

October 12, 2017

RECEIVED

OCT 13 2017

HEALTH FACILITIES &
SERVICES REVIEW BOARD

Ms. Kathryn Olson
Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street – 2nd Floor
Springfield, Illinois 62761

RE: *Applications submittals*
Northwestern Medicine Delnor Hospital
Surgical Services Modernization project

Dear Ms. Olson:

Enclosed are the following materials supporting Northwestern Medicine Delnor Hospital's Certificate of Need application for the modernization of the Surgical Services department:

- CON Permit Application (2 unbound copies, including original)
- CON Permit Application Fee - in the amount \$2,500

If you have any questions/comments, please feel to contact me at (312) 926-8650.

Sincerely,



Bridget S. Orth
Director, Regulatory Planning

enclosures

17-055

ORIGINAL

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

OCT 13 2017

This Section must be completed for all projects.

HEALTH FACILITIES &
SERVICES REVIEW BOARD

Facility/Project Identification

Facility Name:	Northwestern Medicine Delnor Hospital Surgical Services Modernization		
Street Address:	300 Randall Road		
City and Zip Code:	Geneva, IL 60134		
County:	Kane	Health Service Area:	8
		Health Planning Area:	A-12

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

Exact Legal Name:	Delnor-Community Hospital d/b/a Northwestern Medicine Delnor Hospital		
Street Address:	300 Randall Road		
City and Zip Code:	Geneva, IL 60134		
Name of Registered Agent:	Danae Prousis		
Registered Agent Street Address:	211 East Ontario Street, Suite 1800		
Registered Agent City and Zip Code:	Chicago, IL 60611		
Name of Chief Executive Officer:	Maureen A. Bryant		
CEO Street Address:	300 Randall Road		
CEO City and Zip Code:	Geneva, IL 60134		
CEO Telephone Number:	630-208-3071		

Type of Ownership of Applicants

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

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

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

Name:	Rob Christie
Title:	Senior Vice President
Company Name:	Northwestern Memorial HealthCare
Address:	211 East Ontario Street, Suite 1750, Chicago, IL 60611
Telephone Number:	312-926-7527
E-mail Address:	robert.christie@nm.org
Fax Number:	312-926-4545

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

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

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Street Address:	300 Randall Road		
City and Zip Code:	Geneva, IL 60134		
County:	Kane	Health Service Area:	8
		Health Planning Area:	A-12

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

Exact Legal Name:	CDH-Delnor Health System		
Street Address:	25 North Winfield Road		
City and Zip Code:	Winfield, IL 60190		
Name of Registered Agent:	Danae Prousis		
Registered Agent Street Address:	211 East Ontario Street, Suite 1800		
Registered Agent City and Zip Code:	Chicago, IL 60611		
Name of Chief Executive Officer:	Dean M. Harrison		
CEO Street Address:	251 East Huron Street		
CEO City and Zip Code:	Chicago, IL 60611		
CEO Telephone Number:	312-926-3007		

Type of Ownership of Applicants

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

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APPLICATION FOR PERMIT**

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E-mail Address:	robert.christie@nm.org
Fax Number:	312-926-4545

Post Permit Contact

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

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

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Delnor-Community Hospital d/b/a Northwestern Medicine Delnor Hospital
Address of Site Owner:	300 Randall Road, Geneva, IL 60134
Street Address or Legal Description of the Site:	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:	Delnor-Community Hospital d/b/a Northwestern Medicine Delnor Hospital		
Address:	300 Randall Road, Geneva, IL 60134		
<input checked="" type="checkbox"/>	Non-profit Corporation	<input type="checkbox"/>	Partnership
<input type="checkbox"/>	For-profit Corporation	<input type="checkbox"/>	Governmental
<input type="checkbox"/>	Limited Liability Company	<input type="checkbox"/>	Sole Proprietorship
		<input type="checkbox"/>	Other
<ul style="list-style-type: none"> 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.

Northwestern Medicine Delnor Community Hospital proposes to modernize its Surgical Services department. The hospital is located at 300 Randall Road, Geneva.

In the proposed project, a 2-story addition will be constructed at the site of the hospital's current loading dock. The modernized Surgical Services department will be located in the addition as well as in the reconfigured Surgical Services space that is adjacent to the addition. The number of operating rooms will not increase and the number of procedure rooms will decrease by one as a result of this project.

The proposed project scope includes:

- 10 operating rooms, 2 procedure rooms, 11 Phase I recovery stations, 33 Phase II recovery stations
- Expanded pre-admission testing area
- Renovated lounge/locker facilities for staff and surgeons
- Renovated surgical office support functions to accommodate surgery clinic space
- Relocation of the loading dock bulk storage and waste container facilities to the west side of the new first floor addition
- Site work and signage to accommodate the new addition including related utility and store sewer relocation work
- Landscaping work including modification to the sidewalks, driveways, parking, site utilities, site lighting
- Expanded public facilities including larger and more private family waiting/consult spaces, public toilets, and required fire exit corridors around the sterile environment

The project also includes extensive infrastructure work including reworking and tie-ins to new and existing systems.

Related exterior enclosure work includes:

- 3 new rooftop air handling units (RTUs) with maintenance vestibules
- 2 new chillers on the roof of the addition
- Louvered rooftop screen
- Improved roof area access
- Underground utilities and services required for the new building addition
- Repairs to existing kitchen exhaust systems to meet current regulations

The outpatient surgery department, formerly known as the Tri-Cities Surgery Center ASTC, located in the adjacent medical office building, is not part of this project.

The anticipated completion date of the project is July 31, 2021.

The total project cost is \$39,612,776.

The project is classified as non-substantive because it does not establish a new category of service or facility as defined in 20 ILCS 3960/3.

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	\$ 69,937	\$ 60,063	\$ 130,000
Site Survey and Soil Investigation	\$ 16,139	\$ 13,861	\$ 30,000
Site Preparation	\$ 247,332	\$ 212,413	\$ 459,745
Off Site Work			
New Construction Contracts	\$ 5,126,776	\$ 9,178,776	\$ 14,305,552
Modernization Contracts	\$ 9,103,680	\$ 2,608,023	\$ 11,711,703
Contingencies	\$ 1,423,046	\$ 1,178,680	\$ 2,601,726
Architectural/Engineering Fees	\$ 847,529	\$ 727,871	\$ 1,575,400
Consulting and Other Fees	\$ 895,731	\$ 769,269	\$ 1,665,000
Movable or Other Equipment (not in construction contracts)	\$ 5,971,650	\$ 786,000	\$ 6,757,650
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized	\$ 202,279	\$ 173,721	\$ 376,000
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	\$ 23,904,099	\$ 15,708,676	\$ 39,612,776
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	\$ 23,904,099	\$ 15,708,676	\$ 39,612,776
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	\$ 23,904,099	\$ 15,708,676	\$ 39,612,776
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	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Purchase Price: \$	N/A	
Fair Market Value: \$	N/A	

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

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

Estimated start-up costs and operating deficit cost is \$ N/A .

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.

Indicate the stage of the project's architectural drawings:

None or not applicable Preliminary
 Schematics Final Working

Anticipated project completion date (refer to Part 1130.140): _____

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: Delnor Community Hospital		CITY: Geneva			
REPORTING PERIOD DATES:		From: 1/1/16		to: 12/31/16	
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	121	5,609	22,129	0	121
Obstetrics	18	1,421	3,711	0	18
Pediatrics	0	0	0	0	0
Intensive Care	20	860	2,796	0	20
Comprehensive Physical Rehabilitation	0	0	0	0	0
Acute/Chronic Mental Illness	0	0	0	0	0
Neonatal Intensive Care	0	0	0	0	0
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:	159	7,890	28,636	0	159

CERTIFICATION

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

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

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

Maureen A. Bryant

 SIGNATURE

Maureen A. Bryant

PRINTED NAME

President

PRINTED TITLE

Michael B. Johnson

 SIGNATURE

Michael B. Johnson

PRINTED NAME

Vice President, Operations

PRINTED TITLE

Notarization:
 Subscribed and sworn to before me
 this 29 day of October, 2017

Notarization:
 Subscribed and sworn to before me
 this 29 day of October, 2017

C Denise Weigand

 Signature of Notary

Signature of Notary

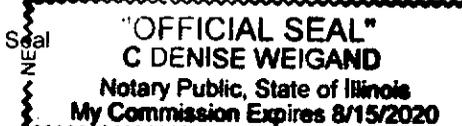


*Insert the EXACT legal name of the applicant

C Denise Weigand

 Signature of Notary

Signature of Notary



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Kevin P. Poorten
 SIGNATURE
 Kevin P. Poorten
 PRINTED NAME
 Senior VP, NMHC & President, West Region
 PRINTED TITLE

Matthew J. Flynn
 SIGNATURE
 Matthew J. Flynn
 PRINTED NAME
 VP & Chief Financial Officer, West Region
 PRINTED TITLE

Notarization:
 Subscribed and sworn to before me
 this 5 day of October, 2017

Notarization:
 Subscribed and sworn to before me
 this 5 day of October, 2017

C Denise Weigand
 Signature of Notary
 Seal
"OFFICIAL SEAL"
C DENISE WEIGAND
 Notary Public, State of Illinois
 My Commission Expires 8/15/2020

C Denise Weigand
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*Insert the EXACT legal name of the applicant

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- o in the case of a sole proprietor, the individual that is the proprietor.

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 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.

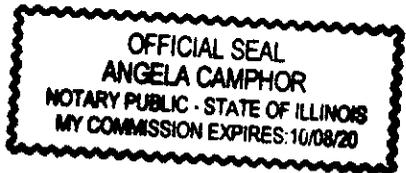
Dean M. Harrison
 SIGNATURE
 Dean M. Harrison
 PRINTED NAME
 President and Chief Executive Officer
 PRINTED TITLE

John A. Orsini
 SIGNATURE
 John A. Orsini
 PRINTED NAME
 Senior Vice President and Chief Financial Officer
 PRINTED TITLE

Notarization:
 Subscribed and sworn to before me
 this 10 day of OCTOBER, 2017
Angela Camphor
 Signature of Notary
 Seal

Notarization:
 Subscribed and sworn to before me
 this 10 day of OCTOBER, 2017
Angela Camphor
 Signature of Notary
 Seal

*Insert the EXACT legal name of the applicant



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

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

Background

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

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

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

Criterion 1110.230 – Purpose of the Project, and Alternatives

PURPOSE OF PROJECT

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

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

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

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

ALTERNATIVES

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

Alternative options **must** include:

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

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

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

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

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative and it shall include the basis used for determining the space and the methodology applied.**
2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following:
 - a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies and certified by the facility's Medical Director.
 - b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that delineates the constraints or impediments.
 - c. The project involves the conversion of existing space that results in excess square footage.
 - d. Additional space is mandated by governmental or certification agency requirements that were not in existence when Appendix B standards were adopted.

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

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

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

PROJECT SERVICES UTILIZATION:

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

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

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

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

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

UNFINISHED OR SHELL SPACE:

Provide the following information:

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

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

ASSURANCES:

Submit the following:

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

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

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

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

2. Indicate changes by Service: Indicate # of key room changes by action(s):

Service	# Existing Key Rooms	# Proposed Key Rooms
<input checked="" type="checkbox"/> Surgical Services - ORs	13	13
<input checked="" type="checkbox"/> Surgical Services - Procedure Rms	5	4
<input type="checkbox"/>		

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

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

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

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

VII. 1120.120 - AVAILABILITY OF FUNDS

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

	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> 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.

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

SECTION VIII. 1120.130 - FINANCIAL VIABILITY

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 35, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

	Historical 3 Years			Projected
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 NUMERIC 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

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

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)	Year	Year	Year
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Medicaid (revenue)	Year	Year	Year
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	27-29
2	Site Ownership	30-34
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	N/A
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	35
5	Flood Plain Requirements	36-37
6	Historic Preservation Act Requirements	38-39
7	Project and Sources of Funds Itemization	40-43
8	Financial Commitment Document if required	44
9	Cost Space Requirements	45
10	Discontinuation	N/A
11	Background of the Applicant	46-47
12	Purpose of the Project	48-49
13	Alternatives to the Project	50-53
14	Size of the Project	54-57
15	Project Service Utilization	58-63
16	Unfinished or Shell Space	N/A
17	Assurances for Unfinished/Shell Space	N/A
18	Master Design Project	N/A
	Service Specific:	
19	Medical Surgical Pediatrics, Obstetrics, ICU	N/A
20	Comprehensive Physical Rehabilitation	N/A
21	Acute Mental Illness	N/A
22	Open Heart Surgery	N/A
23	Cardiac Catheterization	N/A
24	In-Center Hemodialysis	N/A
25	Non-Hospital Based Ambulatory Surgery	N/A
26	Selected Organ Transplantation	N/A
27	Kidney Transplantation	N/A
28	Subacute Care Hospital Model	N/A
29	Community-Based Residential Rehabilitation Center	N/A
30	Long Term Acute Care Hospital	N/A
31	Clinical Service Areas Other than Categories of Service	64-69
32	Freestanding Emergency Center Medical Services	N/A
33	Birth Center	N/A
	Financial and Economic Feasibility:	
34	Availability of Funds	70-87
35	Financial Waiver	70-87
36	Financial Viability	70-87
37	Economic Feasibility	71-87
38	Safety Net Impact Statement	88
39	Charity Care Information	89



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

DELNOR-COMMUNITY HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JULY 29, 1986, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 19TH day of SEPTEMBER A.D. 2017 .



Authentication #: 1726202074 verifiable until 09/19/2018
Authenticate at: <http://www.cyberdriveillinois.com>

Jesse White

SECRETARY OF STATE

ATTACHMENT-1



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

CDH-DELNOR HEALTH SYSTEM, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON OCTOBER 03, 1980, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 19TH day of SEPTEMBER A.D. 2017 .



Authentication #: 1726202088 verifiable until 09/19/2018
Authenticate at: <http://www.cyberdriveillinois.com>

Jesse White

SECRETARY OF STATE

ATTACHMENT-1



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

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

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 20TH day of JULY A.D. 2017 .



Authentication #: 1720101856 verifiable until 07/20/2018
Authenticate at: <http://www.cyberdriveillinois.com>

Jesse White

SECRETARY OF STATE

ATTACHMENT-1

490012

QUIT CLAIM DEED
Statutory (Illinois)
(Corporation to Corporation)

2002K058177

FILED FOR RECORD
KANE COUNTY, ILL.

