

18-015

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

[ORIGINAL]

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

RECEIVED

This Section must be completed for all projects.

MAY 11 2018

Facility/Project Identification

Facility Name: Edward Hospital	HEALTH FACILITIES & SERVICES REVIEW BOARD	
Street Address: 801 S. Washington Street		
City and Zip Code: Naperville 60540		
County: Dupage	Health Service Area: VII	Health Planning Area: A-05

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

Exact Legal Name: Edward Hospital
Street Address: 801 S. Washington Street
City and Zip Code: Naperville 60540
Name of Registered Agent: Chris Mollet
Registered Agent Street Address: 801 S. Washington Street
Registered Agent City and Zip Code: Naperville 60540
Name of Chief Executive Officer: Bill Kottmann
CEO Street Address: 801 S. Washington Street
CEO City and Zip Code: Naperville 60540
CEO Telephone Number: 630-527-7228

Type of Ownership of Applicants

- | | |
|--|--|
| ☒ Non-profit Corporation | ☐ Partnership |
| ☐ For-profit Corporation | ☐ Governmental |
| ☐ Limited Liability Company | ☐ Sole Proprietorship |
| ☐ Other | |
- Corporations and limited liability companies must provide an Illinois certificate of good standing.
 - Partnerships must provide the name of the state in which 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: Kari Runge
Title: System Director, Business Analytics & Data Governance
Company Name: Edward-Elmhurst Health
Address: 801 S. Washington St. Naperville, IL 60540
Telephone Number: 630-527-3917
E-mail Address: Kari.Runge@EEHealth.org
Fax Number: 630-527-3963

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

Name: Annette Kenney
Title: System Executive Vice President, Chief Strategy & Marketing Officer
Company Name: Edward-Elmhurst Health
Address: 801 S. Washington St. Naperville, IL 60540
Telephone Number: 630-527-5803
E-mail Address: Annette.Kenney@EEHealth.org
Fax Number: 630-527-3702

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: Kari Runge
Title: System Director, Business Analytics & Data Governance
Company Name: Edward-Elmhurst Health
Address: 801 S. Washington St. Naperville, IL 60540
Telephone Number: 630-527-3917
E-mail Address: Kari.Runge@EEHealth.org
Fax Number: 630-527-3963

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Edward Hospital
Address of Site Owner: 801 S. Washington St. Naperville, IL 60540
Street Address or Legal Description of the Site: 801 S. Washington St. Naperville, IL 60540
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.
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

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

Exact Legal Name: Edward Hospital	
Address: 801 S. Washington St. Naperville, IL 60540	
☒ Non-profit Corporation	☐ Partnership
☐ For-profit Corporation	☐ Governmental
☐ Limited Liability Company	☐ Sole Proprietorship
☐ Other	☐
- o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. - o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. - o Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	
APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

Organizational Relationships

Provide (for each 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 or www.illinoisfloodmaps.org. **This map must be in a readable format.** In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #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.

Edward Hospital is proposing to construct a 3-story building that will be connected to the existing Education Center and the northeast bed tower. The proposed building will house physician office space, patient education, administrative offices, a conference room, support space and a chronic care center. The support space includes a physician lounge and a mail room that will need to be relocated from the Education Center to allow for a public corridor that will connect the lobby of the Education Center to the ground floor of the proposed building.

The 25,024 GSF of proposed physician office space will be leased to Cardiology and Cardiovascular specialty groups that currently have multi-year leases with Edward-Elmhurst Healthcare. Their existing office space is currently located on the 4th floor of the northeast bed tower.

This project includes the renovation of the 4th floor of the northeast bed tower when the physician offices are relocated to the proposed new building. This floor will be converted into a 12-bed intensive care unit and a 12-bed observation unit.

This project is non-substantive because it does not involve establishment of a new facility, it is not a discontinuation or establishment of a category of service and it is less than 20 beds. Observation is not a category of service and therefore the 12 proposed observation beds are not applicable.

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.

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs	\$163,602	\$564,798	\$728,400
Site Survey and Soil Investigation	\$10,368	\$32,832	\$43,200
Site Preparation	\$390,858	\$1,237,719	\$1,628,577
Off Site Work	\$0	\$0	\$0
New Construction Contracts	\$1,744,970	\$21,370,479	\$23,115,449
Modernization Contracts	\$5,548,665	\$3,809,191	\$9,357,856
Contingencies	\$761,582	\$2,629,193	\$3,390,775
Architectural/Engineering Fees	\$472,517	\$1,938,190	\$2,410,707
Consulting and Other Fees	\$168,145	\$580,483	\$748,628
Movable or Other Equipment (not in construction contracts)	\$2,514,307	\$1,816,403	\$4,330,710
Bond Issuance Expense (project related)	\$0	\$0	\$0
Net Interest Expense During Construction (project related)	\$0	\$0	\$0
Fair Market Value of Leased Space or Equipment	\$0	\$0	\$0
Other Costs To Be Capitalized	\$2,961,316	\$1,974,212	\$4,935,528
Acquisition of Building or Other Property (excluding land)	\$0	\$0	\$0
TOTAL USES OF FUNDS	\$14,736,330	\$35,953,500	\$50,689,830
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	\$14,736,330	\$35,953,500	\$50,689,830
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	\$14,736,330	\$35,953,500	\$50,689,830
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Related Project Costs

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

Land acquisition is related to project ☐ Yes ☒ No

Purchase Price: \$ _____

Fair Market Value: \$ _____

The project involves the establishment of a new facility or a new category of service

☐ Yes ☒ No

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

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

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.
E-011-18

Indicate the stage of the project's architectural drawings:

☐ None or not applicable

☐ Preliminary

☒ Schematics

☐ Final Working

Anticipated project completion date (refer to Part 1130.140): March 2021

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

☐ Purchase orders, leases or contracts pertaining to the project have been executed. ☐ 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

☒ Financial Commitment will occur after permit issuance.

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

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable:

☒ Cancer Registry

☒ APORS

☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted

☒ All reports regarding outstanding permits

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

Cost Space Requirements

Provide in the following format, the **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
REVIEWABLE							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							

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

Facility Bed Capacity and Utilization

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert 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.

FACILITY NAME: Edward Hospital			CITY: Naperville		
REPORTING PERIOD DATES: From: January 2017 to: December 2017					
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	235*	14,755	66,426	0	235*
Obstetrics	38	3,433	9,289	0	38
Pediatrics	7	1,207	2,166	0	7
Intensive Care	49	3,516	12,421	+12	61
Comprehensive Physical Rehabilitation	0	0	0	0	0
Acute/Chronic Mental Illness	0	0	0	0	0
Neonatal Intensive Care	12	322	4,317	0	12
General Long Term Care	0	0	0	0	0
Specialized Long Term Care	0	0	0	0	0
Long Term Acute Care	0	0	0	0	0
Other (identify)	0	0	0	0	0
TOTALS:	341	23,233	94,619	+12	361

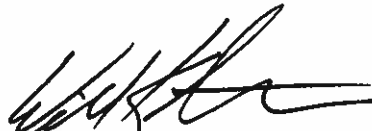
*Medical/Surgical bed inventory increased to 243 on March 19, 2018

CERTIFICATION

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

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

This Application is filed on the behalf of Edward 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



SIGNATURE

William Kottmann
PRINTED NAME

Jeffrey Friant
PRINTED NAME

President/CEO, Edward Hospital
PRINTED TITLE

Vice President, Finance
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 7th day of May, 2018

Notarization:

Subscribed and sworn to before me
this 7th day of May, 2018



Signature of Notary

Seal

OFFICIAL SEAL
MARY ANNE MARKER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES: 07/31/20

*Insert the EXACT legal name of the applicant



Signature of Notary

Seal

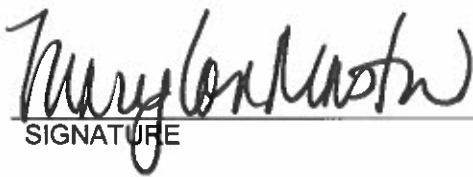
OFFICIAL SEAL
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CERTIFICATION

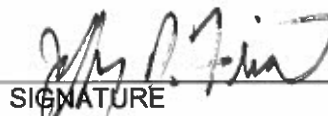
The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

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

This Application is filed on the behalf of Edward Elmhurst Healthcare in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application 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

Mary Lou Mastro
PRINTED NAME


SIGNATURE

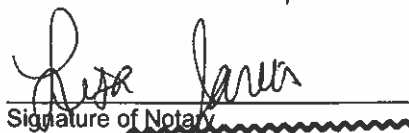
Jeffrey Friant
PRINTED NAME

President/CEO, Edward-Elmhurst Health
PRINTED TITLE

Vice President, Finance Edward-Elmhurst Health
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 9 day of MAY


Signature of Notary

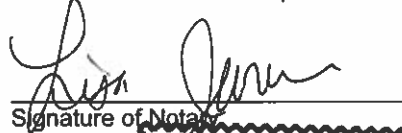
Seal



*Insert the EXACT legal name of the applicant

Notarization:

Subscribed and sworn to before me
this 9 day of MAY


Signature of Notary

Seal



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

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

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	MET STANDARD?
YEAR 1					
YEAR 2					

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

UNFINISHED OR SHELL SPACE: NOT APPLICABLE

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: NOT APPLICABLE

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

- 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:
- Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds
☐ Medical/Surgical		
☐ Obstetric		
☐ Pediatric		
☒ Intensive Care	49	61

- 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

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.530(e)(4) - Occupancy			X
1110.530(f) - Staffing Availability	X	X	
1110.530(g) - Performance Requirements	X	X	X
1110.530(h) - Assurances	X	X	
APPEND DOCUMENTATION AS <u>ATTACHMENT 19</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

1. Applicants proposing to establish, expand and/or modernize Clinical Service Areas Other than categories of service must submit the following information:

Service	# Existing Key Rooms	# Proposed Key Rooms
☒ Adult Observation Unit	0	12
☒ Chronic Care Clinic	4	9
☐		

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

APPEND DOCUMENTATION AS ATTACHMENT 31, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

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

VII. 1120.120 - AVAILABILITY OF FUNDS **NOT APPLICABLE (A Bond Rating)**

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

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

_____ _____ _____	5) For any option to lease, a copy of the option, including all terms and conditions. e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent; f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt; g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
	TOTAL FUNDS AVAILABLE
APPEND DOCUMENTATION AS ATTACHMENT 34, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

SECTION VIII. 1120.130 - FINANCIAL VIABILITY *NOT APPLICABLE (A Bond Rating)*

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
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

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

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 NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IX. 1120.140 - ECONOMIC FEASIBILITY

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

A. Reasonableness of Financing Arrangements

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

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

B. Conditions of Debt Financing ***NOT APPLICABLE (Funding project with Cash)***

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

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

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

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

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

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

SECTION X. SAFETY NET IMPACT STATEMENT *NOT APPLICABLE (Non-Substantive Project)*

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 38.

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

APPEND DOCUMENTATION AS ATTACHMENT 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 39.

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:

INDEX OF ATTACHMENTS			
ATTACHMENT NO.			PAGES
1	Applicant Identification including Certificate of Good Standing		27
2	Site Ownership		28-32
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.		
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.		33-35
5	Flood Plain Requirements		36-37
6	Historic Preservation Act Requirements		38
7	Project and Sources of Funds Itemization		39
8	Financial Commitment Document if required		40
9	Cost Space Requirements		
10	Discontinuation		
11	Background of the Applicant		41-45
12	Purpose of the Project		46-48
13	Alternatives to the Project		49-54
14	Size of the Project		55
15	Project Service Utilization		56-57
16	Unfinished or Shell Space		
17	Assurances for Unfinished/Shell Space		
18	Master Design Project		
	Service Specific:		
19	Medical Surgical Pediatrics, Obstetrics, ICU		58-62
20	Comprehensive Physical Rehabilitation		
21	Acute Mental Illness		
22	Open Heart Surgery		
23	Cardiac Catheterization		
24	In-Center Hemodialysis		
25	Non-Hospital Based Ambulatory Surgery		
26	Selected Organ Transplantation		
27	Kidney Transplantation		
28	Subacute Care Hospital Model		
29	Community-Based Residential Rehabilitation Center		
30	Long Term Acute Care Hospital		
31	Clinical Service Areas Other than Categories of Service		63-65
32	Freestanding Emergency Center Medical Services		
33	Birth Center		
	Financial and Economic Feasibility:		
34	Availability of Funds		
35	Financial Waiver		
36	Financial Viability		66-80
37	Economic Feasibility		81-82
38	Safety Net Impact Statement		
39	Charity Care Information		83

EDWARD HOSPITAL EAST BUILDING/BED ADDITIONS CON APPLICATION

May 2018

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Co-Applicant Identification

Exact Legal Name: Edward-Elmhurst Healthcare
Address: 801 S. Washington St. Naperville, IL 60540
Name of Registered Agent: Chris Mollet
Name of Chief Executive Officer: Mary Lou Mastro
CEO Address: 801 S. Washington St. Naperville, IL 60540
Telephone Number: 630-527-5350

Type of Ownership:

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

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

ATTACHMENT- 1

QUIT CLAIM DEED

Statutory (Illinois)



J.P. "RICK" CARNEY

DUPAGE COUNTY RECORDER

NOV. 02, 2000

9:49 AM

DEED

07-24-400-00

005 PAGES

R2000-171372

CHARGE C.T.I.C. DUPAGE 009521 Clg to

THE GRANTOR, EDWARD
HOSPITAL DISTRICT, a
hospital district created and
existing under and by virtue of the
laws of the State of Illinois and

(The Above Space for Recorder's Use Only)

duly authorized to transact business in the State of Illinois, for the consideration of Ten and no/100 (\$10 00) Dollars, and other good and valuable consideration in hand paid, and pursuant to authority given by the Board of Directors of said corporation, CONVEYS and QUIT CLAIMS to EDWARD HOSPITAL, an Illinois not-for-profit corporation organized and existing under and by virtue of the laws of the State of Illinois having its principal office at the following address: 801 Washington Street, Naperville, Illinois, all interest in the following described Real Estate situated in the County of DuPage and State of Illinois, to wit:

SEE EXHIBIT A ATTACHED HERETO AND BY
THIS REFERENCE MADE A PART HEREOF

Permanent Real Estate Index Numbers: 07-24-400-007; 07-24-400-008,
07-24-400-011; 07-24-400-12

Addresses of Real Estate: 852 West Street, Naperville, IL 60540;
775 Brom Drive, Naperville, IL 60540;
100-120 Spaulding Drive, Naperville, IL 60540
801 Washington Street, Naperville, IL 60566

ATTACHMENT - 2

In Witness Whereof, said Grantor has caused its name to be signed to these presents by
its Chairman this 25th day of October, 2000.

EDWARD HOSPITAL DISTRICT

By. [Signature]

Its: Chairman of the Board

WITNESSED by the Secretary of the Board of Directors of Edward Hospital District, Section 4,
to-wit: [Signature]
Date: 10/25/00

CITY OF NAPERVILLE	
CITY TAX 	OCT 26 00
	NAPERVILLE, IL
# 0000800911	REAL ESTATE TRANSFER TAX
	00000000
	FP326659

ATTACHMENT - 2

State of Illinois)
) SS.
County of Cook)

I, the undersigned, a Notary Public, in and for the County and State aforesaid, DO HEREBY CERTIFY, that Michael Mimnugh is personally known to me to be the Chairman of Edward Hospital District, an Illinois hospital district, and personally known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me this day in person and acknowledged that as such Chairman, he signed and delivered the said instrument, pursuant to authority given by the Board of said Directors of said corporation, for the uses and purposes therein set forth.

