

ORIGINAL

14-051

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

OCT 01 2014

This Section must be completed for all projects.

HEALTH FACILITIES &
SERVICES REVIEW BOARD

Facility/Project Identification

Facility Name:	Central DuPage Hospital		
Street Address:	25 North Winfield Road		
City and Zip Code:	Winfield, Illinois 60190		
County:	DuPage	Health Service Area	7
		Health Planning Area:	A-05

Applicant /Co-Applicant Identification

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

Exact Legal Name:	Central DuPage Hospital Association
Address:	25 North Winfield Road, Winfield, Illinois 60190
Name of Registered Agent:	Liz Rosenberg
Name of Chief Executive Officer:	Brian Lemon
CEO Address:	25 North Winfield Road, Winfield, IL 60190
Telephone Number:	630-933-1600

Type of Ownership of Applicant/Co-Applicant

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

Primary Contact

[Person to receive ALL correspondence or inquiries]

Name:	Bridget Orth
Title:	Director, Regulatory Facility Planning
Company Name:	Northwestern Memorial HealthCare
Address:	211 East Ontario Street Suite 1750, Chicago, IL 60611
Telephone Number:	312-926-8650
E-mail Address:	borth@nmh.org
Fax Number:	312-926-4545

Additional Contact

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

Name:	Katharine Bertani
Title:	Director, Women and Children's Service Line
Company Name:	Cadence Health
Address:	25 North Winfield Road, Winfield, IL 60190
Telephone Number:	630-933-3773
E-mail Address:	katharine.bertani@cadencehealth.com
Fax Number:	630-933-2439

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

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Street Address:	25 North Winfield Road		
City and Zip Code:	Winfield, Illinois 60190		
County:	DuPage	Health Service Area	7
		Health Planning Area:	A-05

Applicant /Co-Applicant Identification

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

Exact Legal Name:	CDH-DeInor Health System d/b/a Cadence Health
Address:	25 North Winfield Road, Winfield, Illinois 60190
Name of Registered Agent:	Liz Rosenberg
Name of Chief Executive Officer:	Michael Vivoda
CEO Address:	25 North Winfield Road, Winfield, IL 60190
Telephone Number:	630-933-1600

Type of Ownership of Applicant/Co-Applicant

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Telephone Number:	312-926-8650
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Name:	Katharine Bertani
Title:	Director, Women and Children's Service Line
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ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Central DuPage Hospital		
Street Address:	25 North Winfield Road		
City and Zip Code:	Winfield, Illinois 60190		
County:	DuPage	Health Service Area	7
		Health Planning Area:	A-05

Applicant /Co-Applicant Identification

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

Exact Legal Name:	Northwestern Memorial HealthCare
Address:	251 East Huron Street, Chicago, Illinois 60611
Name of Registered Agent:	James C. Dechene
Name of Chief Executive Officer:	Dean M. Harrison
CEO Address:	251 East Huron Street, Chicago, Illinois 60611
Telephone Number:	312-926-3007

Type of Ownership of Applicant/Co-Applicant

☒ 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.

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

Primary Contact

[Person to receive ALL correspondence or inquiries]

Name:	Bridget Orth
Title:	Director, Regulatory Facility Planning
Company Name:	Northwestern Memorial HealthCare
Address:	211 East Ontario Street Suite 1750, Chicago, IL 60611
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Telephone Number:	630-933-3773
E-mail Address:	katharine.bertani@cadencehealth.com
Fax Number:	630-933-2439

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:	Bridget Orth
Title:	Director, Regulatory Facility Planning
Company Name:	Northwestern Memorial Healthcare
Address:	211 East Ontario Street Suite 1750, Chicago, IL 60611
Telephone Number:	312-926-8650
E-mail Address:	borth@nmh.org
Fax Number:	312-926-4545

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Central DuPage Hospital Association
Address of Site Owner:	25 North Winfield Road, Winfield, Illinois 60190
Street Address or Legal Description of Site:	25 North Winfield Road, Winfield, Illinois 60190
Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.	
APPEND DOCUMENTATION AS <u>ATTACHMENT-2</u> , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

Operating Identity/Licensee

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

Exact Legal Name:	Central DuPage Hospital Association		
Address:	25 North Winfield Road, Winfield, Illinois 60190		
☒	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 <u>ATTACHMENT-3</u> , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Organizational Relationships

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

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

Flood Plain Requirements

[Refer to application instructions.]

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

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

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

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

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

DESCRIPTION OF PROJECT**1. Project Classification**

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

Part 1110 Classification:

- ☐ Substantive
- ☒ Non-substantive

2. Narrative Description

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

Central DuPage Hospital (CDH) proposes to modernize its pediatrics and neonatal intensive care unit (NICU) at the CDH campus located at 25 North Winfield Road, Winfield.

The modernization project will relocate the pediatrics unit from the 1st floor to the 4th floor of the Women and Children's building and will add 12 pediatrics beds to the current license. The project also expands the NICU on the 1st floor by adding 6 Level II beds and reconfigures the support spaces for the NICU.

The project also includes modernization of non-clinical components including: a satellite pharmacy, on-call room, public waiting areas, etc.

The project will be completed in two phases. The first phase will be the build-out of the main pediatrics unit on the 4th floor. When that is completed, the NICU modernization/expansion will occur in the vacated pediatrics space.

The project is classified as non-substantive pursuant to Section 1110.40.

Total project cost is \$14,213,951. The project close-out will be by December, 2016.

Project Costs and Sources of Funds

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

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs	\$ 187,500	\$ 62,500	\$ 250,000
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts	\$ 7,457,006	\$ 1,592,040	\$ 9,049,046
Contingencies	\$ 745,701	\$ 159,204	\$ 904,905
Architectural/Engineering Fees	\$ 720,000	\$ 240,000	\$ 960,000
Consulting and Other Fees	\$ 337,500	\$ 112,500	\$ 450,000
Movable or Other Equipment (not in construction contracts)	\$ 2,600,000		\$ 2,600,000
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	\$ 12,047,707	\$ 2,166,244	\$ 14,213,951
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	\$ 12,047,707	\$ 2,166,244	\$ 14,213,951
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	\$ 12,047,707	\$ 2,166,244	\$ 14,213,951
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 \$ _____ N/A

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.
Indicate the stage of the project's architectural drawings: ☐ None or not applicable ☐ Preliminary ☒ Schematics ☐ Final Working
Anticipated project completion date (refer to Part 1130.140): <u>December, 2016</u>
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 <u>ATTACHMENT-8</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals

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

Cost Space Requirements

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

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
REVIEWABLE							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							
APPEND DOCUMENTATION AS <u>ATTACHMENT-9</u> , 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: Central DuPage Hospital			CITY: Winfield		
REPORTING PERIOD DATES: CY13 From: 1/1/13 to: 12/31/13					
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	233	15,267	61,759	0	233
Obstetrics	35	3,378	9,920	0	35
Pediatrics	10	1,268	3,650	+12	22
Intensive Care	46	2,188	10,384	0	46
Comprehensive Physical Rehabilitation	0	0	0	0	0
Acute/Chronic Mental Illness	48	1,292	5,475	0	48
Neonatal Intensive Care	8	378	2,920	0	8
General Long Term Care	0	0	0	0	0
Specialized Long Term Care	0	0	0	0	0
Long Term Acute Care	0	0	0	0	0
Other ((identify))	0	0	0	0	0
TOTALS:	380	23,771	94,108	+12	392

CERTIFICATION

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

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

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

Brian Lemon
SIGNATURE

Brian Lemon
PRINTED NAME

President, Central DuPage Hospital
PRINTED TITLE

Lawrence D. Bell
SIGNATURE

Lawrence D. Bell
PRINTED NAME

Vice President, Construction, CDH
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 26th day of September 2014

Susan M. Bove
Signature of Notary

Seal

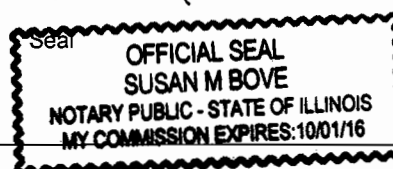


*Insert EXACT legal name of the applicant

Notarization:
Subscribed and sworn to before me
this 26th day of September 2014

Susan M. Bove
Signature of Notary

Seal



CERTIFICATION

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

This Application for Permit is filed on the behalf of CDH-Delnor Health System d/b/a Cadence Health * 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

Michael V. Vivoda
PRINTED NAME

President, Northwestern Medicine Western Region
PRINTED TITLE



SIGNATURE

Deb O'Donnell
PRINTED NAME

Executive Vice President, Patient Care Services & CNO
PRINTED TITLE

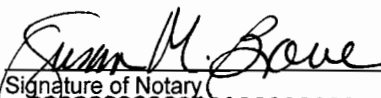
Notarization:

Subscribed and sworn to before me

this 24TH day of September 2014

Notarization:

Subscribed and sworn to before me

this 24TH day of September 2014


Signature of Notary

Seal

OFFICIAL SEAL
SUSAN M BOVE
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES: 10/01/16

*Insert EXACT legal name of the applicant



Signature of Notary

Seal

OFFICIAL SEAL
SUSAN M BOVE
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES: 10/01/16

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- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
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- in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of Northwestern Memorial HealthCare *
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.



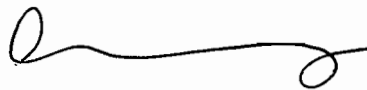
SIGNATURE

Dean M. Harrison

PRINTED NAME

President & CEO, NMHC

PRINTED TITLE



SIGNATURE

Liz Rosenberg

PRINTED NAME

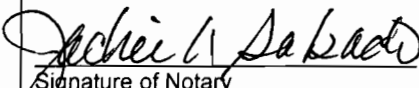
Senior Vice President, Strategy

PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 24th day of September

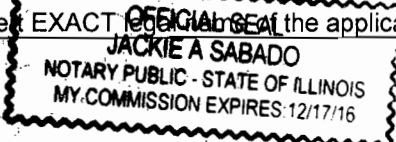
Notarization:

Subscribed and sworn to before me
this 26th day of September 2014


Signature of Notary

Seal

*Insert EXACT legal name of the applicant




Signature of Notary

Seal **OFFICIAL SEAL**
SUSAN M BOVE
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES: 10/01/16

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

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

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

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

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

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

PURPOSE OF PROJECT

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

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

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

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

ALTERNATIVES

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

Alternative options **must** include:

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

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

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

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

SECTION IV - PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE**Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space**

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative.**
2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following:
 - a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;
 - b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;
 - c. The project involves the conversion of existing space that results in excess square footage.

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

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

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

PROJECT SERVICES UTILIZATION:

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

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

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

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MET STANDARD?
YEAR 1					
YEAR 2					

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

UNFINISHED OR SHELL SPACE:

Provide the following information:

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

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

ASSURANCES:

Submit the following:

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

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

SECTION VII - SERVICE SPECIFIC REVIEW CRITERIA

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

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

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

Category of Service	# Existing Beds	# Proposed Beds
☐ Medical/Surgical		
☐ Obstetric		
☒ Pediatric	10	22
☐ Intensive Care		

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

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

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

O. Criterion 1110.3030 - Clinical Service Areas Other than Categories of Service

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

Service	# Existing Key Rooms	# Proposed Key Rooms
☒ NICU - Level II	15	21
☐		
☐		

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

PROJECT TYPE	REQUIRED REVIEW CRITERIA	
New Services or Facility or Equipment	(b) -	Need Determination - Establishment
Service Modernization	(c)(1) -	Deteriorated Facilities
		and/or
	(c)(2) -	Necessary Expansion
		PLUS
	(c)(3)(A) -	Utilization - Major Medical Equipment
		Or
	(c)(3)(B) -	Utilization - Service or Facility
APPEND DOCUMENTATION AS <u>ATTACHMENT-34</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.		