2007 MAY -3 PM 2:00

Sandy Wegman
RECORDER

**THE GRANTOR DELNOR
COMMUNITY HEALTH SYSTEM** a
not for profit corporation created and
existing under and by virtue of the laws of
the State of Illinois

(The Above Space for Recorder's Use Only)

and 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 **DELNOR COMMUNITY HOSPITAL**, a 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 300 Randall Road, Geneva, Illinois 60134 all interest in the following described Real Estate situated in the County of Kane and State of Illinois, to wit:

Delcokosi

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

Permanent Real Estate Index Number(s): 12-05-476-002
Grantor's Address →
Address(es) of Real Estate: 300 Randall Road, Geneva, Illinois 60134

CHICAGO TITLE INSURANCE CO. SECTION 2
Date: 5/2/2002 *Jamie O. Boyd*

chs
19.-

CHICAGO TITLE INSURANCE CO.
Kane County Office
Geneva, Illinois 60134
Phone 232-9788

CH01/12222267.1

2002K058177

1
19.-

5

ATTACHMENT-2

In Witness Whereof, said Grantor has caused its corporate seal to be hereto affixed, and has caused its name to be signed to these presents by its _____ President, and attested by its Assistant Secretary, this 1st day of May, 2002.



DELNOR COMMUNITY HEALTH SYSTEM

By: [Signature]
President

Attest: [Signature]
Assistant Secretary

-2-

2

CH01/12222267.1

2002K058177

State of ILLINOIS)
) SS.
County of Kane)

I, the undersigned, a Notary Public, in and for the County and State aforesaid, DO HEREBY CERTIFY, that Craig A. Lurmore personally known to me to be the President of the Delnor Community Health System, an Illinois not for profit corporation, and Deanna Hodel personally known to me to be the Assistant Secretary of said corporation, and personally known to me to be the same persons whose names are subscribed to the foregoing instrument, appeared before me this day in person and severally acknowledged that as such President and Assistant Secretary, they signed and delivered the said instrument and caused the corporate seal of said corporation to be affixed thereto, pursuant to authority given by the Board of Directors of said corporation, as their free and voluntary act, and as the free and voluntary act and deed of said corporation, for the uses and purposes therein set forth.

Given under my hand and official seal, this 1st day of May, 2002.



C. Denise Weigand
Notary Public

Commission expires August 15, 2004

This Instrument Was Prepared By
and return to:

Steven B. Kite
Gardner, Carton & Douglas
321 North Clark Street, Suite 3400
Chicago, Illinois 60610

SEND SUBSEQUENT TAX BILLS TO:

Delnor Community Hospital
300 Randall Road
Geneva, IL 60134

-3-

3

CH01/1222267.1

2002 K058177



CHICAGO TITLE INSURANCE COMPANY

ORDER NUMBER: 1410 000496012 KA
STREET ADDRESS: DELNOR HOSPITAL SITE
CITY: COUNTY: KANE
TAX NUMBER: 12-05-476-001-0000

LEGAL DESCRIPTION:

PARCEL ONE:

LOT 1 OF UNIT NO. 1, DELNOR-COMMUNITY HOSPITAL SUBDIVISION, GENEVA, KANE COUNTY, ILLINOIS, IN THE CITY OF GENEVA, KANE COUNTY, ILLINOIS.

PARCEL TWO:

THAT PART OF LOT 2, UNIT NO. 1, DELNOR-COMMUNITY HOSPITAL SUBDIVISION, GENEVA, KANE COUNTY, ILLINOIS DESCRIBED AS FOLLOWS: COMMENCING AT THE NORTHWEST CORNER OF SAID LOT 2; THENCE EASTERLY ALONG THE NORTH LINE OF SAID LOT 466.36 FEET; THENCE SOUTHEASTERLY ALONG THE NORTHEASTERLY LINE OF SAID LOT FORMING AN ANGLE OF 135 DEGREES 15 MINUTES 24 SECONDS WITH THE LAST DESCRIBED COURSE (MEASURED COUNTER-CLOCKWISE THEREFROM) 14.38 FEET TO A WESTERLY FACE OF A BUILDING FOR A POINT OF BEGINNING; THENCE SOUTHERLY ALONG SAID WESTERLY FACE FORMING AN ANGLE OF 135 DEGREES 16 MINUTES 56 SECONDS WITH THE LAST DESCRIBED COURSE (MEASURED COUNTER-CLOCKWISE THEREFROM) 0.08 FEET TO AN ANGLE IN THE WESTERLY FACE OF SAID BUILDING; THENCE SOUTHEASTERLY ALONG A SOUTHWESTERLY FACE OF SAID BUILDING FORMING AN ANGLE OF 224 DEGREES 30 MINUTES 32 SECONDS WITH THE LAST DESCRIBED COURSE (MEASURED COUNTER-CLOCKWISE THEREFROM) 22.15 FEET TO A SOUTHERLY FACE OF SAID BUILDING; THENCE EASTERLY ALONG SAID SOUTHERLY FACE FORMING AN ANGLE OF 224 DEGREES 55 MINUTES 08 SECONDS WITH THE LAST DESCRIBED COURSE (MEASURED COUNTER-CLOCKWISE THEREFROM) 0.19 FEET TO SAID NORTHEASTERLY LINE OF SAID LOT; THENCE NORTHWESTERLY ALONG SAID NORTHEASTERLY LINE FORMING AN ANGLE OF 44 DEGREES 42 MINUTES 36 SECONDS WITH THE LAST DESCRIBED COURSE (MEASURED CLOCKWISE THEREFROM) 22.34 FEET TO THE POINT OF BEGINNING, IN THE CITY OF GENEVA, KANE COUNTY, ILLINOIS.

PARCEL THREE:

THAT PART OF LOT 2, UNIT NO. 1, DELNOR-COMMUNITY HOSPITAL SUBDIVISION, GENEVA, KANE COUNTY, ILLINOIS DESCRIBED AS FOLLOWS: COMMENCING AT THE NORTHWEST CORNER OF SAID LOT 2; THENCE EASTERLY ALONG THE NORTH LINE OF SAID LOT 387.0 FEET TO THE WESTERLY FACE OF A BUILDING FOR A POINT OF BEGINNING; THENCE SOUTHERLY ALONG SAID WESTERLY FACE FORMING AN ANGLE OF 90 DEGREES 02 MINUTES 29 SECONDS WITH THE LAST DESCRIBED COURSE (MEASURED COUNTER-CLOCKWISE THEREFROM) 0.05 FEET TO AN ANGLE IN SAID WESTERLY FACE; THENCE EASTERLY ALONG A SOUTHERLY FACE OF SAID BUILDING AT RIGHT ANGLES TO THE LAST DESCRIBED COURSE 65.12 FEET TO THE NORTH LINE OF SAID LOT; THENCE WESTERLY ALONG SAID NORTH LINE 65.12 FEET TO THE POINT OF BEGINNING, IN THE CITY OF GENEVA, KANE COUNTY, ILLINOIS.

PARCEL FOUR:

THAT PART OF LOT 2, UNIT NO. 1, DELNOR-COMMUNITY HOSPITAL SUBDIVISION, GENEVA, KANE COUNTY, ILLINOIS, DESCRIBED AS FOLLOWS: COMMENCING AT THE NORTHWEST CORNER

LEGALD

2002K058177

4



CHICAGO TITLE INSURANCE COMPANY

ORDER NUMBER: 1410 000496012 KA
 STREET ADDRESS: DELNOR HOSPITAL SITE
 CITY: COUNTY: KANE
 TAX NUMBER: 12-05-476-001-0000

LEGAL DESCRIPTION:

OF SAID LOT; THENCE EASTERLY ALONG THE NORTH LINE OF SAID LOT 387.0 FEET TO THE WESTERLY FACE OF A MULTI-STORY BRICK BUILDING; THENCE SOUTHERLY ALONG SAID WESTERLY FACE FORMING AN ANGLE OF 90 DEGREES 02 MINUTES 29 SECONDS WITH THE LAST DESCRIBED COURSE (MEASURED COUNTERCLOCKWISE THEREFROM) 0.05 FEET TO AN ANGLE IN SAID WESTERLY FACE FOR A POINT OF BEGINNING; THENCE EASTERLY ALONG A SOUTHERLY FACE OF SAID MULTI-STORY BUILDING AT RIGHT ANGLES TO THE LAST DESCRIBED COURSE 65.12 FEET TO THE NORTH LINE OF SAID LOT; THENCE EASTERLY ALONG SAID NORTH LINE 14.24 FEET TO AN ANGLE IN SAID NORTH LINE; THENCE SOUTHEASTERLY ALONG A NORTHEASTERLY LINE OF SAID LOT FORMING AN ANGLE OF 135 DEGREES 15 MINUTES 24 SECONDS WITH THE LAST DESCRIBED COURSE (MEASURED COUNTERCLOCKWISE THEREFROM) 14.33 FEET TO A WESTERLY FACE OF SAID MULTI-STORY BUILDING; THENCE SOUTHERLY ALONG SAID WESTERLY FACE FORMING AN ANGLE OF 135 DEGREES 16 MINUTES 56 SECONDS WITH THE LAST DESCRIBED COURSE (MEASURED COUNTERCLOCKWISE THEREFROM) 0.08 FEET TO AN ANGLE IN THE WESTERLY FACE OF SAID MULTI-STORY BUILDING; THENCE SOUTHEASTERLY ALONG A SOUTHWESTERLY FACE OF SAID MULTI-STORY BUILDING FORMING AN ANGLE OF 224 DEGREES 30 MINUTES 32 SECONDS WITH THE LAST DESCRIBED COURSE (MEASURED COUNTERCLOCKWISE THEREFROM) 22.15 FEET TO A SOUTHERLY FACE OF SAID MULTI-STORY BUILDING; THENCE SOUTHWESTERLY ALONG A LINE FORMING AN ANGLE OF 106 DEGREES 23 MINUTES 06 SECONDS WITH THE LAST DESCRIBED COURSE (MEASURED COUNTERCLOCKWISE THEREFROM) 38.91 FEET TO A NORTHEASTERLY CORNER OF A 3-STORY BRICK BUILDING; THENCE WESTERLY ALONG A NORTHERLY FACE OF SAID 3-STORY BRICK BUILDING 37.09 FEET TO AN ANGLE IN SAID NORTHERLY FACE; THENCE NORTHERLY ALONG AN EASTERLY FACE OF SAID 3-STORY BUILDING 21.50 FEET TO AN ANGLE IN SAID EASTERLY FACE; THENCE WESTERLY ALONG A NORTHERLY FACE OF SAID 3-STORY BUILDING 12.70 FEET TO AN ANGLE IN SAID NORTHERLY FACE; THENCE SOUTHERLY ALONG A WESTERLY FACE OF SAID 3-STORY BUILDING 21.45 FEET TO A NORTHERLY FACE OF SAID 3-STORY BUILDING; THENCE WESTERLY ALONG SAID NORTHERLY FACE 16.52 FEET TO AN ANGLE IN SAID NORTHERLY FACE; THENCE SOUTHERLY ALONG A WESTERLY FACE 0.50 FEET TO A NORTHERLY FACE OF SAID BUILDING; THENCE WESTERLY ALONG SAID NORTHERLY FACE 20.05 FEET TO A NORTHWEST CORNER OF SAID 3-STORY BRICK BUILDING; THENCE NORTHERLY ALONG A LINE FORMING AN ANGLE OF 90 DEGREES 27 MINUTES 39 SECONDS WITH THE LAST DESCRIBED COURSE (MEASURED COUNTERCLOCKWISE THEREFROM) 60.45 FEET TO THE POINT OF BEGINNING, IN THE CITY OF GENEVA, KANE COUNTY, ILLINOIS.

LEGALD

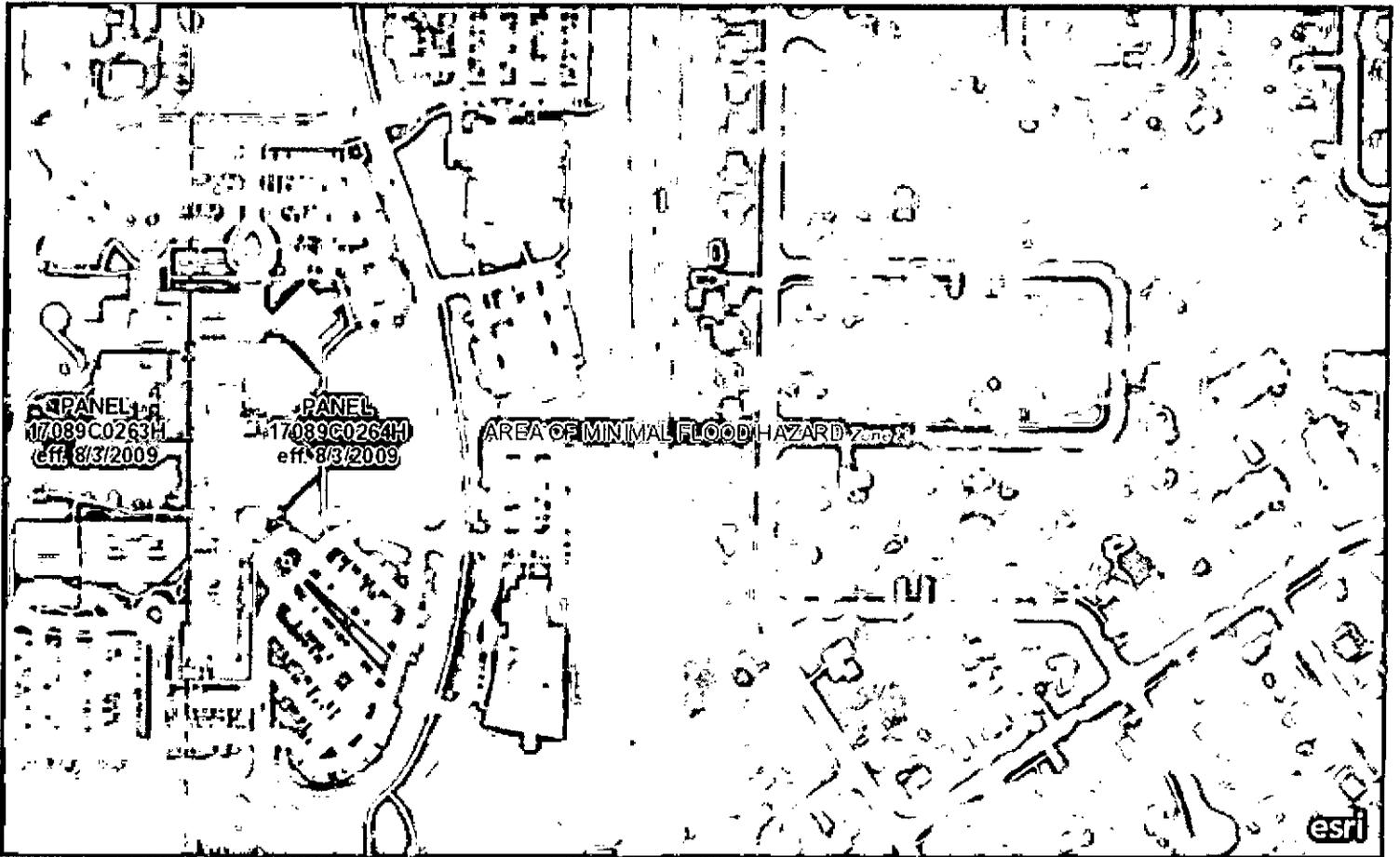
2002K058177

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Flood Plain Requirements

The location for the proposed project is Northwestern Medicine Delnor Hospital at 300 Randall Road in Geneva. As shown on the map on the following page, the project will not be located in a special flood hazard area and therefore complies with the requirements of Illinois Executive Order #2005-5.