Given under my hand and official seal, this 25th day of October, 2000



Mary Helen Crispo
Notary Public

Commission expires March 20, 2002

This Instrument Was Prepared By:

Jennifer R. Breuer, Esq.
Gardner, Carton & Douglas
321 North Clark Street
Suite 3400
Chicago, IL 60610-4795

MAIL TO: Edward Hospital

(Attn: Nanette Bufalino
(801 Washington Street
(P. O. Box 3060
(Naperville, IL 60566

SEND SUBSEQUENT TAX BILLS TO

Edward Hospital
Attention: President
801 Washington Street
P O Box 3060
Naperville, IL 60566

RECORDERS OFFICE BOX NO _____

CH01/12110924 1

ATTACHMENT - 2

EXHIBIT A

LEGAL DESCRIPTION

PARCEL 1:

That part of the Southeast quarter of Section 24, Township 38 North, Range 9, East of the Third Principal Meridian, described by beginning at the Northeast corner of the Southeast quarter of the Southwest quarter of said Section 24, Township 38 North, Range 9, East of the Third Principal Meridian and running thence North 69° East 37.12 chains to stake and stones in center of road; thence South 18° East 4.98 chains along the road to H. Knickerbocker's line; thence South 70° West 38.15 chains along Knickerbocker's line to stake and stones; thence North 1° East 4.70 chains to the place of beginning; also Lot 11 as platted and described in Book 3 on pages 240 and 242 of Circuit Court records described by commencing at stake and stones at Northeast corner of Southeast quarter of Southwest quarter of said Section 24 and running thence North 25° West 4.65 chains to stake and stones; thence North 69 and one-half ° East 39.44 chains to stake and stones in center of road; thence South 4° West 4.61 chains to angle in road; thence South 18° East 1.45 chains to stake and stones; thence South 69 and one-half ° West 37.12 chains to place of beginning, in DuPage County, Illinois.

ALSO

PARCEL 2:

That part of the Southeast quarter of Section 24, Township 38 North, Range 9, East of the Third Principal Meridian, described by commencing at the Northeast corner of said Southeast quarter; thence West along the North line of said Southeast quarter 500.3 feet to the center line of Washington Street; thence South 0° 51' West along the center line of said Washington Street 34.9 feet for a place of beginning; thence South 0° 51' West along said center line of Washington Street 100.0 feet; thence South 66° 08' West 1802.2 feet to the West line of the Naperville Cemetery extended South; thence North 1° 03' East along the West line of said Cemetery extended South 642.4 feet; thence North 83° 29' East 1648.4 feet to the place of beginning, in DuPage County, Illinois.

ATTACHMENT – 2

AFFIDAVIT — METES AND BOUNDS

STATE OF ILLINOIS)
COUNTY OF DU PAGE) SS.

AFFIDAVIT — METES AND BOUNDS

Peter W. Karickhoff, being duly sworn on oath,
states that he/she resides at 1724 S. Ashland St. Wheaton
That the attached deed is not in violation of Section 205/1 of Chapter 765 of the Illinois Compiled Statutes for one of the following reasons:

1. The division or subdivision of land is into parcels or tracts of five acres or more in size which does not involve any new streets or easements of access.
2. The division is of lots or blocks of less than one acre in any recorded subdivision which does not involve any new streets or easements of access.
3. The sale or exchange of parcels of land is between owners of adjoining and contiguous land.
4. The conveyance is of parcels of land or interests therein for use as right of way for railroads or other public utility facilities, which does not involve any new streets or easements of access.
5. The conveyance is of land owned by a railroad or other public utility which does not involve any new streets or easements of access.
6. The conveyance is of land for highway or other public purposes or grants of conveyances relating to the dedication of land for public use or instruments relating to the vacation of land impressed with a public use.
7. The conveyance is made to correct descriptions in prior conveyances.
8. The sale or exchange is of parcels or tracts of land following the division into no more than two parts of a particular parcel or tract of land existing on July 17, 1959 and not involving any new streets or easements of access.
9. The sale is of a single lot of less than five acres from a larger tract, the dimensions and configurations of said larger tract having been determined by the dimensions and configuration of said larger tract on October 1, 1973, and no sale, prior to this sale, or any lot or lots from said larger tract having taken place since October 1, 1973 and a survey of said single lot having been made by a registered land surveyor.
10. The conveyance is of land described in the same manner as title was taken by grantor(s).

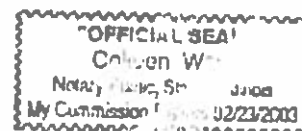
THE APPLICABLE STATEMENT OR STATEMENTS ABOVE ARE CIRCLED.

AFFIANT further states that he/she makes this affidavit for the purpose of inducing the Recorder of DuPage County, State of Illinois, to accept the attached deed for recording.

SUBSCRIBED AND SWORN TO before me

this 21 day of November, 2000

Colleen Ward
Notary Public



J. P. "RICK" CARNEY, DU PAGE COUNTY RECORDER
421 N. COUNTY FARM ROAD, BOX 936, WHEATON, ILLINOIS 60189

(Rev 12/94)

ATTACHMENT - 2



To all to whom these Presents Shall Come, Greeting:

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

EDWARD HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON MARCH 30, 1984, 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 #: 1732102176 verifiable until 11/17/2018
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 17TH
day of NOVEMBER A.D. 2017 .

Jesse White

SECRETARY OF STATE

ATTACHMENT - 3



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

EDWARD-ELMHURST HEALTHCARE, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 27, 1987, 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 #: 1732102148 verifiable until 11/17/2018
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 17TH day of NOVEMBER A.D. 2017 .

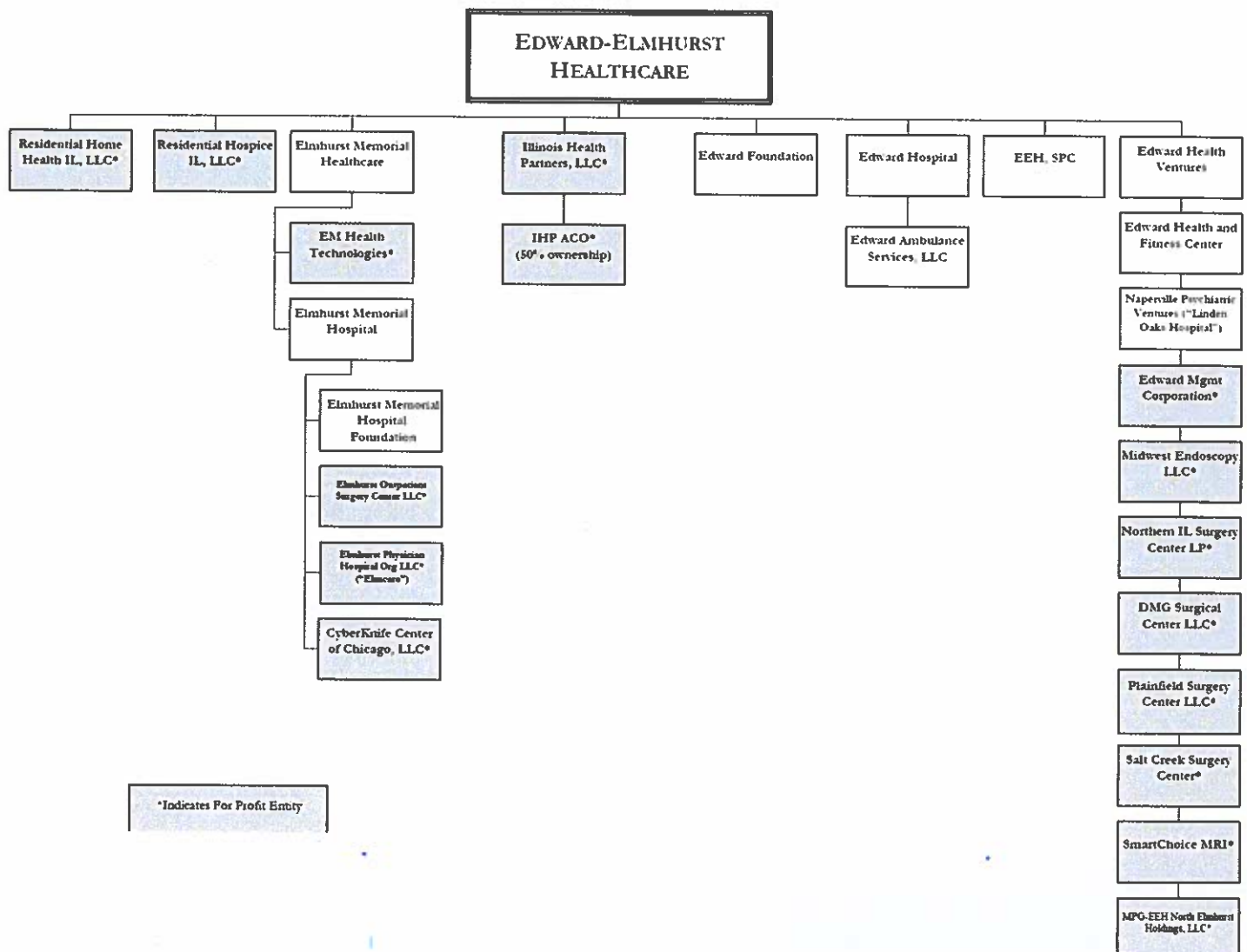
Jesse White

SECRETARY OF STATE

ATTACHMENT - 3

Organizational Relationships—Both Edward-Elmhurst Healthcare and Edward Hospital (co-Applicants) are included on the organizational chart below.

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



Edward-Elmhurst Healthcare ("EEH") is the sole corporate member of Edward Hospital, Edward Health Ventures, Edward Foundation, EEH, SPC, Elmhurst Memorial Healthcare, and Illinois Health Partners, LLC.

EEH participates in the following joint ventures and owns interests as listed:

Residential Home Health Illinois, LLC (60%)

Residential Hospice Illinois, LLC (42.5%)

Edward Hospital participates in the following joint ventures and owns interests as listed:

Edward Ambulance Services LLC (55%)

ATTACHMENT- 4

Healthy Driven™

Edward-Elmhurst

HEALTH

May 7, 2018

Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, 2nd Floor
Springfield, IL 62761

Re: Edward Hospital's CON Application for East Building and Bed Additions Floodplain Requirements

To Whom It May Concern:

I hereby attest that Edward Hospital is not located in a floodplain and that the proposed project complies with the Illinois Executive Order #2006-5.

Sincerely,



William Kottmann
President and CEO, Edward Hospital

Acknowledgement

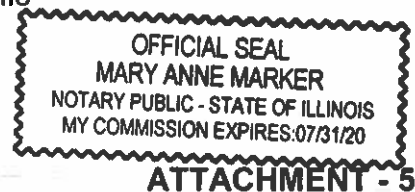
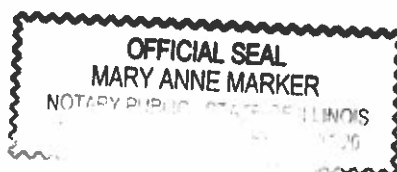
State of Illinois
County of DuPage

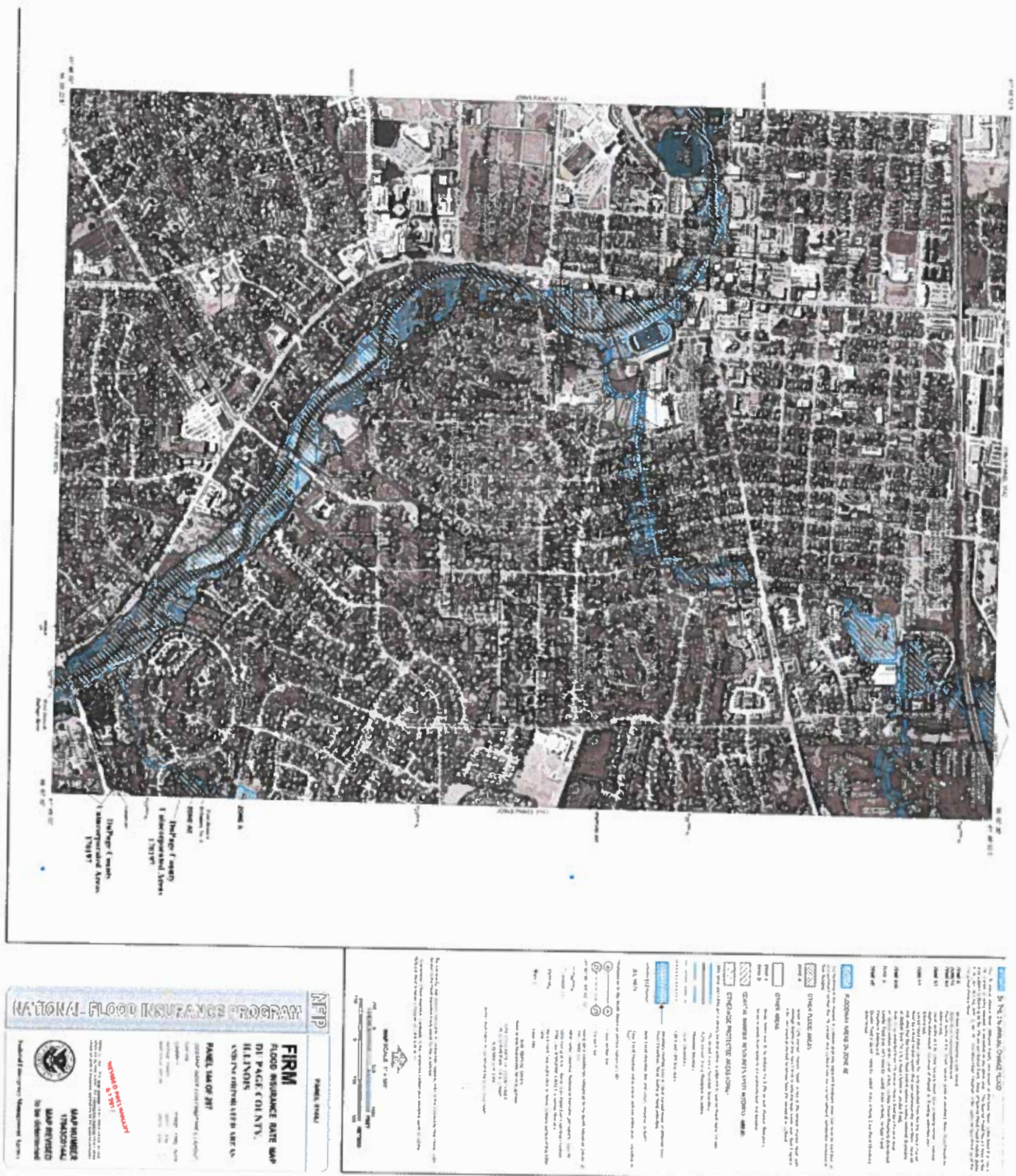
This instrument was acknowledged before me on May 7 2018, by

William Kottmann
(Name of Person)

Mary Anne Marker
Notary Public

Edward Hospital
801 S. Washington Street
Naperville, IL 60540





ATTACHMENT - 5



Illinois Department of Natural Resources

One Natural Resources Way Springfield, Illinois 62702-1271
www.dnr.illinois.gov

Bruce Rauner, Governor
Wayne A. Rosenthal, Director

FAX (217) 524-7525

DuPage County
Naperville
CON - New Construction of East Building
801 S. Washington St.
SHPO Log #012012218

February 21, 2018

Minh Nguyen
Edward Hospital
Attn: Planning/Marketing Department
801 S. Washington St.
Naperville, IL 60540

Dear Mr. Nguyen:

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

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

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

If you have any further questions, please contact me at 217/785-5031.

