ILLINOIS HEALTH FACILITIES PLANNING BOARD
APPLICATION FOR PERMIT

08-051

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION (IDEN)

RECEIVED

ORIGINAL

JUN 30 2008

HEALTH FACILITIES PLANNING BOARD

This section must be completed for all projects.

A. Facility/Project Identification

Facility Name Good Samaritan Regional Health Center Street Address Veteran's Memorial Drive at 42nd Street City Mount Vernon County Jefferson Zip 62864 Illinois State Representative District 107

B. Applicant Identification (provide for each co-applicant [refer to Part 1130.220] and insert after this page)

Exact Legal Name Good Samaritan Regional Health Center Address 605 N. 12th Street Mount Vernon, Illinois 62864 Name of Registered Agent Leo F. Childers, Jr. Name of Chief Executive Officer Leo F. Childers, Jr. Title President CEO Address 605 N. 12th Street Mount Vernon, Illinois 62864 Telephone No. (618)241-2201 Type of Ownership: ☒ Non-profit Corporation ☐ For-profit Corporation ☐ Limited Liability Company ☐ Partnership ☐ Governmental ☐ Sole Proprietorship ☐ Other (specify)

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

APPEND DOCUMENTATION AS ATTACHMENT IDEN-1 AFTER THE LAST PAGE OF THIS SECTION.

C. Primary Contact Person (person who is to receive correspondence or inquiries during the review period)

Name Michael Warren Title Vice President
Company Name Good Samaritan Regional Health Center
Address 605 N. 12th Street Mount Vernon, IL 62864 Telephone No. (618)241-2202
E-mail Address mike.warren@ssmhc.com Fax Number (618) 241-3847

D. Additional Contact Person (person such as consultant, attorney, financial representative, registered agent, etc. who also is authorized to discuss application and act on behalf of applicant)

Name Michael I. Copelin Title President
Company Name Copelin Healthcare Consulting, Inc.
Address 42 Birch Lake Drive Sherman, IL 62684
Telephone No. (217)496-3712 E-mail Address micbball@aol.com Fax Number (217)496-3097

E. Post Permit Contact Person (person to whom all correspondence and inquiries pertaining to the project subsequent to permit issuance are to be directed)

Name Michael Warren Title Vice President
Company Name Good Samaritan Regional Health Center
Address 605 N. 12th Street Mount Vernon, IL 62864
Telephone No. (618)241-2202
E-mail Address mike.warren@ssmhc.com Fax Number (618) 241-3847

F. Site Ownership (complete this information for each applicable site and insert after this page)

ILLINOIS HEALTH FACILITIES PLANNING BOARD
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B. Applicant Identification (provide for each co-applicant [refer to Part 1130.220] and insert after this page)

Exact Legal Name SSM Health Care Corporation Address 477 N. Lindbergh Blvd., St. Louis, MO 63141 Name of Registered Agent Leo F. Childers, Jr. Name of Chief Executive Officer Sr. Mary Jean Ryan , FSM Title President & Chief Executive Officer CEO Address 477 N. Lindbergh Blvd., St. Louis, MO 63141 Telephone No. (314) 994-7800

Type of Ownership: ☒ Non-profit Corporation ☐ For-profit Corporation ☐ Limited Liability Company ☐ Partnership ☐ Governmental ☐ Sole Proprietorship ☐ Other (specify)_____

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ILLINOIS HEALTH FACILITIES PLANNING BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION (IDEN)

This section must be completed for all projects.

A. Facility/Project Identification

Facility Name Good Samaritan Regional Health Center Street Address Veteran's Memorial Drive at 42nd Street City Mount Vernon County Jefferson Zip 62864 Illinois State Representative District 107

B. Applicant Identification (provide for each co-applicant [refer to Part 1130.220] and insert after this page)

Exact Legal Name SSM Regional Health Services Address 477 N. Lindbergh Blvd., St. Louis, MO 63141 Name of Registered Agent Leo F. Childers, Jr. Name of Chief Executive Officer Sr. Mary Jean Ryan Title President & Chief Executive Officer CEO Address 477 N. Lindbergh Blvd., St. Louis, MO 63141 Telephone No. (314) 994-7800

Type of Ownership: ☒ Non-profit Corporation ☐ For-profit Corporation ☐ Limited Liability Company ☐ Partnership ☐ Governmental ☐ Sole Proprietorship ☐ Other (specify)____

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

APPEND DOCUMENTATION AS ATTACHMENT IDEN-1 AFTER THE LAST PAGE OF THIS SECTION.

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Company Name Good Samaritan Regional Health Center
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Company Name Good Samaritan Regional Health Center
Address 605 N. 12th Street Mount Vernon, IL 62864
Telephone No. (618)241-2202 E-mail Address mike.warren@ssmhc.com Fax Number (618) 241-3847

F. **Site Ownership** (complete this information for each applicable site and insert after this page)
Exact Legal Name of Person Who Owns Site Good Samaritan Regional Health Center
Address of Site Owner 605 N. 12th Street Mount Vernon, IL 62864
Street Address or Legal Description of Site Veteran's Memorial Drive at 42nd Street Mount Vernon, IL 62864 (Legal Description is attached.

G. **Operating Entity/Licensee** (complete this information for each applicable facility and insert after this page)
Exact Legal Name Good Samaritan Regional Health Center, 605 N. 12th Street Mount Vernon, IL 62864
Type of Ownership: ☒ Non-profit Corporation ☐ For-profit Corporation ☐ Limited Liability Company ☐ Partnership ☐ Governmental ☐ Sole Proprietorship ☐ Other (specify)_____
Corporations and limited liability companies must provide an Illinois certificate of good standing; partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT IDEN-2 AFTER THE LAST PAGE OF THIS SECTION.

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

APPEND DOCUMENTATION AS ATTACHMENT IDEN-3 AFTER THE LAST PAGE OF THIS SECTION.

I. **Status of Previous Certificate of Need Projects**
Provide the project number for any of the applicant's projects that have received permits but are not yet complete (completion is defined in Part 1130.140) and provide the current status of the project . If all projects are complete, indicate NONE: **NONE**

J. **Flood Plain Requirements** (refer to instructions for completion of this application)
Provide documentation regarding compliance with the Flood Plain requirements of Executive Order #4, 1979.

APPEND DOCUMENTATION AS ATTACHMENT IDEN-4 AFTER THE LAST PAGE OF THIS SECTION.

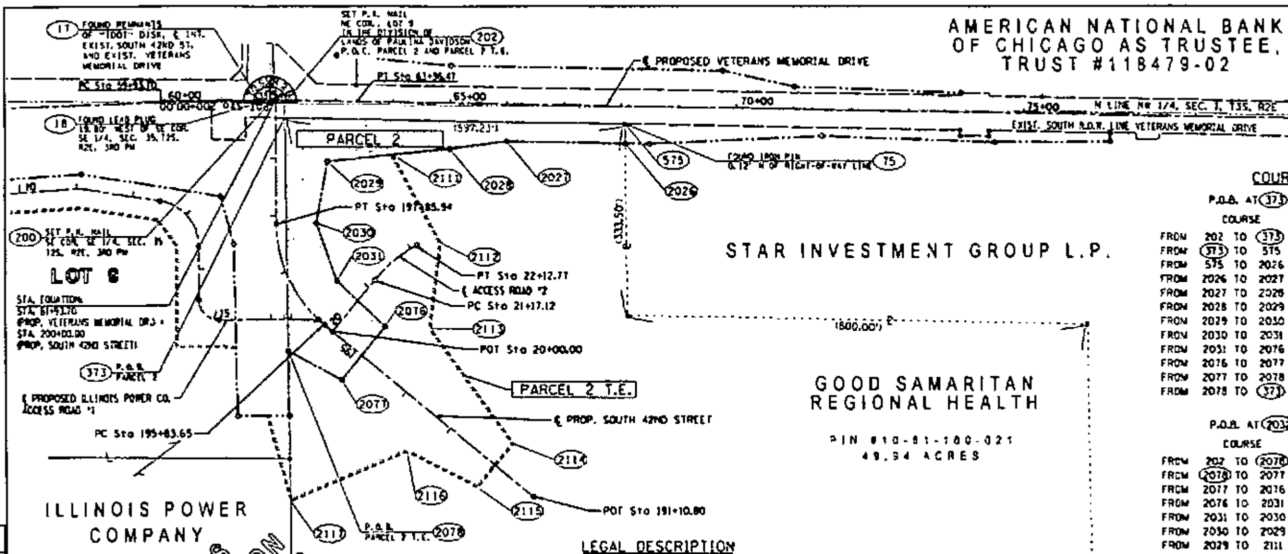
K. **Historic Resources Preservation Act Requirements** (refer to instructions for completion of this application)
Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

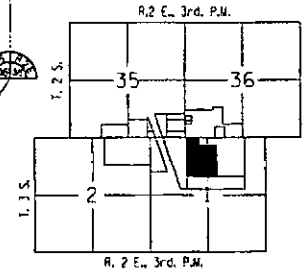
APPEND DOCUMENTATION AS ATTACHMENT IDEN-5 AFTER THE LAST PAGE OF THIS SECTION.

L. **Project Classification** (check those applicable, refer to Part 1110.40 and Part 1120.20.b)

1. Part 1110 Classification	2. Part 1120 Applicability or Classification: (check one only)	
☒ Substantive	☐ Part 1120 Not Applicable	☐ Category A Project
☐Non-substantive	☐ DHS or DVA Project	☒ Category B Project

ORDERED BY: CITY OF MOUNT VERNON, ILLINOIS





R. 2 E., 3rd. P.M.
LOCATION MAP

COURSE TABLES

P.O.B. AT (373) — PARCEL 2

COURSE				BEARING	DISTANCE
FROM	202	TO	(373)	S 00° 36' 08" E	25.35'
FROM	(373)	TO	575	S 88° 56' 26" E	596.51'
FROM	575	TO	2026	S 00° 35' 16" E	34.00'
FROM	2026	TO	2027	N 88° 52' 36" W	207.74'
FROM	2027	TO	2028	S 82° 31' 34" W	101.12'
FROM	2028	TO	2029	S 84° 21' 06" W	215.70'
FROM	2029	TO	2030	S 10° 18' 00" W	110.29'
FROM	2030	TO	2031	S 19° 31' 49" E	106.39'
FROM	2031	TO	2076	S 46° 25' 27" E	115.83'
FROM	2076	TO	2077	S 39° 25' 01" W	120.00'
FROM	2077	TO	2078	N 61° 57' 12" W	105.86'
FROM	2078	TO	(373)	N 00° 36' 08" W	406.91'

P.O.B. AT (2078) — PARCEL 2 T.E.

COURSE				BEARING	DISTANCE
FROM	202	TO	(2078)	S 00° 36' 08" E	432.27'
FROM	(2078)	TO	2077	S 61° 57' 12" E	105.86'
FROM	2077	TO	2076	N 39° 25' 01" E	120.00'
FROM	2076	TO	2031	N 46° 25' 27" W	115.83'
FROM	2031	TO	2030	N 19° 31' 49" W	106.39'
FROM	2030	TO	2029	N 10° 18' 00" E	110.29'
FROM	2029	TO	2111	N 84° 21' 06" E	115.01'
FROM	2111	TO	2112	S 28° 35' 05" E	175.38'
FROM	2112	TO	2113	S 07° 10' 35" W	149.89'
FROM	2113	TO	2114	S 35° 37' 57" E	248.03'
FROM	2114	TO	2115	S 39° 29' 42" W	100.00'
FROM	2115	TO	2116	N 62° 59' 41" W	138.56'
FROM	2116	TO	2117	S 67° 00' 48" W	211.81'
FROM	2117	TO	(2078)	N 00° 36' 08" W	262.33'

TOTAL HOLDING = (2,175,386 SQ. FT.) = 49.94 AC. (TAX MAP)

REQUIRED R.O.W. AREA = (63,805 SQ. FT.) = 1.46 AC
EASEMENT AREA = (123,155 SQ. FT.) = 2.83 AC
REMAINDER = (2,111,581 SQ. FT.) = 48.48 AC

NOTES:

BEARINGS ARE BASED ON THE ILLINOIS STATE PLANE COORDINATE SYSTEM, NAD83(97) EAST ZONE COMBINATION FACTOR 0.99998602

ALL DISTANCES ARE GRID DISTANCES UNLESS OTHERWISE NOTED. THIS PROFESSIONAL SERVICE CONFORMS TO THE CURRENT ILLINOIS MINIMUM STANDARDS FOR BOUNDARY SURVEY.

SURVEY BASED ON TITLE COMMITMENT NO.10600336 ISSUED BY RENSHAW & ASSOCIATES EFFECTIVE DATED: DECEMBER 3, 2003

REFERENCE PLAT OF THE DIVISION OF LANDS OF PAULINA E. DAVIDSON RECORDED IN DEED RECORD #78 ON PAGE 633 IN THE RECORDER'S OFFICE OF JEFFERSON CO., ILLINOIS.

REFERENCE PLAT OF SURVEY DATED 4-7-71 FOR ILLINOIS POWER COMPANY BY MARVIN JENKINS, IL. PLS #35-1824 AND RECORDED IN CABINET 1, DRAWER G, AS INSTRUMENT 2472 IN THE RECORDER'S OFFICE OF JEFFERSON CO., ILLINOIS.

REFERENCE PLAT OF SURVEY DATED 12-10-70 FOR ILLINOIS POWER COMPANY BY MARVIN JENKINS, IL. PLS #35-1824 AND RECORDED IN CABINET 1, DRAWER G, AS INSTRUMENT 2470 IN THE RECORDER'S OFFICE OF JEFFERSON CO., ILLINOIS.

LEGAL DESCRIPTION
RIGHT-OF-WAY PARCEL 2

A PART OF THE NORTHWEST QUARTER OF SECTION 1, TOWNSHIP 3 SOUTH, RANGE 2 EAST OF THE THIRD PRINCIPAL MERIDIAN AND MORE PARTICULARLY DESCRIBED AS FOLLOWS:

COMMENCING AT THE NORTHEAST CORNER OF LOT 9 IN THE DIVISION OF LANDS OF PAULINA E. DAVIDSON AS RECORDED IN THE RECORDER'S OFFICE OF JEFFERSON COUNTY, ILLINOIS IN DEED RECORD NUMBER 78 ON PAGE 633; THENCE SOUTH 00 DEGREES 36 MINUTES 08 SECONDS EAST ALONG THE EAST LINE OF LOT 9, A DISTANCE OF 25.35 FEET TO A POINT ON THE EXISTING SOUTHERLY RIGHT-OF-WAY LINE OF VETERAN'S MEMORIAL DRIVE AND THE POINT OF BEGINNING; THENCE SOUTH 88 DEGREES 56 MINUTES 26 SECONDS EAST ALONG THE EXISTING SOUTHERLY RIGHT-OF-WAY LINE, 596.51 FEET; THENCE SOUTH 00 DEGREES 35 MINUTES 16 SECONDS EAST, 34.00 FEET; THENCE NORTH 88 DEGREES 52 MINUTES 36 SECONDS WEST, 207.74 FEET; THENCE SOUTH 82 DEGREES 31 MINUTES 34 SECONDS WEST, 101.12 FEET; THENCE SOUTH 84 DEGREES 21 MINUTES 06 SECONDS WEST, 215.70 FEET; THENCE SOUTH 10 DEGREES 18 MINUTES 00 SECONDS WEST, 110.29 FEET; THENCE SOUTH 19 DEGREES 31 MINUTES 49 SECONDS EAST, 106.39 FEET; THENCE SOUTH 46 DEGREES 25 MINUTES 27 SECONDS EAST, 115.83 FEET; THENCE SOUTH 39 DEGREES 25 MINUTES 01 SECOND WEST, 120.00 FEET; THENCE NORTH 61 DEGREES 57 MINUTES 12 SECONDS WEST, 105.86 FEET TO THE EAST LINE OF LOT 9 IN THE DIVISION OF LANDS OF PAULINA E. DAVIDSON; THENCE NORTH 00 DEGREES 36 MINUTES 08 SECONDS WEST ALONG THE EAST LINE OF LOT 9, A DISTANCE OF 406.91 FEET TO THE POINT OF BEGINNING, CONTAINING 1.46 ACRES (63,805 SQUARE FEET), MORE OR LESS.

LEGAL DESCRIPTION
EASEMENT PARCEL 2 T.E.

AN EASEMENT FOR CONSTRUCTION IN THE NORTHWEST QUARTER OF SECTION 1, TOWNSHIP 3 SOUTH, RANGE 2 EAST OF THE THIRD PRINCIPAL MERIDIAN AND MORE PARTICULARLY DESCRIBED AS FOLLOWS:

COMMENCING AT THE NORTHEAST CORNER OF LOT 9 IN THE DIVISION OF LANDS OF PAULINA E. DAVIDSON AS RECORDED IN THE RECORDER'S OFFICE OF JEFFERSON COUNTY, ILLINOIS IN DEED RECORD NUMBER 78 ON PAGE 633; THENCE SOUTH 00 DEGREES 36 MINUTES 08 SECONDS EAST ALONG THE EAST LINE OF LOT 9, A DISTANCE OF 432.27 FEET TO THE POINT OF BEGINNING, THENCE SOUTH 61 DEGREES 57 MINUTES 12 SECONDS EAST, 105.86 FEET; THENCE NORTH 39 DEGREES 25 MINUTES 01 SECOND EAST, 120.00 FEET; THENCE NORTH 46 DEGREES 25 MINUTES 27 SECONDS WEST, 115.83 FEET; THENCE NORTH 19 DEGREES 31 MINUTES 49 SECONDS WEST, 106.39 FEET; THENCE NORTH 10 DEGREES 18 MINUTES 00 SECONDS EAST, 110.29 FEET; THENCE NORTH 84 DEGREES 21 MINUTES 06 SECONDS EAST, 115.01 FEET; THENCE SOUTH 28 DEGREES 35 MINUTES 05 SECONDS EAST, 175.38 FEET; THENCE SOUTH 07 DEGREES 10 MINUTES 35 SECONDS WEST, 149.89 FEET; THENCE SOUTH 35 DEGREES 37 MINUTES 57 SECONDS EAST, 248.03 FEET; THENCE SOUTH 39 DEGREES 29 MINUTES 42 SECONDS WEST, 100.00 FEET; THENCE NORTH 62 DEGREES 59 MINUTES 41 SECONDS WEST, 138.56 FEET; THENCE SOUTH 67 DEGREES 00 MINUTES 48 SECONDS WEST, 211.81 FEET TO THE EAST LINE OF LOT 10 IN THE DIVISION OF LANDS OF PAULINA E. DAVIDSON; THENCE NORTH 00 DEGREES 36 MINUTES 08 SECONDS WEST, 262.33 FEET ALONG THE EAST LINE OF LOTS 9 AND 10 TO THE POINT OF BEGINNING, CONTAINING 2.83 ACRES (123,155 SQUARE FEET), MORE OR LESS.

STATIONS AND OFFSETS
ALONG PROPOSED VETERANS MEMORIAL DRIVE

POINT NO.	STATION	OFFSET
17	61+64.49	0.89' LT.
18	61+64.31	4.09' RT.
75	68+06.80	30.91' RT.
200	61+84.12	4.40' RT.
202	62+09.43	4.13' RT.
373	62+09.70	30.09' RT.
575	68+06.81	31.03' RT.
2026	68+07.83	65.01' RT.
2027	66+00.00	65.00' RT.
2028	65+00.00	80.00' RT.
2029	62+65.00	105.00' RT.
2111	64+00.00	91.76' RT.

STATIONS AND OFFSETS
ALONG PROPOSED 42ND STREET

POINT NO.	STATION	OFFSET
373	199+69.89	15.94' RT.
2029	198+94.41	89.93' RT.
2030	197+65.94	70.00' RT.
2031	196+30.04	70.00' RT.
2076	195+00.17	65.00' RT.
2077	195+00.00	55.00' LT.
2078	195+98.74	76.67' LT.
2111	199+09.51	204.41' RT.
2112	195+16.89	240.33' RT.
2113	194+36.79	113.66' RT.
2114	191+97.03	50.00' RT.
2115	191+97.03	50.00' LT.
2116	193+32.32	73.97' LT.
2117	194+34.80	276.68' LT.

CERTIFY TO: CITY OF MOUNT VERNON
GOOD SAMARITAN REGIONAL HEALTH

I, MICHAEL T. MATZKE, DO HEREBY CERTIFY THAT I AM A PROFESSIONAL LAND SURVEYOR, LICENSED IN THE STATE OF ILLINOIS, THAT THE SURVEY OF THIS PLAT WAS MADE UNDER MY DIRECTION; THAT THE SURVEY IS TRUE AND COMPLETE AS SHOWN TO THE BEST OF MY KNOWLEDGE AND BELIEF; AND THAT ALL MONUMENTS AND MARKS ARE OF THE CHARACTER AND OCCUPY THE POSITION SHOWN THEREON.

MICHAEL T. MATZKE — SPRINGFIELD, ILLINOIS — STATE OF ILLINOIS

LICENSE DATE: ______

______________________ DATE: ____________
PROFESSIONAL LAND SURVEYOR NO. 2510
EXPIRES 11/30/04
COMPANY LICENSE NUMBER 184-001084

LEGEND

•	PIN OR PIPE FOUND
⊠	EXISTING RIGHT-OF-WAY MARKER
■	FOUND STONE
○	5/8" IRON PIN SET
△	P.K. NAIL SET
40.00'	MEASURED DISTANCE - GRID
(40')	RECORD DISTANCE - GROUND
ℓ	PROPERTY LINE
\	LOT LINE
———	EXISTING R.O.W. LINE
— · —	PROPOSED R.O.W. LINE
TT TT TT	TEMPORARY EASEMENT LINE

100 0 100 200

N

PARCEL 2 & 2 T.E.

OWNER : GOOD SAMARITAN REGIONAL HEALTH

TOWNSHIP 3 SOUTH, RANGE 2 EAST, 3RD PRINCIPAL MERIDIAN
JEFFERSON COUNTY

RIGHT OF WAY PLAT

FAU ROUTE 8725 SECTIONS 98-00114-00-EG AND 98-00114-01-BR
SCALE 1 : 100' JULY, 2004

DRAWN BY: R.L.T. CHECKED BY: M.T.M. PARCEL NO. 2 & PARCEL NO. 2 T.E.

HANSON
Hanson Professional Services Inc.
1525 South Sixth Street
Springfield, Illinois 62703-2886
Offices Nationwide

LAYOUT	DEF	11/03
DRAWN	RLT	12/03
REVIEWED	MTM	7/04

08/11/2004
T:\98J0051\98J0059\Survey\PG\RWPLAT-002.dgn

M. Narrative Description

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

The proposed project will result in the discontinuation of the Good Samaritan Regional Health Center at 605 N 12 th Street and the construction of a replacement Hospital at 42nd street and Veteran's Memorial Drive in Mount Vernon (Note a legal description of the site is appended to this document.

The current hospital has a total of 161 beds , while the proposed replacement facility will have a total of 134 beds. The only category of service which will be totally discontinued and not replaced is the Pediatrics service which will have its patients accommodated in the facility's Medical Surgical Beds.

The replacement Hospital will have 99 Medical Surgical beds, 16 ICU beds, 10 Rehabilitation, and 9 Obstetric beds. In addition the new hospital will have an 8 bed observation unit located next to the Emergency Department.

The new hospital will also provide Cardiac Catheterization Services and an Open Heart Surgery Service which replace the programs currently operated at the 12th street facility.

The new hospital will have a total of 382,067 GSF including a mechanical penthouse with a total of 23,878 GSF. In addition, a maintenance building with 8,621 GSF will also be constructed on the proposed site,

A medical office building will be constructed adjacent to the proposed new hospital, under a separate CON application. The medical office building will house some of the hospital's outpatient services and administrative space. That space will be justified as a part of that project.

A complete list of the departments involved in this project, their proposed gross square footage and their respective costs are shown on **ATTACHMENT INFO** - 7 to this application.

This is a substantive project since it establishes a new facility. The project is also a Category B project under Part 1120.

N. 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 1190.40.b) of the component must be included in the estimated project cost. If the project contains components that are not related to the provision of health care, complete an additional table for the portions that are solely for health care and insert that table following this page (e.g. separate a nursing home's costs from the components of a retirement community; separate patient care area costs from a hospital project that includes a parking garage.

PROJECT COST AND SOURCES OF FUNDS-TOTAL	
Preplanning Costs	$561,194
Site Survey and Soil Investigation	$60,000
Site Preparation	$7,947,117
Off Site Work	$1,500,000
New Construction Contracts	$123,077,650
Modernization Contracts	
Contingencies	$12,307,765
Architectural/Engineering Fees	$10,861,795
Consulting and Other Fees	$991,192
Movable or Other Equipment (not in construction contracts)	17,701,460
Bond Issuance Expense (project related)	$3,028,261
Net Interest Expense During Construction (project related)	$6,807,439
Fair Market Value of Leased Space or Equipment	
Other Costs To Be Capitalized	
Acquisition of Building or Other Property (excluding land)	
ESTIMATED TOTAL PROJECT COST	$184,843,873

Cash and Securities	$33,430,873
Pledges	
Gifts and Bequests	
Bond Issues (project related)	$151,413,000
Mortgages	
Leases (fair market value)	
Governmental Appropriations	
Grants	
Other Funds and Sources	
TOTAL FUNDS	$184,843,873

N. Project Costs and Sources of Funds

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PROJECT COST AND SOURCES OF FUNDS - Clinical	
Preplanning Costs	$238,528
Site Survey and Soil Investigation	$25,534
Site Preparation	$3,382,008
Off Site Work	$638,346
New Construction Contracts	$51,869,661
Modernization Contracts	
Contingencies	$5,237,742
Architectural/Engineering Fees	$4,622,391
Consulting and Other Fees	$421,815
Movable or Other Equipment (not in construction contracts)	$17,701,460
Bond Issuance Expense (project related)	$1,288,719
Net Interest Expense During Construction (project related)	$2,897,002
Fair Market Value of Leased Space or Equipment	
Other Costs To Be Capitalized	
Acquisition of Building or Other Property (excluding land)	
ESTIMATED TOTAL PROJECT COST	$88,323,206

Cash and Securities	$15,974,132
Pledges	
Gifts and Bequests	
Bond Issues (project related)	$72,349,074
Mortgages	
Leases (fair market value)	
Governmental Appropriations	
Grants	
Other Funds and Sources	
TOTAL FUNDS	$88,323,206

N. 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 1190.40.b) of the component must be included in the estimated project cost. If the project contains components that are not related to the provision of health care, complete an additional table for the portions that are solely for health care and insert that table following this page (e.g. separate a nursing home's costs from the components of a retirement community; separate patient care area costs from a hospital project that includes a parking garage.

PROJECT COST AND SOURCES OF FUNDS - Non-Clinical	
Preplanning Costs	$322,666
Site Survey and Soil Investigation	$34,466
Site Preparation	$4,565,109
Off Site Work	$861,654
New Construction Contracts	$71,207,989
Modernization Contracts	
Contingencies	$7,070,023
Architectural/Engineering Fees	$6,239,404
Consulting and Other Fees	$569,337
Movable or Other Equipment (not in construction contracts)	
Bond Issuance Expense (project related)	$1,739,542
Net Interest Expense During Construction (project related)	$3,910,437
Fair Market Value of Leased Space or Equipment	
Other Costs To Be Capitalized	
Acquisition of Building or Other Property (excluding land)	
ESTIMATED TOTAL PROJECT COST	$96,520,667

Cash and Securities	$17,456,741
Pledges	
Gifts and Bequests	
Bond Issues (project related)	$79,063,926
Mortgages	
Leases (fair market value)	
Governmental Appropriations	
Grants	
Other Funds and Sources	
TOTAL FUNDS	$96,520,667

O. Related Project Costs

1. 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:

☒ No land acquisition is related to project; Purchase Price $_____ ; Fair Market Value$_____

2. Does the project involve 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 $ NONE.

While technically classified as a new hospital the proposed facility is a replacement hospital and does not anticipate additional sart-up costs nor an operating deficit.

P. Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:

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

1. Provide the following dates (indicate N/A for any item that is not applicable):

25% of project costs expended 11/30/2009 50% of project costs expended 5/31/2010
75% of project costs expended 10/31/2010 95% of project costs expended 03/31/2011
100% of project costs expended 7/31/2011 Midpoint of construction date 03/31/2010
Anticipated project completion date (refer to Part 1130.140) 3/31/2012

3. Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):
   - ☐ Purchase orders, leases, or contracts pertaining to the project have been executed;
   - ☐ Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON contingencies.
   - ☒ Project obligation will occur after permit issuance.

APPEND DOCUMENTATION AS ATTACHMENT INFO-6 AFTER THE LAST PAGE OF THIS SECTION.

O. Cost/Space Requirements

Provide in the format of the following example the gross square footage (GSF) and the attributable portion of total project cost for each department/area. Identify each piece of major medical equipment. 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 measurement plus the department or area's portion of the surrounding circulation space. Indicate the proposed use of any vacated space.

		Gross Square Feet		Amount of Proposed Total GSF That Is:			
Department/Area	Cost	Existing	Proposed	New Const.	Remodeled	As is	Vacated Space
Dietary	$1,150,000	3,000	6,000	3,000	1,000	2,000	
Radiation Therapy	3,250,000*	4,000(1)	5,500	5,500			
Medical Records	300,000	2,500	6,500	4,000(1)	2,500		
TOTAL	4,700,000	9,500	18,000	8,500	5,000	4,500	

*Includes $1,500,000 for an 18 MEV linear accelerator
(1) Existing radiation therapy space will be vacated and remodeled and converted to medical records.

APPEND DOCUMENTATION AS ATTACHMENT INFO-7 AFTER THE LAST PAGE OF THIS SECTION.

R. **Facility Bed Capacity and Utilization**

Complete the following chart as applicable. Complete a separate chart for each facility that is part of the project and insert following this page. Provide the existing bed capacity and utilization data for the latest 12 month period for which data is available. Any bed capacity discrepancy from the Inventory will result with the application being deemed incomplete.

FACILITY NAME Good Samaritan Regional Health Center CITY Mount Vernon

REPORTING PERIOD DATES: From 1/1/2007 to 12/31/2007

Category of Service	Existing # of Beds	Number of Admissions	Patient Days	Bed Changes	Proposed # of Beds
Medical/Surgical	106	6,015	24,506	-7	99
Pediatrics	16	146	296	-16	0
Obstetrics	6	1,006	1,861	+3	9
Intensive Care	10	904	3,128	+6	16
Neonatal ICU					
Acute Mental Illness					
Rehabilitation	23	240	2,819	-13	10
Nursing Care					
Sheltered Care					
Other (identify)					
Other (identify)					
Other (identify)					
TOTAL	161	8,311	32,610	-23	134

Note: The above patient days do not include observation days. (509 MS, 36 Peds 4 ICU, and 88 in OB).

2. Is the facility certified for participation in the Medicare "swing bed" (i.e. acute care beds certified for extended care) program? _____ Yes __X__ No

3. For the following categories of service, indicate the number of existing beds that are Medicare certified and the number of existing beds that are Medicaid certified (if none, so indicate):

Service	# Medicare Beds	#Medicaid Beds
Nursing Care	_____	_____
ICF/DD Adult	_____	_____
Children DD	_____	_____

S. Certification

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are in the case of a corporation, any two of its officers or members of its board of directors; in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist); in the case of a partnership, two of its general partners (or the sole general partner when two or more general partners do not exist); in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and in the case of a sole proprietor, the individual that is the proprietor. The signature(s) must be notarized. If the application has co-applicants, a separate certification page must be completed for each co-applicant and inserted following this page. One copy of the application must have the ORIGINAL signatures for all persons that sign for the applicant and for each of the co-applicants.

This Application for Permit is filed on behalf of GOOD SAMARITAN REGIONAL HEALTH CENTER

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

Sr. Mary Jean Ryan, fsm
Signature

Printed Name Sr. Mary Jean Ryan, FSM

Printed Title President/CEO

Notarization:
Subscribed and sworn to before me
this 16th day of June 2008
Ingrid M. Vogel
Signature of Notary

Seal

INGRID M. VOGEL
Notary Public - Notary Seal
State of Missouri, St Charles County
Commission # 07536416
My Commission Expires Jul 24, 2011

William C Schoenhard
Signature

Printed Name William C. Schoenhard

Printed Title Executive Vice President/COO

Notarization:
Subscribed and sworn to before me
this 16th day of June 2008
Ingrid M. Vogel
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This Application for Permit is filed on behalf of SSM Regional Health Services * in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

Signature Sr. Mary Jean Ryan, fsm

Printed Name Sr. Mary Jean Ryan, FSM

Printed Title President/CEO

Notarization:
Subscribed and sworn to before me
this 16th day of June 2008

Ingrid M Vogel
Signature of Notary

Seal

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Printed Name William C. Schoenhard

Printed Title Executive Vice President/COO

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

Signature Sr. Mary Jean Ryan, FSM

Printed Name Sr. Mary Jean Ryan, FSM

Printed Title President/CEO

Notarization:
Subscribed and sworn to before me
this 16TH day of June 2008

Ingrid M. Vogel
Signature of Notary

Seal

INGRID M. VOGEL
Notary Public - Notary Seal
State of Missouri, St Charles County
Commission # 07536416
My Commission Expires Jul 24, 2011

Signature William C. Schoenhard

Printed Name William C. Schoenhard

Printed Title Executive Vice President/COO

Notarization:
Subscribed and sworn to before me
this 16TH day of June 2008

Ingrid M. Vogel
Signature of Notary

Seal

INGRID M. VOGEL
Notary Public - Notary Seal
State of Missouri, St Charles County
Commission # 07536416
My Commission Expires Jul 24, 2011

File Number 5867-568-7

STATE OF ILLINOIS

OFFICE OF

THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

GOOD SAMARITAN REGIONAL HEALTH CENTER, INCORPORATED IN MISSOURI AND LICENSED TO CONDUCT AFFAIRS IN THIS STATE ON JANUARY 22, 1996, 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 A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO CONDUCT AFFAIRS 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 29TH *day of* MARCH *A.D.* 2008 .

Jesse White

SECRETARY OF STATE

Authentication #: 0808900368

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

ATTACHMENT IDEN-1

File Number 6072-438-5

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

SSM REGIONAL HEALTH SERVICES, INCORPORATED IN MISSOURI AND LICENSED TO CONDUCT AFFAIRS IN THIS STATE ON OCTOBER 18, 1999, 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 A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO CONDUCT AFFAIRS 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* 6TH *day of* JUNE *A.D.* 2008 .

Jesse White

SECRETARY OF STATE

Authentication #: 0815802242

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

ATTACHMENT IDEN-1

File Number 0928-961-5

STATE OF ILLINOIS
OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

SSM HEALTH CARE CORPORATION, INCORPORATED IN MISSOURI AND LICENSED TO CONDUCT AFFAIRS IN THIS STATE ON OCTOBER 23, 1952, 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 A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO CONDUCT AFFAIRS 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* 29TH *day of* MARCH *A.D.* 2008 .

Jesse White

SECRETARY OF STATE

Authentication #: 0808900374

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

ATTACHMENT IDEN-1

File Number 5867-568-7

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

GOOD SAMARITAN REGIONAL HEALTH CENTER, INCORPORATED IN MISSOURI AND LICENSED TO CONDUCT AFFAIRS IN THIS STATE ON JANUARY 22, 1996, 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 A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO CONDUCT AFFAIRS 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* 29TH *day of* MARCH *A.D.* 2008 .

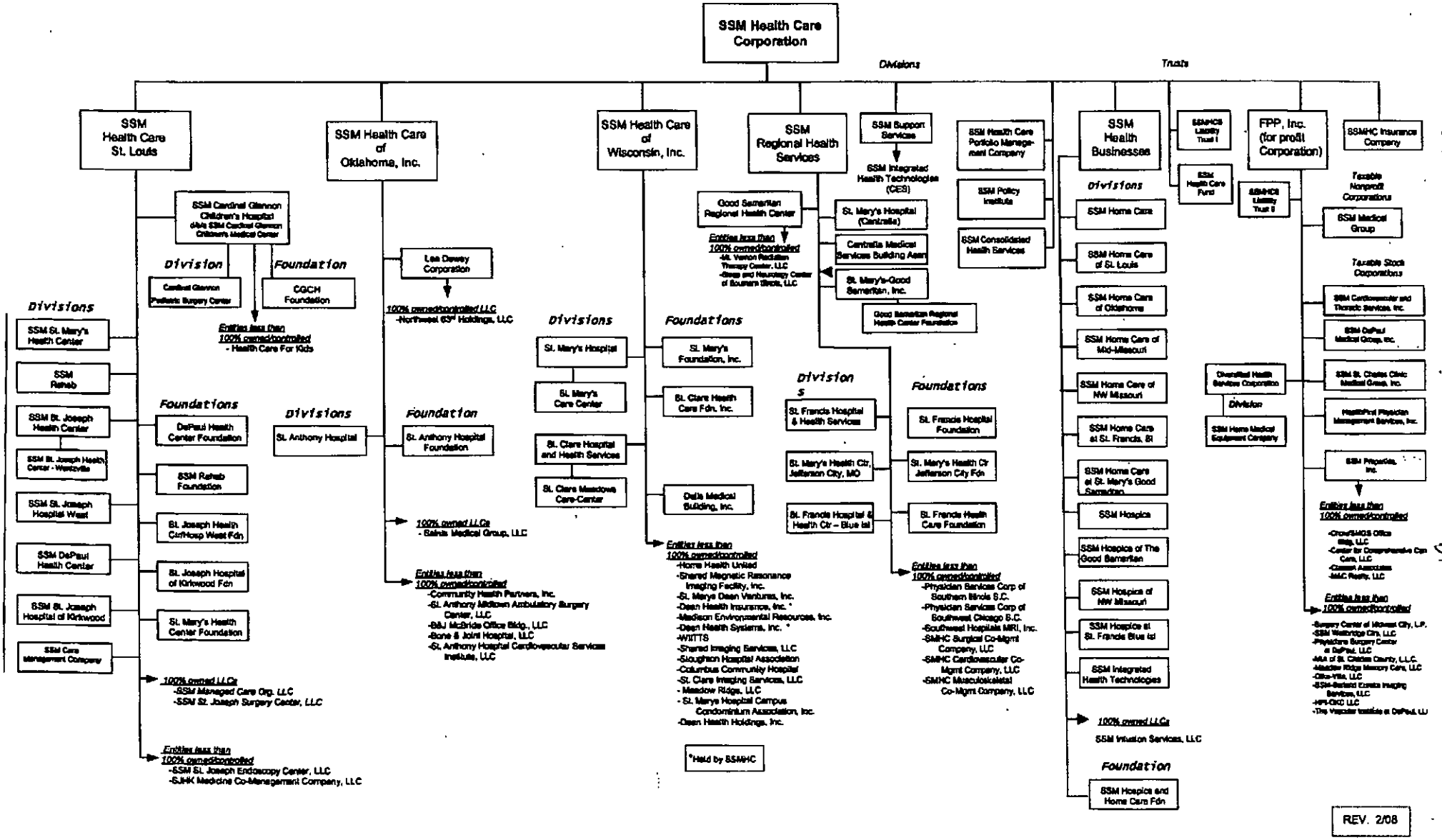
Jesse White

SECRETARY OF STATE

Authentication #: 0808900368

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

ATTACHMENT IDEN-2

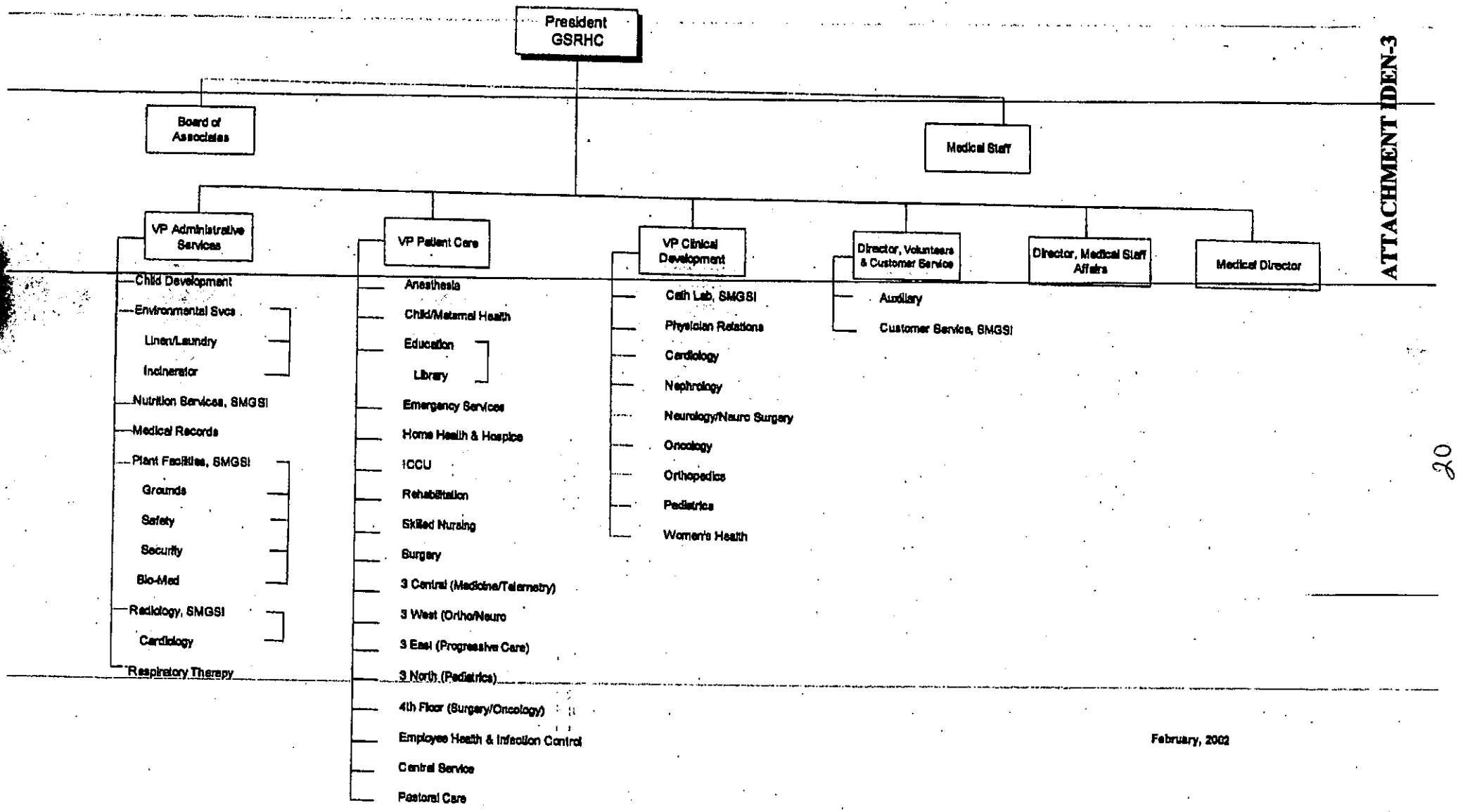


ATTACHMENT IDEN-3

19

REV. 2/08

GOOD SAMARITAN REGIONAL HEALTH CENTER, Mt. Vernon, IL



February, 2002

ATTACHMENT IDEN-3

20

ILLINOIS DEPARTMENT OF NATURAL RESOURCES

Illinois State Water Survey

Main Office • 2204 Griffith Drive • Champaign, IL 61820-7495 • Tel (217) 333-2210 • Fax (217) 333-6540
Peoria Office • P.O. Box 697 • Peoria, IL 61652-0697 • Tel (309) 671-3196 • Fax (309) 671-3106

SWS

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

Requester: Michael I. Copelin
Address: Copelin Healthcare Consulting, 42 Birch Lake Dr.
City, state, zip: Sherman, IL 62684 Telephone: (217) 496-3712

Site description of determination:
Site address: SE corner Veterans Memorial Dr. & 42nd St.
City, state, zip: Mt. Vernon, IL
County: Jefferson Sec¼: N 1/2 Section: 1 T. 3 S. R. 2 E. PM: 3rd
Subject area: Approximately the E 1500 ft of the W 3100 ft of the N 1700 ft of Sec. 1, T. 3 S., R. 2 E., 3rd P.M., Jefferson County IL.

The property described above IS NOT located in a Special Flood Hazard Area or a shaded Zone X floodzone.
Floodway mapped: N/A Floodway on property: No
Sources used: FEMA Flood Hazard Boundary Map (FHBM, annotated copy attached), "existing" site topo (n.d.) site boundary.
Community name: Jefferson County Uninc. Areas Community number: 170305
Panel/map number: 170305 18 A Effective Date: March 4, 1977
Flood zone: C Base flood elevation: N/A ft NGVD 1929

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

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

Note: This determination is based on the current Federal Emergency Management Agency (FEMA) flood hazard map for the community. This letter does not imply that the referenced property will or will not be free from flooding or damage. A property or structure not in a Special Flood Hazard Area may be damaged by a flood greater than that predicted on the FEMA map or by local drainage problems not mapped. This letter does not create liability on the part of the Illinois State Water Survey, or employee thereof for any damage that results from reliance on this determination. This letter does not exempt the project from local stormwater management regulations.

Questions concerning this determination may be directed to Bill Saylor (217/333-0447) at the Illinois State Water Survey. Questions concerning requirements of Governor's Executive Order 5 (2006), or State floodplain regulations, may be directed to Paul Osman (217/782-3862) at the IDNR Office of Water Resources.

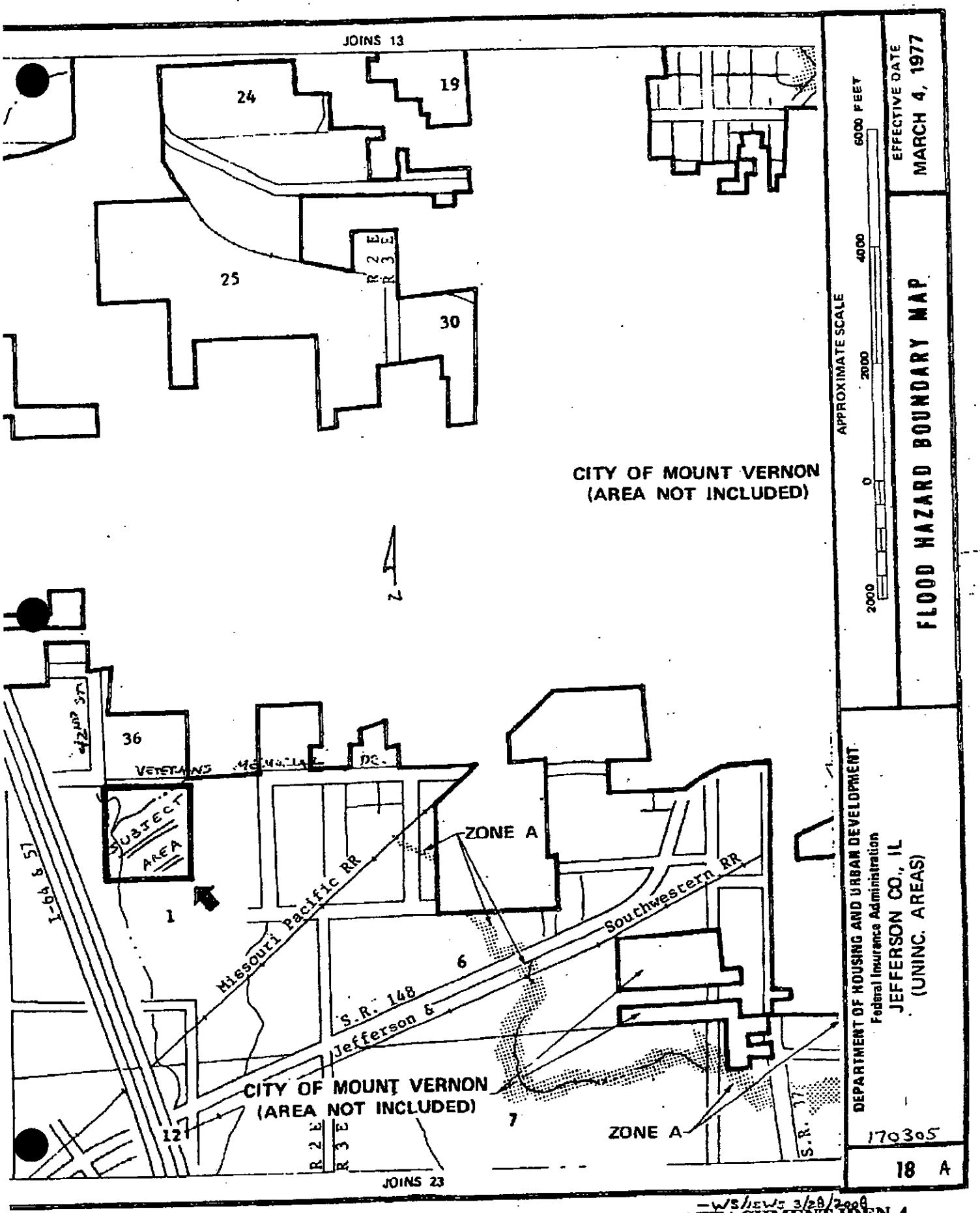
William Saylor Title: ISWS Surface Water & Floodplain Information Date: 3/28/2008
William Saylor, CFM IL-02-00107, Illinois State Water Survey

Printed on recycled paper

Form rev. 1/10/2008

ATTACHMENT IDEN-4

— LEGEND ON REVERSE —



—WS/ewj 3/28/2008

ATTACHMENT IDEN-4

LEGEND

SPECIAL FLOOD HAZARD AREA

Note: These maps may not include all Special Flood Hazard Areas in the community. After a more detailed study, the Special Flood Hazard Areas shown on these maps may be modified, and other areas added.

CONSULT NFIA SERVICING COMPANY OR LOCAL INSURANCE AGENT OR BROKER TO DETERMINE IF PROPERTIES IN THIS COMMUNITY ARE ELIGIBLE FOR FLOOD INSURANCE.

INITIAL IDENTIFICATION DATE:
MARCH 4, 1977

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
Federal Insurance Administration

FLOOD HAZARD BOUNDARY MAP H - 01-40

MAP INDEX

JEFFERSON CO., IL
(UNINC. AREAS)

COMMUNITY NO. 170305 A

ATTACHMENT IDEN-4

Illinois Historic
Preservation Agency

FAX (217) 782-8161

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

Jefferson County
Mt. Vernon
CON - Demolition and New Construction
SE Corner 42nd St. and Veterans Memorial Dr.
IHPA Log #013032708

April 7, 2008

Michael Copelin
Copelin Health Care Consulting
42 Birch Lake Dr.
Sherman, IL 62684

Dear Mr. Copelin:

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 Patrick Gleason, Cultural Resources Manager, 1 Old State Capitol Plaza, Springfield, IL 62701, 217/785-3977.

Sincerely,

Anne E. Haaker

Anne E. Haaker
Deputy State Historic
Preservation Officer

Cost/Space Requirements - Clinical

Department	Proposed GSF	Cost
Pharmacy	2,070	$898,450
Central Sterile Supply	2,495	$1,082,914
Outpatient Testing	2,317	$1,005,656
Outpatient Prep & Recovery	5,897	$2,559,497
Infusion Center	1,665	$772,666
Outpatient Procedure Rooms	2,535	$1,100,276
Cardiac Catheterization	2,478	$1,075,536
Diagnostic Radiology	6,275	$2,723,562
Cardiac Diagnostic Testing	5,132	$2,227,461
Nuclear Medicine	2,140	$928,832
Emergency	10,762	$4,671,072
EMS Facilities	390	$169,732
Observation Beds	2,724	$1,182,308
Surgery	10,780	$4,678,884
Surgery Prep	4,020	$1,744,816
Recovery	2,265	$983,087
Hemodialysis	1,200	$520,841
Respiratory Therapy	1,344	$583,341
Physical Therapy	1,200	$520,841
Occupational Therapy	444	$192,711
ICU Beds	11,658	$5,059,966
Rehab Beds	7,112	$3,086,848
OB Beds	2,771	$1,202,707
LDR	6,305	$2,736,582
C-section Suite	1,018	$441,846
New Born Nursery	1,219	$529,087
Medical Surgical Beds	57,865	$25,115,365
Hospice/Home Health	6,513	$2,826,862
Equipment		$17,701,460

ATTACHMENT INFO-7

Cost/Space Requirements - Non-Clinical

Department	Proposed GSF	Cost ($)
Vertical Circulation	20,972	$9,100,556
General Circulation	34,168	$14,828,064
Public Waiting and Toilets	24,930	$10,564,552
Administration	8,945	$3,880,428
Staff Facilities	19,580	$8,496,377
Materials Management	16,246	$7,049,269
MEP	5,324	$2,308,796
Housekeeping	4,760	$2,064,000
Dietary	7,535	$3,268,040
Cafeteria	3,630	$1,573,540
Maintenance	1,250	$540,540
Information Technology	5,522	$2,394,730
Clinical Engineering	2,708	$1,171,364
Tunnel	983	$424,650
Energy Center	14,592	$6,331,420
Admitting/Registration	1,210	$523,180
Chapel/Pastoral Care	3,290	$1,425,970
Employee Health	408	$175,080,
Gift Shop/Volunteers	1,656	$716,760
Coffee Shop	227	$98,526
Nursing administration	2,253	$975,878
Restricted Corridor	2,505	$1,085,250
Roof Stair and Elevator Closure	1,092	$471,960
Patient Accounts	12,394	$5,377,410
Mechanical Penthouses	23,878	$10,361,859
Maintenance Garage	8,621	$1,312,428

ATTACHMENT INFO-7

SECTION II. DISCONTINUATION (DISC)

This section is applicable to any project that involves discontinuation of a health care facility or discontinuation of a category of service. Refer to Part 1130.140 for the definition of discontinuation. NOTE: If the project is solely for discontinuation and if there is no project cost, the remaining sections of the application are not applicable.

Criterion 1110.130, Discontinuation

Read the review criterion and provide the following information:

(1) The reasons for the discontinuation;

(2) The anticipated or actual date of discontinuation, or the date the last person was or will be discharged or treated, as applicable;

(3) The availability of other services or facilities in the planning area that are available and willing to assume the applicant's workload without conditions, limitations, or discrimination. Documentation must include letters from such facilities attesting to such ability and willingness to accommodate the applicant's workload;

(4) A closure plan indicating the process used to provide alternative services or facilities for the patients prior to or upon discontinuation;

(5) The anticipated use of the physical plant and equipment after discontinuation has occurred and the anticipated date of such use.

APPEND DOCUMENTATION AS <u>ATTACHMENT DISC</u> AFTER THE LAST PAGE OF THIS SECTION.

Criterion 1110.130, Discontinuation

The discontinuation of the existing hospital is proposed for several reasons:

The Original Hospital building and the Sister Joanne Building were constructed in 1947 and 195 respectively. Since then, there have been numerous additions and renovations all determined to be required at the time of construction as meeting a community need. This conglomeration of buildings has creates a facility made up of different materials and systems each of which were required at the time of construction These buildings have been asked to perform beyond their anticipated lifetime. Interim solutions have been implemented, where required, to keep the facility operational. With a better understanding of the requirements of the Healing Environment, along with ever changing technology advances in diagnostics, treatment, equipment and procedures, the facility has become outdated. Additionally, changes in the Life Safety and Building Codes, along with the addition of Seismic Requirements to the building codes leave the existing facility lacking in several of the basic construction requirements for hospitals. It was determined that the continued band-aid approach to meeting the community needs was no longer possible given the age of the building and its infrastructure, therefore the decision was made to construct a replacement hospital. (A more complete list and description of the problems with the existing hospital is given on **ATTACHMENT GRC-4** of this application.)