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

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

VIII. - 1120.120 - Availability of Funds

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

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

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

IX. 1120.130 - Financial Viability

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT-37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

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

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

2. Variance

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

APPEND DOCUMENTATION AS ATTACHMENT 38, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

X. 1120.140 - Economic Feasibility

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

A. Reasonableness of Financing Arrangements

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

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

B. Conditions of Debt Financing

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

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

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

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

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

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

XI. Safety Net Impact Statement

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

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

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

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

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

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

Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

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

XII. Charity Care Information

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

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.
3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

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

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

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

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

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

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



To all to whom these Presents Shall Come, Greeting:

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

CENTRAL DU PAGE HOSPITAL ASSOCIATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON AUGUST 05, 1958, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 14TH day of OCTOBER A.D. 2013

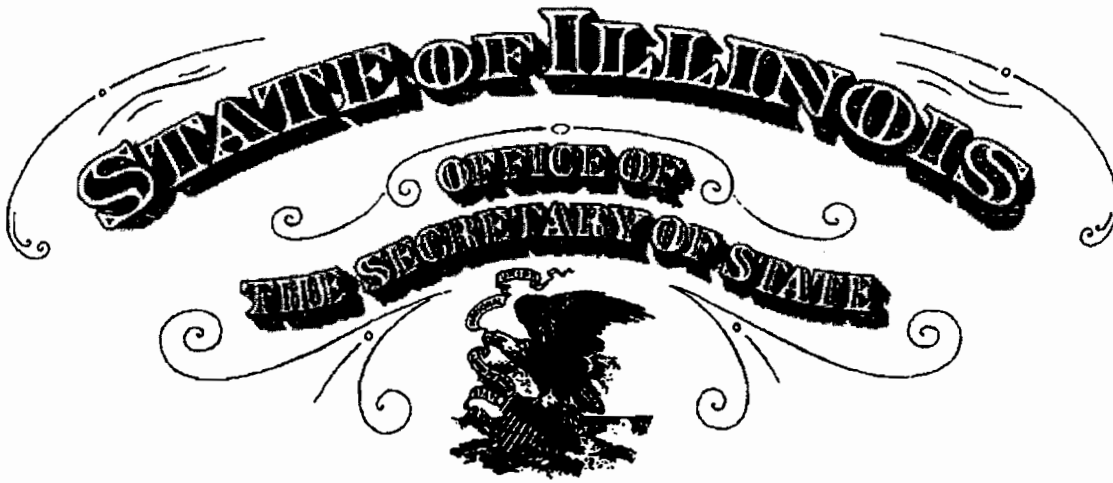
Jesse White

Authentication #: 1328701052

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

SECRETARY OF STATE

File Number 5217-963-7



To all to whom these Presents Shall Come, Greeting:

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

CDH-DELNOR HEALTH SYSTEM, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON OCTOBER 03, 1980, 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.



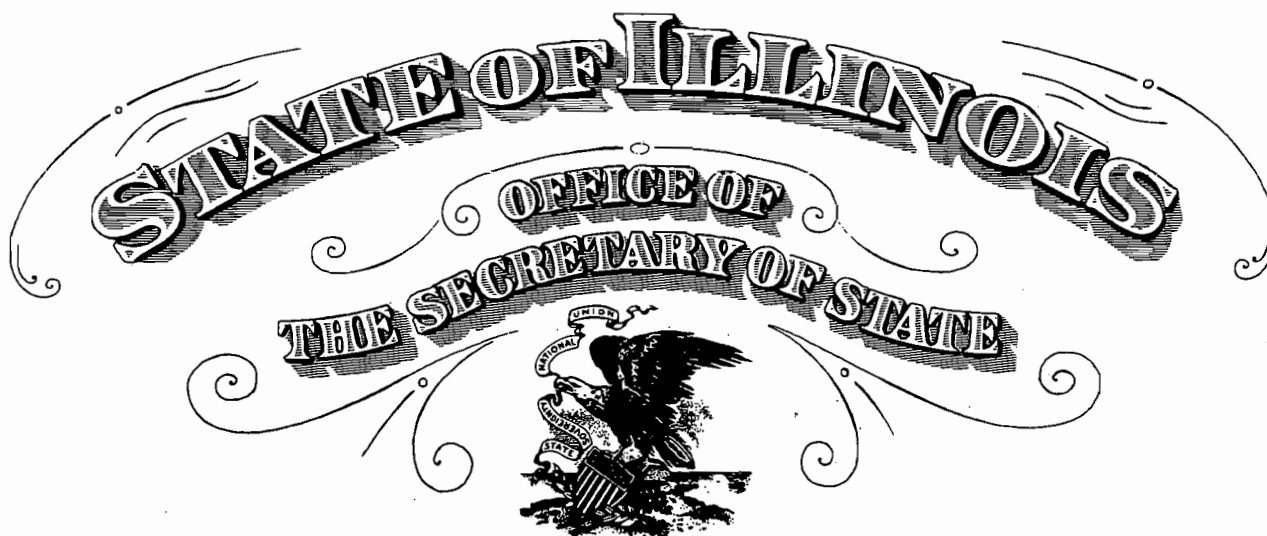
Authentication #: 1328701046

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 14TH
day of OCTOBER A.D. 2013 .*

Jesse White

SECRETARY OF STATE



To all to whom these Presents Shall Come, Greeting:

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

NORTHWESTERN MEMORIAL HEALTHCARE, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 30, 1981, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



Authentication #: 1335102330

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 17TH
day of DECEMBER A.D. 2013***

Jesse White

SECRETARY OF STATE



November 18, 2013

Illinois Health Facilities and
Services review Board
Springfield, Illinois

To Whom It May Concern:

Please be advised that the Central DuPage Hospital site, located at 25 North Winfield Road in Winfield, Illinois, is owned by Central DuPage Hospital Association.

Sincerely,

A handwritten signature in cursive script, appearing to read "Brian Lemon".

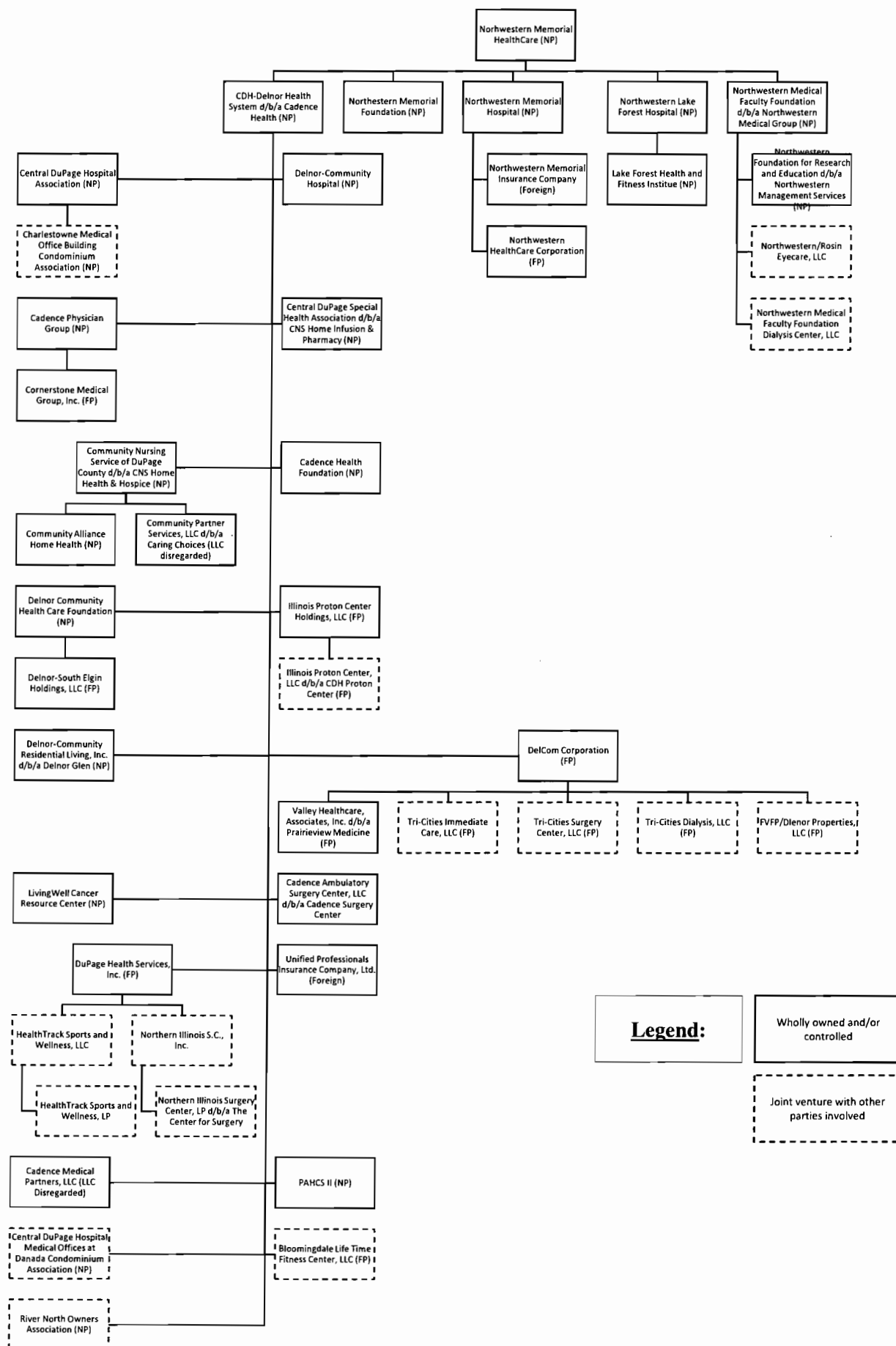
Brian Lemon
President, Central DuPage Hospital

Notarized:

A handwritten signature in cursive script, appearing to read "Susan M. Bove".



Northwestern Medicine Organization Chart





November 18, 2013

Illinois Health Facilities and
Services Review Board
Springfield, IL 62761

To Whom It May Concern:

I hereby attest that the site of Central DuPage Hospital is not located within a special flood hazard area, and that the proposed renovation on that site is consistent with Illinois Executive Order #2005-5.

Sincerely,

A handwritten signature in cursive script that reads "Brian Lemon".

Brian Lemon
President, Central DuPage Hospital

Stormwater Management

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[About Us](#)

[Contact Information](#)

[E-Newsletter Signup](#)

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[Flood Map Sets](#)

FEMA DFIRM Maps

[Addison Township Map](#)

[Bloomingdale Township Map](#)

[Downers Grove North Township](#)

[Downers Grove South Township](#)

[Lisle Township Map](#)

[Wayne Township Map](#)

[Milton Township Map](#)

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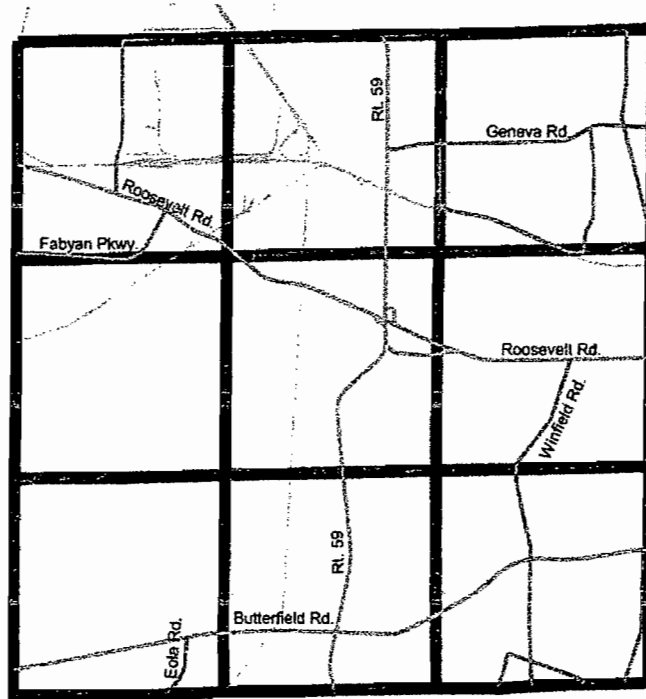
[Water Quality](#)

[Watershed Management](#)

[FOIA](#)

Winfield Township - DFIRM

These must be used for flood insurance ratings only, not for regulatory purposes.



[Wayne Township](#)

[Bloomingdale Township](#)

[Addison Township](#)

[Winfield Township](#)

[Milton Township](#)

[York Township](#)

[Naperville Township](#)

[Lisle Township](#)

[Downers Grove Township North](#)

[Downers Grove Township South](#)

ATTACHMENT 5



Illinois Historic Preservation Agency

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

FAX (217) 782-8161
www.illinoishistory.gov

DuPage County
Winfield

CON - Interior Rehabilitation of North and Central Buildings, Central DuPage
Hospital
25 N. Winfield Road
IHPA Log #023110413

November 20, 2013

Jacob Axel
Axel & Associates, Inc.
675 North Court, Suite 210
Palatine, IL 60067

Dear Mr. Axel:

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

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

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

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

Sincerely,

Anne E. Haaker
Deputy State Historic
Preservation Officer

ATTACHMENT 6

Project Costs and Sources of Funds

USE OF FUNDS

Itemization of each line item:

Line 1 – Preplanning Costs – (\$250,000) – this includes:

- Evaluation of alternatives
- Feasibility assessments

Of the total amount, \$187,500 is the clinical Preplanning cost. This amount is 1.74% of the clinical Modernization, Contingency, and Equipment costs.

Line 6 – Modernization Contracts – (\$9,049,046) – this includes:

- All construction contracts/costs to complete the project. Includes group I fixed equipment and contractor's overhead and profit.