Sincerely,

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

ATTACHMENT - 6

Project Costs and Sources of Funds- ITEMIZATION

Preplanning Costs:	Total:	\$ 728,400
Concept and Programming - MCA	\$	550,264
Pre-Construction Services - Power	\$	116,581
IS Infrastructure - Advanced Data	\$	61,555
Site Survey and Soil Investigation	Total:	\$ 43,200
Site Survey	\$	18,700
Soil Borings and Testing	\$	24,500
Site Preparation:	Total:	\$ 1,628,577
Demolition of Existing Building Structure Components	\$	280,560
Site staging for Construction	\$	426,451
Electrical Site Infrastructure	\$	176,566
Site Utility Reconfiguration	\$	745,000
New Construction Contracts:	Total:	\$ 23,115,449
Construction Cost	\$	21,607,262
General Conditions / Temp Utilities	\$	756,254
Insurance	\$	211,751
Construction Management	\$	540,182
Modernization Contracts:	Total:	\$ 9,357,856
Construction Cost	\$	8,747,295
General Conditions / Temp Utilities	\$	306,155
Insurance	\$	85,724
Construction Management	\$	218,682
Contingencies	Total:	\$ 3,390,775
Architectural/Engineering Fees	Total:	\$ 2,410,707
Consulting and Other Fees:	Total:	\$ 748,628
CON Application	\$	100,000
Post Project Audit	\$	91,669
IDPH Plan Review	\$	106,947
Commissioning	\$	120,000
Building Inspections	\$	95,834
Permits / Testing	\$	234,178
Movable and Other Equipment: (not in construction contracts)	Total:	\$ 4,330,710
Major Medical- Patient Room Equipment	\$	972,529
Major Medical- Nurse Call System	\$	524,931
Major Medical- Telemetry	\$	2,159,045
Minor Medical	\$	674,205
Other Costs to be Capitalized:	Total:	\$ 4,935,528
Furnishings	\$	2,066,260
IS / Telecommunications	\$	2,434,268
Telephony Equipment		
Television System		
Cabling and Infrastructure		
DataRequirements / Interfaces		
Security System	\$	350,000
Signage	\$	85,000

ATTACHMENT- 7

Cost Space Requirements

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	Total Cost	Existing	Proposed	New Construction	Modernized	As Is	Vacated Space
REVIEWABLE							
Adult Intensive Care Unit	\$6,506,262	45,659	55,592		9,933	45,659	NA
Adult Observation Unit	\$4,704,466	0	7,237		7,237	NA	NA
Chronic Care Clinic	\$3,525,602	635	4,135	4,135		NA	635
Total Reviewable	\$14,736,330	46,294	66,964	4,135	17,170	45,659	635
NON REVIEWABLE							
Admin Office/Meeting Room	\$2,011,126		3,899	2,140	1,759		
Support Space	\$1,610,709		3,077	1,622	1,455		
Patient Education	\$1,842,594		3,907	901	3,006		
Physician Office Space	\$14,962,449		42,265	25,024			17,241
Mechanical	\$4,938,139		7,644	7,116	528		
Public Areas (elevator, stairs, corridors)	\$10,588,481		17,068	12,149	4,919		
Total Non-Reviewable	\$35,953,500		77,860	48,952	11,667	0	17,241
TOTAL	\$50,689,830	46,294	144,824	53,087	28,837	45,659	17,876

The 635 GSF that will be vacated when the Center for Heart Wellness ("Chronic Care Center") moves to the proposed building addition will be converted to administrative support space.

The 17,241 GSF of physician office space that will be vacated on the 4th floor of the northeast bed tower and relocated to the proposed building addition will be converted to the proposed 12-bed intensive care unit and the 12-bed observation care unit.

Section III: Background of Applicant

Edward Hospital, Applicant, has ownership over the entities listed below:

Edward Ambulance Services:

State of Illinois License Number: 008967

Plainfield Free-Standing Emergency Department:

State of Illinois License Number: 22003

Copies of licenses and accreditation are included as attachments in the following pages.

There has been no adverse action taken against any facility, as certified in the attached letter. This letter also provides the HFSRB and DPH access to any requisite documents.

ATTACHMENT- 11

Healthy Driven™

Edward-Elmhurst HEALTH

May 7, 2018

Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, 2nd Floor
Springfield, IL 62761

Re: Edward Hospital's CON Application for East Building and Bed Addition

To Whom It May Concern:

In accordance with Review Criteria 1110.230, Background of Applicant, we are submitting this letter assuring the Illinois Health Facilities and Services Review Board that no adverse action have been taken against Edward Hospital or any other facility owned or operated by the co-applicants during the three years prior to the filing of this application.

Further the HFSRB and the DPH is herein given authorization to review any records necessary for the verification of the information provided in this CON application.

Sincerely,



William Kottmann
President and CEO, Edward Hospital

Acknowledgement

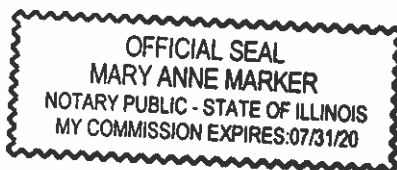
State of Illinois
County of DuPage

This instrument was acknowledged before me on May 7 20 18, by

William Kottmann
(Name of Person)

Mary Anne Marker
Notary Public

Edward Hospital
801 S. Washington Street
Naperville, IL 60540



ATTACHMENT- 11

 Illinois Department of PUBLIC HEALTH		HF113285
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	LD NUMBER
06/30/2018		0003905
General Hospital Effective: 07/01/2017		
Edward Hospital 801 S. Washington Street Naperville, IL 60540		
The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #48240 SM 5/16		

← DISPLAY THIS PART IN A
CONSPICUOUS PLACE

Exp. Date 06/30/2018

Lic Number 0003905

Date Printed 04/21/2017

Edward Hospital

801 S. Washington Street
Naperville, IL 60540

FEE RECEIPT NO.

ATTACHMENT - 11

Edward Hospital

Naperville, 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

August 29, 2015

Accreditation is customarily valid for up to 36 months.


Rebecca J. Patchin, MD
Chair, Board of Commissioners

ID #7394
Print/Reprint Date: 10/30/2015


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.



ATTACHMENT - 11



**Illinois Department of
PUBLIC HEALTH**

HF114133

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
9/10/2018		22003
Free Standing Emergency Center		
Licensed Beds: 15		

Edward Plainfield Emergency Center
24600 W. 127th Street
Plainfield, IL 60585

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #48240 5M 5/16

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

Exp. Date 9/10/2018

Lic Number 22003

Date Printed 9/1/2017

Edward Plainfield Emergency Center

FEE RECEIPT NO.

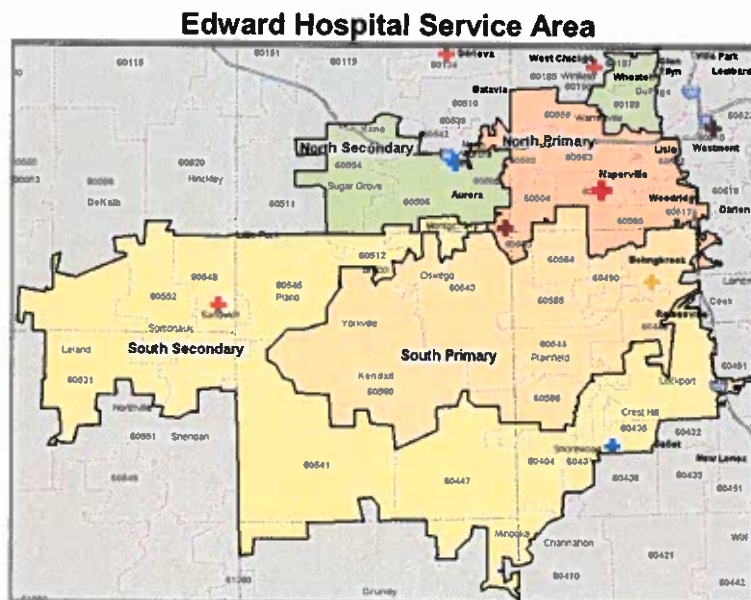
ATTACHMENT - 11

Section III: Criterion 1110.230 – Purpose of the Project

The proposed project provides for the addition of 12 ICU and 12 observation beds to accommodate growing demand for inpatient and observation cases, and the construction of a 3-story building addition adjacent to the northeast bed tower to accommodate increased demand for chronic care management services and physician office space on campus.

Market Area

The market area for this project is presented below. Edward Hospital's Primary Service Area (PSA) consists of the communities located in DuPage, Will, Kane and Kendall Counties, including Naperville, Lisle, Woodridge, Bolingbrook, Plainfield, Oswego and Yorkville. Edward Hospital's PSA has nearly 605,000 residents according to demographic analyses conducted by Environics Analytics iXPRESS for 2017 and is projected to grow 2.6% by 2022, with disproportionate growth expected in the population over 65 years old. Over 70% of inpatients utilizing Edward Hospital live within its defined PSA. Edward Hospital's Secondary Service Area (SSA) consists of the communities of Wheaton, Aurora/Fox Valley, Sugar Grove, Lockport, Crest Hill, Shorewood, Minooka, Plano, Sandwich, Somonauk and Leland. Edward Hospital's SSA has nearly 430,000 residents according to the same source cited above and is projected to grow 1.5% by 2022. Approximately 11% of inpatients utilizing Edward Hospital live within its defined SSA.



Current Issues

There are several issues that this project will address as described below:

- High ICU bed occupancy

Edward Hospital's ICU bed inventory recently decreased by 13 beds due to the closure of an intensive care unit that was converted to recovery room space for pain treatment and electroconvulsive therapy (ECT) procedural patients. However, Edward Hospital's ICU units are now operating at 69% occupancy, significantly above the State standard minimum occupancy rate of 60%. Edward Hospital experienced a 20% growth in ICU patient days over the past 5 years and is projecting ICU patient days to continue to grow another 8% over the next 5 years.

ATTACHMENT – 12

This project will address the shortage of ICU beds that exist at Edward Hospital and in Planning Areas A-05 and A-13, while ensuring sufficient ICU bed capacity to meet the demands of the growing (and aging) population within Edward Hospital's service area.

According to the IDPH Bed Need Determination by Planning Area dated April 18, 2018, a need exists for 9 ICU beds in Planning Area A-05 and 11 ICU beds in adjacent Planning Area A-13—the Planning Areas which comprise 83% of Edward Hospital's ICU admissions. While located in Planning Area A-05, Edward Hospital is an important provider of hospital services to Planning Area A-13 residents, receiving the greatest outmigration from that area of any acute care hospital. According to inpatient market utilization data available from IHA COMPdata (October 2016 – September 2017), there were over 8,000 admissions (excluding newborns and neonates) to Edward Hospital from Planning Area-A-13, making Edward the third largest hospital provider to its residents. Ensuring adequate capacity for residents of both Planning Areas is an essential purpose of this project.

- Inefficient model of care for a growing observation patient population

Edward Hospital recently received approval from the Illinois Health and Facilities Services Review Board to re-designated 8 adult observation beds to inpatient medical/surgical beds to accommodate volume growth. Adult observation patients are dispersed in beds available on various inpatient medical/surgical units, which is inefficient and contributes to longer stays. Observation patient volume has increased significantly—61% from CY 2012 and is anticipated to continue to grow. CMS and commercial payment policies, coupled with shifts of procedural volume to the outpatient setting will drive this growth well into the future. A nursing unit dedicated to observation patients will allow processes and systems to be designed for shorter stay patients resulting in improved efficiencies and lower costs. Edward Hospital is proposing to establish this model of care and construct a 12-bed observation unit on the 4th floor of the northeast bed tower when the existing physician offices are relocated to the proposed building addition.

- Readmission CMS penalties and a growing chronic care population

Edward is proposing to expand the Center for Heart Wellness to accommodate current and future growth of the existing patient population and to add other chronic conditions such as atrial fibrillation, chronic obstructive pulmonary disease (COPD), pneumonia, and other chronic conditions. The existing center has seen tremendous growth in the last 3 years—from 263 patients to 439 patients between fiscal years 2015 and 2017 (67%). At an average 5-6 visits per patient, patient visits have grown from 1,560 in FY 2015 to 2,484 in FY 2017(59%). Additional space is required to accommodate this growing population and to create a more patient-friendly, safe, and efficient environment.

The existing center has 4 exam rooms with a total of 625 gross square feet and is located on the 2nd floor adjacent to a nursing unit. Existing space is deficient in many ways. There is no reception or waiting room space for these patients. Many of these patients require education and consulting, but there is no dedicated space available for these functions. The Center treats 4-8 patients requiring infusion each week but has no dedicated infusion space. Infusion procedures can be very lengthy, requiring exam rooms to be occupied for 4-6 hours per treatment, limiting the ability of the center to accommodate additional patients. In addition, a special clinic is conducted on Wednesday to care for the growing number of patients with Ventricular Assist Devices (VAD) or Transcatheter Aortic Valve Replacement (TAVR) procedures. This scheduling allows for alignment with physician availability, thus enhancing patient convenience and enabling efficient use of resources. During these days, other patient populations cannot be seen, further limiting the number of patients that can be accommodated. The intent of this clinic is to care for the patient as they transition back to their cardiologist or

ATTACHMENT – 12

primary care physician. This may take several weeks. The center is staffed with providers to offer touchpoints for these patients and address educational needs as well as immediate clinical needs, in doing so, we would expect to decrease readmissions and prevent any further penalties received under CMS's Hospital Readmissions Reduction Program.

- **Physician office space need on campus**

Edward-Elmhurst Healthcare (EEH) has a multi-year lease with a cardiology physician group for office space currently located on the 4th floor of the northeast bed tower. Nearly two years ago EEH was able to provide 582 SF of additional space adjacent to the lessee's current location at their request by vacating the only hospital space remaining on that floor. This group is anticipating a need for six to nine (6-9) additional physicians and Advanced Practice Clinicians (APCs) over the next 5-7 years and there is no available space on campus to accommodate this need. Edward's current Cardiac Program is designed to foster a high level of collaboration between cardiac physicians, staff, patients and families to optimize engagement around inpatient and outpatient cardiovascular treatment. This project will maintain the advantages of a tightly integrated network of providers by accommodating the physician office space need in the proposed building addition. The relocation of this leased space will also open up hospital space that is needed to support the proposed 12-bed ICU and 12-bed adult observation unit as discussed above.

The goals and objectives of this project are provided in the following table:

Goal	Objective	Time Frame
Meet Edward Hospital's projected bed need for ICU and address IDPH/IHFSRB calculated need for ICU in Planning Areas A-05 and A-13	Add 12 incremental ICU beds	December 2020
Improve efficiency of observation patient care	Develop a 12-bed dedicated observation unit to centralize the largest population of observation patients (Cardiac)	December 2020
Accommodate a growing population of chronic disease patients through a coordinated approach to care incorporating patient and family engagement, thus improving outcomes	Expand the Center for Heart Wellness and the scope to include other chronic conditions. Treat more patients and reduce readmissions.	January 2020
Ensure retention of sufficient office space to support EEH's highly coordinated approach to the management of heart disease	Increase leased physician office space available to cardiology and cardiovascular physician groups on campus	January 2020

Section III: Criterion 1110.230 – Alternatives

The following alternatives to the proposed project were considered and rejected due to potentially negative impact on patient quality, access and cost.