Due to the constraints of the existing location it was determined that it was necessary to construct the replacement hospital at another site. The site was chosen due to its good accessibility for all of the hospital's existing patients as well as for its size which allows the hospital the ability to grow with the community for many years.

The only service which the applicant proposes to permanently discontinue as a dedicated unit is Pediatrics , the other services now provided by the hospital are proposed to continue to be provided at the new replacement hospital.

The dedicated Pediatrics unit is being discontinue due to its very low census and the hospital's ability in the replacement facility to have private beds for all patients which makes it possible for pediatric patients to be treated in the Medical Surgical Beds. This configuration also allows the families to be involved in the patients care much more directly and allows the parents of a child to stay in the child's room overnight if so desired.

The pediatrics patients are also more likely to utilize the proposed observation beds since they are many times treated in the emergency department sent to a room for a very short time and then discharged. The new observation beds will allow for the patient to be managed and treated more efficiently and discharged directly from the Emergency Department after 23 hours or less of observation.

The hospitals 2007 utilization of the Pediatrics service totaled only 146 admissions and 296 patient days. This equals an admission every 2.5 days and an average daily census of only .81

ATTACHMENT DISC

patients. It is not practical to staff and operate a dedicated unit with this workload. By utilizing staff trained in pediatrics care, the patients can be treated very well in a medical/surgical bed.

The applicant also maintains a transfer agreement with Cardinal Glennon Children's Hospital in St. Louis for the care and treatment of children with more serious health care issues.

No patients will be transferred when the unit is closed other than to the new replacement hospital when it becomes operational. The pediatrics unit will not be discontinued until the new facility opens.

Since the applicant's current patients will continue to be served at the new replacement hospital, there will be no impact on any other facility in the planning area, or in any of the surrounding planning areas. No changes will be made in the hospitals existing charity care policy and no patient will now or have in the past been turned away based upon race, religion, or ability to pay.

The present plan calls for the existing facility to be demolished and the site used for residential development in keeping with the residential nature of the area surrounding the proposed site. The equipment will be re-used where possible, sold or donated for use by other facilities or programs.

ATTACHMENT DISC

PATIENT TRANSFER AGREEMENT

THIS PATIENT TRANSFER AGREEMENT ("Agreement") is made and entered into effective as of the 1st day of January, 2008 ("Effective Date"), by and between Good Samaritan Regional Health Center ("Transferring Hospital") and SSM Cardinal Glennon Children's Medical Center ("Receiving Hospital"). The Transferring Hospital and the Receiving Hospital are also referred to in this Agreement individually as Hospital, or jointly as Hospitals ("Hospitals").

WITNESSETH

WHEREAS, the Transferring Hospital is a licensed acute care hospital;

WHEREAS, the Receiving Hospital is a licensed acute care hospital; and

WHEREAS, the Transferring Hospital and Receiving Hospital have agreed that it is in the best interest of patient care and would promote the optimum use of patient care resources to enter into a patient transfer agreement between the Hospitals.

THEREFORE, in consideration of the promises, agreements and covenants contained herein, the sufficiency of which is hereby acknowledged, the parties agree as follows:

1. Purpose

This Agreement is intended to facilitate the decision-making process and transfer of patients between the Transferring Hospital and Receiving Hospital. The criteria listed in Section 3.2 represents circumstances under which a patient may benefit from a transfer from the Transferring Hospital to the Receiving Hospital. Although these criteria may represent the usual and customary practices of the Transferring Hospital and Receiving Hospital for transferring patients, the ultimate authority and responsibility for a decision to transfer a patient rests with a patient's attending physician and shall be made on a case-by-case basis.

2. Term

The term of this Agreement shall commence on January 1, 2008 ("Commencement Date") and, subject to Sections 2.1 and 2.2, continue until December 31,2012 for an initial contract term of five (5) years.

2.1 Either Hospital may terminate this Agreement at any time without cause by providing the other Hospital with at least thirty (30) days prior written notice; provided, however, that each Hospital promises to carry out its obligations under this Agreement incurred prior to the termination of the Agreement and to ensure the continuity of care to any patient already in the process of being transferred from the Transferring Hospital to the Receiving Hospital.

2.2 Either Hospital may terminate this Agreement immediately if: (a) the other Hospital breaches this Agreement and such breach is not cured within thirty (30) days after receipt by the breaching Hospital of written notice of such breach; (b) either Hospital is destroyed to such an extent that the patient care provided by the Hospital cannot be carried out adequately; (c) either Hospital loses its license or accreditation; or (d) either Hospital is no longer able to provide the services for which this Agreement was executed.

3. Patient Transfer

3.1 Patient Transfer Consultation Procedures

The attending physician of a patient shall determine whether it is appropriate for the patient to be transferred from the Transferring Hospital to the Receiving Hospital. When an attending physician determines that there is a need to transfer a patient from the Transferring Hospital to the Receiving Hospital, Emergency Department staff, in conjunction with the attending physician where appropriate, shall contact the Receiving Hospital's Emergency Department to initiate the patient's transfer. The Transferring Hospital's Emergency Department staff must obtain oral consent from a representative at the Receiving Hospital prior to initiating transfer of the patient to the Receiving Hospital. All transfers shall be documented in accordance with the respective Hospital's policies. The Hospitals shall adopt protocols for follow-up procedures for patients transferred from the Transferring Hospital to the Receiving Hospital to ensure a continuum of quality medical care.

3.2 Patient Transfer Guidelines

The specific circumstances under which the Transferring Hospital shall transfer a patient or patients to the Receiving Hospital are detailed on Exhibit A which is attached hereto and incorporated herein.

3.3 Consent to Transfer

The Transferring Hospital shall be responsible for obtaining appropriate consent from a patient prior to initiating transfer of the patient from the Transferring Hospital to the Receiving Hospital.

3.4 Patient Transport

Unless other arrangements are made with the Receiving Hospital, the Transferring Hospital shall retain responsibility for arranging for the transportation of the patient being transferred from the Transferring Hospital to the Receiving Hospital, including selection of the mode of transportation and providing appropriate health care practitioner(s) to accompany the patient. The Receiving Hospital's responsibility for the patient's care shall begin when the patient is received at the Receiving Hospital.

3.5 Information to Accompany Transferred Patients

At the time a patient is transferred from the Transferring Hospital to the Receiving Hospital the Transferring Hospital shall send a copy of the patient's entire medical record with the patient, including evidence that the patient was transferred promptly and safely, and the physician's order authorizing the transfer of the patient. If any part of the patient's medical record is not available at the time of transfer, the Transferring Hospital agrees to send the documents to the Receiving Hospital as soon as they become available to the Transferring Hospital.

3.6 Return of Patients

The Receiving Hospital agrees to transfer any patient transferred to its facility from the Transferring Hospital back to the Transferring Hospital, if appropriate, and with the consent of the patient, when the special care capabilities at the Receiving Hospital are no longer medically required by the patient.

3.7 Patient's Ability to Pay

A patient's ability to pay for medical care shall not be a factor considered when determining the appropriateness of a patient transfer.

4. Provision of Information to Each Institution

Each Hospital shall provide the other Hospital with the names or classifications of persons authorized to initiate, confirm and accept the transfer of patients on behalf of the Hospitals. The Receiving Hospital shall state specifically where transferred patients are to be delivered at its facility. The Hospitals agree to provide to each other information about new services and any changes in the type of patients and health conditions the Receiving Hospital will accept and the Transferring Hospital will transfer.

5. Payment for Services

Each Hospital shall be responsible for collecting payment for medical services rendered at its respective Hospital and by its staff.

6. Independent Contractor Status

Both Hospitals are independent contractors. Neither Hospitals are authorized or permitted to act as an agent nor employee of the other Hospital and each Hospital shall be responsible for its own acts and omissions and shall not be responsible for the acts and omissions of the other Hospital. Nothing in this Agreement shall in any way alter the freedom enjoyed by either Hospital, nor shall it in any way alter the control of the management, assets, and affairs of the respective Hospitals. Neither Hospital, by virtue of this Agreement, assumes any liability for any debts or obligations of either a financial or a legal nature incurred by the other Hospital pursuant to this Agreement.

7. Insurance and Indemnity

Each Hospital shall maintain general liability insurance or self insurance covering itself and its employees providing services pursuant to the Agreement in the minimum amounts of $1,000,000 per occurrence and $2,000,000 annual aggregate of all claims and professional liability insurance or self insurance covering itself and its employees providing services pursuant to the Agreement in the minimum amounts of $1,000,000 per occurrence and $3,000,000 annual aggregate of all claims. Each Hospital shall maintain Workers' Compensation coverage for its employees performing service pursuant to this Agreement. Each Hospital shall provide to the other party a certificate of insurance evidencing that such coverage is in effect during the term of this Agreement.

Each Hospital agrees to indemnify and hold harmless the other party, its directors, officers, employees and agents from and against any and all claims, costs, expenses (including reasonable attorney fees), actions and/or liabilities which may be asserted against any one or more of them, arising out of any acts

or omissions of the indemnifying party, its directors, officers, employees and agents, except to the extent caused by the negligence of the other party or its directors, officers, employees or agents.

8. Governing Law

This Agreement shall be governed and interpreted according to the laws of the State of Missouri.

9. Amendment

This Agreement may not be amended or modified except by a subsequent written agreement between duly authorized representatives of the Transferring Hospital and Receiving Hospital.

10. Notice

Any notice required or allowed to be given hereunder shall be deemed to have been given upon deposit in the United States mail, registered or certified, within return receipt requested and addressed to the party to this Agreement to whom notice is given.

11. Binding Agreement

This Agreement shall be binding upon the successors or assigns of the parties hereto.

12. Entire Agreement

This Agreement constitutes the entire agreement between the Transferring Hospital and the Receiving Hospital with respect to the subject matter hereof and supersedes all prior proposals, negotiations, representations, drafts and other communications between the Transferring Hospital and the Receiving Hospital with respect to the subject matter hereof, whether oral or written.

IN WITNESS WHEREOF, Transferring Hospital and Receiving Hospital have hereunto caused this Agreement to be executed as by law provided, the day and year first above.

GOOD SAMARITAN REGIONAL HEALTH CENTER:

By:_____

Leo F. Childers, Jr., FACHE

President

CARDINAL GLENNON CHILDREN'S MEDICAL CENTER:

By:_____

Douglas A. Ries, FACHE

President

EXHIBIT A

Transfer Hospital's physician will call Receiving Hospital's physician in order to coordinate patient transfer. Transfer Hospital will transfer any Pediatric patient beyond the specialty of care available at Transfer Hospital and available at Receiving Hospital upon the acceptance of Receiving Hospital's physician and a bed is available for the patient.

or omissions of the indemnifying party, its directors, officers, employees and agents, except to the extent caused by the negligence of the other party or its directors, officers, employees or agents.

8. Governing Law

This Agreement shall be governed and interpreted according to the laws of the State of Missouri.

9. Amendment

This Agreement may not be amended or modified except by a subsequent written agreement between duly authorized representatives of the Transferring Hospital and Receiving Hospital.

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GOOD SAMARITAN REGIONAL HEALTH CENTER:

By: _____

Leo F. Childers, Jr., FACHE

President

CARDINAL GLENNON CHILDREN'S MEDICAL CENTER:

By: _____

Douglas A. Ries, FACHE

President

7/21/03

SECTION III. GENERAL REVIEW CRITERIA

This section is applicable to all projects EXCEPT those projects that are solely for discontinuation with no project costs and those projects that are non-substantive and subject only to a Part 1120 review. Refer to Part 1110.40 for the requirement for non-substantive projects.

A. Criterion 1110.230.a, Location

Check if the project will result in any of the following: ☒ establishment of a health care facility: ☒ establishment of a category of service; ☐ acquisition of major medical equipment (for treating inpatients) that is not or will not be located in a health care facility and is not being acquired by or on behalf of a health care facility. If NO boxes are checked, this criterion is not applicable. If any box is checked, read the criterion and submit the following:

1. A map (8 ½" x 11") of the area showing:

   a. the location of the applicant's facility or project;

   b. the name and location of all the other facilities providing the same service within the planning area and surrounding planning areas within 30 minutes travel time of the proposed facility;

   c. the distance (in miles) and the travel time (under normal driving conditions) from the applicant's facility to each of the facilities identified in b. above;

   d. an outline of the proposed target population area.

2. For existing facilities, provide patient origin data for all admissions for the last 12 months presented by zip code. Note this information must be based upon the patient's legal residence other than a health care facility for the last 6 months immediately prior to admission. For all other projects for which referrals are required patient origin data for the referrals must be provided.

3. The ratio of beds to population (population will be based upon the latest census data by zip code) within 30 minutes travel time of the proposed project.

4. The status of the project in the zoning process. Provide letter(s) from the appropriate local officials.

5. Evidence of legal site ownership, possession, or option to purchase or lease.

APPEND DOCUMENTATION AS <u>ATTACHMENT GRC-1</u> AFTER THE LAST PAGE OF THIS SECTION.

B. Criterion 1110.230.b, Background of Applicant

Read the criterion and submit the following information:

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

2. Proof of current licensing and, if applicable, certification and accreditation of all health care facilities owned or operated by the applicant.

3. A certification from the applicant listing any adverse action taken against any facility owned or operated by the applicant during the three (3) years prior to the filing of the application.

4. Authorization(s) permitting the State Board and Agency access to information in order to verify any documentation or information submitted in response to the requirements of this subsection or to obtain any documentation or information that the State Board or Agency finds pertinent to this subsection. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any action by the State Board.**

APPEND DOCUMENTATION AS ATTACHMENT GRC-2 AFTER THE LAST PAGE OF THIS SECTION.

C. Criterion 1110.230.c, Alternatives to the Proposed Project

Read the criterion and provide the following information:

1. Provide a comparison of all of the alternatives considered including the alternative of doing nothing. The comparison must address cost benefit analyses, patient access, quality, and short and long-term financial benefits.

2. Discuss why the alternative of using other area facilities or resources to meet the needs identified in your project is not feasible.

3. Discuss why the alternative of utilizing underutilized bed or other space in the facility is not feasible.

4. If the alternative selected is based solely or in part on improved quality of care, provide empirical evidence (including quantified outcome data) that verifies improved quality of care.

APPEND DOCUMENTATION AS ATTACHMENT GRC-3 AFTER THE LAST PAGE OF THIS SECTION.

D. Criterion 1110.230.d, Need for the Project

Is the need for the project based upon need assessment per Part 1100 or a variance? ☐ Yes ☐ No.

If no is indicated, read the criterion and submit the following as applicable:

1. Copies of area market studies including explanations regarding how and when these studies were performed.

2. Calculation of the need for the beds or services including the models used to estimate the need (all assumptions used in the model and the mathematical calculations must be included).

3. Identification of the individuals likely to use the proposed beds or service by:

   Provide letters from physicians or hospitals which document how many patients were referred for this service in the past 12 months, where the patients were referred and how many patients will be referred annually to the proposed project.

I 4. f the project is for the acquisition of major medical equipment that does NOT result in the establishment of a category of service, provide documentation that the equipment will achieve or exceed the applicable target utilization levels specified in Appendix B of Part 1110 within 12 months after acquisition.

APPEND DOCUMENTATION AS <u>ATTACHMENT GRC-4</u> AFTER THE LAST PAGE OF THIS SECTION.

E. Criterion 1110.230.e, Size of Project

Read the criterion and provide the following:

1. For any department involved in this project that has a square footage which exceeds the State Norm found in Appendix B of Part 1110 or if no State Norm is shown in Appendix B, provide:

   a. a rationale explaining how the proposed square footage was determined;

   b. copies of any standards used to determine appropriate square footage;

   c. architectural drawings showing any design impediments in the existing facility; and

   d. if the project is for the conversion of beds from one category of service to another an explanation as to why the excess space within the facility cannot be more appropriately used for other purposes.

APPEND DOCUMENTATION AS <u>ATTACHMENT GRC-5</u> AFTER THE LAST PAGE OF THIS SECTION.

2. If the project involves a category of service for which the State Board has established utilization targets, provide the following:

   a. projected utilization for the first two years of operation after project completion;

   b. an explanation regarding how these projections were developed;

c. copies of any contracts with new physicians or professional staff;

d. a list of any new procedures which will affect the workload of the facility.

APPEND DOCUMENTATION AS ATTACHMENT GRC-6 AFTER THE LAST PAGE OF THIS SECTION.

Criterion 1110.230.a, Location

The applicant facility is located in Planning Area F-4 in HSA V. The planning area includes 4 other hospitals: Crossroads Community Hospital in Mount Vernon; Salem Township Hospital in Salem; St. Mary's Hospital in Centralia; and Washington County Hospital in Nashville. In addition to these four hospitals one other hospital is within 30 minutes travel time of the proposed facility, Franklin Hospital in Benton which is 30 minutes travel time down Interstate 57 in Franklin County which is also in HSA V.

A Map showing the location of these hospitals is appended to this attachment. This map shows the distance and the travel time from the proposed site.

The F-4 planning area constitutes the primary service area for the hospital, while the secondary service area encompasses the 9 County area shown on the second map which shows all of the facilities within 60 minutes travel time of the applicant facility.

The ratio of beds (M/S, Peds, OB, and ICU) to population for the applicant's planning area equals 4.2 beds per 1000 population in 2005 according to the Planning Board's Inventory of Health Care Facilities with a projected ratio for 2015 of 4.0 beds per 1000 population. The applicants proposal will reduce the ratio to 4.18 beds per 1000 population based upon the 2005 population and 3.90 beds per 1000in 2015 This compares to a Statewide average of 2.5 beds per 1000 population.

The proposed project will have virtually no impact on the distribution of beds in the planning area, and it will not have any impact upon the existing hospitals in that its purpose is to replace an existing obsolete hospital with an overall decrease in the number of beds in the planning area.

The property is appropriately zoned for the proposed project as evidenced by the letter from the City of Mt. Vernon's Chief Building Inspector/City Engineer dated June 2, 2008.

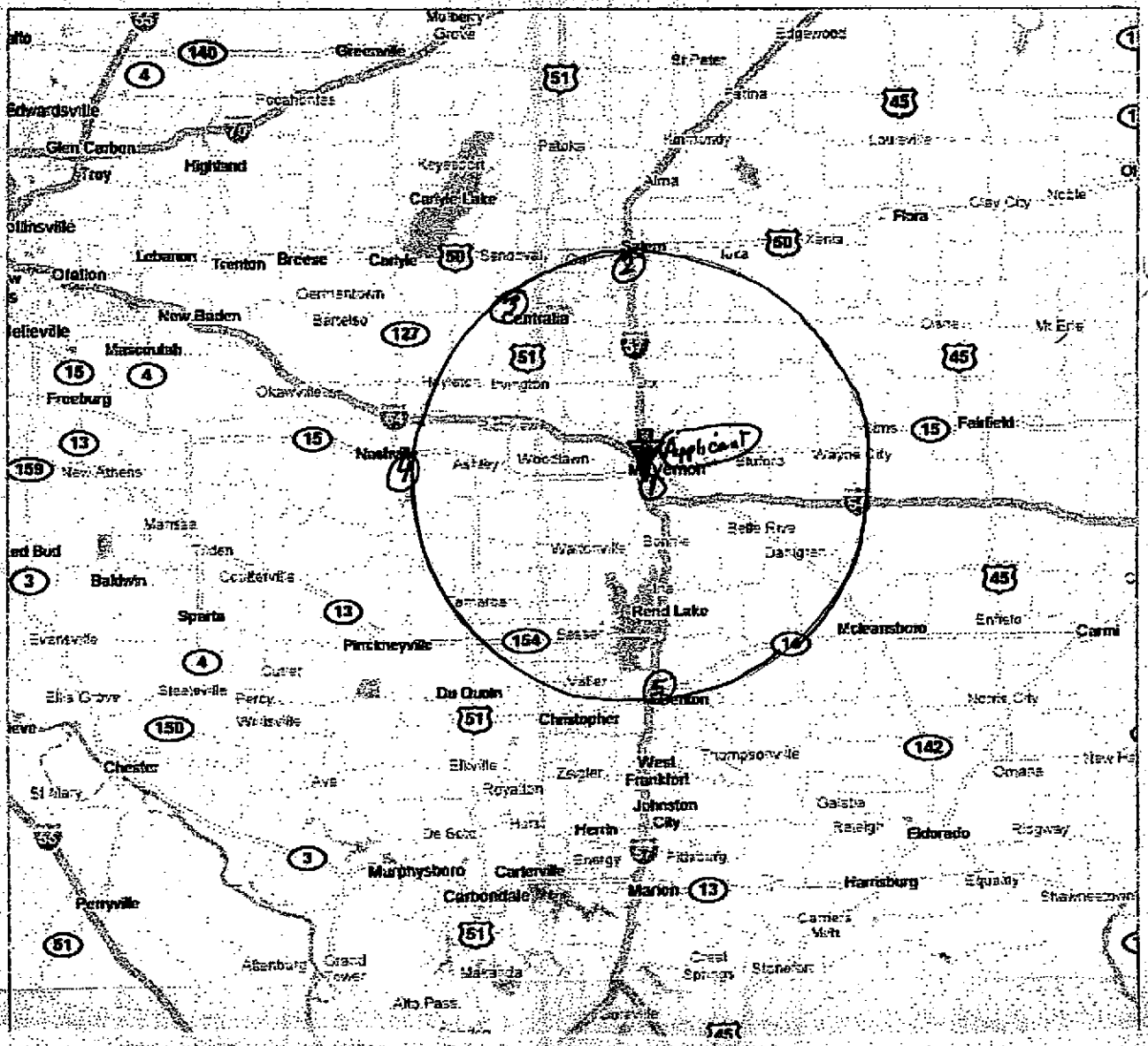
The hospitals patient origin information for 2007 is appended to this attachment.

A warranty Deed for the proposed site is appended to this attachment to show evidence of site control.

ATTACHMENT GRC-1

Google Maps

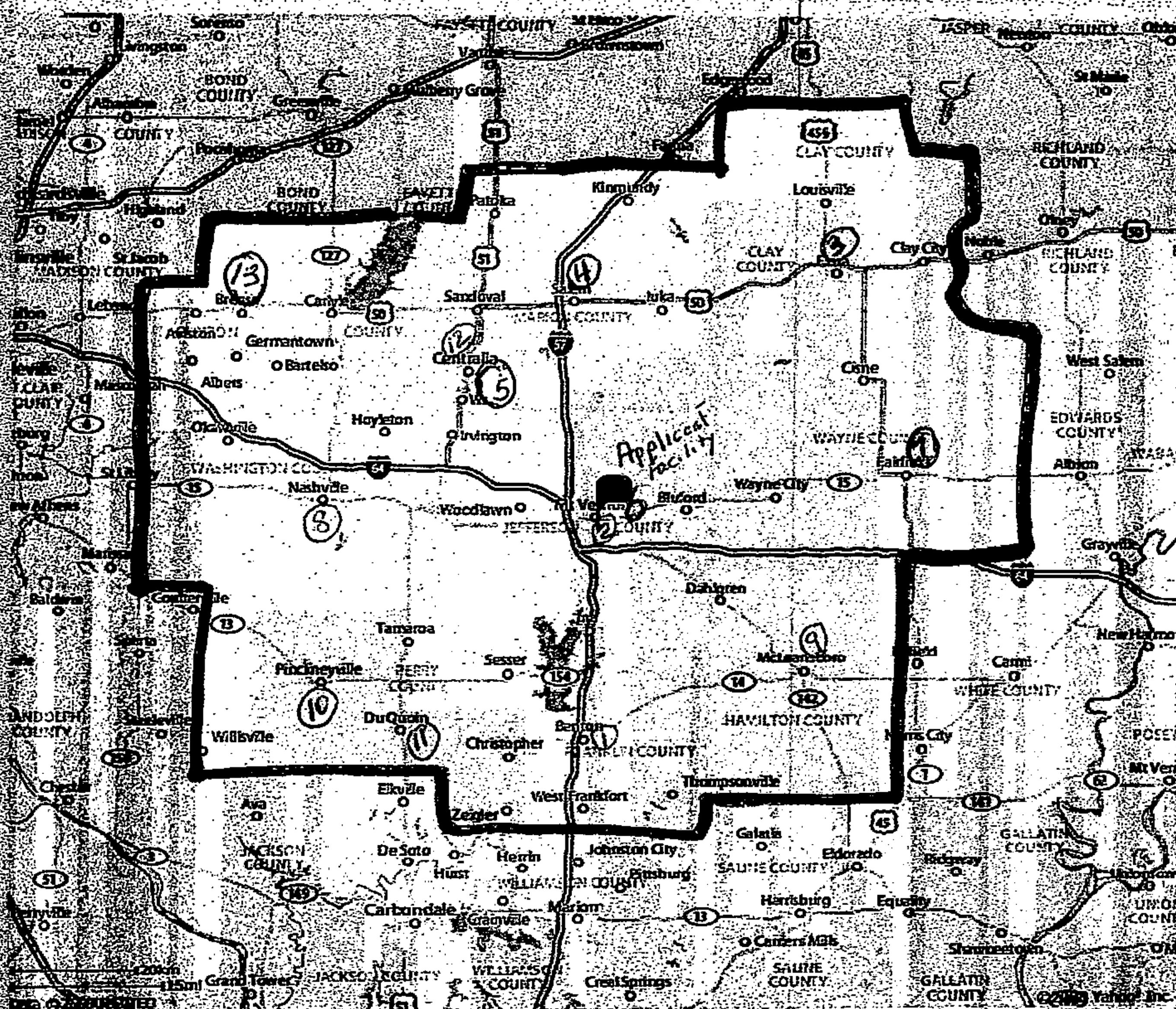
Address Veterans Memorial Dr & S
42nd St
Mt Vernon, IL 62864



Illinois Hospitals Within ≈30 Minutes Travel Time of the Applicant Facility

Hospital	Distance From Proposed Facility	Travel Time
1. Crossroads Community Hospital - Mt. Vernon	1.6 miles	5 minutes
2. Salem Township Hospital	26.1 miles	31 minutes
3. St. Mary's Hospital in Centralia	25.6 miles	31 minutes
4. Washington County Hospital in Nashville	31.3 miles	37 minutes
5. Franklin Hospital in Benton	24.4 miles	30 minutes

YAHOO! LOCAL Maps



1. Franklin Hospital - Benton
2. Cross Roads Community Hospital-Mt. Vernon
3. Clay County Hospital - Flora
4. Salem Township Hospital - Salem
5. St. Mary's Hospital - Centralia
6. Mt. Vernon Eye Center - Mt. Vernon
7. Fairfield Memorial Hospital- Fairfield
8. Washington County Hospital - Nashville
9. Hamilton Memorial Hospital - McLeansboro
10. Pinckneyville Community Hospital - Pinckneyville
11. Marshall Browning Hospital - DuQuoin
12. Surgery Center of Centralia - Centralia
13. St. Joseph's Hospital - Breese

CITY OF MT. VERNON
1100 MAIN CITY HALL
MT. VERNON, ILLINOIS 62864

618-242-6000

June 2, 2008

Good Samaritan Regional Health Center & SSM Health Care
605 North 12th Street
Mt. Vernon, IL 62864

RE: Zoning for site of the proposed health care facilities near intersection of Veterans Memorial Drive and South 42nd Street.

