

17-019

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

**RECEIVED**

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

APR 14 2017

This Section must be completed for all projects.

**HEALTH FACILITIES &  
SERVICES REVIEW BOARD**

**Facility/Project Identification**

Facility Name: SwedishAmerican Hospital Modernization		
Street Address: 1401 East State Street		
City and Zip Code: Rockford, IL 61104		
County: Winnebago	Health Service Area: 1	Health Planning Area: B-01

**Applicant(s)** [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name: SwedishAmerican Hospital
Street Address: 1401 East State Street
City and Zip Code: Rockford, IL 61104
Name of Registered Agent: N/A
Registered Agent Street Address: N/A
Registered Agent City and Zip Code: N/A
Name of Chief Executive Officer: Dr. William Gorski, M.D.
CEO Street Address: 1313 East State Street
CEO City and Zip Code: Rockford, IL 61104
CEO Telephone Number: (815) 489-4003

**Type of Ownership of Applicants**

<input checked="" type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship
	<input type="checkbox"/> Other

- o Corporations and limited liability companies must provide an **Illinois certificate of good standing**.
- o Partnerships must provide the name of the state in which they are 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: Jedediah L. Cantrell, FACHE, MBA, RHIA
Title: Vice President of Operations
Company Name: SwedishAmerican Health System Corporation
Address: 1401 State Street, Rockford, IL 61104
Telephone Number: (779) 696-4005
E-mail Address: jcantrell@swedishamerican.org
Fax Number: (779) 696-2463

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

Name: Daniel J. Lawler
Title: Partner
Company Name: Barnes & Thornburg LLP
Address: One North Wacker Drive, Suite 4400, Chicago, IL 60606
Telephone Number: (312) 214-4861
E-mail Address: dlawler@btlaw.com
Fax Number: (312) 759-5646

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

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Telephone Number: (312) 214-4861
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Facility Name: SwedishAmerican Hospital Modernization		
Street Address: 1401 East State Street		
City and Zip Code: Rockford, IL 61104		
County: Winnebago	Health Service Area: 1	Health Planning Area: B-01

**Applicant(s)** [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name: University of Wisconsin Hospitals and Clinics Authority
Street Address: 600 Highland Avenue, H4/828
City and Zip Code: Madison, WI 53792-8360
Name of Registered Agent: N/A
Registered Agent Street Address: N/A
Registered Agent City and Zip Code: N/A
Name of Chief Executive Officer: Dr. Alan S. Kaplan, M.D.
CEO Street Address: 600 Highland Avenue, H4/828
CEO City and Zip Code: Madison, WI 53792-8360
CEO Telephone Number: (608) 263-8025

**Type of Ownership of Applicants**

<input type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership	
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental	
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship	<input checked="" type="checkbox"/> Other

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E-mail Address: jcantrell@swedishamerican.org
Fax Number: (779) 696-2463

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

Name: Susan M. Ertl, MSN, RN
Title: Vice President, Regional System Integration
Company Name: University of Wisconsin Medical Foundation
Address: 301 South Westfield Road, Suite 320
Telephone Number: (608) 265-5560
E-mail Address: SErtl@UWhealth.org
Fax Number: (608) 263-5393

**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: Jedediah L. Cantrell, FACHE, MBA, RHIA
Title: Vice President of Operations
Company Name: SwedishAmerican Health System Corporation
Address: 1401 State Street, Rockford, IL 61104
Telephone Number: (779) 696-4005
E-mail Address: jcantrell@swedishamerican.org
Fax Number: (779) 696-2463

**Site Ownership**

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: SwedishAmerican Hospital
Address of Site Owner: 1401 East State Street, Rockford, IL 61104
Street Address or Legal Description of the Site: 1401 East State Street, Rockford, IL 61104
<b>Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, 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.</b>
<b>APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>

**Operating Identity/Licensee**

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

Exact Legal Name: SwedishAmerican Hospital
Address: 1401 East State Street, Rockford, IL 61104
<input checked="" type="checkbox"/> Non-profit Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> For-profit Corporation <input type="checkbox"/> Governmental <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other
<ul style="list-style-type: none"> <li>o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.</li> <li>o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.</li> <li>o <b>Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.</b></li> </ul>
<b>APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>

**Organizational Relationships**

Provide (for each 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 #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at [www.FEMA.gov](http://www.FEMA.gov) or [www.illinoisfloodmaps.org](http://www.illinoisfloodmaps.org). **This map must be in a readable format.** In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 (<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

In the space below, provide 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.

This project includes modernization of SwedishAmerican Hospital's existing facility and on-campus construction of a patient tower primarily devoted to women's and children's services at the hospital's current location of 1401 East State Street, Rockford, Illinois. The total project cost is \$128,228,014 and total square footage is 223,384 gsf.

The modernization involves 162,961 gsf of existing space in the following areas; Medical/Surgical unit; Acute Mental Illness unit; Emergency Department; Operating Rooms; Pediatric Acute Care unit; and, Prep and Recovery.

A new 114,830 gsf patient tower for women's and children's services will include the following areas: Labor Delivery and Recovery; C-Section; Post Partum; Pediatrics Clinic; Nursery. The patient tower will be physically connected to the main hospital building. It will have four clinical floors and a fifth floor penthouse for mechanicals.

The first floor of the new women's and children's tower will include pediatric specialty and maternal fetal medicine outpatient clinics, conference rooms, lobby and common staff and public areas. The second floor will include a 14-bed labor and delivery and antepartum inpatient unit with 2 cesarean-section procedure rooms, common areas and a connector to the existing hospital building. The third floor will include the Nursery unit, common areas and a connector to the existing hospital building. The fourth floor will include a 20-bed mother/baby inpatient unit and common areas.

Additional new construction of a one-story 12,000 gsf extension to the existing facility will provide a replacement for the existing Cath Labs and Angiography suites. This will provide space in the existing facility to modernize and expand Surgery which then, in a phased sequence, will in turn provide space for the expansion of the Emergency Department. Other renovations are proposed to modernize, renovate and expand the current instrument processing area to support surgery along with a renovation of the prep/recovery area to accommodate the growth of surgery.

Concurrently with the construction of the Women's and Children's Tower the existing Pediatric Unit will be renovated to provide modern all-private rooms for Pediatric patients. After the completion of the women's and children's tower the existing floor occupied for those services will be renovated as an adult medical/surgical all-private nursing unit which will allow the entire hospital to operate with an all-private patient room model.

This project does not involve an increase in beds or the addition of a category of service. The project will reduce Medical/Surgical beds by 10 beds (a reduction from 209 beds to 199 beds). The project will also redistribute 10 beds from Pediatrics (reduction from 28 beds to 18 beds) to Acute Mental Illness (increase from 32 beds to 42 beds). The project seeks to: add one cath lab to the existing service; add two operating rooms; add nine PACU stations; and, add eight ED stations.

SwedishAmerican Hospital is separately filing an Exemption Application to establish a 10-bed Neonatal Intensive Care Unit (NICU) in accordance with Section 1130.140 and 1130.531 of the Review Board's operational rules. The NICU will be established in the hospital's existing facility and is expected to be operational in 2018. Upon completion of the women's and children's patient tower, the NICU would be re-located to the new facility along with other obstetric and neonatal services.

The project is non-substantive under Section 1110.40 of the Review Board's rules because it does not establish a category of service, increase the total number of beds, or seek redistribution of more than 20 beds.

**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 be equal.

<b>Project Costs and Sources of Funds</b>			
<b>USE OF FUNDS</b>	<b>CLINICAL</b>	<b>NONCLINICAL</b>	<b>TOTAL</b>
Preplanning Costs	\$75,000	\$15,000	\$90,000
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts	\$35,184,274	\$14,851,828	\$50,036,102
Modernization Contracts	\$25,390,551		\$25,390,551
Contingencies	\$10,827,525	\$2,688,222	\$13,515,746
Architectural/Engineering Fees	\$4,837,013	\$1,097,191	\$5,934,203
Consulting and Other Fees	\$208,333	\$41,667	\$250,000
Movable or Other Equipment (not in construction contracts)	\$18,697,226	\$5,047,077	\$27,744,303
Bond Issuance Expense (project related)	\$950,116	\$236,993	\$1,187,019
Net Interest Expense During Construction (project related)	\$6,667,008	\$1,662,992	\$8,330,000
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
<b>TOTAL USES OF FUNDS</b>	<b>\$102,628,712</b>	<b>\$25,599,302</b>	<b>\$128,228,014</b>
<b>SOURCE OF FUNDS</b>	<b>CLINICAL</b>	<b>NONCLINICAL</b>	<b>TOTAL</b>
Cash and Securities	\$5,667,008	\$1,662,992	\$7,330,000
Pledges			
Gifts and Bequests	\$1,000,000		\$1,000,000
Bond Issues (project related)	\$95,961,704	\$23,936,310	\$119,898,014
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
<b>TOTAL SOURCES OF FUNDS</b>	<b>\$102,628,712</b>	<b>\$25,599,302</b>	<b>\$128,228,014</b>
<b>NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>			

**Related Project Costs**

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

Land acquisition is related to project	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Purchase Price: \$	_____	
Fair Market Value: \$	_____	
The project involves the establishment of a new facility or a new category of service		
	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
If yes, provide the dollar amount of all <b>non-capitalized</b> operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.		
Estimated start-up costs and operating deficit cost is \$ _____.		

**Project Status and Completion Schedules**

<b>For facilities in which prior permits have been issued please provide the permit numbers.</b>	
Indicate the stage of the project's architectural drawings:	
<input type="checkbox"/> None or not applicable	<input type="checkbox"/> Preliminary
<input checked="" type="checkbox"/> Schematics	<input type="checkbox"/> Final Working
Anticipated project completion date (refer to Part 1130.140): <u>November 30, 2022</u>	
Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140):	
<input type="checkbox"/> Purchase orders, leases or contracts pertaining to the project have been executed.	
<input type="checkbox"/> Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies	
<input checked="" type="checkbox"/> Financial Commitment will occur after permit issuance.	
<b>APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>	

**State Agency Submittals** [Section 1130.620(c)]

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



**Cost Space Requirements**

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

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
<b>REVIEWABLE</b>							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
<b>NON REVIEWABLE</b>							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
<b>TOTAL</b>							
<p><b>APPEND DOCUMENTATION AS ATTACHMENT 9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b></p>							

**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 the chart after this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which data is 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**.

SwedishAmerican Hospital		CITY: Rockford, Illinois			
<b>FACILITY NAME:</b>					
<b>REPORTING PERIOD DATES:</b>		From: July 1, 2015		to: June 30, 2016	
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	209	10,342	47,170	-10	199
Obstetrics	34	2,520	4,431	0	34
Pediatrics	28	272	1,192	-10	18
Intensive Care	30	368	6,048	0	30
Comprehensive Physical Rehabilitation	0	0	0	0	0
Acute/Chronic Mental Illness	32	1,387	8,540	+10	42
Neonatal Intensive Care	0	0	0	*	10*
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
<b>TOTALS:</b>	333	14,889	67,352	-10	333

\*NOTE: The 10 NICU beds are not being added as part of this CON project. Rather, the applicants have separately filed an Exemption Application for the NICU beds pursuant to 77 Ill. Adm. Code 1130.140 and 1130.531. The NICU Service, if approved, will be set up in the existing facility, then transferred to the new patient tower as part of this project once the tower is completed.

**CERTIFICATION**

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

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

This Application is filed on the behalf of SwedishAmerican 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 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 fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

William R. Gorski, M.D.

PRINTED NAME

Chief Executive Officer

PRINTED TITLE

SIGNATURE

Don F. Daniels

PRINTED NAME

Chief Operating Officer

PRINTED TITLE

Notarization:  
Subscribed and sworn to before me  
this 10<sup>th</sup> day of April 2017

Notarization:  
Subscribed and sworn to before me  
this 10<sup>th</sup> day of April 2017

Signature of Notary

Seal



Signature of Notary

Seal



\*Insert the EXACT legal name of the applicant

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- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of SwedishAmerican Health System Corporation \*  
 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 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 fee required for this application is sent herewith or will be paid upon request.

  
 \_\_\_\_\_  
 SIGNATURE

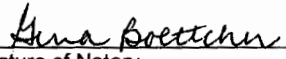
William R. Gorski, M.D.  
 PRINTED NAME  
 Chief Executive Officer  
 PRINTED TITLE

  
 \_\_\_\_\_  
 SIGNATURE

Don F. Daniels  
 PRINTED NAME  
 Chief Operating Officer  
 PRINTED TITLE

Notarization:  
 Subscribed and sworn to before me  
 this 10<sup>th</sup> day of April 2017

Notarization:  
 Subscribed and sworn to before me  
 this 10<sup>th</sup> day of April 2017

  
 \_\_\_\_\_  
 Signature of Notary

  
 \_\_\_\_\_  
 Signature of Notary

Seal 

Seal 

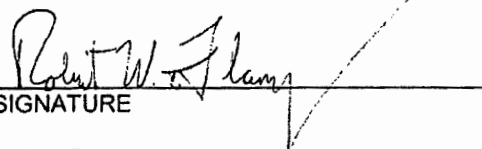
\*Insert the EXACT legal name of the applicant

**CERTIFICATION**

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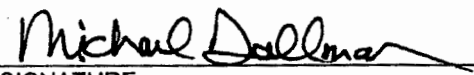
- o in the case of a corporation, any two of its officers or members of its Board of Directors;
- o in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- o in the case of a partnership, two of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

This Application is filed on the behalf of University of Wisconsin Hospitals and Clinics Authority\* 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 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 fee required for this application is sent herewith or will be paid upon request.

  
 \_\_\_\_\_  
 SIGNATURE

Robert Flannery  
 \_\_\_\_\_  
 PRINTED NAME

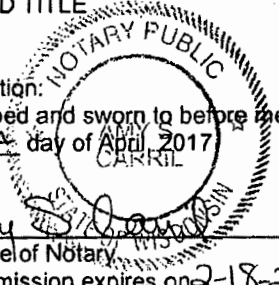
SVP/Chief Financial Officer  
 \_\_\_\_\_  
 PRINTED TITLE

  
 \_\_\_\_\_  
 SIGNATURE

Michael Dallman  
 \_\_\_\_\_  
 PRINTED NAME

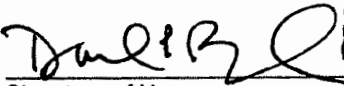
SVP/Chief Strategy Officer  
 \_\_\_\_\_  
 PRINTED TITLE

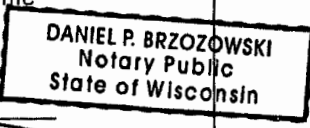
Notarization:  
 Subscribed and sworn to before me  
 this 17<sup>th</sup> day of April, 2017

  
 \_\_\_\_\_  
 Signature of Notary  
 My commission expires on 2-18-2018

Seal

Notarization:  
 Subscribed and sworn to before me  
 this 17<sup>th</sup> day of April, 2017

  
 \_\_\_\_\_  
 Signature of Notary  
 My commission expires on no permit

  
 DANIEL P. BRZOZOWSKI  
 Notary Public  
 State of Wisconsin

Seal

\*Insert the EXACT legal name of the applicant

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

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

#### Background

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 that the information was 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.**

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

##### 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 relevant area, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.
4. Cite the sources of the 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 the age and condition of the project site, as well as 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 Staff 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 and it shall include the basis used for determining the space and the methodology applied.**
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 and certified by the facility's Medical Director.
  - b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that delineates the constraints or impediments.
  - c. The project involves the conversion of existing space that results in excess square footage.
  - d. Additional space is mandated by governmental or certification agency requirements that were not in existence when Appendix B standards were adopted.

**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	MEET 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 (GSF) 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 is 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 VI. SERVICE SPECIFIC REVIEW CRITERIA**

This Section is applicable to all projects proposing the 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 APPLICABLE TO THE CRITERIA THAT MUST BE ADDRESSED:

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

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

Category of Service	# Existing Beds	# Proposed Beds
<input type="checkbox"/> <b>Medical/Surgical</b>	209	199
<input checked="" type="checkbox"/> <b>Obstetric</b>	34	34
<input type="checkbox"/> <b>Pediatric</b>	28	18
<input type="checkbox"/> <b>Intensive Care</b>	30	30

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

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

<b>APPLICABLE REVIEW CRITERIA</b>	<b>Establish</b>	<b>Expand</b>	<b>Modernize</b>
1110.530(f) - Staffing Availability	X	X	
1110.530(g) - Performance Requirements	X	X	X
1110.530(h) - Assurances	X	X	

**APPEND DOCUMENTATION AS ATTACHMENT 19, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

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

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

Category of Service	# Existing Beds	# Proposed Beds
<input checked="" type="checkbox"/> Acute Mental Illness	32	42
<input type="checkbox"/> Chronic Mental Illness		

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

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.730(c)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.730(c)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.730(c)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.730(c)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.730(c)(5) - Planning Area Need - Service Accessibility	X		
1110.730(d)(1) - Unnecessary Duplication of Services	X		
1110.730(d)(2) - Maldistribution	X		
1110.730(d)(3) - Impact of Project on Other Area Providers	X		
1110.730(e)(1), (2), and (3) - Deteriorated Facilities			X
1110.730(e)(4) - Occupancy			X
1110.730(f)(1) - Staffing Availability	X	X	
1110.730(g) - Performance Requirements	X	X	X
1110.730(h) - Assurances	X	X	
<b>APPEND DOCUMENTATION AS ATTACHMENT 21, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>			

**E. Criterion 1110.1330 - Cardiac Catheterization**

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

Category of Service	# Existing Beds	# Proposed Beds
<input checked="" type="checkbox"/> Cardiac Catheterization	4 Labs	5 Labs

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

1. **Criterion 1110.1330(a), Peer Review**  
Read the criterion and submit a detailed explanation of your peer review program.
2. **Criterion 1110.1330(b), Establishment or Expansion of Cardiac Catheterization Service**  
Read the criterion and, if applicable, submit the following information:
  - a. A map (on 8 1/2" x 11" paper) showing the location of the other hospitals providing cardiac catheterization services within the planning area.
  - b. The number of cardiac catheterizations performed for the last 12 months at each of the hospitals shown on the map.
  - c. Provide the number of patients transferred directly from the applicant's hospital to another facility for cardiac catheterization services in each of the last three years.
3. **Criterion 1110.1330(c), Unnecessary Duplication of Services**  
Read the criterion and, if applicable, submit the following information.
  - a. Copies of the letter sent to all facilities within 90 minutes travel time that currently provide cardiac catheterization. This letter must contain a description of the proposed project and a request that the other facility quantify the impact of the proposal on its program.
  - b. Copies of the responses received from the facilities to which the letter was sent.
4. **Criterion 1110.1330(d), Modernization of Existing Cardiac Catheterization Laboratories**  
Read the criterion and, if applicable, submit the number of cardiac catheterization procedures performed for the latest 12 months.
5. **Criterion 1110.1330(e), Support Services**  
Read the criterion and indicate on a service by service basis which of the listed services are available on a 24-hour basis and explain how any services not available on a 24-hour basis will be available when needed.

**6. Criterion 1110.1330(f), Laboratory Location**

Read the criterion and, if applicable, submit line drawings showing the location of the proposed laboratories. If the laboratories are not in close proximity, explain why.

**7. Criterion 1110.1330(g), Staffing**

Read the criterion and submit a list of names and qualifications of those who will fill the positions detailed in this criterion. Also, provide staffing schedules to show the coverage required by this criterion.

**8. Criterion 1110.1330(h), Continuity of Care**

Read the criterion and submit a copy of the fully executed written referral agreement(s).

**9. Criterion 1110.1330(i), Multi-institutional Variance**

Read the criterion and, if applicable, submit the following information:

- a. A copy of a fully executed affiliation agreement between the two facilities involved.
- b. Names and positions of the shared staff at the two facilities.
- c. The volume of open heart surgeries performed for the latest 12-month period at the existing operating program.
- d. A cost comparison between the proposed project and expansion at the existing operating program.
- e. The number of cardiac catheterization procedures performed in the last 12 months at the operating program.
- f. The number of catheterization laboratories at the operating program.
- g. The projected cardiac catheterization volume at the proposed facility annually for the next 2 years.
- h. The basis for the above projection.

**APPEND DOCUMENTATION AS ATTACHMENT 23 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

**M. Criterion 1110.3030 - Clinical Service Areas Other than Categories of Service**

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

Service	# Existing Key Rooms	# Proposed Key Rooms
<input type="checkbox"/> SEE ATTACHMENT 31		
<input type="checkbox"/>		
<input type="checkbox"/>		

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

Project Type	Required Review Criteria
New Services or Facility or Equipment	(c) - Need Determination - Establishment
Service Modernization	(d)(1) - Deteriorated Facilities
	AND/OR
	(d)(2) - Necessary Expansion PLUS
	(d)(3)(A) - Utilization - Major Medical Equipment
	OR
	(d)(3)(B) - Utilization - Service or Facility
<b>APPEND DOCUMENTATION AS ATTACHMENT 31, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>	

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

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

**VII. 1120.120 - AVAILABILITY OF FUNDS** NOT APPLICABLE PER FINANCIAL VIABILITY WAIVER

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

	<p>a) Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to:</p> <ol style="list-style-type: none"> <li>1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and</li> <li>2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;</li> </ol>
	<p>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.</p>
	<p>c) Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;</p>
	<p>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:</p> <ol style="list-style-type: none"> <li>1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated;</li> <li>2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate;</li> <li>3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.;</li> <li>4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment;</li> <li>5) For any option to lease, a copy of the option, including all terms and conditions.</li> </ol>



	<p>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;</p>
	<p>f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;</p>
	<p>g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.</p>
	<b>TOTAL FUNDS AVAILABLE</b>
<p><b>APPEND DOCUMENTATION AS <u>ATTACHMENT 34</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b></p>	

**SECTION VIII. 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 35, 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.

	Historical 3 Years			Projected
<b>Enter Historical and/or Projected Years:</b>				
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.

**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 36, IN NUMERIC ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

**NOT APPLICABLE PER FINANCIAL VIABILITY WAIVER**

**SECTION IX. 1120.140 - ECONOMIC FEASIBILITY**

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

**A. Reasonableness of Financing Arrangements** NOT APPLICABLE PER FINANCIAL VIABILITY WAIVER

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

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

**B. Conditions of Debt Financing**

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

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

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

Read the criterion and provide the following:

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

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

\* Include the percentage (%) of space for circulation

#### D. Projected Operating Costs

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

#### E. Total Effect of the Project on Capital Costs

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

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

### SECTION X. SAFETY NET IMPACT STATEMENT

**SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE STATE-OWNED HEALTH CARE FACILITIES [20 ILCS 3960/5.4]:**

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 40.

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

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

**SECTION XI. CHARITY CARE INFORMATION**

Charity Care information **MUST** be furnished for **ALL** projects [1120.20(c)].

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 41.

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

APPEND DOCUMENTATION AS **ATTACHMENT 39**, 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 included attachments:

<b>INDEX OF ATTACHMENTS</b>		
<b>ATTACHMENT NO.</b>		<b>PAGES</b>
1	Applicant Identification including Certificate of Good Standing	32-41
2	Site Ownership	42-45
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	46-47
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	48
5	Flood Plain Requirements	49-51
6	Historic Preservation Act Requirements	52-79
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### **Type of Ownership of Applicants**

SwedishAmerican Hospital and SwedishAmerican Health System corporation are Illinois not-for-profit corporations. Their Certificates of Good Standing are attached.

University of Wisconsin Hospitals and Clinics Authority (UWHCA) was originally operated as a unit of the Board of Regents of the University of Wisconsin System, an agency of the State of Wisconsin and the governing body of UW-Madison. In 1995, UWHCA was created as a public body corporate and politic by legislation in the State of Wisconsin, and UWHCA took over the operation of the existing UW Hospital and Clinics on June 29, 1996. UWHCA operates an acute care hospitals with over 640 acute care beds, numerous specialty clinics, and ambulatory facilities, and a home health program for the following purposes: (i) delivering high-quality health care to patients using the hospitals and to those seeking care from its programs, including a commitment to provide such care for the medically indigent; (ii) providing an environment suitable for instructing medical and other health professions students, physicians, nurses and members of other health-related disciplines; (iii) sponsoring and supporting research in the delivery of health care to further the welfare of the patients treated and applying the advances in health knowledge to alleviate human suffering, promote health and prevent disease; and (iv) assisting health programs and personnel throughout the State of Wisconsin and region in the delivery of health care.

The Wisconsin statutes creating UWHCA and describing its powers and duties are included with this Attachment.



File Number

1167-170-5



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

*I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that*

SWEDISHAMERICAN HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 06, 1911, 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 16TH day of FEBRUARY A.D. 2017 . .***

*Jesse White*

SECRETARY OF STATE

Authentication #: 1704700670 verifiable until 02/16/2018  
Authenticate at: <http://www.cyberdriveillinois.com>

File Number

5269-562-7



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

*I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that*

SWEDISHAMERICAN HEALTH SYSTEM CORPORATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON MARCH 31, 1982, 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 #: 1705501904 verifiable until 02/24/2018  
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 24TH*  
*day of FEBRUARY A.D. 2017 .*

*Jesse White*

SECRETARY OF STATE

**233.02. University of Wisconsin Hospitals and Clinics Authority:..., WI ST 233.02**

<b>West's Wisconsin Statutes Annotated</b>
<b>Authorities and Public Corporations (Ch. 231 to 235)</b>
<b>Chapter 233. University of Wisconsin Hospitals and Clinics Authority (Refs &amp; Annos)</b>

**W.S.A. 233.02**

**233.02. University of Wisconsin Hospitals and Clinics Authority: creation; organization of board of directors**

(1) There is created a public body corporate and politic to be known as the "University of Wisconsin Hospitals and Clinics Authority". The board of directors shall consist of the following members:

(a) Six members nominated by the governor, and with the advice and consent of the senate appointed, for 5-year terms.

(am) Each cochairperson of the joint committee on finance or a member of the legislature designated by that cochairperson.

(b) Three members of the board of regents appointed by the president of the board of regents.

(c) The chancellor of the University of Wisconsin-Madison or his or her designee.

(d) The dean of the University of Wisconsin-Madison Medical School.

(e) A chairperson of a department at the University of Wisconsin-Madison Medical School, appointed by the chancellor of the University of Wisconsin-Madison.

(f) A faculty member of a University of Wisconsin-Madison health professions school, other than the University of Wisconsin-Madison Medical School, appointed by the chancellor of the University of Wisconsin-Madison.

(g) The secretary of administration or his or her designee.

(2) A vacancy on the board of directors shall be filled in the same manner as the original appointment to the board of directors for the remainder of the unexpired term, if any.

(3) A member of the board of directors may not be compensated for his or her services but shall be reimbursed for actual and necessary expenses, including travel expenses, incurred in the performance of his or her duties.

(4) No cause of action of any nature may arise against and no civil liability may be imposed upon a member of the board of directors for any act or omission in the performance of his or her powers and duties under this chapter, unless the person asserting liability proves that the act or omission constitutes willful misconduct.

(8) The members of the board of directors shall annually elect a chairperson and may elect other officers as they consider appropriate. Eight members of the board of directors constitute a quorum for the purpose of conducting the business and exercising the powers of the authority, notwithstanding the existence of any vacancy. The members of the board of directors specified under sub. (1)(c) and (g) may not be the chairperson of the board of directors for purposes of 1995 Wisconsin Act 27, section 9159(2). The board of directors may take action upon a vote of a majority of the members present, unless the bylaws of the authority require a larger number.

(9) The board of directors shall appoint a chief executive officer who shall not be a member of the board of directors and who shall serve at the pleasure of the board of directors. The chief executive officer shall receive such compensation as the board of directors fixes. The chief executive officer or other person designated by resolution of the board of directors shall keep a record of the proceedings of the authority and shall be custodian of all books, documents and papers filed with the authority, the minute book or journal of the authority and its official seal. The chief executive officer or other person may cause copies to be made of all minutes and other records and documents of the authority and may give certificates under the official seal of

**233.02. University of Wisconsin Hospitals and Clinics Authority:..., WI ST 233.02**

the authority to the effect that such copies are true copies, and all persons dealing with the authority may rely upon such certificates.

**Credits**

<<For credits, see Historical Note field.>>

**W. S. A. 233.02, WI ST 233.02**  
**Current through 2013 Act 380, published 4/25/2014**

End of Document

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West's Wisconsin Statutes Annotated

Authorities and Public Corporations (Ch. 231 to 235)

Chapter 233. University of Wisconsin Hospitals and Clinics Authority (Refs & Annos)

W.S.A. 233.03

233.03. Powers of authority

The authority shall have all the powers necessary or convenient to carry out the purposes and provisions of this chapter. In addition to all other powers granted by this chapter, the authority may:

- (1) Adopt bylaws and policies and procedures for the regulation of its affairs and the conduct of its business.
- (2) Sue and be sued; have a seal and alter the seal at pleasure; have perpetual existence; maintain an office; negotiate and enter into leases; accept gifts or grants, but not including research grants in which the grant investigator is an employee of the board of regents; accept bequests or loans; accept and comply with any lawful conditions attached to federal financial assistance; and make and execute other instruments necessary or convenient to the exercise of the powers of the authority.
- (5) Procure insurance on its debt obligations.
- (7) Subject to s. 233.10 and ch. 40 and 1995 Wisconsin Act 27, section 9159(4), employ any agent, employee or special advisor that the authority finds necessary and fix his or her compensation and provide any employee benefits, including an employee pension plan.
- (8) Appoint any technical or professional advisory committee that the authority finds necessary and define the duties, and provide reimbursement for the expenses, of the committee.
- (9)(a) With any other person, establish, govern and participate in the operation and financing of any corporation or partnership that provides health-related services, if the articles of incorporation of any such corporation conform with par. (b) and if the corporation or partnership provides the secretary of administration, the legislative fiscal bureau and the legislative audit bureau access to examine any books, records or other documents maintained by the corporation or partnership and relating to its expenditures, revenues, operations or structure. The authority may provide administrative and financial services to any such corporation or partnership.
- (b) The articles of incorporation of any corporation under par. (a) shall provide that the secretary of administration, the legislative fiscal bureau and the legislative audit bureau have the access required under par. (a).
- (10) Enter into procurement contracts with the board of regents or joint contracts with the board of regents for procurements from 3rd parties and may enter into other contracts, rental agreements and cooperative agreements and other necessary arrangements with the board of regents which may be necessary and convenient for the missions, purposes, objects and uses of the authority authorized by law.
- (11) Issue bonds in accordance with ss. 233.20 to 233.26.
- (12) Seek financing from, and incur indebtedness to, the Wisconsin Health and Educational Facilities Authority.
- (13) Construct or improve facilities that are on state-owned land, if approval requirements under s. 16.85(14) are met and if the state agency having authority to approve construction or improvement projects on the land approves the project.
- (15) Acquire, design, construct or improve any facility that is not located on state-owned land.
- (16) Buy, sell and lease real estate.

**233.03. Powers of authority, WI ST 233.03**

**Credits**

**<<For credits, see Historical Note field.>>**

**W. S. A. 233.03, WI ST 233.03  
Current through 2013 Act 380, published 4/25/2014**

**End of Document**

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233.04. Duties of authority, WI ST 233.04

West's Wisconsin Statutes Annotated

Authorities and Public Corporations (Ch. 231 to 236)

Chapter 233. University of Wisconsin Hospitals and Clinics Authority (Refs & Annos)

W.S.A. 233.04

233.04. Duties of authority

The authority shall do all of the following:

(1) By October 1, 1997, and annually thereafter, submit to the chief clerk of each house of the legislature under s. 13.172(2), the president of the board of regents, the secretary of administration and the governor a report on the patient care, education, research and community service activities and accomplishments of the authority and an audited financial statement, certified by an independent auditor, of the authority's operations.

(2) Subject to s. 233.10, develop and implement a personnel structure and other employment policies for employees of the authority.

(3) Contract for any legal services required for the authority.

