. NOTE: THE LAND DESCRIBED IN SCHEDULE A EITHER IS UNSUBDIVIDED PROPERTY OR CONSTITUTES PART OF A SUBDIVIDED LOT. AS A RESULT, A PLAT ACT AFFIDAVIT SHOULD

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COMMITMENT FOR TITLE INSURANCE
SCHEDULE B (CONTINUED)

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ACCOMPANY ANY CONVEYANCE TO BE RECORDED. IN THE ALTERNATIVE, COMPLIANCE SHOULD BE HAD WITH THE PROVISIONS OF THE PLAT ACT (765 ILCS 205/1 ET SEQ.).

I 14. RIGHTS OF WAY FOR DRAINAGE DITCHES, FEEDERS AND LATERALS.

(AFFECTS PARCEL ONE)

J 15. EASEMENTS, IF ANY, FOR PUBLIC UTILITIES OR QUASI-PUBLIC UTILITY EASEMENTS, INCLUDING UNDERGROUND UTILITY EASEMENTS.

(AFFECTS PARCEL ONE)

K 16. RIGHTS OF THE PUBLIC, THE STATE OF ILLINOIS AND THE MUNICIPALITY, IN AND TO THE NORTH 17 FEET OF THE SOUTH 50 FEET OF THE EAST 1/2 OF THE EAST 1/2 OF THE SOUTHWEST 1/4 OF SECTION 3, AFORESAID, AS DEDICATED FOR ROAD PURPOSES BY INSTRUMENT RECORDED MARCH 9, 1931 AS DOCUMENT 10858729.

(AFFECTS PARCEL ONE)

L 17. RIGHTS OF THE PUBLIC, THE STATE OF ILLINOIS, THE COUNTY OF COOK, AND THE MUNICIPALITY IN AND TO THE SOUTH 33 FEET OF THE LAND OPENED BY THE HIGHWAY COMMISSIONERS FOR ROAD PURPOSES PURSUANT TO PETITION AND SURVEY.

(AFFECTS PARCEL ONE)

18. RIGHTS OF THE PUBLIC AND OF THE STATE OF ILLINOIS IN AND TO THE SOUTH 50 FEET AND THE EAST 40 FEET AND THE WEST 33 FEET OF THE SOUTH 1/2 OF THE EAST 1/2 OF THE EAST 1/2 OF THE SOUTHWEST 1/4 OF SECTION 3 AS DEDICATED FOR ROAD PURPOSES BY INSTRUMENT DATED JANUARY 14, 1958 AND RECORDED MAY 27, 1958 AS DOCUMENT 17219540.

(AFFECTS PARCEL ONE)

N 19. RIGHTS OF THE PUBLIC, STATE OF ILLINOIS AND THE MUNICIPALITY IN AND TO SO MUCH OF THE LAND AS DEDICATED FOR ROAD PURPOSES BY INSTRUMENT RECORDED FEBRUARY 11, 1984 AS DOCUMENT 19045084.

(AFFECTS THE NORTH 33 FEET EXCEPT THE EAST 40 FEET AND ALSO EXCEPTING THE WEST 33 FEET OF THE LAND)

(AFFECTS PARCEL ONE)

O 20. RIGHTS OF THE PUBLIC, THE STATE OF ILLINOIS AND THE MUNICIPALITY IN AND TO THAT PART OF THE LAND, IF ANY, TAKEN OR USED FOR ROAD PURPOSES OTHER THAN 93RD STREET, KILBOURN AVENUE, 95TH STREET AND KOSTNER AVENUE.

(AFFECTS PARCEL ONE)

P 21. BUILDING LINE 25 FEET ON THE PORTION OF THE LAND FRONTING ON WEST 95TH STREET, CONTAINED IN DEED RECORDED MARCH 18, 1955 AS DOCUMENT 16178707.

(AFFECTS PARCEL ONE)

CHICAGO TITLE INSURANCE COMPANY

COMMITMENT FOR TITLE INSURANCE

SCHEDULE B (CONTINUED)

ORDER NO.: 1410 008284161 UL

Q 22. BUILDING SETBACK IN ALONG THE NORTH LINE OF THE SOUTH 75 FEET OF THE LAND AS PROVIDED FOR IN WARRANTY DEED FROM WIEGEL AND KILGALLEN SALES CO., A CORPORATION OF ILLINOIS, TO EVANGELICAL HOSPITAL ASSOCIATION OF CHICAGO, A CORPORATION OF ILLINOIS, DATED OCTOBER 1, 1954 AND RECORDED MARCH 18, 1955 AS DOCUMENT 16178708.

(AFFECTS PARCEL ONE)

R 23. ELECTRIC FACILITY AGREEMENT MADE BY EVANGLICAL SERVICES CORPORATION, A CORPORATION OF ILLINOIS AND THE COMMONWEALTH EDISON COMPANY, ITS SUCCESSORS AND ASSIGNS AN EASEMENT FOR PUBLIC UTILITIES TO INSTALL ELECTRIC FACILITY AND AN EASEMENT FOR PUBLIC UTILITIES TO INSTALL ELECTRIC FACILITY AND THE RIGHT TO OPERATE, MAINTAIN, REPAIR, RENEW, REPLACE AND REMOVE ITS INSTALLED FACIL BUT OWNER RESERVES THE TRUST TO REQUIRE COMPANY TO RELOCATE ITS FACIL TO ALTERNATE MUTUALLY AGREED UPON LOCATIONS DATED SEPTEMBER 6, 1985 AND RECORDED SEPTEMBER 27, 1985 AS DOCUMENT 85208193, OVER THAT PART OF THE LAND DEPICTED ON EXHIBIT A ATTACHED THERETO.