1. Propose a project of greater or lesser scope:

- **Decrease the scope of the proposed project by constructing fewer beds within the existing footprint of the hospital.**

Under the current facility configuration, 5 ICU beds can be constructed in bed storage space available in the west bed tower, as well as 3 ICU beds adjacent to the current Cardiac/Neuro ICU. However, 8 ICU beds are not sufficient to meet future demand. Further, the 5 bed unit would be inefficiently sized and not contiguous to other ICUs, creating added inefficiency. This option would provide no opportunity to expand and consolidate observation capacity, nor will it address the needs for additional physician office and chronic care center space, each of which is required to meet growing demand.

Cost: \$3M

Impact on quality: Negative. This option will not address short or long term pressures on bed need. Based on high and growing ICU occupancy and an increasing volume of patients in observation status, Edward projects that 24 incremental beds (12 ICU and 12 observation) will be needed by 2022. As the campus is highly utilized, it currently has no ability to accommodate peak census in otherwise vacant beds. As such, construction of additional beds is needed. Inadequate ICU bed supply will increase the number of patients and length of time held in the Emergency Department and post-surgical recovery areas and will contribute to an increased risk of ambulance diversions. This can have a negative impact on quality due to delays in time to treatment. Furthermore, risk is involved with disrupting physician-patient relationships, since the majority of patients are admitted to Edward Hospital by physicians who are not on staff at other hospitals. Additional risk is involved with disruption in care coordination and continuity.

While Edward maintains observation beds for pediatric and obstetrical patients, it currently has no such dedicated unit for adult (non-obstetrical) patients. Instead, observation patients are accommodated in available beds scattered throughout the hospital's 8 medical surgical units. Industry best practice, as well as Edward's own experience, indicates that a dedicated observation unit can improve patient throughput, overall efficiency and patient satisfaction while enhancing quality outcomes as measured by lower readmission rates. Fueled by CMS and commercial payment policies, observation days are expected to grow well into the future.

Finally, this option will not accommodate the need for additional physician office and chronic care center space. 24,700 patients annually are treated at Edward Hospital with cardiac conditions alone—many of whom have significant co-morbidity. Edward's current facility was designed to foster a high level of collaboration between physicians, staff, patients and families to optimize engagement around inpatient and outpatient cardiovascular treatment. Patients have been advantaged by the ability to schedule physician, diagnostic testing and procedures whenever possible on the same day and in the same centralized location. This model of care has been extremely effective, contributing to the development of a nationally recognized cardiovascular program. In 2017, Edward Hospital was awarded several prestigious honors including Consumer Reports' top 50 hospitals nationwide for open heart surgery performance, as well as American Heart Association's Get with Guidelines Heart Failure Gold Plus achievement award. Most recently, Edward Hospital was recognized by the Leapfrog

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Organization as one of only two hospitals in Illinois (the other being its sister-hospital, Elmhurst) as Top General Hospitals for safety and quality, and was further recognized by Truven Analytics as a Top 100 Hospital.

Physicians currently occupying leased space on the fourth floor of the northeast bed tower have a need for six to nine (6-9) additional physicians and Advanced Practice Clinicians (APCs) over the next 5-7 years to accommodate demand. Failure to expand this space in an efficient, centralized location will negatively impact quality by forcing delays in early diagnosis and treatment—a natural consequence of inadequate physician supply. Dispersing providers to other available space on or off campus will disrupt the model of care and compromise the advantages of co-location discussed in the prior paragraph.

Edward's population of chronic patients, including but not limited to congestive heart failure (CHF) continues to grow, driven by the aging of the population and increased prevalence of chronic diseases. Edward currently operates the Center for Heart Wellness adjacent to an inpatient unit on campus. This adjacency has been beneficial as it allows for cross-over staffing by inpatient APCs, thus improving efficiency while ensuring continuity between inpatient and outpatient care. Demand for this unit has surpassed available capacity. As the growth of other chronic disease populations continues, there is opportunity to expand this model beyond CHF, to include patients with atrial fibrillation, chronic obstructive pulmonary disease and pneumonia. Failure to provide the space to accommodate future growth will compromise the quality by forcing treatment delays. This is particularly important post-discharge in preventing readmissions and other negative clinical outcomes.

Impact on patient access: Negative. This option, due to lack of available ICU beds, will increase the likelihood of inpatient transfers and ambulance bypass, potentially delaying time to treatment and requiring longer travel times for both patients and family members.

Failure to grow physician office and chronic disease center space will contribute to longer wait times for appointments. This is a significant issue for chronically ill patients, who need frequent touchpoints with their physicians to manage their condition. Inability to grow the physician complement on site will ultimately lead to longer wait times for initial and follow-up appointments with physicians. This may impact both early detection of new disease and timely follow up for both procedural and medically managed patients.

Financial Impact: Negative. Inadequate ICU bed supply increases the risk of ambulance bypass or transfer, which negatively impacts quality while adding costs to patients as well as the entire healthcare delivery system. Delays in accessing inpatient beds adds cost by prolonging length of stay in the Emergency Department. Inadequate supply of observation beds will exacerbate this issue. Further, the 5 bed ICU unit would be isolated from other inpatient units, generating otherwise avoidable staffing inefficiencies and costs.

An inadequate number and poor configuration of observation beds, which would result under this option, will also have a negative financial impact. The efficiencies that can be achieved through a dedicated observation unit designed and staffed for same-day patient throughput, will not be achieved.

Finally, failure to provide the space needed to treat outpatients in a coordinated way will likely increase readmissions and overall cost to the system by re-introducing the fragmentation of service delivery that has heretofore been avoided through Edward's longstanding commitment to coordinated cardiovascular care delivery.

- **Decrease the scope of the project by accommodating needed beds but relocating and reducing the size of chronic center and physician office space available on campus.**

This option involves vacating 17,241 SF on the 4th floor (currently occupied by physician offices) to accommodate bed need and relocating physician offices to another location on campus, thus avoiding the construction of the East Building. Note, however, that the continued growth of inpatient and outpatient volume at Edward Hospital has resulted in a campus with virtually no vacant or underutilized space. The best of limited alternatives available for this option would involve relocating physician offices to the ground floor of the Hospital. However, this would not add enough space for future expansion and would also involve the renovation as well relocation of other functions, including the Wound Center, administrative offices, support departments, and cardiac rehab.

Cost: \$46M

Impact on quality: Negative. The option of moving physician offices to the Hospital's ground floor was identified as the best of limited options; however, this would result in a cascading impact of many departmental moves off campus. The most problematic of these moves is the Wound Care Center, which treats 10,000 wound cases annually with a variety of modalities, including hyperbaric chambers. The majority of wound patients also have other cardiovascular anomalies. Moving them off campus will disrupt the collaborative treatment model identified above, potentially creating a negative impact on continuity of care.

Furthermore, this option will provide only limited expansion capacity for physician offices and no expansion capacity for CHF/chronic care center. The negative impact on quality is described above.

Impact on Patient Access: Negative. Wound Care patients, many of whom are elderly with multiple comorbidities, would be required to receive some service on campus and some services off campus. Traveling to multiple locations is difficult, confusing and disruptive. The value of contiguous and centralized services is described above. A centrally located and convenient location that could accommodate Wound Care Clinic facility specifications has not been identified to date. Without such a site, there is the risk that Wound Care services would have to be eliminated – further exacerbating access for these patients.

As indicated, this option will provide only limited expansion capacity for physician offices and no expansion capacity for CHF/chronic care center. This will have a negative impact on access, increasing time to diagnosis and treatment for vulnerable patients where early and regular touchpoints with these services is critical to positive outcome.

Financial Impact: Negative. Moving multiple departments will require significant relocation and renovation costs that ultimately would be similar to the East building without the benefit of co-location and care coordination. Moving the Wound Care Center off campus requires relocation of 3 hyperbaric chambers. Given special requirements, including the support of an oxygen farm, this is an expensive relocation and construction project, even if an acceptably accessible location can be identified in the future.

- **Decrease the scope of the project by accommodating needed beds but relocating the chronic care center and physician office space off campus.**

Cost: \$22M

Impact on Quality: Negative. The arguments for keeping physician offices and chronic disease center on campus, well integrated with other clinical services, is described above. It can be strongly argued that co-location of these services has a positive impact on physician, staff and patient/family engagement, satisfaction, and clinical outcomes. Forcing key components of the care delivery model off campus, even if an acceptably accessible and adequately sized location were to be identified, has the potential to disrupt a very effective model of care—one that has been recognized at the National level.

Impact on Patient Access: Negative. All of the arguments presented above would exist with respect to patient access. As indicated, patients often receive additional diagnostic testing, cardiac rehabilitation and other services at times coordinated with their physician appointments. The ability to schedule these services the same day and in the same place as the physician visit expedites time to diagnosis and treatment, reduces patient and family anxiety, and promotes positive patient satisfaction. This benefit would be diminished if physician offices were moved off site. Furthermore, travel times would increase, along with the burden of transportation borne by patients.

Financial Impact: Negative. The cost of relocation and renovation associated with this option will be significant, with no concurrent benefit in quality or access. Furthermore, staffing and administrative costs will increase due to necessary duplication, diminishing the benefits of co-location and associated staffing efficiencies.

- **Add beds in a satellite hospital**

This option would change the scope of the project by developing a satellite hospital in Plainfield, Illinois, to accommodate the projected need for 12 additional observation beds. However, because it would not free up available space on campus, it would not provide an adequate solution for ICU bed need or for physician office and chronic disease center space on the existing Edward Hospital campus. Note that because current IHFSRB rules require new hospitals to be minimally sized at 100 medical/surgical beds, 4 ICU beds and 20 Obstetrical beds, it was deemed infeasible to construct anything other than observation beds in this location.

Cost: \$14M

Impact on Quality: Neutral to Negative. As Edward Hospital quality processes would carry over to a satellite facility, this option could provide a reasonable alternative to meeting the needs of lower acuity observation patients in a convenient location. However, this project would not allow for the expansion of physician office space and chronic disease center. As such, for the purpose of this project and for the reasons outlined above, it is deemed to have a negative impact on quality. While limited ICU capacity could be built under this option, the majority of these beds would not be contiguous to other units and the number of beds added would not be sufficient to meet ICU demand, resulting in the variety of quality issues addressed above.

Impact on Patient Access: While this option may provide some benefits to access for low acuity patients residing in the area, it will not provide the space needed to expand physician

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offices on campus, nor will it provide expansion space for chronic disease center. As such, and for the reasons identified above, it will negatively impact access to physician and chronic disease patient management services. While some ICU capacity could be built under this option, it is not sufficient to meet ICU demand, resulting in the variety of access issues addressed above.

Financial Impact: Negative. This option will require duplication of support and clinical functions as needed to support a unit of observation patients off campus. Again, while some ICU capacity could be built under this option, the majority of these beds would not be contiguous to other units and the number of beds would not be sufficient to meet ICU demand. The negative financial impact of inadequate ICU bed supply, physician office space and chronic disease center space associated with this option are addressed above.

2. Pursuing a Joint Venture or Similar Arrangement or Developing Alternative Settings.

This option is not applicable to this project since there is no natural joint venture partner for the development of additional inpatient beds or added physician office and clinical space on campus. As indicated above, IHFSRB rules require new hospitals to be minimally sized at 100 medical/surgical beds, 4 ICU beds and 20 Obstetrical beds, so an alternative setting, as presented above, could only reasonably accommodate observation beds. This will not address the need for ICU beds. While it may be possible to construct observation beds off campus, there are no opportunities to expand ICU capacity. The negative impact of limiting ICU capacity and shifting physician offices and chronic disease center off campus is discussed above.

3. Utilizing Other Health Care Resources

According to the most recently published IDPH Bed Need Determination dated April 18, 2018, a need exists for 9 ICU beds in Planning Area A-05. Furthermore, approximately one third of Edward's inpatients reside in Planning Area A-13, where an ICU bed need of 11 exists. While Edward Hospital is located in Planning Area A-05, it has a large network of physicians and services, including the Plainfield Freestanding Emergency Center, located in Planning Area A-13. As such, residents of Planning Area A-13 are heavily reliant upon Edward Hospital.

Edward and Elmhurst Hospitals, both located in Planning Area A-05, merged in 2011 to form Edward-Elmhurst Health. The alternative of utilizing Elmhurst Hospital to meet growing demand was considered throughout the planning for this project. However, this option was rejected given the high and growing occupancy rates at Elmhurst- ICU occupancy is currently at 76% and the Hospital has been at full capacity 14 times over the past 6 months forcing ambulances to be diverted to other hospitals. It is clear that Elmhurst will not have the capacity to absorb Edward's bed need.

Cost: \$0

Impact on Quality: Negative. As indicated previously, this options would require diversion of patients to another inpatient facility, which will have a negative impact on quality for the following reasons:

- Lack of ICU and medical/surgical capacity will compromise patient care by delaying waiting times in the Emergency Departments as well as time to treatment.
- Care will be more fragmented since the majority of patients are admitted by physicians who are not on staff, or rarely practice at other hospitals. Requiring patients to receive episodic care by physicians who are unfamiliar with them interfered with best practice around

ATTACHMENT -13

- coordination of care and can have a negative impact on quality.
- Ambulance bypass and patient transfers are can negatively impact quality due to delays in time to treatment.

This option would not allow for the development of expanded observation, medical office and chronic center capacity, the negative consequences of which are addressed above.

Impact on Patient Access: Negative. This option would require patients and families to travel to more distant and less familiar facilities due to an inadequate supply of beds in their local hospital. Furthermore, ICU capacity is particularly constrained in the area and there is no guarantee that a bed will be available when needed. This option would not allow for the development of expanded observation, medical office and chronic center capacity, the negative consequences of which are addressed above.

Financial Impact: Negative. Poorly coordinated care and increased risk of ambulance bypass and inpatient transfers, coupled with the potential to increase length of stay, will have a negative financial impact on the healthcare delivery system. This option would not allow for the development of expanded observation, medical office and chronic center capacity, the negative consequences of which are addressed above.

The chosen alternative is the addition of the East Building to accommodate growth in physician practice space as well as chronic care center space. This will allow physicians currently leasing space on the 4th floor of the Edward bed tower to vacate that space, further allowing for the construction of 12 ICU and 12 observation beds. This was determined to be the best alternative because:

- It will provide adequate capacity to meet existing and future ICU bed need at Edward Hospital while addressing the shortage of ICU capacity in Planning Areas A-05 and A-13.
- It will allow for the construction of a dedicated observation unit for adult patients, allowing for an efficient model of care.
- It will provide for the growth of physician offices space on campus, allowing for the continuation of a highly collaborative and effective model of care.
- It will allow for the growth of the Edward chronic disease center without disrupting the highly efficient and effective staffing model currently in place.
- It will provide sufficient capacity in co-located space to allow patients to be treated efficiently at their preferred hospital by their physician(s) of choice.

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

SIZE OF PROJECT

The amount of physical space proposed in this project is necessary and not excessive. The architectural design firm of Matthei & Colin Associates developed schematic design plans based on the AIA guidelines to meet the functional program needs. The footprint of the new building is limited by existing zoning setbacks, neighborhood roadways and existing site access. As a result, the available space per floor in the new building is less than the existing floor area from which the physician offices will be relocated. As a result, the physician group will be located on two floors as opposed to one contiguous space.