(3b)(a) Except as provided in par. (b), maintain, control and supervise the use of the University of Wisconsin Hospitals and Clinics, for the purposes of:

1. Delivering high-quality health care to patients using the hospitals and to those seeking care from its programs, including a commitment to provide such care for the medically indigent.

2. Providing an environment suitable for instructing medical and other health professions students, physicians, nurses and members of other health-related disciplines.

3. Sponsoring and supporting research in the delivery of health care to further the welfare of the patients treated and applying the advances in health knowledge to alleviate human suffering, promote health and prevent disease.

4. Assisting health programs and personnel throughout the state and region in the delivery of health care.

(b) Paragraph (a) does not apply unless a lease agreement under sub. (7) or (7g) and an affiliation agreement under sub. (7m) or (7p) are in effect that comply with all applicable requirements of those provisions. In the event either of these agreements are not in effect, the on-campus facilities and any improvements, modifications or other facilities specified in sub. (7)(c) shall transfer to the board of regents.

(5) Establish the authority's annual budget and monitor the fiscal management of the authority.

(6) Procure liability insurance covering its officers, employees and agents and procure insurance against any loss in connection with its property and other assets.

(7) Subject to s. 233.05(1) and 1995 Wisconsin Act 27, section 9159(2)(k), negotiate and enter into a lease agreement with the board of regents to lease the on-campus facilities beginning on June 29, 1996, for an initial period of not more than 30 years. The lease agreement shall include all of the following:

(a) A provision that requires the authority to pay the state an amount determined under this paragraph for the lease of the on-campus facilities that are leased under the agreement. The amount of the rental payment for the on-campus facilities may not be less than the greater of the following:

**233.04. Duties of authority, WI ST 233.04**

1. An amount equal to the debt service accruing during the term of the lease agreement on all outstanding bonds issued by the state for the purpose of financing the acquisition, construction or improvement of on-campus facilities that are leased under the agreement, regardless of whether these bonds are issued before or after the lease agreement is entered into. The definition of "bond" under s. 233.01(4) does not apply to this subdivision.

2. A nominal amount determined by the parties to be necessary to prevent the lease agreement from being unenforceable because of a lack of consideration.

(b) A provision that requires the authority to conduct its operations in such a way so that it will not adversely affect the exclusion of interest on bonds issued by the state from gross income under 26 USC 103 for federal income tax purposes.

(c) A provision that gives the state ownership of all of the following:

1. Any improvements or modifications made by the authority to on-campus facilities that are leased to the authority under the lease agreement.

2. Any facility that the authority constructs on state-owned land.

(d) A provision that specifies an amount and that exempts any construction or improvement project on state-owned land that costs less than the amount from review and approval under s. 16.85(14).

(e) Any provision necessary to ensure that the general management and operation of the on-campus facilities are consistent with the mission and responsibilities of the University of Wisconsin System specified in ss. 36.01 and 36.09.

(g) A provision that protects the board of regents from all liability associated with the management, operation, use or maintenance of the on-campus facilities. No such provision shall make the authority liable for the acts or omissions of any officer, employee or agent of the board of regents, including any student who is enrolled at an institution within the University of Wisconsin System, unless the officer, employee or agent acts at the direction of the authority.

(h) A provision on a mechanism for the resolution of disputes.

(7g)(a) Submit any modification, extension or renewal of the lease agreement under sub. (7) to the joint committee on finance. No extension or renewal of the lease agreement may be for a period of more than 30 years. Modification, extension or renewal of the agreement may be made as proposed by the authority and the board of regents only upon approval of the committee.

(b) If the committee does not approve an extension or renewal of the agreement, the on-campus facilities and any improvements, modifications or other facilities specified in sub. (7)(c) shall transfer to the board of regents.

(c) This subsection does not apply to an automatic extension of the lease agreement under s. 233.05(1).

(7m) Subject to 1995 Wisconsin Act 27, section 9159(2)(k), negotiate and enter into an affiliation agreement with the board of regents. The affiliation agreement shall take effect on June 29, 1996. The initial period of the affiliation agreement shall run concurrently with the initial period of the lease agreement under sub. (7), and the affiliation agreement shall include all of the following:

(a) A provision that ensures the authority retains cash reserves at a level not lower than the level recommended by the independent auditor specified under sub. (1).

(b) Provisions that ensure support of the educational, research and clinical activities of the University of Wisconsin-Madison by the authority.

(c) A provision that requires the development of standards relating to the selection and financing by the authority of any corporation or partnership that provides health-related services. The standards shall be consistent with the missions of the authority and the board of regents.



**233.04. Duties of authority, WI ST 233.04**

(d) A provision that requires the board of regents to make reasonable charges for any services provided by the board of regents to the authority.

(e) A provision establishing a mechanism for the resolution of disputes.

(7p)(a) Submit any modification, extension or renewal of the affiliation agreement under sub. (7m) to the joint committee on finance. No extension or renewal of the affiliation agreement may be for a period of more than 30 years. Modification, extension or renewal of the agreement may be made as proposed by the authority and the board of regents only upon approval of the committee.

(b) If the committee does not approve an extension or renewal of the agreement, the on-campus facilities and any improvements, modifications or other facilities specified in sub. (7)(c) shall transfer to the board of regents.

(c) This subsection does not apply to an automatic extension of the affiliation agreement under s. 233.05(2).

(9) Provide, on a monthly basis, the secretary of administration with such financial and statistical information as is required by the secretary of administration.

(10) If Children's Hospital and Health System ceases to operate a poison control center under s. 255.35, administer a statewide poison control program.

**Credits**

<<For credits, see Historical Note field.>>

W. S. A. 233.04, WI ST 233.04  
Current through 2013 Act 380, published 4/25/2014

End of Document

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### **Site Ownership**

The applicant's attestation of site ownership and its Certificate of Liability Insurance for the site are included with this Attachment 2.

**Attestation of Site Ownership by SwedishAmerican Health System**

The undersigned representative of SwedishAmerican Health System attests that SwedishAmerican Health System owns the real estate located at 1401 State Street, Rockford, Illinois.



A handwritten signature in black ink, appearing to read "W. R. Gorski".

Name: William R. Gorski, M.D.  
Title: CEO, SwedishAmerican Health System

A handwritten signature in black ink, appearing to read "Gina Boettcher".

Subscribed and sworn to  
this 10<sup>th</sup> day of April, 2017



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
04/05/2017

**THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.**

**IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).**

<b>PRODUCER</b> Marsh USA Inc. 411 E. Wisconsin Avenue Suite 1300 Milwaukee, WI 53202 Attn: Healthcare.AccountsCSS@marsh.com FAX 212-948-1307	<b>CONTACT NAME:</b> <b>PHONE (A/C, No, Ext):</b> _____ <b>FAX (A/C, No):</b> _____ <b>E-MAIL ADDRESS:</b> _____														
<b>INSURED</b> Swedish American Health System 1401 E. State Street Rockford, IL 61104	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center;">INSURER(S) AFFORDING COVERAGE</th> <th style="text-align: center;">NAIC #</th> </tr> </thead> <tbody> <tr> <td>INSURER A : N/A</td> <td style="text-align: center;">N/A</td> </tr> <tr> <td>INSURER B : N/A</td> <td style="text-align: center;">N/A</td> </tr> <tr> <td>INSURER C : N/A</td> <td style="text-align: center;">N/A</td> </tr> <tr> <td>INSURER D : American Home Assurance Company</td> <td style="text-align: center;">19380</td> </tr> <tr> <td>INSURER E : N/A</td> <td style="text-align: center;">N/A</td> </tr> <tr> <td>INSURER F :</td> <td></td> </tr> </tbody> </table>	INSURER(S) AFFORDING COVERAGE	NAIC #	INSURER A : N/A	N/A	INSURER B : N/A	N/A	INSURER C : N/A	N/A	INSURER D : American Home Assurance Company	19380	INSURER E : N/A	N/A	INSURER F :	
INSURER(S) AFFORDING COVERAGE	NAIC #														
INSURER A : N/A	N/A														
INSURER B : N/A	N/A														
INSURER C : N/A	N/A														
INSURER D : American Home Assurance Company	19380														
INSURER E : N/A	N/A														
INSURER F :															

**COVERAGES**                      **CERTIFICATE NUMBER:** CHI-007035117-01                      **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	<b>COMMERCIAL GENERAL LIABILITY</b> <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR  GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:						EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COMP/OP AGG \$
	<b>AUTOMOBILE LIABILITY</b> <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
	<b>UMBRELLA LIAB</b> <input type="checkbox"/> OCCUR <b>EXCESS LIAB</b> <input type="checkbox"/> CLAIMS-MADE DED    RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$
	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N	N/A				PER STATUTE    OTH-ER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
D	Property-Real & Personal Prop. Replacement Cost, Special Form			025030817	07/01/2016	07/01/2017	LIMIT \$10,000,000 DEDUCTIBLE \$25,000

**DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)**  
 Evidence of coverage

<b>CERTIFICATE HOLDER</b> Swedish American Health System 1401 E. State Street Rockford, IL 61104	<b>CANCELLATION</b> SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.  AUTHORIZED REPRESENTATIVE of Marsh USA Inc. Manashi Mukherjee <i>Manashi Mukherjee</i>
---	---

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AGENCY CUSTOMER ID: 010684

LOC #: Milwaukee



### ADDITIONAL REMARKS SCHEDULE

Page 2 of 2

AGENCY Marsh USA Inc.		NAMED INSURED Swedish American Health System 1401 E. State Street Rockford, IL 61104	
POLICY NUMBER		EFFECTIVE DATE:	
CARRIER	NAIC CODE		

#### ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,  
FORM NUMBER: 25 FORM TITLE: Certificate of Liability Insurance

REGARDING PROPERTY: OTHER DEDUCTIBLES MAY APPLY AS PER POLICY TERMS AND CONDITIONS

### **Operating Licensee**

SwedishAmerican Hospital is the licensee of the facility. Its Certificate of Good Standing is included with this Attachment 3.

File Number

1167-170-5



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

*I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that*

SWEDISHAMERICAN HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 06, 1911, 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.



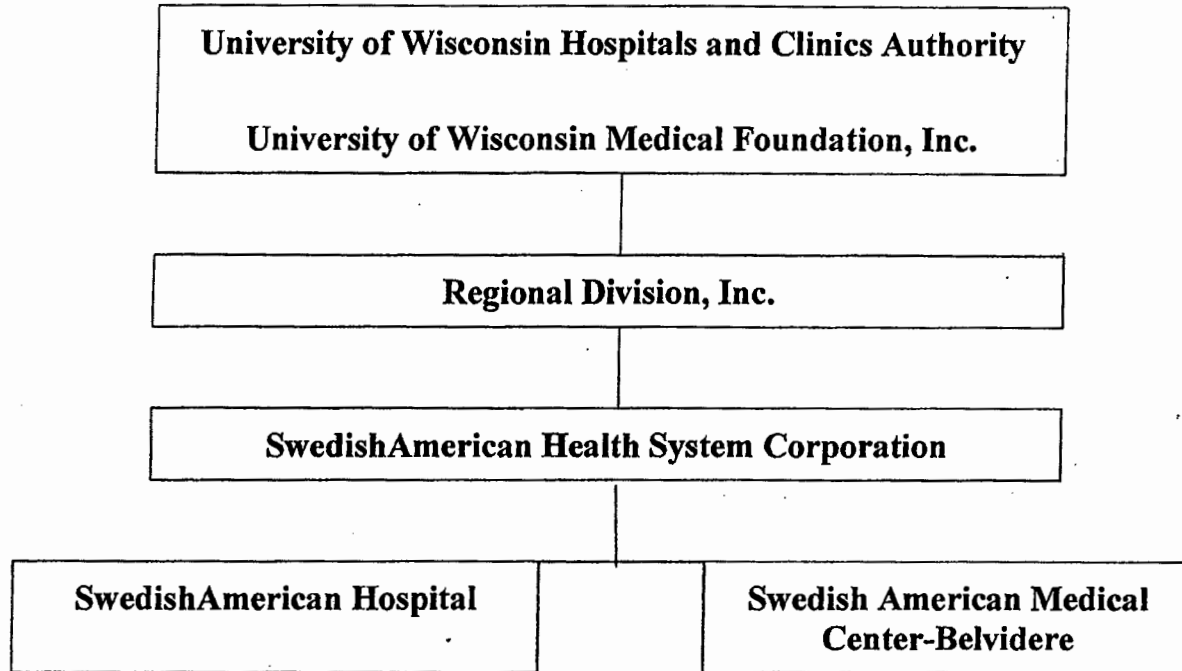
Authentication #: 1704700670 verifiable until 02/16/2018  
Authenticate at: <http://www.cyberdriveillinois.com>

***In Testimony Whereof, I hereto set  
my hand and cause to be affixed the Great Seal of  
the State of Illinois, this 16TH  
day of FEBRUARY A.D. 2017 .***

*Jesse White*

SECRETARY OF STATE

**Facility Organizational Chart**





### **Flood Plain Requirements**

Attached is an attestation that the project complies with the requirements of Illinois Executive Order #2006-5, and a map showing that the proposed project location is not in any identified flood plain areas.

**SWEDISHAMERICAN**

**A DIVISION OF UW HEALTH**



Administration Office  
1401 East State Street  
Rockford, IL 61104  
779.696.4002  
779.696.2469 Fax

**Flood Plain Attestation**

I, William R. Gorski, do hereby attest that the property located at 1401 E. State Street, Rockford, Illinois where SwedishAmerican Hospital is located complies with the requirements of the Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas.

\_\_\_\_\_  
William R. Gorski  
President and CEO, SwedishAmerican Health System



Flood Map Information from [www.illinoisfloodmaps.org](http://www.illinoisfloodmaps.org)

### **Historic Preservation Act Requirements**

Attached is the letter to Historic Preservation Agency (HPA) on behalf of the applicants regarding impact on historic resources. HPA's response will be submitted upon receipt. Also attached is HPA's prior clearance letter indicating that no historic resources were impacted in connection with SwedishAmerican Hospital's last campus modernization project (Permit No. #04-041) at the same location (the hospital campus at 1401 East State Street, Rockford).

Claire M. Reed  
Partner  
(312) 214-4813  
claire.reed@btlaw.com

April 7, 2017

**Via Overnight Delivery**

Illinois Historic Preservation Agency  
Attn: Review and Compliance  
1 Old State Capitol Plaza  
Springfield, IL 62701-1512

**RE: SwedishAmerican Health System  
Historic Preservation Act Determination Request**

Dear Review and Compliance Staff:

In accordance with the Illinois State Agency Historic Resources Preservation Act, 20 ILCS 3420/1 *et seq.*, SwedishAmerican Health System ("SwedishAmerican") seeks a formal determination from the Illinois Historic Preservation Agency (the "Agency") as to whether SwedishAmerican's proposed project to modernize its existing facility and construct new buildings connected to the existing facility (the "Project") affects historic resources. The Project will be located at 1401 East State Street, Rockford, Illinois.

**1. Project Description and Location**

SwedishAmerican is seeking approval from the Illinois Health Facilities and Services Review Board to modernize its existing facility on its campus at 1401 East State Street, Rockford, Illinois and to construct two new buildings that will be connected to the existing facility at the same location. The project scope is as follows:

- Modernization of the existing space of the existing hospital building in the following areas: Medical/Surgical unit; Acute Mental Illness unit; Emergency Department; Operating Rooms; Pediatric Acute Care unit; Nursery; and, Prep and Recovery.
- Construction of a five story new building that will be physically connected to the existing facility and will include women's and children's services including Labor Delivery and Recovery; C-Section; Post-Partum; Pediatrics Clinic; Nursery. The clinical services will be on the first four floors with the fifth story penthouse for

mechanicals. This new construction will also include outpatient clinics, conference rooms, lobby and common staff and public areas.

- Construction of a one story building that will be physically connected to the existing facility that will include modernized catheterization services.

**2. Topographical or Metropolitan Map**

Maps showing the location of the proposed Project are attached as Exhibit 1.

**3. Buildings/Structures in the Project Area**

The Project will include modernization of the existing facility located at 1401 East State Street, Rockford, Illinois, and photographs of the building and its interior spaces are attached as Exhibit 2. Located northwest to the Project and separated by several parking lots, the Lake Peterson House and its carriage house, the only buildings with real architectural presence, are on the National Record of Historic Structures, and they will remain untouched and unaffected by the scope of the Project.

**4. Address for Building/Structure**

The address of the Project is 1401 East State Street, Rockford, Illinois. For your reference, the Lake Peterson House address is 1313 East State Street.

On January 21, 2004, the Agency issued a clearance letter to SwedishAmerican for its project to expand and renovate the acute care hospital and campus at 1401 East State Street, Rockford. The Agency found that no historic, architectural or archaeological sites existed within the project area. A copy of the determination letter is attached for your reference as Exhibit 3.

Thank you for your consideration of our request for a historic preservation determination. If you have any questions or need any additional information, please feel free to contact me at 312-214-4813.

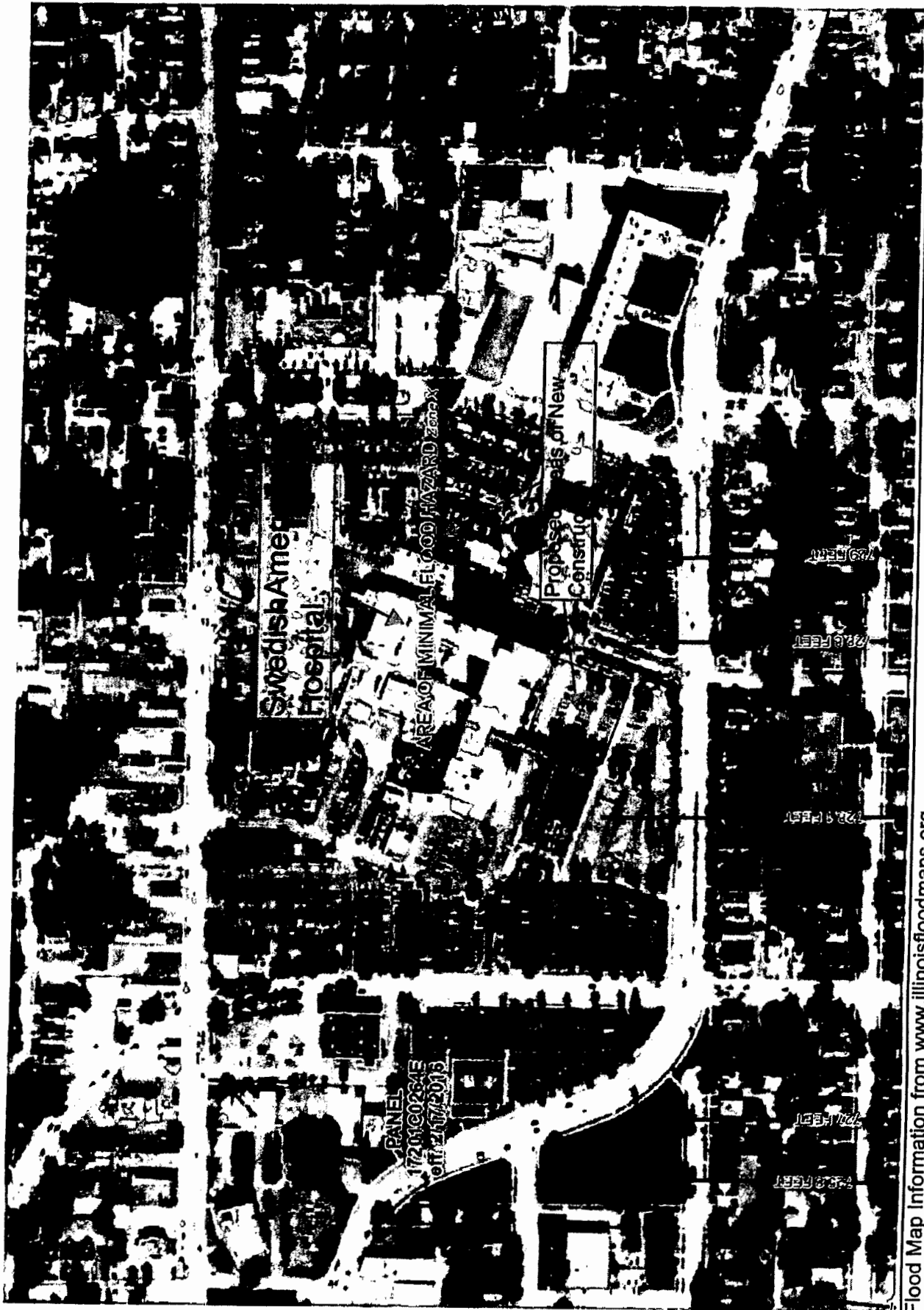
Very truly yours,



Claire M. Reed

Enclosures

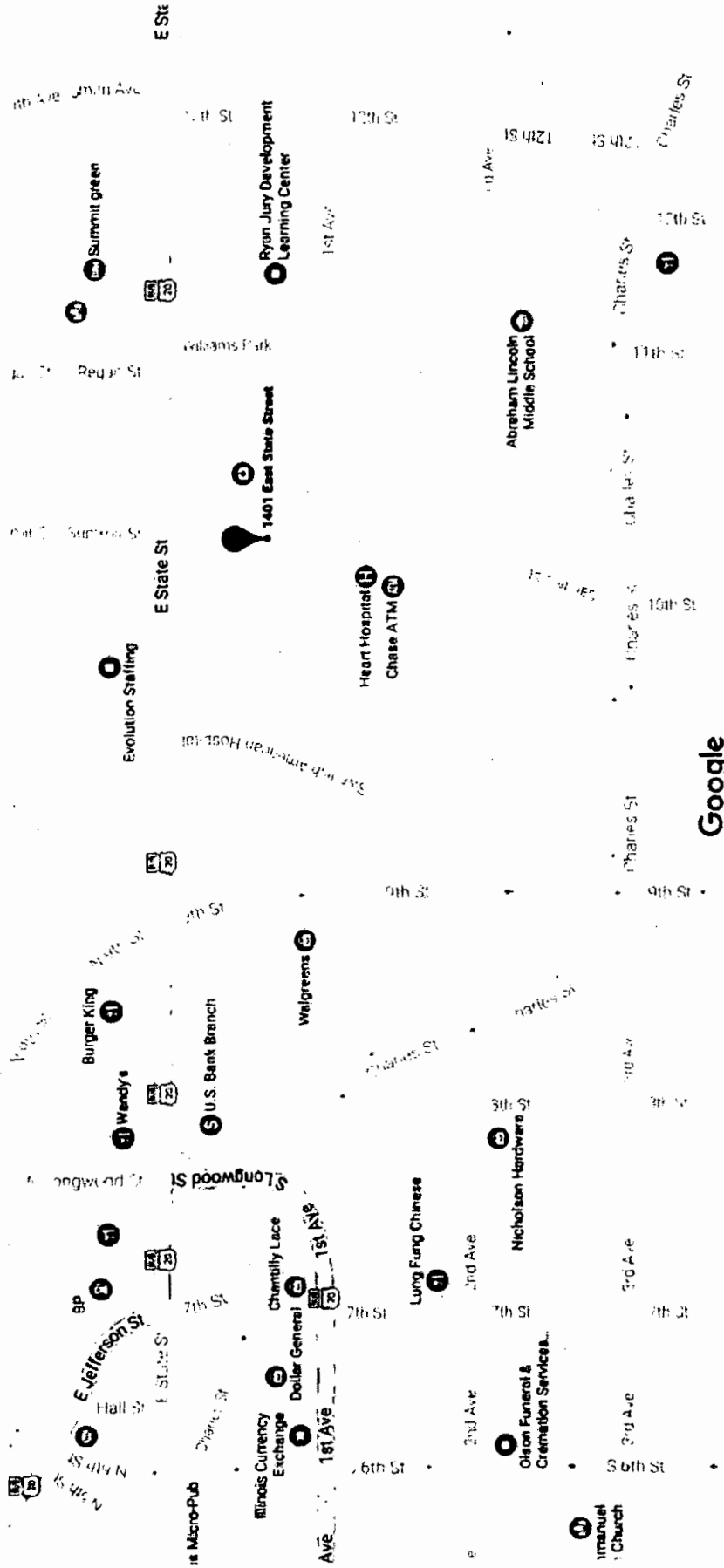
# **EXHIBIT 1**



Flood Map Information from [www.illinoisfloodmaps.org](http://www.illinoisfloodmaps.org)



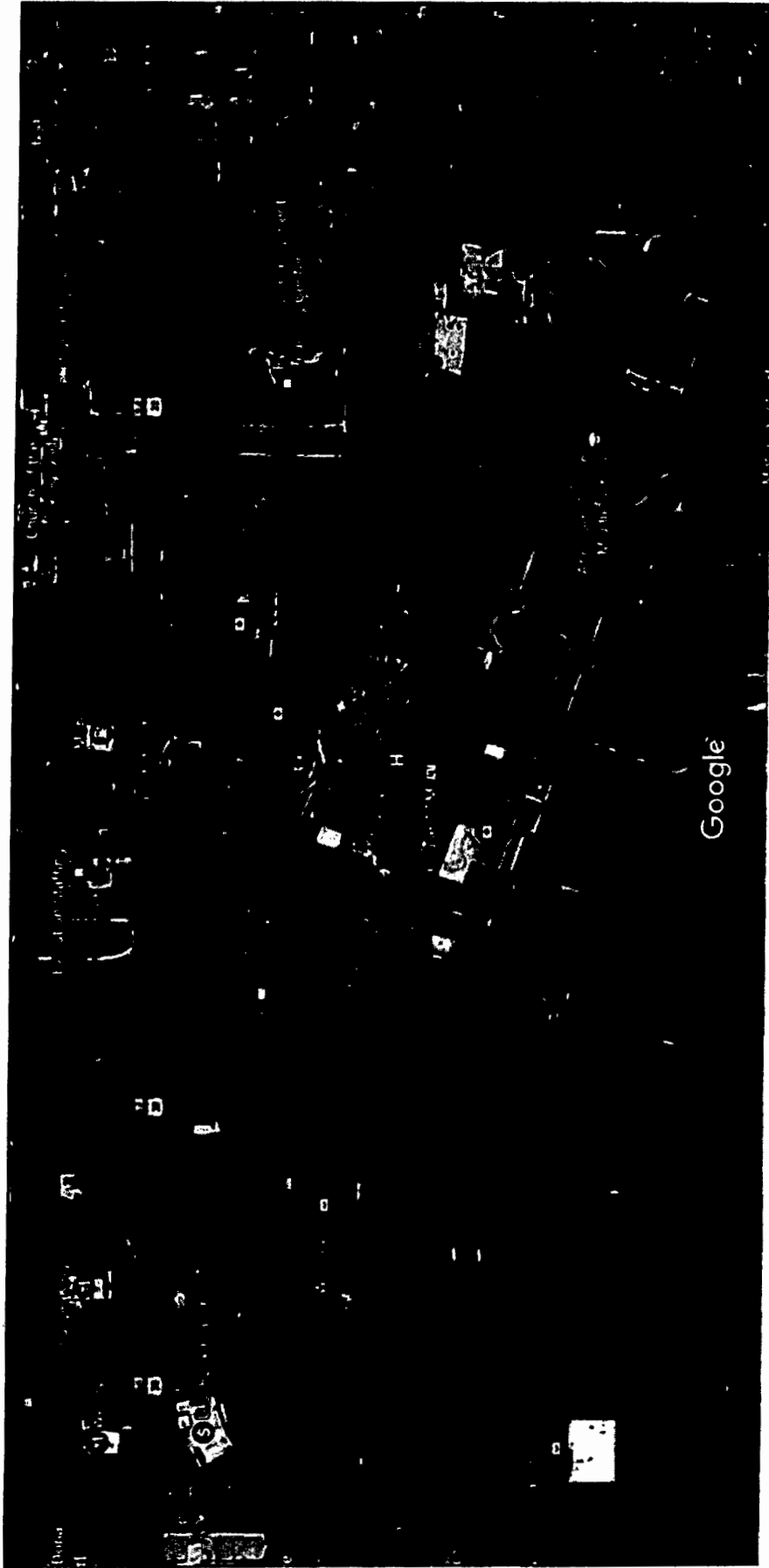
# Google Maps 1401 E State St



Google

Map data ©2017 Google 200 ft

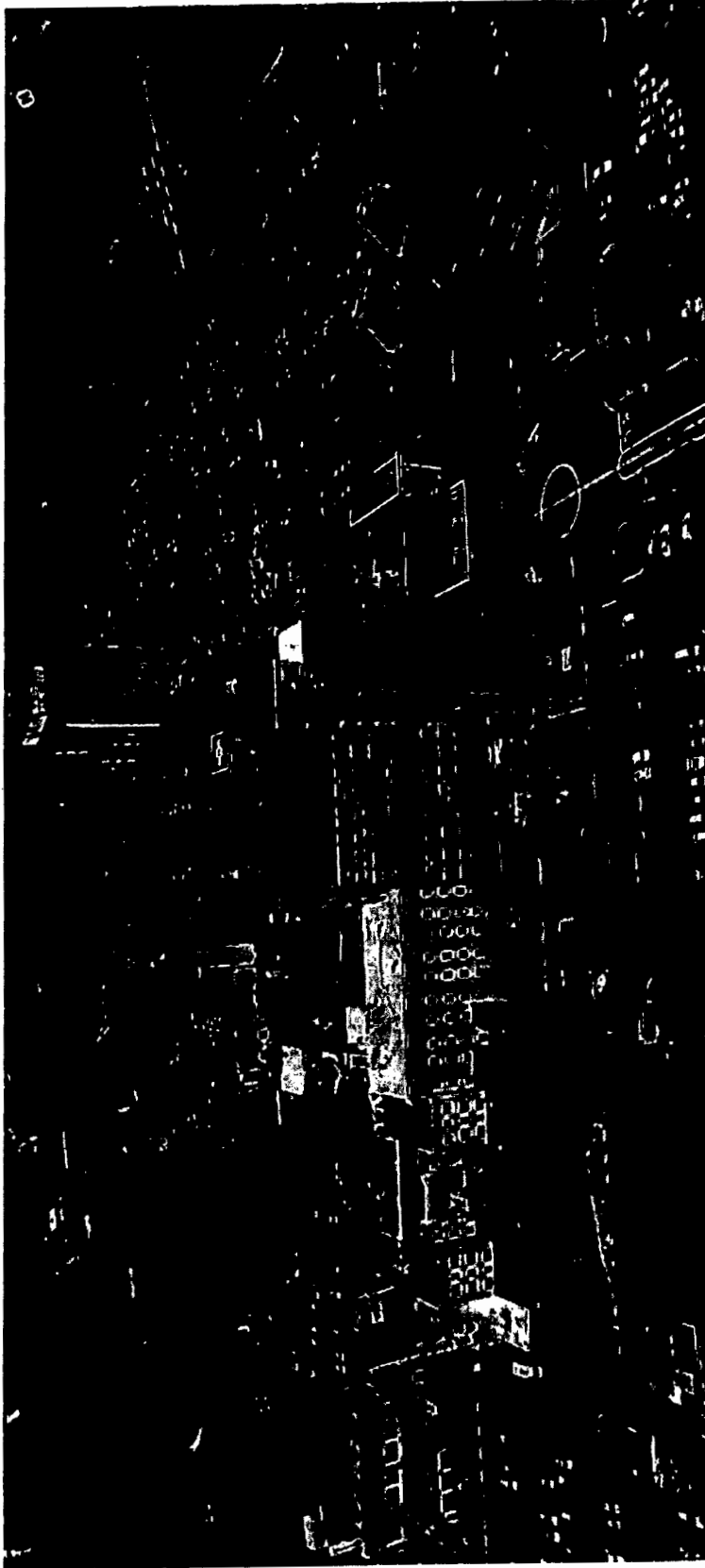
# Google Maps



Imagery ©2017 Google, Map data ©2017 Google 200 ft

## **EXHIBIT 2**

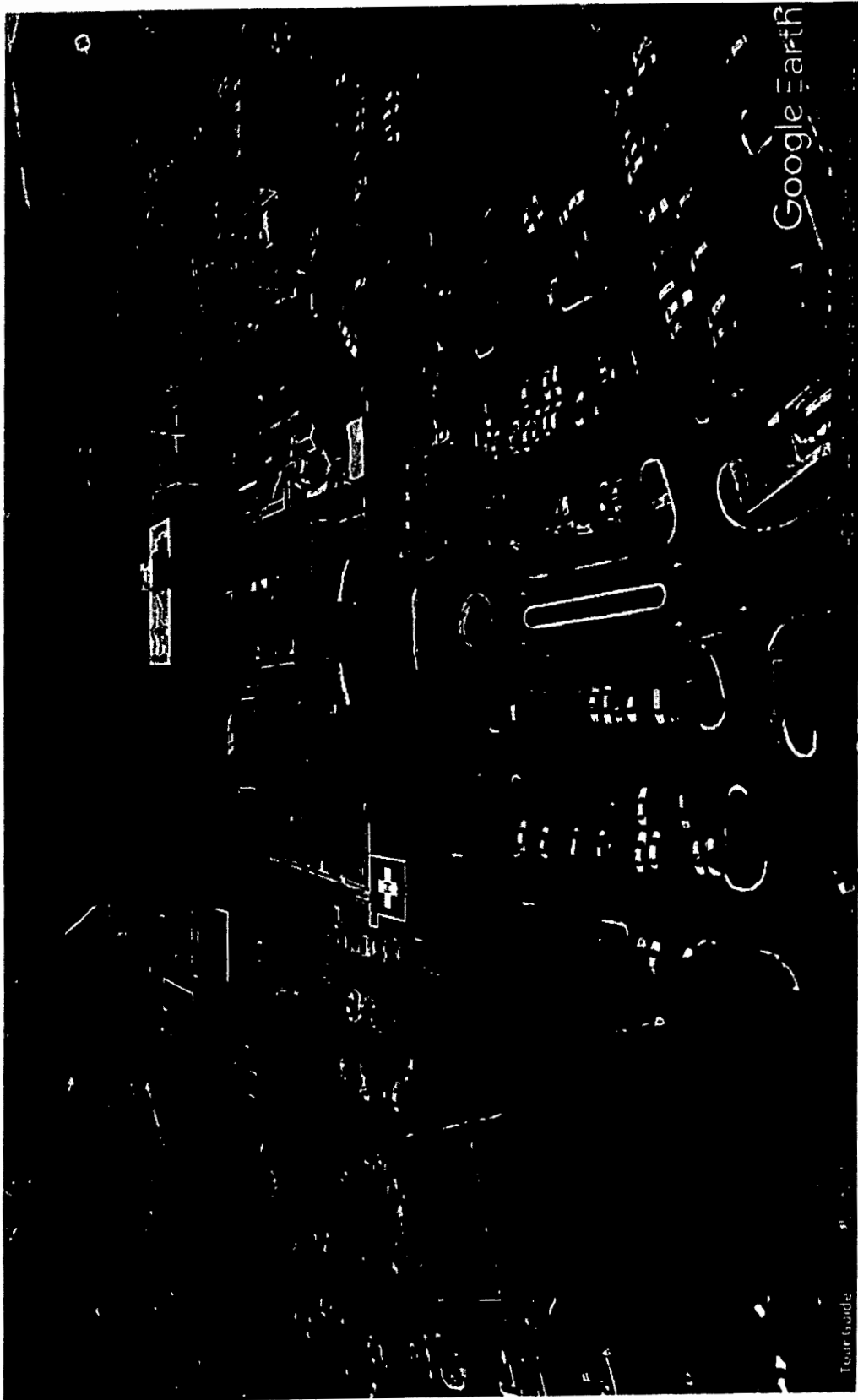
**South View of SwedishAmerican Health System**