(AFFECTS PARCEL ONE)

S 24. EASEMENT IN FAVOR OF THE VILLAGE OF OAK LAWN, A MUNICIPAL CORPORATION OF ILLINOIS, FOR STORM WATER DRAINAGE, AS CREATED BY GRANT OF EASEMENT RECORDED OCTOBER 13, 1992 AS DOCUMENT 92759720, AND THE TERMS AND PROVISIONS CONTAINED THEREIN.

(AFFECTS A STRIP OF LAND OF VARIOUS WIDTHS ACROSS PORTIONS OF THE NORTH 275 FEET OF THE LAND AS DESCRIBED THEREIN)

PURPORTED VACATION OF ABOVE EASEMENT RECORDED MARCH 6, 2003 AS DOCUMENT 0030313059 BY THE VILLAGE OF OAK LAWN.

(AFFECTS PARCEL ONE)

T 25. EASEMENT IN FAVOR OF THE COMMONWEALTH EDISON COMPANY, AND ITS SUCCESSORS AND ASSIGNS, TO INSTALL, OPERATE AND MAINTAIN ALL EQUIPMENT NECESSARY FOR THE PURPOSE OF SERVING THE LAND AND OTHER PROPERTY, TOGETHER WITH THE RIGHT OF ACCESS TO SAID EQUIPMENT, AND THE PROVISIONS RELATING THERETO CONTAINED IN THE GRANT RECORDED JUNE 15, 1995 AS DOCUMENT NO. 95387640, AFFECTING THE SOUTH 7 FEET OF THE NORTH 40 FEET AND THE WEST 7 FEET OF THE EAST 47 FEET OF THE LAND.

(AFFECTS PARCEL ONE)

U 26. EASEMENT IN FAVOR OF NORTHERN ILLINOIS GAS COMPANY, AND ITS SUCCESSORS AND ASSIGNS, TO INSTALL, OPERATE AND MAINTAIN ALL EQUIPMENT NECESSARY FOR THE PURPOSE OF SERVING THE LAND AND OTHER PROPERTY, TOGETHER WITH THE RIGHT OF ACCESS TO SAID EQUIPMENT, AND THE PROVISIONS RELATING THERETO CONTAINED IN THE GRANT RECORDED NOVEMBER 17, 1995 AS DOCUMENT NO. 95800213, AFFECTING THE WEST 3 FEET OF THE EAST 50 FEET OF THE SOUTH 305 FEET OF THE NORTH 345 FEET OF THE SOUTH 1/2 OF THE EAST 1/2 OF THE EAST 1/2 OF THE SOUTHWEST 1/4 OF SECTION 3 AFORESAID.

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COMMITMENT FOR TITLE INSURANCE

SCHEDULE B (CONTINUED)

ORDER NO.: 1410 008284161 UL

(AFFECTS PARCEL ONE)

Y 27. AGREEMENT FOR EASEMENTS AND COVENANT DATED JULY 20, 1981 AND RECORDED SEPTEMBER 10, 1981 AS DOCUMENT 26000393 AND RE-RECORDED JULY 19, 1982 AS DOCUMENT 26293327 MADE BY AND BETWEEN EVANGELICAL HOSPITAL ASSOCIATION, A NOT-FOR-PROFIT CORPORATION, AS OWNER OF LAND, AND OAK LAWN LTD., AN ILLINOIS LIMITED PARTNERSHIP, LEASEHOLD TENANT OF PROPERTY ADJOINING LAND, CREATING AN APPURTENANT EASEMENT FOR INGRESS AND EGRESS AND PARKING IN, ON, OVER AND ACROSS PARTS OF THE LAND DESCRIBED IN EXHIBIT 'A' AND 'B' OF SAID GRANT AND TERMS, PROVISIONS AND CONDITIONS CONTAINED THEREIN.

TERMS, PROVISIONS AND CONDITIONS CONTAINED IN ASSUMPTION AGREEMENT RECORDED APRIL 2, 2004 AS DOCUMENT 0409346120 AND RE-RECORDED AS DOCUMENT 0410608028.

(AFFECTS PARCELS TWO AND THREE)

Z 28. RIGHTS OF THE PUBLIC, THE STATE OF ILLINOIS AND THE MUNICIPALITY IN AND TO THAT PART OF THE LAND, IF ANY, TAKEN OR USED FOR ROAD PURPOSES.

(AFFECTS PARCELS TWO AND THREE)

AB 29. NOTE FOR INFORMATION (ENDORSEMENT REQUESTS):

ALL ENDORSEMENT REQUESTS SHOULD BE MADE PRIOR TO CLOSING TO ALLOW AMPLE TIME FOR THE COMPANY TO EXAMINE REQUIRED DOCUMENTATION.

(THIS NOTE WILL BE WAIVED FOR POLICY).

** END **

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Advocate
Christ Medical Center
Hope Children's Hospital

4440 West 95th Street || Oak Lawn, IL 60453 || T 708.684.8000 || advocatehealth.com

April 11, 2011

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

Dear Ms. Avery:

Advocate Christ Medical Center is submitting a Certificate of Need request to build an Ambulatory Pavilion on its campus. This project not only makes sense from a "needs" standpoint – the campus is operating at and beyond capacity, but it speaks to the ever-growing trend of moving more and more health care services from the hospital to the outpatient setting. In 2010, the medical center recorded more than 345,000 outpatient visits. That number is expected to grow exponentially in future years as the population ages and the new federal Health Reform Act, which is being introduced in phases, becomes fully operational.

In fact, we truly have entered an era of health care reform. Hospital cost reimbursements from government and commercial payers are decreasing, while the demands on hospitals for more efficient and cost-effective services are increasing. The proposed Ambulatory Pavilion would do just that – make the delivery of health care more cost-effective, efficient and convenient. The medical center would be able to move much of its on-campus ambulatory care services, including outpatient surgeries, into one location. That would allow for sharing of resources and even staff in the provision of related ambulatory services. As a bonus, patients in need of outpatient care would have an easier time accessing it. Currently, the campus provides outpatient services in a variety of different areas and departments spread across its campus.