Of the total amount, \$7,457,006 is the clinical Modernization cost.

Line 7 – Contingencies - (\$904,905) – this includes:

- Allowance for unforeseen Modernization costs

Of the total amount, \$745,701 is the clinical Contingency cost. This amount is 10% of the clinical Modernization cost.

The total clinical square footage of the proposed project is 25,595 DGSF. Modernization cost plus contingencies for this space equates to \$320.48/clinical SF.

When determining the reasonableness of the clinical construction and contingency costs, CDH applied the Cost Complexity Ratios found in Section 1120.APPENDIX A:

Service Area/Department	Complexity Ratio
Medical/Surgical	1.0738
Special Care Nursery	1.4052

Line 8 – Architectural / Engineering Fees – (\$960,000) – this includes:

- Design services
- Document preparation
- Construction/Renovation Monitoring
- Interface with review agencies

Of the total amount, \$720,000 is the clinical Architectural / Engineering Fee. This amount is 8.78% of the clinical Modernization and Contingency costs.

Line 9 – Consulting and Other Fees – (\$450,000) – this includes:

Charges for the services of various types of consulting and professional experts, including:

- CON consultant
- IDPH and municipal fees
- Pre-Architectural facility planning
- Bid preparation and solicitation process
- Utilities Systems analyses
- Life Safety Code Consultant
- Reimbursables
- Interior Design Consultant

Of the total amount, \$337,500 is the clinical Consultant and Other Fees cost.

Line 10 – Movable Capital Equipment – (\$2,600,000) – this includes:

Equipment, furniture, and furnishings (FFE) for the proposed project. The equipment cost is a budget, yet to be finalized. Group I (fixed) equipment is included in the Modernization line item above. Group II major medical equipment and Group III mobile equipment is included in this line item.

At this stage, the itemized list of equipment to be purchased is not complete. The aggregate equipment budget, however, is considered appropriate, as it is based on experience on previous projects.

The following list identifies types of equipment in the estimate:

Pediatrics Unit

Patient Rooms

- Recliners
- Sleeper sofas
- Patient beds
- Cribs
- Over bed tables
- Shower chairs
- Patient/family chairs
- Night stands
- Philips Monitors (MP30) with mount + Central Station
- TVs
- DVDs
- Garbage cans
- Tables (for family)
- PlayStations
- Wall transformers (Oto/Optho/Thermometer)
- Clocks
- Phones (patient)
- O2 Flowmeters with neb blocks
- Ohio Heads for suction
- Small garbage cans for bathrooms (step on)

- Computers with wall mount
- Diaper scale

Patient Room Alcoves

- Computers
- Phones

Consult Room

- Computer
- Chairs

Procedure Room

- Stretcher
- TV

Clean Utility

- Pyxis (supply – one double and one single)
- Computer with mount

Playrooms

- Chairs
- Playstations
- TVs

Care Center – Large

- Computers
- Phones
- Chairs
- Lab printer

Care Center – Small

- Computers
- Phones
- Chairs

Family Room

- Refrigerator w/Ice
- Chairs

On-Call Room

- Bed
- TV
- Computer

Waiting Room

- Chairs
- Side tables

Staff Lounge

- Refrigerator/Freezer w/Ice
- Chairs

Offices (4)

- Desks
- Side Chairs
- Desk Chairs
- Computers
- Phones

Cubicles (3)

- Chairs
- Computers
- Cubicles/Desk/etc.

Other

- Isolation carts
- Linen carts
- Blanket warmers
- Wireless phones (and antennas)
- Accucheck
- Lab handheld
- Lift equipment
- Admin Rx handhelds

NICU – Level II

Patient Rooms

- Isolette – Giraffe Omnibeds
- Cribs
- Bedside supply servers
- Clocks
- Recliners
- Computers
- Computer carts
- Chairs

Nursing Station

- Computers
- Chairs
- Phones

Staff Lounge

- Tables
- Chairs
- Refrigerator/Freezer w/Ice Maker
- Bulletin boards
- Computer

Family Room

- Refrigerator/Freezer w/Ice
- Chairs
- Sofa

Other

- Monitors
- Philips MX800's
- Monitor arms
- Additional "sectors"
- Breast milk warmers
- Breast milk refrigerator
- Breast milk freezer
- Medfusion feeding pumps
- Phototherapy lights
- Ventilator – Draager
- Blood gas analyzer
- AVOX machine
- Neonatal scale (Scaletronix)
- Blenders
- Pyxis towers
- Admin Rx handhelds
- Crash carts
- IV poles
- Suction regulators
- Portable phones

Satellite Pharmacy

- Hood
- Computers
- Bins
- Refrigeration system

A detailed list and associated budget will be developed during Design Development.

Freight and installation costs are also included in the budget.

Of the total amount, \$2,600,000 is the clinical component of the Moveable Capital Equipment cost.

SOURCES OF FUNDS

The project will be funded by Cash and Securities.

Cost Space Requirements

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Department	Cost	Existing DGSF	Proposed DGSF	New Const.	Modern-ized	As Is	Vacated Space
CLINICAL							
Pediatrics	\$ 5,094,906	6,507	18,327		18,327		1,692
NICU (Level II and Level III)	\$ 2,362,100	5,542	9,643		7,268	2,375	
Clinical Subtotal =	\$ 7,457,006	12,049	27,970		25,595	2,375	
NON-CLINICAL							
Satellite Pharmacy	\$ 148,680	0	504		504		
Administrative	\$ 110,880	0	504		504		
Public Areas	\$ 190,960	1,698	868		868		
Staff Lounges	\$ 250,360	862	1,138		1,138		
On-Call Room	\$ 81,840	0	372		372		
Storage	\$ 639,320	1,113	2,906		2,906		
Utilities/MEP	\$ -	357	1,014			1,014	
Elevators/Stairs	\$ -	1,714	2,035			2,035	
Access Corridor for PICU	\$ 170,000	0	850		850		
Non-Clinical Subtotal =	\$ 1,592,040	5,744	10,191		7,142	3,049	
TOTAL =	\$ 9,049,046	17,793	38,161		32,737	5,424	
OTHER							
Preplanning Costs	\$ 250,000						
Site Survey & Soil Investigation Fees	\$ -						
Site Preparation	\$ -						
Off-Site Work	\$ -						
Contingencies	\$ 904,905						
A/E Fees	\$ 960,000						
Consulting & Other Fees	\$ 450,000						
Movable or other Equipment	\$ 2,600,000						
Bond Issuance Expense	\$ -						
Net Interest Expense During Construction	\$ -						
Other Costs To Be Capitalized	\$ -						
Other Subtotal =	\$ 5,164,905						
GRAND TOTAL =	\$ 14,213,951						

BACKGROUND OF APPLICANT

Northwestern Memorial HealthCare (NMHC) is the parent corporation of CDH-Delnor Health System d/b/a Cadence Health who is the parent corporation of Central DuPage Hospital.

NMHC is the parent of ten health care facilities, all of which are located in Illinois:

Northwestern Memorial Hospital (IDPH License #0003251)

Northwestern Lake Forest Hospital (IDPH License #0005660)

Central DuPage Hospital (IDPH License #0005744)

Delnor Community Hospital (IDPH License #0005736)

Cadence Health Surgery Center (IDPH License #7003173)

Tri-Cities Surgery Center (IDPH License #7003117)

CDH Proton Center

Grayslake Freestanding Emergency Center: 22002

Grayslake ASTC: 7003156

Grayslake Endoscopy ASTC: 7003149

Central DuPage Hospital

Medicare Provider Number: 140242

Medicaid Provider Number: 23008

The Joint Commission Organization I.D. Number: 7444

September 29, 2014

Ms. Kathryn J. Olson
Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street – Second Floor
Springfield, Illinois 62751

Dear Ms. Olson:

As President and Chief Executive Officer of Northwestern Memorial HealthCare, I hereby certify that no adverse action has been taken against Central DuPage Hospital, directly or indirectly, within three years prior to the filing of this application. For the purpose of this letter, the term "adverse action" has the meaning given to it in the Illinois Administrative Code, Title 77, Section 1130.

I hereby authorize HFPB and IDPH to access any documentation which it finds necessary to verify any information submitted, including, but not limited to: official records of IDPH or other State agencies and the records of nationally recognized accreditation organizations.

If you have questions or need additional information, please contact Bridget Orth at (312) 926-8650.

Sincerely,



Dean M. Harrison
President and Chief Executive Officer

PURPOSE OF PROJECT

The purpose of the proposed modernization project, which is limited to CDH's NICU – Level II and pediatrics unit, is to ensure that the hospital maintains the physical capacity to address the needs of the rapidly increasing number of newborns and children seeking care at CDH.

Utilization of the services proposed to be expanded through the project (pediatrics and Level II NICU) have been extraordinarily high, with demand exceeding the physical capacity of the units, necessitating the placement of pediatrics patients on other units and the "overflow" of Level II newborns to Level III stations. Increases in the pediatric utilization at CDH, while most hospitals are experiencing decreases, are primarily the result of the Cadence Health's major clinical affiliation with Ann & Robert H. Lurie Children's Hospital of Chicago (Lurie Children's) and Cadence's commitment to establish a comprehensive regional pediatric care center at CDH.

Between 2007 and 2012, while the number of approved pediatrics beds at CDH has remained constant, the number of pediatrics beds at the other hospitals in Planning Area A-05 (DuPage County) has decreased from 68 to 48 beds. Similarly, the State of Illinois has experienced a 25% decrease in approved pediatrics beds. During that same period, CDH experienced a 31.4% increase in pediatric patient days (with an additional 7.4% increase from 2012 to 2013), while the State has experienced a decrease of 17.6%. The State-wide decrease in pediatric patient days is likely the result of both shorter lengths-of-stay and lower admissions rates. Similarly, the other hospitals in Planning Area A-05 have experienced a decline in pediatric patient days, likely the result of the movement to centralize pediatric services at "centers of excellence."

The need for area residents to travel to large academic pediatric centers such as Lurie Children's and Comer Children's Hospital in Chicago is being lessened, and in many cases eliminated, through Cadence and Lurie Children's joint commitment to locate pediatric specialists and subspecialists at CDH. As a result of this commitment on the part of both organizations, and this projects, response to the facility-related needs resulting from that commitment, the health care and well-being of the western suburbs' pediatric population will continue to improve.

Typically, CDH's market area is DuPage County, with the primary service area of Wheaton, Glen Ellyn, Winfield, Carol Stream, Warrenville, West Chicago. The primary service area is the source of approximately 75% of CDH's inpatient volumes. However, Cadence's commitment to establish a comprehensive regional pediatric center at CDH is beginning to become realized both by the general recognition in the far western suburbs of Lurie Children's presence at CDH, as well as the hospital's 2013 pediatric patient origin data. The data shows that pediatric patients are now being admitted to CDH from a large number of communities from throughout the far western suburbs (see ATTACHMENT-20 for full list).

The goal of the proposed project is to ensure that CDH has the physical capacity to accommodate all pediatric and NICU Level II patients on the pediatrics and/or NICU Level II units. Last year, 157 pediatric inpatients were placed in units other than the pediatrics unit and 32 patients were not accepted as transfers from other hospitals. The addition of both pediatrics and NICU Level II beds will reduce and/or eliminate these conditions.

ALTERNATIVES

The proposed project has two primary components:

1. Expansion of CDH's inpatient pediatric capacity
2. Expansion of NICU Level II capacity

Alternative Projects Considered

Since 2009, CDH's pediatric average daily census has been over 10. Over the next four years, the pediatrics utilization continued to increase and shows no signs of slowing down. Given the high patient census and the limited space options on campus for expansion, alternatives to the project were very limited. Three options are reviewed below:

Alternative 1: Do Nothing

Alternative 2: Construct a Pediatrics unit with semi-private rooms

Alternative 3: Construct a traditional Level II Nursery

Alternative 1: Do Nothing

CDH is approved to operate 10 pediatric beds, and has historically operated with a pediatrics average daily census of over 10, necessitating the placement of pediatrics patients on other units.

As an alternative to the proposed project, this practice could be continued, without any incremental capital or operating costs. However, doing this would not provide the benefits of placing children on a pediatrics unit, including the specialty-trained staff and non-clinical amenities available on a pediatrics unit.

This option was rejected because it is inconsistent with CDH's desire to provide the best patient experience.

Alternative 2: Construct a Pediatrics unit with semi-private rooms

The proposed pediatrics unit will consist of all private rooms, consistent with contemporary standards. The concept of providing private patient rooms has become the industry and Northwestern Medicine standard for a variety of reasons including infection control and patient/family privacy.

However, the operating costs associated with a pediatrics unit consisting of semi-private rooms would be approximately 30% lower than that of the proposed project. Additionally, the renovation cost would be approximately \$308,000 less.