To whom it may concern,

The site of the proposed health care facilities near intersection of Veterans Memorial Drive and South 42nd Street is zoned B-PL, Planned Business District. Hospitals, medical office buildings and ambulatory surgical treatment centers are permitted use and/or structures in B-PL.

For further information regarding the Zoning Ordinance Codes, they can be located on the City's website, www.mivernon.com under the Ordinance tab.

If you should need any further assistance, please feel free to contact our office at the above-listed number.

Sincerely,

John B. Porter
Chief Building Inspector/City Engineer

Good Samaritan		Sorted in descending	
2007 discharges		order by Grand Total	
4/22/2008			
Sum of CASES	IP OR OP		
PT ZIP CODE	IP	OP	Grand Total
62864	2,898	40,757	43,655
62812	458	3,631	4,089
62801	502	2,550	3,052
62814	166	2,516	2,682
62881	392	2,208	2,600
62898	168	2,210	2,378
62837	242	1,930	2,172
62895	159	2,004	2,163
62859	254	1,817	2,071
62872	132	1,655	1,787
62830	124	1,571	1,695
62816	124	1,505	1,629
62884	138	1,384	1,522
62810	68	1,129	1,197
62828	94	1,067	1,161
62894	77	1,042	1,119
62896	136	923	1,059
62808	70	967	1,037
62846	79	955	1,034
62889	70	959	1,029
62263	138	556	694
62883	46	533	579
62836	38	470	508
62849	63	392	455
62890	46	402	448
62853	40	394	434
62851	37	388	425
62839	62	342	404
62831	31	316	347
62882	60	283	343
62823	42	298	340
62901	4	329	333
62821	29	287	316
62886	27	285	312
62822	37	273	310
62933		302	302
62897	30	261	291
62870	59	229	288
62842	19	264	283
62959	11	254	265
62899	31	220	251
62893	16	232	248
62891	28	211	239
62854	41	182	223
62860	27	185	212
62803	13	193	206
62948	6	199	205
62877	16	188	204
62865	14	173	187
62231	8	174	182

Sum of CASES	IP OR OP		
PT ZIP CODE	IP	OP	Grand Total
62848	11	169	180
62850	16	144	160
62876	9	143	152
62888	25	110	135
62807	24	108	132
62951	9	120	129
62832	18	105	123
62274	17	93	110
62835	8	100	108
62450	8	96	104
62862	12	82	94
62866	4	87	91
62999	8	81	89
62819	12	70	82
62858	17	63	80
62806	12	68	80
62856	7	71	78
62946	3	74	77
62817	12	64	76
62930	8	67	75
62887	7	68	75
62918	1	70	71
62271	15	56	71
62869	10	54	64
62875	10	52	62
62863	7	50	57
62471	8	46	54
62966	1	50	51
62924	1	47	48
62237	2	44	46
62906	5	40	45
62250	10	35	45
62268	5	39	44
62824	8	30	38
62401	2	36	38
62265		38	38
62844	3	34	37
62922	1	31	32
62964	1	30	31
62838	4	27	31
62809	3	27	30
62805	4	24	28
62878	4	23	27
62820	3	23	26
62825	4	21	25
62565		25	25
62446	2	23	25
62892	5	19	24
62249		24	24
62939	2	21	23
62935	6	15	21
62921		20	20
62827	4	16	20
62983	4	15	19

Sum of CASES	IP OR OP		
PT ZIP CODE	IP	OP	Grand Total
62974	1	18	19
44145	2	17	19
62861	5	13	18
62829	4	14	18
62867	1	15	16
62476	2	14	16
62454	1	15	16
62230	3	13	16
62418	1	14	15
62214	3	12	15
62040	1	14	15
62979	3	11	14
62885	1	13	14
62286	2	12	14
80524	3	10	13
62977		13	13
62874	1	12	13
62269	3	10	13
62226	1	12	13
62972	1	11	12
62960		12	12
62880	3	9	12
62411	2	10	12
62002	1	11	12
62949	3	8	11
60004		11	11
62920	1	9	10
62902	1	9	10
62246	1	9	10
62245		10	10
62984		9	9
62833	5	4	9
62815	3	6	9
62264	2	7	9
63376		8	8
30189		8	8
38878		8	8
62260	2	6	8
62234		8	8
62221		8	8
62216		8	8
62207	1	7	8
60901		8	8
60108	3	5	8
53588		8	8
63146		7	7
63126		7	7
63116		7	7
62931		7	7
62917	2	5	7
42001		7	7
29321		7	7
30067	1	6	7
62439		7	7

Sum of CASES	IP OR OP		
PT ZIP CODE	IP	OP	Grand Total
62281	2	5	7
62275	1	6	7
62238		7	7
62220	2	5	7
62034		7	7
61856	1	6	7
62958		6	6
62934		6	6
62916	1	5	6
62910		6	6
62704		6	6
62437		6	6
62282		6	6
62258		6	6
62248	1	5	6
62208	1	5	6
62010		6	6
61723	2	4	6
60507	1	5	6
89021	2	3	5
63379		5	5
63101		5	5
62843		5	5
62522	1	4	5
62449		5	5
62434		5	5
62219		5	5
62061		5	5
62025		5	5
61920		5	5
61554	1	4	5
47630	2	3	5
78102	1	3	4
62987		4	4
62982		4	4
62938		4	4
62926	1	3	4
62915		4	4
62907	1	3	4
42003		4	4
47111		4	4
25510		4	4
62650		4	4
62473		4	4
62466	2	2	4
62458	1	3	4
62294		4	4
62262	1	3	4
33913		4	4
62095		4	4
62001	1	3	4
60645		4	4
55920		4	4
89014		3	3

Sum of CASES	IP OR OP		
PT ZIP CODE	IP	OP	Grand Total
79760		3	3
72076		3	3
70506	2	1	3
47714		3	3
65284		3	3
63138	1	2	3
63122		3	3
41011		3	3
32507		3	3
62997		3	3
62995	1	2	3
62967		3	3
62932		3	3
62903		3	3
38655		3	3
29935	1	2	3
62871		3	3
62841		3	3
62811		3	3
42345		3	3
62656		3	3
62629		3	3
62451	1	2	3
45385		3	3
62426		3	3
62425	3		3
62419		3	3
38242	1	2	3
62239		3	3
62232		3	3
62223		3	3
62215	1	2	3
53190		3	3
62062	1	2	3
62035		3	3
61764		3	3
61443		3	3
60628	1	2	3
60433		3	3
60152	1	2	3
94501		2	2
43055		2	2
85712		2	2
85629		2	2
38024	1	1	2
47711		2	2
78665		2	2
74955		2	2
70526	1	1	2
68826	1	1	2
67701	1	1	2
66204	1	1	2
66047		2	2
66040		2	2

Sum of CASES	IP OR OP		
PT ZIP CODE	IP	OP	Grand Total
65740	1	1	2
65202		2	2
64744	1	1	2
64068		2	2
63863		2	2
63857	1	1	2
60025		2	2
63664	1	1	2
63366		2	2
63303		2	2
63129		2	2
47933		2	2
63109	1	1	2
63108		2	2
63104		2	2
63103		2	2
63090		2	2
63010		2	2
62998		2	2
62988		2	2
62976		2	2
62969	1	1	2
60421	1	1	2
60425		2	2
28376		2	2
42303		2	2
62952		2	2
30901		2	2
60475	1	1	2
35757		2	2
33288		2	2
60505		2	2
34135		2	2
36207		2	2
42323		2	2
62914		2	2
47001		2	2
60601		2	2
28602		2	2
38240		2	2
62879	1	1	2
34470		2	2
62868	1	1	2
0	1	1	2
32329	1	1	2
60629		2	2
32606		2	2
62857		2	2
60644		2	2
62855		2	2
42023		2	2
49938		2	2
31750		2	2
40324		2	2

Sum of CASES	IP OR OP		
PT ZIP CODE	IP	OP	Grand Total
60914	1	1	2
34690		2	2
62818		2	2
33056		2	2
20109		2	2
39503		2	2
50021		2	2
30504		2	2
62557		2	2
37145		2	2
62475		2	2
47501	1	1	2
47591	1	1	2
42028		2	2
62432		2	2
62421	1	1	2
62410	1	1	2
62292		2	2
42352		2	2
39705		2	2
61701		2	2
62257	2		2
62254		2	2
62253		2	2
62252	2		2
33928		2	2
42442		2	2
42086		2	2
62233		2	2
62218		2	2
61846	1	1	2
62080		2	2
62075		2	2
62063		2	2
61938		2	2
53511		2	2
61957		2	2
98937		1	1
47639		1	1
38345		1	1
42728	1		1
62024		1	1
46037		1	1
42223		1	1
40741		1	1
37218		1	1
62049		1	1
62060		1	1
45638		1	1
61956		1	1
61944		1	1
46161	1		1
42276		1	1
47638		1	1

Sum of CASES	IP OR OP		
PT ZIP CODE	IP	OP	Grand Total
62097		1	1
62203		1	1
62205		1	1
62206		1	1
40313		1	1
42634	1		1
37216		1	1
53210	1		1
40299		1	1
61853		1	1
45601		1	1
42167		1	1
40218	1		1
53188		1	1
62225		1	1
38128	1		1
37174	1		1
30062		1	1
52856		1	1
61834		1	1
40215		1	1
47635		1	1
61832		1	1
52802		1	1
62243		1	1
38804		1	1
38671		1	1
61814	1		1
35204		1	1
53933		1	1
61761		1	1
61738		1	1
61727		1	1
42757		1	1
42411		1	1
62259		1	1
40214		1	1
46220	1		1
23452		1	1
61704		1	1
33990		1	1
33931		1	1
38109		1	1
33418		1	1
62272		1	1
32064		1	1
42071	1		1
42066	1		1
61604		1	1
62284		1	1
37857		1	1
62289		1	1
61603		1	1
62293		1	1

Sum of CASES	IP OR OP		
PT ZIP CODE	IP	OP	Grand Total
47620		1	1
62326	1		1
33982		1	1
46201	1		1
52750	1		1
62413		1	1
62417		1	1
37207		1	1
52658	1		1
61484		1	1
51455		1	1
51044		1	1
62427		1	1
61483		1	1
50854		1	1
42347		1	1
61455		1	1
62443		1	1
34747		1	1
62448	1		1
44855		1	1
32162		1	1
50702		1	1
62452		1	1
37167		1	1
54452		1	1
47523		1	1
33804		1	1
61427		1	1
61350		1	1
61348		1	1
62477	1		1
62489		1	1
62513		1	1
62521		1	1
44663		1	1
62549		1	1
62550		1	1
61257		1	1
62561		1	1
34746		1	1
62568		1	1
62626		1	1
50325		1	1
47441		1	1
50266	1		1
62677		1	1
62690		1	1
62702		1	1
50213	1		1
62707		1	1
62708		1	1
62711		1	1
62716		1	1

Sum of CASES	IP OR OP		
PT ZIP CODE	IP	OP	Grand Total
4401		1	1
29440		1	1
34287	1		1
32728		1	1
61241		1	1
22182	1		1
34239	1		1
20906		1	1
61115		1	1
3825		1	1
7059		1	1
61109		1	1
61103	1		1
61102		1	1
61064		1	1
32536		1	1
61032		1	1
27597		1	1
28117	1		1
26582		1	1
33950		1	1
34711		1	1
37027		1	1
21117		1	1
37115		1	1
15359		1	1
26105		1	1
61012		1	1
40210		1	1
62834		1	1
32134		1	1
24347		1	1
8832		1	1
34233		1	1
25801		1	1
60680		1	1
28372		1	1
44278		1	1
33991		1	1
22191		1	1
30066		1	1
24551		1	1
60657		1	1
47172		1	1
62852	1		1
24630		1	1
29150		1	1
60647		1	1
32822		1	1
47665		1	1
60641		1	1
14437	1		1
47112		1	1
37090		1	1

Sum of CASES	IP OR OP		
PT ZIP CODE	IP	OP	Grand Total
60640		1	1
33785		1	1
54495		1	1
30034		1	1
32425		1	1
37116		1	1
60626		1	1
33592		1	1
28208	1		1
49759	1		1
15301	1		1
38107		1	1
33772		1	1
40207		1	1
49507		1	1
60624		1	1
60617		1	1
60614		1	1
7646		1	1
26431		1	1
24224	1		1
20124	1		1
37813	1		1
27616	1		1
33312	1		1
30263		1	1
22553		1	1
24605		1	1
28803	1		1
35160		1	1
60612		1	1
21502		1	1
10552		1	1
21648		1	1
28205		1	1
8731		1	1
28546		1	1
27571		1	1
49301		1	1
48910		1	1
33922		1	1
60609		1	1
42330		1	1
60585		1	1
46901		1	1
60555		1	1
42002	1		1
33322		1	1
62919		1	1
38464		1	1
60525	1		1
60518		1	1
33876		1	1
46601		1	1

Sum of CASES	IP OR OP		
PT ZIP CODE	IP	OP	Grand Total
43050		1	1
41075		1	1
48461	1		1
28152		1	1
42320		1	1
60501	1		1
46582		1	1
35502	1		1
62940		1	1
62941		1	1
32837		1	1
62947		1	1
29576		1	1
38351		1	1
62950		1	1
60481		1	1
60458		1	1
62953		1	1
60445		1	1
54555		1	1
38237	1		1
34203		1	1
33870	1		1
48439		1	1
60426		1	1
38135		1	1
37064		1	1
60415		1	1
38079	1		1
37705		1	1
46410		1	1
37042		1	1
38868	1		1
62985		1	1
46320		1	1
60407		1	1
62992		1	1
48356		1	1
48213	1		1
60401		1	1
48151		1	1
60194		1	1
63028		1	1
63033		1	1
63050		1	1
63052		1	1
63077		1	1
60185		1	1
37066		1	1
60181	1		1
60178		1	1
63106		1	1
54562	1		1
60137	1		1

Sum of CASES	IP OR OP		
PT ZIP CODE	IP	OP	Grand Total
63115		1	1
40517		1	1
63119		1	1
63121		1	1
47905		1	1
63125		1	1
40965		1	1
60107		1	1
47882		1	1
40769		1	1
60090		1	1
63304	1		1
60089		1	1
39773	1		1
43360		1	1
63501		1	1
63537		1	1
63561		1	1
60064		1	1
63701		1	1
63744		1	1
63780		1	1
63781		1	1
63801		1	1
63823		1	1
63830		1	1
63841		1	1
60051	1		1
60010		1	1
63937	1		1
63961		1	1
64024	1		1
64055	1		1
60007		1	1
64093		1	1
64119	1		1
64228		1	1
64468		1	1
64628		1	1
38358		1	1
64836		1	1
64865		1	1
65201		1	1
60002		1	1
65251		1	1
47871		1	1
65459		1	1
65559		1	1
65560	1		1
65652	1		1
59801		1	1
66025		1	1
59741		1	1
59701	1		1

Sum of CASES	IP OR OP		
PT ZIP CODE	IP	OP	Grand Total
59068	1		1
66666	1		1
66716		1	1
67473		1	1
58102		1	1
67951		1	1
68506		1	1
56001		1	1
69123		1	1
47715		1	1
47703		1	1
71303		1	1
71665		1	1
71923		1	1
72007		1	1
72012		1	1
47712		1	1
72140		1	1
72209		1	1
72315		1	1
72401		1	1
72732	1		1
73461		1	1
73533		1	1
74014		1	1
74133		1	1
55812		1	1
75070		1	1
75189		1	1
75440		1	1
75460	1		1
75559		1	1
76107		1	1
76301		1	1
76541		1	1
76542	1		1
76543		1	1
77007		1	1
77056		1	1
77284	1		1
77302	1		1
77340		1	1
77351		1	1
77399		1	1
77624		1	1
46254		1	1
78132		1	1
78234		1	1
78358		1	1
78516		1	1
78550		1	1
55811		1	1
79107	1		1
55746		1	1

Sum of CASES	IP OR OP		
PT ZIP CODE	IP	OP	Grand Total
79924		1	1
80033		1	1
80218		1	1
80439	1		1
55304		1	1
81223		1	1
82003		1	1
82072		1	1
82633		1	1
85029		1	1
85250		1	1
85361		1	1
85374		1	1
54903	1		1
54902		1	1
86406		1	1
86436	1		1
86441	1		1
86442		1	1
87120		1	1
87123		1	1
88202		1	1
47710		1	1
54901	1		1
89139		1	1
89706		1	1
90034		1	1
90815		1	1
94044		1	1
94402		1	1
54766	1		1
95205		1	1
95841	1		1
96020		1	1
96734		1	1
96743	1		1
97048	1		1
97429		1	1
97501	1		1
98208		1	1
Grand Total	7,965	86,106	94,071

#13

Stamps ... on top one 750.00 + one 700.00

STATE OF ILLINOIS
REAL ESTATE TRANSFER TAX
DEPT. OF REVENUE

STATE OF ILLINOIS
COUNTY OF JEFFERSON]SS

FILE FOR RECORD

At 3:29 O'clock PM

MAR 15 1999

Recorded Cabinet 6

Drawer 1 Inst. 3736

Don Rector RECORDER

F 15.00 pd

1999- 01857

WARRANTY DEED

THIS INDENTURE WITNESSETH, That the Grantor, Star Investment Group, L.P., a Missouri limited partnership, for and in consideration of the sum of One Dollar and other good and valuable considerations, the receipt of which is hereby acknowledged, CONVEYS and WARRANTS to Good Samaritan Regional Health Center, a Missouri nonprofit corporation, whose address is 605 N. 12th Street, Mt. Vernon, Illinois 62864, Grantee, the following described real estate situated in the County of Jefferson and State of Illinois, to wit:

See Exhibit A attached hereto and hereby made a part hereof.

Tax Identification Number: 50-1-001-02

Subject only to those matters listed and described on Exhibit B attached hereto and hereby made a part hereof and the general taxes for the calendar year 1998 and thereafter, and the special taxes becoming a lien after the date of this Deed.

The Grantor hereby releases and waives all rights under and by virtue of the Homestead Exemption Laws of the State of Illinois.

Dated this 16th day of March 1999.

STAR INVESTMENT GROUP, L.P.,
a Missouri limited partnership

By: STAR INVESTMENT GROUP
GENERAL, L.L.C.
a Missouri limited liability company,
General Partner

By: [redacted]
Rex C[redacted]

STATE OF Illinois)
) ss
COUNTY OF Jefferson)

I, the undersigned, a Notary Public, in and for the County and State aforesaid, DO HEREBY CERTIFY THAT Rex Cusumano, personally known to me to be the same person whose name is subscribed to the foregoing instrument, as having executed the same, appeared before me this day in person and acknowledged that he is a Manager of Star Investment Group General, L.L.C., a Missouri limited liability company, the General Partner of Star Investment Group L.P., a Missouri limited partnership, and that he signed and delivered the said instrument on behalf of said limited liability company in its capacity as the general partner of said limited partnership, and he acknowledged said instrument to be the free and voluntary act of said limited liability company and said limited partnership.

Given under my hand and official seal this 10th day of March, 1999.

Ora A. Ramsey
Notary Public

OFFICIAL SEAL
ORA A RAMSEY
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 3/22/00

My Commission Expires:

Future Taxes to Grantee's Address

Return this document to:
James E. Adkins, Esq.
Greensfelder, Hemker & Gale, P.C.
10 South Broadway, Suite 2000
St. Louis, Missouri 63102

This Instrument was Prepared by:
Whose Address is:

Suzanne L. Zatlin, Esq.
Gallop, Johnson & Neuman, L.C.
101 South Hanley Road, Suite 1600
St. Louis, Missouri 63105
314/862-1200

::ODMA\PCDOCS\SL01\404510413

EXHIBIT A

PROPERTY

Part of Lots 5, 6, 7 and 9 in the Partition of Land of Rhodam Allen Section 1, Township 3 South, Range 2 East of the 3rd Principal Meridian, Circuit Court Record D, Page 331 in the Office of Circuit Clerk, Jefferson County, Illinois, more particularly described as follows:

Commencing at a point 7 rods and 7 feet (122.50 feet) east of the Northwest corner of said Lot 9; thence South 00 degrees 34 minutes 51 seconds East along the west line of the remainder of said Lot 9 a distance of 25.08 feet to the Point of Beginning on the South Right-Of-Way of Veterans Memorial Drive; thence continuing South 00 degrees 34 minutes 51 seconds East along the west line of the remainder of said Lot 9 a distance of 1749.75 feet to a point; thence South 88 degrees 56 minutes 01 seconds East parallel with the Center Line of Veterans Memorial Drive a distance of 1397.23 feet to a point; thence North 00 degrees 34 minutes 51 seconds West parallel to the west line of the remainder of said Lot 9 a distance of 1416.25 feet to a point; thence North 88 degrees 56 minutes 01 seconds West parallel to the Center Line of Veterans Memorial Drive a distance of 800.00 feet to a point; thence North 00 degrees 34 minutes 51 seconds West parallel to the west line of said Lot 9 a distance of 333.50 feet to a point on the South Right-of-Way Line of Veterans Memorial Drive; thence North 88 degrees 56 minutes 01 seconds West along the South Right-of-Way of Veterans Memorial Drive a distance of 597.23 feet to the point of beginning, containing 50.00 acres.

EXHIBIT B

Permitted Exceptions

1. Easement dated March 6, 1970 and filed November 25, 1970 in Cabinet 1, Drawer G, Instrument No. 333 made by First National Bank and Trust Company as Trustee under the Testamentary Trust established by the Last Will and Testament of Lester E. Starr, deceased to Illinois Power Company.
2. Easement dated March 24, 1981 and recorded July 27, 1981 in Cabinet 3, Drawer 1, Instrument No. 1265 made by First Bank and Trust Co., as Trustee under the provisions of a Trust Agreement dated May 3, 1976 as Trust No. 11118 to Illinois Power Company.
3. General Real Estate Taxes for the year 1998 and subsequent years, the 1998 General Real Estate Taxes being payable by Grantee, an adjustment having been made therefor.

AMERICAN LAND TITLE ASSOCIATION
OWNER'S POLICY
(10-17-92)

14 0205 106 00002273

CHICAGO TITLE INSURANCE COMPANY

SUBJECT TO THE EXCLUSIONS FROM COVERAGE, THE EXCEPTIONS FROM COVERAGE CONTAINED IN SCHEDULE B AND THE CONDITIONS AND STIPULATIONS, CHICAGO TITLE INSURANCE COMPANY, a Missouri corporation, herein called the Company, insures, as of Date of Policy shown in Schedule A, against loss or damage, not exceeding the Amount of Insurance stated in Schedule A, sustained or incurred by the insured by reason of:

1. Title to the estate or interest described in Schedule A being vested other than as stated therein;
2. Any defect in or lien or encumbrance on the title;
3. Unmarketability of the title;
4. Lack of a right of access to and from the land.

The Company will also pay the costs, attorneys' fees and expenses incurred in defense of the title, as insured, but only to the extent provided in the Conditions and Stipulations.

In Witness Whereof, CHICAGO TITLE INSURANCE COMPANY has caused this policy to be signed and sealed as of Date of Policy shown in Schedule A, the policy to become valid when countersigned by an authorized signatory.

Issued by:
KING CITY ABSTRACTERS
716 MAIN STREET
P.O. BOX 402
MT. VERNON, IL 62864
(618) 242-3212

CHICAGO TITLE INSURANCE COMPANY
By:

John Rau
President

By:

Thomas J Adams
Secretary

EXCLUSIONS FROM COVERAGE

The following matters are expressly excluded from the coverage of this policy and the Company will not pay loss or damage, costs, attorneys' fees or expenses which arise by reason of:

1. (a) Any law, ordinance or governmental regulation (including but not limited to building and zoning laws, ordinances, or regulations) restricting, regulating, prohibiting or relating to (i) the occupancy, use, or enjoyment of the land; (ii) the character, dimensions or location of any improvement now or hereafter erected on the land; (iii) a separation in ownership or a change in the dimensions or area of the land or any parcel of which the land is or was a part; or (iv) environmental protection, or the effect of any violation of these laws, ordinances or governmental regulations, except to the extent that a notice of the enforcement thereof or a notice of a defect, lien or encumbrance resulting from a violation or alleged violation affecting the land has been recorded in the public records at Date of Policy.

   (b) Any governmental police power not excluded by (a) above, except to the extent that a notice of the exercise thereof or a notice of a defect, lien or encumbrance resulting from a violation or alleged violation affecting the land has been recorded in the public records at Date of Policy.

2. Rights of eminent domain unless notice of the exercise thereof has been recorded in the public records at Date of Policy, but not excluding from coverage any taking which has occurred prior to Date of Policy which would be binding on the rights of a purchaser for value without knowledge.

3. Defects, liens, encumbrances, adverse claims or other matters:

   (a) created, suffered, assumed or agreed to by the insured claimant;

   (b) not known to the Company, not recorded in the public records at Date of Policy, but known to the insured claimant and not disclosed in writing to the Company by the insured claimant prior to the date the insured claimant became an insured under this policy;

   (c) resulting in no loss or damage to the insured claimant;

   (d) attaching or created subsequent to Date of Policy; or

   (e) resulting in loss or damage which would not have been sustained if the insured claimant had paid value for the estate or interest insured by this policy.

4. Any claim, which arises out of the transaction vesting in the insured the estate or interest insured by this policy, by reason of the operation of federal bankruptcy, state insolvency, or similar creditors' rights laws, that is based on:

   (i) the transaction creating the estate or interest insured by this policy being deemed a fraudulent conveyance or fraudulent transfer; or

   (ii) the transaction creating the estate or interest insured by this policy being deemed a preferential transfer except where the preferential transfer results from the failure:

      (a) to timely record the instrument of transfer; or

      (b) of such recordation to impart notice to a purchaser for value or a judgment or lien creditor.

OWNERS

SCHEDULE A

OFFICE FILE NUMBER	POLICY NUMBER	DATE OF POLICY	AMOUNT OF INSURANCE
1	2	3	4
KCA 41714	14 0205 106 00002273	3-15-1999	$900,000.00

NOTE: A loan Policy on the encumbrance described in this Schedule has been issued naming as the insured:

1. Name of Insured:

GOOD SAMARITAN REGIONAL HEALTH CENTER

2. The estate or interest in the land which is covered by this Policy is:

Fee Simple

3. Title to the estate of interest in the land is vested in the Insured.

4. The land herein described is encumbered by the following mortgage or trust deed, and assignments:

"NOT APPLICABLE"

and the mortgages or trust deeds, if any, shown in Schedule B hereof.

5. The land referred to in this Policy is described as follows:

SEE ATTACHED PAGE FOR LEGAL DESCRIPTION

ADDED PAGE

(Schedule A Continued)

Policy Number:14 0205 106 00002273
Owners

KCA 41714

LEGAL DESCRIPTION

Part of Lots 5, 6, 7, and 9 of the Partition of land of Rhodam Allen, deceased, situated in Section 1, Township 3 South, Range 2 East of the Third Principal Meridian, as shown by plat thereof in the Circuit Court Record D at page 331 in the Circuit Clerk's Office of Jefferson County; more particularly described as follows:

Commencing at a point 7 rods and 7 feet (122.50 feet) East of the Northwest corner of said Lot 9; thence South 00 degrees 34 minutes 51 seconds East along the West line of the remainder of said Lot 9 a distance of 25.08 feet to the point of beginning on the South right of way of Veterans Memorial Drive; thence continuing South 00 degrees 34 minutes 51 seconds East along the West line of the remainder of said Lot 9 a distance of 1749.75 feet to a point; thence South 88 degrees 56 minutes 01 seconds East parallel with the center line of Veterans Memorial Drive a distance of 1397.23 feet to a point; thence North 00 degrees 34 minutes 51 seconds West parallel to the West line of the remainder of said Lot 9 a distance of 1416.25 feet to a point; thence North 88 degrees 56 minutes 01 seconds West parallel to the center line of Veterans Memorial Drive a distance of 800.00 feet to a point; thence North 00 degrees 34 minutes 51 seconds West parallel to the West line of said Lot 9 a distance of 333.50 feet to a point on the South right of way line of Veterans Memorial Drive; thence North 88 degrees 56 minutes 01 seconds West along the South right of way of Veterans Memorial Drive a distance of 597.23 feet to the point of beginning,

SITUATED IN JEFFERSON COUNTY, ILLINOIS.