I urge the planning board to approve the project. It makes ultimately good sense in a changing health care environment and is an important step in enhancing the medical center's ability to meet the future health needs of the region.

Sincerely,

Alexis Barbour, MHA
Market Director
Clinical Institutes and Operations

Advocate
Christ Medical Center
Hope Children's Hospital

4440 West 95th Street || Oak Lawn, IL 60453 || T 708.684.8000 || advocatehealth.com

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

Dear Ms. Avery:

I want to express my support for Advocate Christ Medical Center's plans to construct an Ambulatory Pavilion on its campus. This is a project that has long been needed. Outpatient services are currently spread out across the campus. Many of the services are provided in facilities that no longer can accommodate the growing demands for health care, new technology and the increasing trend of moving more and more health care from the hospital to the ambulatory care setting.

Frankly, Advocate Christ Medical Center is the major provider of health care services south and southwestern Cook County and Will County. It is also a significant teaching hospital, providing clinical training for some 400 resident physicians, 600 medical students and as many as 900 nursing students annually. Allowing the medical center to expand into a 21st century facility within its current location will ensure its ability to remain a clinical and educational leader well into the future.

Maintaining that leadership also is important to the economy of the region. With an estimated 5,500 employees and more than 1,000 physicians, Advocate Christ Medical Center plays a huge role in the economics of the region. A report released last fall by the Metropolitan Chicago Healthcare Council demonstrated that the medical center generates nearly $900 million in community economic activity as the dollars earned by medical center associates are spent on mortgage payments, rent, food, clothing and other expenses. Additionally, according to the report, the campus creates 1.1 additional jobs in the area for every associate working at the institution.

Construction of the proposed Ambulatory Pavilion is important to the strength and vitality of Christ Medical Center, and I ask that the state planning board approve the project.

Sincerely

Kim Valentine APN, MSN, AOCNS

Advocate
Christ Medical Center
Hope Children's Hospital

4440 West 95th Street || Oak Lawn, IL 60453 || T 708.684.6000 || advocatehealth.com

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

Dear Ms. Avery:

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

Construction of an Ambulatory Pavilion will improve patient access to outpatient services on Christ Medical Center's main campus, allow the medical center to perform more ambulatory surgeries by adding 14 more operating rooms and position the medical center for meeting the area's future health care demands. Just as importantly, giving the medical center an opportunity to centralize its outpatient services in a new facility will free up space in the main hospital building, and that newly available space will enable the campus to improve patient throughput and expand some of its other clinical programs, including its undersized emergency department and its Level I trauma center – the only Level I trauma center serving the Southland and the South Side of Chicago.

I applaud Advocate Christ Medical Center and Hope Children's Hospital for developing a master facility plan that calls for a state-of-the-art outpatient center. This project demonstrates the medical center's foresight in preparing for the future. I urge members of the Illinois Health Facilities and Services Review Board to approve the institution's Certificate of Need request for an Ambulatory Pavilion.

Sincerely,

Wendy Kupiec MS, RN, DCN

Advocate
Christ Medical Center
Hope Children's Hospital

4440 West 95th Street || Oak Lawn, IL 60453 || T 708.684.8000 || advocatehealth.com

April 11, 2011

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Sincerely,

John McKee
Lead Radiation Therapist

Advocate
Christ Medical Center
Hope Children's Hospital

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Sincerely

Peggy Kuper
Manager, Advocate Christ Center for Breast Care

Advocate
Christ Medical Center
Hope Children's Hospital

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Sincerely

Patrice A. Stephens, MS, ARN, AOCN
Breast Health Specialist

Advocate Christ Medical Center
Department of Radiation Oncology
4440 W. 95th Street, Oak Lawn, IL 6045, (708)684-5475 Fax (708)684-8955

Radiation Oncologists
H. James Kang, MD
Chairman
Hwa-Kyung Lee, MD
J. David Morgan, MD
Jayant V. Ghule, MD
Ellie Applenbach, MD
Patrick Yuh, MD

Nick Lendvorex, MS
Senior Physicist
Radiation Safety Officer

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

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Sincerely,

J. David Morgan III, M.D.
Radiation Oncologist
JDM/tr

Advocate Christ Medical Center
Department of Radiation Oncology
4440 W. 95th Street, Oak Lawn, IL 6045, (708)684-5475 Fax (708)684-8055

Radiation Oncologists
H. Jason Kang, MD
Chairman
Hoon-Kyung Lee, MD
J. David Morgan, MD
Jayant V. Gude, MD
Elke Jeppesbock, MD
Faisal Yah, MD

Mick Lambaren, MS
Senior Physicist
Radiation Safety Officer

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Sincerely,

H. Jason Kang, M.D., Chairman
Radiation Oncology Department

4440 West 95th Street
Oak Lawn, Illinois 60453
Telephone 708.684.8000
www.advocatehealth.com

Advocate
Christ Medical Center
Hope Children's Hospital

April 11, 2011

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Illinois Health Facilities and Services Review Board
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Sincerely

Laura Wrona, RN

Laura Wrona, RN, CCRC
Manager, Office of Clinical Research and

Advocate
Christ Medical Center
Hope Children's Hospital

4440 West 95th Street || Oak Lawn, IL 60453 || T 708.684.8000 || advocatehealth.com

April 11, 2011

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Construction of the proposed Ambulatory Pavilion is important to the strength and vitality of Christ Medical Center, and I ask that the state planning board approve the project.