The table below provides the clinical areas proposed in this project and the comparison to the State standards in Section 11110 Appendix B. A standard does not exist for an observation nursing unit or chronic care center, which will provide patient visits in exam rooms, infusion services, and patient/family education and consultation space.

The ICU DGSF/Bed exceeds the State standard because the layout of the floor is limited by the physical configuration of the existing structure. This presents a challenge in meeting the ICU DGSF/bed standard for an intensive care unit as described below:

- Each of the (12) inpatient rooms is required to be located at an exterior wall so that it has access to an exterior window. To achieve this requirement, greater departmental circulation is required in the unit and the corridors are single-loaded rather than double-loaded with the patient rooms. This is the most efficient use of departmental circulation given the existing conditions.
- The DGSF/Bed is also larger because ICU rooms require direct visualization of the patient from the nurse station. Because the patient rooms are distributed across the unit at the exterior walls of the existing building, the primary and secondary nurse stations are much larger to provide needed visualization of all rooms.

The proposed ICU size is smaller than the previously approved ICU addition in the Hospital's west building that was completed in 2015 (Project #11-112).

A paper copy of the ICU floor plan is enclosed with this application.

SIZE OF PROJECT				
DEPARTMENT/ SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
Intensive Care	828 DGSF/Bed	600 - 685 DGSF/Bed	+143	No
Observation	603 DGSF/Bed	500 - 660 DGSF/Bed	NA	NA*
Chronic Care Center (Including Infusion Space)	4,135 DGSF	NA	NA	NA

*Meets the Medical/Surgical DGSF/Bed Standard

ATTACHMENT – 14

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

PROJECT SERVICES UTILIZATION

There is only one service proposed in this project that has a utilization standard in Section 1110.Appendix B—Intensive Care Bed Category of Service.

As the table below displays, ICU bed utilization is currently operating at 69% occupancy, significantly above the State standard minimum occupancy rate of 60%.

ICU Utilization							
Historical Utilization			Projected Utilization			State Standard	Met Standard?
Year	ADC	% Occupancy	Year	ADC	% Occupancy		
CY2016	33.4	68%	Year 1 CY 2021	36.2	59%	60%	Yes
CY2017	34.0	69%	Year 2 CY 2022	36.6	60%		

Edward Hospital experienced a 20% growth in ICU patient days over the past 5 years and is projecting 8% growth over the next 5 years. This will result in an average daily census of 37 and an occupancy rate of 60% in CY2022, two years after the proposed 12 new ICU beds become operational. The volume projection detail and methodology is described below.

The volume projection assumptions are as follows:

- 1% average annual growth of inpatient admissions in Edward Hospital's primary service area.

Factors such as new technology adoption, insurance changes, readmission reduction initiatives and investment in care management will drive down this growth. However, the aging population and the increase in disease incidence (including neurological and cardiovascular disease) and comorbid conditions such as diabetes and obesity is projected to drive double digit growth rates in utilization. Edward Hospital's 65+ population is projected to grow much faster than national and Illinois rates resulting in growth that many healthcare providers throughout the county are not experiencing.

The source of the projected annual growth rate for the inpatient market projections in Edward Hospital's primary service area is from the Advisory Board's Market Scenario Planner tool. The Advisory Board provides recommendations around best practices and is a leading think tank in the healthcare industry. Advisory Board's Market Scenario Planner tool applies age-adjusted utilization rates to local zip code-level demographics. The tool provides 5 and 10 year projections by DRG based on anticipated changes of five key growth drivers; disease prevalence, care management, insurance, readmissions and technology shifts.

- The following variables in the projection model were held constant based on CY2017 actual internal accounting statistics and October 2016 – September 2017 market statistics (Illinois Hospital Association COMPdata) :
 - Edward Hospital's share of the primary service area is currently 35%.
 - The percent of Edward Hospital discharges outside of the primary service area is currently 21%
 - The percent of medical/surgical and ICU admissions to total admission is 78%
 - Medical/surgical and ICU average length of stay is 3.8. It is assumed that acuity will increase, however efforts to decrease ALOS to keep costs down will counteract any potential average annual length of stay increases
- ICU patient days as a percent of total medical/surgical and ICU patient days is currently at 17.8% and will increase slightly over the next five years to 18.4% due to the anticipated increase in the age and acuity of the patient population.

	5- Year Historical			5-Year Projection	
	2012	2017	% Growth	2022	% Growth
Total Hospital Admissions	21,174	23,470	11%	24,532	5%
Medical/Surgical and ICU Admissions	16,792	18,271	9%	19,135	5%
Medical/Surgical and ICU Admissions % of Total Admissions	79.3%	77.8%	-1.46%	78.0%	0.15%
Medical/Surgical and ICU ALOS	3.83	3.81	-0.02	3.81	0.00
Medical/Surgical and ICU Patients Days	64,280	69,641	8%	72,934	5%
ICU % of Medical/Surgical and ICU Days	16.1%	17.8%	1.7%	18.4%	0.6%
ICU Patient Days	10,375	12,421	20%	13,420	8%
ICU ADC	28	34		37	
ICU Bed Supply*	40	49		61	
ICU % Occupancy	71%	69%		60%	
*2012 supply is staffed (beds approved in February 2012 were not Operational). Year 2022 includes proposed beds					

Section VI: Criterion 1110.530 - Medical/Surgical, Obstetric, Pediatric and Intensive Care

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

The proposed 12-bed ICU expansion is necessary to reduce Edward Hospital's high occupancy and to meet the projected demand in Planning Area A-05 and A-13. Edward Hospital is located in Planning Area A-05, but is close to the border of Planning Area A-13—in fact, a section of Naperville (the city in which Edward Hospital is located) is in Planning Area A-13. As indicated in the table below, 52% of ICU admissions at Edward Hospital are residents of Planning Area A-05 and 32% reside in Planning Area A-13. According to the most recently published IDPH Bed Need Determination by Planning Area dated April 18, 2018, there is a need for 9 ICU beds in A-05 and 11 ICU beds in A-13.

CY 2017 Edward Hospital ICU Admissions			
County	Planning Area	Inpatients	% of Total
DuPage	A-05	1,815	52%
Will/Grundy	A-13	1,112	32%
<i>Subtotal</i>		<i>2,927</i>	<i>83%</i>
All Others		589	17%
Grand Total		3,516	

The patient origin data for all ICU admissions in CY 2017 is provided on the following page, verifying that at least 50% of admissions were residents of Planning Area A-05.

Edward Hospital Direct ICU Admissions by Zip Code/County- CY 2017									
Zip Code	City	County	Patient Count	% of Total	Zip Code	City	County	Patient Count	% of Total
60563	Naperville	DuPage	340	9.67%	60564	Naperville	WILL	224	6.37%
60540	Naperville	DuPage	310	8.82%	60440	Bolingbrook	WILL	157	4.47%
60565	Naperville	DuPage	291	8.28%	60544	Plainfield	WILL	143	4.07%
60532	Lisle	DuPage	212	6.03%	60446	Romeoville	WILL	110	3.13%
60517	Woodridge	DuPage	140	3.98%	60586	Plainfield	WILL	105	2.99%
60504	Aurora	DuPage	92	2.62%	60585	Plainfield	WILL	85	2.42%
60502	Aurora	DuPage	36	1.02%	60490	Bolingbrook	WILL	60	1.71%
60148	Lombard	DuPage	35	1.00%	60503	Aurora	WILL	33	0.94%
60126	Elmhurst	DuPage	31	0.88%	60431	Joliet	WILL	32	0.91%
60515	Downers Grove	DuPage	31	0.88%	60403	Crest Hill	WILL	30	0.85%
60189	Wheaton	DuPage	30	0.85%	60435	Joliet	WILL	26	0.74%
60555	Warrenville	DuPage	30	0.85%	60404	Shorewood	WILL	23	0.65%
60516	Downers Grove	DuPage	27	0.77%	60441	Lockport	WILL	19	0.54%
60101	Addison	DuPage	22	0.63%	60436	Joliet	WILL	12	0.34%
60185	West Chicago	DuPage	21	0.60%	60410	Channahon	WILL	11	0.31%
60137	Glen Ellyn	DuPage	20	0.57%	60451	New Lenox	WILL	5	0.14%
60187	Wheaton	DuPage	19	0.54%	60481	Wilmington	WILL	4	0.11%
60561	Darien	DuPage	19	0.54%	60423	Frankfort	WILL	3	0.09%
60188	Carol Stream	DuPage	18	0.51%	60491	Homer Glen	WILL	3	0.09%
60527	Willowbrook	DuPage	15	0.43%	60432	Joliet	WILL	2	0.06%
60181	Villa Park	DuPage	14	0.40%	60433	Joliet	WILL	2	0.06%
60139	Glendale Heights	DuPage	10	0.28%	60449	Monee	WILL	2	0.06%
60559	Westmont	DuPage	10	0.28%	60401	Beecher	WILL	1	0.03%
60523	Oak Brook	DuPage	7	0.20%	60408	Braidwood	WILL	1	0.03%
60106	Bensenville	DuPage	6	0.17%	60417	Crete	WILL	1	0.03%
60190	Winfield	DuPage	6	0.17%	60421	Elwood	WILL	1	0.03%
60521	Hinsdale	DuPage	5	0.14%	60434	Joliet	WILL	1	0.03%
60567	Naperville	DuPage	5	0.14%	60442	Manhattan	WILL	1	0.03%
60103	Bartlett	DuPage	4	0.11%	60416	Coal City	Grundy	4	0.11%
60108	Bloomington	DuPage	4	0.11%	60447	Minooka	Grundy	4	0.11%
60143	Itasca	DuPage	1	0.03%	60450	Morris	Grundy	4	0.11%
60172	Roselle	DuPage	1	0.03%	60407	Braceville	Grundy	2	0.06%
60184	Wayne	DuPage	1	0.03%	60424	Gardner	Grundy	1	0.03%
60191	Wood Dale	DuPage	1	0.03%	Planning Area A-13			1,112	31.63%
60566	Naperville	DuPage	1	0.03%	All Other			589	16.75%
Planning Area A-05			1,815	51.62%	Grand Total			3,516	

ATTACHMENT- 19

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

ICU bed utilization has exceeded the target occupancy rate of 60% for more than two years based on Edward Hospital's current ICU bed inventory of 49. The CY2016 IDPH annual questionnaire reported an inventory of 61 ICU beds for Edward Hospital; however, there were 13 beds that were in "transitional" status because these beds were temporarily unavailable. They were being used for surgical recovery patients to accommodate a modernization project that did not require a CON. Recently, Hospital management chose to permanently convert those beds to surgical recovery and now Edward Hospital is staffed and inventoried for 49 ICU beds.

	CY2015	CY2016	CY2017
ICU Patient Days	12298	12215	12421
ICU ADC	33.7	33.4	34.0
ICU Bed Supply*	49	49	49
ICU % Occupancy	68.8%	68.1%	69.4%

1110.530(c)(4)(C) - Planning Area Need - Service Demand – Based on Rapid Population Growth

Over 70% of Edward Hospital's ICU admissions were from the defined primary service area in CY2017 as presented in the following table.

Zip Code	City	County	Patient Count	% of Total
60563	Naperville	DuPage	340	10%
60540	Naperville	DuPage	310	9%
60565	Naperville	DuPage	291	8%
60564	Naperville	WILL	224	6%
60532	Lisle	DuPage	212	6%
60440	Bolingbrook	WILL	157	4%
60544	Plainfield	WILL	143	4%
60517	Woodridge	DuPage	140	4%
60446	Romeoville	WILL	110	3%
60586	Plainfield	WILL	105	3%
60504	Aurora	DuPage	92	3%
60585	Plainfield	WILL	85	2%
60490	Bolingbrook	WILL	60	2%
60543	Oswego	Kendall	58	2%
60502	Aurora	DuPage	36	1%
60560	Yorkville	Kendall	34	1%
60503	Aurora	WILL	33	1%
60555	Warrenville	DuPage	30	1%
60567	Naperville	DuPage	5	0%
60566	Naperville	DuPage	1	0%
Total Primary Service Area			2,466	70%

ATTACHMENT-19

The high rate of growth projected for the 65+ age group will increase the demand for inpatient services at Edward Hospital. Within Edward Hospital's primary service area, this age group is projected to grow 26% over the next five years, according to demographic analyses conducted by Environics Analytics iXPRESS. This is significantly higher than the Illinois and U.S. projected growth rates of 15% and 18%, respectively. Adjusted age-group population growth rates are utilized in the Advisory Board's inpatient Market Scenario planner tool (referenced above) that was used to project ICU future volumes at Edward Hospital as presented in Attachment-15.

65+ Population Growth Rate Comparison		
Area	2017 Estimate -2022 Projection	2010 Census - 2022 Projection
Edward Hospital Primary Service Area	26%	83%
Illinois	15%	36%
United States	18%	47%
Source: Environics Analytics iXPRESS for 2017		

1110.530(f) - Staffing Availability

Incremental staffing needs for the proposed bed expansion at Edward Hospital were considered and included in the internal project evaluation that was presented to the Edward-Elmhurst Health (EEH) and Edward Hospital Boards of Trustees. As this project represents an expansion of current capabilities, staff recruitment to support this project will not be an issue and all licensure and JCAHO staffing requirements will be met.

Recruitment will involve multiple strategies already in place, including advertising by direct mail, social media and in local publications. Edward is a Magnet hospital and generally receives applications far exceeding the number of open positions. Furthermore, Edward also has a long history of a successful nurse intern program which is an excellent resource for recruitment of new graduates.

1110.530(g) - Performance Requirements- Bed Capacity Minimum

The minimum unit size for an intensive care unit is 4 beds. This project proposes a 12-bed intensive care unit and therefore meets the performance requirement for bed capacity.

1110.530(h) - Assurances

A letter attesting that Edward Hospital will achieve and maintain the ICU occupancy standard by the second year of operation is enclosed.

Healthy Driven™
Edward-Elmhurst
HEALTH

May 7, 2018

Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, 2nd Floor
Springfield, IL 62761

Re: Edward Hospital's CON Application for East Building and Bed Additions
Occupancy Assurance per Review Criteria 1110.530

To Whom It May Concern:

Please be advised that it is my expectation that, by the second full year of operation following completion of the proposed ICU bed expansion at Edward Hospital, the occupancy standards specified in 77 Ill. Adm. Code 1100 for the category of service involved in this proposal will be achieved and maintained.

Sincerely,



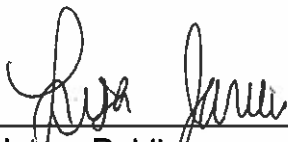
William Kottmann
President and CEO, Edward Hospital

Acknowledgement

State of Illinois
County of DuPage

This instrument was acknowledged before me on May 9 2018, by

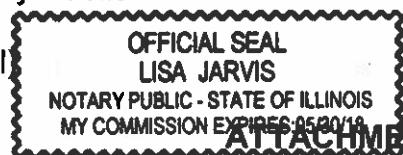
William Kottmann
(Name of Person)



Notary Public

Edward Hospital
801 S. Washington Street
Naperville, IL 60540

(seal)



ATTACHMENT - 19

Section VI: Criterion 1110.3030 – Clinical Service Areas Other than Categories of Service

Adult Observation Unit

1110.3030(d)(2)- Necessary Expansion

Adult observation days (excluding pediatric and obstetrics) increased 106% over the past 5 years (CY 2017 to CY2022). In order to meet continued projected growth, Edward Hospital is proposing the construction a 12-bed dedicated observation unit. Given the lower reimbursement associated with observation-status patients, it is imperative to operate as efficiently as possible while still providing high quality care. By establishing a dedicated unit where the acuity and length of stay is uniformly lower, staff and processes can be deployed more effectively to meet the unique needs of these patients and their families.