KING CITY ABSTRACTERS
716 MAIN STREET,
P.O. BOX 402
MT. VERNON, ILLINOIS 62864

Cynthia A. Ramsey

CYNTHIA A. RAMSEY

POLICY INSERT

OWNERS

SCHEDULE B

Policy Number: 14 0205 106 00002273
Owners

EXCEPTIONS FROM COVERAGE

This policy does not insure loss or damage (and the Company will not pay costs, attorneys' fees expenses) which arise by reason of:

General Exceptions:

(1) Rights or claims of parties in possession not shown by the public records.

(2) Encroachments, overlaps, boundary line disputes, and any other matters which would be disclosed by an accurate survey and inspections of the premises.

(3) Easements or claims of easements not shown by the public records.

(4) Any lien, or right to lien, for services, labor, or materials heretofore or hereafter furnished, imposed by law and not shown by the public records.

(5) Taxes or special assessments which are not shown as existing liens by the public records.

Special Exceptions: The mortgage, if any, referred to in Item 4 of Schedule A.

1. Taxes for the year 1998.

2. Easement dated March 6, 1970 and filed November 25, 1970 in Cabinet 1, Drawer G, Instrument No. 333 made by First National Bank and Trust Company as Trustee under the Testamentary Trust established by the Last Will and Testament of Lester E. Starr, deceased to Illinois Power Company.

3. Easement dated March 24, 1981 and recorded July 27, 1981 in Cabinet 3, Drawer 1, Instrument No. 1265 made by First Bank and Trust Co., as Trustee under the provisions of a Trust Agreement dated May 3, 1976 as Trust No. 11118 to Illinois Power Company.

KING CITY ABSTRACTERS
716 MAIN ST.
MT. VERNON, ILLINOIS 62864

Cynthia A. Ramsey

CYNTHIA A. RAMSEY

SCHEDULE B Schedule B of this Policy consists of 1 page.
Alta Modified Loan/Owners-1970

CONDITIONS AND STIPULATIONS

1. DEFINITION OF TERMS

The following terms when used in this policy mean:

(a) "insured": the insured named in Schedule A, and, subject to any rights or defenses the Company would have had against the named Insured, those who succeed to the interest of the named insured by operation of law as distinguished from purchase including, but not limited to, heirs, distributees, devisees, survivors, personal representatives, next of kin, or corporate or fiduciary successors.

(b) "insured claimant": an insured claiming loss or damage.

(c) "knowledge" or "known": actual knowledge, not constructive knowledge or notice which may be imputed to an insured by reason of the public records as defined in this policy or any other records which impart constructive notice of matters affecting the land.

(d) "land": the land described or referred to in Schedule A, and improvements affixed thereto which by law constitute real property. The term "land" does not include any property beyond the lines of the area described or referred to in Schedule A, nor any right, title, interest, estate or easement in abutting streets, roads, avenues, alleys, lanes, ways or waterways, but nothing herein shall modify or limit the extent to which a right of access to and from the land is insured by this policy.

(e) "mortgage": mortgage, deed of trust, trust deed, or other security instrument.

(f) "public records": records established under state statutes at Date of Policy for the purpose of imparting constructive notice of matters relating to real property to purchasers for value and without knowledge. With respect to Section 1(a)(iv) of the Exclusions From Coverage, "public records" shall also include environmental protection liens filed in the records of the clerk of the United States district court for the district in which the land is located.

(g) "unmarketability of the title": an alleged or apparent matter affecting the title to the land, not excluded or excepted from coverage, which would entitle a purchaser of the estate or interest described in Schedule A to be released from the obligation to purchase by virtue of a contractual condition requiring the delivery of marketable title.

2. CONTINUATION OF INSURANCE AFTER CONVEYANCE OF TITLE

The coverage of this policy shall continue in force as of Date of Policy in favor of an insured only so long as the insured retains an estate or interest in the land, or holds an indebtedness secured by a purchase money mortgage given by a purchaser from the insured, or only so long as the insured shall have liability by reason of covenants of warranty made by the insured in any transfer or conveyance of the estate or interest. This policy shall not continue in force in favor of any purchaser from the insured of either (i) an estate or interest in the land, or (ii) an indebtedness secured by a purchase money mortgage given to the insured.

3. NOTICE OF CLAIM TO BE GIVEN BY INSURED CLAIMANT

The insured shall notify the Company promptly in writing (i) in case of any litigation as set forth in Section 4(a) below, (ii) in case knowledge shall come to an insured hereunder of any claim of title or interest which is adverse to the title to the estate or interest, as insured, and which might cause loss or damage for which the Company may be liable by virtue of this policy, or (iii) if title to the estate or interest, as insured, is rejected as unmarketable. If prompt notice shall not be given to the Company, then as to the insured all liability of the Company shall terminate with regard to the matter or matters for which prompt notice is required; provided, however, that failure to notify the Company shall in no case prejudice the rights of any insured under this policy unless the Company shall be prejudiced by the failure and then only to the extent of the prejudice.

4. DEFENSE AND PROSECUTION OF ACTIONS; DUTY OF INSUREO CLAIMANT TO COOPERATE

(a) Upon written request by the insured and subject to the options contained in Section 6 of these Conditions and Stipulations, the Company, at its own cost and without unreasonable delay, shall provide for the defense of an insured in litigation in which any third party asserts a claim adverse to the title or interest as insured, but only as to those stated causes of action alleging a defect, lien or encumbrance or other matter insured against by this policy. The Company shall have the right to select counsel of its choice (subject to the right of the insured to object for reasonable cause) to represent the insured as to those stated causes of action and shall not be liable for and will not pay the fees of any other counsel. The Company will not pay any fees, costs or expenses incurred by the insured in the defense of those causes of action which allege matters not insured against by this policy.

(b) The Company shall have the right, at its own cost, to institute and prosecute any action or proceeding or to do any other act which in its opinion may be necessary or desirable to establish the title to the estate or interest, as insured, or to prevent or reduce loss or damage to the insured. The Company may take any appropriate action under the terms of this policy, whether or not it shall be liable hereunder, and shall not thereby concede liability or waive any provision of this policy. If the Company shall exercise its rights under this paragraph, it shall do so diligently.

(c) Whenever the Company shall have brought an action or interposed a defense as required or permitted by the provisions of this policy, the Company may pursue any litigation to final determination by a court of competent jurisdiction and expressly reserves the right, in its sole discretion, to appeal from any adverse judgment or order.

(d) In all cases where this policy permits or requires the Company to prosecute or provide for the defense of any action or proceeding, the insured shall secure to the Company the right to so prosecute or provide defense in the action or proceeding, and all appeals therein, and permit the Company to use, at its option, the name of the insured for this purpose. Whenever requested by the Company, the insured, at the Company's expense, shall give the Company all reasonable aid (i) in any action or proceeding, securing evidence, obtaining witnesses, prosecuting or defending the action or proceeding, or effecting settlement, and (ii) in any other lawful act which in the opinion of the Company may be necessary or desirable to establish the title to the estate or interest as insured. If the Company is prejudiced by the failure of the insured to furnish the required cooperation, the Company's obligations to the insured under the policy shall terminate, including any liability or obligation to defend, prosecute, or continue any litigation, with regard to the matter or matters requiring such cooperation.

5. PROOF OF LOSS OR DAMAGE

In addition to and after the notices required under Section 3 of these Conditions and Stipulations have been provided the Company, a proof of loss or damage signed and sworn to by the insured claimant shall be furnished to the Company within 90 days after the insured claimant shall ascertain the facts giving rise to the loss or damage. The proof of loss or damage shall describe the defect in, or lien or encumbrance on the title, or other matter insured against by this policy which constitutes the basis of loss or damage and shall state, to the extent possible, the basis of calculating the amount of the loss or damage. If the Company is prejudiced by the failure of the insured claimant to provide the required proof of loss or damage, the Company's obligations to the insured under the policy shall terminate, including any liability or obligation to defend, prosecute, or continue any litigation, with regard to the matter or matters requiring such proof of loss or damage.

In addition, the insured claimant may reasonably be required to submit to examination under oath by any authorized representative of the Company and shall produce for examination, inspection and copying, at such reasonable times and places as may be designated by any authorized representative of the Company, all records, books, ledgers, checks, correspondence and memoranda, whether bearing a date before or after Date of Policy, which reasonably pertain to the loss or damage. Further, if requested by any authorized representative of the Company, the insured claimant shall grant its permission, in writing, for any authorized representative of the Company to examine, inspect and copy all records, books, ledgers, checks, correspondence and memoranda in the custody or control of a third party, which reasonably pertain to the loss or damage. All information designated as confidential by the insured claimant provided to the Company pursuant to this Section shall not be disclosed to others unless, in the reasonable judgment of the Company, it is necessary in the administration of the claim. Failure of the insured claimant to submit for examination under oath, produce other reasonably requested information or grant permission to secure reasonably necessary information from third parties as required in this paragraph shall terminate any liability of tha Company under this policy as to that claim.

6. OPTIONS TO PAY OR OTHERWISE SETTLE CLAIMS; TERMINATION OF LIABILITY

In case of a claim under this policy, the Company shall have the following additional options:

(a) To Pay or Tender Payment of the Amount of Insurance.

To pay or tender payment of the amount of insurance under this policy together with any costs, attorneys' fees and expenses incurred by the insured claimant, which were authorized by the Company, up to the time of payment or tender of payment and which the Company is obligated to pay.

Upon the exercise by the Company of this option, all liability and obligations to the insured under this policy, other than to make the payment required, shall terminate, including any liability or obligation to defend, prosecute, or continue any litigation, and the policy shall be surrendered to the Company for cancellation.

(b) To Pay or Otherwise Settle With Parties Other than the Insured or With the Insured Claimant.

(i) to pay or otherwise settle with other parties for or in the name of an insured claimant any claim insured against under this policy, together with any costs, attorneys' fees and expenses incurred by the insured claimant which were authorized by the Company up to the time of payment and which the Company is obligated to pay; or

(ii) to pay or otherwise settle with the insured claimant the loss or damage provided for under this policy, together with any costs, attorneys' fees and expenses incurred by the insured claimant which were authorized by the Company up to the time of payment and which the Company is obligated to pay.

Upon the exercise by the Company of either of the options provided for in paragraphs (b)(i) or (ii), the Company's obligations to the insured under this policy for the claimed loss or damage, other than the payments required to be made, shall terminate, including any liability or obligation to defend, prosecute or continue any litigation.

7. DETERMINATION, EXTENT OF LIABILITY AND COINSURANCE

This policy is a contract of indemnity against actual monetary loss or damage sustained or incurred by the insured claimant who has suffered loss or damage by reason of matters insured against by this policy and only to the extent herein described.

(a) The liability of the Company under this policy shall not exceed the least of:

(i) the Amount of Insurance stated in Schedule A; or,

(ii) the difference between the value of the insured estate or interest as insured and the value of the insured estate or interest subject to the defect, lien or encumbrance insured against by this policy.

(b) In the event the Amount of Insurance stated in Schedule A at the Date of Policy is less than 80 percent of the value of the insured estate or interest or the full consideration paid for the land, whichever is less, or if subsequent to the Date of Policy an improvement is erected on the land which increases the value of the insured estate or interest by at least 20 percent over the Amount of Insurance stated in Schedule A, then this Policy is subject to the following:

(i) where no subsequent improvement has been made, as to any partial loss, the Company shall only pay the loss pro rata in the proportion that the amount of insurance at Date of Policy bears to the total value of the insured estate or interest at Date of Policy; or

(ii) where a subsequent improvement has been made, as to any partial loss, the Company shall only pay the loss pro rata in the proportion that 120 percent of the Amount of Insurance stated in Schedule A bears to the sum of the Amount of Insurance stated in Schedule A and the amount expended for the improvement.

The provisions of this paragraph shall not apply to costs, attorneys' fees and expenses for which the Company is liable under this policy, and shall only apply to that portion of any loss which exceeds, in the aggregate, 10 percent of the Amount of Insurance stated in Schedule A.

(c) The Company will pay only those costs, attorneys' fees and expenses incurred in accordance with Section 4 of these Conditions and Stipulations.

8. APPORTIONMENT

If the land described in Schedule A consists of two or more parcels which are not used as a single site, and a loss is established affecting one or more of the parcels but not all, the loss shall be computed and settled on a pro rata basis as if the amount of insurance under this policy was divided pro rata as to the value on Date of Policy of each separate parcel to the whole, exclusive of any improvements made subsequent to Date of Policy, unless a liability or value has otherwise been agreed upon as to each parcel by the Company and the insured at the time of the issuance of this policy and shown by an express statement or by an endorsement attached to this policy.

9. LIMITATION OF LIABILITY

(a) If the Company establishes the title, or removes the alleged defect, lien or encumbrance, or cures the lack of a right of access to or from the land, or cures the claim of unmarketability of title, all as insured, in a reasonably diligent manner by any method, including litigation and the completion of any appeals therefrom, it shall have fully performed its obligations with respect to that matter and shall not be liable for any loss or damage caused thereby.

(b) In the event of any litigation, including litigation by the Company or with the Company's consent, the Company shall have no liability for loss or damage until there has been a final determination by a court of competent jurisdiction, and disposition of all appeals therefrom, adverse to the title as insured.

(c) The Company shall not be liable for loss or damage to any insured for liability voluntarily assumed by the insured in settling any claim or suit without the prior written consent of the Company.

10. REDUCTION OF INSURANCE; REDUCTION OR TERMINATION OF LIABILITY

All payments under this policy, except payments made for costs, attorneys' fees and expenses, shall reduce the amount of the insurance pro tanto.

11. LIABILITY NONCUMULATIVE

It is expressly understood that the amount of insurance under this policy shall be reduced by any amount the Company may pay under any policy insuring a mortgage to which exception is taken in Schedule B or to which the insured has agreed, assumed, or taken subject, or which is hereafter executed by an insured and which is a charge or lien on the estate or interest described or referred to in Schedule A, and the amount so paid shall be deemed a payment under this policy to the insured owner.

12. PAYMENT OF LOSS

(a) No payment shall be made without producing this policy for endorsement of the payment unless the policy has been lost or destroyed, in which case proof of loss or destruction shall be furnished to the satisfaction of the Company.

(b) When liability and the extent of loss or damage has been definitely fixed in accordance with these Conditions and Stipulations, the loss or damage shall be payable within 30 days thereafter.

13. SUBROGATION UPON PAYMENT OR SETTLEMENT

(a) The Company's Right of Subrogation.

Whenever the Company shall have settled and paid a claim under this policy, all right of subrogation shall vest in the Company unaffected by any act of the insured claimant.

The Company shall be subrogated to and be entitled to all rights and remedies which the insured claimant would have had against any person or property in respect to the claim had this policy not been issued. If requested by the Company, the insured claimant shall transfer to the Company all rights and remedies against any person or property necessary in order to perfect this right of subrogation. The insured claimant shall permit the Company to sue, compromise or settle in the name of the insured claimant and to use the name of the insured claimant in any transaction or litigation involving these rights or remedies.

If a payment on account of a claim does not fully cover the loss of the insured claimant, the Company shall be subrogated to these rights and remedies in the proportion which the Company's payment bears to the whole amount of the loss.

If loss should result from any act of the insured claimant, as stated above, that act shall not void this policy, but the Company, in that event, shall be required to pay only that part of any losses insured against by this policy which shall exceed the amount, if any, lost to the Company by reason of the impairment by the insured claimant of the Company's right of subrogation.

(b) The Company's Rights Against Non-Insured Obligors.

The Company's right of subrogation against non-insured obligors shall exist and shall include, without limitation, the rights of the insured to indemnities, guaranties, other policies of insurance or bonds, notwithstanding any terms or conditions contained in those instruments which provide for subrogation rights by reason of this policy.

14. ARBITRATION

Unless prohibited by applicable law, either the Company or the insured may demand arbitration pursuant to the Title Insurance Arbitration Rules of the American Arbitration Association. Arbitrable matters may include, but are not limited to, any controversy or claim between the Company and the insured arising out of or relating to this policy, any service of the Company in connection with its issuance or the breach of a policy provision or other obligation. All arbitrable matters when the Amount of Insurance is $1,000,000 or less shall be arbitrated at the option of either the Company or the insured. All arbitrable matters when the Amount of Insurance is in excess of $1,000,000 shall be arbitrated only when agreed to by both the Company and the insured. Arbitration pursuant to this policy and under the Rules in effect on the date the demand for arbitration is made or, at the option of the insured, the Rules in effect at Date of Policy shall be binding upon the parties. The award may include attorneys' fees only if the laws of the state in which the land is located permit a court to award attorneys' fees to a prevailing party. Judgment upon the award rendered by the Arbitrator(s) may be entered in any court having jurisdiction thereof.

The law of the situs of the land shall apply to an arbitration under the Title Insurance Arbitration Rules.

A copy of the Rules may be obtained from the Company upon request.

15. LIABILITY LIMITED TO THIS POLICY; POLICY ENTIRE CONTRACT

(a) This policy together with all endorsements, if any, attached hereto by the Company is the entire policy and contract between the insured and the Company. In interpreting any provision of this policy, this policy shall be construed as a whole.

(b) Any claim of loss or damage, whether or not based on negligence, and which arises out of the status of the title to the estate or interest covered hereby or by any action asserting such claim, shall be restricted to this policy.

(c) No amendment of or endorsement to this policy can be made except by a writing endorsed hereon or attached hereto signed by either the President, a Vice President, the Secretary, an Assistant Secretary, or validating officer or authorized signatory of the Company.

16. SEVERABILITY

In the event any provision of the policy is held invalid or unenforceable under applicable law, the policy shall be deemed not to include that provision and all other provisions shall remain in full force and effect.

17. NOTICES, WHERE SENT

All notices required to be given the Company and any statement in writing required to be furnished the Company shall include the number of this policy and shall be addressed to the Company at the issuing office or to:

Chicago Title Insurance Company
Claims Department
171 North Clark Street
Chicago, Illinois 60601-3294

Criterion 1110.230.b, Background of Applicant

SSM Health Care Corporation through its affiliates currently operates three hospitals in the State of Illinois: Saint Francis Hospital and Health Center in Blue Island Illinois; St. Mary's Hospital in Centralia and Good Samaritan Regional Health Center which is the co-applicant on the proposed project. The required copies of the licenses for these three hospitals and their respective letters of accreditation from JCAHO are also appended to this application. The required letter regarding adverse action and authorization to review licensure files is also appended.

ATTACHMENT GRC-2

SSM HEALTH · CARE

May 29, 2008

Mr. Jeffrey Mark
Executive Secretary
Health Facilities Planning Board
525 W. Jefferson Street, Second Floor
Springfield, Illinois 62761

Dear Mr. Mark:

The applicant SSM Health Care Corporation is a not-for-profit entity which through its related organizations owns and operates three licensed hospitals in Illinois. SSM Health Care Corporation is the ultimate corporate member of the operations of St. Francis Hospital and Health Center in Blue Island, Illinois, of Good Samaritan Regional Health Center in Mt. Vernon, Illinois and of St. Mary's Hospital in Centralia, Illinois. Except as disclosed herein, SSM Health Care Corporation does not "own or operate" any other health care facilities within the meaning of Section 1110.230(b) of the State Board's Rules.

I herby certify that there has been no "adverse action" (as defined by Section 1110.230(b) of the State Board's Rules) taken against St. Francis Hospital and Health Center, Good Samaritan Regional Health Center or St. Mary's Hospital during the past three years.

SSM Health Care Corporation hereby authorizes the Illinois Health Facilities Planning Board and the Illinois Department of Public Health access to information in order to verify any documentation or information submitted in response to the requirements of Criterion 1110.230.b, Background of Applicant or to obtain documentation of information the State Board or Agency finds pertinent to this subsection.

I am President and Chief Executive Officer of SSM Health Care Corporation and am authorized to make these statements herein.

Sincerely,

Sister Mary Jean Ryan, fsm

Sister Mary Jean Ryan, FSM
President and CEO

SUBSCRIBED and SWORN to before me
this 29th day of May, 2008.

Norma R. Tucker

Notary Public

OFFICIAL SEAL
NORMA R. TUCKER
Notary Public, State of Illinois
My Commission Expires 08-24-11

477 N. Lindbergh Blvd.
St. Louis, MO 63141-7832
www.ssmhc.com

(314) 994 7800 phone
(314) 994 7900 fax

State of Illinois 1859680

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

DAMON T. ARNOLD, M.D.
DIRECTOR

Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
02/28/09	BGBD	0004705

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 03/01/08

BUSINESS ADDRESS

GOOD SAMARITAN REGIONAL HEALTH CENTER

605 NORTH 12TH STREET

MOUNT VERNON IL 62864

The face of this license has a colored background. Printed by authority of the State of Illinois • 4/97 •

72

DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

State of Illinois 1859680

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

GOOD SAMARITAN REGIONAL HEALTH CENTER

EXPIRATION DATE	CATEGORY	I.D. NUMBER
02/28/09	BGBD	0004705

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 03/01/08

01/05/08

GOOD SAMARITAN REGIONAL HEALTH CENTI
605 NORTH 12TH STREET

MT. VERNON IL 62864

FEE RECEIPT NO.

State of Illinois 1849761

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

DAMON T. ARNOLD, M.D.
DIRECTOR

Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/08	BGBD	0002642

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/08

BUSINESS ADDRESS

ST. MARY'S HOSPITAL
400 NORTH PLEASANT AVENUE
CENTRALIA IL 62801

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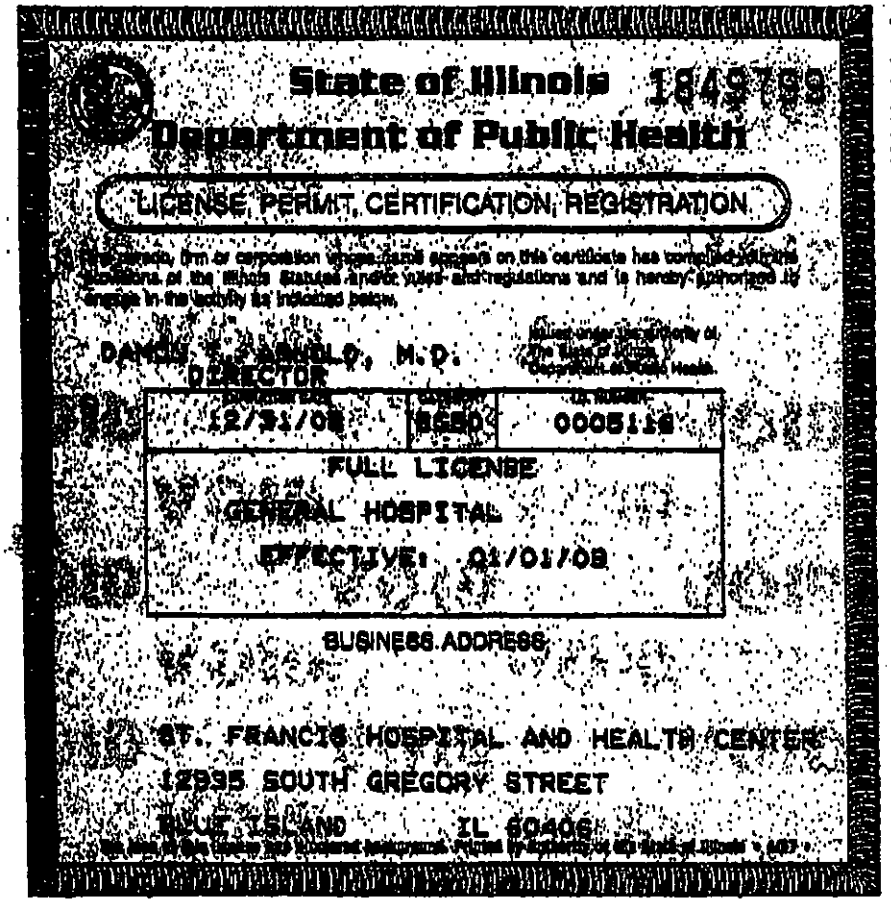

State of Illinois 1849759

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

DANIEL T. ARNOLD, M.D.
DIRECTOR

Issued under the authority of the State of Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	ID NUMBER
12/31/08	065G0	0005118

FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 01/01/08

BUSINESS ADDRESS

ST. FRANCIS HOSPITAL AND HEALTH CENTERS
12935 SOUTH GREGORY STREET
BLUE ISLAND IL 60406

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← DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

↓

State of Illinois 1849759
Department of Public Health
LICENSE, PERMIT, CERTIFICATION, REGISTRATION

ST. FRANCIS HOSPITAL AND HEALTH CENTER

EXPIRATION DATE	CATEGORY	ID NUMBER
12/31/08	065G0	0005118

FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 01/01/08

11/03/07

ST. FRANCIS HOSPITAL & HEALTH SVS
12935 SOUTH GREGORY STREET
BLUE ISLAND IL 60406

FEE RECEIPT NO.

Attachment GRC-2

The Joint Commission

February 2, 2007

Leo F. Childers, Jr., FACHE
President
Good Samaritan Regional Health Center
605 North 12th Street
Mount Vernon, IL 62864

Joint Commission ID #: 7391
Accreditation Activity: Measure of Success
Accreditation Activity Completed: 2/2/2007

Dear Mr. Childers:

The Joint Commission would like to thank your organization for participating in the Joint Commission's accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Home Care
- Comprehensive Accreditation Manual for Hospitals.

This accreditation cycle is effective beginning July 22, 2006. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 39 months.

Please visit Quality Check® on the Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that the Joint Commission will keep the report confidential, except as required by law. To ensure that the Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Russell P. Massaro

Russell P. Massaro, MD, FACPE
Executive Vice President
Division of Accreditation and Certification Operations

The Joint Commission

February 2, 2007

Bruce A. Merrell
President
St. Mary's Hospital
400 North Pleasant Avenue
Centralia, IL 62801

Joint Commission ID #: 7254
Accreditation Activity: Measure of Success
Accreditation Activity Completed: 2/2/2007

Dear Mr. Merrell:

The Joint Commission would like to thank your organization for participating in the Joint Commission's accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Behavioral Health Care
- Comprehensive Accreditation Manual for Hospitals.

This accreditation cycle is effective beginning October 12, 2006. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 39 months.

Please visit Quality Check® on the Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that the Joint Commission will keep the report confidential, except as required by law. To ensure that the Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Russell P. Massaro

Russell P. Massaro, MD, FACPE
Executive Vice President
Division of Accreditation and Certification Operations

The Joint Commission

May 23, 2008

Colleen L. Kennaday
Chief Executive Officer
St. Francis Hospital and Health Center
12935 South Gregory Street
Blue Island, Illinois 60406

ORG ID: 7249

Dear Ms. Kennaday:

This letter is to confirm the accreditation status for St. Francis Hospital and Health Center.

The Joint Commission accreditation survey on August 29, 2006 for St. Francis Hospital and Health Center included the following sites of care:

St. Francis Hospital and Health Center, 12935 South Gregory Street, Blue Island, Illinois 60406

This accreditation cycle is effective beginning July 25, 2007. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 39 months.

If I can be of further assistance I can be reached at (630) 792-5184 or tmullin@jointcommission.org. Thank you for your cooperation and support of the accreditation process.