This option was dismissed because it was inconsistent with contemporary design standards.

Alternative 3: Construct a Traditional Level II Nursery

CDH considered the alternative of providing a more traditional Level II newborn nursery, instead of co-locating the Level II and Level III beds together in the NICU. A more traditional Level II nursery would have an open concept, rather than private rooms.

Based on extensive research conducted by Northwestern Memorial Hospital during the planning of the new Prentice Women's Hospital, it was determined that given the increasing acuity level of the Level II newborns, an all private bay concept would be better patient care. Consistent with the NMH research, the large open rooms with bright lights, loud monitors, and minimal privacy does not support the neurologic development of the infant or the development of the parent's relationship with the infant.

While the operating costs would be approximately the same as the proposed project, the capital cost savings associated with this alternative is approximately \$1 million.

This option was rejected because it does not meet contemporary NICU standards.

Summary

The following table provides a summary cost benefit analysis of the preferred project and the alternatives:

Alternative	Provides Best Patient Experience?	Construction Cost Savings	Operating Cost Savings
Do Nothing	No	\$14M	\$0
Construct Pediatrics Unit w/Semi-Private rooms	No	\$308,000	30%
Construct Traditional Level II Nursery	No	\$1M	\$0

Construction of an expanded pediatrics unit with all private rooms and expanded NICU Level II with all private bays is the preferred option because it provides an optimal patient environment and meets contemporary industry standards.

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

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

SIZE OF PROJECT

Clinical Components

Pediatrics Unit

The pediatric inpatient unit at CDH will be a light-filled, colorful, and kid-friendly inpatient unit that is designed to ease stress and provide comfort for children requiring inpatient hospitalization. The pediatric unit will provide state-of-the-art technologies and advanced therapies for the families in the Western region of Chicago.

The new unit on the 4th floor will have 22 private rooms which will reduce the risk of infection, provide space for families, and increase bed availability. The pediatrics unit will be staffed by Lurie Children's hospitalists 24 hours/day, 7 days/week, Pediatric Nurse Practitioner, Pediatric nurses and child-life specialists.

The beds will be placed on the periphery of the floor in order to provide windows for each room. Because this placement creates a large unit, several support spaces will be duplicated in order to best serve all of the beds. These support spaces include nurses stations, playrooms, etc.

This unit will also include a procedure room that will allow for minor procedures to take place on the inpatient unit, including:

- (Spinal taps) lumbar puncture
- bone marrow aspirations
- chest tube placements
- incision and drainage
- other minor procedures that may require sedation

Comparison of Space to Cost Standard

Proposed square footage for the Pediatrics department is 18,327 DGSF.

Components and space standards used are as follows:

PEDIATRICS	DGSF
22 Pediatric beds, as designed	18,327
State Standard for 22 pediatrics beds, 660 dgsf/bed	14,520
Amount of difference, explained and justified below	3,807

Explanation/Justification of difference, by component

1.	Room Design	
	Patient/Family/Visitor Zone As in the medical/surgical inpatient rooms, the pediatrics rooms at CDH are designed to be patient and family-centered. The patient/family/visitor zone has additional space requirements. The daybed/seating area has been adopted all over the country as a model for providing comfortable seating and overnight sleeping arrangements for family members. This will eliminate the need to move a cot into the patient rooms or providing recliners for family members, neither of which is comfortable, and both are often in the way of providing patient care. 22 x 40 nsf/room difference x 1.55 n-g conversion factor = 1,364 DGSF	1,364
2.	Unit Design	
	There will be one room provided for use by families in need of a private space on the unit to meet and/or rest. Family Room 1 x 100 nsf x 1.55 n-g conversion factor = 155 DGSF	155
	There will be one consult room on the unit in order to provide space for the physicians to speak with the family separate from the patient. Consult Room 1 x 132 nsf x 1.55 n-g conversion factor = 205 DGSF	205
	As mentioned above, a procedure room will be included to allow for minor procedures to take place on the inpatient unit. Procedure Room 1 x 247 nsf x 1.55 n-g conversion factor = 383 DGSF	383
3.	Design Impediments Due to Existing Space	
	As mentioned above, while not required, the configuration of the unit creates long distances between some of the patient rooms and some of the support spaces on the unit. For that reason, certain support spaces are duplicated in order to provide better access to all patient rooms. Additional Play Room 1 x 330 nsf x 1.55 n-g conversion factor = 512 DGSF Additional Nurses Station 1 x 288 nsf x 1.55 n-g conversion factor = 446 DGSF	958
	Additionally, because of the placement of existing infrastructure, 3 rooms are sized larger than the other rooms on the unit. 3 x 90 nsf x 1.55 n-g conversion factor = 419 DGSF	419
	While a typical unit would have 1 isolation room, there will be 3 isolation rooms on the proposed unit due to the larger size of 3 other rooms. 2 x 120 nsf x 1.55 n-g conversion factor = 372 DGSF	372
	TOTAL SQUARE FOOTAGE JUSTIFIED	3,856

The square footage justifications exceed the difference from the State standard by 49 sf.

Neonatal Intensive Care Unit (NICU)

The NICU at CDH has 8 Level III beds and 15 Level II beds. This project proposes to add 6 Level II beds to the existing NICU in space that will be vacated by the relocation of the pediatrics unit to the 4th floor. The Level III beds will remain in their current locations however, with the expansion of the Level II beds, most of the support space for the entire NICU will be reconfigured to better fit the new space.

In an effort to provide an excellent patient and family experience, especially under situations in a NICU, the proposed Level II stations will be designed as a private bay model. This not only facilitates infection control, but allows parental presence. The separation of patients creates a calming atmosphere while facilitating family inclusion.

As with both the NICU at Northwestern Memorial Hospital and the new Lake Forest Hospital, the NICU at CDH will provide an environment that will support the medical and developmental needs of the infant as well as respect the need of families to be active participants in the care of their infant. This, along with acuity, are the drivers of the larger size of the proposed NICU.

Each private bay will be a three-walled space and have one open side to enable efficient monitoring as well as provide privacy for families for discussions with physicians and staff. This design allows an intimate level of care without squeezing patients together; each patient will benefit from a one-on-one interface with staff, and will consequently benefit family inclusion in the care plan as well.

To support the unit, rooms such as clean utility, medication room, and pantry have been located inside the doors of the NICU so staff can remain in constant proximity to patients. Staff is supported in the unit by two nurses stations as well as a staff lounge.

Comparison of Space to Cost Standard

Square footage for the NICU department is 9,643 DGSF.
Components and space standards used are as follows:

NICU	DGSF
8 Level III Nursery bassinets, not part of the proposed project	
21 Level II Nursery bassinets, as designed	9,643
State Standard for 8 Level III nursery bassinets, 568 dgsf/bassinet	4,544
State Standard for 21 Level II nursery bassinets, 160 dgsf/obstetrics bed	3,360
	7,904
Amount of difference, explained and justified below	1,739

Explanation/Justification of difference, by component

1.	Size Considerations	
	Level I vs. Level II While the State standard for Level II bassinets is the same as for Level I bassinets, there is a large difference in the amount of space needed for the two acuity levels. Additional space is needed for equipment and family-centered care in a Level II nursery that are not needed in a Level I nursery. 21 x 80 nsf x 1.55 n-g conversion factor = 2,604 DGSF	2,604
	TOTAL SQUARE FOOTAGE JUSTIFIED	2,604

The square footage justifications exceed the difference from the State standard by 865 sf.

SIZE OF PROJECT				
DEPARTMENT	PROPOSED DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
Pediatrics	18,327	14,520	3,807	No
NICU – Level II & III	9,643	7,904	1,739	No

Non-Clinical Components

Satellite Pharmacy

A Satellite Pharmacy will be located immediately adjacent to the NICU to support the needs of the unit.

The Satellite Pharmacy area of the proposed project totals 504 DGSF.

Administrative

Administrative space will be provided near the NICU for Nursing Administration (previously not included near the NICU).

The Administrative space of the proposed project totals 504 DGSF.

Public Areas

Public spaces will include reception/waiting areas and public toilets. These functions will be located at the entry point of both the pediatrics unit and the NICU in an effort to separate staff/patient and public flows.

The Public Areas of the proposed project total 868 DGSF.

Staff Lounges

Both the pediatrics unit and the NICU will have a Staff Lounge. The Staff Lounge on the 1st floor will be shared with the PICU.

The Staff Lounge areas of the proposed project total 1,138 DGSF.

On-Call Room

An On-Call Room will be provided on the pediatrics unit and will consist of a sleeping room and a bathroom. The purpose of this space is to provide physicians with a place for respite while they are on-call while still allowing them to be proximate to patients and staff when needed.

The On-Call Room in the proposed project is 372 DGSF.

Storage

There will be multiple storage areas provided both the pediatrics and NICU unit. The storage will be used for cribs, isolets, I.T. systems, monitors, etc

The Storage area of the proposed project is 2,906 DGSF.

Utilities/MEP

The current Utility shafts/closets will remain in their current locations.

The Utilities/MEP areas of the proposed project total 1,014 DGSF.

Elevators/Stairs

The Elevators and Stairwells will remain in their current locations.

The Elevator and Stair areas of the proposed project are 2,035 DGSF.

Access Corridor for PICU

Because the NICU is a secured unit, a separate corridor must be created to provide access to the diagnostic imaging area of CDH from the PICU.

The Access Corridor is 850 DGSF.

PROJECT SERVICES UTILIZATION

Detailed projection rationale is provided in ATTACHMENT-20 AND ATTACHMENT-34. Projections are provided for CY18, two years after project completion.

UTILIZATION				
DEPARTMENT	HISTORICAL Patient Days CY13	PROJECTED Patient Days CY18	STATE STANDARD	MET STANDARD ?
Pediatrics	4,805 (131.6%)	6,453 (80.4%)	80%	Yes
NICU – Level II	5,499 (100.4%)	6,176 (80.6%)	No Standard	N/A

UNFINISHED OR SHELL SPACE

Not Applicable – there is no unfinished or shell space in the proposed project.

ASSURANCES

Not Applicable – there is no unfinished or shell space in the proposed project.

SECTION VII – SERVICE SPECIFIC REVIEW CRITERIA

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

Category of Service	# Existing Beds	# Proposed Beds
Pediatric	10	22

According to the 8/28/14 Update to Inventory of Hospital Services, there is a calculated excess of 239 medical-surgical/pediatrics beds in Planning Area A-05. However, of the total 1,100 medical-surgical/pediatric beds in the planning area, only 58 are pediatric beds.

FACILITY	PEDIATRIC BEDS
Adventist Hinsdale Hospital	19
Advocate Good Samaritan Hospital	16
Central DuPage Hospital	10
Edward Hospital	7
Elmhurst Memorial Hospital	6

1110.530(c)(2) – Planning Area Need – Service to Planning Area Residents

Cadence Health is committed to the continued development of a comprehensive regional pediatric center through its major clinical affiliation with Ann & Robert H. Lurie Children's Hospital of Chicago. The analysis of the hospital's 2013 pediatric patient origin data documents the regional nature of its inpatient pediatric programming and that services are provided primarily to patients residing in the western suburbs.

NLFH Primary Service Area CY12 ICU Patient Origin Data by Zip Code

City	Zip Code	% CY13 Pediatric Admissions	Cumulative %
West Chicago	60185	9.7%	9.7%
Carol Stream	60188	7.4%	17.1%
Aurora	60505	5.8%	23.0%
Wheaton	60187	5.5%	28.5%
Aurora	60506	5.0%	33.4%
Wheaton	60189	4.6%	38.0%
Glen Ellyn	60137	4.0%	42.0%
St. Charles	60174	3.8%	45.9%
Glendale Heights	60139	3.2%	49.1%
Bartlett	60103	2.7%	51.8%
Bloomington	60108	2.1%	53.9%
Hanover Park	60133	2.1%	56.0%
Batavia	60510	2.0%	56.0%
Geneva	60134	2.0%	57.9%
Warrenville	60555	2.0%	59.9%
Winfield	60190	1.7%	61.6%
Aurora	60504	1.6%	63.2%
Montgomery	60538	1.6%	64.8%
Lombard	60148	1.5%	66.3%
Oswego	60543	1.5%	67.8%
Roselle	60172	1.4%	69.2%
St. Charles	60175	1.4%	70.6%
Plano	60545	1.2%	71.8%
Naperville	60563	1.2%	73.0%
Addison	60101	1.1%	74.2%
DeKalb	60115	1.1%	75.3%
Elgin	60123	1.1%	76.4%
South Elgin	60177	1.1%	77.6%
N. Aurora	60542	1.1%	78.7%
Streamwood	60107	1.1%	79.8%
Aurora	60502	1.1%	80.8%
Other <1.0%		19.2%	100.0%

1110.530(c)(4) – Planning Area Need – Service Demand – Expansion of an Existing Category of Service

The request for expansion of CDH's pediatric beds is based on three supporting justifications:

1. Historical occupancy well above the State Occupancy Standard
2. Significant fluctuations in census resulting in periods of very high occupancy
3. CDH's continued commitment to locate pediatric specialists and subspecialists at CDH

1. Historic Occupancy above the State Occupancy Standard

Category of Service	Board Occupancy Standard	CY12	CY13
Pediatrics	80%	122.6%	131.6%

The historical demand for pediatrics beds at CDH has significantly surpassed the hospital's pediatrics bed capacity in recent years, resulting in the need to place pediatrics patients on other units when the 10-bed pediatrics unit is operating at capacity.