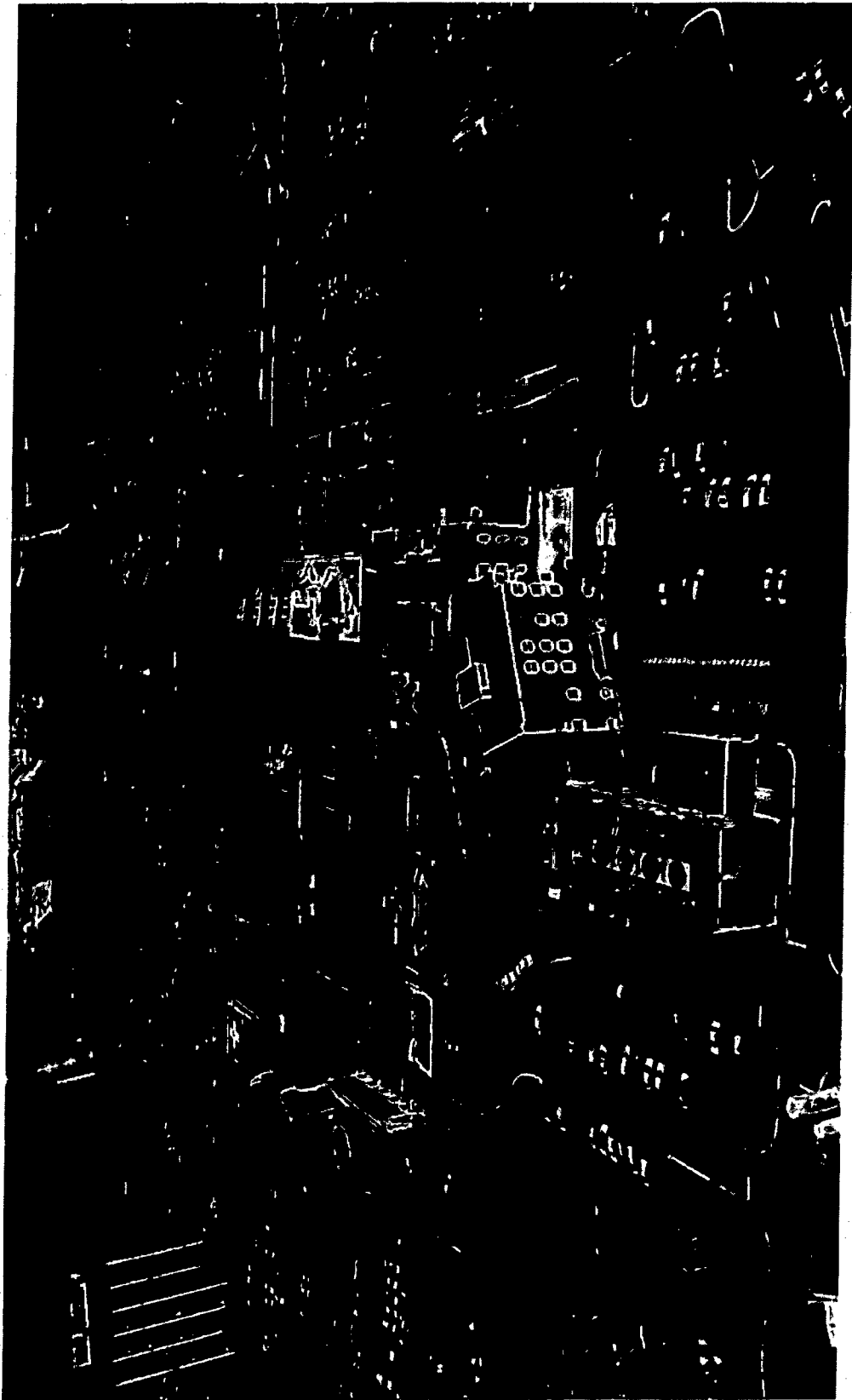
# East View of SwedishAmerican Health System

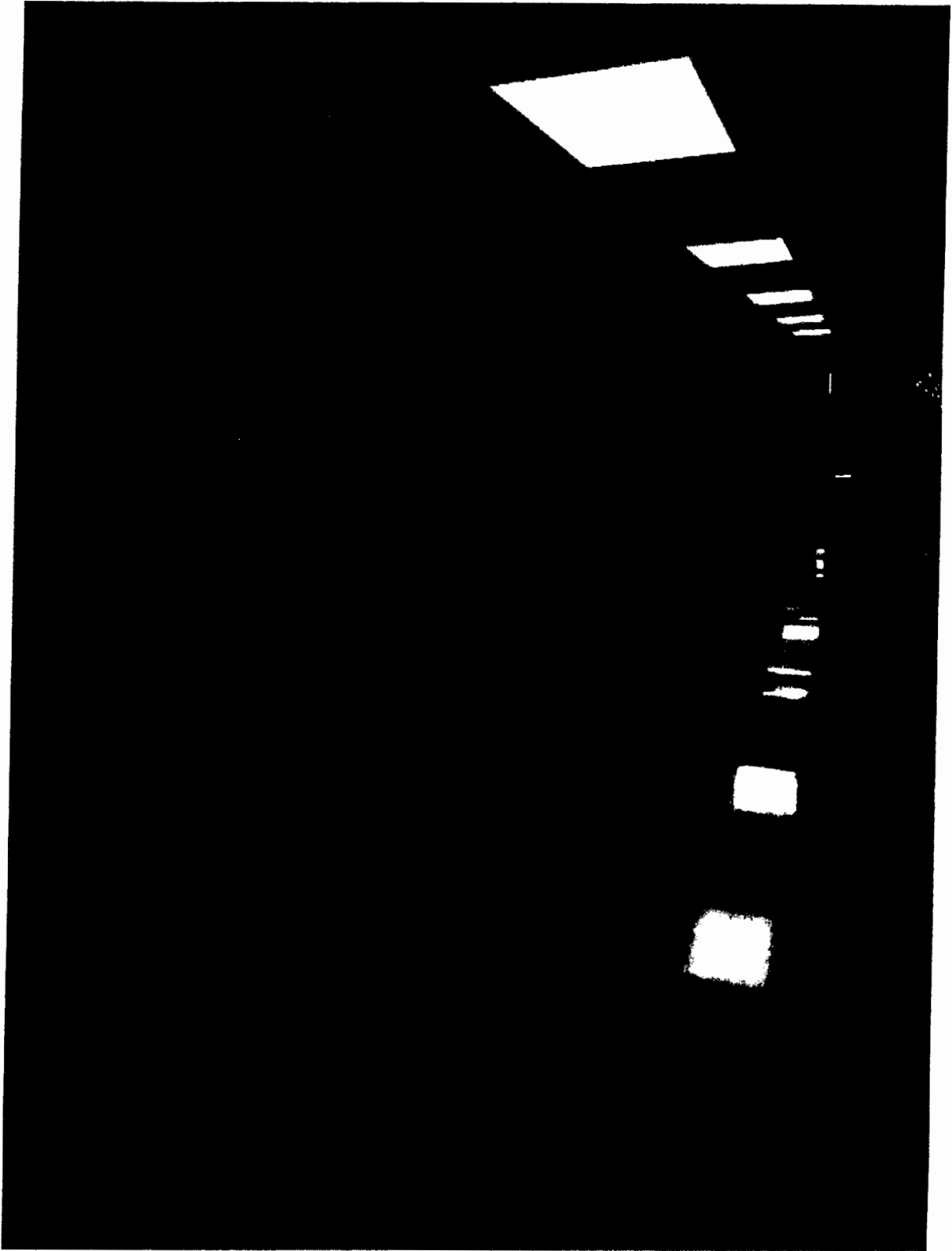


# North View of SwedishAmerican Health System

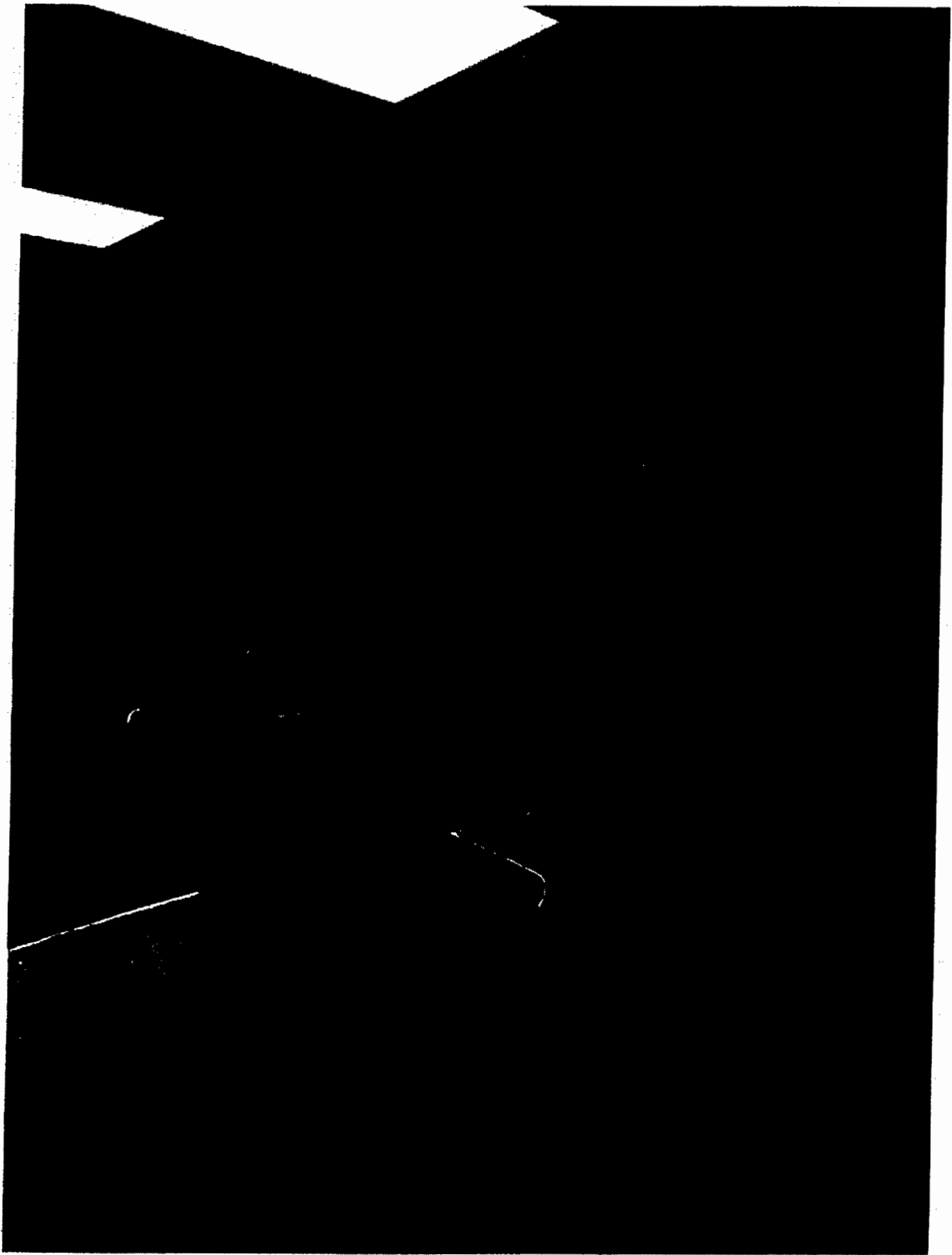


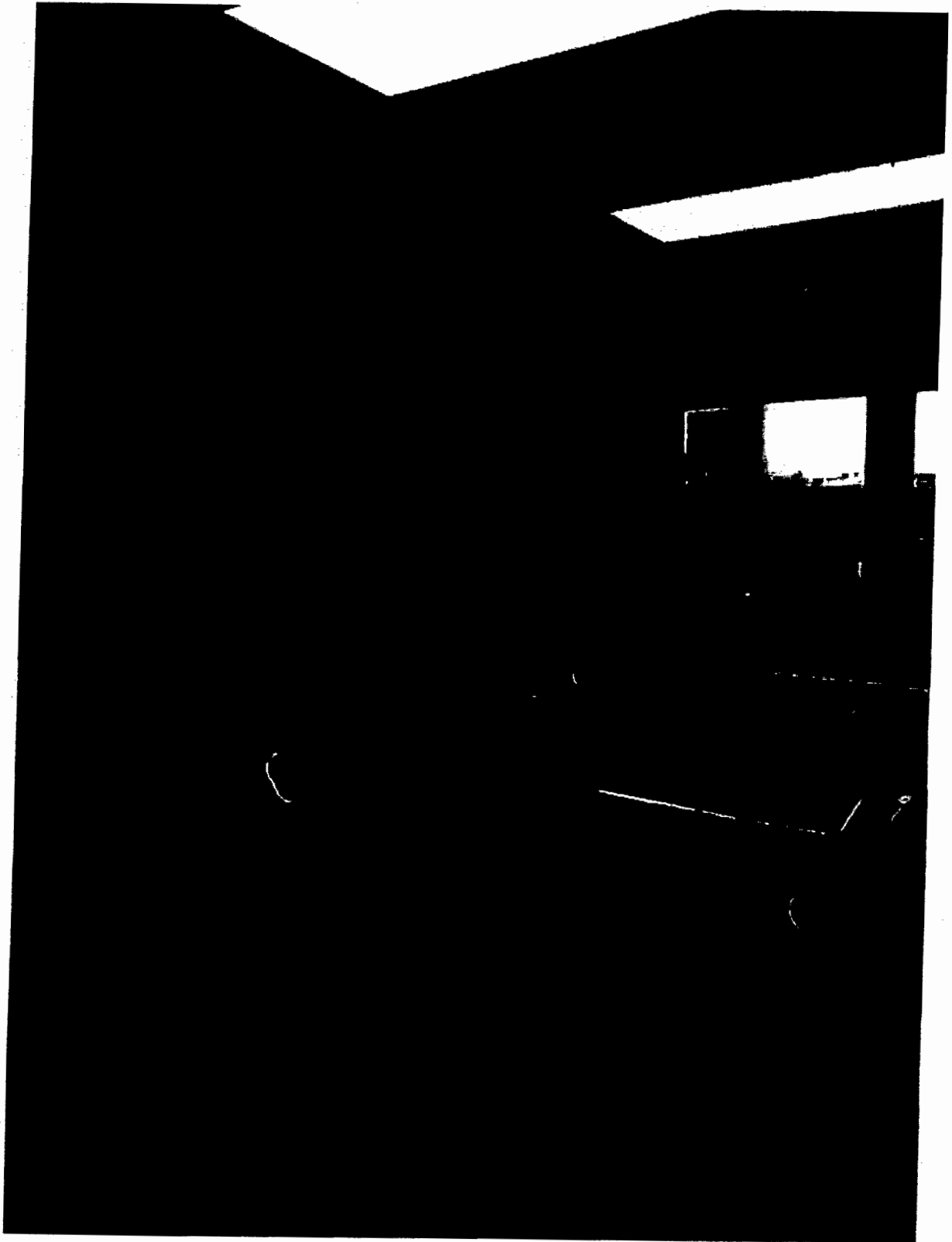
# West View of SwedishAmerican Health System