1110.3030(d)(3)(C)- Utilization

The goal of this component of the project is to shift a cohort of observation patients that are currently admitted to medical/surgical inpatient beds to a dedicated unit. There is no utilization standard that exists for observation patient care. Observation projections are based off of the percent of the projected hospital patient days that is presented in the 1110.234 project utilization section of this Application for intensive care services (Attachment- 15).

The percentage of adult observation to total medical/surgical inpatient days plus observation days is currently 12%. The projection model assumes a minimal increase to 12.5%. The following table shows total projected observation patient days on a medical/surgical unit, which equates to a conservative 14% 5-year growth rate compared to the 106% historical rate. A portion of this shift can be attributed to the changing definition of an observation stay as defined by CMS and other commercial payors, which led to reclassification of some patients that would have historically been defined as an inpatient. Another component of this growth can be attributed to growth in our cardiovascular population. In 2017, there were 2,383 observation days from patients with a cardiac disease diagnosis, representing a 50% increase from 2012. This patient population made up 26% of all observation patient days on a medical/surgical unit in 2017 and is the cohort of patients that the Hospital proposes to centralize in the dedicated unit. The 63% occupancy rate in year 2 is consistent with the medical/surgical modernization target occupancy rate for a bed size range of 1-25.

Adult Observation Unit Projections	5- Year Historical			5-Year Projection	
	2012	2017	% Growth	2022	% Growth
Total Hospital Admissions	21,174	23,470	11%	24,532	5%
Medical/Surgical and ICU Admissions	16,792	18,271	9%	19,135	5%
Medical/Surgical and ICU Admissions % of Total Admissions	79.3%	77.8%	-1.46%	78.0%	0.15%
Medical/Surgical and ICU ALOS	3.83	3.81	-0.02	3.81	0.00
Medical/Surgical and ICU Patients Days	64,280	69,641	8%	72,934	5%
Medical/Surgical and ICU Patients Days + Observation Days	68,739	78,847	15%	83,384	6%
Adult Observation % of Medical/Surgical, ICU and Observation Days	6.5%	11.7%		12.5%	
Adult (non-Obstetric) Observation Patient Days	4,459	9,206	106%	10,450	14%
Cardiac Observation Patient Days	1,586	2,383	50%	2,705	14%
Cardiac % of Adult Observation Patient Days	36%	26%		26%	
Cardiac Observation ADC	4.3	6.5		7.4	
Proposed Adult Dedicated Observation Unit Bed Supply				12	
% Occupancy				62%	

ATTACHMENT – 31

Chronic Care Center

1110.3030(d)(2)- Necessary Expansion

Edward Hospital is proposing to expand the existing Center for Heart Wellness and extend services to other chronic conditions.

The Center for Heart Wellness currently serves patients with heart failure, heart valve disease and pulmonary hypertension. Patients are seen in this center after an inpatient stay and remain under the center's care until they can be transitioned back to their cardiologist. Additionally, one of the objectives of this center is to decrease re-admission in a highly vulnerable patient population. In FY 2017, the center served 439 individuals, an increase of 67% patients since FY 2015. Visits per patient vary depending on the patient's condition, however, the average number of visits to the center is 5.6. Total patient visits in FY 2017 was 2,484, an increase of 59% compared to FY 2015. The significant growth in patient visits coupled with long infusion visits have caused less than optimal wait times to get into the center. Based on demographic and epidemiological trends, we expect continued, rapid growth in this patient population.

Due to physical capacity constraints, the center is currently limiting its scope to patients with chronic heart failure, valve disease and pulmonary hypertension; however, the center would open their services to other conditions if and when space allows. Opening the center up to other chronic conditions will help this vulnerable population transition to home and their primary care physician after an inpatient stay. A Georgetown University Hospital study showed that 75% of patients did not understand important aspects of their medical condition when leaving the hospital, and a third of patients failed to understand what to do at home in terms of self-care and follow-up appointments after being discharged. The goal of this center will be to help patients better understand their condition and how to care for themselves, coordinate their care and address intermediate clinical needs thereby decreasing re-admissions to the hospital and decreasing costs to the system. Providers in the center will utilize existing information in the hospital's electronic medical record and a predictive tool to identify patients most at risk for re-admission to target patients that would benefit most from the center.

The current Center for Heart Wellness is housed in the northeast bed tower, adjacent to an inpatient nursing unit, allowing for efficient use of staff, resources and physician expertise. Relocation of the center to the new building is a preferred option because it provides adequate room for expansion while remaining in close proximity to the same inpatient bed tower.

1110.3030(d)(3)(C)- Utilization

There is no utilization standard that exists for the Chronic Care Center, which will have an infusion area for Chronic Heart Failure patients that include Bumex, Lasix, blood, Albumin and iron infusions, in addition to exam rooms for clinic visits.

Incidence rates both nationally and locally show growth in the cardiac disease population. In Edward Hospital's Primary Service Area, it is estimated that the population ages 65 and older will increase 26% from 2017 to 2022 and it is this population that is particularly vulnerable to cardiac conditions. More specific, the population 85 years and older will increase 6% within five years. Sg2, a nationally known healthcare research and analytics firm, estimates that nine out of ten patients within this age group have a cardiovascular disease. The existing Center for Heart Wellness does not have the physical capacity keep up with the current demand let alone future patient demand.

ATTACHMENT – 31

In addition to the patients currently being seen through the Center for Heart Wellness, Edward Hospital expects to service patients with atrial fibrillation (a fib), chronic obstructive pulmonary disease (COPD), pneumonia, and other chronic conditions. There is currently a large population of chronically ill patients, and these populations continue to grow.

Edward Hospital utilizes a predictive readmission risk tool to identify patients most at risk for death or readmission within 30 days of discharge. The tool looks at the length of stay of the index admission, acuity of the admission, co-morbidities using the Charlson Co-Morbidity Index, and the number of emergency department visits within the last 6 months. Utilizing this tool, it is predicted that approximately 4,500 patients are at moderate or high at risk for readmission or death within 30 days of discharge in FY 2017. Utilizing historical data, the predictive readmission risk tool and conservative assumptions, it is estimated the center will have 4,900 patient visits in the first year of occupancy and will grow 73% in the next 2 years. Below is a table of historical patient visits for the existing Center for Heart Wellness and projections for the next 5 years.

	Center for Heart Wellness/Chronic Care Center Patient Visits
FY 2015 (actual)	1,560
FY 2016 (actual)	1,987
FY 2017 (actual)	2,484
FY 2018 (annualized)	2,782
FY 2019 ¹	3,648
FY 2020 ^{2,3}	4,941
FY 2021 ³	6,713
FY 2022 ³	8,556

¹ FY 2019 projections based on Center for Heart Wellness only and growth is limited due to capacity constraints.

² The proposed building is projected to be complete in January 2020.

³ FY 2020 – FY 2022 volume projections includes expansion of the Center for Heart Wellness to include other patient populations

Inability to provide space for this program will have a negative clinical outcome for these patients who need frequent touchpoints with providers to manage their condition.

SECTION VII. 120.130 – Financial Viability

Financial Viability Waiver

The applicant, Edward-Elmhurst Healthcare, has an A/Stable Bond Rating from S&P Global Ratings and Fitch Ratings as reflected in the attached documents.

Edward-Elmhurst Healthcare, Illinois

New Issue Report

Ratings

New Issues	
\$197,820,000 Illinois Finance Authority Fixed-Rate Revenue Bonds, Series 2017A	A
\$47,590,000 Variable-Rate Direct Purchase Bonds (JPMorgan), Series 2017B	NR
\$42,990,000 Variable-Rate Direct Purchase Bonds (Bank of America), Series 2017C	NR

NR – Not rated.

Outstanding Debt

See page 2 for a full listing of outstanding rated debt

Rating Outlook

Stable

Related Research

Fitch Rates Edward-Elmhurst Healthcare's (IL) Series 2017A Revenue Bonds 'A', Outlook Stable (January 2017)

Fitch Rates Edward-Elmhurst Healthcare (IL) Series 2016A Revenue Bonds 'A', Outlook Stable (October 2016)

Analysts

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New Issue Details

Sale Information: \$197,820,000 Illinois Finance Authority Fixed-Rate Revenue Bonds, Series 2017A, expected to sell on Jan. 11 via negotiation.

Security: Bond payments are to be secured by a joint and several revenue pledge of the Edward-Elmhurst Healthcare (EEH) obligated group, which will be created upon the issuance of the series 2017 financing. The bonds are not to be supported by a mortgage or a debt service reserve fund (DSRF).

Purpose: Bond proceeds from the series 2017 financings will refund and advance refund Edward Hospital's (Edward) series 2008A fixed-rate bonds, Edward's series 2008B-1 variable-rate demand bonds (VRDBs), Edward's series 2009A VRDBs, Elmhurst Memorial Healthcare's (Elmhurst) series 2008A fixed-rate bonds and pay the costs of issuance. Pro forma maximum annual debt service (MADS) is \$45.1 million.

Final Maturity: 2047.

Key Rating Drivers

Plan to Combine Obligated Groups: The creation of the EEH obligated group is one of the final steps in the process of merging Edward and Elmhurst. While the formation of the EEH obligated group is happening one or two years earlier than originally planned, this is not unexpected as Edward-Elmhurst has been operating as a single system since the merger was finalized on July 1, 2013. After the issuance of the series 2017 bonds, the separate Edward and Elmhurst obligated groups will cease to exist.

Growing Market Presence In Favorable Service Area: EEH is benefiting from volume growth in its favorable western Chicago suburban service area. Despite a competitive service area, EEH has realized market share growth in recent years.

Somewhat Modest Operating Margins: While profitable, EEH's operating EBITDA margins are somewhat modest for the 'A' rating category. In fiscal years 2015 and 2016, EEH recorded operating EBITDA margins of 8.7% and 8.4%, respectively.

Elevated Debt Load: Due to Elmhurst's heavy debt burden, EEH's pro forma debt service ratios are somewhat stressed. Pro forma MADS coverage by EBITDA is modest at 2.9x as is debt-to-EBITDA at 5.5x. Pro forma MADS as a percentage of revenue is manageable at 3.6%.

Mixed Liquidity Ratios: EEH's liquidity position is mixed. While pro forma cash on hand (226 days) and cushion ratio (16.0x) are adequate, pro forma cash to debt is thin at 100%.

Rating Sensitivities

Sustained Operating Results: Fitch Ratings expects the newly combined EEH obligated group to benefit from its growing market position, modern physical plant and favorable physician relationships to sustain, if not improve, operating margins over time. Given that the system does not have new money debt plans in the coming years, debt service coverage and liquidity ratios should improve over time.

Rating History — Edward

Rating	Action	Outlook/ Watch	Date
A	Downgraded	Stable	10/19/16
A+	Assigned	Stable	11/18/15

Rating History — Elmhurst

Rating	Action	Outlook/ Watch	Date
A	Upgraded	Stable	10/19/16
BBB	Affirmed	Positive	10/8/15
BBB	Affirmed	Stable	10/9/14
BBB	Downgraded	RWN	7/30/12
A-	Affirmed	Stable	2/7/11
A-	Downgraded	Stable	4/25/08
A	Affirmed	Stable	1/18/08
A	Upgraded	Stable	12/20/04
A-	Affirmed	Positive	12/11/03
A-	Assigned	Stable	11/26/02

RWN – Rating Watch Negative.

Rating History — Edward-Elmhurst

Rating	Action	Outlook/ Watch	Date
A	Assigned	Stable	1/6/17

Related Criteria

U.S. Nonprofit Hospitals and Health Systems Rating Criteria (June 2015)
Revenue-Supported Rating Criteria (June 2014)

Outstanding Debt^{a b}

\$86,100,000 Illinois Finance Authority Fixed-Rate Revenue Bonds (Edward), Series 2008A	A
\$48,560,000 Illinois Finance Authority Variable-Rate Demand Bonds (Edward), Series 2008B-1 (JPM LOC)	A (underlying)
\$48,560,000 Illinois Finance Authority Variable-Rate Demand Bonds, Series (Edward), 2008B-2 (JPM LOC)	A (underlying)
\$9,170,000 Illinois Finance Authority Variable-Rate Demand Bonds (Edward), Series 2008C (JPM LOC)	A (underlying)
\$42,890,000 Illinois Finance Authority Variable-Rate Demand Bonds (Edward), Series 2009A (BMO LOC)	A (underlying)
\$14,375,000 Illinois Finance Authority (Edward), Series 2012A	NR

\$76,025,000 Illinois Finance Authority Taxable Fixed-Rate Revenue Bonds (Elmhurst), Series 2013A	A
\$30,500,000 Illinois Finance Authority Taxable Variable-Rate Revenue Bonds (Elmhurst), Series 2013B	A
\$124,815,000 Illinois Finance Authority Fixed-Rate Revenue Bonds (Elmhurst), Series 2008A	A
\$50,000,000 Illinois Finance Authority Variable-Rate Revenue Bonds, Series (Elmhurst), Series 2008D (supported by BMO Harris Bank LOC)	A
\$190,000,000 Illinois Finance Authority Variable-Rate Private Placement (Elmhurst), Series 2013C&D	NR

^aOutstanding debt from Edward was downgraded from 'A+' on Oct. 19, 2016. ^bOutstanding debt from Elmhurst was upgraded from 'BBB' on Oct. 19, 2016. NR – Not rated.

Credit Profile

EEH is the result of the July 2013 merger between Edward and Elmhurst. EEH is a 613-licensed-bed health system headquartered in Naperville, IL, with inpatient acute care hospitals in Naperville and Elmhurst and the Linden Oaks Hospital, a 108-bed psychiatric hospital in Naperville. Naperville and Elmhurst are located 33 miles and 18 miles, respectively, west of downtown Chicago. EEH generated just over \$1.2 billion in operating revenue in fiscal 2016 (June 30 fiscal year end).

Growing Market Presence in Favorable Service Area

EEH has benefited from considerable volume growth in its favorable western Chicago suburban service area. Between fiscal years 2014 and 2016, inpatient admissions increased 10% (9.7% including observation stays), total surgeries 6.1% and outpatient visits 17.6%. These volume trends are particularly notable given that inpatient trends are stagnant in the Chicago metropolitan service area. The EEH management team has been successful at implementing strategic growth initiatives for expansion, particularly at the Elmhurst campus, which had been underperforming prior to the merger.

EEH continues to benefit from its tight relationship with the DuPage Medical Group (DMG), a multispecialty group with over 600 physicians. EEH and DMG share the same instance of the Epic electronic medical record (EMR). In addition, EEH and DMG participate in Illinois Health Partners and Illinois Health Partners, ACO, physician-hospital organizations that manage nearly 150,000 covered lives.

Despite a competitive service area, EEH's volume growth has led to market share gains in recent years. Between fiscal 2013 and nine-months fiscal 2016, EEH increased its inpatient market share position in its primary service area (PSA) each year, to 35.9% from 32.9%. EEH's market share growth has come largely at the expense of Good Samaritan Hospital (a member of Advocate Health Care, rated 'AA/Stable' by Fitch), whose market share position in EEH's PSA decreased to 7.5% from 8.5% and Central DuPage Hospital (a member of Northwestern Medicine), whose market share position decreased to 5.4% from 6.4%.