Sincerely,

Theresa Mullin

Theresa Mullin
Account Executive, Corporate Region
Accreditation and Certification Operations

cc: Correspondence File

Attachment GRC-2

Criterion 1110.230.c. Alternatives to the Proposed Project

Planning and strategic analysis of the proposed project has been ongoing for the past ten years. In June of 1998, a study was completed which outlined the deficiencies and corresponding short and long term needs of the existing hospital structures and campus (see Plan Development 16 June 1998 at the end of this Attachment). As per the detailed discussion below, the decision was made at that time that the existing campus could not be reconfigured at any cost to adequately address projected patient needs and anticipated health care delivery requirements.

Availability of a healthy, state of the art medical complex in Mount Vernon is essential to the health care needs not only of Good Samaritan Regional Health Center's service area, but to the entirety of southern Illinois. Good Samaritan Regional Health Center has been a leader in the development and provision of services such as tertiary-level cardiac care, rehabilitation care, and orthopedic and neurological modalities. In addition, Good Samaritan Regional Health Center has taken a strong initiative to develop and maintain relationships with small rural and Critical Access Hospitals in southern Illinois; these initiatives include establishment and operation of outpatient clinics and the provision of critical physician services to areas which would otherwise be without.

Subsequently, the proposed site became available and was purchased for the specific purpose of near-term outpatient and ancillary needs and long-term complete relocation of the hospital.

The discussion below, in the presentation of considered alternatives, clearly outlines the detailed planning which has gone into the proposed project as described in this application.

Alternative #1: Do Nothing; Continue to Provide Services in the Existing Hospital

This alternative has been identified as unfeasible for both short and long term community needs.

The original hospital building and Sister Joanne building were constructed in 1947 and 1950 respectively, nearly 60 years ago. Since that time, there have been numerous additions and renovations. The resulting conglomeration of buildings has created a facility made up of various materials and systems, which were appropriate to the time they were constructed. These buildings are all performing at present beyond anticipated life. Interim solutions have been implemented, as required, to keep the facility operational. With a better understanding of the Healing Environment, along with technological advances in diagnostics, patient treatment, equipment and procedures, the existing facility is no longer able to keep up.

Additionally, changes in the Life Safety and Building Codes over time, along with the addition of seismic requirements to the building code, make the existing campus inadequate in several basic elements required for hospitals.

Structural issues: some of the original buildings were constructed using bearing wall construction. These existing conditions create situations where the locations and operations of the existing bearing walls do not allow for expansion to accommodate the current program space requirements. Moving structural columns, piers or walls is very expensive and creates height restrictions that often make areas unusable. In addition, some of the newer pieces of healthcare equipment exceed the allowable loading limits and the inherent capacity of the existing structure.

Seismic requirements: hospital expansion projects before 1974 did not include the reinforcement of concrete joists to provide adequate detailing to resist lateral seismic loads (the rudimentary seismic requirements were not introduced until 1974). The 1979 addition is constructed of a two-way dropped panel slab with possible shear walls at one end. The current Seismic Code precludes the use of a two-way slab system in Seismic Hazard Group D, which is the classification for a hospital in Mount Vernon. The recent earthquake in the area points to the fact that adequate seismic protection is more than an academic exercise in our community.

Height restrictions: when the original and subsequent buildings were constructed, the cooling and heating was often done via piped systems and the ventilation provided via operational windows. Individual room systems were provided, and the above-ceiling heights were minimized, creating floor-to-floor heights that are minimal at best. The 1969/1970 addition has floor-to-floor heights of 10'8", 11', and 12'. Current codes and standards have established ventilation requirements and air quality levels that cannot be achieved through individual room systems. Forced air systems require filtration and humidification of the air to specific levels. The existing minimal floor-to-floor heights do not allow for the efficient distribution of ductwork within the ceiling spaces, so ceiling heights are minimized. This compromises or restricts the use of the floor space below. New hospital construction generally requires floor-to-floor heights of 14' to 17' to accommodate newer system and ventilation/air requirements.

Vertical shafts: similar to the height restrictions noted above, the HVAC ductwork sizes and configurations required for the efficient distribution of air have dramatically increased the amount of vertical circulation shafts required. This takes away from usable floor areas and creates floor-to-floor fire separation issues that are expensive to overcome.

Fire resistance of materials: as the campus has expanded over the years, some additions were constructed using materials and methods that are not acceptable under current standards for hospital construction. Retrofitting or change of use of some of these portions of the building would require full demolition and new construction to meet the current code and its fire resistance requirements. Additionally, over time gaps may have developed in fire-resistant material surrounding pipe, conduit, and duct penetrations through fire and smoke walls. Finding and repairing all locations is costly, and in some cases physically impossible without total removal and replacement of the affected area or system component.

Existing room sizes and configurations: the Strategic Facility Plan identifies specific instances where appropriate room sizes, configurations, and/or required amenities are not

available or achievable within the confines of the existing buildings. The existing critical care, medical/surgical and obstetric patient rooms are inadequate in size, required headwall lengths, bathroom availability and proximity to the nursing station. Existing facilities can be renovated; however, the construction required to meet current space requirements and standards is prohibitively expensive due to existing structural elements, including the confines of the existing exterior walls. The only practical solution is to tear down and rebuild.

Site restrictions: the existing campus is located within a residential neighborhood. It is landlocked on all sides. This eliminates the possibility of sequential modernization and expansion; that is, new buildings or wings can not be constructed to replace outdated ones, which could then be demolished once the replacement space is available. In addition, parking availability is currently inadequate; and, as is typical of every hospital operating today, parking demands are increasing. The only way to provide additional parking would be to construct a multi-level parking facility; unfortunately, the only place to do this is on the site of the current surface grade parking.

Fire protection system: there is a smoke detection system installed in all of the areas required by the Life Safety Code and the Office of the Fire Marshall. An automatic sprinkler system has been installed in limited areas of the hospital, as additions and renovations have allowed. Therefore, the facility is not considered "fully sprinklered". This places restrictions on use and directly impacts the insurance costs of the facility.

Mechanical systems: most of the existing systems have reached or exceeded anticipated life expectancy. The boilers in the existing Steam System are obsolete and extremely inefficient, leading to greater-than-necessary operational costs. The cooling system requires the use of an outdated coolant that is no longer manufactured. Conversion to new refrigerants will soon be a necessity, meaning replacement of the system will be mandatory. Many of the existing air handlers are at the end of their useful life and must be replaced to improve operations and efficiencies. Additionally, new requirements for air changes and filtration of the air to maintain standards have made several of the air handlers undersized and inefficient. New temperature control systems are more precise, giving patients and staff better control over the interior environment. The existing system must be replaced to achieve this control. The existing domestic water systems, including heating, softening, back flow prevention, etc. have reached or exceeded anticipated life expectancies and must be replaced.

Electrical systems: the existing electrical systems are obsolete because they have exceeded useful life expectancy and because current code requirements have defined the systems and their components and applications more precisely. The existing systems are not separated correctly and the entire electrical distribution system must be re-worked, separated and defined in order to create safer environments for patients, staff and visitors. Separation of these branches into Critical, Equipment and Life Safety categories creates a more reliable system and ensures that power is available when needed for essential services. Finally, the existing generators have exceeded their expected useful life and must be replaced.

These facility issues alone preclude exercising the option of doing nothing. Therefore, this alternative has not been selected.

Cost of this alternative (capital costs): $0

Alternative #2: Expansion and Modernization of the Existing Campus

The previously-cited Plan development document, dated June 16 1998, is included with this Attachment and contains a highly-detailed area by area analysis of the individual projects and costs associated with existing campus modernization.

Since the detail is provided in that document, this discussion will summarize the salient points.

First, the total cost of the needed renovations and expansions was $55 million in 1998 dollars. Healthcare construction costs have increased dramatically since that time; using a conservative inflation factor of three per cent per year, the cost of the plan in 2008 dollars rises to $74 million.

This $74 million expenditure would **not** address the following deficiencies:

- It does not allow for the construction of any new buildings for patient care. Owing to the inability to construct new buildings without taking existing services out of operation, projects would be limited to modernization only. This restriction effectively precludes the ability to bring the hospital up to state of the art patient care standards.
- It does not address short and long term needs for service expansion; it merely addresses critical shortcomings in existing areas.
- It does not address inherent structural issues such as seismic compliance and existing room sizes and configurations.
- It does not address inherent campus issues: lack of space for expansion, for adequate parking and wayfinding, or for separation of pedestrian and ambulance traffic.

Commitment to a major capital expenditure of at least 74 million dollars, without a solution to basic structural and operational deficiencies, is not a responsible fiscal decision and is not in the best interests of the patients or the larger community served by Good Samaritan Regional Health Center. Therefore, this alternative has not been selected.

Cost of this alternative: $74,000,000

Alternative #3: Construct a Replacement Facility at a new location

This alternative actually has several associated iterations and nuances; as follows:

#3A: Construct a Replacement Facility at a Location Different than the Proposed Location

This alternative has not been selected for the following reasons.

- Good Samaritan Regional Health Center already has possession of the proposed site
- Good Samaritan Regional Health Center already has associated services such as the Oncology Center operational on the proposed new campus
- The proposed location is perfectly situated for access from all areas of our patient service area and from southern Illinois as a whole, being located just south of the junction of the major north/south (I-57) and east/west (I-64) highways in southern Illinois; further, the proposed location is directly adjacent to an Interstate 57 exit.
- This alternative would require additional expenditures for land acquisition (estimated at $1.5 million) as well as for architectural site plans (estimated at $250 thousand).

Cost of this Alternative: $186,593,873

#3B: Construct a Replacement Facility at the Proposed Location; Retain Possession of the Existing Campus and Buildings for Various Patient-Related Services

This alternative has not been selected for the following reasons:

- Previously-discussed structural and functional deficiencies of the existing buildings on campus render the main structures virtually obsolete
- Significant capital outlay would be required for minimum modernization or demolition (approximately $30 million)
- Health care use is not consistent with the residential nature of the surrounding neighborhood
- Parking would continue to be a major deficiency, particularly since the campus would presumably be converted to higher-traffic, outpatient and ancillary uses
- Owing to the cost of the proposed project, the revenue associated with the sale of the existing campus is necessary

Cost of this alternative: $215 million

#3C: Construct a Replacement Facility at the Proposed Location, with a Greater Complement of Inpatient Beds

A detailed justification for the number of beds included in this proposed project is included in attachments elsewhere in this application, including Need for the Project and Establishment of Additional Beds.

This discussion relates to the options considered during the course of project planning.

In June 2006, a comprehensive data analysis and needs assessment was completed as part of the overall objective of project sizing. At that time, the appropriate number of beds for the replacement hospital was determined as follows:

- Medical/surgical: 116 beds
- Critical Care: 20 beds
- Obstetrics: 10 beds
- Pediatrics: 4 beds
- Inpatient Rehabilitation: 10 beds

- **Total bed complement** **160 beds**

This initial optimal bed complement was developed based upon historic patient census, projected increases in the service area population, and new physician volumes not included in historic data. The initial proposed complement did not assume any changes in relative market share or any increases in use rates.

The first iteration of a space program for the proposed facility was based on the above number of beds. Subsequently, however, the proposed bed complement was reduced to 134 as the result of the following factors:

- It was determined that operation of a distinct pediatric unit was not operationally or cost efficient
- The June 2006 plan was based upon real data through 2005. Subsequent availability of 2006 and 2007 data served to modify projected needs.
- Although it is generally recognized that IHFPB standards for utilization of beds are somewhat conservative, the initial proposed bed complement was significantly inconsistent with standards and could potentially jeopardize ultimate project approval.

Reduction in the number of proposed beds has removed approximately $100,000 per bed in total proposed project cost.

Cost of this Alternative: $187,500,000

<u>#3D: Construct a New Replacement 134-Bed Good Samaritan Regional Health Center at a New Location in Mount Vernon</u>

This is the selected alternative. Detailed justification for the proposed project is this application in its entirety. A summary of the reasons for the selection of this alternative is as follows:

- The proposed project addresses existing deficiencies of the current campus
- The current campus cannot be modernized or expanded sufficiently to reach established standards of patient care or operational efficiency
- The capital costs required to bring the existing campus into minimum compliance with standards would be prohibitive
- Replacement at a new location allows provision of state of the art care, maximizes patient convenience and operational efficiency, and allows for any necessary future modification and expansion
- Replacement at the new location greatly improves facility access.

Cost of this Alternative: $184,843,873

St. Mary's Good Samaritan Inc
Strategic Facility Planning
Concept Options - 14 July 1998

Good Samaritan Hospital Engineering Systems PRIORITY RANK 1 = Next 2 years 2 = 2 - 5 Years 3 = Beyond 5 Years

System	Development Concepts	PRIORITY RANK	Issues	Opportunities
Steam Generation System	1. Replace boilers	1	1. The boilers have exceeded their expected useful lifetime	1. Install smaller, more efficient boilers
Emergency Power Generation System	1. Create 3 branches of emergency power 2. Replace existing emergency generators	1	1. Present day codes require 3 branches of emergency power 2. Existing generators have reached their expected useful lifetime	1. Increased system reliability and patient/staff life safety and future flexibility to accommodate facility modifications
Chilled Water Generation System	1. Upgrade chiller refrigerant to R-134a 2. Replace cooling towers	1	1. Existing R-11 refrigerant no longer manufactured 2. Cooling towers are at or near their expected useful lifetime	1. Upgrade refrigerant to type manufactured today
Normal Power System	1. Repair medium voltage switchgear 2. Replace low voltage double ended switchgear 3. Upgrade branch circuit panelboards and feeders	1	1. Existing medium voltage switchgear need be repaired immediately 2. Existing switchgear and branch circuit panelboards/feeders have exceeded their expected useful lifetime	1. Improved system reliability and future flexibility to accommodate facility modifications
Heating Hot Water System	1. Install new system to serve North Wing	1	1. Replacement of existing ASU-20 (multi-zone) with new single zone AHU will require installation of new heating hot water system	1. Improved temperature control, thus improved patient comfort
Emergency and Normal Power Distribution Systems	1. Install grounding conductors	1	1. Present day codes require grounding conductors between branch circuit panelboards and receptacles in health care facilities	1. Improved patient/staff life safety
Air Handling Unit (AHU) Systems	1. Replace ASU-20 2. Replace ASU-18 3. Replace ASU-14 4. Replace ASU-15 5. Replace ASU-11 6. Upgrade Mitchell Hall HVAC System	1	1. Existing units have exceeded their expected useful lifetime 2. Improved Mitchell Hall comfort	1. Upgrade HVAC systems to improve operation and efficiency of systems
Temperature Control System	1. Continue to extend BAS System to entire facility	1,2	1. Upgrade temperature controls to direct digital technology with pneumatic actuators and thermostats	1. Increase HVAC system efficiencies , occupant comfort and system reliability
Fire Protection system System	1. Sprinkle remainder of facility	1	1. Continue to incorporate sprinklers into all future renovation projects	1. Increase patient and staff safety

St. Mary's Good Samaritan Inc.
Strategic Facility Planning
Concept Options - 11 June, 1998 Revised DRAFT

Good Samaritan Hospital Engineering Systems PRIORITY RANK 1 = Next 2 years 2 = 2 - 5 Years 3 = Beyond 5 Years

System	Development Concepts	PRIORITY RANK	Issues	Opportunities
Medical Gas System	1. Install emergency oxygen supply connection 2. Install new medical air compressor system 3. Replace standby medical vacuum pump	1	1. Code revisions require emergency oxygen supply connection and oil free air compressors 2. Existing backup medical vacuum pump has exceeded its expected useful lifetime	1. Increase life safety for patients and improve equipment system reliability
Fire Alarm System	1. Upgrade fire alarm system to be ADA compliant	1	1. Present day ADA codes are not presently met	1. Increase patient/staff life safety
Domestic Water Heating System	1. Replace existing domestic water heaters	1	1. Existing water heaters have exceeded their expected useful lifetime	1. Increased system reliability and efficiency
Domestic Water Softening Equipment	1. Replace water softeners	1	1. Existing softeners have exceeded their expected useful lifetime	1. Increase system reliability
Domestic Water Backflow Prevention System	1. Install backflow preventers	1	1. Present day codes require backflow preventers on all make-up water connections	1. Eliminate potential contamination of domestic water system

St. Mary's Good Samaritan Inc
Strategic Facility Planning - GOOD SAMARITAN CAMPUS
Plan Development 16 June 1998

Program / Area	Planning Criteria & Development Concepts	ESTIMATED DGSF	Projected Cost	Phase 1 a Next 2 years	Phase 1 b Within 3 years	Phase 2 Within 5 Years	Phase 3 Beyond 5 Years
Rehab Services (PT,OT, Speech) *(NEW)* *(AMBUL. BLDG.)*	1. Provide easy access for OP 2. Provide for adequate space at each site 3. Improve treatment space privacy 4. Support growth in Specialty Services 5. Develop as part of Amb. Care bldg **(Cost included in Amb. Bldg)**		Phase 1 : Phase 2 : Phase 3 :	Relocate OP to new OP Building Relocate IP to vacated Behavioral Health area ***SEQUENCING*** New Ambulatory Building			
Laboratory *(NEW)* *(AMBUL. BLDG.)*	1. Consolidation of Laboratories at SMH 2. Provide convenient access for OP 3. Respond to technology changes 4. Establish Satellite at GSH **(Cost estimates included in Amb. Bldg)**		Phase 1 : Phase 2 : Phase 3 :	Consolidate main lab at SMH Establish satellite lab in new OP building Access Center			
Ambulatory Services *(NEW)* *(AMBUL. BLDG.)*	1. Develop new facility with OP Focus 2. Provide new access and entry to hospital 3. Provide for physician offices 4. Convenient parking and access	103,300	Phase 1 : $ 13,406,563 Phase 2 : Phase 3 :	Construct new Amb. Services Bldg OP Programs, Access Ctr, Physician offices ***SEQUENCING*** New Parking Garage Temp. site relocations			
Oncology & Radiation Therapy *(NEW)* *(CAN. CENTER)*	1. Develop Oncology Image and visibility (Integrated) 2. Consolidate OP Services at Rad. Oncology site 3. Respond to technology changes 4. Provide expanded treatment therapies		Phase 1 : $ 810,418 Phase 2 : Phase 3 :	Acquire Rad Onc. Bldg Expand for Chemotherapy			
(CENTER FOR COMPREHENSIVE CANCER CARE CONSTRUCTED IN 2005 ON 50 ACRES SITE WITH CHEMOTHERAPY PROGRAM ADDED)							
Power Plant *(NEW)* *(SERVICE BLDG.)*	1. See separate Facility Assessment Report		Phase 1 : $ 332,500 Phase 2 : Phase 3 :	Construct new services bldg ***SEQUENCING*** Temporary dock/ site rerouting			
Buildings & Grounds *(NEW)* *(SERVICE BLDG.)*	1. Adequate space to support services 2. Site work for projects		Phase 1 : $ 1,950,000 Phase 2 : Phase 3 :	Construct new services bldg ***SEQUENCING*** Temporary dock/ site rerouting	Demo. of west wing Sr. Joanne		
Assisted Living *(NEW)* *(ASSIST. LVG. B.)*	1. Develop an Assisted Living Facility on campus		Phase 1 : $ 2,050,000 Phase 2 : Phase 3 :	Plan development based on special study			

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St. Mary's Good Samaritan Inc
Strategic Facility Planning - GOOD SAMARITAN CAMPUS
Plan Development 16 June 1998

Program / Area	Planning Criteria & Development Concepts	ESTIMATED DGSF	Projected Cost	Phase 1 a Next 2 years	Phase 1 b Within 3 years	Phase 2 Within 5 Years	Phase 3 Beyond 5 Years
Rehabilitation Unit (REMODEL)	1. Reduction in beds based on $ changes 2. Development of subacute capacity 3. Integrate with SNF unit 4. Improve patient room access /ADA 5. Improvements in nursing station/support facilities 6. Integration of Rehab Therapy on unit		Phase 1 : $ 1,185,838 Phase 2 : Phase 3 :	Retain existing	Relocate Adjacent to SNF Expand /share support space Changes based on Bed Plan	Changes based on Bed Plan	Changes based on Bed Plan
Interior Upgrades on Nursing Floors (REMODEL)	1. Improve appearance and comfort 2. Coordinate with planned unit renovations		Phase 1 : $ 939,078 Phase 2 : $ 201,300 Phase 3 : $ 201,300	Renovate public areas based on Bed plan sequencing	Renovate public areas based on Bed plan sequencing	Renovate public areas based on Bed plan sequencing	Renovate public areas based on Bed plan sequencing
Dietary/Food Service (REMODEL)	1. Provide pleasant dining areas for staff and visitors 2. Provide preventive maintenance for equipment 3. Provide adequate staff work space 4. Provide equipment to maintain reg. compliance (Cost Included in 2nd floor Renovations)		Phase 1 : Phase 2 : Phase 3 :	Retain existing			
Pharmacy (REMODEL)	1. Maintain access to inpatient units and surgery 2. Provide office space for Clinical Pharmacist 3. Provide automated dispensing systems 4. Centralize main production at GSH 5. Relocation to Critical Care area at GSH		Phase 1 : $ 585,000 Phase 2 : Phase 3 :	Retain existing	Relocate to PT/OT area Consolidate main product. at GSH SEQUENCING New Ambulatory Bldg Relocation of PT/OT Renovation of area		
Mitchell Hall (REMODEL)	1. Improve facility deficiencies 2. Renovate for relocated offices 3. Consolidate management offices into building	4,000	Phase 1 : $ 312,250 Phase 2 : $ 289,775 Phase 3 :		Exterior and systems upgrades	Renovation for offices	
Sister Joanne Building (REMODEL)	1. Use as business / support office building 2. Upgrade building to meet functional needs 3. Improve infrastructure systems 4. Demolish West Wing		Phase 1 : $ 4,525,938 Phase 2 : Phase 3 :	Sitework improvements Demolition of west wing Systems upgrades Exterior enclosure	Renovations for offices		
Women's Health (NEW) (MAMMO. BLDG.)	1. Development of Women's Diagnostic Center 2. Development of Tertiary Services 3. Respond to diagnostic technology changes 4. Provide adequate space for OP programs 5. Upgrade epidural services		Phase 1 : $ 41,000 Phase 2 : Phase 3 :			SEQUENCING	
Behavioral Health (NEW) (MAMMO. BLDG.)	1. Consolidated IP at SMH 2. Relocation of OP services outside hospital facility 3. Establish vision for future program 4. Relocate to Mammo building (Cost Included in Mammo. Bldg)		Phase 1 : Phase 2 : Phase 3 :	Relocate OP to Mammo Bldg SEQUENCING Renovation of building			

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St. Mary's Good Samaritan Inc
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Program / Area	Planning Criteria & Development Concepts	ESTIMATED DGSF	Projected Cost	Phase 1 a Next 2 years	Phase 1 b Within 3 years	Phase 2 Within 5 Years	Phase 3 Beyond 5 Years
Education *Library* *Classrooms* *(REMODEL)*	1. Development of adequate class/meeting rooms 2. Improve library space allocation 3. Expand computer access 4. Respond to specific facility needs 5. Locate accessible to physicians and staff	2,600	Phase 1 : $ 579,800 Phase 2 : Phase 3 :	Convert courtyard to meeting room			
Medical Records *Physician Lounge* *(REMODEL)*	1. Accessibility to physicians 2. Provide adequate storage space for active files 3. Development of specific archival program 4. Respond to specific facility needs at each site 5. Establishment of Record Management Program 6. Relocate from Mitchell Hall to hospital	2,700	Phase 1 : Phase 2 : Phase 3 :	Retain existing	Retain existing	Relocate to vacated Cardiac area ***SEQUENCING*** New Ambulatory Bldg Relocation of Cardiac services Renovation of area	
Support Renovation *(2nd Floor)* *(REMODEL)*	Note specific components included under departments - Cost estimates only Cost Includes Refurbishment/Interiors		Phase 1 : $ 939,940 Phase 2 : $ 340,000 Phase 3 : $ 340,000	Coordinate with dept. Renovations	Coordinate with dept. Renovations	Coordinate with dept. Renovations	
Materials Mgmt *Storeroom* *Receiving Dock* *CSS* *(REMODEL)*	1. Provide for adequate Dock 2. Consolidation of space in new services building 3. Separation of materials handling/ delivery in public hallways	22,000	Phase 1 : $ 3,136,500 Phase 2 : Phase 3 :	Construct new services bldg ***SEQUENCING*** Temporary dock/ site rerouting			
Infrastructure *(REMODEL)*	1. Improve elevators 2. Update/replace HVAC systems		Phase 1 : $ 3,480,366 Phase 2 : $ 1,552,083 Phase 3 :	Elevator Modernization Systems replacement and upgrade	Boiler Room updates Systems replacement and upgrade	Systems replacement and upgrade	Systems replacement and upgrade
Critical Care *Intensive Care* *Step Down* *(REMODEL)*	1. Units supportive of clinical needs 2. Development of Open Heart capacity 3. Replacement of Intesive Care Unit 4. Improvements in nursing station/support facilities 5. Expansion of Step Down Capacity	6,520	Phase 1 : $ 1,568,875 Phase 2 : Phase 3 :	Relocate to 2nd Floor ***SEQUENCING*** Relocate offices to Sr. Joanne Relocate nursing offices to temp.	Revise 3rd Floor for Step Down ***SEQUENCING*** Relocation of ICU		
(ADDED 2 CRITICAL CARE BEDS IN 2004)							
Medical Surgical *(REMODEL)*	1. Consolidation based on decreased census 2. Establishment of Observation approach to facility 3. Improvements to meet ADA requirements 4. Continued development of continuum beds 5. Improvements in nursing station/support facilities		Phase 1 : $ 1,970,044 Phase 2 : $ 172,500 Phase 3 :		Revised based on Step Down and Rehab unit Changes Changes based on Bed Plan	Changes based on Bed Plan	Changes based on Bed Plan
Obstetrics & *Newborn Services* *(REMODEL)*	1. Establishment of Women's Centers 2. Development of Newborn ICU potential 3. Ongoing relationships with tertiary care facilities 4. Renovation of nursery at GSH 5. Improvements in nursing station/support facilities	1,200	Phase 1 : $ 172,500 Phase 2 : Phase 3 :	Renovate nursery			
Skilled Nursing *(REMODEL)*	1. Continued expansion at GSH 2. Integration of Rehab Therapy on unit 3. Provide added suppport with Rehab Unit		Phase 1 : $ 590,333 Phase 2 : Phase 3 :	Retain existing	Changes based on Bed Plan	Changes based on Bed Plan	Changes based on Bed Plan

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Strategic Facility Planning - GOOD SAMARITAN CAMPUS
Plan Development 16 June 1998