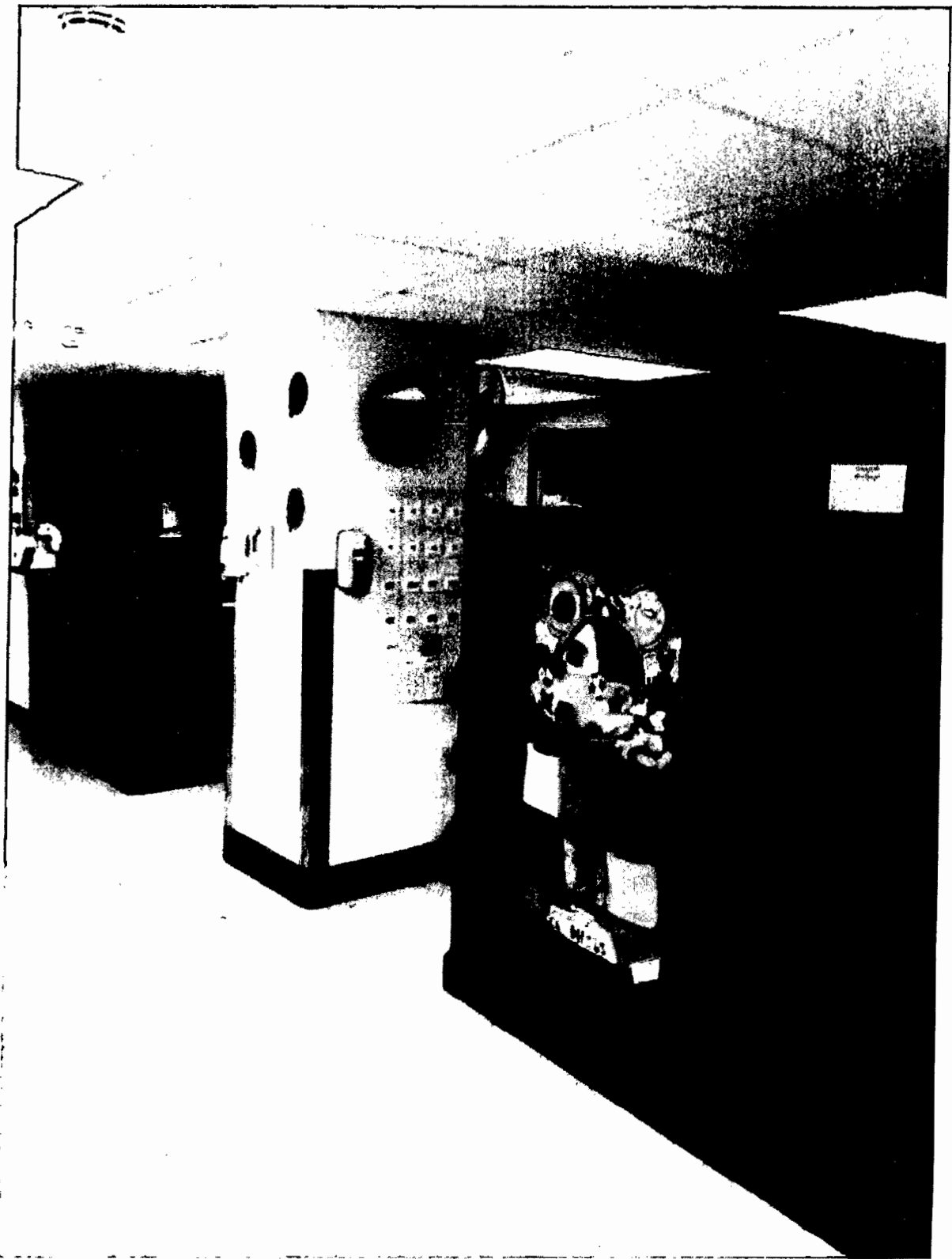


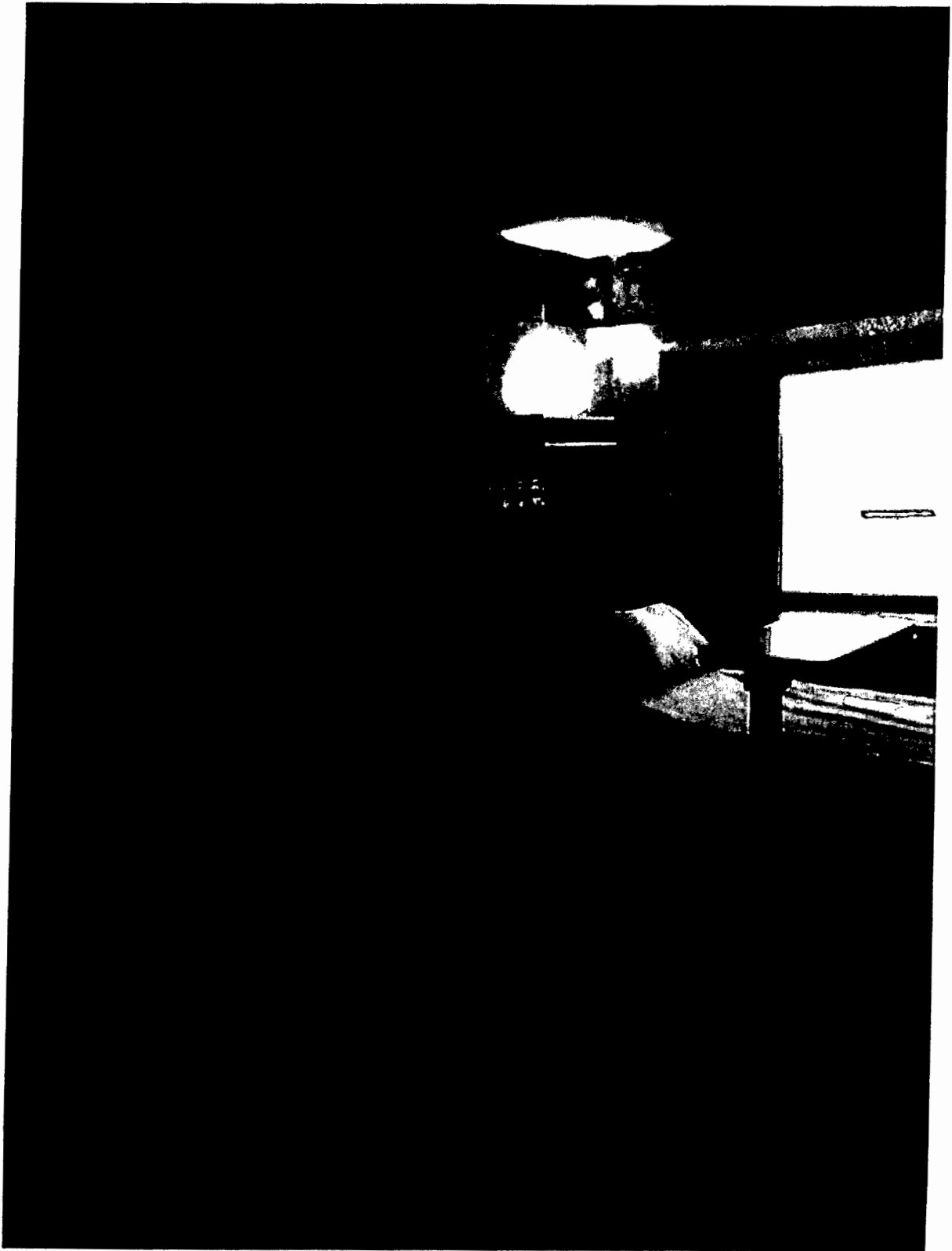


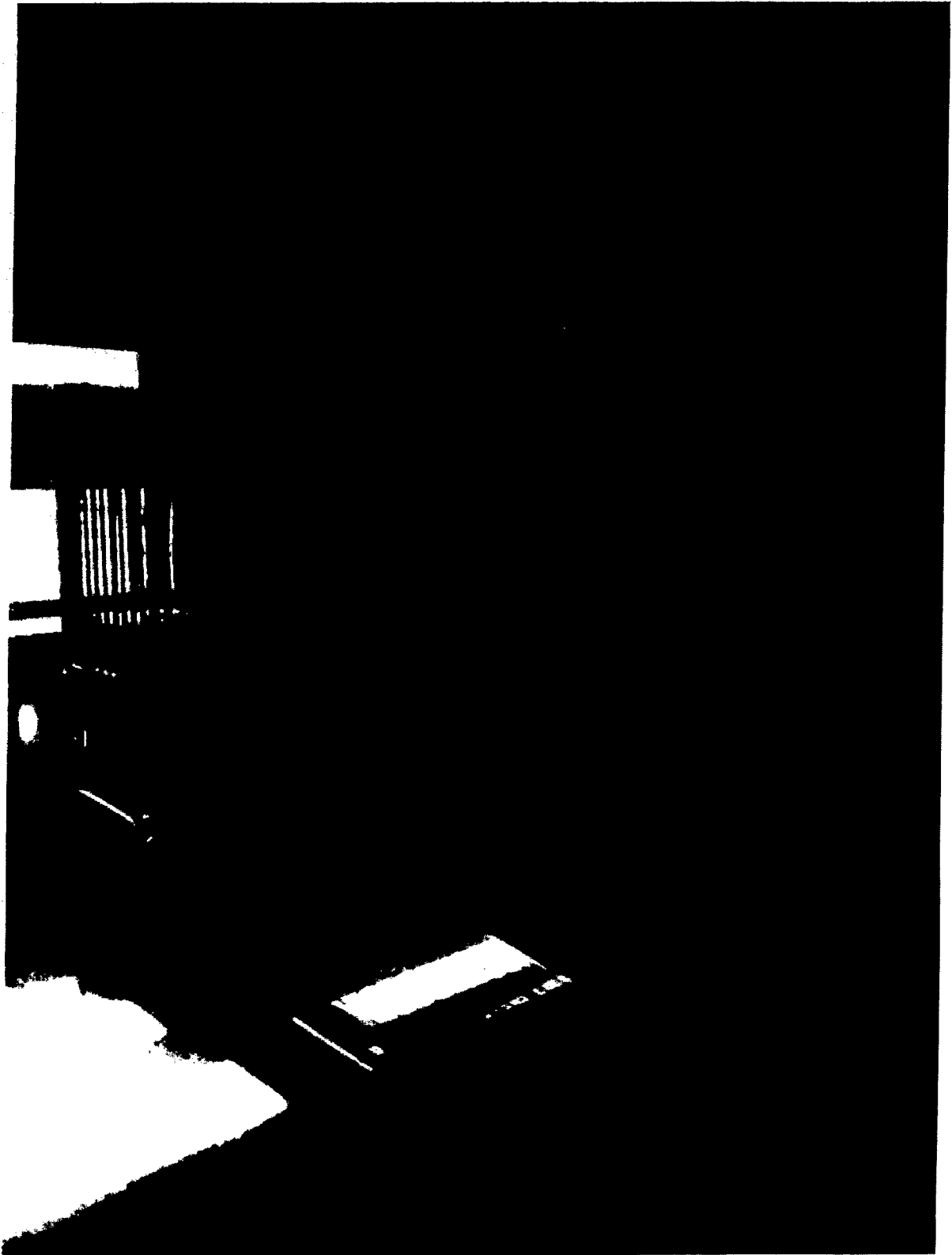




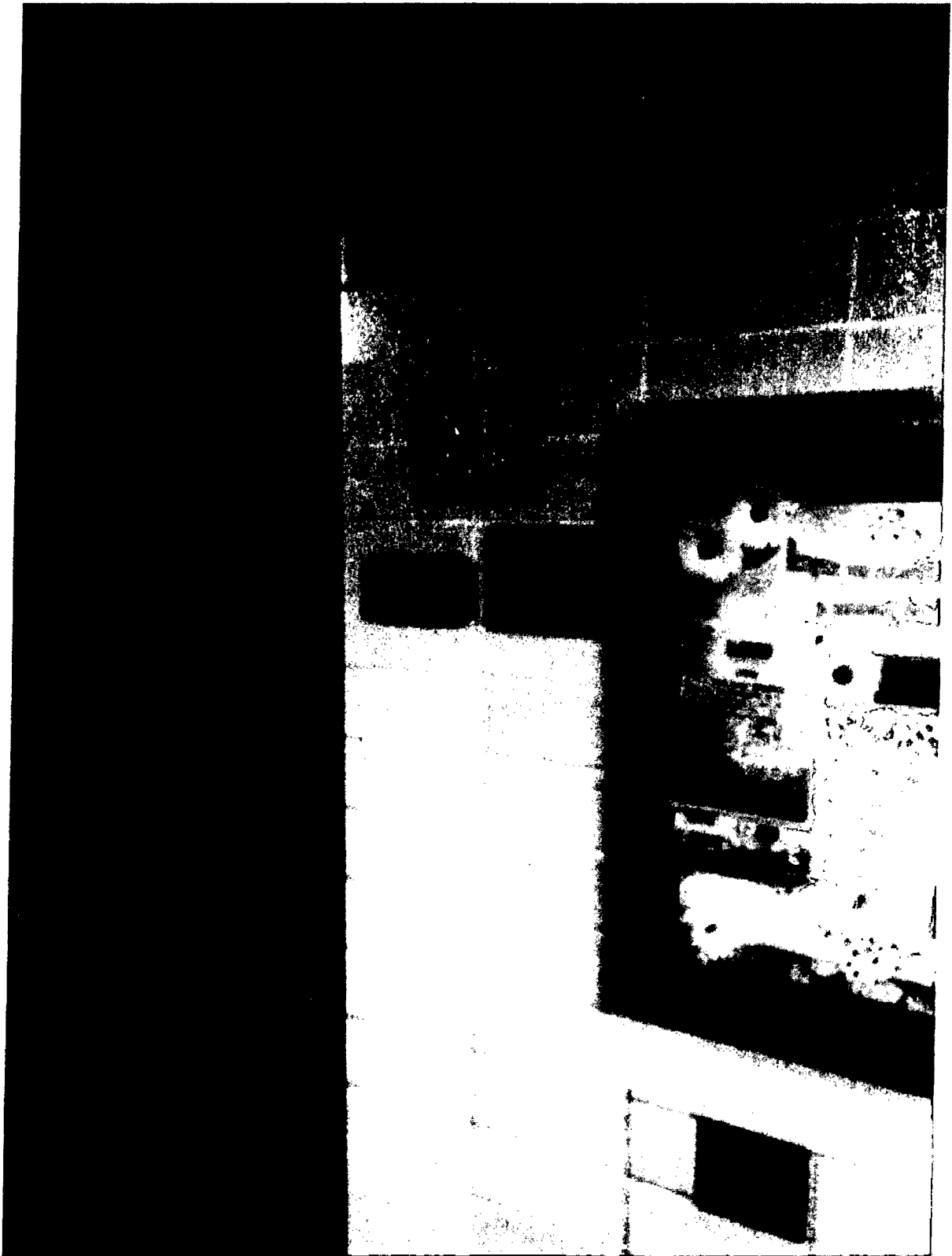




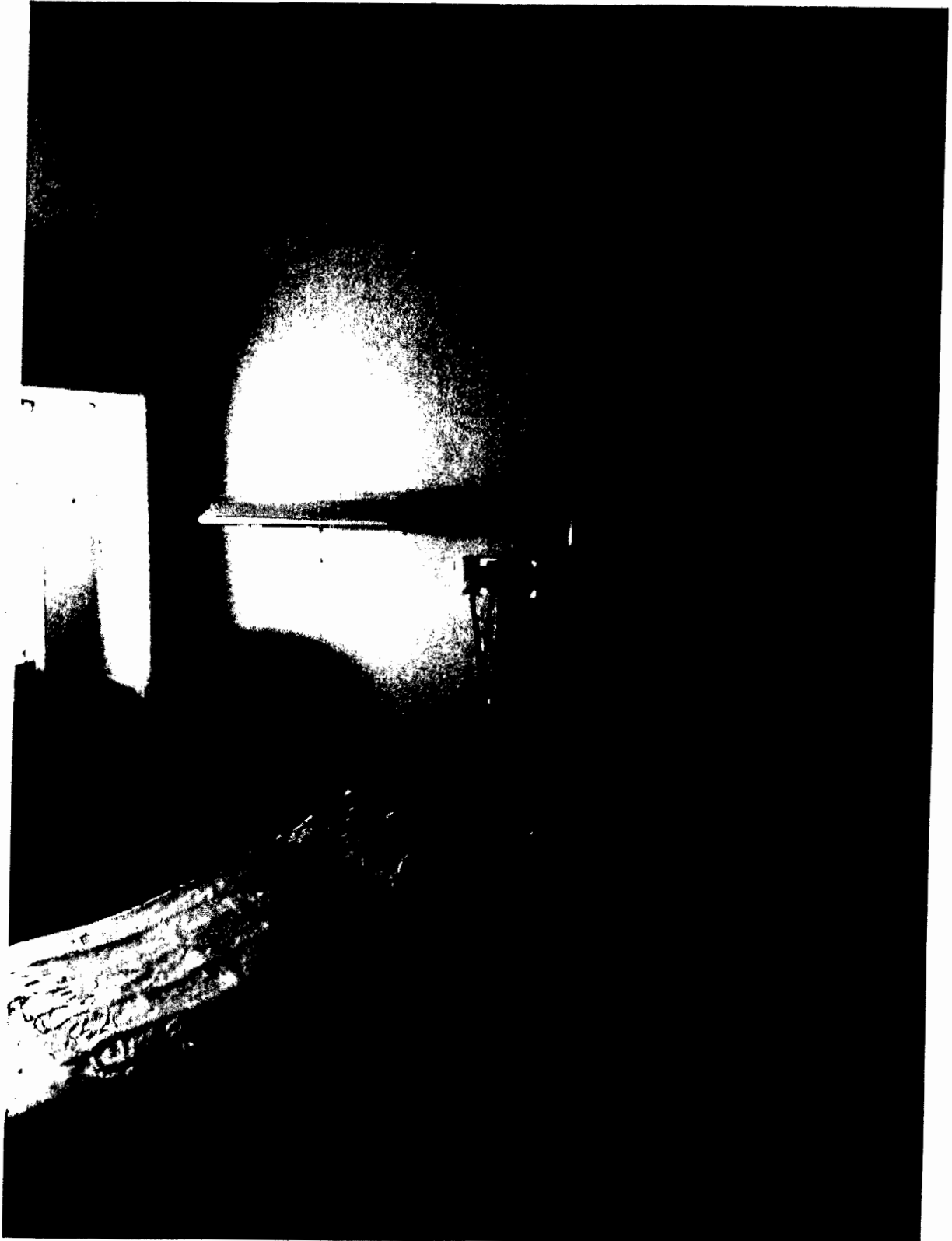


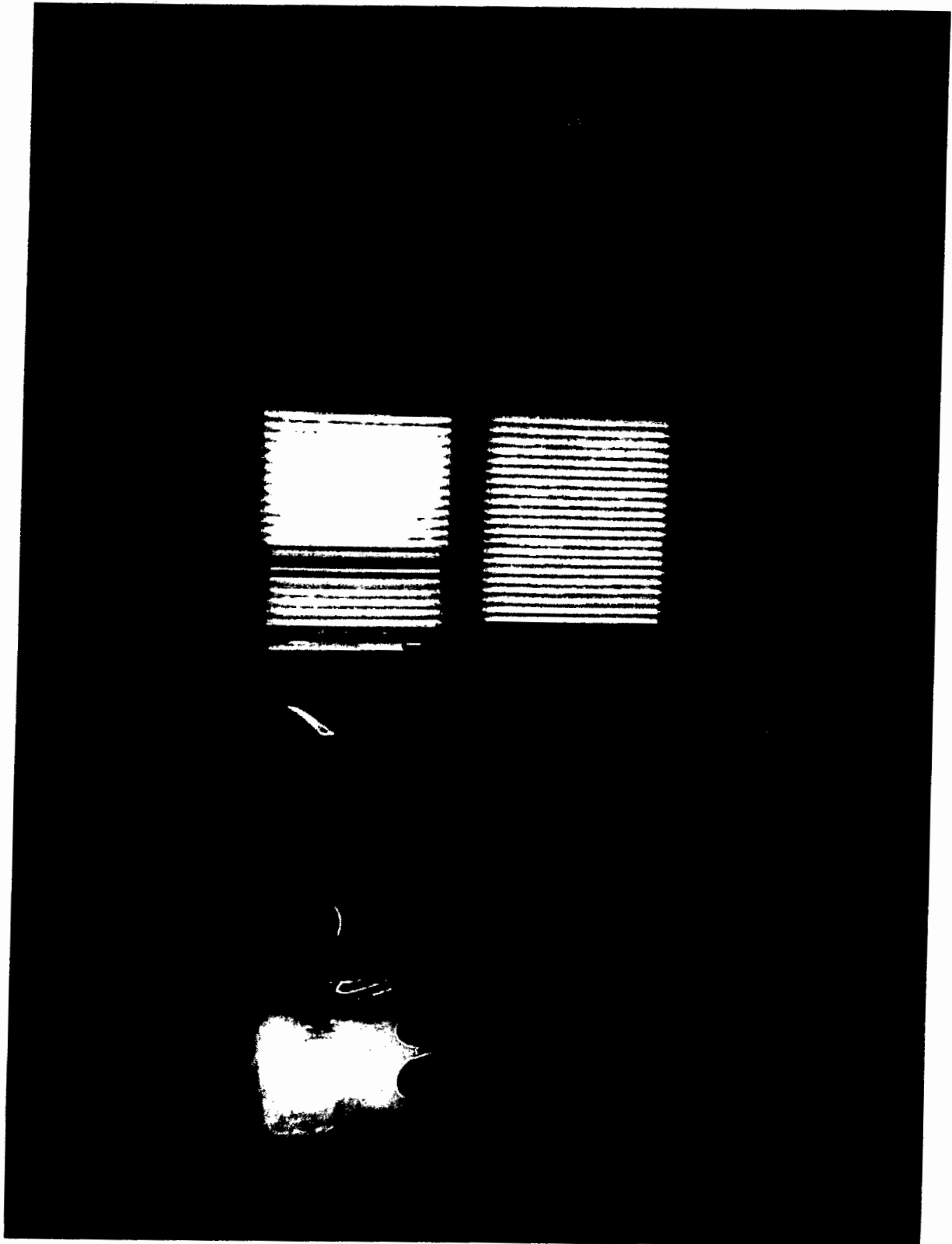


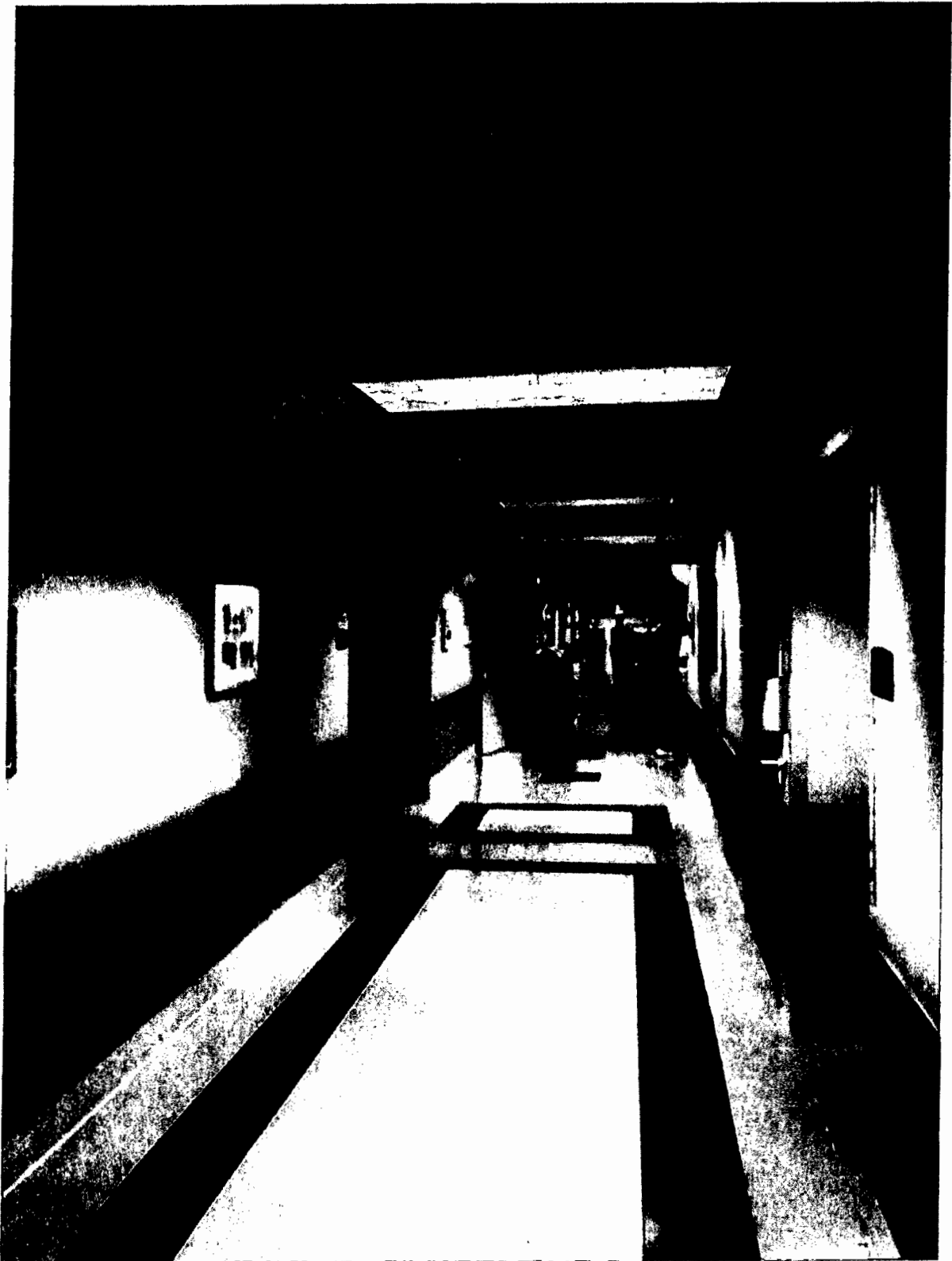


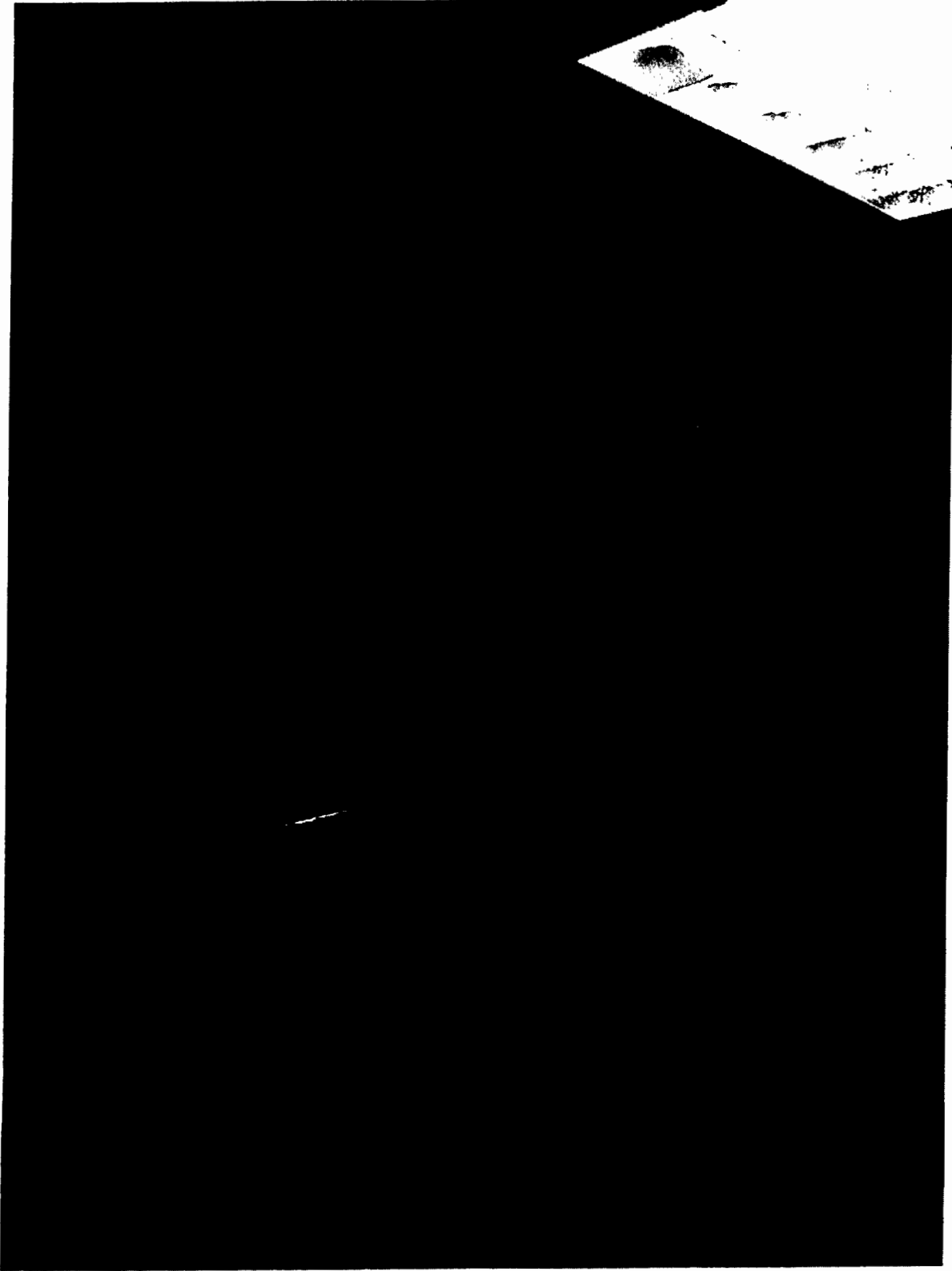












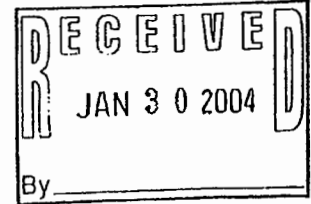


# **EXHIBIT 3**



Illinois Historic  
Preservation Agency

1 Old State Capitol Plaza • Springfield, Illinois 62701-1507 • Teletypewriter Only (217) 524-7128



Voice (217) 782-4836

Vinnebago County  
Rockford

Campus Expansion -- Phase II, SwedishAmerican Health System  
Camelot Towers - 1415 East State Street  
Lake Peterson House - 1313 East State Street  
LP Johnson Building - 1221 East State Street  
Sanders House - 200 Sanders Street  
Hospital - 1401 East State Street  
Renaissance Pavilion - Charles Street

IHPA Log #009010804

January 21, 2004

Jeffery S. Kent  
Swedish American Health System  
1400 Charles St.  
Rockford, IL 61104-2298

Mr. Kent:

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 Andrew Heckenkamp, Manager, 1 Old State Capitol Plaza, Springfield, IL 62701, 217/782-8168.

Sincerely,

*Anne E. Haaker*

Anne E. Haaker  
Deputy State Historic  
Preservation Officer

AEH

## Itemization of Project Costs

Items	Cost
<b>Pre-Planning</b>	<b>\$90,000</b>
Space Programming & Pre-Schematic Planning	90,000
<b>Site</b>	
<b>Off-Site Work</b>	-
<b>New Construction Contracts</b>	<b>\$50,036,102</b>
Women's & Childrens Pavilition	\$43,821,805
Cath/EP IR Addition	\$6,214,297
<b>Moderization Contracts</b>	<b>\$25,390,551</b>
Surgery Renovation	\$13,889,772
Emergency Department Renovation	\$3,761,325
Nursing Unit Renovations	\$7,739,454
<b>Contingencies</b>	<b>\$13,515,746</b>
<b>Architect/Engineering Fees</b>	<b>\$5,934,203</b>
Architect/Engineering Basic Services	\$5,747,203
Specialty Consultant Services	\$187,000
<b>Consulting and Other Fees</b>	<b>\$250,000</b>
CON Application Fee, Consulting and Legal Fees	\$250,000
<b>Movable/Other Equipment</b>	<b>\$27,744,303</b>
Clinics 1st Floor	\$2,872,817
Labor & Delivery/C-Section 2nd Floor	\$4,309,655
NICU 3rd Floor	\$1,000,000
Post Partum 4th Floor	\$3,065,683
Cath/EP/IR Addition	\$5,446,388
Modernization Areas	\$7,049,760
<b>Bond Issuance Expense</b>	<b>\$1,189,609</b>
<b>Net Interest Expense</b>	<b>\$8,330,000</b>
<b>Other Costs To Be Capitalized</b>	-
<b>TOTAL PROJECT COST</b>	<b>\$128,228,014</b>



## **Cost Space Requirements**

The Departmental Gross Square Feet and Cost Chart is included with this Attachment 9.

Project Cost Space Requirements	Project Cost	Gross Square Feet		Amount of Proposed Total GSF that is:			Vacated Space
		Existing	Proposed	New Construction	Remodeled	As Is	
Department							
<b>Reviewable/Clinical</b>							
Pediatric Clinics	\$ 11,511,832		25,750	25,750			0
LDR	\$14,205,602	18,302	21,330	21,330			0
C-section	\$4,341,463	Inc. in LDR	5,400	5,400			0
Post Partum	\$13,538,511	15,265	21,330	21,330			0
NICU/SCN	\$10,865,709	2,539	21,330	21,330			0
Pediatric Inpatient	\$3,903,509	10,250	10,250		10,250		0
Invasive Cath/Angiography	\$8,389,301	17,257	12,000	12,000			0
PACU	\$3,011,318	4,400	4,660		4,660		0
Surgery	\$6,224,641	26,647	12,859		12,859	12,000	0
Prep/Recovery	\$1,755,130	9,242	3,600		3,600		0
Central Sterile Processing	\$7,760,104	9,091	14,800		14,800		0
Emergency	\$6,919,885	24,220	17,175		17,175	16,000	0
Acute Mental Illness	\$2,000,000	25,748	5,250		5,250	25,748	0
Medical/Surgical	\$10,648,010		27,960		27,960	-	0
Other Non-Reviewable	\$13,885,890		19,690	19,690			
<b>Total Clinical</b>	<b>\$118,960,905</b>	<b>162,961</b>	<b>223,384</b>	<b>128,830</b>	<b>96,554</b>	<b>53,748</b>	

## Background of the Applicants

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

SwedishAmerican Health System owns the following health care facilities in Illinois:

SwedishAmerican Hospital  
1401 East State Street  
Rockford, Illinois  
IDPH License #0002725

SwedishAmerican Medical Center – Belvidere  
1625 South State Street  
Belvidere, Illinois  
IDPH License #0005504

Copies of SwedishAmerican's licenses and Joint Commission certifications are included with this Attachment 11.

University of Wisconsin Hospitals and Clinics Authority operates the following hospital facilities in Wisconsin licensed by the Wisconsin Department of Health Services (WDHS):

University Hospital  
600 Highland Ave.  
Madison, WI 53792  
WDHS License #125

American Family Children's Hospital  
1675 Highland Ave.  
Madison, WI 53792  
WDHS License #125

UW Health at the American Center  
4602 Eastpark Blvd.  
Madison, WI 53792  
WDHS License #125

UW Health Rehabilitation Hospital  
5115 N. Biltmore Lane  
Madison, WI 53718  
WDHS License #321

Copies of the WDHS licenses for the above facilities are included with this Attachment 11. (The first three facilities are operated under a single license.)

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.*

Included with this Attachment 11 are the applicants' certifications of no adverse action.

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.*

Included with this Attachment 11 are the applicants' authorizations to access documents.

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 that the information was 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 applicants have not submitted any applications for permit within the calendar year



**Illinois Department of  
PUBLIC HEALTH**

HF112035

← DISPLAY THIS PART IN A  
CONSPICUOUS PLACE

**LICENSE, PERMIT, CERTIFICATION, REGISTRATION**

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

**Niray D. Shah, M.D., J.D.**  
Director

Issued under the authority of  
the Illinois Department of  
Public Health

EXPIRATION DATE	CATEGORY	LD NUMBER
12/31/2017	General Hospital	0002725
Effective: 01/01/2017		

Exp. Date 12/31/2017

Lic Number 0002725

Date Printed 10/26/2016

**SwedishAmerican Hospital**  
1401 East State Street  
Rockford, IL 61104

**SwedishAmerican Hospital**  
1401 East State Street  
Rockford, IL 61104

This face of this license has a colored background. Printed by Authority of the State of Illinois - P.O. 34012320 10M 3/12

FEE RECEIPT NO.

DISPLAY THIS PART IN A  
CONSPICUOUS PLACE

HF112319

**Illinois Department of  
PUBLIC HEALTH**

**LICENSE, PERMIT, CERTIFICATION, REGISTRATION**

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

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

Issued under the authority of  
the Illinois Department of  
Public Health

EXPIRATION DATE <b>1/13/2018</b>	CATEGORY <b>General Hospital</b>	LD NUMBER <b>0005504</b>
Effective: 01/14/2017		

**SwedishAmerican Medical Center Belvidere  
1625 South State Street  
Belvidere, IL 61008**

This face of this license has a colored background. Printed by Authority of the State of Illinois • PO #4612220 10M 3/12

Exp. Date 1/13/2018  
Lic Number 0005504  
Date Printed 12/16/2016

SwedishAmerican Medical Center Belv  
1625 South State Street  
Belvidere, IL 61008

FEE RECEIPT NO.



# The State of Wisconsin

## Department of Health Services Division of Quality Assurance

### CERTIFICATE OF APPROVAL

This is to certify that UNIVERSITY OF WI HOSPITALS & CLINICS AUTHORITY  
doing business as UNIVERSITY OF WI HOSPITALS & CLINICS AUTHORITY  
at the location 690 HIGHLAND AVENUE  
MADISON, WI 53792

License Number: 125  
Effective Date: 02/03/2016  
Initial Date: 01/02/1966

is licensed to operate a GENERAL ACUTE HOSPITAL in DANE COUNTY, WISCONSIN

License Type: REGULAR

This license is granted for a maximum capacity of 648 total beds.

General beds: 628

Psychiatric beds: 20

Alcohol beds: 0

Rehab beds: 0

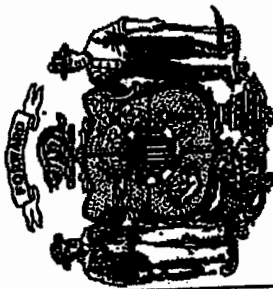
In further accordance with Wisconsin §50.35 the following locations are listed for reimbursement purposes under Wisconsin §49.25(2)(e)10m: Research Park, University Station, West Clinic, East Clinic, Waisman Center, Adolescent Intervention, Middleton Clinic, Oakwood Village Clinic, UWHC Renal Clinic, Hand & Upper Extremity Rehab Clinic, The American Center, Digestive Health Center, & Yahara Rehab Clinic.

The Facility Profile/Statistical Report is available at this facility for inspection upon request.  
This license will remain in effect unless expired, suspended, revoked or voluntarily surrendered. Any and all exceptions, stipulations, or conditions to this license shall be posted next to the license certificate.

*M. S. Rhoades*

Kitty Rhoades, Secretary DHS

This license is not transferrable or assignable



# The State of Wisconsin

Department of Health Services  
Division of Quality Assurance

## CERTIFICATE OF APPROVAL

This is to certify that MADISON REHABILITATION HOSPITAL, LLC  
doing business as UW HEALTH REHABILITATION HOSPITAL  
at the location 5115 N BILTMORE LN  
MADISON, WI 53718

License Number: 321  
Effective Date: 09/22/2015  
Initial Date: 09/22/2015

is licensed to operate a REHABILITATION HOSPITAL in DANE COUNTY, WISCONSIN

License Type: REGULAR

This license is granted for a maximum capacity of 50 total beds.

General beds: 0	Alcohol beds: 0
Psychiatric beds: 0	Rehab beds: 50

The Facility Profile/Biennial Report is available at this facility for inspection upon request. This license will remain in effect unless expired, suspended, revoked or voluntarily surrendered. Any and all exceptions, stipulations, or conditions to this license shall be posted next to the license certificate.

*M.J. Rhoades*

Kitty Rhoades, Secretary DHS

This license is not transferrable or assignable



# SwedishAmerican Health System

Rockford, IL

has been Accredited by



## The Joint Commission

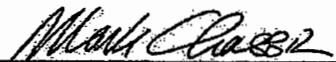
Which has surveyed this organization and found it to meet the requirements for the  
Hospital Accreditation Program

March 15, 2014

Accreditation is customarily valid for up to 36 months.

  
Rebecca J. Patchin, MD  
Chair, Board of Commissioners

Organization ID #7420  
Print/Reprint Date: 06/03/2014

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

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



# SwedishAmerican Health System

Rockford, IL

has been Accredited by



## The Joint Commission

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

March 15, 2014

Accreditation is customarily valid for up to 36 months.

  
Rebecca J. Patchin, MD  
Chair, Board of Commissioners

Organization ID #7420  
Print/Reprint Date: 06/03/2014

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

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



# SwedishAmerican Health System

Rockford, IL

has been Accredited by



## The Joint Commission

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

March 15, 2014

Accreditation is customarily valid for up to 36 months.

  
Rebecca J. Patchin, MD  
Chair, Board of Commissioners

Organization ID #7420  
Print/Reprint Date: 06/03/2014

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

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



# CERTIFICATE OF DISTINCTION

*has been awarded to*

SwedishAmerican A Division of UW Health

Rockford, IL

*in the management of*

Joint Replacement - Hip

*by*



The Joint Commission

*based on a review of compliance with national standards,  
clinical guidelines and outcomes of care.*

August 23, 2016

*Certification is customarily valid for up to 24 months.*

  
Craig A. Jones, FACHE  
Chair, Board of Commissioners

ID #7420  
Print/Reprint Date: 10/06/2016

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

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



Attachment 11

# CERTIFICATE OF DISTINCTION

*has been awarded to*

SwedishAmerican Regional Cancer Center

Rockford, IL

*in the management of*

Lung Cancer

*by*



The Joint Commission

*based on a review of compliance with national standards,  
clinical guidelines and outcomes of care.*

January 14, 2017

*Certification is customarily valid for up to 24 months.*

  
Craig W. Jones, FACHE  
Chair, Board of Commissioners

ID #7420  
Print/Reprint Date: 01/16/2017

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

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



Attachment 11

# CERTIFICATE OF DISTINCTION

*has been awarded to*

SwedishAmerican A Division of UW Health

Rockford, IL

*for Advanced Certification as a*  
Primary Stroke Center  
*by*

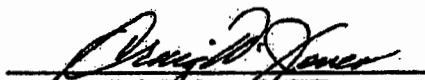


**The Joint Commission**

*based on a review of compliance with national standards,  
clinical guidelines and outcomes of care.*

**October 28, 2016**

*Certification is customarily valid for up to 24 months.*

  
Craig W. Jones, FACHE  
Chair, Board of Commissioners

ID #7420  
Print/Reprint Date: 12/29/2016

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

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



Attachment 11

**CENTERS FOR MEDICARE & MEDICAID SERVICES  
CLINICAL LABORATORY IMPROVEMENT AMENDMENTS  
CERTIFICATE OF ACCREDITATION**

**LABORATORY NAME AND ADDRESS**  
SWEDISH AMERICAN HOSPITAL LAB POC TEST  
1401 E STATE ST  
ROCKFORD, IL 61104

**CLIA ID NUMBER**  
14D0699775

**EFFECTIVE DATE**  
01/03/2017

**LABORATORY DIRECTOR**  
SAMUEL PARK M D

**EXPIRATION DATE**  
01/02/2019

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown herein (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures. This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.



*Karen W. Dyer*  
Karen W. Dyer, Acting Director  
Division of Laboratory Services  
Survey and Certification Group  
Center for Clinical Standards and Quality

882 Certs2\_120616

If you currently hold a Certificate of Compliance or Certificate of Accreditation, below is a list of the laboratory specialties/subspecialties you are certified to perform and their effective date:

<u>LAB CERTIFICATION (CODE)</u>	<u>EFFECTIVE DATE</u>	<u>LAB CERTIFICATION (CODE)</u>	<u>EFFECTIVE DATE</u>
MYCOLOGY (120)	03/02/2011		
PARASITOLOGY (130)	03/02/2011		
ROUTINE CHEMISTRY (310)	03/29/2001		
TOXICOLOGY (340)	01/15/2015		
HEMATOLOGY (400)	03/29/2001		

FOR MORE INFORMATION ABOUT CLIA, VISIT OUR WEBSITE AT [WWW.CMS.GOV/CLIA](http://WWW.CMS.GOV/CLIA)  
OR CONTACT YOUR LOCAL STATE AGENCY. PLEASE SEE THE REVERSE FOR  
YOUR STATE AGENCY'S ADDRESS AND PHONE NUMBER.  
PLEASE CONTACT YOUR STATE AGENCY FOR ANY CHANGES TO YOUR CURRENT CERTIFICATE.