Since CY07, occupancy of CDH's 10 pediatric beds has been over 80% (State Occupancy Standard) every year. Average annual occupancy has ranged from 93.3% - 131.6%.

Historic Utilization

CDH's pediatrics patient days (including observation days) have increased by 41.2% from CY07 to CY13, from 3,404 in CY07 to 4,805 in CY13. This is an average annual increase of 6.9%.

Pediatrics	CY07	CY08	CY09	CY10	CY11	CY12*	CY13*
Admissions	1,123	1,075	1,191	1,076	1,074	1,845	1,328
Patient Days	3,163	3,083	3,650	3,088	3,236	3,799	3,914
Observation Days	241	289	461	582	595	675	891
Total Days	3,404	3,372	4,111	3,670	3,831	4,474	4,805
ADC	9.3	9.2	11.3	10.1	10.5	12.3	13.2
Beds	10	10	10	10	10	10	10
Occupancy	93.3%	92.4%	112.6%	100.5%	105.0%	122.6%	131.6%

*Reporting limitations associated with IDPH's *Annual Hospital Questionnaires* (the source for *Hospital Profiles*) limit reported patient days for categories of service to 100% occupancy, or 3,650 patient days for a 10-bed unit. The data distortion caused by this restriction has been discussed with IDPH staff. In both CY12 and CY13, CDH's *Hospital Profile* lists the maximum of 3,650 patient days for pediatrics when in reality, in CY12 there was a total of 4,474 patient days provided to pediatrics patients (excluding newborns, AML patients, and obstetrics patients), with that number increasing to 4,805 in CY13. The above table identifies the actual utilization of pediatrics services at CDH, including those pediatrics patients placed on another nursing unit because a bed was not available on the pediatrics unit.

The demand for pediatrics services at CDH and the resultant increases in utilization contradict both the planning area and state-wide trends.

Between 2007 and 2012, while the number of approved pediatrics beds at CDH has remained constant, the number at other hospitals in Planning Area A-05 (DuPage County) has decreased

from 68 to 48 beds, and the State of Illinois as a whole has experienced a 25% decrease in approved pediatrics beds.

During that same period (CY07 – CY12), CDH experienced a 31.4% increase in pediatric patient days (with an additional 7.4% increase from 2012 to 2013), while the State has experienced a decrease of 17.6%. The State-wide decrease in pediatric patient days is likely the result of both shorter lengths-of-stay and lower admissions rates. Similarly, the other hospitals in Planning Area A-05 have experienced a decline in pediatric patient days, likely the result of the movement to centralize pediatric services at “centers of excellence.”

2. Significant Fluctuations in Census

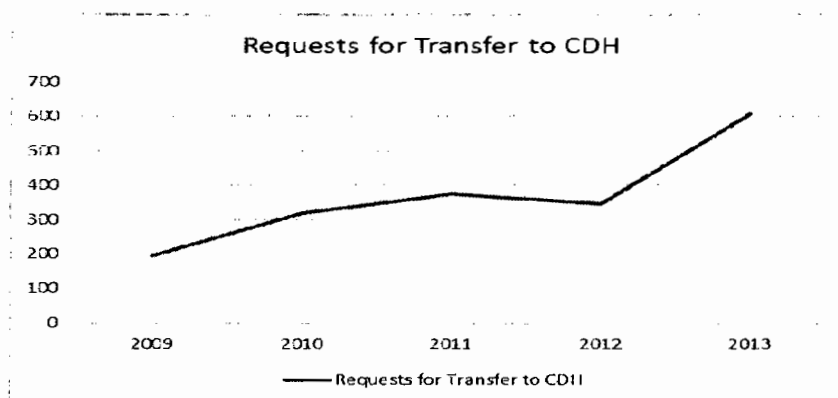
As mentioned above, the demand for pediatrics beds at CDH has significantly surpassed the hospital's pediatrics bed capacity in recent years, resulting in the need to place pediatrics patients on other units when the 10-bed pediatrics unit is operating at capacity.

In CY12, 157 pediatrics patients were placed on other units because the pediatrics unit was full.

In CY12, the peak census for the pediatrics unit was 19 (based on midnight census) and there were 151 days that the pediatrics unit had a census of over 10. In CY13, peak census was 19 and the census was over 10 almost half of the year or 169 days.

When the pediatrics unit is at capacity, optimal patient care is compromised. Patients are placed on other units, the Emergency Department gets backed up, and requests for transfer from other hospitals are denied.

Requests for transfers from other hospitals without a pediatric unit or specialized pediatric services have increased over the last five years. In FY09, there were 194 requests for transfer. In 2013, there were 608 requests with 32 patient transfer requests denied.



Adding to the fluctuations in census are observation patients. Placing observation patients on the pediatrics unit allows for staffing and supply efficiencies and allows for the pediatric hospitalists to be the attending provider.

Typical pediatric observation patients include:

- Injuries presenting in the ED (such as minor head trauma in young infants) for which the physicians order short term observation to determine the extent of the injury
- Asthmatic patients requiring nebulizer treatments

- Patients being monitored for seizure conditions
- Chemotherapy patients who require closer monitoring than provided in the outpatient infusion center
- Patients receiving blood transfusions
- Post-operative patients who require short-term pain management or who are recovering from anesthesia
- Patients being monitored for possible appendicitis, as the new standard of care is to use ultrasound and monitor patients rather than expose the pediatric population to radiation from a CT scan

However, the conversion of observation hours to days often does not demonstrate the effect that observation patients have on an inpatient unit. For example, 4 observation patients each with a length of stay of 4 hours would equal less than 1 patient day but if they were all on a unit at the same time, they would occupy 4 beds. Additional pediatric beds are needed to adequately respond to both inpatient and observation demand.

3. CDH's Clinical Affiliation with Ann & Robert H. Lurie Children's Hospital of Chicago

Increases in pediatric utilization at CDH, when most hospitals are experiencing decreases, are primarily the result of Cadence Health's major clinical affiliation with Ann and Robert H. Lurie Children's Hospital of Chicago (Lurie Children's) and Cadence's commitment to establish a comprehensive regional pediatric care center at CDH. The clinical affiliation with Lurie Children's was initiated in 2006 and has continued to grow programmatically, as evidenced by the growing census, bringing more Lurie Children's specialists to the CDH campus.

Both Lurie Children's and the Cadence Physician Group have continued to recruit highly qualified physicians which will result in continued growth in the pediatric utilization at CDH, particularly in the pediatric specialties (see Letter from Patrick Magoon, President and CEO of Lurie Children's and a list of the Pediatric Specialists at Cadence at the end of this attachment).

Over the past two years, CDH has averaged 141 transfers to Lurie Children's for services not available at CDH. With the continued programmatic growth at CDH envisioned by both Cadence and Lurie Children's, the number of pediatric transfers out of CDH is anticipated to decrease over the next two years by approximately 100 patients/year.

Additionally, as Cadence continues to be recognized for its exceptional pediatric care with its pediatric Emergency Departments at CDH, it is anticipated that patients who would have been hospitalized in Chicago in the past, including those seen on a pre-admission basis at Lurie Children's, will elect to stay closer to home, resulting in additional pediatric admissions to CDH.

1110.530(e) – Category of Service Modernization

The current pediatric unit is on the 1st floor, consisting of 10 inpatient beds and 2 observation beds, located adjacent to the Pediatric Intensive Care Unit (PICU) and the Neonatal Intensive Care Unit (NICU). The proposed additional beds cannot be accommodated on the 1st floor and therefore the pediatric unit will be moved to the 4th floor. This unit will consist of 22 inpatient beds (the maximum that will fit in the space). Most of the vacated space of the 1st floor will be used for the proposed expansion of Level II NICU beds also part of this project.

The pediatric category of service will be modernized to provide patient rooms that are consistent with contemporary design standards and will be an all-private room configuration.

CDH's CY13 pediatrics volume justifies an additional 6-7 beds. However, for the reasons previously listed, CDH is requesting an additional 12 beds to accommodate both current and future demand for pediatrics services.

Projections

Projections for pediatric patient days assume an average annual increase of 6.9% from CY13 – CY18 (two years after project completion). This assumption is equal to the historic average annual increase of 6.9% from CY07 – CY13. Using this conservative growth rate, the proposed 22 pediatrics beds will operate at over 80% occupancy by CY18.

Pediatrics	CY14	CY15	CY16	CY17	CY18
Admissions	1,476	1,566	1,661	1,762	1,869
Patient Days	4,281	4,541	4,817	5,110	5,420
Observation Days	816	865	918	973	1,032
Total Days	5,097	5,407	5,735	6,083	6,453
ADC	14.0	14.8	15.7	16.7	17.7
Beds	10	10	22	22	22
Occupancy	139.6%	148.1%	71.4%	75.8%	80.4%

Projections for the pediatric patient days assume an average length of stay of 2.9, consistent with CY07 – CY13 experience. This ALOS is consistent with the other 4 pediatric programs in the A-05 planning area.

CY13 Planning Area A-05 Other Pediatric Programs

FACILITY	ICU ALOS
Advocate Good Samaritan Hospital	3.2 days
Adventist Hinsdale Hospital	2.6 days
Edward Hospital	2.6 days
Elmhurst Memorial Hospital	2.2 days

Even with these conservative projection assumptions, the 22 pediatrics beds in the proposed project will be at the State's target occupancy by two years after project completion.

1110.530(f) – Staffing Availability

The required clinical and professional staffing needs for all components of the project were considered and are fully understood by the applicants. Cadence health has historically experienced little difficulty in the recruitment and hiring of highly qualified staff, and anticipates no difficulties to result from the staffing requirements of this project.

Recruitment efforts for the additional pediatric beds will be conducted with both internal and external candidates. Cadence Health employees having proper qualifications will be given priority consideration for positions, with the remaining positions being filled through traditional recruitment methods such as specialty organization journals, professional recruiters, current staff referrals and the CDH website. Staff will be recruited, hired, and complete an orientation program prior to the project's completion.

1110.530(g) – Performance Requirements

The minimum unit sized for a pediatric unit is 4 beds. CDH is proposing to have 22 beds.

1110.530(h) – Assurances

See letter at the end of this attachment.

July 22, 2014

Ms. Courtney Avery
Administrator
Illinois Health Facilities and
Services Review Board
5252 West Jefferson
Springfield, IL 62761

**RE: Support for Central DuPage Hospital's Application to Expand its
Pediatric and Level II Nursery Services**

Dear Ms. Avery:

Please accept this letter as an indication of Ann & Robert H. Lurie Children's Hospital of Chicago's support for Central DuPage Hospital's plans to expand its inpatient capacity to treat children and newborns.

Lurie Children's and Central DuPage Hospital entered into a clinical affiliation agreement in 2006, and since that time the pediatric services provided at Central DuPage Hospital have steadily grown, both in terms of clinical scope and utilization. The breadth of programs and depth of services at Central DuPage Hospital are the most robust of any of our partner hospitals. Since the inception of this affiliation, there has been a significant increase in the types of diagnoses we treat and the pediatric programs developed for the families and patients. Lurie Children's envisions the capabilities and services offered to pediatric patients to continue to expand in the future.

Over 120 pediatricians affiliated with Lurie Children's now maintain staff privileges at Central DuPage Hospital, and approximately 30 of those physicians practice there on a full-time basis. We expect to expand the physician practice as the Central DuPage Hospital program expands.

As a direct result of the clinical affiliation between Central DuPage Hospital and Lurie Children's, many children from the western suburbs that had historically needed to travel outside their community for care to Lurie Children's in downtown Chicago, are now able to receive care closer to home at Central DuPage Hospital.

Support for Central DuPage
Application
Page 2

This clinical affiliation has significantly improved access to pediatric specialty services for families located in this delivery area.

Best contemporary practice in pediatric care often involves the coordination of care among a wide range of pediatric specialists and, as a result, pediatric medical care has seen a significant shift from general acute adult hospitals to children's hospitals in the last ten years. The Central DuPage Hospital model – which brings Lurie Children's expertise to the patient -- allows families to access many of the services available at a children's hospital in a setting that is proximate to their homes. We think that it is a model that works well and the expansion of the pediatric services at Central DuPage Hospital will improve access to healthcare services for children.