Program / Area	Planning Criteria & Development Concepts	ESTIMATED DGSF	Projected Cost	Phase 1 a Next 2 years	Phase 1 b Within 3 years	Phase 2 Within 5 Years	Phase 3 Beyond 5 Years
Campus Image & Site *(REMODEL)*	1. Medical Center Image 2. Planned Development of Campus 3. Improved Vehicular access / circulation 4. Improved Main Entry / OP Entry 5. Improvements in Parking 6. Consistent image between Campuses		Phase 1 : $ 540,000 Phase 2 : Phase 3 :	Improve campus road circulation New campus entry Addition of OP Building New signage			
Patient Access & Parking *(REMODEL)*	1. Distinct OP Entry w/Parking access 2. Separation of ER Ambulances/ Pedestrians 3. Convenient Parking 4. Internal Access from New Building 5. Acquire land as required for projects		Phase 1 : $ 2,878,540 Phase 2 : Phase 3 :	Add new Parking lots Split deck garage ***SEQUENCING*** Acquire adjacent needed property New services bdlg	Add new Parking lots		
Wayfinding & Circulation 1st Floor *(REMODEL)*	1. Convenience for OP using all services 2. Separation of Staff /Patients/Visitors 3. Privacy for IP using Diagnostic Services 4. Minimization of Materials distribution with patient / visitor traffic		Phase 1 : $ 425,000 Phase 2 : $ 425,000 Phase 3 : $ 425,000	New signage based on Op Bldg Retain existing on 1st Floor	Develop new based on OP Bldg Dev. based on specific projects ***SEQUENCING*** OP Building completion	Develop based on specific projects ***SEQUENCING*** Department relocations	
Imaging *(REMODEL)*	1. Separation of IP/ OP flow; Improve privacy 2. Improve outpatient access/flow 3. Develop off-campus imaging center 4. Continue to respond to technology changes 5. Locate services (ie. MRI) adjacent to department 6. Provide for adequate support space	13,500	Phase 1 : $ 3,245,000 Phase 2 : Phase 3 :	Retain existing	Expand into adjacent support svcs Reorient/relocate OP services Relocate high tech CT/MRI (add fixed) ***SEQUENCING*** New Service support bldg/Dock Renovation in phases		
Cardiopulmonary Cariac Services *(REMODEL)*	1. Integration of Invasive / non - invasive programs 2. Ease of access for OP to departments 3. Provide for patient privacy 4. Provide adequate support space	5,500	Phase 1 : Phase 2 : $ 907,500 Phase 3 :	Retain existing	Retain existing	Relocate non invasive adjacent to Cath Lab - Cardiac Center ***SEQUENCING*** New OP building Relocation of Amb. Surgery Renovation	
(CARDIAC CATH PROGRAM ADDED IN 2002 AND EXPANDED IN 2006)							
Surgery & Anesthesia Outpatient Surgery *(REMODEL)*	1. Provide separate flow for IP and OP cases 4. Provide easy access to OP/ambulatory area 3. Develop Open Heart Capacity 4. Continued response to technology changes 5. Respond to specific facility needs	13,000 3,200	Phase 1: $ 1,868,750 Phase 2 : $ 725,000 Phase 3 :	Retain existing	Expand OR for Open Heart/support services; retain OP location ***SEQUENCING*** Relocation of Lab New OP building	Relocation of OP Surgery ***SEQUENCING*** Renovation phased	
Endoscopy *(REMODEL)*	1. Provide appropriate, accessible OP services 2. Develop service capacity for region 3. Provide adequate facilities for functions 4. Expand capacity in OR suite area **(Cost estimates included in Surgery)**		Phase 1 : Phase 2 : Phase 3	Retain existing	Same As Surgery	Same as OP Surgery	
Emergency Room *(REMODEL)*	1. Separate ambulance and walk-in entrance 2. Improve patient privacy in triage and registration 3. Improve nursing station flow and work space 4. Provide convenient parking 5. Develop Observation and Urgent Care facilities 6. Improve patient flow within & to diagnostic areas	8,900	Phase 1 : Phase 2 : $ 1,732,550 Phase 3 :	Retain existing	Retain existing	Expand into High Tech area and Imaging ; reconfigure area Revise and separate entries ***SEQUENCING*** Services Building addition Relocation of Imaging; Renovation	
(EMERGENCY ROOM REMOFDELING COMPLETED IN 2005)							

St. Mary's Good Samaritan Inc.
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Good Samaritan Sister Jo Anne Building Engineering Systems

PRIORITY RANK
1 = Next 2 years 2 = 2 - 5 Years 3 = Beyond 5 Years

System	Development Concepts	PRIORITY RANK	Issues	Opportunities
Fire Alarm System	1. Replace fire alarm system	1	1. Multiple systems serve facility	1. Upgrade fire alarm system to be totally addressable 2. Improve system performance and reliability
Domestic Water Backflow Prevention System	1. Install backflow preventers	1	1. Present day codes require backflow preventers on all make-up water connections	1. Eliminate potential contamination of domestic water system
Domestic Hot Water System	1. Replace water softener 2. Replace water heater 3. Install hot water return loop	1	1. Existing equipment has exceeded its expected useful lifetime	1. Improve system reliability
Sanitary and Storm Drainage Systems	1. Replace sanitary and storm lift pumps	1	1. Existing equipment has exceeded its expected lifetime	1. Increase system reliability
		1		

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St. Mary's Good Samaritan Inc.
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Concept Options - 14 July 1998

Good Samaritan Sister Jo Anne Building Engineering Systems

PRIORITY RANK
1 = Next 2 years 2 = 2 - 5 Years 3 = Beyond 5 Years

System	Development Concepts	PRIORITY RANK	Issues	Opportunities
Steam Generation System	1. Replace existing boilers	1	1. Existing boilers have exceeded their expected useful lifetime	1. Improve reliability and efficiency of system
Emergency Power Generation System	1. Remove emergency generator 2. Remove transfer switch	1	1. Existing generator and transfer switch have been abandoned in place	1. Remove abandoned equipment to eliminate potential hazard
Chilled Water Generation System	1. Replace chillers 2. Install new chiller(s), cooling tower and pumps	1	1. Existing chilled water generation system equipment has exceeded its expected lifetime	1. Increase efficiency and reliability of central chilled water plant
Normal Power System	1. Repair "original" distribution equipment 2. Install grounding conductors	1	1. Switchgear equipment has exceeded its expected lifetime	1. Plan replacement of equipment rather than wait for a failure and act in an emergency mode 2. Improve occupant life safety
Fuel Oil System	1. Remove underground fuel oil storage tank	1	1. Existing tank does not meet present day codes	1. Eliminate potential for fuel oil leakage in the future
Air Handling Unit (AHU) Systems	1. Replace ventilation AHU 2. Replace West Wing AHU	1	1. AHU's are near to or have exceeded their expected lifetime	1. Improve reliability of systems
Temperature Control System	1. Install new temperature control system	1,2	1. Existing temperature controls have exceeded their expected lifetime	1. Improved engineering systems operation and efficiency
Fire Protection System	1. Sprinkle entire facility	1	1. Incorporate sprinklers into all future renovation projects	1. Improve occupant life safety
Fan Coil Unit (FCU) System	1. Replace existing FCU's	1	1. Existing FCU's have exceeded their expected useful lifetime	1. Improve building comfort with ability to heat or cool rooms simultaneously 2. Improve system reliability and efficiency

Criterion 1110.230.d, Need for the Project

The need for this project is based upon the historical utilization as well as the projected patient population increases projected for this planning area. A variance to the calculated bed need has been addressed for the bed services involved in this project.

The applicant determined that the existing facility needed to be replaced because it was impossible to make the changes which needed to be made to the facility in its current location.

The existing hospital is located in a residential area in the middle of Mt. Vernon and is landlocked with inadequate space to meet the facility's needs. The site is surrounded by residences which means that any construction which takes place disrupts the community , and with the main hospital buildings being 60+ years old it is not possible to rehabilitate them to meet today's health care requirements.

The new proposed site is located in Mt Vernon adjacent to Interstate 57 where a new exit ramp will be constructed. This re-location will greatly improve the access to the facility and it will allow the hospital to continue to meet the needs of the population of the planning area as well as to meet the needs of its patient base, which extends beyond the planning area.

It is not anticipated that the relocation of the facility will negatively impact the other hospitals in the planning area. In fact the applicant is proposing to have fewer beds at the new site than they have currently. These new beds will all be in single rooms which will allow the hospital greater flexibility in meeting its patient needs and will help to eliminate the situation where the applicant facility goes on By-pass status which happens frequently now.

The new facility will also allow the hospital to work more closely with their physicians several of whom will be located in an adjacent Medical Office Building for which the IHFPB has also received an application.

The replacement of the existing hospital will allow the applicant to provide service to the community in a modern up-to-date facility and to continue to provide the specialty services currently provided to the community such as Open Heart Surgery, Cardiac Catheterization, and Rehabilitation beds.

The applicant is proposing to increase their number of ICU beds from 10 to 16 which will allow them to always have beds available for their Open Heart Surgery Program and for accident cases, while still meeting the needs of their other critical care patients. The facility is located near the intersection of two major interstates I-57 and I-64 both of which have high traffic volumes which leads to more accidents and a higher than normal instance of accident cases which come to the applicant facility.

The need for the bed services are based on the bed need and the variances to that bed need and are discussed under those criteria. The need for the Open Heart Surgery Program and the Cardiac Catheterization Program are also discussed under those criteria. The need for the other

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Catheterization Program are also discussed under those criteria. The need for the other departments in the hospital is discussed below.

A. Pharmacy

The pharmacy is proposed to be used to supply all pharmaceutical supplies required for the treatment of inpatients and for the use by outpatients who are seen by the physicians at the hospital or in the Emergency Department. This department will not be a retail pharmacy.

The department will be located on the Garden or lowest level of the hospital in close proximity to the material management department with convenient vertical access to the emergency department , surgery, and the bed units.

This department is an essential part of the provision of inpatient care as well as to the provision of emergency care. It is a department which is included in every new hospital and as such is needed in this hospital.

B. Central Sterile Supply

This department will be located on the Garden level of the hospital and will have direct vertical access to the cardiac catheterization Labs, The Surgery, and the outpatient services (endoscopy, and minor procedure) departments. The department will also be located in close proximity vertically to the Emergency Department.

The department will be responsible for providing sterile packs to the various departments in the hospital. The department will also house the sterilization equipment used to sterilize instruments and other re-usable supplies to these departments.

Again this department is an integral part of all hospitals. Even with today's reliance on disposable supplies the sterilization of equipment and supplies must be done, and this department is also responsible for preparing the packages of disposal for use in the other departments of the hospital.

C. Outpatient Testing

This department will be located on the first floor adjacent to the main entrance to the hospital. This will be where the patients go for their pre-admission testing, to have blood drawn, to answer questions, provide medical histories, etc,.before they are admitted to the hospital, for any type of elective procedure, whether it be inpatient or outpatient. All of the testing here will be done on an outpatient basis.

This department provides a central location for patients who are coming into the hospital, many for the first time, to be met and escorted to the various departments where the testing will actually take place.

This department will have small rooms where blood can be drawn or where patients can answer the medical questions they or the hospital may have in privacy which is not now available at the existing hospital Absent this department, patients would have to find their way to the various departments for their tests, and in many cases would have to answer the same questions multiple times. With this department the patient can have a much less stressful visit for these pre-admission tests while providing all of the information necessary to admit the patient for their actual procedure at a single location.

The requirements for privacy advanced by HIPAA require that the hospital provides private spaces for the taking of the pre-admission information. This department will allow that to be provided in an efficient manner.

D. Outpatient Prep and Recovery

This department is where outpatients requiring special procedures such as endoscopy, bronchoscopy, cardiac catheterization, etc, are prepared for the procedure and come back to for recovery. This department is outside of the PACU and stage two recovery areas for surgery. It basically consists of small rooms with a dressing area, a recliner or a space for a stretcher. These areas are monitored by the nursing staff and the patients are directly discharged from this area.

In 2007 the hospital had 1,330 outpatient endoscopy patients; 1,087 Catheterization patients and 712 angiography patients, in addition the applicant also has a contract with Archway Associates of Saint Louis to perform lithotripsy procedures and in 2007, 184 of those procedures were performed. All of the endoscopy patients a large percentage of the cardiac cath patients, many of the angiography patients and all of the lithotripsy patients will pass through this department many going into surgery, and again for recovery before they can be released to go home. This department by its nature has daily peaks and valleys in terms of occupancy with the early morning hours being the busiest and weekends being very quiet. Therefore the department must be built large enough to accommodate the busy times.

Again this department is an integral part of any modern health care facility with a strong outpatient department.

E. Infusion Center

This department will have five treatment stations on the first floor of the hospital and will be on a hallway that directly connects to the Medical Office Building This unit will be isolated somewhat from the rest of the hospital as many times the patients receiving care in this area have compromised immune systems which would make it dangerous for them to be in close contact with other hospital patients.

This department will also be located on an outside wall of the hospital in order to provide the patients with exterior views . These patients are sometimes in the treatment rooms for several hours and this view to the outside is essential in their treatment.

The historical volume for this department for 2007 total 6,351 visits for an average of 24.4 visits per day 260 work days per year (5 days per week X 52 weeks). This volume would mean that, based upon an average time of 1.5 hours per patient, including setting up the room before each patient would mean that the rooms would be occupied 92% of the time.

The five rooms proposed are necessary to support the existing volume of infusions and that volume has increased from 5,262 visits in 2005 to 6,351 visits in 2007, and it is expected to continue to increase as the patients' age and new forms of chemotherapy are developed.

F. Outpatient Procedure Rooms.

This department will house the four procedure rooms, two rooms will be set-up to perform endoscopy procedures, one room will be used for pulmonary function testing and one room will be used for minor procedures not done in the surgery requiring only local anesthesia.

The existing facility performed a total of 1,336 hours of endoscopy in 2007 which was a 13% increase from the year before. It is projected that the volume will surpass the 1,500 hours of utilization level which justifies a second room by 2010 based upon a conservative increase of 4% per year. This increase is based upon the increase in population projected for the area approximately 2.2% over those 3 years, the increase in the population age 65 and over up which is projected to increase by 10% over those same three years. When these two population increases are taken into consideration along with an increase in the use of colonoscopies as a screening test the 4% increase in volume is very conservative.

The pulmonary function testing volume has remained relatively constant between 966 procedures and 1,193 procedures over the last three years with the volume in 2007 at 979 procedures. This volume supports the need for one room for this procedure.

The one room proposed for minor procedures is new and no historical volume is available, however, based upon discussions with our physicians it was determined that one room was need to allow these procedures to be performed outside of the physicians' offices.

G. Cardiac Catheterization

The hospital currently has two Cardiac Catheterization units in the existing building and the new replacement hospital will also have two cardiac catheterization laboratories. The applicant's 2007 volume totaled 1,087 visits. Based upon the State standard for Cardiac Catheterization of 400 procedures per machine the applicant can justify up to 3 laboratories.

H. Diagnostic Radiology

The applicant is proposing to have 1 angiography room, 1 Radiographic /Fluoroscopic Unit, 1 General X-ray Unit, Chest X-ray Unit, 2 ultrasound units, and 1 CT Scanner in this department in the hospital. The hospital is proposing to have an outpatient Imaging Department in the MOB which will be discussed in that application.

The applicant's 2007 workload for general X-ray units total 12,389 exams for inpatients which, based upon the State standard of 6,500 procedures justifies only two of the three general units proposed by the applicant. However, each of the three units proposed to be located in the hospital serves a different purpose and all three are needed to support the applicant's inpatient and Emergency Department workload. The units, while capable of doing some of the same procedures, are much more efficient when used in their standard configuration.. The hospital will have a total of 5 ultrasound rooms counting the three units in the outpatient imaging department and the combined total volume for 2007 was 8,273 exams, which based upon the State Norm of 2000 exams per piece of equipment justifies 4.2 or 5 rooms.

The applicant's 2007 CT volume totaled 3,864 procedures performed on inpatients and 8,728 performed on outpatient. These volumes together justify up to 6.2 or 7 units based upon the State standard of 2,000 procedures per unit per year. The applicant is proposing to have 1 unit in the hospital and 1 unit in the MOB.

The applicant is proposing to have 1 angiography room in the hospital and none in the MOB. The 2007 hospital volume totaled 1,105 procedures, which based upon the State Norm of 400 procedures per machine would justify up to 3 angiography rooms in the hospital.

I. Cardiac Diagnostic Testing

The applicant is proposing to have 5,131 GSF to house this unit, which will have space for stress testing, echocardiography testing, general EKG testing, storage space for the cardiology equipment and support space for the staff of the diagnostic cardiology department.

The workload for this department for 2007 totaled 20,716 procedures both inpatient and outpatient. With the hospitals busy cardiology department including two cardiac catheterization labs and an open heart surgery program, this space is needed to meet the patients needs for both pre and post surgery and catheterization testing. Patients are routinely followed up subsequent to Open Heart Surgery and following therapeutic catheterizations.

Utilizing this department to determine which patients might need a catheterization or surgery is equally important to the follow-up care. If a catheterization can be avoided utilizing other less invasive testing methods, both time and money can be saved and the patient can avoid the risks associated with an invasive procedure.

This department, in conjunction with the cardiac catheterization service and the Open Heart Surgery Program offers the full range of cardiac care in one location convenient to the population of the planning area.

J. Nuclear Medicine

The hospital currently has three pieces of nuclear medicine equipment and will have three pieces of equipment in the new facility.

The proposed plan is to have two identical dual camera nuclear medicine rooms (A and B) that would perform the majority of all requested studies (79%) utilization of each room. We have proposed a third room ©) with only a single camera nuclear medicine machine system that would be configures for specialty studies (20%). These are longer duration studies that require a change in columnator configurations and calibration. These changes add 30 minutes each to the set-up and take-down of the configuration if the studies were performed on the routine (room A&B) system. By having Room C configured and calibrated will eliminate the set-up and take-down time for the 1.4 procedures performed per day.

The space difference is negligible as evidenced by the fact that the State Norm for Nuclear Medicine calls for 1,135 GSF per room which would allow the hospital to have 2,270 GSF for two units and the hospital is proposing to house the three units in only 2,140 GSF.

It is the most cost effective and efficient alternative available to the applicant to utilize the three units rather than the two the State Standard would allow. Note if only the special camera and one of the other two units was utilized the one unit would be operating at more than 100% occupancy.

K. Emergency Department

The existing facility currently has 14 treatment rooms and is proposing to have 18 treatment rooms.

The historical volume for this department is shown on the following table.

Year	Volume -Visits
2005	23,952
2006	24,072
2007	24,679

Of the 18 treatment rooms proposed 1 room is dedicated to trauma patients with a second room for backup. The proposed back-up trauma room would be used for general emergency treatment unless the trauma room is being used. Then this proposed second room would be used as a back-up trauma room. Another room is designed for privacy for use as a Women's crisis treatment room (Rape Victims or domestic abuse). A third room will not be set up specifically for treatment but will be used as a dedicated Behavioral Holding Room (a safe room to lock a disruptive patient in until the police can arrive.).

In all, three rooms will be dedicated and will not be used for routine treatment rooms.

Based upon the State Standard of 2,000 visits per room per year the 2007 workload justifies 13 rooms. However, as has been put forth in several of the applications considered by the IHFPB in the last two years, a more commonly accepted standard is 1,500 visits per room per year which would justify 17 rooms at the applicant facility, based upon the 2007 workload. Even if all of the specialty rooms are counted except for the single holding room where no treatment is actually taking place, the applicant is proposing to have only 17 treatment rooms which is consistent with the 1,500 procedure standard .

L. EMS Facilities

This area consists of a small 390 GSF area which will be utilized by the EMS call system and EMS personnel when they are at the hospital making their reports and awaiting the return of their equipment or picking up supplies. It will be located adjacent to the Emergency Department, but will not be used for patient care or treatment.

M. Observation Beds

This area consists of four rooms with a capacity for two beds in each room. These beds will be utilized for the observation of patients who have not yet been admitted to the hospital. These patients are currently placed in inpatient beds on the patient floor or they are held in the ER treatment rooms until a bed can be found or they are released.

The patients will not be held for more than 23 hours in these rooms and they will be monitored by staff which can also be used in the ER if needed.

The establishment of this unit will allow for shorter waiting times in the ER and reduce the expense of transporting patients to the bed floors when they may or may not be admitted. This unit will also help the hospital to keep from having to go onto diversion (by-pass) due to lack of staff or available beds by maintaining open beds on the patient floors rather than utilizing them for these observation patients.

This unit is especially helpful when the hospital discontinues the pediatric unit because many times pediatric patients are admitted for very short stays and the observation unit could be used to monitor these patients and prevent them from being admitted when they can be stabilized and sent home for care.

The patient observation days for 2007 were as follows: 509 MS, 36 Peds, 4 ICU, and 88 in OB. This does not include any patients who were held in the Emergency room for observation. These patients could now be cared for in the observation unit with no disruption on the patient floor and with better resources for testing at there immediate disposal. This location also allows the Emergency Room physicians to continue to monitor the patients and be close at hand in case of an emergency involving the patient.

The four rooms are in one pod which makes it easy to segregate the patients as needed for isolation or differences in age or sex of the patient. The State Board does not publish utilization standards for this type of bed, but this unit appears to be the ideal size to handle virtually any observation scenario.

N. Surgery

The hospital is proposing to have 4 General Surgery Rooms, one dedicated Open Heart Surgery Room, and one dedicated Cystoscopy room. The ASTC in the adjacent MOB is projecting to perform 6,295.5 hours of surgery which if removed from the hospitals 2007 volume would leave 6,701.5 Hours to be performed in the hospital based upon the State Standard of 1,500 hours of surgery per year per room this workload would justify 4.46 or 5 rooms needed. However, if the two dedicated rooms and their volumes are removed from the hours of surgery the applicant's 2007 workload would be 4,320 hours which would justify three of the four rooms proposed.

As has been discussed elsewhere in the application the population of the planning area is projected to grow by 3.5 % between now and the opening of this hospital with another 2.5 % over the first three years of operation of the new hospital with the population over the age of 65 to grow at nearly twice that rate. If one only considers the smaller growth in the overall population the applicant's workload would be above the State standard (5,533 hours ÷1,500 hours per year per room = 3.02 or 4 rooms needed.) by the second year after project completion. It is unreasonable to build a new hospital which will already be inadequately sized within a two year period.

O. Surgical Prep and Stage II Recovery

This department will be used for the patients who come into the hospital the day of their surgery. The patients will be shown to a small room where they change from their street clothes into the gowns they will wear when they are transported to surgery. They will then be prepared for surgery with IV's started and any other pre-anesthesia medication administered. They will also meet here with their physician, or his representative and with a member of the anesthesiology department to go over what is going to be done and to answer any final questions they may have before surgery.

The patients will be transported from this area into surgery where they will have their procedure performed and then they will go to the PACU for stage one recovery and either be sent to their hospital room for stage two recovery or if they area an outpatient they will come back to this department for stage II recovery.

This department will have 11 bays which is less than two bays for each of the 6 OR's. These bays will be highly utilized throughout the morning when patients will be arriving, and again when the patients come into Stage II recovery. The PACU will have only 9 recovery rooms, so the two recovery areas will have a total of 20 bays for 6 operating rooms the Illinois Department of Public Health Establishes a recommended level of 4 bays per OR, which is above the applicant's 3.3 bays per OR, this can be accomplished due to the fact that most of the outpatient surgery will be performed in the ASTC in the adjacent MOB. The ASTC has its own recovery and prep area.

P. Recovery

The applicant is proposing to have a stage one recovery area with 8 bays and one isolation bay. This is very near the minimum number of recovery stations allowed by licensure and again can be accomplished due to the fact that the majority of the outpatient procedures, which normally have the quickest turn over in the OR's are done in the ASTC in the adjacent MOB. The ASTC has its own recovery area totally separate from the hospital based PACU.

A stage I recovery area is mandated for a hospital which performs surgery. Therefore, this unit is required and based upon licensure standards the 9 recovery stations are needed.

Q. Hemodialysis - Inpatient

The applicant is proposing to have an inpatient dialysis unit with 4 stations in a total of 1,200 GSF. The 2007 workload totaled 1,430 treatments.

The patients cared for in this unit will be patients who come into the hospital already on dialysis and those patients who because of kidney failure during their hospital stay require dialysis treatment. Dialysis treatment takes several hours for each treatment and a schedule of treatment must be maintained for patients once treatment is started. There must also be back-up equipment available in case of an emergency.

Based upon a 6 day per week schedule the 2007 volume would mean that on average 4.6 patients per day utilize the 4 stations proposed. However, inpatient dialysis does not maintain the same type of schedule that a freestanding dialysis unit would have, as people leave the hospital and go back to their regular dialysis facilities, the utilization of these units go up and down. Many times these units are utilized by two patients in the same day, or in some cases not utilized at all that day. The department must have sufficient capacity to handle the peak workloads. After reviewing the historical utilization patterns at the hospital it was determined that the four units would be the number required to meet the peak utilization times.

O. Surgical Prep and Stage II Recovery

This department will be used for the patients who come into the hospital the day of their surgery. The patients will be shown to a small room where they change from their street clothes into the gowns they will wear when they are transported to surgery. They will then be prepared for surgery with IV's started and any other pre-anesthesia medication administered. They will also meet here with their physician, or his representative and with a member of the anesthesiology department to go over what is going to be done and to answer any final questions they may have before surgery.

The patients will be transported from this area into surgery where they will have their procedure performed and then they will go to the PACU for stage one recovery and either be sent to their hospital room for stage two recovery or if they area an outpatient they will come back to this department for stage II recovery.

This department will have 11 bays which is less than two bays for each of the 6 OR's. These bays will be highly utilized throughout the morning when patients will be arriving, and again when the patients come into Stage II recovery. The PACU will have only 9 recovery rooms, so the two recovery areas will have a total of 20 bays for 6 operating rooms the Illinois Department of Public Health Establishes a recommended level of 4 bays per OR, which is above the applicant's 3.3 bays per OR, this can be accomplished due to the fact that most of the outpatient surgery will be performed in the ASTC in the adjacent MOB. The ASTC has its own recovery and prep area.

S. Physical Therapy

The applicant is proposing to have this department located on the third floor of the hospital between the Rehabilitation bed unit and the Medical Surgical Bed unit on that floor.

This department will be used solely for inpatients and is needed to support the proposed Rehabilitation Service. While, it will also serve the inpatient rehabilitation needs of the hospital's other inpatients, its primary purpose is to provide space for the rehabilitation of patients in the Comprehensive Rehabilitation unit.

In 2007 the inpatient workload for this department total 17,029 visits which based upon the State standard of 7.5 visits per GSF would justify 2,270.5 GSF while the applicant is proposing to have only 1,200 GSF. The difference is in the fact that the State Norm includes the outpatient space which is normally larger due to the need for changing rooms, and larger exercise spaces as the patients progress, and in this hospital that space is to be provided in the outpatient rehabilitation department in the MOB.

The hospital's proposed Comprehensive Rehabilitation Bed Unit requires that the applicant have an active Physical Therapy Department and an Occupational Therapy Department. The existing hospital provides both of those services and the new hospital will also have those services available.

T. Occupational Therapy

The applicant is proposing to located this department immediately adjacent to the Physical Therapy Department in 444 GSF. This department will be used solely for the inpatients of the hospital and will be separate from the outpatient Occupational Therapy area which is located in the MOB which is attached to the hospital.

This unit is required in order to provide "Comprehensive Rehabilitation Services" as proposed by the applicant. The square footage proposed is the minimum amount of space needed to provide this service and is supplemented on an outpatient basis by the department in the MOB. This unit provides basic occupational therapy with the more comprehensive program provided through the outpatient unit.

The inpatient program is designed to provide services which will enable the patient to be discharged where they will then be provided further services on an outpatient basis.

U. ICU Beds

The applicant is proposing to increase the number of inventoried ICU beds from 10 to 16. The IHFPB Inventory of Health Care Facilities shows that a need for one additional bed in the applicant's F-004 Planning Area.

The 2007 workload for this department totaled 3,128 patient days. Based upon the Board's target occupancy of 60% this volume supports the need for 14.2 or 15 beds.

The population of this planning area is projected to increase by 7.1% between 2005 and 2015. This amounts to 3.5% over the next 4 years which is when the first full year of operation will be complete this would increase the number of patient days by 109 days which would then justify 14.78 beds. In 2007, the applicant also went on diversion/bypass 20 times for periods ranging from1hr and 55 minutes up to 88hrs and 25 minutes. The total time on diversion was 26.5 days . A log of that by-pass time is appended to this attachment. This by-pass affects the ICU in several ways, when the Medical Surgical Unit is full, the ICU can not move patients out to monitored beds and free space in the ICU and on the other side when the ICU is full the ambulances which bring patients to the hospital must be diverted to other facilities which means that patients are not being admitted through the ER or normally for any type of elective surgery that might require ICU care initially.