FEMA's National Flood Hazard Layer (Official)



Data from Flood Insurance Rate Maps (FIRMs) where available digitally. New NFHL FIRMette Print app available:
<http://tinyurl.com/j4xwp5e>

400ft

USGS The National Map: Orthoimagery | National Geospatial-Intelligence Agency (NGA); Delta State University; Esri | Print here instead:
<http://tinyurl.com/j4xwp5e> Support: FEMAMapSpecialist@riskmapcdfs.com | Kane County IL/Pictometry, St.Charles Illinois, USDA FSA, Microsoft

Historic Resources Preservation Act Requirements

The location for the proposed project is Northwestern Medicine Delnor Hospital at 300 Randall Road in Geneva. The attached letter from the Illinois Historic Preservation Agency indicates that the site for the hospital is not considered a historic, architectural or archaeological site.



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

Kane County

Geneva

CON - Relocation of Loading Dock for 2-Story Addition and Rehabilitation, Northwestern Medicine Delnor Hospital
300 Randall Road
SHPO Log #009080217

August 24, 2017

Bridget Orth

Northwestern Memorial HealthCare
211 E. Ontario St., Suite 1750
Chicago, IL 60093

Dear Ms. Orth:

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 David Halpin, Cultural Resources Manager, at 217/785-4998.

Sincerely,

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

ATTACHMENT-6

Project Costs and Sources of Funds

The line item costs attributed to clinical components were calculated as a percentage of clinical square footage or clinical cost to the total project when actual break-outs were not available.

Itemization of each line item:

Line 1 – Preplanning Costs – (\$130,000) – this includes:

- Feasibility Study/Concept planning
- Testing/Balancing of existing system

Of the total amount, \$69,937 is the clinical Preplanning Costs cost which is 0.3% of the clinical new Construction, Modernization, Contingencies, and Moveable Capital Equipment costs.

Line 2 – Site Survey and Soil Investigation Fees – (\$30,000) – this includes:

- Soil borings
- Site survey

Of the total amount, \$16,139 is the clinical Site Survey and Soil Investigation Fees cost.

Line 3 – Site Preparation – (\$459,745) – this includes:

- Excavation for addition
- Replacement of underground utilities

Of the total amount, \$247,332 is the clinical Site Preparation cost which is 1.6% of the clinical new Construction, Modernization, Contingencies costs.

Line 5 – New Construction Contracts – (\$14,305,552) – this includes:

- All construction contracts/costs to complete the addition portion of the project. Includes Group I fixed equipment and contractor's markups, overhead, and profit. Costs are escalated to the mid-point of construction (FY19).

Of the total amount, \$5,126,776 is the clinical New Construction cost.

Line 6 – Modernization Contracts – (\$11,711,703) – this includes:

- All construction contracts/costs in the existing building to complete the project. Includes Group I fixed equipment and contractor's markups, overhead, and profit. Costs are escalated to the mid-point of construction (FY19).

Of the total amount, \$9,103,680 is the clinical Modernization cost.

**The total clinical square footage of the proposed project is 44,396 BGSF. Of that amount, approximately 29% will be new construction and 71% will be modernization of existing space.

Line 7 – Contingencies - (\$2,601,726) – this includes:

- Allowance for unforeseen New Construction and Modernization costs

Of the total amount, \$1,423,046 is the clinical Contingency cost which is 10% of the clinical New Construction and Modernization costs.

Line 8 – Architectural / Engineering Fees – (\$1,575,400) – this includes:

- Schematic Design:
 - Develop diagrammatic plans and documentation to describe the size and character of the space in a way that meets all programmatic and functional objectives, as well as accounting for all existing structure, shafts, elevators and stairs, communications and electrical closets, and all other pre-existing design constraints.
 - Evaluate the capacity of all building systems (such as electrical, mechanical, plumbing, fire protection, pneumatic tube and vertical transportation) as well as support functions to determine modifications necessary for the new use proposed on the floor.
- Design Development
 - Develop detailed drawings and documentation to describe the size and character of the space. Includes room layouts, structural, mechanical, electrical, and plumbing.
 - The equipment and furniture consultants will prepare room-by-room FF&E requirement lists. The requirements lists identify room name, item description, product specification, and total quantity required. The product specifications include installation requirements that will be provided to the architect/engineer to ensure that spaces and building systems are planned to appropriately accommodate the equipment.
- Construction Documents:
 - Provide proposed Reconciled Statement of Probable Construction Cost
 - Provide drawings and specifications
 - Prepare documentation for alternate bids
 - Assist in filing Construction Documents for approval by City and State agencies
 - Signage and Way Finding expertise
- Bidding and Negotiation Phase Services:
 - Revise Construction Documents as necessary in accordance with Reconciled Statement of Probable Construction Cost

Of the total amount, \$847,529 is the clinical Architectural / Engineering Fee. This amount is 5.4% of the clinical New Construction, Modernization, and Contingencies costs.

Line 9 – Consulting and Other Fees – (\$1,665,000) – this includes:

- Charges for the services of various types of consulting and professional experts including:
 - Testing and Inspection

- Legal and Accounting Services
- Pre-Construction Services
- Equipment Planning Consultant
- Project Management Services
- Construction Management Services

Of the total amount, \$895,731 is the clinical Consultant and Other Fees cost.

Line 10 – Movable Capital Equipment – (\$6,757,650) – this includes:

- All furniture, furnishings, and equipment for the proposed project. Group I (fixed) equipment is included in the New Construction and Modernization line items above. Group II and III medical equipment is included herein. The equipment cost is a budget yet to be finalized.

The aggregate equipment budget is based on input from consultants and NMHC personnel with experience on the recent surgery unit projects at Northwestern Memorial Hospital in Chicago.

Equipment and furnishing planning will be closely coordinated with architectural design. Furniture procurement will be managed by the hospital with support from outside consultants.

Total acquisition costs will be evaluated during market assessment and contract award, including purchase, installation, training, and maintenance. The approval process during contract award will be consistent with existing Hospital financial procedures.

Product standards will facilitate detailed equipment planning and appropriate building design, maximize the effectiveness of competitive bidding, and minimize costs for training and long-term maintenance.

The following list identifies types of equipment in the estimate:

- Booms/Lights
- Operating Room Tables – General
- Operating Room Table – Ortho
- Operating Room Table – Cysto
- Operating room beds
- Table – side, over-bed, circular
- Double ring stands
- Single ring stands
- Kick buckets
- Mayo stands – regular
- Mayo stands – large
- IV poles
- Garbage cans
- Stirrups
- Stirrups – Bariatrics

- Stools
- Infusion pumps
- X-Ray view boxes
- Blanket/fluid warmers
- Crash carts
- Equipment carts
- Linen carts
- Monitors
- ENT Microscope
- C-Arms
- Mobile shelving units
- GI Scope storage
- X-Ray film processor
- Air pressure tourniquets
- Furniture: Seating, Patient Chairs, Staff Seating and Workstations, Files
- Refrigerators, Ice Makers, Coffee Dispensers
- Telephones, Copiers, Printers, PCs, Televisions
- Miscellaneous Items: Glove Dispensers, Sharps Receptacles, Hampers, Waste Containers
- Housekeeping Equipment

Of the total amount, \$5,971,650 is the clinical component of the Moveable Capital Equipment cost.

Line 14 – Other Costs To Be Capitalized – (\$376,000) – this includes:

- Permits and Fees
- Parking Study
- Certificate of Need Final Audit

Of the total amount, \$202,279 is the clinical component of the Other Costs to be Capitalized.

Project Status and Completion Schedules

Stage of the project's architectural drawings: Schematics

Anticipated project construction start date: April, 2018

Anticipated midpoint of construction date: July, 2019

Anticipated project construction substantial completion date: September, 2020

Anticipated project completion date: July, 2021

Project obligation will occur after permit issuance.

Cost Space Requirements

Department	Cost	Departmental Gross Square Feet		Building Gross Square Feet		Amount of Proposed Total Building Gross Square Feet That Is:			
		Existing DGSF	Proposed DGSF	Floor Gross Factor	Proposed BGSF	New Const.	Modern-ized	As Is	Vacated Space
CLINICAL									
Surgical Services	\$ 14,230,456	24,437	43,192	1.03	44,396	12,786	31,610	0	0
Clinical Subtotal =	\$ 14,230,456	24,437	43,192		44,396	12,786	31,610	0	0
NON-CLINICAL									
Administration	\$ 1,068,104	4,357	4,054	1.03	4,187	0	4,187	0	0
Public Facilities	\$ 1,333,905	6,106	5,115	1.02	5,231	0	5,231	0	0
Materials Management / loading docks	\$ 2,346,231	6,693	12,470	1.00	12,470	11,607	863	0	0
MEP Systems	\$ 7,038,559	390	15,850	1.02	16,240	15,850	390	0	0
Non-Clinical Subtotal =	\$ 11,786,799	17,546	37,489		38,128	27,457	10,671	0	0
TOTAL =	\$ 26,017,255	41,983	80,681		82,524	40,243	42,281	0	0
OTHER									
Preplanning Costs	\$ 130,000								
Site Survey & Soil Investigation Fees	\$ 30,000								
Site Preparation	\$ 459,745								
Off-Site Work	\$ -								
Contingencies	\$ 2,601,726								
A/E Fees	\$ 1,575,400								
Consulting & Other Fees	\$ 1,665,000								
Movable or other Equipment	\$ 6,757,650								
Bond Issuance Expense	\$ -								
Net Interest Expense During Construction	\$ -								
Other Costs To Be Capitalized	\$ 376,000								
Other Subtotal =	\$ 13,595,521								
GRAND TOTAL =	\$ 39,612,776								

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

Background

BACKGROUND OF APPLICANT

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

Northwestern Memorial HealthCare:

	IDPH License No.	Joint Commission Organization No.
Northwestern Memorial Hospital	0003251	7267
Northwestern Lake Forest Hospital	0005660	3918
Central DuPage Hospital	0005744	7444
Delnor-Community Hospital	0005736	5291
Marianjoy Rehabilitation Hospital	0003228	7445
Kishwaukee Community Hospital	0005470	7325
Valley West Community Hospital	0004690	382957
Grayslake Freestanding Emergency Center	22002	3918
Grayslake ASTC	7003156	3918
Grayslake Endoscopy ASTC	7003149	3918
Cadence Ambulatory Surgery Center	7003173	n/a
The Midland Surgical Center*	7003148	n/a
Illinois Proton Center*	n/a	n/a

*denotes partial ownership in excess of 51%

2. *A certified listing of any adverse action taken against any facility owned and/or operated by the applicants during the three years prior to the filing of the application.*

By their signatures on the Certification pages of this application, each of the Applicants attest that no adverse action has been taken against any facility owned and/or operated by Northwestern Memorial HealthCare during the three years prior to the filing of this application. For the purpose of this letter, the term "adverse action" has the meaning given to it in the Illinois Administrative Code, Title 77, Section 1130.140.

3. *Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, by 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.*

By their signatures on the Certification pages of this application, each of the Applicants authorize HFSRB and DPH access any documentation which it finds necessary to verify any information submitted, including, but not limited to: official records of DPH or other State agencies and the records of nationally recognized accreditation organizations.

Criterion 1110.230 – Purpose of the Project, and Alternatives

PURPOSE OF PROJECT

1. This project responds to the continued need for quality healthcare in the A-12 Planning area and the region surrounding Northwestern Medicine Delnor Hospital (DCH). The project is intended to modernize the Surgical Services department at the hospital in order to increase operational efficiencies to improve surgical capacity at DCH. This will be done by increasing the number of pre/post-operative rooms/stations, creating a more efficient layout, and standardizing the operating rooms. The project will improve health care for residents of the hospital's primary market area and the A-12 planning area by enhancing access to surgical services at DCH.
2. DCH's primary market area is comprised of nine contiguous ZIP codes surrounding the hospital. The primary market area includes Batavia (60510), Elburn (60119), Geneva (60134), North Aurora (60542), Saint Charles (60174), South Elgin (60177) Sugar Grove (60554), and one ZIP code in Aurora (60506). This market area is the source of approximately 72% of DCH's admissions.
3. Since CY11, DCH's surgery volume has experience tremendous growth. As documented in DCH's IDPH Hospital Profiles, demand for surgical services has increased each year, with the number of surgical hours increasing by over 49% from CY11 to CY16.

DCH's Surgical Services department has not undergone a significant renovation in over 25 years and the current space is undersized and needs improvements to provide care in the best setting for patients. There is an opportunity to improve patient flow and patient and provider satisfaction which will help DCH provide more surgical care to patients in the DCH community.

In addition to an overall inefficient layout, the current operating rooms at DCH vary in size from 383 nsf to 648 nsf with 7 of the 10 operating rooms not large enough to meet current IDPH standards. Because of the varying sizes and layout, the operating rooms are not identical. As experienced with other recent NMHC projects, standardized operating rooms will provide faster access, consistent care, and higher productivity of staff.

The current space does not have enough pre/post-operative stations. Currently, there are 33 stations while the current IDPH Building Code warrants 44 (source: Illinois Administrative Code, Title 77, Part 250.2440 – general hospital standards for the required 4:1 ratio of pre/post-operative rooms to operating rooms/2:1 ratio of pre/post-operative rooms to procedure rooms). The number of existing pre/post-operative rooms is putting constraints on the surgical demand.

4. Sources of information include:
 - Hospital Records
 - Illinois Administrative Code, Title 77
 - IDPH Hospital Profiles, CY11 – CY16

5. The modernization of the Surgical Services department with the increase in the number of pre/post-operative rooms/stations and improve the efficiency of the department layout which will alleviate the current surgical capacity constraints at DCH, allowing for increased access to surgical services at DCH.