Sincerely,

Ghassan Zalzaleh, MD
Member, Cancer Committee
Advocate Christ Medical Center

Advocate
Christ Medical Center
Hope Children's Hospital

4440 West 95th Street || Oak Lawn, IL 60453 || T 708.684.8000 || advocatehealth.com

April 11, 2011

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Sincerely,

Thomas Hoeltgen, MD
Co-Chairman, Cancer Committee
Advocate Christ Medical Center

Advocate
Christ Medical Center
Hope Children's Hospital

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April 11, 2011

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I urge the planning board to approve the project. It makes ultimately good sense in a changing health care environment and is an important step in enhancing the medical center's ability to meet the future health needs of the region

Sincerely,

Barbara Krueger, MD
Department of Surgery
Advocate Christ Medical Center

Advocate
Christ Medical Center
Hope Children's Hospital

4440 West 95th Street || Oak Lawn, IL 60453 || T 708.684.8000 || advocatehealth.com

April 11, 2011

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

Dear Ms. Avery:

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

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Sincerely,

Jami Walloch, MD
Member, Cancer Committee
Advocate Christ Medical Center

Advocate
Christ Medical Center
Hope Children's Hospital

Cancer Institute
Inspiring medicine.
Changing lives.

4400 West 95th St., Suite 107 POB || Oak Lawn, IL 60453 || T 708.684.6000 || advocatehealth.com

April 12, 2011

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

Dear Ms. Avery:

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

As the Medical Director of the Cancer Institute, I feel the importance of providing multidisciplinary care to patients with cancer is critical. The Cancer Institute is planned to occupy a floor of the new outpatient facility. In this space we will provide a patient-centered environment which will allow evaluation and treatment by the multidisciplinary team. Patients will be able to receive chemotherapy, participate in clinical research, and be cared for in a facility designed to focus on the best evidence-based care in a setting that will also address quality of life issues that are vital to successful completion of therapy. There are facilities for counseling and educational programs as well.

Construction of an Ambulatory Pavilion will improve patient access to outpatient services on Christ Medical Center's main campus, allow the medical center to perform more ambulatory surgeries by adding 14 more operating rooms, and position the medical center for meeting the area's future health care demands. Just as important, giving the medical center an opportunity to centralize its outpatient services in a new facility will free up space in the main hospital building, and that newly available space will enable the campus to improve patient throughput and expand some of its other clinical programs, including its undersized emergency department and its Level I trauma center – the only Level I trauma center serving the Southland and the South Side of Chicago.

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Sincerely,

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

JLW/rd

4440 West 95th Street
Oak Lawn, Illinois 60453
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www.advocatehealth.com

Advocate
Christ Medical Center
Hope Children's Hospital

April 11, 2011

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I urge the planning board to approve the project. It makes ultimately good sense in a changing health care environment and is an important step in enhancing the medical center's ability to meet the future health needs of the region.

Sincerely,

Michele Goodier

Michele Goodier, MHSA, FACHE
Market Executive Director
Cancer Institute and Kidney Transplant

Advocate
Christ Medical Center
Hope Children's Hospital

4440 West 95th Street || Oak Lawn, IL 60453 || T 708.684.8000 || advocatehealth.com

April 15, 2011

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

Dear Ms. Avery:

I am in total support of Advocate Christ Medical Center's plans to construct a modern ambulatory care facility on its campus. As the Executive Director of the Cancer Institute, our cancer team is continuously challenged with the need to take care of more and more patients in a facility that is at capacity. Being able to build this new ambulatory building with the incremental space we need now and into the future would be greatly beneficial to our cancer patients and their families.

The medical center has reached capacity. Some of its oldest facilities were built 50 years ago and are insufficient for accommodating the advanced health services required by 21st century medicine and standards of care. For example, the number of people who are needed to provide safe high quality care has increased in some arenas like the operating rooms. The size and amount of equipment necessary in an OR has drastically changed over the past 50 years. New facilities to help with the congestion and space limitations are sorely needed.

Within this new building, we will be able to consolidate all of the outpatient clinical services related to care of the cancer patient. Our intent is to have a variety of specialists seeing patients in one location. This cannot currently be done due to space constraints. The new building would enable us to do this fostering greater communication and coordination of a patient's care. It would also give other clinical staff such as genetic counselors, research nurses, and nutritionists, for example, an opportunity to more easily access the cancer physicians and talk with them about additional services for the patient and coordinating that care all in one location. The coordination and communication regarding patients' plans of treatment will be greatly enhanced simply by the caregivers' proximity to one another.

Construction of an ambulatory facility on the Advocate Christ Medical Center campus is long overdue. Our community and patients will truly benefit by this expansion and my fervent hope is that the planning board will expedite approval of the project.

Sincerely,

Michele Goodier

Michele Goodier, MHSA, FACHE
Market Executive Director
Cancer Institute and Kidney Transplant Program

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Hope Children's Hospital

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Springfield, Illinois 62761

Dear Ms. Avery:

I want to express my support for Advocate Christ Medical Center's plans to construct an Ambulatory Pavilion on its campus. This is a project that has long been needed. Outpatient services are currently spread out across the campus. Many of the services are provided in facilities that no longer can accommodate the growing demands for health care, new technology and the increasing trend of moving more and more health care from the hospital to the ambulatory care setting.

Frankly, Advocate Christ Medical Center is the major provider of health care services south and southwestern Cook County and Will County. It is also a significant teaching hospital, providing clinical training for some 400 resident physicians, 600 medical students and as many as 900 nursing students annually. Allowing the medical center to expand into a 21st century facility within its current location will ensure its ability to remain a clinical and educational leader well into the future.

Maintaining that leadership also is important to the economy of the region. With an estimated 5,500 employees and more than 1,000 physicians, Advocate Christ Medical Center plays a huge role in the economies of the region. A report released last fall by the Metropolitan Chicago Healthcare Council demonstrated that the medical center generates nearly $900 million in community economic activity as the dollars earned by medical center associates are spent on mortgage payments, rent, food, clothing and other expenses. Additionally, according to the report, the campus creates 1.1 additional jobs in the area for every associate working at the institution.

Construction of the proposed Ambulatory Pavilion is important to the strength and vitality of Christ Medical Center, and I ask that the state planning board approve the project.