I urge the Illinois Health Facilities and Services Review Board to act favorably on Central DuPage Hospital's request.

Sincerely,



Patrick Magoen
President & CEO

First Name	Last Name	Specialty	Dedicated to Lurie Children's @ Cadence
Mohammad	Akhtar	Pediatrics - Critical Care	x
Bradley	Albers	Anesthesia - Pediatrics	
Risa	Alperin	Pediatrics - Rheumatology	
Eugene	Anandappa	Radiology	
Asta	Astraukas	Pediatrics - Hospitalist	
Michael	Balbus	Pediatrics - Neonatology	x
Heather	Ballard	Anesthesia - Pediatrics	
Lee	Bass	Pediatrics - Gastroenterology	
Sarah	Bauer	Pediatrics - General Pediatrics	
Elizabeth	Bello	Pediatrics - Critical Care	x
Ellen	Benya	Radiology	
Hubert	Benzon	Anesthesia - Pediatrics	
Helen	Binns	Pediatrics - General Pediatrics	
Patrick	Birmingham	Anesthesia - Pediatrics	
Aimee	Brasher	Surgery - Pediatric Orthopaedic	x
Dana	Brazdziunas	Pediatrics - General Pediatrics	
Corey	Bregman	Radiology	
Jeffrey	Brown	Pediatrics - Gastroenterology	
Marybeth	Browne	Pediatrics - Pediatric Surgery	
Delilah	Burrowes	Radiology	
Joseph	Camarda	Pediatrics - Cardiology	
Rebecca	Carl	Surgery - Pediatric Orthopaedic	
Michael	Carr	Pediatrics - Cardiology	
Kristin	Chenault	Anesthesia - Pediatrics	
Earl	Cheng	Surgery - Urology	
Patricia	Chiamas	Pediatrics - Hospitalist	
Ming	Chien	Emergency Medicine - Pediatric	x
Anthony	Chin	Pediatrics - Pediatric Surgery	
Ashish	Chogle	Pediatrics - Gastroenterology	
Youngran	Chung	Pediatrics - Pulmonary	
Stephen	Cico	Emergency Medicine - Pediatric	
Kristine	Cieslak	Emergency Medicine - Pediatric	x
Steven B	Coker	Pediatrics - Neurology	x
Jacqueline	Corboy	Emergency Medicine - Pediatric	
Agnes	Costello	Psychiatry	x
Roger	De Freitas	Pediatrics - Cardiology	
Barbara	Deal	Pediatrics - Cardiology	
James	Donaldson	Radiology	
Richard	Dsida	Anesthesia - Pediatrics	
Catherine	Duffy	Pediatrics - Cardiology	
Walter	Eppich	Emergency Medicine - Pediatric	
Jason	Fangusaro	Pediatrics - Pediatric Hematology/Oncology	
Mark	Fishbein	Pediatrics - Gastroenterology	
Susan	Fuchs	Emergency Medicine - Pediatric	
Peggy	Garvey	Pediatrics - Pulmonary	
Bessey	Geevarghese	Pediatrics - Infectious Disease	x
Loretto	Glynn	Pediatrics - Pediatric Surgery	x
Stewart	Goldman	Pediatrics - Pediatric Hematology/Oncology	
Nina	Gotteiner	Pediatrics - Cardiology	
John	Grayhack	Surgery - Pediatric Orthopaedic	
Jared	Green	Radiology	
Arie	Habis	Emergency Medicine - Pediatric	x
Steven	Hall	Anesthesia - Pediatrics	

Courtney	Hardy	Anesthesia - Pediatrics	
Ammar	Hayani	Pediatrics - Pediatric Hematology/Oncology	x
Russell	Horowitz	Emergency Medicine - Pediatric	
Narasimhan	Jagannathan	Anesthesia - Pediatrics	
Alok	Jaju	Radiology	
Joseph	Janicki	Surgery - Pediatric Orthopaedic	
Carolyn	Jones	Pediatrics - Genetics	x
Rashmi	Kabre	Pediatrics - Pediatric Surgery	
Amir	Kagalwalla	Pediatrics - Gastroenterology	
Ronald J	Kallen	Pediatrics - Nephrology	x
Mariam	Kappil	Radiology	
Mary Ella	Kenefake	Emergency Medicine - Pediatric	x
Brandi	Kenner-Bell	Pediatrics - Dermatology	
S. Taeson	Kim	Radiology	
Peter	Koenig	Pediatrics - Cardiology	
Joy	Koopmans	Emergency Medicine - Pediatric	x
David	Krodel	Anesthesia - Pediatrics	
Steven	Krug	Emergency Medicine - Pediatric	
Lacey	Kruse	Pediatrics - Dermatology	
Sulekha	Kumar	Pediatrics - Cardiology	x
Amy	Lay	Pediatrics - Cardiology	
Bruce	Lindgren	Surgery - Urology	
Dennis	Liu	Surgery - Urology	
Jeffrey	Loughead	Pediatrics - Neonatology	x
Rishi	Lulla	Pediatrics - Pediatric Hematology/Oncology	
Charles	MacDonald	Pediatrics - Neonatology	x
Mary Beth	Madonna	Pediatrics - Pediatric Surgery	
Karen	Mangold	Emergency Medicine - Pediatric	
Melissa	Manrique	Pediatrics - Hospitalist	x
Jennifer	Matczak	Pediatrics - Hospitalist	x
Deanne	Miller	Pediatrics - Hospitalist	x
Saeed	Mohammad	Pediatrics - Gastroenterology	
Michael	Monge	Cardiovascular - Pediatric CV Surgery	
Isabella	Mukherji	Anesthesia - Pediatrics	
Jennifer	Nicholas	Radiology	
Jackson	Norman	Radiology	
Ann	O'Connor	Pediatrics - Pediatric Surgery	x
Jamie	Pacis	Psychiatry	x
Angira	Patel	Pediatrics - Cardiology	
Sheetal	Patel	Pediatrics - Cardiology	
George	Paul	Emergency Medicine - Pediatric	
Francine	Pearce	Pediatrics - Hospitalist	
Selvi	Pillai	Pediatrics - Hospitalist	x
Zachary	Pittsenbarger	Emergency Medicine - Pediatric	
Andrada	Popescu	Radiology	
Allan	Pratt	Pediatrics - Gastroenterology	x
Francis	Prendergast	Radiology	
H. Jay	Przybylo	Anesthesia - Pediatrics	
William	Reda	Pediatrics - Neonatology	x
Marleta	Reynolds	Pediatrics - Pediatric Surgery	
Cynthia	Rigsby	Radiology	
Andrew	Roth	Anesthesia - Pediatrics	
David	Rothstein	Pediatrics - Pediatric Surgery	
Erin	Rowell	Pediatrics - Pediatric Surgery	
Hyde	Russell	Cardiovascular - Pediatric CV Surgery	

Maura	Ryan	Radiology	
Michelle	Sagan	Surgery - Pediatric Orthopaedic	
Martha	Saker	Radiology	
Sharad	Salvi	Pediatrics - Pediatric Hematology/Oncology	x
Jonathan	Samet	Radiology	
Vytautas	Sapiega	Pediatrics - Critical Care	x
Tania	Saroli	Pediatrics - Cardiology	
Amod	Sawardekar	Anesthesia - Pediatrics	
Ann	Schmidt	Emergency Medicine - Pediatric	
Farshad	Sedaghat-Yazdi	Pediatrics - Cardiology	
Svetlana	Serlin	Pediatrics - Hospitalist	x
Lavanya	Shankar	Pediatrics - Hospitalist	x
Richard	Shore	Radiology	
Aisha	Siddiqui	Anesthesia - Pediatrics	
Carmen	Simion	Anesthesia - Pediatrics	
Craig	Smith	Pediatrics - Critical Care	
Lisa	Sohn	Anesthesia - Pediatrics	
David B	Sperry	Pediatrics - Neurology	x
Jessica	Stern	Radiology	
Santhanam	Suresh	Anesthesiology - Pain Management - Pediatric	
Darshit	Thakrar	Radiology	
Candy	Tolentino	Pediatrics - Neonatology	x
Luis	Torero	Pediatrics - Pulmonary	
Sabrina	Tsao	Pediatrics - Cardiology	
Mark	Wainwright	Pediatrics - Neurology	
Kendra	Ward	Pediatrics - Cardiology	
Robert	Webster	Pediatrics - Cardiology	
Mary	Wyers	Radiology	
Luciana	Young	Pediatrics - Cardiology	
Naser	Zahran	Pediatrics - Hospitalist	x



September 23, 2014

Ms. Kathryn Olson
Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street – Second Floor
Springfield, Illinois 62751

Dear Ms. Olson:

As required by 77 Ill. Adm. Code 1110.530 for the expansion of the Pediatrics category of service, as President of Central DuPage Hospital, I hereby attest that by CY18 (the second year of operation after project completion), CDH plans to achieve and maintain the occupancy standards specified in 77 Ill. Adm. Code 1100.

Sincerely,

A handwritten signature in black ink, appearing to read "Brian Lemon".

Brian Lemon
President, Central DuPage Hospital

ATTACHMENT-20

25 North Winfield Road
Winfield, Illinois 60190
T. 630.933.1600
TTY for the hearing
impaired 630.933.4833
cdh.org

D. Projected Operating Costs**Projected Direct Operating Expenses – FY18**

	Pediatrics Unit	NICU
Total Direct Operating Costs	\$ 5,666,029	\$ 7,686,805
Equivalent Patient Days	6,393	8,743
Direct Cost per Equivalent Patient Day	\$ 886.29	\$ 879.20

E. Total Effect of the Project on Capital Costs**Projected Capital Costs – FY18**

	CDH
Equivalent Patient Days	217,891
Total Project Cost	\$ 14,213,951
Useful Life (years)	7
Total Annual Depreciation	\$ 2,030,564
Depreciation Cost per Equivalent Patient Day	\$ 9.32

O. Criterion 1110.3030 – Clinical Service Areas Other than Categories of Service

Indicate changes by Service:

Service	# of Existing Key Rooms	# of Proposed Key rooms	Δ
Level II Nursery beds	15	21	+6

CDH's NICU has 8 Level III beds and 15 Level II beds.

Typical Level II NICU patients may have medical or surgical conditions related to the following systems: respiratory, cardiac, gastrointestinal, endocrine, genitourinary, neurological or musculoskeletal systems.

A team of caregivers include neonatologists, neonatal nurse practitioners, patient care manager, clinical shift coordinators, charge nurses, registered nurses, dieticians, physical therapists, occupational therapists, and speech therapists, respiratory care practitioners, care coordinators, administrative technicians and social workers work collaboratively, and have direct accountability for clinical decision making and outcomes surrounding patient care in the NICU. A women's and children's outcomes manager, clinical educator, clinical nurse specialist, spiritual care, clinical engineers, child life therapists and health unit coordinators support the team.

Historic Utilization

CDH's Level II patient days increased 23.5% from CY07 – CY13, from 4,453 in CY09 to 5,499 in CY13. This is an average increase of 3.9% per year.

Level II	CY07	CY08	CY09	CY10	CY11	CY12	CY13
Patient Days	4,453	4,955	5,088	5,213	4,088	4,344	5,499
ADC	12.2	13.6	13.9	14.3	11.2	11.9	15.1
Beds	15	15	15	15	15	15	15
Occupancy	81.3%	90.5%	92.9%	95.2%	74.7%	79.3%	100.4%

As a result of the hospital's growing maternal fetal medicine (MFM) program, babies with greater needs are routinely delivered at CDH, resulting in a dramatic increase in Level II patient days. In 2013, Cadence added three MFM specialists with a fourth anticipated by the end of this year. As a result of the growth of the MFM program, more space and stations are dedicated to Level II care. As a result of the high Level II census, Level II babies are frequently placed in Level III beds.

Projections

Projections for CDH's Level II patient days assume an average annual increase of 2.5%, which is less than the actual growth rate from CY07 – CY13. The projected patient days justify an additional 6 beds.

Level II	CY14	CY15	CY16	CY17	CY18
Patient Days	5,628	5,760	5,896	6,034	6,176
ADC	15.4	15.8	16.2	16.5	16.9
Beds	15	15	21	21	21
Occupancy	102.8%	105.2%	76.9%	78.7%	80.6%

There are no occupancy standards or specific review criteria for Level II Newborn bassinets.

VIII. 1120.120 – Availability of Funds

Not Applicable – see attached proof of bond rating.

IX. 1120.130 – Financial Viability

Not Applicable – see attached proof of bond rating.