6. The broad goal of this project is to create a Surgical Services department that is code compliant and highly functional. This project seeks to improve the surgical experience at DCH and increase capacity through a more efficient design. The Surgical Services department will strive for a coordinated and seamless patient/family experience. By designing the project as a clean core concept with standardized, same-handed operating rooms, DCH will experience improvements in patient, family, staff, and material flows, patient privacy and facilities in pre/post-operative recovery, and case turnaround times.

ALTERNATIVES

The proposed project addresses the need to modernize the Surgical Services department at DCH. DCH's Surgical Services department has not undergone a significant renovation in over 25 years and the current space is undersized and needs improvements to provide care in the best setting for patients. There is an opportunity to improve patient flow and patient and provider satisfaction which will help DCH provide more surgical care to patients in the DCH community.

Current Deficiencies

Space limitations and an outdated clinical environment have impacted the patient, staff, and physician experience. There are three main operational constraints on DCH's Surgical Services program:

1. Inadequate/Non-uniform Size of Operating Rooms

In addition to an overall inefficient layout, the current operating rooms at DCH vary in size from 383 nsf to 648 nsf with 7 of the 10 operating rooms not large enough to meet current IDPH standards. Additionally, many of the operating rooms cannot accommodate new specialty surgery equipment, creating wait times for the larger operating rooms for the procedures that require the new equipment.

Because of the varying sizes and layout, the operating rooms are not identical. As we have experienced with recent NMHC projects at other hospitals, standardized operating rooms provides faster access, consistent care, and higher productivity of staff.

2. Insufficient Pre/Post-Operative Rooms

The existing space does not have enough pre/post-operative stations. Currently, there are 33 stations while current IDPH Building Code warrants 44 (source: Illinois Administrative Code, Title 77, Part 250.2440 – general hospital standards for the required 4:1 ratio of pre/post-operative rooms to operating rooms/2:1 ratio of pre/post-operative rooms to procedure rooms). The number of existing pre/post-operative rooms is putting constraints on the surgical demand by creating back-ups in patient flow.

The pre-operative and Phase II recovery area is congested with individual "rooms" separated by half walls and curtains with four fully enclosed rooms at the end of the hallway that are isolated from the nurses station. Space is limited in the individual rooms for patients' families and care givers which make it difficult to perform necessary pre-operative procedures. Adding to the congestion is patient equipment that needs to be readily available for patients coming out of surgery with no accessible storage space. Additionally, there is no enclosed room for patients requiring isolation.

3. Inefficient Layout

The existing Surgical Services department has an inefficient design/flow. Phase II recovery areas are separate and non-contiguous, there is comingling of sterile and non-sterile areas, and caregivers must leave the sterile environment to access the storage areas. A modernized unit with a more efficient design will improve safety, privacy, and infection control.

Proposed Project

In the proposed project, 8 of the 10 operating rooms will be built on the second floor of a two-story addition that will be constructed adjacent to the existing Surgical Services space. An additional 2 operating rooms, 2 procedure rooms, and recovery area will be built in the current Surgical Services space.

The proposed project is the least expensive of the realistic options for modernizing Surgical Services at DCH. It is also the most practical in both the short- and long-term and is therefore the preferred alternative.

This section presents the following alternatives considered:

1. Do nothing;
2. Renovate in the current building footprint (do not build addition);
3. Relocate to another location in the hospital;
4. Build a lesser number of operating rooms

Alternative 1: Do Nothing

The space limitations detailed above have constrained DCH's Surgical Services program. If the Surgical Services department is not modernized, DCH would be forced to cap surgery volume at some point in the near future which would not meet the needs of the community.

Additionally, the proposed infrastructure improvements included in the project are needed to correct existing facility infrastructure including humidity control, negative pressure, and other facility infrastructure investments.

This alternative was rejected because it does not meet the current or projected demand for surgical services at DCH.

Alternative 2: Renovate in the Current Building Footprint (Do Not Build Addition)

The overall area of the current Surgical Services department is not large enough to accommodate the required surgical program.

Additionally, if there was enough space for the proposed program, renovating the operating rooms in place would be disruptive to patient care and take as much as five years longer than the proposed project.

Renovating in place would have to be done two operating rooms at a time and the corresponding construction and inspection time would result in a much longer schedule. This additional time would equate to additional General Conditions and contractor fees, resulting in a higher cost. This alternative would cost approximately \$500,000 more than the proposed project.

In addition to a higher construction cost, this alternative would result in a loss of revenue for the duration of the project because two operating rooms would be down until the completion of the department. This loss of revenue would be approximately \$33 million dollars (assuming a 40 month construction period).

This alternative was rejected because it is does not meet the required space program, is more expensive, and takes more time than the proposed project.

Alternative 3: Relocate to Another Location in the Hospital

There is no available space within the existing hospital to accommodate the Surgical Services program. Relocations of existing departments and the construction of an addition to accommodate them would be required to provide sufficient space which would add costs of approximately \$1.6 million.

Additionally, relocations could be disruptive to patient care and would add time to the project schedule.

This alternative was rejected because it is more expensive and takes more time than the proposed project.

Alternative 4: Build a Lessor Number of Operating Rooms

The proposed project includes 10 operating rooms which are needed to accommodate the demand for surgical services at DCH. While there is currently some capacity in the 3 operating rooms in the adjacent medical office building due to the 2016 acquisition and conversion from ASTC to hospital-based outpatient surgery department, this capacity will be used to accommodate the surgery volume during the construction period for the proposed project.

Additionally, based on from CY11 – CY16, DCH's outpatient surgery hours increased by 70.8%, an average annual increase of 14.2% per year. The total number of surgery hours increased 49.1%, an average of 9.8% per year. If DCH surgical volume

continues to grow at the historic growth rate, DCH could justify 16 operating rooms by CY22, 3 more operating rooms that they will have.

While building less than 10 operating rooms would reduce the project cost, it does not meet the projected demand for surgical services.

This alternative was rejected because does not meet the projected demand for surgical services at DCH.

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

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

SIZE OF PROJECT

Clinical Components

Surgical Services

The proposed project is for the modernization of the Surgical Services department. The existing Surgical Services unit is on the 2nd floor of the hospital. There is also an outpatient surgical unit (formerly Tri-Cities Surgery Center) on the 1st floor of the connected medical office building that is not part of this project.

The modernized surgical services unit will have 10 Class C standardized operating rooms with a scrub sink at every room. The operating rooms will accommodate both inpatients and outpatients.

The 10 operating rooms will be arranged around a sterile core. In addition to direct access from each operating room, there will be the ability to enter and exit the sterile core from two portals.

There will also be 11 Phase I recovery bays for post-anesthesia care where a patient will stay until they are cognizant of his/her surroundings. There will be one Phase I recovery bay dedicated to pediatric patients and one for isolation cases. There will be 33 Phase II recovery bays. Phase II recovery bays will be used by patients who received local anesthesia and don't need as much observation after surgery.

The suite contains a nourishment room equipped with a large refrigerator, microwave oven, and ice machine for patients who may require dietary support consisting of light meals, beverages, and snacks.

The proposed staff lounges and lockers will be larger than what is currently in the department to accommodate the anticipated number of staff members. They will be arranged to allow for one-way traffic.

A 2-room pre-admission exam area will be provided for pre-surgery evaluations and testing the day before surgery. Physician consultation will also take place in this area.

Comparison of Space to Standard

The proposed square footage for the Surgical Services department on the 2nd floor is 43,192 DGSF.

Components and Space Standards used are as follows:

Surgical Services unit, as designed	43,192 DGSF
10 Class C operating rooms	
2 Class B procedure rooms	
11 Phase I recovery bays	
33 Phase II recovery bays	
State Standard for Surgical Operating unit	44,880 DGSF
Class C Surgical Operating Suite: 2,750 dgsf/operating room x 10 = 27,500	
Class B Surgical Operating Suite: 1,100 dgsf/procedure room x 2 = 2,200	
Post-Anesthesia Recovery Phase I: 180 dgsf/recovery station x 11 = 1,980	
Post-Anesthesia Recovery Phase II: 400 dgsf/recovery station x 33 = 13,200	
Amount of difference	(1,688)

The proposed Surgical Services unit is within the State Guidelines for Square Footage.

SIZE OF PROJECT				
DEPARTMENT	PROPOSED DGSF	STATE STANDARD	DIFFERENC E	MET STANDARD?
Surgical Services	43,192	44,880	(1,688)	Yes

Non-Clinical Components

Administration

Space for surgical administrative offices will be provided. Office billing and nurse follow-up calls will also be done in this area.

The Administration area of the proposed project is 4,054 DGSF.

Public Facilities

Expanded public facilities including larger, more private family waiting/consult spaces, public toilets, and required fire exit corridors around the sterile environment are included in the proposed project.

The Public Facilities areas of the proposed project total 5,115 DGSF.

Materials Management/Loading Dock

The relocation of the loading dock bulk storage and waste container facilities to the west side of the new first floor addition are included. This will replace the existing loading facilities that will be absorbed within the new construction.

In the proposed project, the Materials Management/Loading Docks areas total 12,470 DGSF.

MEP Systems

Infrastructure work includes re-working and tie-ins to new and existing systems. Related exterior enclosure work includes:

- 3 new rooftop air handling units (RTUs) with maintenance vestibules
- 2 new chillers on the new roof
- Louvered rooftop screen
- Improved roof area access
- Underground utilities and service required for the new building addition
- Repairs to existing kitchen exhaust systems to meet current regulations

The MEP Systems space of the proposed project is 15,850 DGSF.

Floor Gross Assumptions

As in previous CON applications submitted by Northwestern Memorial HealthCare, floor gross elements that are not part of the "usable floor area" were not included in the departmental square footage (DGSF) determination. These elements include:

- Elevator cores and lobbies

- Stairs
- Shafts including mechanical and plumbing
- Electrical rooms
- Communication rooms
- Non-departmental circulation

The building gross takes the departmental square footage and adds the floor gross as well as the building's exterior wall, resulting in a building gross square footage (BGSF).

PROJECT SERVICES UTILIZATION

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.

Surgical Services

Currently, DCH has a total of 13 operating rooms located in two different locations on campus: 10 in the main hospital and 3 in the Outpatient Surgery department in the adjacent medical office building. The proposed project is for the modernization of the main hospital Surgical Services department. No changes will be made to the 3 operating rooms in the Outpatient Surgery department in the adjacent medical office building. This project will not increase the number of operating rooms at DCH.

	Current	Proposed
LOCATION	# of OPERATING ROOMS	# of OPERATING ROOMS
Main Hospital	10	10
Adjacent MOB	3	3
TOTAL	13	13

Additionally, DCH has a total of 5 surgical procedure rooms located in the same two locations on campus: 3 in the main hospital and 2 in the Outpatient Surgery department in the adjacent medical office building. If approved, the proposed project will reduce the number of surgical procedure rooms in the main hospital from 3 to 2. No changes will be made to the 2 surgical procedure rooms in the Outpatient Surgery department in the adjacent medical office building.

	Current	Proposed
LOCATION	# of PROCEDURE ROOMS	# of PROCEDURE ROOMS
Main Hospital	3	2
Adjacent MOB	2	2
TOTAL	5	4

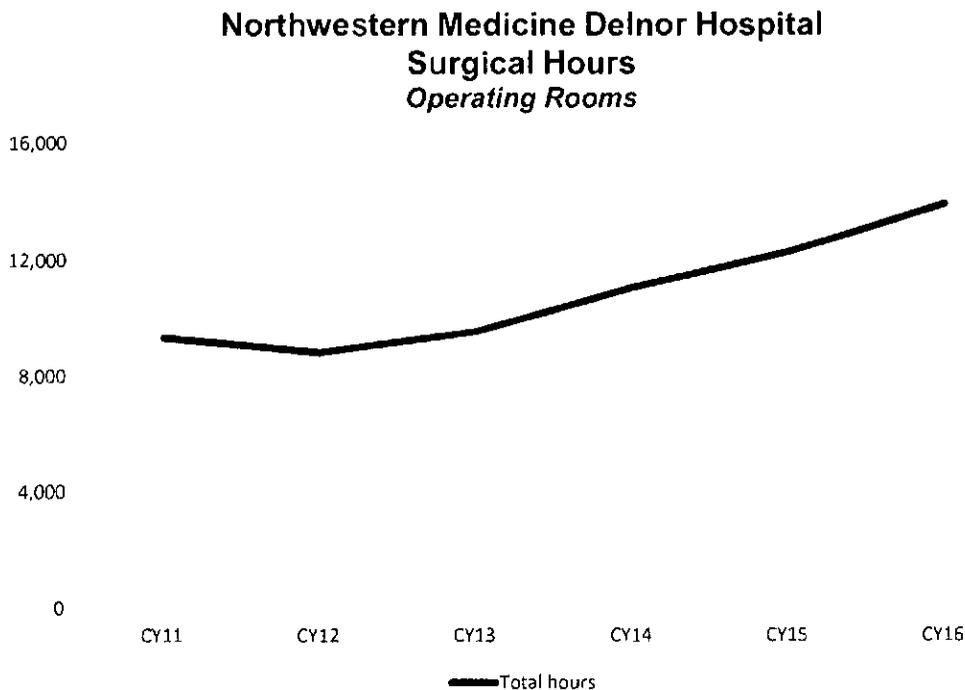
OPERATING ROOMS

Like other clinical services at DCH such as emergency services and the cancer program, surgery volume has experienced significant growth in recent years. As presented in the COE application (#E-013-16) for the change of ownership of Tri-Cities Surgery Center in early 2016, the number of total surgical hours at DCH increased by 26.4% from CY10 – CY14. Because DCH is land locked, the acquisition of the ASTC seemed to be the most non-disruptive, cost-effective option to accommodate the demand for surgical services at DCH.

However, since that time, from CY14 – CY16, the demand for surgical services has continued to increase by 26.0%, which created the need to renovate the existing Surgical Services department earlier than expected.

From CY11 – CY16, the outpatient surgery hours increased by 70.8%, an average annual increase of 14.2% per year. The total number of surgery hours (including time for set-up and clean-up of the operating room) increased 49.1%, an average of 9.8% per year.

This growth has been achieved despite the underutilization of some of DCH's operating rooms. As stated in the Alternatives section (ATTACHMENT-13), there are procedures that surgeons cannot perform in the undersized, non-standardized operating rooms due to equipment and instrumentation requirements, resulting in underutilization of the smaller operating rooms and a higher wait times for the larger operating rooms.