Sincerely,

Vanessa Prorwicz-Lehnhardt, PharmD, BCOP

Advocate Christ Medical Center
Department of Radiation Oncology
4440 W. 95th Street, Oak Lawn, IL 6045, (708)684-8475 Fax (708)684-8055

Radiation Oncologists
H. Jason Kang, MD
Chairman
Hun-Nyung Lee, MD
J. David Hoeppner, MD
Sajjad U. Gondi, MD
Elke Algyersbrock, MD
Faisal Vali, MD

Nick Lembesis, MS
Senior Physicist
Radiation Safety Officer

April 11, 2011

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

Dear Ms. Avery:

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

Construction of an Ambulatory Pavilion will improve patient access to outpatient services on Christ Medical Center's main campus, allow the medical center to perform more ambulatory surgeries by adding 14 more operating rooms and position the medical center for meeting the area's future health care demands. Just as importantly, giving the medical center an opportunity to centralize its outpatient services in a new facility will free up space in the main hospital building, and that newly available space will enable the campus to improve patient throughput and expand some of its other clinical programs, including its undersized emergency department and its Level I trauma center – the only Level I trauma center serving the Southland and the South Side of Chicago.

I applaud Advocate Christ Medical Center and Hope Children's Hospital for developing a master facility plan that calls for a state-of-the-art outpatient center. This project demonstrates the medical center's foresight in preparing for the future. I urge members of the Illinois Health Facilities and Services Review Board to approve the institution's Certificate of Need request for an Ambulatory Pavilion.

Sincerely,

Faisal Vali, M.D.
Radiation Oncologist
FV/tr

Advocate Christ Medical Center
Department of Radiation Oncology
4440 W. 95th Street, Oak Lawn, IL 6045, (708)684-6475 Fax (708)684-3055

Radiation Oncologists
H. Jerrie Kelly, MD
Chairman
Hoon-Kyung Lee, MD
J. David Morgan, MD
Jayant V. Ghate, MD
Elke Aippersbach, MD
Faisal Yaik, MD

Nick Lembares, MS
Senior Physicist
Radiation Safety Officer

April 11, 2011

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

Dear Ms. Avery:

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

Construction of an Ambulatory Pavilion will improve patient access to outpatient services on Christ Medical Center's main campus, allow the medical center to perform more ambulatory surgeries by adding 14 more operating rooms and position the medical center for meeting the area's future health care demands. Just as importantly, giving the medical center an opportunity to centralize its outpatient services in a new facility will free up space in the main hospital building, and that newly available space will enable the campus to improve patient throughput and expand some of its other clinical programs, including its undersized emergency department and its Level I trauma center – the only Level I trauma center serving the Southland and the South Side of Chicago.

I applaud Advocate Christ Medical Center and Hope Children's Hospital for developing a master facility plan that calls for a state-of-the-art outpatient center. This project demonstrates the medical center's foresight in preparing for the future. I urge members of the Illinois Health Facilities and Services Review Board to approve the institution's Certificate of Need request for an Ambulatory Pavilion.

Sincerely,

Elke Aippersbach, M.D.
Radiation Oncologist
EA/tr

4440 West 95th Street
Oak Lawn, Illinois 60453
Telephone 708.684.8000
www.advocatehealth.com

Advocate
Christ Medical Center
Hope Children's Hospital

April 13, 2011

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

Dear Ms. Avery:

Advocate Christ Medical Center is submitting a Certificate of Need request to build an Ambulatory Pavilion on its campus. This project not only makes sense from a "needs" standpoint – the campus is operating at and beyond capacity, but it speaks to the ever-growing trend of moving more and more health care services from the hospital to the outpatient setting. In 2010, the medical center recorded more than 345,000 outpatient visits. That number is expected to grow exponentially in future years as the population ages and the new federal Health Reform Act, which is being introduced in phases, becomes fully operational.

In fact, we truly have entered an era of health care reform. Hospital cost reimbursements from government and commercial payers are decreasing, while the demands on hospitals for more efficient and cost-effective services are increasing. The proposed Ambulatory Pavilion would do just that – make the delivery of health care more cost-effective, efficient and convenient. The medical center would be able to move much of its on-campus ambulatory care services, including outpatient surgeries, into one location. That would allow for sharing of resources and even staff in the provision of related ambulatory services. As a bonus, patients in need of outpatient care would have an easier time accessing it. Currently, the campus provides outpatient services in a variety of different areas and departments spread across its campus.

Advocate Christ medical Center is also a significant teaching hospital, providing clinical training for some 400 resident physicians, 600 medical students and as many as 900 nursing students annually. With an estimated 5,500 employees and more than 1,000 physicians, Advocate Christ Medical Center plays a huge role in the economics of the region. A report released last fall by the Metropolitan Chicago Healthcare Council demonstrated that the medical center generates nearly $900 million in community economic activity as the dollars earned by medical center associates are spent on mortgage payments, rent, food, clothing and other expenses. Additionally, according to the report, the campus creates 1.1 additional jobs in the area for every associate working at the institution.

Allowing the medical center to expand into a 21st century facility within its current location will ensure its ability to remain a clinical and educational leader well into the future. Maintaining this leadership is important to the economy of the region.

I urge the planning board to approve the project. It makes ultimately good sense in a changing health care environment and is an important step in enhancing the medical center's ability to meet the future health needs of the region.

Sincerely,

Deborah A. Stlasko MSN, APN, AOCNS
Oncology Clinical Nurse Specialist
Cancer Institute

Advocate
Christ Medical Center
Hope Children's Hospital

4440 West 95th Street || Oak Lawn, IL 60453 || T 708.684.8000 || advocatehealth.com

April 11, 2011

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

Dear Ms. Avery:

I favor Advocate Christ Medical Center's plans to construct a modern ambulatory care facility on its campus, and here is why:

- The medical center has reached capacity. Some of its oldest facilities were built 50 years ago and are insufficient for accommodating the advanced health services required by 21st century communities. In the fall of last year, *Crain's Chicago Business* published its annual listing of the Chicago area's largest 25 hospitals. According to the report, Christ Medical Center led all area hospitals with an 89.4 percent daily patient occupancy rate in 2009, based on 653 available beds. In terms of total inpatient days, Advocate Christ Medical Center and Hope Children's Hospital also placed first with 212,977 days in 2009.