Attachment 11

**CERTIFICATION AND AUTHORIZATION**  
of  
**SWEDISHAMERICAN HEALTH SYSTEM and SWEDISHAMERICAN HOSPITAL**

The undersigned representative of SwedishAmerican Health System and SwedishAmerican Hospital in connection with the application submitted herewith hereby states as follows:

I certify that no adverse action has been taken against SwedishAmerican Health System and SwedishAmerican Hospital by the federal government, licensing or certifying bodies, or any other agency of the State of Illinois against any health care facility owned or operated by SwedishAmerican Health System and SwedishAmerican Hospital, directly or indirectly, within three years preceding the filing of this application of change of ownership exemption.

I authorize the Illinois Health Facilities and Services Review Board and the Illinois Department of Public Health (IDPH) access to any documents pertaining to University of Wisconsin Hospitals and Clinics Authority necessary to verify the information submitted with this application, including, but not limited to official records of IDPH or other Illinois agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations.



Gina Boettcher  
Subscribed and sworn to  
this 10<sup>th</sup> day of April, 2017

William R. Gorski  
Name: William R. Gorski, M.D.  
Title: CEO, SwedishAmerican Hospital and  
SwedishAmerican Health System

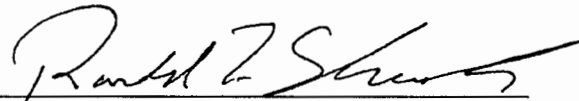


**CERTIFICATION AND AUTHORIZATION  
OF  
UNIVERSITY OF WISCONSIN HOSPITALS AND CLINICS AUTHORITY**

The undersigned representative of University of Wisconsin Hospitals and Clinics Authority in connection with application submitted herewith hereby states as follows:

I certify that no adverse action has been taken against University of Wisconsin Hospitals and Clinics Authority by the federal government, licensing or certifying bodies, or any other agency of the State of Illinois against any health care facility owned or operated by University of Wisconsin Hospitals and Clinics Authority, directly or indirectly, within three years preceding the filing of this application of change of ownership exemption.

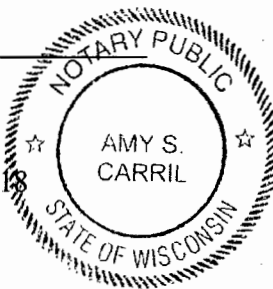
I authorize the Illinois Health Facilities and Services Review Board and the Illinois Department of Public Health (IDPH) access to any documents pertaining to University of Wisconsin Hospitals and Clinics Authority necessary to verify the information submitted with this application, including, but not limited to official records of IDPH or other Illinois agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations.



Name: Ronald T. Sliwinski  
Title: SVP/Chief of Hospital Division



Notary Public  
Subscribed and sworn to  
this 7<sup>th</sup> day of April, 2017  
My commission expires 2-18-2018



### **Criterion 1110.230: Purpose of the 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.*

The project will provide health services that improve the health care and well-being of the market area population to be served by providing upgraded and modern service areas, many of which are currently located in a 50-year old patient tower. The following health care services will be improved with this project:

**Women's and Children's services:** The project proposes construction of a new women's and children's tower addition to the main campus. The completely new OB/GYN unit will allow for the most modern services available to mothers and children while further improving infection control, provider/patient communication, patient throughput, and patient and family preferences.

**Acute Mental Illness:** There is a current need in the planning area for 11 AMI beds and this need will be addressed by the redistribution of ten Pediatric beds to AMI. The addition of ten AMI beds will also reduce the delay of patient placement for this vulnerable population.

**Medical/Surgical:** The project will convert 32 medical/surgical beds from multi-occupancy to single occupancy rooms. This will improved patient comfort and privacy, facilitate HIPPA compliance, greatly improve infection prevention and control. These renovated rooms will also provide hand washing sinks for staff and modernized infrastructure such as electrical, lighting, HVAC/AIR exchanges, med gas and data systems. The project also proposes the reduction of ten medical/surgical beds which will improve the utilization rate of that service.

**Pediatrics:** SwedishAmerican's Pediatric unit had been historically underutilized and the reduction of ten Pediatric beds will improve the utilization rate of that service. Also, the project will convert the remaining multi-occupancy Pediatric beds to single-occupancy and provide the same benefits mentioned above in connection with converting medical/surgical beds to single occupancy.

**Cardiac Cath:** SwedishAmerican has had a nearly 16% increase in its cardiac catheterization service from 2013 to 2015 and some of its catheterization equipment is over eleven years old. The expansion and modernization will provide state of the art equipment in newly designed space to care for the Rockford community's population which has heart disease risk factors that are greater than the population at large.

**Other Clinical Service Areas:** Modernization of out-dated areas in the existing facility will include the operating rooms, recovery stations and emergency department. These services have had no significant upgrades or updates in over a decade.

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

SwedishAmerican Hospital is located in Hospital Service Area HSA 1 and in Planning Area B-01.

HSA 1 is the service area comprised of the following counties in northern Illinois: Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside and Winnebago.

Planning Area B-01 consists of Boone and Winnebago counties and portions of DeKalb and Ogle counties.

Maps of HSA 1 and Planning Area B-01 are included with this Attachment 12.

3. *Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.*

The existing problems and issues that need to be addressed include several service areas that are limited by facility footprint and current infrastructure. The current 1963 patient tower consists of semi-private patient rooms with a shared toilet rather than a private room. Additionally, patients who are treated in the emergency department are cared for in a semi-private setting rather than a private room. A few of the current operating rooms are too small to hold all necessary equipment and personnel sufficient to perform surgery which limits the utilization of the rooms and the workflow of the surgical suites. These current facilities are inefficient and provide less than optimal workflow.

4. *Cite the sources of the documentation.*

- 2014 Healthy Community Study, Rockford Health Council (for Winnebago and Boone Counties)
- 2016 Community Health Needs Assessment, SwedishAmerican Hospital
- American Heart Association (April 4, 2017, Volume 135, Issue 14)
- Emergency Department Performance Measures, ED Benchmarking Alliance (2014)
- <http://www.acepnow.com/article/emergency-department-benchmarking-alliance-reports-data-survey-next-generation-ed-design/?singlepage=1>
- <https://www.illinois.gov/sites/hfsrb/InventoriesData/FacilityProfiles/Pages/default.aspx>
- <https://www.illinois.gov/sites/hfsrb/InventoriesData/HealthCareFacilities/Pages/default.aspx>

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

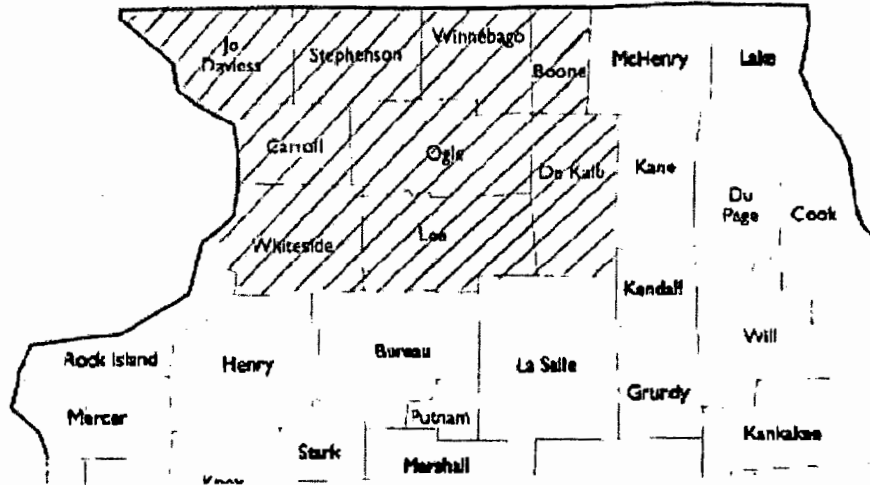
The proposed project will provide private rooms rather than semi-private rooms for all inpatients and private rooms for patients seen in the emergency department. The renovated emergency department will provide additional trauma rooms and pediatric emergency

department rooms. The proposed project will renovate the surgery department to create larger, higher functioning operating rooms and will increase the number of operating rooms by two rooms. The proposed project will increase beds in the behavioral health unit to better meet the needs of the behavioral health community in SwedishAmerican Health System's service area.

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

The goals of the proposed project include reducing privacy-related issues for patients, reducing the infection control-related risks to patients and healthcare workers and to support the growing need for inpatient behavioral health services. Another goal is to create a higher functioning and more efficient surgery department that meets the needs of the patients and healthcare providers by providing space that is conducive to performing surgical procedures including the necessary equipment and technology in every operating room.

**HEALTH SERVICE AREA 1**



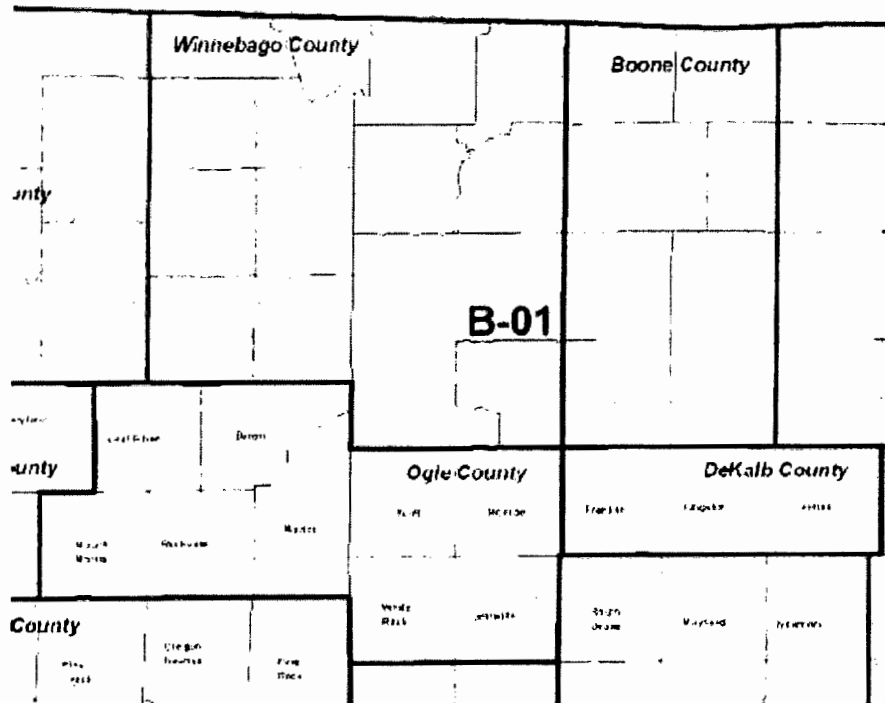
**Inventory of Health Care Facilities and Services  
and Need Determinations**

Illinois Health Facilities and Services Review Board  
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2) **Region B (comprised of Health Service Area 1)**

A) **Planning Area B-1: Boone and Winnebago Counties; DeKalb County Townships of Franklin, Kingston, and Genoa; Ogle County Townships of Monroe, White Rock, Lynnville, Scott, Marion, Byron, Rockvale, Leaf River and Mount Morris.**



### **Criterion 1110.230: Alternatives**

The alternatives considered were to develop services and facilities off-site or to remain at the SwedishAmerican's existing campus with modernization of existing facilities and construction of new space.

#### **1. Develop off Site**

Rejected for the following reasons:

- There was no current property owned by SAHS that was suitable for a satellite facility
- The cost of acquiring property for a new location would provide no cost benefit to expanding on the current main campus
- The cost of duplication of basic services (Imaging, Dietary, Housekeeping, Materials etc.) would increase capital cost of construction and equipment and operational costs of staffing and provide no cost benefit.
- Cost comparison: the off Site option would require the purchase of property large enough for this project estimated to cost \$15,000,000 for land plus a new building to house Women's and Children's services with the other services required listed above would require a building of 220,000 square feet resulting in a total project, including the property purchase, of \$138 million

#### **2. Develop on Site**

Alternative of choice for the following reasons:

- Replaces and modernizes outdated facilities for Women's/Obstetrical and Pediatric Services
- Maintains connection to other hospital services, Emergency, Imaging, Surgery, Dietary, Housekeeping, Materials, etc. to optimize use of existing facilities and staff and prevents duplication of services another site would require
- Maintains all services centrally located in the Rockford area the better serve all parts of the community
- Allows the existing Women's/Obstetrical area to be modernized to adult medical/surgical beds to provide all private rooms to provide enhanced patient privacy, reduction of infection control issues and a higher utilization of beds in all private model.
- Cost Comparison: Total project cost of \$128,228,014 compared to off-site option total project cost of \$138 million.

### Criterion 1110.234: Size of Project

1. *Document that the amount of physical space proposed for the proposed project is necessary and not excessive.*

The following Size of Project Table shows that the project meets the State standards set for in Part 1110 Appendix B for the following departments and services:

- Pediatric clinics
- LDR
- C-Section
- Post Partum
- Pediatric Inpatient
- Surgical Prep/Recovery, Phase II
- Cardiac Catheterization Prep/Recovery, Phase II

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 and certified by the facility's Medical Director.*
  - b. *The existing facility's physical configuration has constraints or impediments and requires an architectural design that delineates the constraints or impediments.*
  - c. *The project involves the conversion of existing space that results in excess square footage.*
  - d. *Additional space is mandated by governmental or certification agency requirements that were not in existence when Appendix B standards were adopted.*

The following areas are above the state standards:

**Cardiac Cath/Angiography:** The State standard is 1,800 dgsf and the proposed rooms are 2,000 dgsf. The proposed Cath/EP/IR/Angiography addition is replacing the current area in order to open space for the expansion of Surgery. The existing area includes space for five key rooms and five are planned for the new construction. The rooms are designed to accommodate the latest technology and be highly flexible for future equipment upgrades resulting in the need for somewhat larger rooms.

**PACU, Phase I:** The State Standard is 180 dgsf per recovery station and that proposed stations are 225 dgsf. The additional 45 dgsf of space allow for larger patient stations and for more flexibility in the long term use of the PACU stations. The PACU will be located in proximity to the Cath/Interventional Pre/Post area to provide operational efficiency and flexibility. The individual patient spaces are planned to be have more privacy in the pre-procedure use and more openness in the post-procedure use requiring a larger amount of SF per patient station.



**Emergency Department:** The State standard is 900 dgsf per treatment station and the proposed stations are 954 dgsf. The Emergency Department expansion will provide additional and modernized Trauma and High Acuity Exam rooms plus additional exam rooms for the increasing patient volume and a designated area for pediatric patients. The average DGSF per room is higher than the State standard because the primary areas that are being renovated require larger rooms for trauma and higher acuity patients.

**Medical/Surgical:** The State standard is 660 dgsf per bed and the proposed beds will be 688 dgsf. The 32 medical/surgical beds being modernized in connection with this project are being relocated to the 5th floor of the existing facility in space that is currently used for Labor/Delivery/C-Section. The renovation of this space into an adult medical/surgical patient unit with 32 beds results in rooms slightly above the State standard (by about 4%) due to working within the existing structural constraints of the building including existing ten-foot-wide corridors that result in the 28 dgsf overage per room.

**Level II with Extended Neonatal Capabilities/NICU:** The State standard is 160 dgsf/OB bed for Level IIE and 550 for NICU. The overages on these services is related to changes in industry standards to an all private room model for beds of this type. The all private room model allows for parents to stay with their babies and provides a superior environment that enhances infection control, temperature, acoustical and lighting control. This room model also provides for great operational flexibility. The private room model results in a higher than State Guideline/Allowable. The current best practice planning standards that CannonDesign uses for all private NICU is 700 dgsf per key room and the entire nursery is being designed to this standard. See, e.g., Development of Care in the NICU, Designing and operating NICUs in the 21<sup>st</sup> Century (Robert White, MD) and Recommended Standards for Newborn ICU Design, Report of the Eighth Consensus Conference on Newborn ICU Design (January 26, 2012).

**Size of Project**

Department/ Service	# of Key Rooms	Proposed DGSF	Proposed DGSF/Room	State Standard DGSF		DGSF Difference/ Room	Met Standard?
Pediatric Clinics	24	13,200	550	800		(250)	Yes
LDR	14	16,165	1,155	1,120	1600	(235)	Yes
C-Section	2	4,100	2,050	2,075		(25)	Yes
Post-Partum	20	12,750	638	550	660	(22)	Yes
Pediatric Inpatient	18	10,250	569	500	660	(91)	Yes
Cath/Angiography	5	10,000	2,000	1,800		200	No
PACU Phase I	16	4,750	297	180/station		117	No
Surgery	6	12,859	2,143	2,750		(607)	Yes
Emergency	18	17,175	954	900		54	No
Surgical Prep/Rec Phase II	6	2,100	350	400		(50)	Yes
Cath/IR Prep/Rec Phase II	14	4,044	289	400		(111)	Yes
Medical/Surgical	32	22,000	688	660		28	No
Level II+ Nursery	14	9,394	276 OB/Bed	160/OB		116	No
NICU	10	6,710	671	434	550	121	No

**Criterion 1110.234: 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.*

The projected utilization of services for which the Review Board has utilization standards is included in the table on the following page. A narrative of the rationale supporting the utilization projections is also with the table.

**UTILIZATION OF SERVICES WITH PART 1100 STATE STANDARDS**

	DEPT/SERVICE	HISTORICAL UTILIZATION (FY 15)	PROJECTED UTILIZATION	STATE STANDARD	MEET STANDARD?
Year 1	Medical-Surgical		82%		
Year 2	Medical-Surgical	60.9%	86%	85%	YES
Year 1	Pediatric		12%		
Year 2	Pediatric	7.5%	16%	65%	NO
Year 1	Obstetric		75%		
Year 2	Obstetric	55.6%	78%	78%	YES
Year 1	AMI		85%		
Year 2	AMI	72.8%	85%	85%	YES
Year 1	Cardiac Cath				
Year 2	Cardiac Cath	2,445 Cases	3,000 Cases	200 Cases	YES

The project completion date is November 30, 2022 (due to the phasing of on-site expansion). The first year after project completion is 2023 and the second year after project completion is 2024. The projected utilization rates for the above services were determined as follows:

**Medical/Surgical:** The medical/surgical utilization projections are based on: (1) SwedishAmerican's historical increase in patient days; (2) projected increases in patient days based on the IHFSRB Inventory; (3) SwedishAmerican's physician recruitment plan that includes surgeons; (4) the reduction of services at MercyRockford's west side facility; (5) SwedishAmerican's reduction of ten medical/surgical beds. SwedishAmerican's physician recruitment plan and the IHFSRB Inventory for Medical/Surgical services in Planning Area B-01 are included with this Attachment.

In the two year period from 2013 to 2015, SwedishAmerican's Medical/Surgical utilization increased 4.5% even while med/surg utilization within the Planning Area B-01 and hospital service area HSA 1 declined over the same period. Other factors are expected to increase this growth rate. This includes the IHFSRB Inventory for the Medical/Surgical service in Planning Area B-01 which projects a 14% increase in patient days from 2013 to 2018. Also, over the next five years, SwedishAmerican plans to recruit 36 primary care physicians, 21 surgical specialists, and 40 non-surgical specialists. (See attached Physician Recruitment 5-Year Plan.) Medical/Surgical utilization is also expected to increase due to MercyRockford's significant reduction of emergency services, including trauma services, and a majority of its medical/surgical beds at its west side facility as part of its current relocation project. Finally, SwedishAmerican is reducing its medical/surgical bed complement by ten beds, which will

improve the occupancy rate. (In its 2004 modernization project (#04-041), SwedishAmerican reduced its medical/surgical bed compliment by 40 beds.) Based upon the foregoing, SwedishAmerican believes that an annualized average increase of 4.25% in patient days is a reasonable projection and would attain target utilization by the second year following project completion.

**Pediatric:** The pediatric utilization projections are based on the same factors above for medical/surgical beds using a 4.25% annual growth rate. SwedishAmerican does not anticipate meeting target utilization in its Pediatric unit. However, SwedishAmerican will be recruiting Pediatric primary care physicians, Pediatric surgical specialists and Pediatric hospitalists, including those affiliated with the UW Health's American Family Children's Hospital in Madison, Wisconsin, and this will significantly increase utilization of the Pediatric unit. In addition, SwedishAmerican is reducing its Pediatric bed compliment by over 35% from 28 beds to 18 beds, which will improve the occupancy rate.

**Obstetric:** The Obstetric utilization projections are based on: (1) SwedishAmerican's physician recruitment plan that includes four OB/GYN surgical specialists; (2) the closure of MercyRockford's entire Obstetric service at its west side facility; and, (3) SwedishAmerican's exemption application for a Neonatal Intensive Care Unit that will allow SwedishAmerican to apply to IDPH for designation as a Level III facility. SwedishAmerican projects that the above factors will result in an annualized average increase in patient days of 5%, and this would allow for target utilization to be met in the second year of operation.

**Acute Mental Illness:** Projected AMI utilization is based upon the IHFSRB's Inventory for the Acute Mental Illness Category of Service for AMI Planning Area 01. The Inventory projects a need for an additional 11 AMI beds and further states that, based on projected increases in patient days, all facilities within the planning area will be at the target occupancy rate of 85%. A copy of the IHFSRB Inventory for AMI services in Planning Area 01 is included with this Attachment.

**Cardiac Cath:** From 2013 to 2015, SwedishAmerican's cardiac catheterizations increased from 2,445 to 2,829 which is a 15.7% increase. If cath volume increases maintain just half of this percentage increase in the next three years, cath volume will reach 3,000 cases, or 600 cath per lab. The target utilization for a cath services in Part 1100 is 200 cases.

**SwedishAmerican Physician Recruitment  
5-Year Plan**

Primary	2017	2018	2019	2020	2021
Primary Care	6	8	8	5	6
Pediatrics	1	1		1	
Subtotal	7	9	8	6	6

Surgical Specialists	2017	2018	2019	2020	2021
Breast Surgery	1				
Cardiothoracic Surgery	1				
ENT Surgery	1		1		
General Surgery	3	1	1	1	
OB/GYN	2		1		1
Orthopedic Surgery	1		1	1	1
Pediatric Surgery	1	1			
Plastic Surgery		1			
Subtotal	10	3	4	2	2

Non-Surgical Specialists	2017	2018	2019	2020	2021
Adolesent Psychiatry		1			
Cardiology	7	3		1	1
Dermatology		1			
Endocrinology	1		1		
Headache Medicine		1			
Maternal Fetal Medicine		1			
Neonatology / Neonatal NP	7				
Neurology		1		1	
Pediatric Cardiology	1		1		
Pediatric GI		1		1	
Pediatric Hospitalists	4.5			1	
Pediatric Neurology		2			
Rheumatology	1				
Subtotal	21.5	11	2	4	1

<b>Grand Total</b>	<b>38.5</b>	<b>23</b>	<b>14</b>	<b>12</b>	<b>9</b>
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**INVENTORY OF HEALTH CARE FACILITIES AND SERVICES AND NEED DETERMINATIONS**

Illinois Health Facilities and Services Review Board  
 Illinois Department of Public Health

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**MEDICAL-SURGICAL and PEDIATRIC Categories of Service**

Hospital Planning Area: **B-01**

Hospital	City	2013 Beds	2013 Admissions	2013 Patient Days
Rockford Memorial Hospital	Rockford	223	7,375	41,557
7/31/2014 Bed Change	Discontinued 8 Medical-Surgical beds; facility now has 223 beds authorized for Medical-Surgical care.			
Saint Anthony Medical Center	Rockford	190	7,909	43,370
6/2/2015 15-021	Received permit to modernize 190 Medical-Surgical beds. No change in licensed beds.			
Swedish/American Hospital	Rockford	209	10,325	44,415
Swedish/American Medical Center Belvidere	Belvidere	34	4	28
10/7/2014 Board Order	Board reduced authorized Medical-Surgical beds from 37 to 34.			
<b>Medical-Surgical TOTAL</b>		<b>656</b>	<b>25,613</b>	<b>129,370</b>

CATEGORY OF SERVICE:		2018 Population	Use Rates	Total Projected Days	Adjusted Days
<b>Pediatrics</b>		<b>76</b>	<b>1,499</b>	<b>27,112</b>	<b>134,427</b>
Rockford Memorial Hospital	Rockford	35	1,124	3,782	
Saint Anthony Medical Center	Rockford	13	63	354	
Swedish/American Hospital	Rockford	28	312	921	
Swedish/American Medical Center Belvidere	Belvidere	0	0	0	
4/21/2015 Board Action	Approved discontinuation of 2 bed Pediatrics category of service.				

Patient Days by Age	Medical-Surgical/Pediatrics Planning Area Totals			2013 Population	Use Rates	2018 Population	Projected Days	
	2011	2012	2013					
0-14 Years Old	5,076	4,693	5,057	14,826	0.0632	77,680	4,907	
15-44 Years Old	17,353	16,123	15,581	49,057	0.1141	149,090	17,007	
45-64 Years Old	43,719	42,282	41,361	127,362	0.4065	105,660	42,946	
65-74 Years Old	28,262	29,031	29,445	86,738	0.9124	38,540	35,162	
75-up Years Old	46,029	44,250	42,983	133,262	1.8318	27,850	51,015	
<b>Out-Migration</b>	<b>In-Migration</b>	<b>Net Migration</b>	<b>Average Length of Stay</b>	<b>Migration Days</b>	<b>Adjustment Factor</b>	<b>Adjustment</b>	<b>Total Projected Days</b>	<b>Adjusted Days</b>
2,527	4,052	-1,525	4,756	-7,253	0.50	-3,626	151,038	147,411
<b>Adjusted Days</b>	<b>Days in Year 2018</b>	<b>Adjusted Average Daily Census</b>	<b>Occupancy Target*</b>	<b>Adjusted Beds Needed</b>	<b>Existing Beds</b>	<b>Excess Beds</b>		
147,411	365	404	0.90	449	732	283		

\* If ADC less than 100 in Planning Area, Occupancy Target is 80%, if the Planning Area has ADC of 100-199, the Occupancy Target is 85%; if ADC is 200 or more, 90%.

**INVENTORY OF HEALTH CARE FACILITIES AND SERVICES AND NEED DETERMINATIONS**

**ACUTE MENTAL ILLNESS Category of Service**

Hospital	City	Acute Mental Illness Planning Area: 01				2013 Utilization				
		Beds	Admissions	Patient Days	Planned Bed Need	Calculated Bed Need	Target Occupancy Rate	Projected Average Daily Census	Projected Patient Days	Planned Bed Need
Katherine Shaw Bethea Hospital	Dixon	14	552	3,122						
Rockford Memorial Hospital	Rockford	20	640	4,084						
SwedishAmerican Hospital	Rockford	32	1,145	6,931						
<b>Planning Area Totals</b>		<b>66</b>	<b>2,337</b>	<b>14,137</b>						
<b>Estimated 2013 Total Population</b>	<b>679,000</b>	<b>0.11</b>	<b>77</b>	<b>20.8</b>	<b>699,200</b>	<b>14,558</b>	<b>39.9</b>	<b>0.85</b>	<b>77</b>	<b>11</b>

Hospital	City	Acute Mental Illness Planning Area: 02				2013 Utilization				
		Beds	Admissions	Patient Days	Planned Bed Need	Calculated Bed Need	Target Occupancy Rate	Projected Average Daily Census	Projected Patient Days	Planned Bed Need
Galesburg Cottage Hospital	Galesburg	12	164	1,962						
McDonough District Hospital	Macomb	12	0	0						
7/14/2014 14-018 Permit issued to establish 12 bed Acute Mental Illness category of service.										
Methodist Medical Center of Illinois	Peoria	68	2,950	20,344						
OSF Saint Elizabeth Medical Center	Ottawa	26	1,005	4,687						
Proctor Community Hospital	Peoria	18	275	3,059						
11/5/2013 E-022-13 Approved for change of ownership.										
<b>Planning Area Totals</b>		<b>136</b>	<b>4,394</b>	<b>30,052</b>						

Estimated 2013 Total Population	Minimum Beds per 1,000	Minimum AMI Bed Need	Experienced AMI Use Rate	Projected 2018 Total Population	Projected Patient Days	Days in Year 2018	Projected Average Daily Census	Target Occupancy Rate	Calculated Bed Need		Planned Bed Need		Excess Beds
									96	96	96	96	
675,300	0.11	73	44.5	667,700	29,714	365	81.4	0.85	96	96	96	96	40



**Criterion 1110.234: Assurances**

The undersigned representative of the applicants understands that, by the end of the second year of operation after the project completion, the applicant is to meet or exceed the utilization standards specified in Appendix B. The applicants anticipate that by the second year of operation, utilization targets will be met for the service areas indicated on the attached Utilization Table which also indicates that Appendix B utilization targets may not be met in some areas and these areas are addressed in the Attachments below for the respective service areas.



*Gina Boettcher*

Subscribed and sworn to  
this 10<sup>th</sup> day of April 2017, 2017

A handwritten signature in black ink, appearing to read "Don F. Daniels".

Name: Don F. Daniels  
Title: COO, SwedishAmerican Health System

**UTILIZATION OF SERVICES WITH PART 1100 STATE STANDARDS**

	DEPT/SERVICE	HISTORICAL UTILIZATION (FY 15)	PROJECTED UTILIZATION	STATE STANDARD	MEET STANDARD?
Year 1	Medical-Surgical		82%		
Year 2	Medical-Surgical	60.9%	86%	85%	YES
Year 1	Pediatric		12%		
Year 2	Pediatric	7.5%	16%	65%	NO
Year 1	Obstetric		75%		
Year 2	Obstetric	55.6%	78%	78%	YES
Year 1	AMI		85%		
Year 2	AMI	72.8%	85%	85%	YES
Year 1	Cardiac Cath				
Year 2	Cardiac Cath	2,445 Cases	3,000 Cases	200 Cases	YES

**Criterion 1110.530: Medical/Surgical; Pediatrics; OB**

This project includes the modernization of SwedishAmerican's Medical/Surgical, Pediatrics, and OB Departments. Specifically, 32 Medical/Surgical beds will be modernized, and the total Medical/Surgical bed compliment will be reduced by ten beds from 209 to 199 beds. The entire Pediatric unit will be modernized and its bed compliment reduced by 10 from 28 to 18 Pediatric beds (with the 10 beds being redistributed to Acute Mental Illness). Finally, all 34 OB beds will be built part of the newly constructed women's and children's tower.

<b>Category of Service</b>	<b># Existing Beds</b>	<b># Proposed Beds</b>
Medical / Surgical	209	199
Pediatrics	28	18
Obstetrics	34	34

Under Section 1110.530, the modernization of existing services must address the following criteria:

- (b)(1) & (3): Background of the Applicant
- (e)(1)-(3): Deteriorated Facilities
- (e)(4): Occupancy
- (g): Performance Requirements

These criteria are addressed below and in the following pages of this Attachment 19.

**Criterion 1110.530(b)(1): Listing of the health care facilities currently owned and operated by the applicants**

SwedishAmerican Health System owns the following health care facilities in Illinois:

SwedishAmerican Hospital  
1401 East State Street  
Rockford, Illinois  
IDPH License #0002725

SwedishAmerican Medical Center – Belvidere  
1625 South State Street  
Belvidere, Illinois  
IDPH License #0005504

Copies of SwedishAmerican's licenses and Joint Commission certifications are included with this Attachment 11.

University of Wisconsin Hospitals and Clinics Authority operates the following hospital facilities in Wisconsin licensed by the Wisconsin Department of Health Services (WDHS):

University Hospital  
600 Highland Ave.  
Madison, WI 53792  
WDHS License #125

American Family Children's Hospital  
1675 Highland Ave.  
Madison, WI 53792  
WDHS License #125

UW Health at the American Center  
4602 Eastpark Blvd.  
Madison, WI 53792  
WDHS License #125

UW Health Rehabilitation Hospital  
5115 N. Biltmore Lane  
Madison, WI 53718  
WDHS License #321

Copies of the WDHS licenses for the above facilities are included with this Attachment 11. (The first three facilities are operated under a single license.)

**Criterion 1110.530(b)(3): Certification of No Adverse Action**

Following this page are the applicants' certifications that no adverse action has been taken against any health care facility listed above; that applicants are not in default of any judgment of any court or governmental agency; and that no Board member or executive officer of the respective applicants have been convicted of a crime or charged with fraudulent conduct.