HISTORIC DATA – Operating Rooms

DELNOR	CY11		CY12		CY13		CY14		CY15		CY16	
	Cases	Hours										
Inpatient	2,038	4,767	1,762	4,139	1,649	3,818	1,138	2,302	1,138	2,407	2,365	6,119
Outpatient	3,631	4,568	3,657	4,683	3,134	5,713	3,941	8,746	4,354	9,861	4,291	7,801
Total	5,669	9,335	5,419	8,822	4,783	9,531	5,079	11,048	5,492	12,268	6,656	13,920
# of ORs	10		10		9		9		10		10	
ORs justified	6.2		5.9		6.4		7.4		8.2		9.3	
Legacy TCSC	CY11		CY12		CY13		CY14		CY15		CY16	
	Cases	Hours										
Outpatient	2,513	2,741	1,290	1,414	1,602	1,759	1,283	1,443	1,321	1,634	774	801
# of ORs	3		3		3		3		3		3	
ORs justified	1.8		0.9		1.2		1.0		1.1		0.5	
COMBINED	CY11		CY12		CY13		CY14		CY15		CY16	
	Cases	Hours										
Inpatient	2,038	4,767	1,762	4,139	1,649	3,818	1,138	2,302	1,138	2,407	2,365	6,119
Outpatient	6,144	7,309	4,947	6,097	4,736	7,472	5,224	10,189	5,675	11,495	5,065	8,602
Total	8,182	12,076	6,709	10,236	6,385	11,290	6,362	12,491	6,813	13,902	7,430	14,721
# of ORs	13		13		12		12		13		13	
ORs justified	8.1		6.8		7.5		8.3		9.3		9.8	

Source: IDPH Annual Hospital Profiles
Legacy TCSC = Tri-Cities Surgery Center

Note: due to the 2016 acquisition and conversion from ASTC to hospital-based outpatient surgery department, there is capacity in the 3 operating rooms in the medical office building (Legacy TCSC). This capacity will be used to accommodate the surgery volume during the construction period for the proposed project.

DCH Growth Factors

There are several factors that have contributed to the growth in surgical volume at DCH:

- The addition of more surgeons to the DCH medical staff
- Investment in specialized surgical equipment to expand procedure capability including:
 - Laparoscopic scopes and instrumentation
 - Robotic-assisted technology
 - Specialized instrumentation
 - Advanced intra-operative monitoring capability
 - Staff training
- Investment in pre-procedure programs and diagnostic imaging infrastructure to support surgical volume growth including:
 - PET/CT
 - 640 CT scanner
 - MRI
 - 3D Tomography
- Investment in clinical infrastructure and physician specialization to enhance post-operative care for surgical patients including:
 - 24/7 critical care coverage

- 24/7 in-house hospitalist coverage

DCH expects these factors to continue to impact surgical growth in the coming years.

PROJECTIONS – Operating Rooms

Assuming a conservative average annual growth of 5.4% for surgical hours (4.4% less than the actual growth rate experienced from CY11 – CY16), DCH can justify 13 operating rooms in CY22, the second year of utilization.

ALL DCH	CY17		CY18		CY19		CY20		CY21		CY22	
	Cases	Hours	Cases	Hours	Cases	Hours	Cases	Hours	Cases	Hours	Cases	Hours
Inpatient	2,754	6,333	2,850	6,555	2,950	6,784	3,053	7,022	3,160	7,267	3,270	7,522
Outpatient	5,682	9,090	6,004	9,607	6,345	10,152	6,705	10,728	7,086	11,338	7,488	11,981
Total	8,436	15,423	8,854	16,162	9,295	16,936	9,758	17,750	10,246	18,605	10,758	19,503
# of ORs	13		13		13		13		13		13	
ORs justified	10.3		10.8		11.3		11.8		12.4		13.0	

If DCH surgical volume continues to grow at the actual average annual rate of 9.8%, DCH could justify 16 operating rooms by CY22.

Population Increase

Additionally, according to Sg2 Health Care Intelligence data, the population in DCH's primary market area, which is comprised of nine contiguous ZIP codes surrounding the hospital including Batavia (60510), Elburn (60119), Geneva (60134), North Aurora (60542), Saint Charles (60174), South Elgin (60177) Sugar Grove (60554), and one ZIP code in Aurora (60506), is projected to increase by 1.5% by CY22. More importantly, the population of the 65+ age group is projected to increase by 20%. Approximately one-third of DCH's surgical cases in CY16 were in that age group which is expected to increase with the projected population increase.

Age Groups	2017 Population	2017 % of Total	2022 Population	2022 % of Total	Population % Change
00-17	57,453	24.5%	53,509	22.5%	(6.9)%
18-44	76,474	32.6%	78,868	33.2%	3.1%
45-64	68,796	29.4%	67,570	28.4%	(1.8)%
65-UP	31,640	13.5%	37,954	16.0%	20.0%
Total	234,363	100.0%	237,901	100.0%	1.5%

PROCEDURE ROOMS

Like the operating rooms, DCH's surgical procedure rooms have also experienced an increase in volume. From CY11 – CY16, the total number of surgical procedure room hours (including time for set-up and clean-up of the operating room) increased 90.7%, an average of over 18% per year.

HISTORIC DATA – Procedure Rooms

DELNOR	CY11		CY12		CY13		CY14		CY15		CY16	
	Cases	Hours										
Inpatient	652	696	534	617	618	604	578	752	705	880	532	610
Outpatient	3,373	1,562	2,016	1,575	1,232	859	1,349	1,362	1,664	1,774	3,730	3,696
Total	4,025	2,258	2,550	2,192	1,850	1,463	1,927	2,114	2,369	2,654	4,262	4,306
# of PRs	3		3		3		3		3		3	
PRs justified	1.5		1.5		1.0		1.4		1.8		2.9	
Legacy TCSC	CY11		CY12		CY13		CY14		CY15		CY16	
	Cases	Hours										
Outpatient	3,302	3,522	5,165	5,445	5,647	3,964	5,720	4,678	4,965	3,417	2,167	1,967
# of ORs	2		2		2		2		2		2	
ORs justified	2.3		3.6		2.6		3.1		2.3		1.3	
COMBINED	CY11		CY12		CY13		CY14		CY15		CY16	
	Cases	Hours										
Inpatient	652	696	534	617	618	604	578	752	705	880	532	610
Outpatient	6,675	5,084	7,181	7,020	6,879	4,823	7,069	6,040	6,629	5,191	5,897	5,663
Total	7,327	5,780	7,715	7,637	7,497	5,427	7,647	6,792	7,334	6,071	6,429	6,273
# of ORs	5		5		5		5		5		5	
ORs justified	3.9		5.1		3.6		4.5		4.0		4.2	

Source: IDPH Annual Hospital Profiles
Legacy TCSC = Tri-Cities Surgery Center

PROJECTIONS – Procedure Rooms

Despite the significant increase in surgical procedure room volume, DCH is planning to include only 2 procedure rooms in the proposed project in the main Surgical Services department (overall decrease of one procedure room). DCH is projecting a much lower growth rate than historic experience primarily due to the healthcare market trend of procedures migrating to lower acuity, outpatient settings, often outside of a hospital environment. DCH also anticipates future enhancements in mobile equipment and technology that will allow for more procedures to be performed in patient rooms, negating the need for patients to transfer to a procedure room.

DCH can justify the number of proposed procedure rooms with actual CY16 volume and assuming a very conservative average annual growth of 2% for surgical procedure hours, DCH can justify 5 procedure rooms in CY22, the second year of utilization.

ALL DCH	CY17		CY18		CY19		CY20		CY21		CY22	
	Cases	Hours										
Inpatient	557	613	560	616	563	620	566	623	569	626	572	630
Outpatient	7,231	5,785	7,387	5,909	7,545	6,036	7,708	6,166	7,874	6,299	8,043	6,434
Total	7,788	6,398	7,947	6,525	8,108	6,656	8,274	6,789	8,443	6,925	8,615	7,064
# of PRs	5		5		5		5		4		4	
PRs justified	4.3		4.4		4.4		4.5		4.6		4.7	

Utilization Tables

Operating Rooms

UTILIZATION					
	SERVICE	HISTORICAL UTILIZATION CY16 OR Hours	PROJECTED UTILIZATION OR Hours	STATE STANDARD 1,500 hours per OR for 13 ORs	MET STANDARD?
YEAR 1 – CY21	Surgery – operating rooms	14,721	18,610	19,500	Yes
YEAR 2 – CY22	Surgery – operating rooms		19,503	19,500	Yes

Procedure Rooms

UTILIZATION					
	SERVICE	HISTORICAL UTILIZATION CY16 PR Hours	PROJECTED UTILIZATION PR Hours	STATE STANDARD 1,500 hours per PR for 4 PRs	MET STANDARD?
YEAR 1 – CY21	Surgery – procedure rooms	6,273	6,925	6,000	Yes
YEAR 2 – CY22	Surgery – procedure rooms		7,064	6,000	Yes

SECTION VI. SERVICE SPECIFIC REVIEW CRITERIA

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

Indicate changes by Service:

Service			# of Existing Key Rooms	# of Proposed Key Rooms
Surgical Services operating rooms	-		13	13
Surgical Services procedure rooms	-		5	4

Service Modernization

d) 1) Deteriorated Facilities

As stated in the Alternatives section (ATTACHMENT-13), DCH's Surgical Services department has not undergone a significant renovation in over 25 years and the current space is undersized and needs improvements to provide care in the best setting for patients. There is an opportunity to improve patient flow and patient and provider satisfaction which will help DCH provide more surgical care to patients in the DCH community.

Current Deficiencies

Space limitations and an outdated clinical environment have impacted the patient, staff, and physician experience. There are three main operational constraints on DCH's Surgical Services program:

1. Inadequate/Non-uniform Size of Operating Rooms

In addition to an overall inefficient layout, the current operating rooms at DCH vary in size from 383 nsf to 648 nsf with 7 of the 10 operating rooms not large enough to meet current IDPH standards. Additionally, many of the operating rooms cannot accommodate new specialty surgery equipment, creating wait times for the larger operating rooms for the procedures that require the new equipment.

Because of the varying sizes and layout, the operating rooms are not identical. As we have experienced with recent NMHC projects, standardized operating rooms provides faster access, consistent care, and higher productivity of staff.

2. Insufficient Pre/Post-Operative Rooms

The existing space does not have enough pre/post-operative stations. Currently, there are 33 stations while current IDPH Building Code warrants 44 (source: Illinois Administrative Code, Title 77, Part 250.2440 – general hospital standards for the required 4:1 ratio of pre/post-operative rooms to operating rooms/2:1 ratio of pre/post-operative rooms to procedure rooms).

The number of existing pre/post-operative rooms is putting constraints on the surgical demand by creating back-ups in patient flow.

The pre-operative and Phase II recovery area is congested with individual "rooms" separated by half walls and curtains with four fully enclosed rooms at the end of the hallway that are isolated from the nurses station. Space is limited in the individual rooms for patients' families and care givers which make it difficult to perform necessary pre-operative procedures. Adding to the congestion is patient equipment that needs to be readily available for patients coming out of surgery with no accessible storage space. Additionally, there is no enclosed room for patients requiring isolation.

3. Inefficient Layout

The existing Surgical Services department has an inefficient design/flow. Phase II recovery areas are separate and non-contiguous, there is comingling of sterile and non-sterile areas, and caregivers must leave the sterile environment to access the storage areas. A modernized unit with a more efficient design will improve safety, privacy, and infection control.

d) 3) B) Utilization – Service

Currently, DCH has a total of 13 operating rooms and 5 surgical procedure rooms in two locations on campus. The main Surgical Services unit has 10 operating rooms and 3 procedure rooms. The proposed project includes 10 operating rooms and 2 procedure rooms. The Outpatient Surgery Department, located in the adjacent medical office building, is not part of this project.

As stated in the Project Services Utilization section (ATTACHMENT-15), like other clinical services at DCH such as emergency services and the cancer program, surgery volume has experienced significant growth in recent years. As presented in the COE application (#E-013-16) for the change of ownership of Tri-Cities Surgery Center in early 2016, the number of total surgical hours at DCH increased by 26.4% from CY10 – CY14. Because DCH is land locked, the acquisition of the ASTC seemed to be the most non-disruptive, cost-effective option to accommodate the demand for surgical services at DCH.

However, since that time, from CY14 – CY16, the demand for surgical services has continued to increase by 26.0%, which created the need to renovate the existing Surgical Services department earlier than expected.

From CY11 – CY16, the outpatient surgery hours increased by 70.8%, an average annual increase of 14.2% per year. The total number of surgery hours (including time for set-up and clean-up of the operating room) increased 49.1%, an average of 9.8% per year.

This growth has been achieved despite the underutilization of some of DCH's operating rooms. As stated above, there are procedures that surgeons cannot perform in the undersized, non-standardized operating rooms due to equipment and instrumentation requirements, resulting in underutilization of the smaller operating rooms and a higher wait times for the larger operating rooms.

HISTORIC DATA – Operating Rooms

DELNOR	CY11		CY12		CY13		CY14		CY15		CY16	
	Cases	Hours										
Inpatient	2,038	4,767	1,762	4,139	1,649	3,818	1,138	2,302	1,138	2,407	2,365	6,119
Outpatient	3,631	4,568	3,657	4,683	3,134	5,713	3,941	8,746	4,354	9,861	4,291	7,801
Total	5,669	9,335	5,419	8,822	4,783	9,531	5,079	11,048	5,492	12,268	6,656	13,920
# of ORs	10		10		9		9		10		10	
ORs justified	6.2		5.9		6.4		7.4		8.2		9.3	
Legacy TCSC	CY11		CY12		CY13		CY14		CY15		CY16	
	Cases	Hours										
Outpatient	2,513	2,741	1,290	1,414	1,602	1,759	1,283	1,443	1,321	1,634	774	801
# of ORs	3		3		3		3		3		3	
ORs justified	1.8		0.9		1.2		1.0		1.1		0.5	
COMBINED	CY11		CY12		CY13		CY14		CY15		CY16	
	Cases	Hours										
Inpatient	2,038	4,767	1,762	4,139	1,649	3,818	1,138	2,302	1,138	2,407	2,365	6,119
Outpatient	6,144	7,309	4,947	6,097	4,736	7,472	5,224	10,189	5,675	11,495	5,065	8,602
Total	8,182	12,076	6,709	10,236	6,385	11,290	6,362	12,491	6,813	13,902	7,430	14,721
# of ORs	13		13		12		12		13		13	
ORs justified	8.1		6.8		7.5		8.3		9.3		9.8	

Source: IDPH Annual Hospital Profiles
Legacy TCSC = Tri-Cities Surgery Center

Note: due to the 2016 acquisition and conversion from ASTC to hospital-based outpatient surgery department, there is capacity in the 3 operating rooms in the medical office building (Legacy TCSC). This capacity will be used to accommodate the surgery volume during the construction period for the proposed project.