X. 1120.140 – Economic Feasibility

A. Reasonableness of Financial Arrangements

Not Applicable – see attached proof of bond rating.

B. Conditions of Debt Financing

Not Applicable – the project is being funded through internal sources.

C. Reasonableness of Project and Related Costs

COST AND GROSS SQUARE FEET BY DEPARTMENT									
Department	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Mod.	DGSF New	Circ.*	DGSF Mod.	Circ.*	Const. \$ (A x C)	Mod. \$ (B x E)	
CLINICAL									
Pediatrics		\$ 278.00			18,327			\$5,094,906	\$5,094,906
NICU (Level II and Level III)		\$ 325.00			7,268			\$2,362,100	\$2,362,100
Clinical Subtotal =		\$ 291.35			25,595			\$7,457,006	\$7,457,006
NON-CLINICAL									
Satellite Pharmacy		\$ 295.00			504			\$148,680	\$148,680
Administration		\$ 220.00			504			\$110,880	\$110,880
Public Areas		\$ 220.00			868			\$190,960	\$190,960
Staff Lounges		\$ 220.00			1,138			\$250,360	\$250,360
On-Call Room		\$ 220.00			372			\$81,840	\$81,840
Storage		\$ 220.00			2,906			\$639,320	\$639,320
Utilities/MEP		\$ -			0			\$0	\$0
Elevators/Stairs		\$ -			0			\$0	\$0
Access Corridor for PICU		\$ 200.00			850			\$170,000	\$170,000
Non-Clinical Subtotal =		\$ 222.91			7,142			\$1,592,040	\$1,592,040
GRAND TOTAL =					32,737			\$9,049,046	\$9,049,046

D. Projected Operating Costs**Projected Direct Operating Expenses – FY18**

	Pediatrics Unit	NICU
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Depreciation Cost per Equivalent Patient Day	\$ 9.32

RatingsDirect®

Illinois Health Facilities Authority Illinois Finance Authority CDH-Delnor Health System d/b/a Cadence Health and Affiliates Delnor Community Hospital; Hospital

Primary Credit Analyst:

Suzie R Desai, Chicago (1) 312-233-7046; suzie.desai@standardandpoors.com

Secondary Contact:

Brian T Williamson, Chicago (1) 312-233-7009; brian.williamson@standardandpoors.com

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Related Criteria And Research

Illinois Health Facilities Authority

Illinois Finance Authority

CDH-Delnor Health System d/b/a Cadence Health and Affiliates

Delnor Community Hospital; Hospital

Credit Profile

Illinois Fin Auth, Illinois

CDH/Delnor Hlth Sys d/b/a Cadence Hlth & Affiliates, Illinois

Series 2009

Long Term Rating

AA/Stable

Affirmed

Illinois Hlth Fac Auth, Illinois

Delnor Comnty Hosp, Illinois

Illinois Hlth Fac Auth (Delnor Community Hospital)

Unenhanced Rating

AA-(SPUR)/Stable

Upgraded

Many issues are enhanced by bond insurance.

Rationale

Standard & Poor's Ratings Services raised its underlying rating (SPUR) to 'AA-' from 'A+' on the Illinois Health Facilities Authority's series 2002 and 2003 hospital fixed-rate revenue bonds issued for Delnor Community Hospital (Delnor). Standard & Poor's also affirmed its 'AA' long-term rating on the Illinois Finance Authority's \$240 million series 2009B and \$90 million series 2009 fixed-rate revenue bonds issued for Central DuPage Hospital Assn. (CDH). The outlook is stable.

CDH and Delnor (and various Delnor-related entities that were previously part of Delnor Community Health System, Delnor's prior parent) formed CDH-Delnor Health System, doing business as Cadence Health and Affiliates, in April 2011.

The rating action reflects our application of the group rating methodology and our view of Delnor obligated group's highly strategic status relative to Cadence Health. The two entities, while integrated operationally and strategically, maintain two distinct obligated groups; Delnor's operating income and total assets account for 7% and 15%, respectively, of Cadence Health's. The financial results and analysis presented in this article, however, cover the consolidated system unless otherwise indicated.

The 'AA' long-term rating on CDH's debt reflects our view of Cadence Health's group credit profile and the CDH obligated group's core status. Accordingly, the long-term rating is at the level of the group credit profile. The rating further reflects our view of Cadence Health's strong financial profile, location in a favorable demographic service area

in the western suburbs of Chicago, and good business position as a regionally based two-hospital system with a focus on several key high-acuity service lines. However, we view debt levels as slightly moderate for the rating, as some additional debt was consolidated at the time of Cadence Health's acquisition of a majority interest in an existing joint venture.

We anticipate that Cadence will maintain its strong financial profile as services on both campuses are enhanced and as management continues to focus on expenses. We also anticipate that the declining volumes at Delnor will gradually improve (volume decreases have slowed through interim 2014) given management's experience in developing and expanding service lines and integrating physicians. However, the market remains fairly competitive and several mergers and consolidations have occurred in the larger geographic region, possibly making market dynamics slightly more fluid.

In addition, Cadence Health and Northwestern Memorial HealthCare (AA+) recently announced a letter of intent to enter exclusive discussions to form an integrated academic health care delivery system in which governance would have equal board representation from the two entities. Although both entities are independently strong credits and an affiliation would broaden the overall footprint of the combined service area, we have not incorporated this affiliation into the credit review given the very recent announcement and a due diligence period that we anticipate could take several months.

The ratings reflect our view of Cadence Health's:

- Healthy unrestricted reserves (totaling \$1.3 billion, equal to 482 days' cash on hand, at Dec. 31, 2013) although days' cash has decreased in recent years, with growth in the expense base and acquisition of physicians offsetting absolute increases in overall unrestricted reserves;
- Continued revenue growth and robust operating profitability, with an operating margin of 11.0% for the fiscal year ended June 30, 2013 and 9.8% through the first unaudited six months of fiscal 2014 ended Dec. 31;
- Solid 6.6x maximum annual debt service coverage (MADS) in fiscal 2013 that has been modestly affected by additional debt related to the consolidation of a previously minority-owned joint venture;
- Management team that has implemented a strategic plan to enhance facilities and operations and that will broaden some key strategic initiatives at Delnor during the next few years; and
- Location in an economically and demographically favorable and large service area in the western suburbs of Chicago, with a leading and growing 29.4% market share in its primary and secondary service areas (despite competition in the suburban Chicago market) and a strong 67% market share in the primary service area.

Partly offsetting the above strengths, in our view, are Cadence Health's:

- Location in a highly competitive service area with recent mergers and affiliations among different providers,
- Continued inpatient volume softness at Delnor, and
- Debt levels that have increased slightly along with some related growth in contingent liabilities in the most recent year as well.

Cadence Health is the sole member of both CDH (333 licensed beds) and Delnor (159 licensed beds). Cadence Health (the parent corporation) and CDH are members of the CDH obligated group, while Delnor remains a separate obligated group. The CDH obligated group debt is a general obligation of the CDH obligated group. Delnor obligated debt is secured by Delnor's gross receivables and a springing mortgage on Delnor. At Dec. 31, 2013, Delnor had

approximately \$136 million of debt outstanding and CDH had \$444 million of debt outstanding. Cadence Health also had about \$104 million of debt that was not secured by either CDH or Delnor's master trust indentures. All of Cadence Health's debt has been included in this analysis. The CDH obligated group accounted for approximately 80% of Cadence Health's total assets and more than 100% of Cadence Health's operating income in 2013. Delnor's obligated group accounted for 15% of Cadence Health's total assets and 7% of Cadence Health's operating income.

Outlook

The stable outlook reflects our view of Cadence Health's flexibility derived from its strong unrestricted reserves and good trend of solid operating performance along with its stable and dominant business position in the primary service area. We continue to monitor the broader metropolitan Chicago market, which remains competitive and whose potentially evolving landscape (given several consolidations in the past few years) might affect Cadence Health. We have not fully incorporated how an affiliation with Northwestern Memorial HealthCare will affect Cadence given the very preliminary nature of the announcement and lack of details. We will more fully incorporate the affiliation into the rating once more details are provided.

We could consider raising the rating as Cadence Health decreases debt levels to provide additional strength and flexibility to the balance sheet, and if Cadence Health's enterprise profile, including market share, strengthens and thus further minimizes operating risks.

We could lower the rating during the next one to two years in the unlikely event that operating margins decrease and are sustained at less than 3% or if cash on hand declines to 200 days. We do not anticipate such a situation, based on historical trends and the ability of management and the board to manage Cadence Health's overall operating performance and balance sheet in a competitive service area.

Enterprise Profile

Organizational profile and market

The combined organization has more than \$1 billion of operating revenue, with CDH's revenue base accounting for about three-fourths of the total. Cadence Health formally came together in April 2011, and fiscal 2012 (ended June 30) was the system's first full fiscal year. CDH and its affiliates are located in Winfield, a western suburb of Chicago, and Delnor is located approximately 11 miles west of CDH. Other entities that are part of Cadence Health but are not part of the obligated groups are Community Nursing Service of DuPage County Inc. (providing home health care and hospice), Cadence Physician Group (which employs more than 230 physicians, including the 23-member orthopedic group acquired in early fiscal 2013), an orthopedic ambulatory surgery center, foundations for both Delnor and CDH, a residential living facility, a captive for managing self-insurance, and a few smaller entities with more limited operations.

After June 30, 2013, Cadence Health acquired additional interest in its existing joint venture, doing business as CDH Proton Center (the only proton therapy in Illinois), and went from a 12.2% equity interest to a majority owner (81.25% equity interest). Prior to the majority ownership, some operating challenges occurred at the CDH Proton Center joint venture, including a debt default. Cadence Health bought out one of the three partners (ProCure Treatment Centers).

and along with Cadence Health's acquisition of additional interests in the proton center, the CDH Proton Center's debt was restructured; the proton center is in compliance with its debt obligations. Cadence Health began to consolidate the operations of the proton center into its financial results in fiscal 2014. Cadence Health also has a number of smaller joint ventures, including two ambulatory surgery centers and two fitness centers. The system derives its operating income from CDH and Delnor, with the physician group generating the only anticipated (though sizable) operating loss.

Cadence Health has an expansive footprint in the western suburbs of Chicago, from Sycamore in the west to Lombard in the east. The combined organization maintains a leading position of 29.4% in a fairly competitive primary and secondary service area with a total population of about 1.1 million. Edward-Elmhurst has the second-highest market share at 12.3%, followed by Alexian Brothers (part of Ascension Health) at 11.5%.

Several hospitals have service areas that overlap in CDH's greater service area, including Alexian Brothers Medical Center to the northeast, Advocate Sherman Hospital (BBB/Stable but part of AA/Stable rated Advocate Health Care) to the northwest, Edward Hospital (A/Stable) to the south (Edward Hospital joined with Elmhurst Hospital in 2013), Advocate Good Samaritan (part of Advocate Health Care) to the southeast, and Elmhurst Hospital to the east. In addition, recent consolidations in the broader market could affect broader market dynamics.

Cadence Health's geographic area has maintained fairly favorable demographics, including a favorable payor mix with about 72.5% of net revenue coming from commercial payors, and population growth in certain parts of the greater service area, specifically Delnor's immediate service area.

In recent years, Cadence Health has focused on key service lines that support its solid business position: cardiac care, pediatrics, oncology, neurosciences, and orthopedics.

In the past couple of years, Cadence Health has aligned with the Cleveland Clinic Health System (AA-/Positive) to share clinical protocols and work on reducing costs related to cardiovascular surgery, cardiology, and adult oncology services. Although still in the early stages, the marketing for this kind of affiliation could also benefit Cadence Health through a competitive position in the competitive suburban market. Management aims to enhance some of the same services at Delnor to bolster its competitive position.

Cadence Health also has an affiliation with the Ann and Robert H. Lurie Children's Hospital of Chicago (A/stable) to provide certain subspecialty pediatric services at CDH, and those services are expanding to Delnor as well.

The consolidated system has rapidly expanded its physician group to more than 230 physicians (compared with 48 in 2008) and continues to focus on physician alignment strategies, including a physician hospital organization that aims to incorporate many of the independent physicians in the market. Delnor has historically lacked an integrated physician staff, but management is working to develop that area as well. Although Cadence Health maintains one employed physician group, the two hospitals have separate medical staffs (with some overlap).