Somewhat Modest Operating Margins

While profitable, EEH's operating EBITDA margins are somewhat modest for the 'A' rating category. In fiscal years 2015 and 2016, EEH recorded operating EBITDA margins of 8.7% and 8.4%, respectively (fiscal 2015 adjusted to remove one-time \$6 million recovery audit contractor payment and \$2.5 million rural floor settlement from operating revenue). These are modest compared to the 'A' rating category median of 10.3%. Despite driving notable improvement at Elmhurst, operating profitability at Elmhurst continues to be a drag on system results; in fiscal years 2015 and 2016, the Elmhurst campus recorded operating EBITDA margins of 6.0% and 6.6%, respectively.

Looking forward, management has budgeted a 7.7% operating EBITDA margin in fiscal 2017, which includes one-time costs associated with Elmhurst's go-live of the Epic EMR system in October 2016. In the first quarter of fiscal 2017, EEH recorded a modest operating EBITDA margin of 5.3%. Beyond, fiscal 2017, management projects an operating EBITDA margin in the 8%-9% range, which Fitch expects EEH to meet if not exceed.

Payor Mix

(% Gross Revenues, Fiscal Years Ended June 30)

	2014	2015	2016
Medicare	39.3	40.8	40.2
Medicaid	7.6	8.5	8.5
Commercial and Managed Care	47.6	46.6	47.5
Self-Pay	3.2	1.7	1.6
Other	2.3	2.4	2.2
Total	100.0	100.0	100.0

Source: Edward-Elmhurst Healthcare and Fitch

Utilization Data

(Fiscal Years Ended June 30)

	2014	2015	2016
Operated Beds	674	721	721
Acute Adult Admissions/Discharges	34,678	37,791	38,146
Acute Adult Patient Days	173,459	185,085	183,979
Average Length of Stay (Days)	5.0	4.9	4.8
Average Daily Census	475	507	504
Occupancy (%)	77.0	76.3	75.8
Observation Cases	12,131	12,563	13,209
Hospital Stays (Admissions plus Observation Cases)	46,809	50,354	51,355
Births	4,392	4,596	4,532
Inpatient Surgeries	8,869	9,766	10,042
Outpatient Surgeries	17,524	16,977	17,953
Emergency Department Visits, Net of Admissions	123,331	136,512	141,112
Outpatient/Clinic Visits	729,717	781,155	858,013
Medicare Casemix Index	1.65	1.66	1.70

Source: Edward-Elmhurst Healthcare and Fitch

Elevated Debt Load

Because of Elmhurst's heavy debt burden, EEH's pro forma debt service ratios are somewhat stressed. Pro forma MADS is \$45.1 million. Pro forma MADS coverage by EBITDA is modest at 2.9x ('A' rating category median is 4.5x) as is debt-to-EBITDA at 5.6x ('A' rating category median is 2.9x). Pro forma MADS as a percentage of revenue is manageable at

3.6% ('A' rating category median is 2.7%) Fitch expects EEH to grow absolute cash flow and, therefore, debt ratios should improve over time.

EEH's pro forma debt will be a mix of fixed rate debt (42% of pro forma debt outstanding) and variable rate (58%). Variable-rate debt series will consist of VRDBs supported by letters of credit (LOC), direct bank purchases and R-Floats.

EEH's financial covenants in the MTI include a minimum debt service coverage ratio of 1.10x (consultant call-in) and a 1.00x event of default if debt service coverage is below this level for two consecutive fiscal years (unless at the end of the second fiscal year cash on hand exceeds 70 days).

EEH has a legacy defined benefit pension plan (from Elmhurst) that was frozen in December 2013. The plan was 75% funded relative to a projected benefit obligation of \$237 million at year-end fiscal 2016.

EEH has just over \$500 million notional of swaps outstanding, including fixed payor, fixed-spread basis, and basis swaps. Counterparties include JPMorgan, PNC, Deutsch Bank, Goldman Sachs, Citi, UBS, Morgan Stanley and Merrill Lynch. The net termination value of the swaps at the end of fiscal 2016 was a negative \$53 million to EEH.

New Issue Details

As part of the 2017 plan of finance, EEH also plans to issue \$47.6 million of series 2017B direct purchase variable-rate bonds (with JPMorgan) and \$43.0 million of series 2017C direct purchase variable-rate bonds (with Bank of America), the series 2017B&C bonds are not rated by Fitch. Bond proceeds from the series 2017 financings, which include releasing \$10.5 million of DSRFs, will refund and advance refund Edward's series 2008A fixed-rate bonds, Edward's series 2008B-1 VRDBs, Edward's series 2009A VRDBs, Elmhurst series 2008A fixed-rate bonds and pay the costs of issuance. The bonds are expected to sell the week of Jan. 11 via negotiation.

Mixed Liquidity Ratios

EEH's liquidity position is mixed relative to its 'A' rated peer group. Unrestricted cash and investments measured \$721 million at the end of fiscal 2016. EEH's pro forma cash on hand of 226 days and cushion ratio of 16.0x are adequate ('A' rating category medians are 216 days and 19.4x, respectively). Pro forma cash-to-debt is thin at 100% ('A' rating category median is 149%). EEH's liquidity ratios should strengthen over time as EEH has manageable capital spending plans and absolute cash flow growth is expected.

Manageable Capital Spending

EEH has manageable capital spending plans, as both Edward and Elmhurst invested considerably in physical plant in recent years. EEH's average age of plant measured 11.7 years at the end of fiscal 2016 ('A' rating category median is 11.0 years). Capital spending in the coming years will be focused on ambulatory development and information technology. EEH does not have new money debt plans in the near term.

Disclosure

EEH covenants to provide annual audited financial statements within 150 days of fiscal year end and unaudited quarterly statements within 45 days of quarter end to bondholders. Quarterly disclosures for both Edward and Elmhurst in the past have included a balance sheet, income statement, cash flow statement and volume statistics.

Financial Summary

(\$000, Audited Fiscal Years Ended June 30)

	2014	2015	Pro Forma 2016
Balance Sheet Data			
Unrestricted Cash and Investments	716,573	759,666	720,591
Restricted Cash and Investments	111,450	104,708	103,516
Trustee-Held Cash and Investments	31,424	31,503	31,878
Net Patient Accounts Receivable	194,385	202,741	226,926
Property, Plant and Equipment, Net	993,014	969,085	977,602
Total Assets	2,247,747	2,274,486	2,282,370
Current Liabilities	344,155	367,882	385,761
Total Debt (Including Current Portion)	741,666	730,470	717,790
Demand Debt		233,895	229,670
Unrestricted Net Assets	1,007,956	1,007,358	969,455
Income and Cash Flow Data			
Net Patient Revenue	1,020,074	1,131,465	1,184,597
Other Revenue	63,349	57,702	63,774
Total Revenues	1,083,423	1,189,167	1,248,371
Salaries, Wages, Fees Benefits	578,562	626,545	668,027
Depreciation and Amortization	80,434	79,620	67,642
Interest Expense	20,046	19,294	18,233
Total Expenses	1,079,495	1,184,567	1,229,181
Income from Operations	3,928	4,600	19,190
Non-Operating Gains	141,737	51,343	24,139
Excess of Revenues over Expenses	145,665	55,943	43,329
EBITDA	246,145	154,857	129,204
Operating EBITDA	104,408	103,514	105,065
Net Unrealized Gains/(Losses)	(28,624)	(33,373)	(41,357)
Cash Flow from Operations	146,002	85,565	75,612
Net Capital Expenditures	86,205	71,795	78,668
Maximum Annual Debt Service (MADS)	45,088	45,088	45,088
Actual Annual Debt Service (AADS)	33,777	30,660	32,178
Liquidity Ratios			
Days Cash on Hand	261.8	250.9	226.4
Days in Accounts Receivable	69.6	65.4	69.9
Days in Current Liabilities	125.7	121.5	121.2
Cushion Ratio (x)	15.9	16.9	16.0
Cash/Debt (%)	96.6	104.0	100.4
Unrestricted Cash and Investments/Demand Debt (%)	—	324.8	313.8
Profitability and Operational Ratios (%)			
Operating Margin	0.4	0.4	1.5
Operating EBITDA Margin	9.6	8.7	8.4
Excess Margin	11.9	4.5	3.4
EBITDA Margin	20.1	12.5	10.2
Personnel Cost/Total Revenue	53.4	52.7	53.5
Bad Debt Provision/Patient Service Revenue	4.8	3.5	2.9
Capital Related Ratios			
MADS Coverage – EBITDA (x)	5.5	3.4	2.9
MADS Coverage – Operating EBITDA (x)	2.3	2.3	2.3
AADS Coverage – EBITDA (x)	7.3	5.1	4.0
MADS/Total Revenue (%)	4.2	3.8	3.6
Debt/EBITDA (x)	3.0	4.7	5.6
Debt/Capitalization (%)	42.4	42.0	42.5
Average Age of Plant (Years)	8.8	9.8	11.7
Capital Expenditures/Depreciation (%)	107.2	90.2	116.3

EBITDA – Earnings before interest, taxes, depreciation and amortization. N/A – Not available. Note: Fitch may have reclassified certain financial statement items for analytical purposes.
Source: Edward-Elmhurst Healthcare and Fitch

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Illinois Finance Authority

Edward-Elmhurst Healthcare; Hospital; Joint Criteria

Credit Profile

Illinois Finance Authority, Illinois

Edward-Elmhurst Healthcare, Illinois

Illinois Finance Authority (Edward-Elmhurst Healthcare)

<i>Long Term Rating</i>	AA+ / A-1	Affirmed
<i>Unenhanced Rating</i>	A(SPUR)/Stable	Affirmed
2008B-2		
<i>Unenhanced Rating</i>	A(SPUR)/Stable	Affirmed
<i>Long Term Rating</i>	AA+ / A-1	Affirmed
2008 C		
<i>Unenhanced Rating</i>	A(SPUR)/Stable	Affirmed
<i>Long Term Rating</i>	AA+ / A-1	Affirmed

Rationale

S&P Global Ratings affirmed its 'A' underlying rating (SPUR) and long-term rating on the Illinois Finance Authority's debt (2013A and 2013B) issued for Edward Hospital and Health Services Corp. and Elmhurst Memorial Healthcare, which are now part of the Edward-Elmhurst Healthcare (EEH) obligated group. S&P Global Ratings also affirmed its 'A' underlying rating (SPUR) and long-term rating on the the authority's debt outstand (2017A) issued for EEH obligated group. The outlook is stable.

At the same time, S&P Global Ratings affirmed its 'AA+ / A-1' dual ratings on Edward-Elmhurst Healthcare's outstanding revenue variable rate demand bonds. We base the ratings on the application of our joint criteria using the low-correlation chart.

The 'AA+' long-term rating component on the series 2008B-2 and 2008C VRDBs is jointly based on the long-term rating on the EEH (A/Stable) and the letters of credit (LOCs) provided by JPMorgan Chase Bank N.A. (A+ / Stable / A-1), with the short-term rating component based solely on JPMorgan Chase. The 'AA+' long-term rating component on the series 2008D bonds is jointly based on the long-term rating on EEH and the LOC provided by Bank of America N.A. (A+ / Stable / A-1), with the short-term rating component based solely on Bank of America N.A.

The rating continues to reflect our expectation of EEH's solid financial profile, which results from healthy liquidity and financial flexibility. EEH recently performed a valuation of its accounts receivable and determined that net revenues had been overstated since before Edward and Elmhurst Memorial Hospital merged. We expect EEH to maintain its solid enterprise profile, including healthy volume trends. As a result, fiscal 2016, 2017, and first-quarter 2018 results were restated, resulting in operating losses. However, there was no cash impact, and management has taken action to

improve revenue reporting and improve internal controls.

The ratings reflect our view of EEH's:

- Solid enterprise profile in the western Chicago suburbs and consistent growth in inpatient market share, ambulatory and physician activity, and footprint;
- Stable leadership team that continues to execute its strategic plan; and
- Solid days' cash on hand that provides a buffer for unforeseen events.

Partially offsetting the above strengths, in our view, are the hospital's:

- Somewhat high leverage relative to 'A' medians, as well as an elevated contingent liability profile from variable-rate debt and private placement bonds;
- Recent operating losses due to an accounting error that had overstated accounts receivables; and
- Dependence on key large, independent medical groups.

Outlook

The stable outlook reflects our expectation that EEH will maintain its strong financial profile and market position despite the highly competitive market. Our outlook also reflects our expectation that EEH has improved its overall risk controls and risk management following the accounting error in fiscal 2017.

Downside scenario

We could lower the rating in the two-year outlook horizon if EEH's overall financial profile does not improve or operating margins are notably less than budgeted in the next two fiscal years, affecting other measures that might align with a lower rating. Also, we could revise the outlook or lower the rating following significant balance-sheet weakness. There is limited room for negative financial deviation across both the balance sheet and income statement.

Upside scenario

We could consider a higher rating over the two-year outlook period if EEH can improve its financial and enterprise profile to levels more in line with a higher rating category. This would include substantial improvement in cash on hand, operating margin, maximum annual debt service coverage, and unrestricted reserves to long-term debt.

Enterprise Profile: Strong

EEH's enterprise profile reflects a healthy business position with continuing market share growth and stability.

EEH operates in DuPage and Will counties in Illinois and defines its primary service area (PSA) as Naperville, Plainfield, and Elmhurst. The PSA population, totaling 975,312, is robust and minor growth is anticipated over the next five years. Wealth and income levels within the PSA are above national averages.

Edward is in Naperville, about 30 miles southwest of downtown Chicago. The service area has several clinics, urgent

care clinics, and ambulatory surgery centers, and Edward has a substantial presence in Plainfield (with a freestanding emergency room, a surgery center, and an outpatient center that includes cancer services). With the Elmhurst merger, the contiguous markets have been a positive factor. EEH continues to value its relationships with independent medical groups. EEH also owns 100% of Illinois Health Partners, which took effect Oct. 16, 2016; it had previously operated it with DuPage Medical Group in a 50/50 joint venture.

EEH's payor mix is satisfactory, in our opinion, because it has limited contracts that incorporate full risk outside of the shared-risk contracts in which it participates. No payors offer full-risk contracts.

Management and governance

The management team has been fairly stable since our previous analysis. However, EEH is looking for a new chief financial officer (CFO) given that the previous CFO departed in June 2017. Jeffrey Friant is serving as the interim CFO; he has worked as vice-president finance for more than three years. The team, in our opinion, has executed well on the strategic plan instituted when Edward and Elmhurst came together. Since that time, the leadership has fine-tuned and updated its strategic focus, continuing to look at adding physicians, spending capital, and watching the competitive landscape in the greater service area. EEH combined its two obligated groups in February 2017.

Also, management is working to strengthen its financial accounting and controls and has a strong emphasis on its quality and service model. The team continues to focus on improving its overall risk management given the recent accounting error.

Financial policies

The financial policies assessment is neutral, reflecting our opinion that, while there may be some areas of risk, the organization's overall financial policies are not likely to negatively affect its ability to pay debt service. Our analysis of financial policies includes a review of the system's financial reporting and disclosure, investment allocation and liquidity, debt profile, contingent liabilities, and legal structure, and a comparison of these policies to those of comparable providers. However, we consider EEH's debt profile and contingent liabilities principles negative because contingent liabilities are more than 50% of total long-term debt and swap usage is high.