DCH Growth Factors

There are several factors that have contributed to the growth in surgical volume at DCH:

- The addition of more surgeons to the DCH medical staff
- Investment in specialized surgical equipment to expand procedure capability including:
 - Laparoscopic scopes and instrumentation
 - Robotic-assisted technology
 - Specialized instrumentation
 - Advanced intra-operative monitoring capability
 - Staff training
- Investment in pre-procedure programs and diagnostic imaging infrastructure to support surgical volume growth including:

- PET/CT
- 640 CT scanner
- MRI
- 3D Tomography
- Investment in clinical infrastructure and physician specialization to enhance post-operative care for surgical patients including:
 - 24/7 critical care coverage
 - 24/7 in-house hospitalist coverage

DCH expects these factors to continue to impact surgical growth in the coming years.

PROJECTIONS – Operating Rooms

Assuming a conservative average annual growth of 5.4% for surgical hours (4.4% less than the actual growth rate experienced from CY11 – CY16), DCH can justify 13 operating rooms in CY22, the second year of utilization.

ALL DCH	CY17		CY18		CY19		CY20		CY21		CY22	
	Cases	Hours	Cases	Hours	Cases	Hours	Cases	Hours	Cases	Hours	Cases	Hours
Inpatient	2,754	6,333	2,850	6,555	2,950	6,784	3,053	7,022	3,160	7,267	3,270	7,522
Outpatient	5,682	9,090	6,004	9,607	6,345	10,152	6,705	10,728	7,086	11,338	7,488	11,981
Total	8,436	15,423	8,854	16,162	9,295	16,936	9,758	17,750	10,246	18,605	10,758	19,503
# of ORs	13		13		13		13		13		13	
ORs justified	10.3		10.8		11.3		11.8		12.4		13.0	

If DCH surgical volume continues to grow at the actual average annual rate of 9.8%, DCH could justify 16 operating rooms by CY22.

Population Increase

Additionally, according to Sg2 Health Care Intelligence data, the population in DCH's primary market area, which is comprised of nine contiguous ZIP codes surrounding the hospital including Batavia (60510), Elburn (60119), Geneva (60134), North Aurora (60542), Saint Charles (60174), South Elgin (60177) Sugar Grove (60554), and one ZIP code in Aurora (60506), is projected to increase by 1.5% by CY22. More importantly, the population of the 65+ age group is projected to increase by 20%. Approximately one-third of DCH's surgical cases in CY16 were in that age group which is expected to increase with the projected population increase.

Age Groups	2017 Population	2017 % of Total	2022 Population	2022 % of Total	Population % Change
00-17	57,453	24.5%	53,509	22.5%	(6.9)%
18-44	76,474	32.6%	78,868	33.2%	3.1%
45-64	68,796	29.4%	67,570	28.4%	(1.8)%
65-UP	31,640	13.5%	37,954	16.0%	20.0%
Total	234,363	100.0%	237,901	100.0%	1.5%

PROCEDURE ROOMS

Like the operating rooms, DCH's surgical procedure rooms have also experienced an increase in volume. From CY11 – CY16, the total number of surgical procedure room hours (including time for set-up and clean-up of the operating room) increased 90.7%, an average of over 18% per year.

HISTORIC DATA – Procedure Rooms

DELNOR	CY11		CY12		CY13		CY14		CY15		CY16	
	Cases	Hours										
Inpatient	652	696	534	617	618	604	578	752	705	880	532	610
Outpatient	3,373	1,562	2,016	1,575	1,232	859	1,349	1,362	1,664	1,774	3,730	3,696
Total	4,025	2,258	2,550	2,192	1,850	1,463	1,927	2,114	2,369	2,654	4,262	4,306
# of PRs	3		3		3		3		3		3	
PRs justified	1.5		1.5		1.0		1.4		1.8		2.9	
Legacy TCSC	CY11		CY12		CY13		CY14		CY15		CY16	
	Cases	Hours										
Outpatient	3,302	3,522	5,165	5,445	5,647	3,964	5,720	4,678	4,965	3,417	2,167	1,967
# of ORs	2		2		2		2		2		2	
ORs justified	2.3		3.6		2.6		3.1		2.3		1.3	
COMBINED	CY11		CY12		CY13		CY14		CY15		CY16	
	Cases	Hours										
Inpatient	652	696	534	617	618	604	578	752	705	880	532	610
Outpatient	6,675	5,084	7,181	7,020	6,879	4,823	7,069	6,040	6,629	5,191	5,897	5,663
Total	7,327	5,780	7,715	7,637	7,497	5,427	7,647	6,792	7,334	6,071	6,429	6,273
# of ORs	5		5		5		5		5		5	
ORs justified	3.9		5.1		3.6		4.5		4.0		4.2	

Source: IDPH Annual Hospital Profiles
Legacy TCSC = Tri-Cities Surgery Center

PROJECTIONS – Procedure Rooms

Despite the significant increase in surgical procedure room volume, DCH is planning to include only 2 procedure rooms in the proposed project in the main Surgical Services department (overall decrease of one procedure room). DCH is projecting a much lower growth rate than historic experience primarily due to the healthcare market trend of procedures migrating to lower acuity, outpatient settings, often outside of a hospital environment. DCH also anticipates future enhancements in mobile equipment and technology that will allow for more procedures to be performed in patient rooms, negating the need for patients to transfer to a procedure room.

DCH can justify the number of proposed procedure rooms with actual CY16 volume and assuming a very conservative average annual growth of 2% for surgical procedure hours, DCH can justify 5 procedure rooms in CY22, the second year of utilization.

ALL DCH	CY17		CY18		CY19		CY20		CY21		CY22	
	Cases	Hours										
Inpatient	557	613	560	616	563	620	566	623	569	626	572	630
Outpatient	7,231	5,785	7,387	5,909	7,545	6,036	7,708	6,166	7,874	6,299	8,043	6,434
Total	7,788	6,398	7,947	6,525	8,108	6,656	8,274	6,789	8,443	6,925	8,615	7,064
# of PRs	5		5		5		5		4		4	
PRs justified	4.3		4.4		4.4		4.5		4.6		4.7	

SECTION VII. 1120.120 – AVAILABILITY OF FUNDS

Not Applicable – see bond rating documents

SECTION VIII. 1120.130 – FINANCIAL VIABILITY

Not Applicable – see bond rating documents

SECTION IX. 1120.140 – ECONOMIC FEASIBILITY

A. Reasonableness of Financing Arrangements

Not Applicable – see bond rating documents

B. Conditions of Debt Financing

Not Applicable – the proposed project will be funded by cash and securities

C. Reasonableness of Project and Related Costs

COST AND GROSS SQUARE FEET BY DEPARTMENT											
Department	A	B	C		D	E		F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Mod.	BGSF New	Circ.*	BGSF Mod.	Circ.*	Const. \$ (A x C)	Mod. \$ (B x E)			
CLINICAL											
Surgical Services	\$ 400.97	\$ 288.00	12,786	24.4%	31,610	14.5%	\$ 5,126,776	\$ 9,103,680		\$14,230,456	
Clinical Subtotal =			12,786		31,610		\$ 5,126,776	\$ 9,103,680		\$14,230,456	
NON-CLINICAL											
Administration	\$ -	\$ 255.10	0	0.0%	4,187	19.7%	\$ -	\$ 1,068,104		\$ 1,068,104	
Public Facilities	\$ -	\$ 255.00	0	0.0%	5,231	62.0%	\$ -	\$ 1,333,905		\$ 1,333,905	
Materials Management / loading docks	\$ 194.80	\$ 98.71	11,607	0.0%	863	12.0%	\$ 2,261,044	\$ 85,188		\$ 2,346,231	
MEP Systems	\$ 436.45	\$ 309.81	15,850	0.0%	390	0.0%	\$ 6,917,733	\$ 120,826		\$ 7,038,559	
Non-Clinical Subtotal =			27,457		10,671		\$ 9,178,776	\$ 2,608,023		\$11,786,799	
GRAND TOTALS =			40,243		42,281		\$14,305,552	\$11,711,703		\$26,017,255	

D. Projected Operating Costs

Project Direct Operating Expenses – FY22

Total Direct Operating Costs	\$ 23,446,686
Equivalent Patient Days (all DCH)	27,765
Direct Cost per Equivalent Patient Day	\$ 844.47

E. Total Effect of the Project on Capital Costs

Projected Capital Costs – FY22

Equivalent Adult Patient Days (All DCH)	27,765
Total Project Cost	\$ 39,612,776
Useful Life	26
Total Annual Depreciation	\$ 1,523,568
Depreciation Cost per Equivalent Patient Day	\$ 54.87

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CREDIT OPINION

20 September 2016

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Northwestern Memorial HealthCare, IL

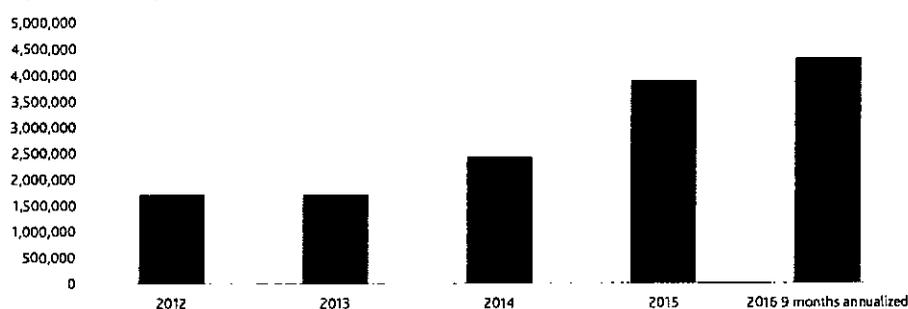
New Issue – Moody's Assigns P-1 to Northwestern Memorial HealthCare's (IL) \$100M Commercial Paper Notes; Aa2 Affirmed

Summary Rating Rationale

Moody's Investors Service assigns a P-1 to Northwestern Memorial HealthCare's (NMHC) proposed Taxable Commercial Paper Notes, Series A. The Notes are authorized for up to \$100 million and supported by self-liquidity. We are affirming the Aa2 on \$1.2 billion of outstanding NMHC debt, including bonds initially issued by Central DuPage Health and Delnor-Community Hospital and secured by the NMHC obligated group. The outlook is stable.

The P-1 reflects NMHC's strong liquidity and processes to pay commercial paper maturities if needed. The Aa2 reflects NMHC's prominent and growing market position in the Chicago region, very good investment position and margins, manageable leverage, and fully funded pension plan. The rating incorporates challenges related to increasing competition in a consolidating market, execution risks during rapid expansion, and comparatively moderate monthly liquidity.

Exhibit 1
 Rapid 3-Year Expansion Period Doubles Revenue (\$000s)



Source: Moody's Investors Service

Credit Strengths

- » Prominent and growing market position in the Chicago region, supported by favorable locations and affiliation with Northwestern University's Feinberg School of Medicine
- » Very strong 419 days of cash on hand and 285% unrestricted cash-to-total debt
- » Good 3-year average operating cashflow margin of 13%, even during rapid growth period
- » Manageable leverage with favorably low 1.7 times debt-to-cashflow and high 10 times peak debt service coverage
- » Moderate Medicare and Medicaid dependency, limiting exposure to funding delays and cuts, especially in Medicaid
- » Fully funded pension plan and modest operating lease obligations
- » Disciplined approach to evaluating strategic alternatives and capital commitments

Credit Challenges

- » Increasingly competitive market with rapid consolidation and several large academic medical centers
- » Execution risks related to rapid expansion with revenue more than doubling in three years through mergers
- » High allocation to alternative investments, resulting in a low 57% monthly liquidity

Rating Outlook

The stable rating outlook is based on our expectation that NMHC will maintain strong operating cash flow margins, manage growth and integration risks with little disruption to operations, and maintain liquidity and debt metrics given capital spending can be funded with cashflow.

Factors that Could Lead to an Upgrade

- » Diversification of cashflow geographically
- » Significant increase in market share
- » Material and sustained improvement in operating margins, along with reduction in leverage
- » Stronger wealth position with greater liquidity

Factors that Could Lead to a Downgrade

- » Large increase in leverage with weakening of debt metrics
- » Multi-year decline in margins or investment position
- » Materially dilutive acquisition or merger

This publication does not announce a credit rating action. For any credit ratings referenced in this publication, please see the ratings tab on the issuer/entity page on www.moody's.com for the most updated credit rating action information and rating history.

Key Indicators

Exhibit 2

Northwestern Memorial HealthCare, IL

	2012	2013	2014	2015	2016 9 months annualized
Operating Revenue (\$'000)	1,701,540	1,709,666	2,426,460	3,885,630	4,313,325
3 Year Operating Revenue CAGR (%)	7.9	3.1	13.0	31.7	37.6
Operating Cash Flow Margin (%)	14.3	17.2	11.8	13.2	14.9
PM: Medicare (%)	33.5	32.6	33.5	34.6	N/A
PM: Medicaid (%)	10.6	9.7	9.0	10.6	N/A
Days Cash on Hand	477	601	445	435	419
Unrestricted Cash and Investments to Total Debt (%)	236.8	296.7	334.7	282.0	285.2
Total Debt to Cash Flow (x)	2.1	1.6	1.7	1.9	1.7

Based on financial statements for Northwestern Memorial HealthCare & Subsidiaries, fiscal year ended August 31 through 2015; fiscal year 2016 based on annualized nine months ended May 31, 2016

Adjustments: Grants and academic support provided (representing transfers to the school of medicine) reallocated to operating expenses from nonoperating gains (losses)

Investment returns normalized at 6% prior to FY 2015 and 5% in FY 2015 and beyond

Source: Moody's Investors Service

Recent Developments

In April 2016 NMHC and Centegra Health System signed a non-binding letter of intent to explore an affiliation. Centegra is a \$500 million revenue system with hospitals in McHenry and Woodstock. Given Centegra's high leverage, the potential combination would be somewhat dilutive to NMHC financially, although geographically complementary.

Detailed Rating Considerations

Market Position: Prominent and Growing Market Position in Competitive Market

NMHC has grown rapidly to a large \$4.3 billion regional system, more than doubling from \$1.7 billion in revenue in 2013. The September 2014 affiliation with Cadence expanded and enhanced NMHC's locations in attractive and growing markets. Most business consolidation has been achieved. NMHC merged with KishHealth System December 2015 and Marianjoy Rehabilitation Hospital March 2016; these smaller organizations did not have a material financial impact on NMHC. The system has developed an integrated and consolidated platform to consider other affiliations that allow geographic expansion and access and add management expertise in certain areas.