Volumes

Cadence Health has experienced volume trends that are similar to those of the overall industry, with slower growth in inpatient volumes and more growth in outpatient volumes and observation cases. Inpatient volumes did increase by

2% to 31,603 in fiscal 2013, but have declined 1% through the first six months of interim 2014 compared with the prior-year period, with greater declines at Delnor relative to the system (although the rate of volume decreases is beginning to slow at Delnor). Inpatient volume growth in 2013 resulted primarily from Central DuPage and growth in key service lines. Adjusted discharges -- which incorporate inpatient and outpatient volume -- were up 2.2% in 2013 and 3.0% through interim 2014 compared with the prior-year period. Adjusted discharges were up at both CDH and Delnor as a result of physician integration and continued of enhancement and expansion of services at Delnor. Inpatient surgeries grew modestly, by almost 1% to 9,956 (primarily because of CDH), and outpatient surgeries decreased 5.1% 13,732, with declines at both hospitals. Through interim 2014, both inpatient and outpatient surgical procedures were up compared with the prior-year period, with support from both hospitals.

CDH, which is in a competitive service area with a relatively stable population, continues to increase market share and volumes (albeit at a slower rate than that of a few years ago) because management has focused on key service lines and because the opening of the new patient tower in the most recent fiscal year has allowed more efficient use of space. We anticipate that, as with many hospitals, CDH will continue to experience more outpatient growth although some moderate inpatient growth may occur, particularly in some of the areas of focus.

Delnor has exhibited volume declines during the past few years because of increased competition, particularly to the north with the opening of Sherman's replacement hospital on Randall Road a couple of years ago, and because of some physician turnover, which management is addressing. We anticipate that CDH's experience in employing physicians and expanding services, such as the new oncology center that opened in fall 2013, should help Delnor stabilize volumes within its market during the next few years. And as mentioned above, declines in inpatient volumes have begun to slow through interim 2014 and surgical procedures have begun to improve.

Management

Overall management has been stable since the consolidation of the system a couple of years ago. Mike Vivoda, was appointed CEO at the time of the consolidation in late fiscal 2011. Mr. Vivoda has been with the organization for nine years, and prior to being CEO was president of CDH. Chief financial officer (CFO) John Orsini started in January 2013, is the newest member of the team, and was most recently CFO at Presence Health (BBB+). The 23-member board of Cadence Health was formed in 2011 with 10 representatives from both CDH and Delnor; a representative of Cleveland Clinic joined the board in calendar 2012, and an additional physician joined in 2013. Management has historically been effective at implementing strategic plans and generating volumes for its key service lines, and this, along with strong cost controls, has allowed CDH to either meet or exceed its budget for the past five years. We believe that this experience, along with continued focus on process improvement and the use of data to manage the cost and quality of care (partly through the use of its Epic electronic health record system), should allow Cadence Health to continue to generate strong operating performance.

Financial Profile

Change in accounting for bad debt

In accordance with our report "New Bad Debt Accounting Rules Will Alter Some U.S. Not-for-Profit Health Care Ratios But Won't Affect Ratings," published Jan. 19, 2012 on RatingsDirect, we recorded Cadence Health's 2012 and 2013

audits, including the adoption of Financial Accounting Standards Board Accounting Standards Update No. 2011-07 in 2012 but not in prior periods. The new accounting treatment means that Cadence Health's financial statistics for fiscal 2012 and subsequent years are directly comparable neither with the results for 2011 and prior years, nor with the 2011 median ratios. For an explanation of how the change in accounting for bad debt affects each financial measure, including the direction and size of the change, please see the above report.

Income statement

Cadence Health posted strong operating income in 2013, and this trend continues into interim 2014. However, expenses have begun to outpace revenue growth in the most recent interim year, and we will continue to monitor this trend and its impact on operations. On a net patient revenue base of \$1.1 billion in fiscal 2013, Cadence posted strong operating income of \$124.6 million (11.0% margin) compared with \$108.2 million (10.8% margin) in 2012. Through the first half of fiscal 2014, Cadence Health generated an unaudited \$59.8 million (9.8% margin) of operating income. Management attributed its strong operations in 2013 to a good payor mix and continued focus on increasing top-line revenue, particularly in key service lines, in conjunction with management of expense growth. CDH continues to focus on key higher-acuity and higher-intensity service lines, and continues to work on revenue enhancement. However, in interim fiscal 2014, total operating expenses grew 12.7% while total revenue grew at a slightly lower rate of 11.9%.

Excess income, excluding unrealized losses on investments and changes in swap valuation, amounted to \$184.8 million (15.6% margin) for fiscal 2013, up from the prior year's \$154.6 million (14.7% margin) as a result of improved investment income. The good non-operating income yields and strong operating performance contributed to good MADS coverage of 6.6x. Cadence Health's debt burden, at 3.8%, is slightly more moderate than the median of 2.4%. Excluded from non-operating income was an approximately \$61 million loss related to a one-time non-cash write-down related to the CDH Proton Center.

Management anticipates continuing its focus on expense management while increasing outpatient revenue and reducing costs of delivery of care. Although we believe that this focus, coupled with efficiencies and continued service line enhancements at Delnor, make Cadence Health's \$115.1 million operating income budget for fiscal 2014 an attainable goal, we note that Cadence Health, as with all hospitals, is beginning to experience some headwinds related to the industry and that overall margins could attenuate from recent years' highs.

Balance sheet

Cadence Health's unrestricted reserves totaled \$1.3 billion at Dec. 31, 2013 (equal to 482 days' cash on hand), an increase of 10% since 2012. (All unrestricted reserve levels have been adjusted to exclude cash that is equal to the full long-term professional self-insurance liability.) Although growth has occurred, overall unrestricted reserve growth has attenuated slightly in recent years given increased capital spending and acquisitions (physician groups, the proton center, and a medical office building on the Delnor campus). Cash on hand has declined since 2012, when it measured 530 days, because of these acquisitions and growth in the total expense base.

Overall debt levels have bumped up slightly as the CDH Proton Center's \$102 million of long-term debt was consolidated on Cadence Health's balance sheet, resulting in softening of certain debt-related ratios. Although Cadence Health is not obligated on the proton center's debt, we have fully incorporated the debt into Cadence Health's debt profile. Unrestricted reserves to long-term debt for Cadence Health was 197% at Dec. 31, 2013, down from 219%

at the end of 2013. Leverage is at 27%, which is slightly higher than the median level of 24%. The \$102 million of debt at the joint venture CDH Proton Center has a maturity of Aug. 30, 2016; it will need to be refinanced or paid off by that date and is being considered a contingent liability. Cadence has no puttable debt but maintains a little less than \$300 million of contingent liabilities.

CDH, prior to the creation of Cadence Health, has a history of strong capital investment and that trend has continued in recent years. Although average age of plant is very good at 7.1 years, Cadence Health has continued to invest, with some focus on Delnor in the most recent year and on information technology (IT) investment at both hospitals; total capital spending was \$140 million in 2013. Large areas of recent spending included Epic at Delnor (completed in the second quarter of fiscal 2013), a new cancer center and infrastructure updates at Delnor, and other smaller building and IT-related projects. We anticipate that if operating cash flow (budgeted at \$259 million for fiscal 2014) remains robust, unrestricted reserves should continue to improve, depending on the actual capital spending, which is budgeted at around \$140 million. Cadence Health has no significant capital projects in the 2014 budget or on the near-term horizon, but as mentioned it continues to invest at levels above depreciation. Despite an anticipated increase of Cadence Health's investment allocation to alternatives (to about 35% from 16%), we believe that Cadence Health maintains a manageable investment allocation relative to its reserves, with 45% to be allocated to fixed income and cash and 20% to equities.

Contingent liabilities: Swaps, Direct Purchase Debt and other Contingent Liabilities

Cadence is party to four variable- to fixed-rate swaps. Two swaps are with CDH, with Morgan Stanley Capital Services Inc. (guaranteed by 'A' rated Morgan Stanley) as the counterparty, for a current notional amount of \$126.5 million. CDH's net variable-rate exposure, including the swaps, is approximately 3%. The other two variable- to fixed-rate swaps are with Delnor, with UBS AG as the counterparty, for a current notional amount of \$64.1million. Delnor has 0% net variable-rate exposure after taking into account the effect of the swaps.

The four swaps collectively had a negative mark-to-market value of \$31.2 million, with no collateral posted at Dec. 31, 2014. (CDH is not required to post collateral, and Delnor must maintain an 'A' rating or better and its insurance to avoid collateral posting.)

CDH Proton Center has a swap for a total notional amount of about \$95.7 million. This swap has a negative mark-to-market value of approximately \$7.9 million, with no collateral posting required at this time. The counterparties are BNP Paribas and KBC Bank NV.

Cadence Health has additional contingent liability risk related to \$179.2 million of direct purchase debt (series 2011A, B, and C), and has an additional \$102 million of contingent liability with the consolidation of the CDH Proton Center's debt. Total contingent liabilities are approximately 42% of total debt, with unrestricted reserves to contingent liabilities at an adequate 467%.

Cadence Health and Affiliates Financial Summary

	--Six-month interim ended Dec. 31--	--Fiscal year ended June 30--		--Medians--
	2013	2013	2012	'AA' rated stand-alone hospitals 2012
Financial performance				
Net patient revenue (\$000s)	581,848	1,066,585	956,362	998,771
Total operating revenue (\$000s)	609,850	1,127,210	1,006,867	MNR
Total operating expenses (\$000s)	550,039	1,003,605	898,665	MNR
Operating income (\$000s)	59,811	123,605	108,202	MNR
Operating margin (%)	9.81	10.97	10.75	5.20
Net non-operating income (\$000s)	9,405	61,221	46,436	MNR
Excess income (\$000s)	69,216	184,826	154,638	MNR
Excess margin (%)	11.18	15.55	14.68	6.90
Operating EBIDA margin (%)	21.46	21.89	21.36	12.50
EBIDA margin (%)	22.66	25.92	24.83	14.70
Net available for debt service (\$000s)	140,298	307,989	261,498	178,150
Maximum annual debt service (MADS; \$000s)	46,978	46,978	46,978	MNR
MADS coverage (x)	5.97	6.56	5.57	5.80
Operating-lease-adjusted coverage (x)	N.A.	5.80	5.01	4.30
Liquidity and financial flexibility				
Unrestricted reserves (\$000s)	1,311,747	1,240,968	1,192,976	1,120,520
Unrestricted days' cash on hand	481.9	498.1	530.4	386.9
Unrestricted reserves/total long-term debt (%)	197.2	218.7	205.9	245.2
Average age of plant (years)	N.A.	7.1	7.5	9.0
Capital expenditures/Depreciation and amortization (%)	309.5	148.6	154.0	141.0
Debt and liabilities				
Total long-term debt (\$000s)	665,126	567,334	579,424	MNR
Long-term debt/capitalization (%)	27.4	25.6	27.7	24.3
Contingent liabilities (\$000s)	281,050	185,910	220,052	MNR
Contingent liabilities/total long-term debt (%)	42.3	32.8	38.0	MNR
Debt burden (%)	3.79	3.95	4.46	2.40
Defined benefit plan funded status (%)	N/A	N/A	N/A	67.5

N/A--Not applicable. N.A.--Not available. MNR--Median not reported.

Related Criteria And Research

Related Criteria

- USPF Criteria: Not-For-Profit Health Care, June 14, 2007
- General Criteria: Group Rating Methodology, Nov. 19, 2013
- USPF Criteria: Contingent Liquidity Risks, March 5, 2012

Related Research

- Glossary: Not-For-Profit Health Care Ratios, Oct. 26, 2011
- The Outlook For U.S. Not-For-Profit Health Care Providers Is Negative From Increasing Pressures, Dec. 10, 2013
- U.S. Not-For-Profit Health Care Stand-Alone Ratios: Operating Pressures Led To Mixed Results In 2012, Aug. 8, 2013
- Health Care Providers And Insurers Pursue Value Initiatives Despite Reform Uncertainties, May 9, 2013
- U.S. Not-For-Profit Health Care Providers Hone Their Strategies To Manage Transition Risk, May 16, 2012
- U.S. Not-For-Profit Health Care Providers Hone Their Strategies For Reform, May 16, 2011
- Alternative Financing: Disclosure Is Critical To Credit Analysis In Public Finance, Feb. 18, 2014

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XI. Safety Net Impact Statement

Not Applicable – the proposed project is neither substantive nor a discontinuation project.

XII. Charity Care Information

Charity Care

CDH is committed to providing care for those who are unable to pay as the 10th largest provider of charity care in Illinois (ranked by dollars). Additionally, Cadence is the largest single provider of inpatient care for Access DuPage enrollees. 56% of all Access DuPage enrollees in need of hospitalization are cared for at CDH.

CDH CHARITY CARE			
	2011	2012	2013
Net Patient Revenue**	\$ 637,910,854	\$ 732,234,894	\$ 793,060,812
Amount of Charity Care (charges)	\$ 62,138,565	\$ 70,346,122	\$ 93,114,396
Cost of Charity Care	\$ 13,595,000	\$ 16,479,941	\$ 19,833,966
Charity Care as % of Net Revenue	2.1%	2.3%	2.5%