- Centralization of outpatient care in a single location at the medical center will free up space in other buildings for necessary expansion of clinical programs, including emergency services, and make the delivery of health care much more efficient by improving patient throughput.

- The new facility will greatly enhance the ability of area residents to access outpatient services on the campus. Parking also will be much more convenient.

- The project addresses the federal health reform mandate to make health care services more efficient and cost-effective.

Construction of an ambulatory pavilion at Advocate Christ Medical Center is overdue. My hope is that the planning board will expedite approval of the project.

Sincerely,

Paul Gordon, MD
Medical Director, Thoracic Oncology Program
Advocate Christ Medical Center

Advocate Christ Medical Center
Department of Radiation Oncology
4440 W. 95th Street, Oak Lawn, IL 60415, (708)684-8475 Fax (708)684-8855

Radiation Oncologists
H. Jason Kang, MD
Chairman
Hun-Hyung Lee, MD
J. David Morgan, MD
Jayant V. Gude, MD
Elke Hyperstedt, MD
Farid Vali, MD

Mick Lambaris, MS
Senior Physicist
Radiation Safety Officer

April 11, 2011

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

Dear Ms. Avery:

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

Construction of an Ambulatory Pavilion will improve patient access to outpatient services on Christ Medical Center's main campus, allow the medical center to perform more ambulatory surgeries by adding 14 more operating rooms and position the medical center for meeting the area's future health care demands. Just as importantly, giving the medical center an opportunity to centralize its outpatient services in a new facility will free up space in the main hospital building, and that newly available space will enable the campus to improve patient throughput and expand some of its other clinical programs, including its undersized emergency department and its Level 1 trauma center – the only Level 1 trauma center serving the Southland and the South Side of Chicago.

I applaud Advocate Christ Medical Center and Hope Children's Hospital for developing a master facility plan that calls for a state-of-the-art outpatient center. This project demonstrates the medical center's foresight in preparing for the future. I urge members of the Illinois Health Facilities and Services Review Board to approve the institution's Certificate of Need request for an Ambulatory Pavilion.

Sincerely,

Jayant Gude, MD
Radiation Oncologist
JG/tr

Advocate Christ Medical Center
Department of Radiation Oncology
4440 W. 95th Street, Oak Lawn, IL 6045, (708)684.5475 Fax (708)684.3055

Radiation Oncologists
H. Jesse Kagg, MD
Chairman
Ham-Nyung Lee, MD
J. David Morgan, MD
Jayant V. Gholap, MD
Elke Abuwarda, MD
Faisal Taj, MD

Nick Lembersi, MS
Senior Physicist
Radiation Safety Officer

April 11, 2011

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

Dear Ms. Avery:

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

Construction of an Ambulatory Pavilion will improve patient access to outpatient services on Christ Medical Center's main campus, allow the medical center to perform more ambulatory surgeries by adding 14 more operating rooms and position the medical center for meeting the area's future health care demands. Just as importantly, giving the medical center an opportunity to centralize its outpatient services in a new facility will free up space in the main hospital building, and that newly available space will enable the campus to improve patient throughput and expand some of its other clinical programs, including its undersized emergency department and its Level I trauma center – the only Level I trauma center serving the Southland and the South Side of Chicago.

I applaud Advocate Christ Medical Center and Hope Children's Hospital for developing a master facility plan that calls for a state-of-the-art outpatient center. This project demonstrates the medical center's foresight in preparing for the future. I urge members of the Illinois Health Facilities and Services Review Board to approve the institution's Certificate of Need request for an Ambulatory Pavilion.

Sincerely,

Ham-Nyung Lee, M.D.
Radiation Oncologist
HNL/tr

Advocate Christ Medical Center
Department of Radiation Oncology
4440 W. 95th Street, Oak Lawn, IL 60453, (708)684-8475 Fax (708)684-8056

Radiation Oncologists
H. Jason Kang, MD
Chairman
Hee-Kyung Lee, MD
J. David Morgan, MD
Jayasri V. Gilada, MD
Elke Aggerbeck, MD
Faisal Fali, MD

Nick Lenkaree, MS
Senior Physicist
Radiation Safety Officer

April 11, 2011

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

Dear Ms. Avery:

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

Construction of an Ambulatory Pavilion will improve patient access to outpatient services on Christ Medical Center's main campus, allow the medical center to perform more ambulatory surgeries by adding 14 more operating rooms and position the medical center for meeting the area's future health care demands. Just as importantly, giving the medical center an opportunity to centralize its outpatient services in a new facility will free up space in the main hospital building, and that newly available space will enable the campus to improve patient throughput and expand some of its other clinical programs, including its undersized emergency department and its Level I trauma center – the only Level I trauma center serving the Southland and the South Side of Chicago.

I applaud Advocate Christ Medical Center and Hope Children's Hospital for developing a master facility plan that calls for a state-of-the-art outpatient center. This project demonstrates the medical center's foresight in preparing for the future. I urge members of the Illinois Health Facilities and Services Review Board to approve the institution's Certificate of Need request for an Ambulatory Pavilion.

Sincerely,

H. Jason Kang, M.D.
Radiation Oncologist
HJK/tr

Advocate
Christ Medical Center
Hope Children's Hospital

4440 West 95th Street || Oak Lawn, IL 60453 || T 708.684.8000 || advocatehealth.com

April 7, 2011

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

Dear. Ms. Avery:

I am writing to express my support of the construction of a new Ambulatory Pavilion on the Christ Medical Center Campus in Oak Lawn, IL. The addition of the Ambulatory Pavilion will support the growing need for additional space in order to continue to provide top level medical treatment. Presently the hospital is a 665-bed State Designated Level I Trauma Center serving the entire South Side of Chicago and surrounding suburbs. The addition of the Ambulatory Pavilion will improve patient care and provide a state-of-the-art ambulatory treatment center for the community and surrounding areas.