NMHC continues to integrate and coordinate strategies with Northwestern University's Feinberg School of Medicine (NU) through a joint planning process and governance oversight structure that coordinates activities for the school, the faculty practice plan and hospitals. Strategically, we believe closer integration is positive in advancing the strong brand of Northwestern and building on clinical capabilities.

The Chicago market is increasingly competitive with an increase in the pace of consolidation among hospitals. Of note is the intended merger between Advocate Health Network and NorthShore University HealthSystem, which would become the largest healthcare system in the state if completed. The state's strict Certificate of Need process reduces the presence of for-profit hospital companies.

Operating Performance, Balance Sheet and Capital Plans: Good Margins and Strong Investment Position

NMHC has reported operating cashflow margins, averaging 13% over three years, even during a period of rapid expansion. Same-facility revenue growth picked up to about 3.5% and 6.7% in FY 2015 and through nine months of FY 2016, respectively, in part due to supplemental Medicaid payments. Same-facility admissions declined by 2.7% and 2.8% in FY 2015 and through nine months of FY 2016, respectively, in part due to shifts in cases to observation status. Cadence accounted for most of the reported increase in

operating cashflow in FY 2015. Margins include transfers to the school of medicine as an operating expense. The transfers are formulaic and tied to net patient revenue and operating cashflow of NMHC.

NMHC is budgeting to maintain margins within recent ranges as the system focuses on core operating performance and continued integration initiatives. While NMHC has a good track record of integration, execution risks are heightened during this expansion period. While another Medicaid enhancement program is expected to increase supplemental funding, the state's budget situation also introduces risk regarding future Medicaid payments.

LIQUIDITY

NMHC has a strong investment position, but liquidity is less than peers due to the asset allocation. Days cash on hand was 419 days at May 31, 2016, providing a good 285% unrestricted cash-to-total debt. Based on FYE 2015, monthly liquidity was low at 57%, reflecting a heavy allocation to alternative investments. NMHC has minimal swap collateral posted and no pension requirements, which limits liquidity needs.

Capital spending is expected to be manageable and funded with operating cashflow. Total capital spending is budgeted at \$590 million in FY 2017. The largest projects are a replacement hospital for Northwestern Lake Forest Hospital, estimated to cost \$419 million, and the installation of an electronic medical record. Certain facilities are already on parts of an electronic medical record, including the revenue cycle component; the project will bring all hospitals onto both clinical and revenue cycle systems by early 2018.

Debt Structure and Legal Covenants: Manageable Leverage and Debt Structure Risks

NMHC has manageable leverage with favorably low 1.7 times debt-to-cashflow and 10 times peak debt service coverage based on annualized FY 2016 results. Debt-to-revenue is adequate at 37%. No incremental leverage is expected in the next couple years, outside of merger-related debt.

DEBT STRUCTURE

NMHC had approximately 40% demand debt at FYE 2015, including bonds supported by bank standby bond purchase agreements and private bank placements. The bank counterparties are diversified and expiration dates are staggered. Monthly liquidity-to-demand debt was good at 383%.

Financial covenants are consistent across bank agreements and are limited to a 1.0 times debt service coverage covenant.

The P-1 rating reflects NMHC's strong daily liquidity and processes to pay maturing commercial paper if needed. The proposed commercial paper notes will be authorized for up to \$100 million of issuance. NMHC projects issuing up to \$100 million over the next twelve months. Although not legally restricted in the Issuing and Paying Agent Agreement, NMHC intends to limit maturities to \$60 million within any five business-day period. Liquidity for maturing notes will be provided by NMHC if needed. At July 31, 2016, NMHC had \$294 million in daily liquidity consisting primarily of P-1 rated bank accounts and US treasuries/agencies with maturities less than a year. Discounted daily liquidity provides 2.9 times coverage of the entire CP amount. The system will also have \$130 million in operating lines of credit and has strong weekly liquidity (\$1.1 billion undiscounted at July 31, 2016) as supplemental sources.

DEBT-RELATED DERIVATIVES

NMHC's debt-related derivatives pose minimal credit risk, given modest collateral posting requirements and NMHC's strong liquidity. As of August 31, 2016, NMHC has interest rate swaps with three counterparties with a total notional amount of \$388 million. All of the swaps convert variable rate bonds to synthetic fixed rate bonds. Two of the swaps have \$35 million thresholds at Aa2, two have no collateral requirements and two have no collateral requirements unless the rating falls below A3. NMHC has posted limited collateral in recent years; at August 31, 2016 the mark-to-market was negative \$155 million and \$25 million of collateral was posted. NMHC has plans to novate certain swaps, which will reduce collateral requirements.

PENSIONS AND OPEB

NMHC's pension plan is fully funded.

Management and Governance

The management team has shown a disciplined and detailed approach to evaluating strategic alternatives and capital commitments and ability to adapt to periods of moderate revenue growth with effective expense management strategies. Planning capabilities are particularly important during the current period of rapid growth and integration.

Debt structure risks have been well managed with diversified counterparties and staggered commitment periods. NMHC's bank agreements have consistent covenants and reporting requirements.

Legal Security

Bonds and commercial paper are unsecured general obligations of the Obligated Group, including Northwestern Memorial HealthCare (parent), Northwestern Memorial Hospital, Northwestern Lake Forest Hospital, Northwestern Memorial Foundation, Northwestern Medical Faculty Foundation (dba Northwestern Medical Group), CDH-Delnor Health System, Marianjoy, Inc. and KishHealth System. The Obligated Group comprises virtually all of the NMHC system entities.

Use of Proceeds

Proceeds from the sale of commercial paper notes will be used to redeem the Series 2002C bonds and repay a bank line of credit.

Obligor Profile

NMHC's largest subsidiaries are noted in the Legal Security section. Northwestern Memorial Hospital is a major academic medical center located in the Streeterville neighborhood of Chicago, providing a complete range of adult inpatient and outpatient services, primarily to residents of Chicago and surrounding areas, in an educational and research environment. It is licensed for 894 beds. NMH is the primary teaching hospital for Northwestern University's Feinberg School of Medicine (FSM). The system operates sizable hospitals in the northern and western suburbs of Chicago.

Methodology

The principal methodology used in this rating was Not-For-Profit Healthcare Rating Methodology published in November 2015. The additional methodology used in the commercial paper rating was Rating Methodology for Municipal Bonds and Commercial Paper Supported by a Borrower's Self-Liquidity published in January 2012. Please see the Ratings Methodologies page on www.moodys.com for a copy of these methodologies.

Ratings

Exhibit 3

Northwestern Memorial HealthCare, IL

Issue	Rating
Taxable Commercial Paper Notes, Series A	P-1
Rating Type	Underlying ST
Sale Amount	\$100,000,000
Expected Sale Date	10/03/2016
Rating Description	Revenue: Other

Source: Moody's Investors Service

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Table Of Contents

Rationale

Outlook

Enterprise Profile

Financial Profile

Related Research

Illinois Finance Authority Northwestern Memorial HealthCare; CP; System

Credit Profile

US\$100.0 mil CP nts (Northwestern Mem HlthCare) (Direct Issue Taxable Commercial Paper) dtd 09/29/2016 due 10/01/2046

<i>Short Term Rating</i>	A-1+	New
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Illinois Finance Authority, Illinois

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

Series 2009

<i>Long Term Rating</i>	AA+/Stable	Affirmed
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Illinois Finance Authority, Illinois

Northwestern Mem HlthCare, Illinois

Illinois Finance Authority (Northwestern Mem HlthCare) CP nts (Northwestern Mem HlthCare) (Direct Issue Taxable Commercial Paper) dtd 09/29/2016 due

<i>Short Term Rating</i>	A-1+	Affirmed
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Series 2009 A&B, 2013

<i>Long Term Rating</i>	AA+/Stable	Affirmed
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Illinois Hlth Fac Auth, Illinois

Delnor Comnty Hosp, Illinois

Illinois Hlth Fac Auth (Delnor Community Hospital)

<i>Unenhanced Rating</i>	AA+(SPUR)/Stable	Affirmed
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Rationale

S&P Global Ratings assigned its 'A-1+' short-term rating to the Illinois Finance Authority's taxable commercial paper notes, series A, issued on behalf of Northwestern Memorial HealthCare (NMHC). At the same time, S&P Global Ratings affirmed its 'AA+' long-term rating on the authority's series 2013, 2009A, and 2009B bonds, and its 'AA+/A-1+' dual rating on the authority's series 2002C bonds. The series 2013 bonds were issued on behalf of NMHC, while the series 2002C, 2009A, and 2009B were issued on behalf of Northwestern Memorial Hospital (NMH).

Finally, S&P Global Ratings affirmed its 'AA+' long-term rating on the authority's series 2009 and 2009B fixed-rate revenue bonds issued for Central DuPage Health (CDH) and its underlying rating (SPUR) on the authority's series 2002D and 2003A hospital fixed-rate revenue bonds issued for Delnor Community Hospital (Delnor). CDH and Delnor together previously operated as CDH-Delnor Health System, doing business as Cadence Health, and is a member of the NMHC obligated group. The outlook, where applicable, is stable.

At a later date, S&P Global Ratings will review its ratings for the authority's series 2007A-2, 2007A-4, 2008A-1, 2008A-2, 2007A-1, and 2007A-3 bonds, as NMHC is in the process of getting extensions and changing a standby bond purchase agreement (SBPA) provider.

NMHC identified approximately \$415.5 million in assets (market value) as of May 31, 2016 to cover the maximum authorized \$100 million taxable commercial paper (CP) program. NMHC has internally set maturity restrictions of a maximum of \$60 million during a five-business day period. The internally set restrictions are not legally binding. In the event of a failed rollover, the assets identified in the portfolio would provide sufficient liquidity. The eligible assets include cash, fixed-income assets, and domestic equities. Upon a failed remarketing, NMHC has provided us with the operational procedures that will be followed to liquidate assets to provide for a timely payment of a CP maturity. S&P Global Ratings will provide monthly surveillance on the bonds.

The ratings continue to reflect our view of NMHC's strong operations for the first nine months of fiscal 2016. As a system, NMHC has continued to seamlessly integrate new members into the organization. The most recent additions include KishHealth System and Marianjoy Inc. As of this analysis, NMHC has continued to focus on the integration of the newly acquired entities such that they operate more as a system than a federation of hospitals. With this in mind, NMHC has been able to spend capital on various projects, continue with the implementation of the Epic electronic medical record, and continue to see growth in its overall share of the Chicagoland market. With the addition of KishHealth and Marianjoy, NMHC has been able to maintain its financial flexibility so that NMHC is able to assess future acquisitions in the greater Chicagoland area. With this in mind, NMHC has executed a letter of intent to acquire Centegra Health System (CHS; BBB/Stable) with NMHC becoming the sole corporate member of Centegra. CHS operates Centegra Hospital-McHenry, Centegra Hospital-Woodstock, and the recently opened Centegra Hospital-Huntley. The affiliation, if finalized, will bring NMHC to a total of 10 hospitals and more than 100 locations covering eight counties. Finally, NMHC's management team maintained its solid balance sheet even amid continued investments in capital, and this helps NMHC remain an important provider in the very competitive Chicagoland market.

The 'AA+' rating continues to reflect our view of NMHC's:

- Strong liquidity while it continues to invest in capital projects and mergers/acquisitions;
- Solid pro forma maximum annual debt service (MADS) coverage as a result of the solid operations noted above and solid investment income for the first nine months of fiscal 2016;
- Outstanding governance and management, including the numerous benefits realized through affiliations with all Northwestern University-related entities, including the Feinberg School of Medicine; and
- Growing business position through its acquisition strategy.

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

- Potential acquisition partner that has not performed at the strong level of operations that NMHC has historically added to the system; and
- Increasingly competitive service area, with provider consolidation continuing in the greater Chicago market.

The 'AA+' rating is based on our view of NMHC's group credit profile and the credit group's "core" status. Accordingly, we rate the bonds at the same level as the group credit profile. The analysis and financial figures in this report pertain to the activities of NMHC, the sole corporate member of NMH, Northwestern Lake Forest Hospital (NLFH), Northwestern Medical Faculty Foundation (NMFF, doing business as Northwestern Medical Group, or NMG), Northwestern Memorial Foundation (NMF) and Cadence Health. The revenue bonds are an unsecured general

obligation (GO) of the NMHC obligated group, which consists of NMHC, NMH, NLFH, NLHF's not-for-profit subsidiary, NMF, NMG, and NMG's not-for-profit subsidiary. As of Nov. 25, 2014, Cadence Health, CDH, Delnor, and Cadence Physician Group became members of NMHC's obligated group and NMHC provided guarantees of the obligations of the Cadence Health obligated group for full and timely payment of the debt of the aforementioned entities. KishHealth and Marianjoy became members of the obligated group as of Dec. 18, 2015 and May 31, 2016, respectively.

Outlook

The stable outlook reflects our opinion that the system will maintain strong operations as NMHC's leadership continues to improve on its strategies to maintain the expense base while investing in facilities and expanding the system through affiliations.

Downside scenario

NMHC continues to define a level of operations that it will need to achieve to allow the system to achieve its plan. However, if operations begin to trend negatively for a sustained period and capital spending begins to negatively affect the balance sheet, we could lower the rating or revise the outlook to negative. Finally, because of market consolidation, a dilutive acquisition or loss of leading market position by NMHC could also affect the rating.

Upside scenario

We do not anticipate raising the rating in the outlook period.

Enterprise Profile

Industry risk

Industry risk addresses our view of the health care sector's overall cyclical and competitive risk and growth through application of various stress scenarios and evaluating barriers to entry; the level and trend of industry profit margins; risk from secular change and substitution of products, services, and technologies; and risk in growth trends. We believe the health care services industry represents an intermediate credit risk when compared with other industries and sectors.

Enterprise

NMHC is the corporate parent of NMH, NLFH, NMG, NMF, and Cadence Health. NMH has a total of 894 licensed beds (823 staffed) in the Feinberg/Galter Pavilion and Prentice Women's Hospital. It is the primary teaching hospital for Northwestern University's Feinberg School of Medicine. NLFH is a 198-bed community hospital with more than 700 physicians who are board certified in 68 medical specialties and who are located in offices throughout Lake County. NMG has approximately 1,100 employed physicians, including 145 physicians from Northwestern Memorial Physicians Group, a primary care medical group practice that merged with NMG on May 1, 2014. NMHC also includes Northwestern Memorial Insurance Co., a subsidiary of NMH.