Financial Profile: Strong

Accounting restatement led to prior period operating losses, but 2018 projections looks sound

In mid-2017, management engaged in a process with outside advisors to review its revenue and managed care contracts. The valuation showed that net revenues have been overstated at both organizations since before Edward and Elmhurst merged, so the reported cash flow has been overstated. At June 30, 2017, EEH's financial statements overstated accounts receivable by \$92 million; it restated 2016, 2017, and first-quarter 2018 results resulting in income statement reductions of \$21.7 million, \$16.9 million, and \$8.4 million, respectively. These numbers represent accounting adjustments recorded to reduce accounts receivable on the balance sheet and resulted in net operating losses for these periods. There was no cash impact and management has taken remedial actions. Notably, the team has engaged a national consulting firm for a revenue revitalization project and implemented new accounting procedures. Another consulting firm was engaged to review managed care contract practices related to installing and monitoring calculations in health care IT systems. The team has embarked on an overall effort to improve risk controls

and we believe it has made significant progress.

Given the 2016 and 2017 restatements, EEH reported operating margins of negative 0.85% and negative 1.61%, respectively, and negative 0.71% through the interim 2018 period ended March 2018. However, management is targeting a 2.8% operating margin for fiscal 2018 based on cost-cutting efforts and expected rate increases. We expect overall improvement based on continued cost-cutting and implementation of more stringent accounts receivable controls. Management's fiscal 2018 goal was to reduce expenditures by \$50 million; it has already exceeded this by reducing non-labor costs \$28 million and \$25 million of labor costs due to the team eliminating more than 200 positions.

Through March 31, 2018, the excess margin stood at 3.57% and the overall EBITDA margin rebounded to 9.96%. We expect income statement metrics to improve given the overall volume growth and focus on costs.

Liquidity and financial flexibility remain sound

We consider EEH's unrestricted reserves and overall liquidity to be solid. For the interim period March 31, 2018, overall days' cash on hand stood at a healthy 243 days. Unrestricted reserves to contingent liabilities stood at a healthy 200% and we expect the hospital to maintain a solid cushion. We believe EEH will maintain a minimum of 150 days' cash on hand to cover unforeseen events.

Debt and contingent liabilities

EEH continues to have contingent liability risk exposures from financial instruments with payment provisions that may change on certain events, but we consider the risk manageable at the rating. EEH's unrestricted reserves provide acceptable coverage in the event of acceleration, at 200%. Management has no new money debt plans over the outlook period but might refinance some existing private placement debt over the next year.

As of fiscal 2017, EEH had a total amount of \$446 million of contingent liability debt:

- Various variable rate demand bonds with acceleration provisions; and
- Direct placement debt with acceleration provisions.

The overall master trust indenture has covenants including a historical debt service requirement of 1.1x, and a minimum requirement of 75 days' cash on hand.

Table 1

Edward-Elmhurst Healthcare System--Enterprise Statistics

	--Nine months ended March 31--	--Fiscal year ended June 30--		
	2018	2017	2016	2015
PSA population	NA	975,312	974,986	970,742
PSA market share (%)	NA	36.5	35.8	32.6
Inpatient admissions	NA	40,103	38,159	37,791
Equivalent inpatient admissions	NA	95,074	90,773	94,644
Emergency visits	NA	169,269	164,842	136,512
Inpatient surgeries	NA	11,126	10,042	9,766
Outpatient surgeries	NA	17,890	17,953	16,977

Table 1

Edward-Elmhurst Healthcare System--Enterprise Statistics (cont.)

	--Nine months ended March 31--	--Fiscal year ended June 30--		
	2018	2017	2016	2015
Medicare case mix index	N.A.	1.8000	1.6700	1.6600
FTE employees	N.A.	4,824	4,638	6,254
Active physicians	N.A.	1,000	982	905
Top 10 physicians admissions (%)				
Based on net/gross revenues	N/A	Gross	Gross	Gross
Medicare (%)	N.A.	41.0	39.5	40.1
Medicaid (%)	N.A.	9.2	8.5	8.5
Commercial/Blues (%)	N.A.	46.9	48.8	47.4

Note: Inpatient admissions exclude normal newborn, psychiatric, rehabilitation, and long-term care facility admissions. N.A.--Not available.
N/A--Not applicable.

Table 2

Edward-Elmhurst Healthcare System--Financial Statistics

	--Nine months ended March 31--	--Fiscal year ended June 30--			--Medians for 'A' rated stand-alone hospitals--
	2018	2017	2016	2015	2016
Financial performance					
Net patient revenue (\$000s)	951,814	1,229,286	1,162,897	1,131,465	378,530
Total operating revenue (\$000s)	1,051,487	1,350,591	1,222,282	1,197,667	MNR
Total operating expenses (\$000s)	1,058,959	1,372,373	1,232,693	1,193,741	MNR
Operating income (\$000s)	(7,472)	(21,782)	(10,411)	3,926	MNR
Operating margin (%)	(0.71)	(1.61)	(0.85)	0.33	2.80
Net nonoperating income (\$000s)	46,656	16,498	30,540	53,503	MNR
Excess income (\$000s)	39,184	(5,284)	20,129	57,429	MNR
Excess margin (%)	3.57	(0.39)	1.61	4.59	4.80
Operating EBIDA margin (%)	5.96	4.94	6.30	8.59	9.40
EBIDA margin (%)	9.96	6.09	8.58	12.50	11.20
Net available for debt service (\$000s)	109,352	83,204	107,504	156,343	50,424
Maximum annual debt service (\$000s)	44,756	44,756	44,756	44,756	MNR
Maximum annual debt service coverage (x)	3.26	1.86	2.40	3.49	4.70
Operating lease-adjusted coverage (x)	3.26	1.61	2.02	2.80	3.30
Liquidity and financial flexibility					
Unrestricted reserves (\$000s)	892,324	821,048	733,176	759,666	252,399
Unrestricted days' cash on hand	243.4	229.8	229.7	248.9	239.60
Unrestricted reserves/total long-term debt (%)	131.8	118.5	104.8	106.0	213.20
Unrestricted reserves/contingent liabilities (%)	200.1	184.1	168.9	191.3	449.00
Average age of plant (years)	12.4	12.5	11.7	9.8	10.70
Capital expenditures/depreciation and amortization (%)	88.2	112.6	116.3	88.5	122.50

Table 2

Edward-Elmhurst Healthcare System--Financial Statistics (cont.)

	--Nine months ended March 31--	--Fiscal year ended June 30--			--Medians for 'A' rated stand-alone hospitals--
	2018	2017	2016	2015	2016
Debt and liabilities					
Total long-term debt (\$000s)	677,144	692,957	699,675	716,690	MNR
Long-term debt/capitalization (%)	39.3	41.3	43.9	41.6	27.00
Contingent liabilities (\$000s)	446,010	446,010	434,045	397,145	MNR
Contingent liabilities/total long-term debt (%)	65.9	64.4	62.0	55.4	34.40
Debt burden (%)	3.06	3.27	3.57	3.58	2.50
Defined-benefit plan funded status (%)	N/A	81.74	74.79	80.32	74.90
Pro forma ratios					
Unrestricted reserves (\$000s)	N/A	N/A	N/A	N/A	MNR
Total long-term debt (\$000s)	N/A	N/A	N/A	N/A	MNR
Unrestricted days' cash on hand	N/A	N/A	N/A	N/A	MNR
Unrestricted reserves/total long-term debt (%)	N/A	N/A	N/A	N/A	MNR
Long-term debt/capitalization (%)	N/A	N/A	N/A	N/A	MNR

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

Credit Snapshot

- **Security pledge:** The obligated group's gross revenue pledge secures the bonds.
- **Group rating methodology:** Core. The 'A' rating reflects our view of EEH's (GCP) and the obligated group's "core" status. Accordingly, we rate the bonds at the same level as the GCP.
- **Organization description:** EEH, the parent, operates two acute care hospitals: Edward Hospital in Naperville and Elmhurst Memorial Hospital in Elmhurst. Naperville and Elmhurst are western suburbs of Chicago. EEH operates several affiliates, including Edward Health Ventures (EHV), the Edward Foundation, and captive insurance company EEH SPC. EHV includes physician practices, Edward-Elmhurst Health & Fitness, and has a 99% interest in Naperville Psychiatric Ventures LLC (NPV), which operates Linden Oaks Hospital, a behavioral health hospital also on the Edward Hospital campus. EEH also operates Elmhurst Memorial Hospital Foundation. The obligated group consists of EEH, Edward Hospital, EHV, Elmhurst Hospital, Elmhurst Memorial Healthcare, and NPV. The timing of the two obligated groups' combination is uncertain.
- **Swaps:** As of fiscal 2017, EEH had \$506.3 million on notional interest rate swaps outstanding with no collateral posted at this time. The swaps are executed with various bank counterparties and include a termination event should ratings on it fall below investment-grade.

Ratings Detail (As Of May 1, 2018)

Illinois Finance Authority, Illinois
Edward-Elmhurst Healthcare, Illinois

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Ratings Detail (As Of May 1, 2018) (cont.)

Illinois Finance Authority rev bnds (Edward Hosp & Hlth Services Corp)

<i>Long Term Rating</i>	A/Stable	Affirmed
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Illinois Finance Authority (Edward-Elmhurst Healthcare)

<i>Long Term Rating</i>	A/Stable	Affirmed
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Illinois Finance Authority (Edward-Elmhurst Healthcare)

<i>Long Term Rating</i>	A/Stable	Affirmed
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2009 A

<i>Unenhanced Rating</i>	A(SPUR)/Stable	Affirmed
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<i>Long Term Rating</i>	AA+/A-1	Affirmed
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SECTION IX. 1120.140 – ECONOMIC FEASIBILITY

B. Conditions of Debt Financing

This project is being paid through cash and securities and, therefore, this criterion is not applicable

C. Reasonableness of Project and Related Costs

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Clinical Dept./Area	Cost/Square Foot		Gross Sq. Ft		Gross Sq. Ft		New \$	Mod \$	Total Cost
	A New	B Mod	C New	D Circ*	E Mod	F Circ*	G (A x C)	H (B x E)	
REVIEWABLE									
Adult Intensive Care Unit	NA	\$ 324	0	0%	9,933	26%	\$0	\$3,220,225	\$3,220,225
Adult Observation Unit	NA	\$ 322	0	0%	7,237	29%	\$0	\$2,328,440	\$2,328,440
Chronic Care Clinic	\$ 422	NA	4,135	23%	0	0%	\$1,744,970		\$1,744,970
Total Reviewable	\$ 422	\$ 323	4,135	23%	17,170	27%	\$1,744,970	\$5,548,665	\$7,293,635
NON REVIEWABLE									
Administrative	\$ 405	\$ 308	2,140	18%	1,759	0%	\$866,700	\$541,772	\$1,408,472
Support Space	\$ 412	\$ 316	1,622	0%	1,455	0%	\$668,264	\$459,780	\$1,128,044
Patient Education	\$ 418	\$ 304	901	26%	3,006	26%	\$376,618	\$913,824	\$1,290,442
Physician Office Space	\$ 419	NA	25,024	24%	0	0%	\$10,478,800	\$0	\$10,478,800
Mechanical	\$ 486	NA	7,116	0%	0	0%	\$3,458,376	\$0	\$3,458,376
Public Areas	\$ 455	\$ 385	12,149	94%	4,919	75%	\$5,521,721	\$1,893,815	\$7,415,536
Total Non-Reviewable	\$ 437	\$ 342	48,952	36%	11,139	40%	\$21,370,479	\$3,809,191	\$25,179,670
Total Excl Contingency	\$ 435	\$ 331	53,087		28,309		\$23,115,449	\$9,357,856	\$32,473,305
Contingency							\$2,413,653	\$977,122	\$3,390,775
GRAND TOTAL	\$481	\$365	53,087	36%	28,309	16%	\$25,529,101	\$10,334,978	\$35,864,079

* Percentage of space for circulation

D. Projected Operating Costs

<u>Resultant Operating Costs</u>				
Name of Service		<u>Facility</u>		
Total direct operating costs per proforma Units of Service (EPD)	\$	15,862,200		
		223,135		
Cost Per Unit	\$	71.09		
HOSPITAL				
Outpatient Gross Revenue / Inpatient Revenue = Equivalency Factor		<u>Outpatient</u> \$1,784,686,406	<u>Inpatient</u> \$992,344,235	<u>Equivalency Factor</u> 1.798
Patient Days X Equivalency Factor = Equivalency Add-On		<u>Patient Days</u> 79,735	<u>Equivalency Factor</u> 1.798	<u>Equivalency Add</u> 143,400
Patient Days + Equivalency Add-On = Equiv Patient Days (EPD)		<u>Patient Days</u> 79,735	<u>Equivalency Add</u> 143,400	<u>Equiv Patient Days</u> 223,135

E. Total Effect of the Project on Capital Costs

<u>Projected Capital Expense</u>			
	<u>Total Capital Expense</u>	<u>Equiv Patient Days</u>	<u>Capital Expense Per EPD</u>
Facility Capital Expense	\$ 37,727,058	223,135	\$ 169.08
Project Capital Expense	\$ 3,203,000	223,135	\$ 14.35
Calculation of Capital Expense			
	<u>Total Facility*</u>	<u>Project</u>	<u>Facility</u>
Interest Expense	\$ -	\$ -	\$ -
Depreciation Expense	\$ 37,727,058	\$ 3,203,000	\$ 34,524,058
Total	\$ 37,727,058	\$ 3,203,000	\$ 34,524,058

SECTION XI. CHARITY CARE INFORMATION

The chart below provides, for the last three audited fiscal years, the amount and cost of charity care and the ratio of charity care to net patient revenue at Edward Hospital and Elmhurst Hospital. The system's mission is to support community health needs by providing outstanding healthcare services. As the need for charity care support increases in the community so will the amount of charity care provided at each hospital as shown by the data below.

Edward Hospital			
	FY 2015	FY 2016	FY 2017
Net Patient Revenue	\$567,759,659	\$574,141,138	\$618,451,379
Amount of Charity Care (charges)	\$44,391,235	\$49,956,169	\$52,133,314
Cost of Charity Care	\$8,728,888	\$9,566,782	\$9,106,698
Ratio of Charity Care Cost to Net Patient Revenue	1.5%	1.7%	1.5%

Elmhurst Hospital			
	FY 2015	FY 2016	FY 2017
Net Patient Revenue	\$379,832,416	\$385,431,170	\$418,514,774
Amount of Charity Care (charges)	\$32,842,986	\$38,437,352	\$39,461,369
Cost of Charity Care	\$6,873,152	\$7,245,149	\$6,840,095
Ratio of Charity Care Cost to Net Patient Revenue	1.8%	1.9%	1.6%

18-015

May 7, 2018

Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, 2nd Floor
Springfield, IL 62761

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HEALTH FACILITIES &
SERVICES REVIEW BOARD

To Whom It May Concern:

Enclosed please find Edward Hospital's CON Application for East Building and Bed Additions. You will also find the \$2,500 check for the initial application fee.

Please contact me at 630-527-3917 if you have any questions about the materials enclosed.

Sincerely,



Kari Runge
System Director, Planning

Edward Hospital
801 S. Washington Street
Naperville, IL 60540

Elmhurst Hospital
155 E. Brush Hill Road
Elmhurst, IL 60126
EEHealth.org