**Criterion 1110.530(b)(3): Authorization of Access to Documents**

Following this page are the applicants' authorizations for HFSRB and IDPH access to documents necessary to verify the information submitted, including, but not limited to: official records of IDPH or other State ; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations.



**Illinois Department of  
PUBLIC HEALTH**

HF112035

**LICENSE, PERMIT, CERTIFICATION, REGISTRATION**

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

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

Issued under the authority of  
the Illinois Department of  
Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/2017	General Hospital	0002725
Effective: 01/01/2017		

**SwedishAmerican Hospital**  
1401 East State Street  
Rockford, IL 61104

The face of this license has a colored background. Printed by Authority of the State of Illinois, P.O. #4012820 10M 3/12

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

Exp. Date 12/31/2017

Lic Number 0002725

Date Printed 10/26/2016

SwedishAmerican Hospital

1401 East State Street  
Rockford, IL 61104

FEE RECEIPT NO.

DISPLAY THIS PART IN A CONSPICUOUS PLACE

HF112319

**Illinois Department of PUBLIC HEALTH**

**LICENSE, PERMIT, CERTIFICATION, REGISTRATION**

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

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

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE <b>1/13/2018</b>	CATEGORY <b>General Hospital</b>	ID NUMBER <b>0005504</b>
<b>Effective: 01/14/2017</b>		

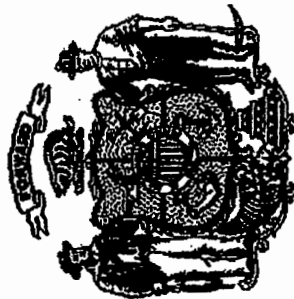
**SwedishAmerican Medical Center Belvidere**  
**1625 South State Street**  
**Belvidere, IL 61008**

The face of this license has a colored background. Printed by Authority of the State of Illinois - P.O. #4012520 10M 3/12

Exp. Date 1/13/2018  
Lic Number 0005504  
Date Printed 12/16/2016

SwedishAmerican Medical Center Belv  
1625 South State Street  
Belvidere, IL 61008

FEE RECEIPT NO.



# The State of Wisconsin

## Department of Health Services Division of Quality Assurance

### CERTIFICATE OF APPROVAL

This is to certify that UNIVERSITY OF WI HOSPITALS & CLINICS AUTHORITY  
being business as UNIVERSITY OF WI HOSPITALS & CLINICS AUTHORITY  
at the location 600 HIGHLAND AVENUE  
MADISON, WI 53792

License Number: 125  
Effective Date: 02/03/2016  
Initial Date: 01/02/1966

is licensed to operate a GENERAL ACUTE HOSPITAL in DANE COUNTY, WISCONSIN

License Type: REGULAR

This license is granted for a maximum capacity of 648 total beds.

General beds: 628

Alcohol beds: 0

Psychiatric beds: 20

Rehab beds: 0

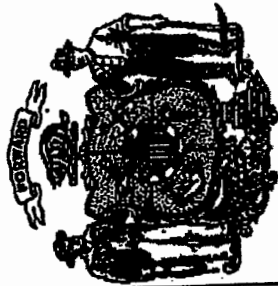
In further accordance with Wisconsin §50.35 the following locations are listed for reimbursement purposes under Wisconsin §49.25(3)(e) 10m: Research Park, University Station, West Clinic, East Clinic, Waisman Center, Adolescent Intervention, Middleton Clinic, Oakwood Village Clinic, UWHC Renal Clinic, Hand & Upper Extremity Rehab Clinic, The American Center, Digestive Health Center, & Yakara Rehab Clinic.

The Facility Profile/Biennial Report is available at this facility for inspection upon request.  
This license will remain in effect unless expired, suspended, revoked or voluntarily surrendered. Any and all exceptions, stipulations, or conditions to this license shall be posted next to the license certificate.

*M. Rhoades*

Kitty Rhoades, Secretary DHS

This license is not transferrable or assignable



# The State of Wisconsin

Department of Health Services  
Division of Quality Assurance

## CERTIFICATE OF APPROVAL

License Number: 321  
Effective Date: 09/22/2015  
Initial Date: 09/22/2015

This is to certify that MADISON REHABILITATION HOSPITAL, LLC  
doing business as UW HEALTH REHABILITATION HOSPITAL  
at the location 5115 N BILTMORE LN  
MADISON, WI 53718

is licensed to operate a REHABILITATION HOSPITAL in DANE COUNTY, WISCONSIN

License Type: REGULAR

This license is granted for a maximum capacity of 50 total beds.

General beds: 0                      Alcohol beds: 0  
Psychiatric beds: 0                  Rehab beds: 50

The Facility Profile/Biennial Report is available at this facility for inspection upon request. This license will remain in effect unless expired, suspended, revoked or voluntarily surrendered. Any and all exceptions, stipulations, or conditions to this license shall be posted next to the license certificate.

*M.S. Rhoades*  
Kitty Rhoades, Secretary DHS

This license is not transferable or assignable



**CERTIFICATION AND AUTHORIZATION**  
of  
**SWEDISHAMERICAN HEALTH SYSTEM and SWEDISHAMERICAN HOSPITAL**

The undersigned representative of SwedishAmerican Health System and SwedishAmerican Hospital in connection with the application submitted herewith hereby states as follows:

I certify that no adverse action has been taken against SwedishAmerican Health System and SwedishAmerican Hospital by the federal government, licensing or certifying bodies, or any other agency of the State of Illinois against any health care facility owned or operated by SwedishAmerican Health System and SwedishAmerican Hospital, directly or indirectly, within three years preceding the filing of this application of change of ownership exemption.

I authorize the Illinois Health Facilities and Services Review Board and the Illinois Department of Public Health (IDPH) access to any documents pertaining to University of Wisconsin Hospitals and Clinics Authority necessary to verify the information submitted with this application, including, but not limited to official records of IDPH or other Illinois agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations.



Gina Boettcher  
Subscribed and sworn to  
this 10<sup>th</sup> day of April, 2017

A handwritten signature in black ink, appearing to read "William R. Gorski, M.D.", written over a horizontal line.

Name: William R. Gorski, M.D.  
Title: CEO, SwedishAmerican Hospital and  
SwedishAmerican Health System

### **Criterion 1110.530(e)(1)-(3): Deteriorated Facilities**

For the inpatient beds involved in this project there have been little, and in some cases no, renovations to these rooms other than cosmetic facelifts in the 56 years since they were first built. All of the 32 medical/surgical beds involved and some of the pediatric beds are still in semi-private rooms, and these beds will all be converted to single occupancy rooms. Swedish American Hospital wants to provide a private room experience to the patients and families we serve. Improved patient privacy and HIPPA compliance is achieved in the private patient room experience. Infection prevention/control issues are greatly reduced in the private patient room environment. These renovated rooms will also provide hand washing sinks for staff and modernized infrastructure such as electrical, lighting, lighting, HVAC/AIR exchanges, med gas and data systems.

Transitioning from semi private rooms to private rooms is a major initiative addressing the issues of consumer preference, along with clinical concerns resulting from shared space. Also, a significant number of adult/pediatric inpatient beds in the existing facility date back to 1963. Additionally, the inability to accommodate families that wish to stay with the patients remains a dissatisfier.

The relocation of existing women's and children's services into the new patient tower will allow the conversion of remaining multi-occupancy rooms in the existing facility to all private rooms.

### **Criterion 1110.530(g): Performance Requirements**

The proposed project satisfies the Performance Requirements for all categories of service for which the Review Board has minimum unit sizes:

- 1) **Medical-Surgical:** The project involves the reduction of ten medical/surgical beds which will reduce the unit size from 209 beds to 199 beds. This meets the required minimum of 100 beds.
- 2) **Pediatrics:** The project reduces Pediatric beds from 28 to 18, and this meets the required minimum of 4 beds.
- 3) **Obstetrics:** The project maintains the hospital's existing 34 bed OB unit and meets the required minimum of 20 beds.

**Criterion 1110.730: Acute Mental Illness**

This project proposes to redistribute 10 Pediatric beds to the Acute Mental Illness (AMI) which results in an increase of the AMI unit from 32 beds to 42 beds.

<b>Category of Service</b>	<b># Existing Beds</b>	<b># Proposed Beds</b>
Acute Mental Illness	32	42

Under Section 1110.730, the Expansion of Existing Services requires that the following criteria be addressed:

- (b)(1) &(3): Background of the Applicant
- (c)(2): Planning Area Need: Service to Planning Area Residents
- (c)(4): Planning Area Need: Expansion of AMI
- (f): Staffing Availability
- (g): Performance Requirements
- (h): Assurances

These criteria are addressed below and in the following pages of this Attachment 21.

**Criterion 1110.730(b)(1)&3): Acute Mental Illness: Background of the Applicant**

The background of the applicants documentation is provided in Attachment 19 and, per 77 Ill. Adm. Code 1110.730(b)(5), this documentation "is required one time per application, regardless of the number of categories of service involved in a proposed project."

**Criterion 1110.730(c)(2): Planning Area Need: Service to Planning Area Residents**

- A. The primary purpose of the project will be to provide necessary health care to residents of the area in which the proposed project will be physically located.
- B. The following attachment provides patient origin information for all admissions for the most recent 12-month period and verifies that at least 50% of admissions were residents of the area.
- C. The following attachment also provides patient origin information by zip code, based on the patient's legal residence.

Consumer Zip Code	Zip Type	Community	County	SA Classification	Inpatient	Inpatient
					Acute Mental Illness	Acute Mental Illness
					CY2015	CY2016
61104	Standard	Rockford	Winnebago County	Primary	140	153
61101	Standard	Rockford	Winnebago County	Primary	147	131
61103	Standard	Rockford	Winnebago County	Primary	124	124
61109	Standard	Rockford	Winnebago County	Primary	100	118
61102	Standard	Rockford	Winnebago County	Primary	94	107
61108	Standard	Rockford	Winnebago County	Primary	87	86
61008	Standard	Belvidere	Boone County	Primary	71	78
61111	Standard	Loves Park	Winnebago County	Primary	44	76
61107	Standard	Rockford	Winnebago County	Primary	86	73
61115	Standard	Machesney Park	Winnebago County	Primary	61	64
61073	Standard	Roscoe	Winnebago County	Primary	30	48
61065	Standard	Poplar Grove	Boone County	Primary	24	34
61080	Standard	South Beloit	Winnebago County	Primary	23	26
61114	Standard	Rockford	Winnebago County	Primary	36	26
61010	Standard	Byron	Ogle County	Primary	13	20
61072	Standard	Rockton	Winnebago County	Primary	16	19
61054	Standard	Mount Morris	Ogle County	Primary	2	11
61020	Standard	Davis Junction	Ogle County	Primary	9	10
61016	Standard	Cherry Valley	Winnebago County	Primary	7	9
61068	Standard	Rochelle	Ogle County	Primary	6	8
61061	Standard	Oregon	Ogle County	Primary	8	7
61063	Standard	Pecatonica	Winnebago County	Primary	9	6
61084	Standard	Stillman Valley	Ogle County	Primary	9	6
61038	Standard	Garden Prarie	Boone County	Primary	1	4
61011	Standard	Caledonia	Boone County	Primary	6	3
61088	Standard	Winnebago	Winnebago County	Primary	9	3
61024	Standard	Durand	Winnebago County	Primary	2	2
61052	Standard	Monroe Center	Ogle County	Primary	-	2
61126	PO Box	Rockford	Winnebago County	Primary	3	2
61012	Standard	Capron	Boone County	Primary	3	1
61030	Standard	Forreston	Ogle County	Primary	1	1
61047	Standard	Leaf River	Ogle County	Primary	2	1
61064	Standard	Polo	Ogle County	Primary	2	1
60113	PO Box	Creston	Ogle County	Primary	1	-
61049	Standard	Lindenwood	Ogle County	Primary	2	-
61077	PO Box	Seward	Winnebago County	Primary	1	-
61132	PO Box	Loves Park	Winnebago County	Primary	2	-
<b>Primary Service Area Totals</b>					<b>1,181</b>	<b>1,260</b>
% of Total					92.6%	92.4%
All Inpt Market					1276	1364

**Criterion 1110.730(c)(4): Planning Area Need: Expansion of AMI**

The Review Board's Inventory shows a bed need in Planning Area 01 for 11 AMI beds. The project proposes to add 10 AMI beds (an increase from 32 to 42 AMI beds) to address this projected demand for services.

Section 1110.730(c)(4) directs the applicant to address Historical Service Demand and either Projected Referrals ((c)(3)(B)) or Projected Service Demand (Subsection (c)(3)(C)), Historical Service Demand and Projected Service Demand are addressed below.

**A. Historical Service Demand**

**i. Average annual occupancy rate:**

The average annual occupancy rate for SwedishAmerican's AMI unit in 2015 was 72.8%. Although below the 85% target utilization, the unit's Peak Census in 2015 was 29 beds which reflects 91% occupancy. Also, 2015 utilization of 8,498 patient days was a 22.6% increase from the 2013 patient days of 6,931 patient days and 60.3% occupancy. Further, as addressed above, the Review Board's Inventory projects that by 2018 all planning area AMI beds will reach target utilization by 2018 and their will be an 11 bed need for additional AMI beds. This project addresses that need with the addition of 10 AMI beds.

With the closure of the State run Singer Mental Health Hospital in Rockford in 2012, in addition to the earlier closures of two for-profit psychiatric facilities in the area, the demand for acute mental health beds has increased. This has also resulted in demand/capacity mismatches in the ED at SwedishAmerican and in its inpatient AMI unit. Expanding the bed capacity in the AMI unit is necessary.

**B. Projected Service Demand**

- i. The applicant shall define the facility's market area based upon historical patient origin data by zip code or census tract. Applicants proposing to use zip code data to define the project market area shall indicate the sources of that information. 77 Ill. Adm. Code 1130.730(c)(3)(C)(i).*

SwedishAmerican is in Planning Area 01 for AMI services which consists of a nine county area in Northwest and North Central Illinois (see attached Planning Area Map). The entire nine-county Planning Area has only three AMI units: SwedishAmerican's 32 bed unit in Winnebago County; Mercy Rockford's 20-bed unit in Winnebago County; and, Katherine Shaw Bethea's 14 bed unit in Lee County. SwedishAmerican's Zip Code data for AMI patients shows that SwedishAmerican's primary service area for AMI services consists of counties within HSA 1. The source of the patient zip code data is the applicant's MedAssets Decision Support System.

- ii. Population projections shall be produced, using, as a base, the population census or estimate for the most recent year, for county, incorporated place, township or community area, by the U.S. Census Bureau or IDPH. 77 Ill. Adm. Code 1130.730(c)(3)(C)(ii).*

Population projections are based on the Review Board's Inventory. The projections show the estimated Planning Area Population for 2013 was 679,000 and is projected to grow to 699,200 by 2018. (See attached AMI Inventory for Planning Area 01.) Based upon this population growth and the Board's factor for minimum beds per 1000 population, the projected AMI bed need by 2018 is 77 beds, compared to only 66 beds in the Planning Area, and creating a need for eleven AMI beds. The Review Board's Inventory for AMI services in HSA 1 is included with this Attachment.

- iii. Projection shall be for a maximum period of 10 years from the date the application is submitted. 77 Ill. Adm. Code 1130.730(c)(3)(C)(iii).*

The Board's AMI Inventory projects population and need to the year 2018 which is well within the maximum 10 year period required by the criterion. See attached Inventory.

- iv. Historical data used to calculate projections shall be for a number of years no less than the number of years projected. 77 Ill. Adm. Code 1130.730(c)(3)(C)(iv).*

The Review Board's AMI Inventory population project was calculated in August 2015 and the historical data is based on the Review Board's and IDPH's bed need projections as set forth in 77 Ill. Adm. Code 1100.560, a copy of which is included with this Attachment. The projection methodology derived from the 2010 census and projects population to the year 2018. It is therefore consistent with the methodology required by the criterion.

- v. Projections shall contain documentation of population changes in terms of births, deaths and net migration for a period of time equal to, or in excess of, the projection horizon. 77 Ill. Adm. Code 1130.730(c)(3)(C)(v).*

The Review Board's Inventory for AMI services and bed need projection was performed in August 2015, utilized historical population data for 2013 and projected population changes to 2018, which satisfies this criterion.

- vi. Projections shall be for total population and specified age groups for the applicant's market area, as defined by HFSRB, for each category of service in the application. 77 Ill. Adm. Code 1130.730(c)(3)(C)(vi).*

The Review Board's AMI Inventory uses total population as required by 77 Ill. Adm. Code 1100.560 and satisfies this criterion.

- vii. Documentation on projection methodology, data sources, assumptions and special adjustments shall be submitted to HFSRB. 77 Ill. Adm. Code 1130.730(c)(3)(C)(vii).*

The projected methodology is based on 77 Ill. Adm. Code 1100.560(e) as set forth below:

"Need Determination for Bed Not Operated by the Department of Human Services

The following methodology is utilized to determine the projected number of acute mental illness beds needed in a planning area:

- 1) A bed need of .11 beds per 1,000 projected population is established in each planning area as the minimum bed need.

- 2) Calculate the planning area's experienced use rate by dividing the number of patient days in the base year by the base year population in thousands. Multiply the experienced use rate by the population estimate in thousands to obtain estimated patient days. Divide the estimated patient days by the number of days in the population projection (which is five years from the base year) to determine the projected average daily census (ADC). Divide the estimated ADC by .85 (85% occupancy factor) to obtain a projected bed need in the planning area.
- 3) When the projected bed need is less than the minimum bed need, the minimum bed need is the projected bed need. When the estimated bed need is greater than the minimum bed need, the estimated bed need is the projected bed need.
- 4) Calculate the number of additional beds needed in each area by subtracting the number of existing beds from the projected bed need.
- 5) Subtract the number of existing beds in the planning area from the projected planning area bed need to determine the projected number of excess (surplus) beds or the projected need for additional beds (deficit) in the area."

**INVENTORY OF HEALTH CARE FACILITIES AND SERVICES AND NEED DETERMINATIONS**

Illinois Health Facilities and Services Review Board  
Illinois Department of Public Health

8/4/2015  
Page E- 5

**ACUTE MENTAL ILLNESS Category of Service**

Hospital	City	Acute Mental Illness Planning Area: 01				2013 Utilization			
		Beds	Admissions	Patient Days	Excess Beds	Beds	Admissions	Patient Days	Excess Beds
Katherine Shaw Bethea Hospital	Dixon	14	552	3,122					
Rockford Memorial Hospital	Rockford	20	640	4,084					
SwedishAmerican Hospital	Rockford	32	1,145	6,931					
<b>Planning Area Totals</b>		<b>66</b>	<b>2,337</b>	<b>14,137</b>					

Estimated 2013 Total Population	Minimum Beds per 1,000	Minimum AMI Bed Need	Experienced AMI Use Rate	Projected 2018 Total Population	Projected Patient Days	Days in Year 2018	Projected Average Daily Census	Target Occupancy Rate	Calculated Bed Need	Planned Bed Need	Beds Needed
679,000	0.11	77	20.8	699,200	14,558	365	39.9	0.85	47	77	11

Hospital	City	Acute Mental Illness Planning Area: 02				2013 Utilization			
		Beds	Admissions	Patient Days	Excess Beds	Beds	Admissions	Patient Days	Excess Beds
Galesburg Cottage Hospital	Galesburg	12	164	1,962					
McDonough District Hospital	Macomb	12	0	0					
<b>Planning Area Totals</b>		<b>136</b>	<b>4,394</b>	<b>30,052</b>					

Estimated 2013 Total Population	Minimum Beds per 1,000	Minimum AMI Bed Need	Experienced AMI Use Rate	Projected 2018 Total Population	Projected Patient Days	Days in Year 2018	Projected Average Daily Census	Target Occupancy Rate	Calculated Bed Need	Planned Bed Need	Excess Beds
675,300	0.11	73	44.5	667,700	29,714	365	81.4	0.85	96	96	40

7/14/2014 14-018 Permit issued to establish 12 bed Acute Mental Illness category of service.  
Methodist Medical Center of Illinois  
OSF Saint Elizabeth Medical Center  
Proctor Community Hospital  
11/5/2013 E-022-13 Approved for change of ownership.



**Criterion 1110.730(f): Staffing Availability**

SwedishAmerican's clinical and professional staff for its existing 32-bed AMI unit currently meets licensure and Joint Commission staffing requirements. The expansion of the AMI unit by ten beds will result in the need for additional staff. The provider complement will be increased to service the increased number of patients with physician and mid-level provider support. Nursing, therapy and social service staff will be increased to provide the comprehensive care required for these populations. This department provides care that encompasses all the needs of behavioral health patients. It is expected that only one additional physician will be needed for the expanded AMI unit and SwedishAmerican does not anticipate any difficulties in recruiting the physician. No new types of staff roles will be added. Case management, educational, physical therapy support will be added as patient loads expand.

**Criterion 1110.730(g): Performance Requirements**

The proposed 42 bed AMI unit satisfies the performance requirement of a minimum size unit of 20 AMI beds within a Metropolitan Statistical Area as required by 77 Ill. Adm. Code 1110.730(g).

**Criterion 1110.730(h): Assurances**

The undersigned representation of SwedishAmerican Hospital attests to the applicant's understanding that by the second year of operation after the project completion, the applicant will achieve and maintain the occupancy standards specified in 77 Ill. Adm. Code 1100 for the acute mental illness service.



A handwritten signature in black ink, appearing to read "Don F. Daniels".

Name: Don F. Daniels  
Title: COO, SwedishAmerican Health System

A handwritten signature in black ink, appearing to read "Gina Boettcher".

Subscribed and sworn to  
this 10<sup>th</sup> day of April, 2017

**Criterion 1110.1330 Cardiac Catheterization**

The project proposes to modernize the existing cardiac catheterization service and to add one cardiac catheterization lab. Currently, SwedishAmerican Hospital has three cath labs used for angiography procedures and one cath lab designated for electrophysiology (EP). The project proposes to add one cath lab for angiography procedures.

**1. Criterion 1110.1330(a), Peer Review**

Currently there is a peer review process within the cath lab that has two levels of measure in place. First are the clinical implications that the medical staff has decided upon that require a peer review. Second are radiation exposure levels that are set in place by our Nuclear Safety Office. A report is run on a monthly basis for look for these items, when they are found the physician involved is notified and they are asked to come and present at meeting of their peers who then score the event in accordance with our medical quality bylaws. These cases are then forwarded on the Adult Medicine Quality where a group of physician peers again review the findings and then issue a request for further information if needed.

**2. Criterion 1110.1330(b), Expansion of Cardiac Catheterization Service**

a. A map showing the location of the other hospitals providing cardiac catheterization services within the planning area is attached. SwedishAmerican is in Planning Area HSA 01.

b. The number of cardiac catheterizations performed for the last 12 months at each of the hospitals shown on the map.

<b>Hospital</b>	<b>No. of Labs</b>	<b>Cardiac Cath Volume</b>
SwedishAmerican	4*	2,445
OSF St. Anthony	3	2,499
MercyRockford	3	2,081
Kishwaukee Community	1	540
Katherine Shaw Bethea	1	646
FHN Memorial	1	463
CGH Medical Center	1	802

Source: 2015 Hospital Profiles

\*Three labs for angiography and one lab designated for electrophysiology (EP).

c. Transfers from the applicant's hospital to another facility for cardiac catheterization services in each of the last three years: SwedishAmerican has averaged only one transfer a year over last three years.

### **3. Criterion 1110.1330(c), Unnecessary Duplication of Services**

a. *"Any application proposing to establish cardiac catheterization services must indicate if it will reduce the volume of existing facilities below 200 catheterizations."* 77 Ill. Adm. Code 1110.1330(c)(1).

The proposed project will not reduce the volume of any existing facility within the planning area below 200 catheterizations. The two other hospitals in Rockford, OSF St. Anthony and MercyRockford performed 2,499 cath and 2,081 caths, respectively. The other four hospitals, all of which are outside of Winnebago County where SwedishAmerican is located have performed between 463 and 802 catheterizations.

SwedishAmerican anticipates an increase in cardiac catheterizations at the hospital for the following reasons:

- Aging of the population.
- Growing number of cardiology practioners at SwedishAmerican.
- Growing number of interventional radiologists at SwedishAmerican.
- Emergency Department volume continue to increase.
- SwedishAmerican's proposed establishment of new primary care clinics on the West side of Rockford.
- MercyRockford's relocation of its own cardiac cath service from its current location on Rockford's West side to the far North East side of Rockford thereby leaving SwedishAmerican as the closest provider of cardiac cath services for the West side community.
- American Heart Association reports show that heart disease will have risen 46% by the year 2030 in the US (Circulation April 4, 2017, Volume 135, Issue 14).
- 2014 Community Health Assessment shows that heart disease has been the number 1 cause of death in the community since 2010.
- 2014 Community Health Assessment reveals that the Rockford area has a significant higher rate of smoking than the national average (21% vs. 17%) which is a risk factor for heart disease.
- 2014 Community Health Assessment reveals that the top two diseases and conditions across all age groups in the Rockford area were hypertension (23%) and high cholesterol (18.4%), which are risk factors for heart disease.

b. *"Any applicant proposing the establishment of cardiac catheterization services must contact all facilities currently providing the service within the planning area in which the applicant facility is located, to determine the impact the project will have on the patient volume at existing services. b. Copies of the responses received from the facilities to which the letter was sent."* 77 Ill. Adm. Code 1110.1330(c)(2).

SwedishAmerican has an existing cardiac catheterization service and is not proposing the establishment of cardiac catheterization services. Therefore, this criterion is not applicable.

**4. Criterion 1110.1330(d), Modernization of Existing Cardiac Catheterization Laboratories**

*"No proposed project for the modernization of existing equipment providing cardiac catheterization services will be approved unless the applicant documents that the minimum utilization standards (as outlined in 77 Ill. Adm. Code 1100.620) are met."* 77 Ill. Adm. Code 1330(d).

The utilization standard for cardiac catheterization services is that, "There should be a minimum of 200 cardiac catheterization procedures performed annually within two years after initiation." 77 Ill. Adm. Code 1100.620. SwedishAmerican performed 2,445 catheterizations in 2015, which is above the minimum utilization standards.

**5. Criterion 1110.1330(e), Support Services**

The Support Services criterion applies to establishment of cardiac catheterization service and is not applicable as SwedishAmerican already has the service. .

**6. Criterion 1110.1330(f), Laboratory Location**

All of the catheterization labs will be located in close proximity to each other as shown on the attached floor plan.

**7. Criterion 1110.1330(g), Staffing**

The Staffing criterion applies to an applicant proposing to establish the cardiac catheterization service and is not applicable as SwedishAmerican already has the service.

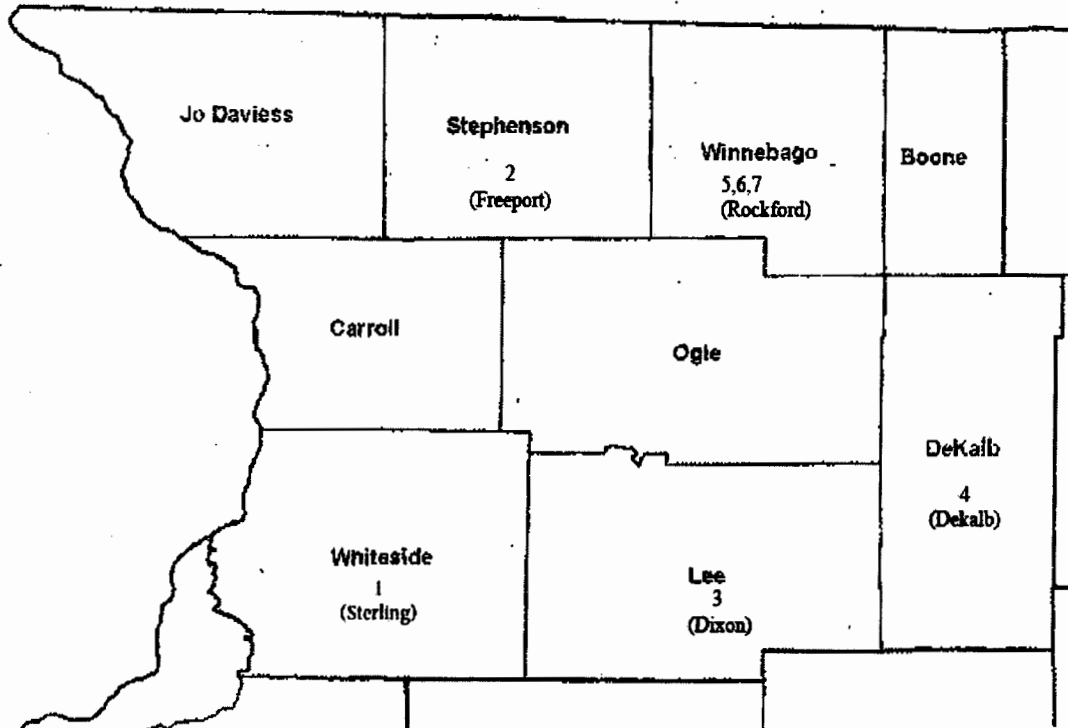
**8. Criterion 1110.1330(h), Continuity of Care**

The Continuity of Care criterion requires "written transfer agreements have been established with facilities with open-heart surgery capabilities." SwedishAmerican has an open heart surgery service and therefore satisfies the requirements of this criterion.

**9. Criterion 1110.1330(i), Multi-institutional Variance**

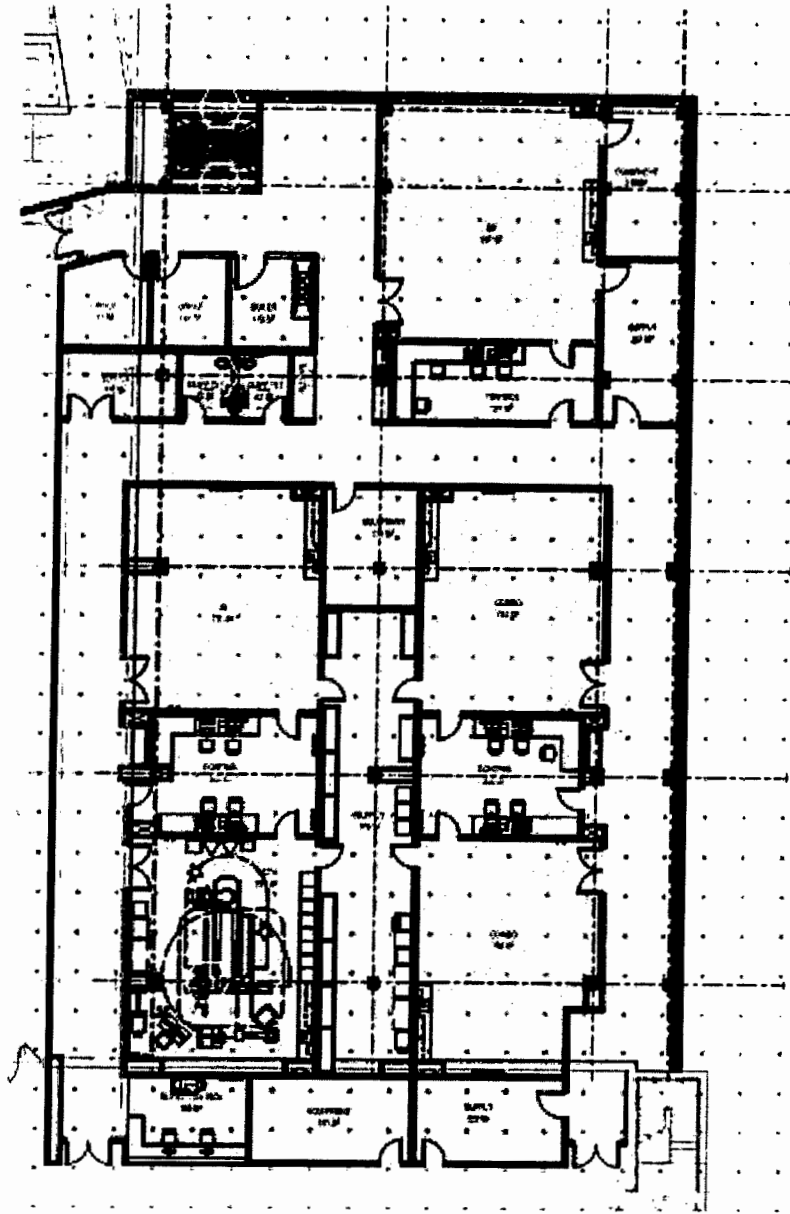
The Multi-institutional Variance criterion applies to the establishment of a cardiac catheterization service and is not applicable as SwedishAmerican already has the service. .