Northwestern University (AAA) is a separate corporation and is not obligated to repay debt service associated with the bonds, but we believe the university's Feinberg School of Medicine is integrally linked with NMHC through a shared

strategic plan.

Cadence Health formally came together in April 2011. CDH is a 392-licensed-bed hospital and Delnor is a 159-licensed-bed hospital. CDH and its affiliates are located in Winfield, a western suburb of Chicago, and Delnor is located approximately 11 miles west of CDH. Other entities that are part of Cadence Health but are not part of the obligated group are Community Nursing Service of DuPage County Inc. (providing home health care and hospice), Cadence Physician Group (which employs more than 230 physicians, including the 23-member orthopedic group acquired in early fiscal 2013), an orthopedic ambulatory surgery center, a foundation for both Delnor and CDH, a residential living facility, a captive for managing self-insurance, and a few smaller entities with more limited operations.

KishHealth System's Kishwaukee Hospital is a 98-bed acute care hospital in DeKalb, Ill., with more than 230 physician members on the medical staff representing nearly every specialty. Kishwaukee Hospital opened its Joint Center in 2007 and added a Spine Center in 2013. The Valley West Hospital is a 25-bed critical access hospital in Sandwich, Ill., that has served the Fox Valley community for more than 70 years. In 2014, the hospital completed construction of a new patient wing and renovations to remaining areas, including a new MRI suite that is home to one of the only large bore MRI machines in the area.

Marianjoy Rehabilitation Hospital is located in Wheaton, Ill., and offers 100 acute inpatient rehabilitation beds and 27 Medicare-licensed sub-acute beds for adult and pediatric patients recovering from illness or injury who require intensive therapy to regain function and independence. The main hospital is a free-standing 170,000-square-foot facility with a number of niche inpatient and outpatient offerings, including specialty programs focused on treatment of stroke, spinal cord injury, brain injury, pediatrics, and orthopedic/musculoskeletal conditions.

Utilization

NMHC's leadership reports that the overall market has continued to see a decline in inpatient utilization. The decline is no different from that of the industry overall. For NMHC, utilization has been stable at the facilities that have been a part of the system for at least a year. However, growth continues in the outpatient area. Also, as the NMHC-aligned physicians' patients tend to remain within the system and NMHC continues to take advantage of the favorable geographic relationship of the hospitals and health care sites in the system, NMHC has been able to maintain its business position.

NMHC's primary service area market share (a seven-county area) equates to an 8.6% market share. NMHC's market share may seem modest, but admissions and related market share among other hospitals in the service area remain stagnant when consolidation is excluded. This, coupled with the expectation of further health care reform, results in more consolidations, with health systems and hospitals aligning to strengthen their competitive position.

Table 1

Northwestern Memorial HealthCare and Subsidiaries Utilization			
	--Nine-month interim ended May 31--		--Fiscal year ended Aug. 31--
	2016	2015	2014
PSA population	9,436,609	9,436,609	N.A.
PSA market share %	8.6	8.6	N.A.
Inpatient admissions*	59,228	78,022	51,592

Table 1

Northwestern Memorial HealthCare and Subsidiaries Utilization (cont.)			
	--Nine-month interim ended May 31--		--Fiscal year ended Aug. 31--
	2016	2015	2014
Equivalent inpatient admissions	126,805	179,975	101,324
Emergency visits	206,482	247,935	129,070
Inpatient surgeries	16,987	22,338	14,435
Outpatient surgeries	34,068	42,588	27,349
Medicare case mix index	1.91	1.84	1.89
FTE employees	16,984	16,984	10,362
Active physicians	3,858	3,858	2,508
Medicare %¶	23.0	18.7	21.8
Medicaid %	4.4	8.2	5.0
Commercial/Blues %	68.2	67.2	67.0

*Excludes newborns, psychiatric, and rehabilitation admissions. ¶Based on net revenue. FTE—Full-time equivalent. N.A.—not available.

Management

NMHC continues to have a strong leadership team. The team has continued to produce strong operations and balance sheet measures while investing in its facilities. To date, NMHC has had no major missteps in aligning with the facilities that it has acquired over the years, including KishHealth and Marianjoy. NMHC utilizes an integration team that helps to assess the positives and negatives of an acquired entity. The team will then put together an integration plan to help NMHC and the newly acquired entity integrate with little to no interruption.

NMHC leadership remains focused on growth, as noted in its letter of intent to acquire Centegra. NMHC also has a focus on further system integration. As NMHC has grown rather rapidly over the past couple of years, the leadership team has noted that room for further system formation. Project One is an example of the steps that NMHC is taking to become even further aligned. For NMHC, Project One is the vehicle to get the entire system onto one electronic medical record, Epic. This, along with other measures, will help to increase efficiency.

Financial Profile

Financial policies

We assess NMHC's financial policies as neutral, which reflects our opinion that financial reporting and disclosure, investment allocation and liquidity, debt profile, contingent liabilities, and legal structure are appropriate for an organization of its type and size and are not likely to hamper the organization's ability to pay debt service.

Operations

NMHC's financial performance remained strong through the first nine months of fiscal 2016 ended May 31. NMHC generated an operating margin of 7.1% for the period compared with 7.7% for the prior year. The continued success of the operations can still be attributed to the attention that management has placed on watching the expense base as NMHC faces the challenges of the market and operates on a much larger scale. Management reports that NMHC will continue to address strategies to help offset the challenge of inpatient volumes coupled with health care reform. With

this in mind, management maintains that its long-term goal is to break even on Medicare patients while continuing to produce operating margins of at least 4.5% to 5.0% to meet NMHC's future needs, which include capital expenditures and the tightening of the relationship with the university and others.

With the strong operations and investment income, NMHC continues to post solid MADS coverage. For the first nine months of fiscal 2016, NMHC posted MADS coverage of 7.6x.

Balance sheet

As of May 31, 2016, NMHC's leverage remained in line with that of other 'AA+' rated systems. For the same date, unrestricted reserves to long-term debt improved when compared with the prior year, while unrestricted reserves to contingent liabilities was strong at greater than 800%.

Short-term bank-supported ratings

The 'A-1+' short-term component of the rating on the series 2002C bonds reflects our view of the likelihood of payment of tenders as well as a liquidity facility: an SBPA provided by The Northern Trust Company (AA-/A-1+). The SBPA provides for a maximum of 35 days' interest at the 12% maximum rate. Proceeds from the proposed CP notes are intended to refinance the series 2002C bonds, at which time we will withdraw our rating. However, if the CP is not used for this purpose, we will withdraw our short-term rating on the expiration date unless the SBPA is extended pursuant to its terms or an alternative SBPA is delivered.

Bondholders may tender their bonds during the daily and weekly modes upon delivering appropriate notice. The bonds are further subject to mandatory tender upon conversion to another interest rate mode and one business day before expiration, substitution, or termination. The bonds may be called because of optional redemptions and are subject to mandatory sinking fund payments.

Contingent liabilities: swaps, direct purchase debt, and other contingent liabilities

NMHC is a party to two floating- to fixed-rate swaps with a notional amount of \$207.2 million as of May 31, 2016: one with a notional amount of \$103.6 million with UBS AG (A+/A-1/Negative) as the counterparty and one with the same notional amount with JPMorgan Chase Bank (A+/A-1/Stable) as the counterparty.

Cadence is party to four floating- to fixed-rate swaps. Two swaps are with CDH, with Morgan Stanley Capital Services Inc. (guaranteed by 'A' rated Morgan Stanley) as the counterparty, for a current notional amount of \$125.426 million. The other two variable- to fixed-rate swaps are with Delnor, with UBS AG as the counterparty, for a current notional amount of \$59.675 million.

As of May 31, 2016, there is \$13.1 million of collateral posted for the swaps listed above.

Cadence Health has additional contingent liability risk related to \$175 million of direct purchase debt (series 2011A, 2011B, and 2011C) which are simultaneously being restructured to diversify bank risk and to reduce interest costs.

Table 2

Northwestern Memorial HealthCare and Subsidiaries Financial Summary					
	--Nine-month interim ended May 31--	--Fiscal year ended Aug. 31--		'AA+' rated health care system medians	'AA' rated health care system medians
	2016	2015	2014	2014	2014
Financial performance					
Net patient revenue (\$000s)	3,020,006	3,702,986	2,296,846	2,678,034	1,989,096
Total operating revenue (\$000s)	3,233,523	3,885,077	2,426,460	MNR	MNR
Total operating expenses (\$000s)	3,005,670	3,671,766	2,284,349	MNR	MNR
Operating income (\$000s)	227,853	213,311	142,111	MNR	MNR
Operating margin (%)	7.05	5.49	5.86	6.5	5.3
Net non-operating income (\$000s)	51,797	167,808	224,107	MNR	MNR
Excess income (\$000s)	279,650	381,119	366,218	MNR	MNR
Excess margin (%)	8.51	9.4	13.82	9.9	8.5
Operating EBIDA margin (%)	15.21	14.5	13.45	12.1	10.9
EBIDA margin (%)	16.55	18.04	20.77	15.2	14.4
Net available for debt service (\$000s)	543,761	731,333	550,391	538,975	421,930
Maximum annual debt service (MADS; \$000s)	95,463	95,463	95,463	MNR	MNR
MADS coverage (x)	7.59	7.66	5.77	7.9	7.2
Operating-lease-adjusted coverage (x)	5.84	6.41	5.36	4.5	5.2
Liquidity and financial flexibility					
Unrestricted reserves (\$000s)	4,279,600	4,085,104	2,648,946	4,024,012	2,395,574
Unrestricted days' cash on hand	421.1	441.1	454.1	440.5	296.6
Unrestricted reserves/long-term debt (%)	303.1	288.9	342.7	295.7	256.4
Unrestricted reserves/contingent liabilities (%)	876.2	832.7	841.9	MNR	MNR
Average age of plant (years)	6.1	5.5	8.9	8.9	9.4
Capital expenditures/depreciation and amortization (%)	145.5	125.6	135.9	186.9	143
Debt and liabilities					
Long-term debt (\$000s)	1,411,870	1,414,209	772,867	MNR	MNR
Long-term debt/capitalization (%)	19.8	21.6	19.2	24.1	24.6
Contingent liabilities (\$000s)	488,445	490,565	314,625	MNR	MNR
Contingent liabilities/long-term debt (%)	34.6	34.7	40.7	MNR	MNR
Debt burden (%)	2.18	2.36	3.6	1.7	1.9
Defined benefit plan funded status (%)	N.A.	116.13	115.06	94.6	83.8
Pro forma ratios					
Unrestricted reserves (\$000s)	4,279,600	N/A	N/A	MNR	MNR
Total long-term debt (\$000s)*	1,424,670	N/A	N/A	MNR	MNR
Unrestricted days' cash on hand	421.1	N/A	N/A	MNR	MNR
Unrestricted cash/total long-term debt (%)	300.39	N/A	N/A	MNR	MNR

Table 2

Northwestern Memorial HealthCare and Subsidiaries Financial Summary (cont.)					
	--Nine-month interim ended May 31--	--Fiscal year ended Aug. 31--		'AA+' rated health care system medians	'AA' rated health care system medians
	2016	2015	2014	2014	2014
Long-term debt/capitalization (%)	19.97	N/A	N/A	MNR	MNR

*Assumes \$100 million CP is fully drawn. Incrementally adds \$12.8 million of new debt. MNR--Median not reported. N/A--Not applicable.

Related Research

- Glossary: Not-For-Profit Health Care Ratios, Oct. 26, 2011
- U.S. Not-For-Profit Health Care Sector Outlook Revised To Stable From Negative, Though Uncertainties Persist, Sept. 9, 2015
- U.S. Not-For-Profit Health Care System Median Ratios Likely To Remain Stable Through 2016 Despite Industry Pressures, Sept. 1, 2015
- Health Care Providers And Insurers Pursue Value Initiatives Despite Reform Uncertainties, May 9, 2013
- Standard & Poor's Assigns Industry Risk Assessments To 38 Nonfinancial Corporate Industries, Nov. 20, 2013
- Alternative Financing: Disclosure Is Critical To Credit Analysis In Public Finance, Feb. 18, 2014

Ratings Detail (As Of September 23, 2016)

Illinois Finance Authority, Illinois

Northwestern Mem HlthCare, Illinois

Illinois Fin Auth (Northwestern Mem HlthCare) rev bnds ser 2013 dtd 02/27/2013 due 08/15/2033 2037 2042 2043

Long Term Rating AA+/Stable Affirmed

Series 2002C

Long Term Rating AA+/A-1+/Stable Affirmed

Many issues are enhanced by bond insurance.

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SECTION X. SAFETY NET IMPACT STATEMENT

Not Applicable – the proposed project is NON-SUBSTANTIVE and does not involve discontinuation.

SECTION XI. CHARITY CARE INFORMATION

With a mission-driven commitment to providing quality medical care, regardless of the patients' ability to pay, NMHC/DCH maintain their dedication to improve the health of the most medically underserved members of the community.

Northwestern Medicine Delnor Hospital

	FY14	FY15	FY16
Net Patient Revenue	\$ 213,310,618	\$ 255,168,156	\$ 291,113,383
Amount of Charity Care (charges)	\$ 11,371,095	\$ 12,795,269	\$ 12,623,926
Cost of Charity Care	\$ 2,649,465	\$ 2,345,261	\$ 2,179,655

DCH experienced a decrease in the amount of charity care provided since 2014, which is primarily due to the health insurance coverage expansions that took effect in 2014 as a result of the Affordable Care Act (specifically, the ACA's expansion of Medicaid and the implementation of *GetCovered Illinois*, the State's health insurance marketplace, or "exchange"). This decrease in charity care is consistent with the statewide average from 2013-2015. Over the same period (2014 – 2016), the number of Medicaid patients treated by DCH increased by 41%.

DCH regularly engages with Kane County organizations committed to improving the health of its residents, including the Kane County Health Department, the Tri City Health Partnership, a Kane County free health clinic that had more than 1,500 patient visits in 2016 through its entirely volunteer medical staff, and the INC 708 organization, which focuses on mental health services.

Northwestern Memorial HealthCare

	FY14	FY15	FY16
Net Patient Revenue	\$2,296,846,000	\$3,702,986,000	\$4,081,581,000
Amount of Charity Care (charges)	\$ 304,890,000	\$ 418,054,000	\$ 386,070,000
Cost of Charity Care	\$ 66,747,000	\$ 81,601,000	\$ 80,459,000

Note: numbers do not reflect the impact on acquisitions/affiliations for periods prior to the acquisition/affiliation.

During FY16, Northwestern Memorial HealthCare contributed \$747.4 million in community benefits including charity care, other unreimbursed care, research, education, language assistance, donations and other community benefits.