The Ambulatory Pavilion will focus on patient centered care while providing timely services designed around outpatient needs. Outpatients requiring multiple laboratory services will be more efficiently served as all of their needs will be met in one updated location. Patients with mobility issues will benefit greatly without the burden of traveling to multiple locations for testing and treatment. With the increased need for efficient and cost-effective cancer diagnosis and treatment, this new facility will greatly benefit patient care. Centralizing outpatient treatment will free up space in the main hospital enabling better utilization for the expansion of inpatient services and clinics. Most importantly it will reduce the overcapacity of the Emergency Department that often goes into bypass due to the high volume and lack of space. As health care demands increase the Ambulatory Pavilion will be a great asset for patients in the community to continue to receive quality healthcare customized to meet their needs.

I am in full support of Advocate Christ Medical Center and Hope Children's Hospital plans for the addition of the Ambulatory Pavilion. This addition will benefit the community and surrounding areas now and well into the future. I urge members of the Illinois Health Facilities and Services Review Board to approve the institutions Certification of Need request for an Ambulatory Pavilion.

Sincerely,

John F. Hamilton, M.D.
Chairman, The Department of Pathology

Advocate
Christ Medical Center
Hope Children's Hospital

4440 West 95th Street || Oak Lawn, IL 60453 || T 708.684.8000 || advocatehealth.com

April 8, 2011

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

Dear Ms. Avery:

I am writing this letter in my capacity as director of maternal-fetal medicine at Advocate Christ Hospital. I wholeheartedly support plans by Advocate Christ Medical Center to construct an Ambulatory Pavilion on its Oak Lawn campus. This proposal responds to the hospital's critical need to increase its capacity. The medical center serves as the only comprehensive tertiary and quaternary care facility in the Southland and more specifically for pregnant woman is the only level III hospital in the region.

Pregnant woman who rely on Christ arrive with the most complex maternal and fetal issues, and construction of the new pavilion will serve in many ways. The patients, most unable to obtain the care they need at other centers, will not only have their care enhanced by the improved access the Pavilion will provide, but their ability to obtain quality lifelong care will also be enhanced.

Physicians in the community have come to rely on the maternal, fetal and neonatal services at Christ. This critical expansion will allow us better to serve all.

Respectfully

James Keller MD
Director Maternal-Fetal Medicine

Advocate
Christ Medical Center
Hope Children's Hospital

4440 West 95th Street | Oak Lawn, IL 60453 | T 708.684.8000 | advocatehealth.com

April 7, 2011

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

Dear Ms. Avery:

As the Chief/Medical Director of Surgical Services at Advocate Christ Medical Center, I sincerely support plans to construct an Ambulatory Pavilion on its Oak Lawn campus. This proposal responds to the hospital's critical need to increase its capacity. The medical center serves as the only comprehensive tertiary and quaternary care facility in the Southland, and the residents whom I represent depend on it remaining a top-level facility that is able to expand to meet the growing needs of communities in our region.

Construction of an Ambulatory Pavilion will improve patient access to outpatient services on Christ Medical Center's main campus, allow the medical center to perform more ambulatory surgeries by adding 14 more operating rooms and position the medical center for meeting the area's future health care demands. Just as importantly, giving the medical center an opportunity to centralize its outpatient services in a new facility will free up space in the main hospital building, and that newly available space will enable the campus to improve patient throughput and expand some of its other clinical programs, including its undersized emergency department and its Level I trauma center – the only Level I trauma center serving the Southland and the South Side of Chicago.

I, the Chief/Medical Director of Surgical Services, support Advocate Christ Medical Center and Hope Children's Hospital for developing a master facility plan that calls for a state-of-the-art outpatient center. This project demonstrates the medical center's foresight in preparing for the future. I urge members of the Illinois Health Facilities and Services Review Board to approve the institution's Certificate of Need request for an Ambulatory Pavilion.

Sincerely,

George F. Mesleh, M.D. F.A.C.S.
Chief/Medical Director
Surgical Services

ASSOCIATES IN REHABILITATION MEDICINE, S.C.

April 13, 2011

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

Dear Ms. Avery:

I am writing you to express my wholehearted support for Advocate Christ Medical Center's plans to construct an Ambulatory Pavilion on its campus. I have practiced at this medical center for 25 years both as a practioner and as president of the medical staff. Over this time I have witnessed the ever increasing need for clinical services, including outpatient, and the worsening inadequacy of our facilities to provide that care. This project is long overdue.

The medical center has reached capacity. Some of its oldest facilities were built 50 years ago and are insufficient for accommodating the advanced health services required by 21st century communities. In the fall of last year, *Crain's Chicago Business* published its annual listing of the Chicago area's largest 25 hospitals. According to the report, Christ Medical Center led all area hospitals with an 89.4 percent daily patient occupancy rate in 2009, based on 653 available beds. In terms of total inpatient days, Advocate Christ Medical Center and Hope Children's Hospital also placed first with 212,977 days in 2009.

Construction of an Ambulatory Pavilion will improve patient access to outpatient services on Christ Medical Center's main campus, providing an opportunity to centralize its outpatient services in a new facility that will free up space in the main hospital building. That newly available space will enable the campus to improve patient throughput and expand some of its other clinical programs, including its undersized emergency department and its Level I trauma center – the only Level I trauma center serving the Southland and the South Side of Chicago.

Construction of the proposed Ambulatory Pavilion is important to the strength and vitality of Christ Medical Center and the many communities it serves, and I ask that the state planning board approve the project.

Sincerely,

William A. Adair, MD, FAAPM&R
President, Associates in Rehabilitation Medicine, S.C.