## Cardiac Catheterization Services in Planning Area HSA 1



1. CGH Medical Center, Sterling
2. FHN Memorial Hospital, Freeport
3. Katherine Shaw Bethea Hospital, Dixon
4. Kishwaukee Community Hospital, DeKalb
5. MercyRockford Memorial Hospital, Rockford
6. Saint Anthony Medical Center, Rockford
7. SwedishAmerican Hospital, Rockford

# CARDIAC CATH LAB FLOOR PLAN



**Criterion 1110.3030: Clinical Service Area Other than Category of Service**

This project includes the modernization of the following Clinical Service Areas other than Categories of Services:

Service	# Existing Key Rooms	# Proposed Key Rooms
OR	13	15
PACU I	14	16
PACU II	40	49
ED Stations	42	50

For modernization of these services, Criterion 1110.3030(a)(2) requires the following criteria to be addressed:

- (b)(1) &(3): Background of the Applicant
- (d)(2): Necessary Expansion or
- (d)(3)(B): Utilization – Service or Facility

The Background criteria and Necessary Expansion criteria are addressed below and on the following pages of this Attachment 31.

**Criterion 1110.3030(b)(1)&(3): Clinical Service Areas: Background of the Applicant**

The background of the applicants documentation is provided in Attachment 19 and, per 77 Ill. Adm. Code 1110.3030(b)(5), this documentation "is required one time per application."

**Criterion 1110.3030(d)(2): Clinical Service Areas: Necessary Expansion**

*"The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project." 77 Ill. Adm. Code 1110.3030(d)(2).*

The Surgery and Emergency departments are both being modernized in the proposed project. In Surgery, four of the existing very small operating rooms are being replaced and relocated with larger operating rooms consistent in size with the other remaining eight operating rooms; plus, two additional operating rooms will be provided to accommodate the current physician/surgeon recruitment plan that includes 21 surgical specialists. (See attached 5-Year recruitment plan.)

In the Emergency Department, the modernization will focus on providing additional trauma rooms and larger exam rooms for higher acuity patients. The annual number of ED patient visits continues to increase. The existing ED was designed and built to accommodate 40,000 annual patients while the total number of ED visits in 2015 was 70,742. Additional



trauma, triage and exam rooms are needed to adequately manage a quality patient care experience.

The need for eight additional ED stations was based on current utilization, historical annual growth rate of 17.5% in ED visits in the two year period from 2013 to 2015, and the planned reduction of MercyRockford's emergency department and closure of its trauma center on the West side of Rockford. SwedishAmerican's projections for ED station need is also based on industry standards of 1,542 Visits per Station for emergency departments with 60K to 80K annual visits. See attached Emergency Department Performance Measures Data Guide published by the Emergency Department Benchmarking Alliance (2014) at Page 16.

The historical utilizations of the service areas for which standards are available in Part 1110 Appendix B:

<b>Service</b>	<b>Rooms</b>	<b>CY15 Utilization</b>	<b>Utilization Rate</b>	<b>State Standard</b>
OR	13*	16,139 Hours	1,241 Hrs/OR	1,500 Hrs/OR
ED Stations	42	70,742 Visits	1,684 Visits/Rm	2000 Visits/Rm

\*Includes 12 ORs and 1 Procedure Room

**SwedishAmerican Physician Recruitment  
5-Year Plan**

<b>Primary</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>
Primary Care	6	8	8	5	6
Pediatrics	1	1		1	
Subtotal	7	9	8	6	6

<b>Surgical Specialists</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>
Breast Surgery	1				
Cardiothoracic Surgery	1				
ENT Surgery	1		1		
General Surgery	3	1	1	1	
OB/GYN	2		1		1
Orthopedic Surgery	1		1	1	1
Pediatric Surgery	1	1			
Plastic Surgery		1			
Subtotal	10	3	4	2	2

<b>Non-Surgical Specialists</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>
Adolescent Psychiatry		1			
Cardiology	7	3		1	1
Dermatology		1			
Endocrinology	1		1		
Headache Medicine		1			
Maternal Fetal Medicine		1			
Neonatology / Neonatal NP	7				
Neurology		1		1	
Pediatric Cardiology	1		1		
Pediatric GI		1		1	
Pediatric Hospitalists	4.5			1	
Pediatric Neurology		2			
Rheumatology	1				
Subtotal	21.5	11	2	4	1

<b>Grand Total</b>	<b>38.5</b>	<b>23</b>	<b>14</b>	<b>12</b>	<b>9</b>
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# Emergency Department Performance Measures

*Data Guide*



**EMERGENCY DEPARTMENT  
BENCHMARKING ALLIANCE**

Built by emergency department leaders for emergency department leaders

## 2014

**Emergency Department Performance Measures  
Data Guide from the  
Emergency Department Benchmarking Alliance (EDBA)**

The Emergency Department Benchmarking Alliance (EDBA) is a membership organization composed of high performance American Emergency Departments (ED's) that share a commitment to quality. Since 2004 the Alliance has surveyed its members to collect ED performance data. The 2014 database includes operating statistics for over 1,100 ED's and 40 million patient visits. In addition, affiliated urgent care centers and Freestanding ED's for EDBA members represented an additional 45 centers that saw 650,000 patients. Data from all facilities is included in the 2014 database.

Founded in 1994 and dedicated to the identification, development, and implementation of future best practices in Emergency Medicine, the EDBA is a group of ED leaders dedicated to sharing data to improve quality medical care, patient satisfaction, medical education, and community service.

Every year, the Data Survey includes a growing number of contributors. In 2012, the Board approved the distribution of data survey results, including a formal release of data to The Joint Commission. Many groups interested in hospital and emergency department performance now preferentially use the EDBA Data Survey to assess their ED operations.

In February, 2014 the EDBA conducted its third Summit to develop ED Performance Measures and Definitions. Previous Summits were held in 2006 and 2010. The 2014 Summit proceedings are contained in the article in *Academic Emergency Medicine* 2015; 22:542-553, titled ***Emergency Department Performance Measures Updates: Proceedings of the 2014 ED Benchmarking Alliance Consensus Summit***. The article, written by Jennifer L. Wiler, MD, MBA, Shari Welch, MD, Jesse Pines, MD, Jeremiah Schuur, MD, MHS, Nick Jouriles, MD, and Suzanne Stone-Griffith, RN, MSN updates the key definitions and metrics for ED performance and operations.

The EDBA Summits have provided a broad range of Federal, regional, and emergency leaders the opportunity to develop and influence the future of ED data collection and reporting. The proceedings of the Summits have been published in peer-reviewed manuscripts and used in ED operations nationwide.

## The EDDBA 2014 Data Guide

### Executive Highlights

The 2014 EDDBA Performance Measures survey includes over 1,100 EDs that served over 40 million patients, plus 45 additional freestanding ED's or urgent care centers.

#### ***Volume increased as Acuity Decreased***

Patient volume at same sites reporting in 2013 and 2014 increased by 4.3%. Many EDs had a higher increase in volume than that figure. Acuity mix, measured by physician level of service and by the percentage of patients that were admitted to the hospital from the ED decreased to the lowest level in the 11 years of data survey.

There was a decreasing percentage of children treated in EDs

#### ***EDs are Changing Structure as they Grow in Volume and Complexity***

There were a growing number of trauma centers. Comparing the EDDBA and NHAMCS databases showed that the new trauma centers served populations that included large numbers of elderly patients.

Bed utilization in EDs was about 1,500 visits per patient care space.

There was an increased use of ED electronic information systems. Computerized physician order entry (CPOE) was present in over 80% of EDs

About 75% of EDs over 40K volume reported a Fast Track, and about 35% had a CDU or Observation Unit

#### ***There is Better Patient Processing in EDs***

The "Door to Doctor" time has decreased to 27 minutes, and overall length of stay for all ED patients was under 3 hours. The "Boarding Time" interval decreased for patients being placed in an inpatient unit of the hospital. This is the time from "decision to admit" until "patient physically leaves the ED"

About 17% of patients arrive by EMS, and about 37% of those persons were admitted

The percentage of patients who leave the ED prior to the completion of treatment decreased to 2.1%.

Processing times remains highly correlated with ED volume. The cohort system used in the EDDBA survey process has data comparators for adult and pediatric EDs, and for EDs that see patients in 20,000 volume bands. Higher volume EDs have higher acuity, higher use of diagnostic testing, and longer patient processing times. The trends related to these cohorts remain intact for 2014.

#### ***Patients who Require Transfer and Inpatient Boarding are a Significant Challenge to ED Operations***

There was a decrease in inpatient service disposition of ED patients, for the first time in 11 years. Still about 68% of hospital inpatients are processed in through the ED.

There were fewer patient transfers: 1.4% of all patients, or almost 3 million a year. According to the 2011 CDC report, about one third of patient transfers from EDs were for mental health treatment, or about 1 million patients per year

Overall admissions from EDs, for either full admission or observation, decreased to around 15.6% of patients treated.

ED boarding of inpatients remained a burden on ED performance, and accounted for about 40% of the time the admitted patient spent in the ED

The average boarding time in American EDs was 105 minutes, but this time was very cohort dependent

#### ***Diagnostic Testing is Evolving in the ED***

There was increased use of diagnostic EKGs and MRI scans.

MRI scans were performed a little over 1 time per 100 patients seen in the ED, CT scans in about 20 procedures per 100 patients. Ultrasound usage is about 5 procedures per 100 patients seen.

## The Data Guide

This data guide contains the results of a data survey report conducted annually by the EDDBA. This survey is the only one that measures Emergency Department performance in key areas that relate to staffing, design, flow, and application of technology tools.

The EDDBA Data Guide report consists of sixteen pages of a Microsoft Excel spreadsheet. The Data Guide is blinded as to the identity of the individual hospitals that submitted data. Individual ED leaders can identify their site based on the number assigned by the EDDBA, and the ED volume they reported for the year 2014.

The sixteen spreadsheet tabs contain pages of data as follows.

1. The Cohort Summary, presenting the results of the survey for the established cohorts for 2014 alone
2. The Trends in the Cohort Summary 2004 to 2014
3. The Volume Organized Spreadsheet for Hospital-based Emergency Departments
4. The Separate Cohort of Freestanding EDs, Hospital-based Urgent Care Centers, and Specialty Hospitals
5. The Cohort of Hospitals over 100,000 Volume
6. The Cohort of Hospitals between 80,000 and 99,999 Volume
7. The Cohort of Hospitals between 60,000 and 79,999 Volume
8. The Cohort of Hospitals between 40,000 and 59,999 Volume
9. The Cohort of Hospitals between 20,000 and 39,999 Volume
10. The Cohort of Hospitals under 20,000 Volume
11. The Cohort of Adult Hospitals
12. The Cohort of Pediatric Hospitals
13. The Cohort of Specialty Hospitals
14. The Cohort of all Level 1 and Level II Trauma Centers
15. The Cohort of all Level III and Level IV Trauma Centers
16. The Cohort of all hospitals with no Trauma Designation
17. The Cohort of all Adult Level 1 and Level II Trauma Centers
18. The Cohort of all Adult Level III and Level IV Trauma Centers
19. The Cohort of all Adult hospitals with no Trauma Designation
20. The Cohort of all Pediatric Level 1 and Level II Trauma Centers
21. The Cohort of all Pediatric Level III and Level IV Trauma Centers
22. The Cohort of all Pediatric hospitals with no Trauma Designation
23. A Presentation Version of the Cohort Summary
24. Type of Physician Documentation Systems in use
25. Median Length of Stay Charts, Scattergram Representations of Lengths of Stay
26. Charts Representing:
  - a. Door to Doctor Times
  - b. Functional Areas in the ED
  - c. What Providers are in the ED Greeting Process
  - d. Acuity Comparisons of Adult versus Pediatric EDs
  - e. Patient Boarding Times
  - f. ED Transfer Rates

A Summary Sheet for calculating the type of physician documentation used in EDs

Each page representing a hospital cohort has a top line in gray, which contains the relevant total or average numbers for the column below. This top line then can be used as the guide for that data cohort.

In 2012, the EDDBA survey initiated the process of asking an open-ended question on the survey, "Would you describe how your ED defines the 'decision to admit' point, or what computer time marker is used to calculate the admit time". The results of that question are present in the last column in narrative form for each ED. *There is great disparity in how EDDBA responders defined the starting point for this interval.*

### **Emergency Department Performance Measures and Definitions**

The public, payers, hospitals, and Centers for Medicare and Medicaid Services (CMS) are demanding that Emergency Departments measure and improve performance. This cannot be done unless the terms used in ED operations are defined and consistent. In February 2006, the Emergency Department Benchmarking Alliance (EDBA) conducted the Emergency Department Performance Measures and Benchmarking Summit, a meeting of groups with oversight responsibilities of the operation of Emergency Departments. This meeting resulted in the development of ED Performance Measures definitions. These definitions were first published in the emergency medicine literature, in an article authored by the Chair of that Summit meeting, Shari Welch, MD (1).

The Performance Measures from the initial meeting were widely disseminated, and feedback on those measures led to the need for further definitions. In February 2010, 32 stakeholders, representing about 20 professional organizations, met to further standardize ED operations metrics and definitions. This resulted in two consensus papers. These papers were published in July, 2011 (2, 3). The definitions used in the EDBA survey have been unchanged since 2004, with the addition of a few new elements each year. The definitions are individually published in the data guide.

The data set collected for 2014 included 25 operating statistics, collected at each site and entered into a spreadsheet maintained by the Alliance. The 2014 report asked for additional descriptive statistics regarding methods for documentation, order entry, ED service units, and staffing.

The 2014 ED Performance Measure Data Guide provides a trend analysis of the data collected and reported for the last 11 years. This allows the group to identify significant trends in the numbers, and draft recommendations to improve the management of EDs of all sizes and types.

## **Survey Results for 2014**

### **Annual Volume and Patients Seen per Day**

The sum of patients who present to the ED for service and are recognized by the institution as entering the ED during the calendar year. The annual volume number is then divided by the number of days in the calendar year (365 for the year 2014) to calculate the average number of Patients seen per Day (PPD).

The data is arrayed based on one useful method of categorizing EDs: the average PPD volume. For later analysis, that volume and type of facility were used to place the EDs in the cohort system proposed at the Summit, to stratify the EDs for more useful trend identification. For 2014, there are 9 categories of EDs based on volume seen or service population:

- "Super center" EDs, serving over 100,000 patients per year (over 275 PPD)
- Very high volume EDs, serving over 80,000 patients per year (221 to 274 PPD)
- High volume ED's serving 60-80,000 patients (165 to 220 PPD)
- Average volume ED's serving 40-60,000 patients (110 to 164 PPD),
- Moderate volume ED's serving 20-40,000 patients (55 to 110 PPD).
- Low volume ED's serving under 20,000 patients per year (under 55 PPD).
- Pediatric EDs are those serving patients that are predominantly serving patient populations under the age of 18, and those community EDs that see over 50% patients under the age of 18.



- Adult EDs are those that see 5% or less patients under age 18, and define themselves as EDs that serve adult populations. These are EDs that serve communities that have another hospital that serves as a regional pediatric emergency center.
- Freestanding and Standalone EDs, and hospital-based Urgent Care Centers. This group of facilities serves unscheduled needs of a community, and transfer persons that need inpatient services to a full service hospital.

*Analysis for the year 2014:*

For the calendar year 2014, American EDs likely saw an increase in patient volumes compared to 2013. All sizes and types of EDs seemed to have participated in the increased volumes.

The data guide separately will include the 2011 year of the National Hospital Ambulatory Medical Care Survey (NHAMCS), from the Centers for Disease Control and Prevention (4). This is the latest published NHAMCS report gives a statistical estimate of Emergency Department patients, treatment, and disposition, based on Federal demographic data and a statistical sampling of visits to American EDs. The 2011 report is the *data tables* only. For reference, the 2007 report (5) contains the data tables *and a concise analysis of the interpretation of the data and the trends* in the ED data since the initiation of the NHAMCS annual survey in 1992. The EDBA data release precedes the NHAMCS release, but the two data sets are showing identical trends in patient volumes in the ED.

**Percentage of Patients Coded in CPT as High Acuity**

The percent of patients seen that are coded *using physician CPT codes* that define higher acuity illnesses or injuries. These are codes 99284, 99285, and 99291. Using emergency physician CPT coding of levels of Evaluation and Management provides the most reliable method of defining higher acuity patient visits to an ED. *Unrelated to this survey, it should be noted that despite attempts to standardize coding, one institution in the EDBA published a study that shows a wide variation in coding based on the ambiguity in the CPT coding system (6).*

*Analysis for the year 2014:*

The patients presenting to the EDBA database appears to show a decrease in acuity compared to the trend over the last 3 years. High Acuity visits represented about 60% of ED volume. EDs seeing Adult patients report high acuity coding in about 72% of ED visits. Pediatric EDs, over the 7 years of data sufficient to study this group of EDs, has demonstrated a higher acuity mix for children at about 45%, lower than adult or general community EDs.

**Percentage of Patients Coded as Pediatric**

There are two groups of patients identified in this element, the percent of patients seen in the ED that are defined as under age 2, and the percent of patients over age 2 and under age 18. This is the seventh year that a separate cohort of Children's EDs has been reported on, and this survey has 39 facilities that see all or a substantial part of their volume among patients under age 18.

*Analysis for the year 2014:*

The year 2014 saw a reported drop in pediatric patients in the overall mix of ED patients. The data shows 2.2% of all patients were below the age of 2, and about 12.1% were between 2 and 18 years of age. That means a total of 14.3% of patients seen in general service EDs are under the age of 18. This number has been decreasing for the last 10 years. Pediatric mix generally represents lower acuity, with the high acuity mix for children at 49%, as compared to 72% in adult EDs.

### Percentage of Patients that are Admitted from the ED to the Hospital

The percent of patients seen that are seen in the ED and then placed in an inpatient area of the hospital, either as “full admission” or “observation status”. There is considerable inconsistency in policies now between hospitals, payors (especially CMS), and medical staff members are now defining, measuring, and reimbursing between these designations of patients who need service beyond the ED. So they are being considered here as one outcome measure collectively, until there is much more consistency in definitions. The merged number of patients receiving this service is generally a very well-defined number, since all hospitals have uniform requirements for coding those patients.

#### *Analysis for the year 2014:*

About 15.6% of patients seen in the ED are admitted, down from a high of 18% in 2010. This percentage has been generally decreasing over the last 11 years, in all types of EDs. There is significant variation between the ED volume cohorts. Admission rates are by far highest in EDs seeing adults, and in those over 40K volume. Those EDs admit over 19% of patients seen, and there are a number of those EDs with an admission rate over 30%. Admit rates are down to about 10.3% in pediatric EDs, and in small community EDs, with about 10.7% of ED volume. Cohort data is in Table 1.

Admission rates are inversely correlated with transfers to other hospitals.

**Table 1: ED Admission and Transfer Rates, and Relative Time Breakdown**

ED Type	Admission or Observation, as % of ED Volume	Transferred to Another Hospital	Admitted Patient Median Length of Stay (Minutes)	Median Length of Boarding (Minutes)
<i>All EDs</i>	15.6%	1.4%	289	131
Adult	23.8%	1.1%	355	175
Pediatric	10.3	0.8	251	97
Over 100K volume	20.2	0.9	370	161
80-100K	21.9	0.9	371	161
60-80K	18.8	1.2	336	144
40-60K	18.4	1.4	318	122
20-40K	15.0	1.6	271	105
Under 20K volume	10.7	1.4	240	83

### Percentage of Patients that are Transferred out of the ED to another Hospital

The percent of patients seen that are seen in the ED and then transferred from the ED to another ED or hospital. This is generally a very well-defined number, since all hospitals have uniform requirements under EMTALA to manage, document, and maintain data on transferred patients.

#### *Analysis for the year 2014:*

The transfer percentages are increasing, but still very predictable by cohort. Across all EDs, transfer rates are about 1.4%. Small EDs have the highest percentage of transfers. Transfer rates correlate inversely with admission rates. Pediatric EDs do few transfers, with a rate less than 0.8%.

The CDC has characterized ED transfer patients in its 2011 NHAMCS report on Emergency Department visits. From their data, about one third of the transfers are done to access psychiatric, mental health, or substance abuse care. That means that about 3 million patients are transferred in total each year from

EDs, and about 1 million would be being transferred for mental health and related services. The other two-thirds of ED transfers are performed to allow the patient to have access to a higher level of care, or specialty services.

**Percentage of Patients that Arrive by EMS, and then the Percentage of those Patients that Require Admission to the Hospital**

The percent of patients seen in the ED that arrive in an ambulance. This would include both ambulances serving the community as 911 providers, and ambulances that perform routine transport of patients. The second statistic is the percentage of those patients arriving by ambulance that are subsequently admitted to the hospital.

*Analysis for the year 2014:*

Patients arriving by ambulance constitute about 16% of overall arrivals, and high volume EDs have the highest arrival rates by EMS. Few EDs had less than 10% arrival by EMS. All hospitals had a significantly higher percentage of admissions from patients that arrive by EMS, versus those arriving by other forms of transportation. This would indicate that overall, EMS services are being used by significantly ill or injured patients. For most hospitals, arriving by EMS would predict admission about three times as often as arriving via other means. Cohort data is in Table 2.

Children are less frequent users of EMS, with about 8% of volume arriving by EMS in pediatric EDs. A child arriving by ambulance is also less likely to be admitted, with only about 26% of these patients being admitted to the hospital.

In the universe of non-pediatric EDs, about 17% of patients arrive by EMS, and about 40% of patients arriving by EMS are admitted. EMS patients arriving in the largest hospitals have the greatest likelihood of being admitted, and a substantial number of the EDs with volumes over 40K have over 50% admission rates for EMS patients.

The trending data (Table 3) indicate that a stable percentage of patients arrive by EMS, and are admitted. EMS arrival is also tightly correlated with overall admissions. EMS arriving patients are admitted in about 37% of arrivals, and in about 12% of arrivals by means other than an ambulance.

One could speculate that ED crowding and diversion are increasing the acuity of EMS patients. The diversion process causes some EMS providers to advise lower acuity patients to go to the ED by private vehicle, so they can select the hospital of their choice. The remaining EMS patients would be more likely to have high acuity needs, and require hospital admission. It is also notable that communities having extensive networks of urgent care centers have EMS patients that are more likely to be admitted.

Table 2: EMS Arrival and Admission, 2014

Type of ED	% of Pts Arriving by EMS	% of ED patients that are Admitted	% of EMS Arrivals that are Admitted
All EDs	16%	15.6%	37%
Adult EDs	23	23.8	43
Pediatric	8	10.3	29
Over 100K ED Volume	21	20.2	42
80 to 100K ED	21	21.9	43
60 to 80K ED	19	18.8	41
40 to 60K ED	18	18.4	40
20 to 40K ED	14	15.0	35
Under 20K ED	12	10.7	30

Table 3: Trending EMS Arrival and Admission Rates

Year	% of ED Patients Arriving by EMS	Overall ED Admission Rate	% of EMS Arrivals that are Admitted	% of Walk-in Patients Admitted
2014	16%	15.6%	37%	12.3%
2013	17	16.5	39	12.5
2012	16	16.5	39	12.2
2011	17	17.6	42	12.6
2010	16	18.0	43	13.2
2009	16	17.3	43	12.4
2008	17	16.6	43	11.2
Back to 2004	15	16.3	38	12.5

#### Median Length of Stay, for Patients that are Admitted, for Patients that are Treated and Released, and for all Patients

The number of minutes for each group of patients that are spent in the ED, reported as a *median*. The EDBA analysis of time markers for process flow has found that an arithmetic *mean* does not characterize the function of the ED as well as the *median* number. So the *median* statistic is utilized for all time parameters in the EDBA survey.

CMS has been focused on studying the process flow for admitted patients, expressed as a median time. Hospital and ED leaders will recognize this as CMS Clinical Quality Measure ED-1 (and NQF 0495).

#### Analysis for the year 2014:

The median length of stay for all patients for all EDs is about 171 minutes. There is a clear stratification of ED length of stay by ED volume. The EDs over 80K volume have median length of stay of 225 minutes, and decreases down to about 135 minutes for patients seen in EDs under 20K volume. For the year 2014, most cohorts of EDs saw a small increase in length of stay.

There has been a correlation noted between median length of stay and walkaway rates of patients from the ED. In the groups of EDs with notable changes in processing times this year, the predictable walkaway changes occurred: *where processing times decreased, the walkaway rate decreased.*

Many ED leaders in community EDs have identified time in Department as a key operating indicator, and initiated a variety of process changes to begin reducing that time. There are a large number of EDs that have developed programs for having physicians and midlevel providers in the greeting process for the ED.

#### **Median Times for Door to Bed and Door to Doctor for all Patients**

The number of minutes for patients to be placed in a treatment area, and then seen by a responsible emergency physician or midlevel provider, reported as a *median*. The start time for this interval is generally when the patient is first recognized as a patient by the ED staff, and a time of arrival is placed on the chart.

#### *Analysis for the year 2014:*

The median time from door to doctor for all patients for all EDs has decreased to about 27 minutes. Although all cohorts of EDs are improving the door to doctor times, there remains a clear stratification by ED volume. The EDs over 40K volume have median door to doctor times of about 35 minutes, and decreases down to about 23 minutes for patients seen in EDs under 40K volume. The majority of the time is in processing the patients from door to a treatment area, which takes about 22 minutes in the largest EDs.

Patient front end processing in Pediatric EDs takes generally about the same amount of time that it does in a general service ED with similar volume.

There has been a correlation noted between door to doctor and walkaway rates of patients from the ED. ***Where processing times in the greeting area decreased, the walkaway rate decreased.***

#### **ED Median Patient Admission Time (AKA "Boarding Time")**

The median length of stay for admitted patients includes all aspects of moving those patients through the ED. Flow includes the total time from patient arrival and recognition as a patient, through the time to contact with a mid-level or physician provider, to the time of decision regarding disposition, to the time of patient movement out the doors of the ED to the inpatient unit. It is best expressed as a MEDIAN time, as do all time elements in the ED process.

Included within this measure is the time measure ED-2 (NQF 0497), or in CMS language: ***Median time (in minutes) from admit decision time to time of departure from the ED for patients admitted to inpatient status.*** This is the length of boarding of an inpatient in the ED, so most ED leaders call this time interval "boarding time".

In the EDDBA survey, ED leaders were asked to describe what is used to mark the ***admission decision time***. There is no way to completely characterize the results of those answers, but it is apparent that there are wide variations in the definition of this time marker. The definitions used by responding EDs included actions by the ED clerk (placing a bed order), by the ED charge nurse (contacting the bed coordinator), by the admitting physician (placing an admission order), and by the emergency physician (changing status to admitted in the ED information system). There are hundreds of descriptors by the EDDBA responders that defined this time marker.

***It is likely that CMS will need to do further work in concert with ED leaders and the major information technology vendors, to develop a consistent definition for this time marker.*** At the 2014 EDDBA Summit, there were as many answers to this question as there were participants. As such, the EDDBA recommends

that 'decision to admit time' be standardized as the time an admission order is placed. While this is not the same as the time that decision was made, it is measurable and can be standardized across hospitals (7).

*"Boarding Time" Analysis for the year 2014:*

The cohort data is summarized in Table 4, with results for 2014 for each cohort, and comparisons to 2013 and 2012. For 2014, the Admit Time median is 105 minutes, compared to 119 minutes that were reported by hospitals in 2012. The highest number is found in adult serving EDs, and those EDs seeing over 80K patients per year. These EDs have boarding times of around 160 minutes. Since CMS does not report this data point in ED volume cohorts, all hospitals report and are displayed equally. *CMS makes an assumption that all hospitals have the same opportunity to reduce the boarding time of admitted patients in the ED.*

A new analysis, in Table 5 table, allows ED leaders to view each cohort's calculated percentage of time that admitted patients spend in boarding time. Across all EDs, the admitted patient has about 43% of their time in the ED spent after the decision is made to admit.

**Table 4: Boarding Time in the ED Data Survey through 2014**

ED Type	ED Boarding Time, Median Minutes, 2012	ED Boarding Time, Median Minutes, 2013	ED Boarding Time, Median Minutes, 2014
All EDs	119	112	105
Adult EDs	175	161	154
Pediatric EDs	97	96	98
Over 100K volume	161	174	149
80-100K	161	153	168
60-80K	144	131	128
40-60K	122	128	124
20-40K	80	101	96
Under 20K volume	83	73	65

**Table 5: ED Admission and Relative Time Breakdown of Boarding**

ED Type	Admission or Observation, as % of ED Volume	Admitted Patient Median Length of Stay (Minutes)	Median Length of Boarding (Minutes)	Boarding Time as % of Total Time in ED for Admitted Pts.
All EDs	15.6%	289	105	36%
Adult	23.8	355	154	43
Pediatric	10.3	251	98	39
Over 100K volume	20.2	370	149	40
80-100K	21.9	371	168	45
60-80K	18.8	336	128	38
40-60K	18.4	318	124	39
20-40K	15.0	271	96	35
Under 20K volume	10.7	240	65	27

**Left Before Treatment Complete (LBTC)**

A single statistic that compiles the annual number of patients who are recognized by the ED, but leave prior to completion of treatment. This provides the most complete accounting for all patients who leave the ED before they are supposed to, and includes those patients who leave before or after the Medical Screening Exam, those that leave against medical advice (AMA), and those that elope.

*Analysis for the year 2014:*

This number had trended lower across EDDBA hospitals over the prior 8 years. In 2010, the rate dropped below 2% for the first time. In 2014, the number is 2.1%. The walkaway rate is cohort-dependent, with the lowest rate in the low volume EDs. EDs above 40K volume have a walkaway rate above 2.8%. In EDs below 40K volume, the walkaway rate is about 1.7%. Patients in the larger EDs tolerate longer lengths of stay before leaving. There is an association of walkaway rates to the Median Length of Stay, and a lesser association to the volume of patients seen per day.

Pediatric EDs have similar walkaway rates to those general EDs with comparable volumes.

The EDDBA data indicates there is correlation between intake processing of patients, overall flow, and walkaway rates. Despite ED volume and acuity increases that challenge ED providers, improved operations have been evident in many EDs.

**Table 6: ED Processing and Patients Leaving before Treatment Complete (LBTC)**

ED Type	Median Minutes, Door to Provider	Median Length of Stay, Patients Treated and Released	Patients who Left Before Treatment Complete (LBTC)
All EDs	27	146	2.1%
Adult EDs	35	200	3.0%
Pediatric EDs	27	124	1.4%
Over 100K volume	39	222	3.6%
80-100K	32	185	3.1%
60-80K	34	170	2.9%
40-60K	30	163	2.6%
20-40K	25	136	1.9%
Under 20K volume	21	119	1.5%

**Usage Rates of Diagnostic Services, measured as Number of Units of Service per Hundred Patients Seen**

The EDDBA respondents reported on data regarding EKGs obtained; X-ray imaging studies done; and advanced imaging by CT, MRI, and ultrasound performed. The number of procedures done were then divided by the number of patients seen, and the number expressed as procedures per 100 patients seen. It was reported this way *so that it does not unintentionally get interpreted to reflect the percent of patients that had those diagnostic tests performed* (this is how the CDC reports the use of these tests in the NHAMCS study).

It is critical that ED managers compare the operating statistics of their Departments with those of their peers. Higher acuity centers tend to utilize more procedures. Trauma Centers at Level I and Level II tend to do more diagnostic imaging. The statistics on utilization of diagnostic services is one area that

demonstrates the value of working with cohorts. The large EDs utilize many more diagnostic services than smaller EDs, correlating with a higher acuity patient population, and a higher percentage of admissions.

*Analysis for the year 2014:*

Table 7 summarizes the use of diagnostic testing by cohort. There are a large number of diagnostic tests performed in all EDs, but the highest utilization rates are in the busiest EDs. The most dramatic change in the last 10 years is the utilization of EKGs. The number of EKGs and utilized has increased significantly over the past 10 years, from about 17 per 100 patients to about 26. This correlates with a population of patients that are older, and presenting with a variety of symptoms that reflect Acute Coronary Syndromes (ACS). EKGs are obtained about 30 times per 100 patients seen in EDs over 40K volume, and about 22 times in EDs under 40K volume. EKGs utilization is very age dependent, with the test being used about 2 times per 100 patients seen in Pediatric EDs, and about 34 times per 100 patients in Adult EDs.

This is the second year that the EDDBA cohort has reported independently on the use of MRI studies. ED leaders note that the use of MRI scanning has increased, with a current rate of about 1.1 study per 100 patients seen. But some EDs are now applying the MRI much more frequently, and report the use of these scans to the tune of 5 to 10 procedures per 100 patients seen. MRI utilization increases to 1.4 in the high-level trauma centers.

***Critical Differences and Trends from EDDBA and CDC NHAMCS data surveys***

There are two sources of data related to the utilization of diagnostic imaging in the ED over the last decades. The CDC gathers and reports data through the National Hospital Ambulatory Medical Care Survey (NHAMCS). NHAMCS data from the CDC is available from the year 1992 through 2011, the last available year. The Emergency Department Benchmarking Alliance (EDDBA) uses a voluntary data submission process from a large number of EDs.

The NHAMCS data survey measures ***the percent of patients that receive an imaging study***, not taking into account how many imaging procedures are done on any single patient. The NHAMCS report found that 44% of patients received a simple x-ray in 1992. In 2011, that number was only 34%. The NHAMCS report indicates that 2% of patients had CT scanning performed in 1992. This increased to 14% in 2007, and peaked at 16% for 2010 and 2011.

The EDDBA reports on ED utilization of diagnostic imaging as measured in the ***number of procedures performed*** per 100 patients seen. A patient having multiple imaging procedures done (e.g. a hip x-ray and a chest x-ray) would have two procedures in the EDDBA reporting system, but only be credited as one imaging patient in the NHAMCS data. The trending data for NHAMCS and EDDBA data is reported in Table 8.

Utilization of CT scans appears to have peaked, and has decreased during the last two years, based on the EDDBA data surveys over the last 11 years. CT utilization peaked at 22 CT scans per 100 patients between the years 2006 and 2011. Starting in 2012 there is a 10% drop in utilization to 20 CT procedures per 100 patients.

Trauma centers utilize diagnostic imaging to evaluate patients with critical injuries. Within the EDDBA data set, the data has been sorted into separate cohorts of Trauma Centers (Table 9). Pediatric trauma



centers have very different profiles than general EDs, so they are excluded. The three cohorts are Trauma Level I and II centers; Level III and IV centers; and all other EDs.

Table 9 also shows that the higher level centers see patient populations with higher acuity, admission rates, EMS arrival, and longer time for processing. There are also differences in the use of diagnostics commensurate with the trauma level.

CT scans are used more frequently in Level I and II trauma centers than in lower level centers. There are 24 CT procedures per 100 patients in Level I and II trauma centers, and around 19 procedures in lower level and non-trauma centers. ED leaders should be aware of the differences, and when called upon to study their utilization, should compare their experience to cohorts at a similar level of trauma designation and pediatric mix.

**Table 7: Utilization of Diagnostic Testing by Cohort**

ED Type	EKGs done per 100 patients	Simple Xray Procedures per 100 patients	CT Procedures per 100 patients	MRI Procedures per 100 patients	Ultrasound Procedures per 100 patients
<i>All EDs</i>	26	48	20	1.1	5.4
Adult	34	51	28	1.5	1.5
Pediatric	2	28	4	0.6	4.3
Over 100K volume	31	49	22	1.4	6.7
80-100K	28	54	24	2.2	9.8
60-80K	28	52	22	1.4	6.7
40-60K	30	51	22	1.4	6.6
20-40K	25	47	20	1.0	5.1
Under 20K volume	22	42	17	0.6	3.1
Freestanding EDs, Urgent Care Centers	16	41	13	0.7	4.2

**Table 8: Diagnostic Testing Trend Data**

Year	EKGs done per 100 patients	Simple Xray Procedures per 100 patients	CT Procedures per 100 patients	CT Utilization by CDC NHAMCS Data, % of ED visits with CT performed
2014	26	48	20	Not Available
2013	26	46	20	Not available
2012	26	48	20	Not available
2011	26	48	22	15.8%
2010	23	44	22	16.4%
2009	23	43	21	14.3%
2008	22	44	22	14.6%
2007	20	48	22	13.9%
2006	19	48	22	11.6%
2005	18	48	18	10.7%
2004	17	49	NA	9.3%
<b>1992 NHAMCS</b>	13	42	2.4%	2.4%
<b>2011 NHAMCS</b>	19	34	15.8%	

**Table 9: Diagnostic Testing Comparison of Trauma and Non-Trauma Centers**

Year	Level I and II	Level III and IV	No Trauma Center
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	Trauma Centers, not Pediatric	Trauma Centers	Designation
Number of Hospitals	140	149	816
High Acuity %	67%	66%	58%
Admit %	22%	15%	16%
Transfers out %	1.0%	1.4%	1.5%
EMS Arrival %	22%	16%	15%
Median LOS (mins)	227	166	173
LBTC %	3.1%	2.2%	2.0%
EKGs per 100	30	24	27
Xrays per 100	46	41	52
CT per 100	24	19	20
MRI per 100	1.4	0.5	1.4

#### Percentage of Hospital Admissions that are Processed thru the ED

This number is calculated from the number of patients that are placed in the status of "admitted" or "observation" status in a hospital, looking at the percentage that are processed in through the ED.

#### Analysis for the year 2014:

Over 64% of hospital admissions are processed through the ED, continuing an 11 year trend in this survey. Data for cohorts is presented in Table 10. It would indicate that the general medical staffs of the hospitals are utilizing the ED to provide intensive diagnostic and treatment services, and may feel that the ED is the most effective way to process their patients into the inpatient environment.

Consistently through the 11 years of this survey, the smaller hospitals have the highest utilization for processing in patients to the inpatient units. The small community EDs are processing at least 66% of hospital admissions, and a number of small EDs are managing over 80% of admissions. Combined with the longer ED lengths of stay for admitted patients, ED leaders can appreciate the difficulty of managing more admitted patients for longer periods of time. This challenges the ED staff to find open space for incoming patients, and leads to the difficulty keeping walkaway rates from climbing.

**Table 10: ED Admissions and Percent of Hospital Inpatients Processed through the ED**

ED Type	Admission Rate	% of Hospital Admissions Processed thru ED
All EDs	15.6%	64%
Adult	23.8%	61%
Pediatric	1.3%	61%
Over 100K volume	20.2%	66%
80-100K	21.9%	60%
60-80K	18.8%	60%
40-60K	18.4%	66%
20-40K	15.0%	66%
Under 20K volume	10.7%	64%

#### Design Elements for Renovation or New ED Design

First concern: Square Footage and Visits per Square Foot

The square footage contained within the Emergency Department. Most EDs report a gross square footage number as approximated by the hospital facility managers. The Visits per Square Foot is then calculated by dividing the annual visits by the square footage.

*Analysis for the year 2014:*

It is a crude proxy for how "space compact" an ED is. It has not been reported in any available literature. There is currently no basis to compare these numbers, but they are of use for ED leaders to identify those EDs that might have unusually small footprints.

Most EDs are sized so that they see 3 to 3.5 visits per square foot. Small EDs generally have a relatively larger size. For those EDs that are very small relative to volume, the space compression can result in higher walkaway rates.

*Second concern: ED Beds and Care Spaces and Visits per Care Space*

The number of "beds" as reported as being contained within the Emergency Department, and in some states that is a number that is licensed. Because many EDs now designate spots for care that are not beds, the more useful term is patient care spaces. The definition will include all spots, including chairs and vertical treatment areas used routinely for patient care. Visits per patient care space is calculated by dividing the annual patient volume by the number of patient care spaces.

*Analysis for the year 2014:*

Most EDs are designed to see 1300 to 1700 visits per patient care space. Small EDs generally have a relatively smaller number of patients seen per bed, or care space. Pediatric EDs see patients more quickly, so have relatively higher utilization, at about 1,824 visits per care space. For those EDs that have high numbers of visits per bed, the result is generally higher walkaway rates. For those EDs that saw more than 1,900 visits per space, the walkaway rate jumped to over 3%

**Table 11: ED Design Elements**

ED Type	Visits Per Patient Care Space	Visits per Square Foot
Adult ED	1,347	3.7
Pediatric ED	1,824	3.5
Over 100K volume	1,435	3.4
80-100K	1,585	3.3
60-80K	1,542	3.0
40-60K	1,547	3.4
20-40K	1,584	3.0
Under 20K volume	1,236	2.5
Freestanding ED, Urgent Care	1,355	2.4

**Application of Design Data for ED Leaders**

*Many hospital CEOs will insist that the ED be built for 2,000 encounters per bed because that rate is a known fact. Like many "facts" about the ED, this one is wrong.*

Experienced emergency providers realize that an ED with an unusually small footprint is noisy, is cramped, has relatively little privacy, and has little room for families. It is possible that sophisticated analysis would show that these EDs have higher infection rates, lower rates of staff satisfaction due to cramped workspaces and constant noise, and less need for sophisticated staff communication systems. EDs that have a very low number of visits per square foot need sophisticated staff communication systems, Segway transporters for the physicians, and monitor systems that will help patients or families not get lost.

There are many areas that now design their space and process to essentially eliminate triage process and space. These new processes use a greeting model that is expanded beyond traditional nurse-based triage, including initial treatment decision-making. In EDs over 40,000 volume, there is a growing use of team triage models, which feature emergency physicians or advanced practice providers (APPs). The higher the volume, the more likely it is that the ED is using either physicians or APPs in the greeting model.

There are important decisions that must be made about the design of functional areas within or around the ED. Many EDs have patient volumes and needs that justify the development of fast-track areas for low-acuity patients, trauma-receiving areas, mental health suites for safe management of those patients, and clinical decision or observation units. Most EDs that see more than 40,000 patients per year have one or more of these functional areas. Smaller-volume EDs typically don't have the need for designated service areas.

Emergency leaders must be able to use and understand the elements of ED design that provide an environment for high-quality emergency care and have comparison data available for their peers. This will accommodate higher patient volumes, acuity, and management of patients through the diagnostic and treatment phase of their emergency care.

#### **ED Descriptive Data**

ED leaders are facing a number of new operating challenges, so a couple descriptive elements were included in this year's survey.

The **"Location and Type"** for all reporting EDs included the geographic setting, status as a training center, and status as a trauma center. The results are presented in table form, by cohort.

**"Order Entry"** method was reported for about most EDs in 2014. Of the group that has reported, over 70% are utilizing computerized physician order entry (CPOE). The other EDs use clerk or nurse order entry. There has been a remarkable adoption of CPOE over the last 5 years in the ED.

The majority of EDs that reported the **"Documentation system"** report the use of computerized documentation systems. That has increased to about 60% of EDs. Of note is the increased use of ED scribes, which are now present in about 15% of reporting EDs. About 8% use some form of dictation, about 9% use some form of templates, and 12% have handwritten charts.

The **"Greeting Model"** for almost all reporting EDs includes nurse triage. In EDs over 40K volume, there is a growing use of team triage models. In the over 40K EDs that reported, about 16% are using a physician greeting model, and a slightly lower percentage use physician extenders. There are a number of EDs that report "pull till full" greeting models.

### Staffing Ratios

This data element is reported for a significant number of EDs for 2014. It is summarized by cohort in Table 12.

The data requested is the scheduled number of work hours per day of nurses, techs, clerks, physicians, and mid-level providers.

Nurse Staffing ratios indicate there are about 0.62 patients managed per nurse staffed hour per day.

Combining tech and clerk hours, the service ratio averaged about 1.5 staffed hours per patient seen.

Attending Physician staffing averaged 2.4 patients per staffed physician hour per day. When attending physician coverage was supplemented by Advanced Practice Providers (APPs), and the APP hours were given a factor of 0.5 the number of physician hours, the staffing ratio averaged 3.4 patients per staffed hour per day.

**Table 12: ED Staffing Ratios**

ED Type	Patients Seen per Staffed Hour Nursing	Patients Seen per Staffed Hour Tech + Clerk	Patients Seen per Staffed Hour Physician	Patients Seen per Staffed Hour Physician + APP
<i>All EDs</i>	0.62	1.5	2.4	3.4
Adult	0.56	1.2	2.7	3.7
Pediatric	0.62	1.9	2.4	3.6
Over 100K volume	0.64	1.2	2.9	4.0
80-100K	0.58	1.0	3.1	3.9
60-80K	0.62	1.3	3.1	3.9
40-60K	0.63	1.3	2.9	3.7
20-40K	0.66	1.9	2.7	3.5
Under 20K volume	0.56	1.5	1.4	2.4
Freestanding EDs and Urgent Care	0.64	1.6	1.9	3.1

### Limitations of the Data and the Analysis

- Not all sites are able to report all data elements.
- Definitions are difficult to standardize across sites, especially with the newer members of the EDDBA added each year. The classifications used in this study are still not able to be uniformly collected in all EDs, and ED information systems are not yet built to use uniform definitions.
- The data has trends that have been identified by classifying hospitals by certain characteristics. Unfortunately, there are no uniform definitions that characterize EDs. The EDDBA developed its own characteristics and then grouped the hospitals according to those classifications.

### The Value of the EDBA Survey Process

There is value to timely data collection and sharing within an individual ED, and between EDs. Managing EDs requires leaders to have useful, well-defined data and a context under which to understand and utilize the data. The EDBA survey process has assimilated data from a large number of ED visits to create a picture of the ED practice in America, and allow ED leaders to more effectively manage the Department. The EDBA has developed definitions, collected the data, and put the results in context.

There is not an extensive literature on American ED operations. The process used to develop performance measure definitions, local collection and analysis, and reporting of results for comparison with like operations is a process that is used extensively in other service industries. ED managers are embracing that same process in emergency department administration.

### Future Applications

This survey is used to identify trends in populations served by Emergency Departments, and changes in service delivery. EDBA leaders utilize the survey results to improve service to future ED patients. It is also desirable to establish mechanisms to further clarify the definitions, and provide useful cohorts for ED managers to compare and improve operations. With years of data for analysis, effective ED processes can be identified, and a system for continuous process improvement can be initiated by a universe of American EDs.

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# EMERGENCY DEPARTMENT BENCHMARKING ALLIANCE

Built by emergency department leaders for emergency department leaders

## Emergency Department Benchmarking Alliance 2014 Data Report

	PPD	% CRT Acuity	Under Age 2	Peds %	Admit %	Transfer %	EMS Arrival	ENS Arrival	Median LOS	LOS Treat & Release	LOS Final Track	LOS Admit	Boarding Time	LRTC	Door to Bed	Door to Doc	EDG - Yrly CT per 100	MRG per 100	LOS per 100	% Hosp Admits per ED	Wallo per Foot	Bed	Wallo per Space	
<b>Total All EDs</b>	107	68%	2.4%	15.3%	15.8%	1.0%	38%	38%	172	147	112	296	105	3.1%	16	27	25	46	20	5	64%	3.0	28	1,487
Over 100K EDs	313	63%	2.7%	14.7%	26.7%	0.9%	21%	42%	222	188	111	370	149	3.6%	22	30	31	49	22	7	64%	3.4	72	1,032
80 to 100K EDs	241	60%	2.0%	12.5%	21.8%	0.9%	21%	43%	227	185	148	371	169	3.1%	17	32	28	54	24	10	69%	3.3	57	1,262
60 to 80K EDs	187	61%	2.8%	14.7%	19.0%	1.2%	19%	42%	207	170	115	338	128	2.8%	20	30	28	52	22	7	60%	2.9	45	1,339
40 to 60K EDs	135	62%	1.8%	12.0%	16.5%	1.0%	19%	40%	186	163	113	377	124	2.6%	18	30	30	51	22	7	67%	3.4	32	1,543
20 to 40K EDs	80	60%	2.7%	16.0%	11.3%	1.0%	15%	30%	160	127	105	271	96	1.9%	15	25	25	47	20	5	66%	3	20	1,578
Under 20K EDs	33	59%	2.1%	16.5%	11.0%	1.0%	12%	32%	137	121	116	228	82	1.6%	13	22	22	41	17	3	63%	2.6	10	1,262
Pediatric EDs	114	45%	37.8%	67.0%	18.3%	0.6%	8%	29%	108	124	102	251	98	1.4%	15	27	3	28	6	4	39%	3.5	23	1,024
Adult, Specialty EDs	167	72%	0.0%	4.0%	23.8%	1.1%	20%	47%	239	260	150	355	154	3.0%	19	35	34	51	28	8	61%	3.7	42	1,347
Urgent Care, Freestanding EDs	48	51%	2.0%	14.0%	6.5%	1.5%	6%	16%	219	199	80	285	99	1.2%	10	21	16	41	12	4	60%	2.7	15	1,404

Total All Eds	Total Volume	FWD	In Crd	Unit Age	Peak H	Adm H	Transfer H	CNS	SAS	Institution	LOS	LOS Trend	LOS Post	LOS	Scheduling	LIFE	Over 100		Over 150	Over 200	Over 250	Over 300	Over 350	Over 400	Over 450	Over 500	Over 550	Over 600	Over 650	Over 700	Over 750	Over 800	Over 850	Over 900	Over 950	Over 1000				
																	100	150																						
Total All Eds	88,832,532	107	69%	2.4%	18.2%	18.0%	2.0%	16%	30%	173	147	132	200	205	2.2%	18	27	26	40	20	3.2	5	6%	3.0	28	2,427	805													
2014 in 1000 Eds	44,819,270	107	65%	4.8%	18.0%	16.5%	2.7%	17%	35%	172	147	132	200	115	2.7%	17	30	26	46	20	3.3	4	6%	3.0	27	1,553	312													
2013 in 1000 Eds	39,948,319	106	64%	4.9%	21.5%	16.5%	2.0%	16%	30%	171	147	143	207	119	2.2%	18	32	26	48	20	1.1		6%	3.1	27	1,597	119													
2011 in 833 Eds	29,917,742		63%	4.7%	20.8%	17.0%	1.8%	17%	37%	167	146	110	205		2.0%	16	33	23	44	21			6%	3.2	27	1,610	100													
2010 in 503 Eds	20,262,001		61%	5.1%	23.2%	18.0%	1.7%	16%	43%	167	146	105	207		1.4%	18	35	23	43	21			6%	3.7	27	1,615	100													
2009 in 411 Eds	16,016,157		64%	5.1%	22.2%	17.0%	1.7%	16%	43%	167	146	105	207		1.4%	25	41	22	48	21			6%	3.7	27	1,615	100													
2008 in 345 Eds	6,463,122		67%	5.1%	21.5%	16.0%	1.7%	16%	43%	167	146	105	207		1.4%	25	41	22	48	21			6%	3.7	27	1,615	100													
2007 in 146 Eds	5,100,010		62%	22.3%	16.5%	1.6%	17%	41%	109	109	109	109	109		1.0%	18	48	22					6%																	
2006 in 120 Eds	4,870,789		59%	20.5%	16.7%	1.5%	17%	39%	108	108	108	108	108		1.0%	20	48	22					6%																	
2005 in 96 Eds	3,656,555		64%	20.3%	19.7%	1.4%	16%	35%	175	149					1.0%	18	48	22					6%																	
2004 in 59 Eds	3,114,943		60%	22.5%	16.3%	1.4%	15%	38%	103	156					1.8%	17	49	0					6%																	
<b>Over 1000 Eds</b>																																								
2014 in 80 Eds	4,226,854	213	63%	2.7%	14.7%	20.7%	0.8%	23%	42%	222	188	211	479	149	3.8%	33	39	31	43	32	2.4	2	6%	3.4	37	1,628	189													
2013 in 37 Eds	4,190,888	209	67%	4.5%	19.3%	18.7%	0.9%	22%	40%	241	399	140	414	174	4.1%	27	47	31	46	33	1.3	7	6%	3.4	37	1,547	164													
2012 results	3,530,473	311	66%	5.3%	21.6%	19.1%	0.8%	22%	39%	238	399	137	401	161	3.5%	26	53	31	42	18	1.0		6%	4.2	37	1,448	161													
2011 results	18	315	66%	5.7%	20.0%	21.9%	0.7%	22%	47%	217	187				2.4%	23	36	30	49	23			6%	3.9	38	1,441	150													
<b>80 to 1000 Eds</b>																																								
2014 in 40 Eds	4,130,231	241	69%	5.4%	12.5%	21.8%	0.9%	21%	41%	227	185	140	377	150	3.2%	17	32	28	54	24	2.2	10	5%	3.4	37	1,606	189													
2013 in 47 Eds	4,130,434	241	69%	5.4%	12.5%	21.8%	0.9%	21%	41%	227	185	140	377	150	3.2%	17	32	28	54	24	2.2	10	5%	3.4	37	1,606	189													
2012 results	3,940,000	245	68%	6.4%	23.2%	20.8%	0.8%	18%	45%	221	187	167	362	161	3.2%	24	41	27	48	22	1.0		6%	3.4	37	1,574	163													
2011 results	28	244	65%	5.3%	18.4%	20.0%	1.1%	21%	44%	218	187	103	361	161	3.4%	21	38	26	47	22			6%	3.2	38	1,606	193													
2010 results	23	273	64%	5.8%	21.0%	20.6%	1.1%	21%	44%	217	187	121	374		3.5%	20	40	25	44	24			6%	3.4	38	1,550	175													
2009 results	24	274	64%	6.1%	22.9%	21.0%	1.1%	21%	45%	221	187	122	377		3.6%	25	41	27	41	23			6%	3.7	37	1,511														
<b>60 to 800 Eds</b>																																								
2014 in 116 Eds	2,722,286	167	61%	2.8%	14.7%	18.0%	1.2%	18%	42%	201	174	155	306	120	2.8%	28	29	28	52	22	1.5	7	6%	2.9	45	1,530	128													
2013 in 126 Eds	2,722,286	167	61%	2.8%	14.7%	18.0%	1.2%	18%	42%	201	174	155	306	120	2.8%	28	29	28	52	22	1.5	7	6%	2.9	45	1,530	128													
2012 results	8,040,306	188	66%	5.0%	21.9%	19.4%	1.2%	19%	42%	201	174	155	306	120	2.8%	28	29	28	52	22	1.5	7	6%	2.9	45	1,530	128													
2011 results	80	189	67%	4.9%	19.0%	20.4%	1.2%	19%	44%	202	173	127	341		2.8%	21	34	31	51	25			6%	2.8	46	1,500	178													
2010 results	55	192	64%	5.2%	20.3%	20.5%	1.0%	20%	47%	191	167	125	327		2.7%	20	41	27	45	25			6%	2.9	45	1,550	160													
2009 results	35	180	60%	5.3%	22.0%	20.3%	1.0%	18%	44%	194	144	182	328		2.8%	24	42	25	44	21			6%	3.8	41	1,614														
2008 results	21	211	63%	20.8%	19.9%	0.9%	20%	48%	235	215	387				4.0%	28	44	25	48	23			6%																	
2007 results	39	222	60%	18.0%	21.3%	0.6%	20%	46%	257	234	414				4.7%	24	44	25	48	23			6%																	
2006 results	15	218	63%	18.6%	21.7%	0.5%	20%	47%	246	211	415				4.1%	22	51	25					6%																	
2005 results	13	222	57%	22.2%	22.4%	0.5%	20%	46%	230	181	335				3.1%	21	48	22					6%																	
2004 results	0	227	51%	23.2%	23.5%	0.4%	20%	41%	240	191	349				2.7%	22	50	0					6%																	
<b>40 to 600 Eds</b>																																								
2014 in 180 Eds	5,699,816	188	62%	1.8%	12.0%	18.5%	1.2%	18%	40%	195	169	139	347	134	2.5%	18	20	20	51	27	1.5	7	6%	3.4	32	1,545	124													
2013 in 244 Eds	12,040,822	135	67%	4.2%	12.7%	19.7%	1.5%	19%	44%	181	167	125	315	128	2.6%	10	14	30	46	24	1.7	5	6%	3.1	33	1,578	128													
2012 results	10,963,539	133	67%	4.0%	12.3%	19.7%	1.5%	19%	44%	187	150	117	334	144	2.8%	20	11	30	50	24	1.2		6%	3.3	33	1,659	132													
2011 results	105	135	60%	4.4%	15.5%	19.4%	1.4%	18%	44%	187	157	106	303		2.3%	18	33	16	50	23			6%	3.3	33	1,613	98													
2010 results	136	139	65%	4.5%	16.2%	19.6%</																																		



**Criterion 1120.130: Financial Viability Waiver  
"A" Bond Rating**

Financing will be obtained by the applicant University of Wisconsin Hospitals and Clinic authority. This applicant has an AA- Bond Rating from S&P Global Ratings as reflected in the attached letter dated February 28, 2017. SwedishAmerican Hospital has an A+ Bond Rating from S&P Global Ratings (ratings letter also attached).

# S&P Global Ratings

130 East Randolph Street  
Suite 2900  
Chicago, IL 60601  
tel 312-233-7000  
reference no.: 40391602

February 28, 2017

Swedish American Hospital  
1313 East State Street  
Rockford, IL 61104  
Attention: Mr. Robert Flannery, Senior Vice President and Chief Financial Officer

**Re: *Illinois Finance Authority (Swedish American Hospital), Illinois, Fixed Rate Bonds***

Dear Mr. Flannery:

S&P Global Ratings has reviewed the rating on the above-listed obligations. Based on our review, we have raised our credit rating from "A" to "A+" and changed the outlook to stable from positive. A copy of the rationale supporting the rating and outlook is enclosed.

This letter constitutes S&P Global Ratings' permission for you to disseminate the above rating to interested parties in accordance with applicable laws and regulations. However, permission for such dissemination (other than to professional advisors bound by appropriate confidentiality arrangements) will become effective only after we have released the rating on [standardandpoors.com](http://standardandpoors.com). Any dissemination on any Website by you or your agents shall include the full analysis for the rating, including any updates, where applicable.

To maintain the rating, S&P Global Ratings must receive all relevant financial and other information, including notice of material changes to financial and other information provided to us and in relevant documents, as soon as such information is available. Relevant financial and other information includes, but is not limited to, information about direct bank loans and debt and debt-like instruments issued to, or entered into with, financial institutions, insurance companies and/or other entities, whether or not disclosure of such information would be required under S.E.C. Rule 15c2-12. You understand that S&P Global Ratings relies on you and your agents and advisors for the accuracy, timeliness and completeness of the information submitted in connection with the rating and the continued flow of material information as part of the surveillance process. Please send all information via electronic delivery to [pubfin\\_statelocalgovt@spglobal.com](mailto:pubfin_statelocalgovt@spglobal.com). If SEC rule 17g-5 is applicable, you may post such information on the appropriate website. For any information not available in electronic format or posted on the applicable website,

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S&P Global Ratings  
Public Finance Department  
55 Water Street

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New York, NY 10041-0003

The rating is subject to the Terms and Conditions, if any, attached to the Engagement Letter applicable to the rating. In the absence of such Engagement Letter and Terms and Conditions, the rating is subject to the attached Terms and Conditions. The applicable Terms and Conditions are incorporated herein by reference.

S&P Global Ratings is pleased to have the opportunity to provide its rating opinion. For more information please visit our website at [www.standardandpoors.com](http://www.standardandpoors.com). If you have any questions, please contact us. Thank you for choosing S&P Global Ratings.

Sincerely yours,

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# S&P Global Ratings

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# S&P Global Ratings

130 East Randolph Street  
Suite 2900  
Chicago, IL 60601  
tel 312-233-7000  
reference no.: 40413747

February 28, 2017

University of Wisconsin Hospital and Clinics  
600 Highland Avenue, Suite H5/803  
Madison, WI 53792  
Attention: Mr. Robert Flannery, Senior Vice President and Chief Financial Officer

Re: *University Of Wisconsin Hospital & Clinics Authority, Wisconsin, Hospital Revenue & Refunding Bonds*

Dear Mr. Flannery:

S&P Global Ratings has reviewed the rating on the above-listed obligations. Based on our review, we have raised our credit rating from "A+" to "AA-" and changed the outlook to stable from positive. A copy of the rationale supporting the rating and outlook is enclosed.

This letter constitutes S&P Global Ratings' permission for you to disseminate the above rating to interested parties in accordance with applicable laws and regulations. However, permission for such dissemination (other than to professional advisors bound by appropriate confidentiality arrangements) will become effective only after we have released the rating on [standardandpoors.com](http://standardandpoors.com). Any dissemination on any Website by you or your agents shall include the full analysis for the rating, including any updates, where applicable.

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PF Ratings U.S. (4/28/16)

Attachment 35

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55 Water Street  
New York, NY 10041-0003

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# S&P Global Ratings

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**Criterion 1120.140: Economic Feasibility**  
**Conditions of Debt Financing**

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

*Patricia Dewane*

Patricia Dewane  
Vice-President of Finance and Treasurer, SwedishAmerican Hospital

Subscribed and sworn to before me on this  
10<sup>th</sup> day of April, 2017.

*Gina Boettcher*

Notary Public



**Criterion 1120.140: Economic Feasibility**  
Project Operating Costs and  
Total Effect of the Project on Capital Costs

**Projected Operating Costs:** The projected direct annual operating costs by the second year following project completion is \$1,832 per equivalent patient day.

**Total Effect of the Project on Operating Costs:** The total projected annual capital costs for the first full year at target utilization (which is anticipated to be within two years following project completion) is \$206 per equivalent patient day.

## Charity Care Information

<b>SWEDISHAMERICAN HOSPITAL</b>			
	<b>Year 2014</b>	<b>Year 2015</b>	<b>Year 2016</b>
<b>Net Patient Revenue</b>	\$ 384,030,000	\$ 405,907,000	\$ 420,610,000
<b>Amount of Charity Care</b>	\$ 40,891,730	\$ 21,533,725	\$ 14,959,155
<b>Cost of Charity Care</b>	\$ 8,666,418	\$ 4,077,946	\$ 2,486,713

NOTE: 2015 Audit covered 13 months due to change in year end, net patient revenue converted to 12 months.

<b>SWEDISHAMERICAN MEDICAL CENTER/BELVIDERE</b>			
	<b>Year 2014</b>	<b>Year 2015</b>	<b>Year 2016</b>
<b>Net Patient Revenue</b>	\$ 13,681,000	\$ 14,435,000	\$ 13,992,000
<b>Amount of Charity Care</b>	\$ 2,420,156	\$ 1,068,069	\$ 850,050
<b>Cost of Charity Care</b>	\$ 424,991	\$ 178,687	\$ 139,898

NOTE: 2015 Audit covered 13 months due to change in year end, net patient revenue converted to 12 months.

<b>UNIVERSITY OF WISCONSIN HOSPITALS AND CLINICS AUTHORITY</b>			
	<b>Year 2014</b>	<b>Year 2015</b>	<b>Year 2016</b>
<b>Net Patient Revenue</b>	\$ 1,773,816,238	\$ 1,949,553,501	\$ 2,120,527,956
<b>Amount of Charity Care</b>	\$ 87,252,117	\$ 59,772,212	\$ 56,472,261
<b>Cost of Charity Care</b>	\$ 35,570,620	\$ 23,659,531	\$ 21,222,433