Associates in Rehabilitation Medicine, S.C.
4440 W. 95th St.
Oak Lawn, IL 60453
708.684.5428

4440 West 95th Street
Oak Lawn, Illinois 60453
Telephone 708.684.8000
www.advocatehealth.com

Advocate
Christ Medical Center
Hope Children's Hospital

04/07/2011

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

Dear Ms. Avery:

I am writing to express my support for Advocate Christ Medical Center's plans to construct an Ambulatory Pavilion on its campus. I have been on the medical staff since 1986 and am presently the Chair and Medical Director of the department of Physical Medicine and Rehabilitation. I have seen tremendous growth in the services provided here, with an attendant unacceptable difficulty in meeting our patients' needs because of limited space. Outpatient services are currently spread out across the campus. On a daily basis, patients experience great difficulty accessing the various outpatient services. Every day, in my area of rehabilitation, patients arrive late to appointments for reasons directly related to the lack of centrality of outpatient services. In addition, it is common for patients to be forced to go elsewhere for services because of the inconvenience of parking and scheduling delays. This is a project that is long overdue.

Construction of an Ambulatory Pavilion will drastically improve patient access to outpatient services on Christ Medical Center's main campus and will free up space in the main hospital building. That newly available space will enable the campus to improve patient throughput and expand some of its other clinical programs, including its undersized emergency department and its Level I trauma center – the only Level I trauma center serving the Southland and the South Side of Chicago.

Construction of the proposed Ambulatory Pavilion is important to the strength and vitality of Christ Medical Center, and I urge the state planning board to approve the project.

Sincerely,

Roy L. Adair MD

Roy L. Adair, MD, FAAPMR, FAANEM
Chair and Medical Director
Department of Physical Medicine and Rehabilitation
Advocate Christ Medical Center

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

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

4440 West 95th Street
Oak Lawn, Illinois 60453
Telephone 708.684.8000
www.advocatehealth.com

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Christ Medical Center
Hope Children's Hospital

04/07/2011

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

Dear Ms. Avery,

My name is Melvin Wichter M.D. and I am Chairman of the Department of Neurology at Advocate Christ Medical Center and Co-Director of the Neuroscience Institute at that institution. I have been working as a neurologist at Christ hospital for the past 34 years, and I have watched its extraordinary growth and development. We have emerged from a community hospital to a nationally ranked tertiary hospital capable of treating the most complex patients imaginable. Along the way, however, our physical growth has been slower than our programmatic growth. The consequence of this discrepancy is a hospital space incapable of supporting the volume of patients and services. Simply put, we are working in a sardine can without room for another fish.

We are the busiest neuroscience service in the State; this includes neurosurgical trauma and stroke as part of its essential core activities. In order to accommodate the expanding baby boomer population, in which neurologic disease is over-represented, we must decompress our outpatient facility to provide improved care for Alzheimer's, Parkinson's, stroke and epilepsy patients, and other guests who will be better served by receiving care in a less frantic environment. This would provide our inpatient service an improved environment to treat the urgently sick patients that we have become extraordinarily adept at managing.

Our present circumstances are becoming increasingly unacceptable, as our system gets backed up from the moment patients arrive in the emergency room because of unavailable ICU beds, operating theaters, recovery space, unacceptable multiple patient rooms, and lack of usable space to gather our thoughts and take a breath.

For all of these reasons and many more, I fully endorse the construction of our Outpatient Pavilion which would include significant space devoted to the Neuroscience Institute.

Sincerely,

Melvin D. Wichter, M.D.
Professor of Clinical Neurology
University of Illinois Chicago College of Medicine
Chairman, Department of Neurology
Advocate Christ Medical Center

4440 West 95th Street
Oak Lawn, Illinois 60453
Telephone 708.684.8000
www.advocatehealth.com

Advocate
Christ Medical Center
Hope Children's Hospital

04/07/2011

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

Dear Ms. Avery,

Advocate Christ Medical Center (ACMC) is planning to build a state of the art ambulatory care center at the Oak Lawn campus. For too long, ACMC has been evaluating and treating outpatients under constraints of very limited facilities. In fact, last year approximately 345,000 outpatient visits were completed. Being one of the largest hospitals in the Chicago metro region and, certainly, the largest hospital in the southwest corridor necessitates that both inpatient and outpatient facilities be expanded to accommodate not only the current population but also the expected population growth of the suburban southwest corridor. Currently, outpatient services are provided at several locations on the campus of ACMC. For patient convenience, cost effectiveness, and to provide the hospital room to decompress its current inpatient services, it makes good sense that an ambulatory facility be built. ACMC is not only a top notch tertiary hospital but is also a major teaching center for 3 medical schools including; the University of Illinois, Rosalind Franklin School of Medicine and Science and Midwestern University. Having a centralized ambulatory facility center would enhance student and resident education and experience.

Advocate Christ Medical Center is an important fixture in the southwest corridor. Its presence allows patients in this region access to both routine and high-level tertiary care within a reasonable distance of their residences. Medical care in the southwest corridor is dependent on the viability and expansion of ACMC services because ACMC offers services that are unique to the area. A large segment of the hospital employees and physicians live within the catchment area of the hospital, thus the hospital also provides economic and employment stability in the region. In an era of austerity for delivery of medical care, it is requisite that an ambulatory center be erected.

It is my wish to not only sustain Advocate Christ Medical Center but also to grow the facility in order to continue to assume its role as a leader of healthcare delivery. I wholeheartedly support the Certificate of Need request to build this ambulatory center. The new pavilion will ensure convenient care for patients, state of the art facilities for physician and support personnel, and offer a better environment for preparing students and residents to take their rightful place as physicians of the next generation.

Sincerely,

Robert T. Egel, M.D.
Div. Head, Pediatric Neurology
Vice Chair, Dept. of Neurology
Advocate Christ Med Ctr/Hope Children's Hosp