The applicant averaged 2.47 patients being admitted to ICU per day so if the facility was on bypass for 26.5 days it could be projected that the facility would have admitted an additional 66 Patients which with an average length of stay of 3.46 days this would have resulted in another 228 patient days. When those patient days are added to the 2007 patient days the total patient days would be 3,358 patient days which at the target occupancy would support the need for 15.3 or 16 beds, which is the number the applicant proposes to have.

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V. Rehabilitation Beds

The proposed project while technically classified as the establishment of a new category of service because the applicant will be licensed as a new facility, is in reality a replacement for an existing service in the old facility which is being replaced as a part of this application. The existing facility has 23 beds , while the new facility will have only 10 beds. There is only one other provider of rehabilitation services in the applicant's planning area which is all of HSA V. (See the appended map to see the location of the two facilities). The two facilities are 42.72 miles and 48 minutes travel time from each other and both are located in the middle of the HSA one to the North and 1 to the South in close proximity to Interstate 57. (See the second map showing HSA V.)

Herrin Hospital does not have any admission restrictions to their facility, but the travel time is excessive for the residents of the northern half of HSA V.

If the applicant were to discontinue the service totally a need for 9 additional beds would be created. The proposed reduction in beds from 23 to 10 reduces the number of excess beds in the planning area to 1 bed.

Based upon the historical utilization the applicant and the Board's 85% occupancy target the facility can justify 9.1 or 10 beds. Since this is the existing facility's historical utilization it appears reasonable to assume that these are the patients who would not have reasonable geographic access to Herrin Hospital if the existing facility's beds were not replaced at the new facility.

The State Board has established a minimum unit size of 15 beds for this service, however, given the rural nature of this planning area and the utilization experienced by the existing facility over several years, it does not appear that a 15 bed unit would be appropriately utilized while the proposed 10 bed unit would be.

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W. OB Beds/ LDR

The facility will have 6 LDRP beds, 2 Post-Partum Beds and one Ante-Partum bed for a total of 9 beds which will be inventoried as Obstetric beds. The LDRP beds (Labor/Delivery/Recovery/Post-Partum) beds will be the primary location in which the patients will be admitted. The patient will be admitted to an LDRP bed where they will stay through labor, delivery, recovery, and until they are ready for discharge. The two post-partum beds and the ante-partum beds will we used for patients who have not delivered and are being admitted for medical reasons, or patients who have had C-sections are recovering from the surgery.

The 2007 workload, 1,861patient days supports the need for 9 beds based upon the Board's target occupancy of 60%. (1,861÷365 = 5.2 patients per day ÷.60 =8.7 or 9 beds needed)

The beds are further justified under the variance to computed bed need shown on ATTACHMENT ACUTE-2.

X. C-section Site

The hospital is proposing one operating room for c-sections which will be located on the Fourth Floor of the new hospital adjacent to the LDRP and the Obstetric Unit. The total GSF for this area is 1,018 GSF.

In 2007 the volume of C-sections totaled 228 out of the 787 total deliveries at the hospital. This volume supports the need for one C-section room, which is what the applicant is proposing.

An operating room in which C-sections can be performed is an integral part of the hospitals provision of Obstetric Services and locating that room immediately adjacent to the rest of the OB services is the best way quality care can be delivered in an efficient and safe manor.

The proposed room will only be used for C-sections and will not be used for any other surgical procedure which means that its volume should not be used to justify any space in the OR nor should room capacity in the OR be considered as available for this service.

Illinois Hospital licensure requires that a C-section suite be available unless Operating Rooms can be shown to be immediately available for use. Since the surgery department is located on another floor the C-section suite is required and it must meet surgical standards.

The IHFPB guidelines allow for 2,078 GSF per Operating Room. The applicant is proposing to have only 1,018 GSF for this departmental area since it will be able to share some support space with the LDRP unit.

Y. New Born Nursery

The new born nursery will be located on the fourth floor immediately adjacent to the Obstetric and LDRP units, as is required by Illinois State Hospital Licensure.

While the patient rooms will have space for the baby to room-in with the mother the nursery will be used for respite times for the mothers or if the baby needs additional care.

Z. Medical Surgical Beds

The proposed project calls for the discontinuation of a 106 bed Medical Surgical Service and the replacement of those beds by a 99 bed service in the new replacement hospital.

A map showing all of the facilities within 30 minutes travel time of the proposed facility and those facilities in the applicant's planning area is appended to this Attachment. It is important to note that Franklin Hospital in Benton, while within 30 minutes travel time is in another planning area for this service. The map also shows the only other non-planning area facility that is located between 30 and 45 minutes travel time of the proposed facility, that is Hamilton Memorial Hospital, in Mcleansboro, which is also in another planning area.

Only one other facility in the Planning area is within 30 minutes travel time of the proposed facility, that is Crossroads Community Hospital also located in Mt. Vernon.

The applicant's 2007 workload for Medical Surgical and Pediatric beds totaled 24,802 patient days, which results in an average daily census of 67.95 patients. Based upon the State Board's target occupancy rate of 75% for modernization of facilities with between 26 and 99 beds the 2007 workload justifies 91 beds. Based upon the 80% utilization target for new facilities the workload justifies 85 beds.

The applicant's peak census for 2007 was 99 beds which is also the number of beds proposed in the new hospital. The peak census for Pediatrics was 5. Together the peak census was 104 beds. This is important because all pediatric cases will be cared for in Medical/Surgical beds in the new replacement hospital.

In 2007, the applicant also went on diversion/bypass 20 times for periods ranging from1hr and 55 minutes up to 88hrs and 25 minutes. A log of that by-pass time is appended to this attachment. This by-pass effects not only the Medical Surgical Unit but also the ICU. When the Medical Surgical Unit is full, the ICU can not move patients out to monitored beds and free space in the ICU and on the other side when the ICU is full the ambulances which bring patients to the hospital must be diverted to other facilities which means that patients are not being admitted through the ER or normally for any type of elective surgery that might require ICU care initially.

The bypass issue is a situation the hospital feels it must address in the new hospital as it critically impacts the ability to insure prompt care to the area residents.

The applicant proposes to have all private rooms in the facility which will allow for better utilization of the facilities beds by eliminating problems with isolation or with patient mix by age or sex. This is especially important now that pediatric patients are being treated in Medical Surgical beds, as it is inappropriate to mix pediatric and adolescent patients with adults.

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The other facilities in the planning area do not appear to have admission restrictions, but they are with the exception of Crossroads Hospital a substantial distance away and would result in hardships for the patients and their families to have to use facilities so remote from where they live.

Good Samaritan Regional Health Center has been for a number of years a regional resource for programs such as cardiac catheterization, open heart surgery and Rehabilitation beds. The other facilities within either the 30 minute travel time or the forty-five minute travel time do not either offer the service (rehab and open heart) or have the capacity (cardiac catheterization) to accommodate the facility's historical workload were the facility to not be replaced.

The proposed location of the new facility is on property next to Interstate 57 which will dramatically improve the access to the hospital by the planning area residents. The existing hospital is located in a residential area and is not on one of the main roads in the community which makes it difficult to locate for any patient who is not familiar with Mt. Vernon itself.

The hospital has always maintained a generous charity care program and does not deny access to any patient regardless of their ability to pay. This policy will continue at the facility.

The proposed 99 beds are needed to support the facility's peak census as it now exists and to prevent the hospital from having to go on diversion/bypass, even if no growth in the population occurs. The Illinois Department of Public Health Center for Health Statistics predicts that the total population of the planning area is projected to grow by 7.1% between 2005 and 2015, while the population age 65 and over is projected to grow by 33.9% during that same time period. The only population which is projected to decrease during that time is the 0-14 age group which is the pediatric patients for which the applicant is proposing to discontinue the dedicated unit. The number of medical surgical patient days for the area is projected to increase by 12,100 days in the age 65 and over group for that time period and by 464 in the 15-64 age group

Based on the 2005 utilization data, as published in the Planning Board's Inventory of Health Care Facilities dated March 11, 2008, the applicant treated 43.36% of the patient days in the planning area. If that market share remains the same in 2012 the first year after project completion the applicant's patient days would increase by 3,672 patient days which at the 80% occupancy target supports the need for 13 beds which more than justifies the difference between the number of beds the 2007 volume currently supports and the number of beds the applicant is proposing to have.

ATTACHMENT GRC-4

AA. Hospice and Home Health

This area will be used primarily as office space and counseling space for the nurses and care givers in the Home Health and Hospice departments.

This unit will not be used to house patients and will have no bed space on the unit. It will have meeting rooms and spaces for the families of the patients to meet with the professional care givers who provide the care for the patients in their homes. It will also have materials for the patients and their families to refer to as they make decisions regarding their care.

The home health nurses and their supervisors will also be housed here as needed and the administrative portion of their care will be done here.

This department is located on the fifth floor of the hospital in an area which is otherwise administrative in nature.

This space is basically non-clinical in nature and could have been excluded from the Board's review, however, the decision was made that since it involves staff with direct patient care responsibility and in some instances meetings with the patient, that it would be treated as clinical space and justified in that fashion.

It is difficult to assign workload figures to this department because the patients served vary greatly, and nurses are used as needed.

Criterion 1110.230.e, Size of Project

Department	State Standard	Allowable GSF	Proposed GSF
Pharmacy	12 GSF/Bed	1,608	2,070
Central Sterile Supply	18 GSF/Bed	2,412	2,495
Cardiac Catheterization	1,596 GSF/Laboratory	3,192	2,478
Diagnostic Radiology	1,386 GSF/Room	8,316	6,275
Emergency	744.6 GSF/Room	13,402.8	10,762
Nuclear Medicine	1,135 GSF/Room	3,405	2,140
Surgery	2,078 GSF/OR	12,468	10,780
Recovery	180 GSF/Station	1,620	2,265
Hemodialysis	470 GSF/Room	1,880	1,200
Respiratory Therapy	20,5 Proc/GSF	4,537	1,344
Physical Therapy	7.5 Treatments/GSF	2,270.5	1,200
Occupational Therapy	4.3 GSF/bed (Less OB and ICU)	468.7 GSF	444
ICU beds	603 GSF/Bed	9,648	11,658
Rehab Beds	588 GSF/Bed	5,880	7,112
OB beds	476 GSF/Bed	1,428	2,771
LDRP	1,119 GSF/Bed	6,714	6,305
C-section Suite (OR)	2078 GSF/OR	2,078	1,018
New Born Nursery	152 GSF/OB Bed	1,368	1,219
Medical Surgical Beds	401 GSF/Bed	39,699	57,865

The table above shows that several departments exceed the State Norms: Pharmacy, Central Sterile Supply, Recovery, ICU beds, Rehab Beds, Ob beds, and Medical Surgical Beds. Each of these departments will be discussed separately under this attachment. In addition several clinical departments do not have State Norms and they also will be discussed separately.

ATTACHMENT GRC-5

A. Pharmacy

The State Norm bases the size of this department upon the number of beds in the hospital which was a good measure of departmental size at the time it was developed several years ago. However, the hospital today operates much differently than the hospital did then and as a result the space needs for Pharmacy have increased. The pharmacy now is responsible for preparing all of the infusion material for the chemotherapy patients which takes more room than in the past and the use these mixtures of drugs increases every year as more types of chemotherapy become available. The hospital is also now treating many more outpatient and provides medication for them from the pharmacy in many cases. The hospitals have all gone to a more controlled, unit dose system, which requires each patients meds to be dispensed from the pharmacy rather than on the patient floor from medicine cabinets. This requires more storage for carts and for medications.

All of the above factors increase the need for space in the pharmacy. Based upon our evaluation of the space needs at the hospital it was determined that the proposed 2,070 GSF was needed to provide these functions. This amounts to only 15.5 GSF/bed for a total of only 462 GSF more than the Board's State Norm would allow.

B. Central Sterile Supply

The proposed square footage exceeds the State Norm by a total of 83 GSF and if the Observation beds are counted, as they will also need supplies for their operation, the proposed size is within the State Norm (8 X18 GSF/bed = 144 GSF). Even if those beds are not counted , the difference in the proposed square footage can be explained by the increase use of sterile disposables in the OR and in the ED which have required that the Central Sterile Supply Departments have to become larger in order to accommodate the storage and distribution of these items.

C. Outpatient Testing

This department will be located on the first floor adjacent to the main entrance to the hospital. This will be where the patients go for their pre-admission testing, to have blood drawn, to answer questions, provide medical histories, etc., before they are admitted to the hospital for any type of elective procedure, whether it be inpatient or outpatient. All of the testing here will be done on an outpatient basis.

The State Agency has not developed any norms for this department. The size of the department was determined based upon the past experience of the applicant and their architects and in through discussions with the end user groups for this department. No published standards could be found specifically for this department.

D. Outpatient Prep and Recovery

This department is where outpatients requiring special procedures such as endoscopy, bronchoscopy, cardiac catheterization, etc, are prepared for the procedure and come back to for recovery. This department is outside of the PACU and stage two recovery areas for surgery. It basically consists of small rooms with a dressing area, a recliner or a space for a stretcher. These areas are monitored by the nursing staff and the patients are directly discharged from this area.

In 2007 the hospital had 1,330 outpatient endoscopy patients,1,087 Catheterization, and 712 angiography procedures, in addition the applicant also has a contract with Archway Associates of Saint Louis to perform lithotripsy procedures and in 2007, 184 of those procedures were performed. All of the endoscopy patients, a large percentage of the cardiac cath patients, many of the angiography patients and all of the lithotripsy patients will pass through this department going into surgery, and again for recovery before they can be released to go home. This department, by its nature, has daily peaks and valleys in terms of occupancy with the early morning hours being the busiest and weekends being very quiet. Therefore the department must be built large enough to accommodate the busy times.

Again this department is an integral part of any modern health care facility with a strong outpatient department.

The State Agency has not developed any norms for this department and the applicant was unable to find any published norms for the industry. Therefore the size of this department was developed based upon the experience of the Architects, the space planning consultants our own experience and discussion with the physicians and nurses and the patients who will be utilizing this space. Based upon all of these factors, the space proposed was determined to be the best arrangement possible to meet our needs.

E. Infusion Room

This department will have five treatment stations on the first floor of the hospital and will be on a hallway that directly connects to the Medical Office Building This unit will be isolated somewhat from the rest of the hospital as many times the patients receiving care in this area have compromised immune systems which would make to dangerous for them to be in close contact with other hospital patients.

The space proposed equals 333 GSF per room which is even smaller than the State Norm for Dialysis rooms, which is the closest comparison that could be made to the type of procedure which takes place in these rooms.

This departments rooms are all small single rooms where the patient comes to receive the infusion and then goes home after the procedure. Since the patient is awake during the procedure, windows are desired and televisions or other media are provided to make the experience less difficult for the patient. These rooms are minimally sized for the purpose for which they are to be used.

F. Outpatient Procedure Room

This department will house four procedure rooms, two rooms will be set-up to perform endoscopy procedures, one room will be used for pulmonary function testing and one room will be used for minor procedures not done in the surgery requiring only local anesthesia.

The proposed square footage for this department is 2,535 GSF. Using the norm for radiology rooms, as a good comparison, the endoscopy and pulmonary function testing rooms could justify 4,158 GSF. Since the space can be more efficiently designed by placing the endoscopy rooms immediately adjacent to one another the department can be made smaller, hence the proposed 2,535 GSF.

G. Cardiac Diagnostic Testing Space.

The applicant is proposing to have 5,131 GSF to house this unit, which will have space for stress testing, echocardiography testing, general EKG testing, storage space for the cardiology equipment and support space for the staff of the diagnostic cardiology department.

The workload for this department for 2007 totaled 20,716 procedures both inpatient and outpatient. With the hospitals busy cardiology department including two cardiac catheterization labs and an open heart surgery program, this space is needed to meet the patients needs for both pre and post surgery and catheterization testing. Patients are routinely followed up subsequent to Open Heart Surgery and following therapeutic catheterizations.

The State Agency has not yet developed any norms for this department and there does not appear to be industry standards to rely upon in determining the appropriate space for this department so the applicant in conjunction with the architects and space planning consultants visited other facilities, held discussion group meetings with the physicians, nurses and other staff and patients who utilize the department in order to determine what the appropriate size should be. Based upon these endeavors it was determined that based upon the facilities historical utilization the proposed 5,132 GSF was appropriate.

H. EMS Facilities

This area consists of a small 390 GSF area which will be utilized by the EMS call system and EMS personnel when they are at the hospital making their reports and awaiting the return of their equipment or picking up supplies. It will be located adjacent to the Emergency Department, but will not be used for patient care or treatment.

The size of this space was based upon discussions with the EMS personnel to determine their needs. There are no standards for this department and it appears that the proposed 390 GSF is minimal.

I. Observation Beds

This area consists of four rooms with a capacity for two beds in each room. These beds will be utilized for the observation of patients who have not yet been admitted to the hospital. These patients are currently placed in inpatient beds on the patient floor or they are held in the ER treatment rooms until a bed can be found or they are released.

The patients will not be held for more than 23 hours in these rooms and they will be monitored by staff which can also be used in the ER if needed.

The department will have a total of 2,724 GSF, which based upon the 8 bed capacity of the unit amounts to 340.5 GSF per bed. Which is below standard for Medical Surgical beds in 2-bed rooms (401 GSF per bed). Since these patients are in these beds for observation and not longer term care, this space was determined to be adequate for a short stay.

J. Surgery Prep

This department will be used for the patients who come into the hospital the day of their surgery. The patients will be shown to a small room where they change from their street clothes into the gowns they will wear when they are transported to surgery. They will then be prepared for surgery with IV's started and any other pre-anesthesia medication administered. They will also meet here with their physician, or his representative and with a member of the anesthesiology department to go over what is going to be done and to answer any final questions they may have before surgery.

The patients will be transported from this area into surgery where they will have their procedure performed and then they will go to the PACU for Stage-I recovery and either be sent to their hospital room for Stage-II recovery or if they are an outpatient they will come back to this department for Stage-II recovery.

The space for this department was determine in two phases the need for a preparation area and the need for Stage-II recovery. The size of the preparation phase was determined

based upon the need to have a large number of small dressing rooms available for the early morning hours when patients are coming into the department prior to surgery, and the need to have sufficient space for the anesthesiologist and surgeons to see the patients prior to surgery to explain what was going to happen and to answer any last minute question. This area will also be used to provide the nurses an area to prepare the individual patients for surgery.

It is common during the early morning hours to have 12 to 15 patients in the preparation area awaiting their turn to go into surgery. This area can become quite congested therefore, additional space is necessary..

It was determined that the space for this area needed to be somewhat larger than the Stage-II recovery area so it was determined that 2,100 GSF was to be allocated to the preparation area and an additional 1,920 GSF was allocated to Stage-II recovery, with some of the space capable of being utilized for both parts of the patients' stays

The space for the eleven Stage-II recovery stations is within the State Norm of 1,980 GSF

K. Recovery

The applicant is proposing to have 9 recovery stations in 2,265 GSF. This exceeds the State standard of 180 GSF by 71 GSF per station

There are two reason why the space exceeds the standard. First the applicant is proposing to have actual rooms for these patients to recover in rather than the open bays with curtains surrounding the patient. This is done for two primary reasons. Infection control is a major issue in all hospitals today and this is one way to make sure that patients do not come in contact with infection from another patient, and second, HIPAA privacy rules require hospitals to be much more sensitive to patient privacy which is very difficult to maintain in open bay type area.

The second reason why this space is larger than the State Norm relates to its location in the hospital. Due to the need to place this unit immediately adjacent to the surgery area the location is fixed. However, there is a large vertical ventilation chase from the kitchen area that passes directly through this department. Therefore, more corridor and addition room space is necessary to maintain patient flow and allow the nurses direct observation of the patients.

These two factors dictate the size of this unit, and explain the discrepancy between the proposed square footage and the State Norm.

L. ICU beds

The applicant is proposing to have 16 ICU beds in 11,658 GSF which amounts to 728.6 GSF per bed which exceeds the State Norm of 603 GSF/bed by 125.6 GSF per bed.

The proposed GSF for this department is larger than the State Norm due primarily to the use of private rooms and the relatively small number of beds involved. The applicant proposes to develop a unit which has all private rooms which are not in open bays. But rather are in actual rooms. Each of these rooms will also have a bathroom, and will be sized to handle all of the equipment necessary for a modern ICU. These rooms will also be sized to handle Cardiac Cases such as patients who are coming to the unit following open heart surgery. The use of the rooms as private rooms increases square footage in several ways. It causes the department to be bigger just to account for the wall thicknesses , and the door opening, It causes the department to be bigger because each room will have its own restroom facilities and it causes the department to be bigger because more rooms require more corridor space and a larger nurses station to maintain direct visual observation of the patients. Modern ICU rooms also allow more room for a family member to be with the patient throughout his or her stay and to allow a somewhat larger number of visitors than was allowed in the past. All of these factors add up to a need for larger rooms.

The Board has seen in the more recent applications which have appeared before the Board that larger spaces are needed to support the ICU patients. The applicant's proposed 728.6 GSF falls well within the range of projects previously approved by the Board.

M. Rehab Beds

The applicant is proposing to have 7,112 GSF to house the proposed 10-bed Comprehensive Rehabilitation Unit. This amounts to 711 GSF per bed which exceeds the State Norm of 588 GSF/bed. The primary reason for this discrepancy is the number of beds proposed for this unit. While the applicant's historical occupancy supports the need for only the 10 beds proposed the programs which make up the State Norm are much larger units and there is an economy of size factor for this service. Because you need large pieces of equipment such as lifts to transfer patients, more wheel chairs and other devices to assist in making the patients more mobile storage is a must on these units and the more beds on the unit the smaller the GSF per bed is. The same holds true of the clean and soiled utility areas and the rehabilitation treatment areas on the floor. It takes virtually the same amount of space for rehabilitation treatment on the floor for a 16 bed unit as it does for a 10 Bed unit. There are minimum sizes for each of the support areas and they are virtually the same for a 10 Bed unit as they are for a 15 -20 Bed unit.

The department is minimally sized to provide all of the support space necessary to operate a comprehensive rehabilitation unit.

N. Obstetric Beds

The applicant is only proposing to have 3 beds in this unit. However, it is more appropriate to consider the entire LDRP and OB sections together, since the utilization which justifies the nine total beds Is considered together. The State Norm for LDRP is listed at 1,119 GSF per room and OB is listed at 476 GSF per room. These two norms would allow the applicant to have a total of 8,142 GSF total the applicant is asking for 9,076 GSF. The difference between the State Norm and the applicant's proposal results from the small number of OB beds proposed The three beds are needed to support the applicant's historical workload but the result in a very small unit which has built in inefficiency when it comes to square footage. The unit must meet all of the Life Safety Code requirements and the licensure requirements of a larger unit. It must have a nurses station, it must have utility rooms, medication stations, etc. but the square footage for these rooms can not be spread over alarger number of rooms. This makes it impossible for the applicant to meet the Board's size standards. Another factor in the size discrepancy is the desire to provide family space in the rooms and to give each room its own bathroom, this also causes the overall space in the unit to be larger.

O. Medical Surgical Beds

The applicant is proposing to have 99 Medical Surgical Beds in 57,865 GSF. This amounts to 584.5 GSF/bed which exceeds the State Norm of 401 GSF/bed by 183 GSF/bed. However, the applicant's proposed 584.5 GSF per bed is well within the range of space proposed for projects previously approved by the Board.. In the past few months, the space approved has varied from 497 GSF/bed to 680.6GSF bed.

The reasons for the difference between the State Norm and the applicant's proposal are the same reasons the Board has heard on many occasions. The applicant is proposing to have family space in the rooms so that someone can stay overnight with the patient if they wish. This space will also include space for other visitors in the room including space for the doctor to sit down and discuss treatment with the patient. Each of the rooms will be private rooms which require additional corridor space, space for door swings and space for charting for the nurses. This will include space for laptop hook-ups to allow electronic medical records capability and immediate ordering capability for the physicians.

Each room will have its own bathroom which means that additional space will be needed to accommodate the additional bathrooms.

The proposed square footage is needed to accommodate the state-of-the-art unit proposed for this new hospital.

P. Hospice and Home Health

The Hospice and Home Health Departments will occupy space on the fifth floor of the

Criterion 1110.230.e, Size of Project

The projected utilization levels for the bed services are based on two factors, one is the increase in the population especially the age 65 and over population and the number of days the applicant was on diversion in 2007. Both of these factors were discussed under the Variances to the computed bed need.

It is important to note that the days on diversion were not considered in the projections for Rehab nor in OB since neither would be particularly impacted by the hospitals diversion status.

For purposes of this application the Obstetric patient days are projected to remain at the 2007 levels. The population change in the OB patient age group is negligible.

Department	2007 Volume	2012 Volume	2013 Volume
Obstetrics	1,861 Patient days	1,861 Patient Days	1,861 Patient Days
Rehab*	2,819	2,918	2,938.4
Medical Surgical/Peds	24,802	28,615	29,164
ICU**	3,128	3,465	3,488
Cardiac Cath***	1,087	1,200	1,250
Open Heart Surgery	84	84	84

*The overall population of the planning area is projected to increase .7% per year for the 10 years between 2005 and 2015
**Includes days which would be realized if not on diversion plus a .7% annual increase in population
*** during 2007 one interventional cardiologist left, but was replaced shortly by another, the projections conservatively project returning to 2005 and 2006 volumes

ATTACHMENT GRC-6

SECTION VI. REVIEW CRITERIA RELATING TO ESTABLISHMENT OF ADDITIONAL BEDS OR SUBSTANTIAL CHANGE IN BED CAPACITY (BEDS)

This section is applicable to all projects proposing the establishment of additional beds or the conversion of beds from one category of service to another.

A. Criterion 1110.320.b, Allocation of Additional Beds

Read this criterion and explain how establishment of the new category of service will improve the distribution or accessibility of the service. Include any supporting documentation.

APPEND DOCUMENTATION AS ATTACHMENT BEDS-1 AFTER THE LAST PAGE OF THIS SECTION.

B. Criterion 1110.320.c, Addition of Beds to Existing Facilities

Read this criterion and address the following:

1. If applicable, explain why it is not architecturally or programmatically feasible to rearrange and use presently underutilized bed capacity for this project.

2. Provide documentation that there will not be sufficient space in the proposed room to accommodate any additional beds.

3. Provide a comparison of the applicant facility's average length of stay with the length of stay of any similar facilities in the planning area. If there is a discrepancy, provide a rationale.

APPEND DOCUMENTATION AS ATTACHMENT BEDS-2 AFTER THE LAST PAGE OF THIS SECTION.

Criterion 1110.320.b, Allocation of Additional Beds

The proposed project is considered to be the establishment of a new hospital because it involves the construction of the replacement hospital on a new site. This new site is much more accessible to the population of the planning area for two reason.

1. The existing site is located in a residential area in the center of the community and is not on one of the main arterial roads of the community. It is located on two lane residential streets which can be congested with parked cars on one or sometimes both sides of the road. While the signage enables people to find the hospital it can be somewhat confusing in stressful emergency situations for people unfamiliar with the community.

   The existing hospital's large service area for services such as Rebabilitation, Cardiac Catheterization and Cardiac Surgery make this location more of a problem since it brings many more patients who are unfamiliar with the community into the hospital.

2. The proposed location will be adjacent to a new off-ramp to Interstate 57 will make the facility more visible and much easier to access. Mt. Vernon's location at the intersection of two major interstate highways, I-57 and I-64 means that this area has a high concentration of traffic which leads to more traffic accidents and locating this facility adjacent to the interstate will make the job of getting a patient to the hospital for emergency workers much easier.

The proposed project will actually reduce the number of beds overall in the planning area while increasing the number of ICU and Obstetric beds. A discussion of the need for these additional beds occurs elsewhere in this application, but the two services are being increased for similar reasons. As more and more of the smaller hospitals in Southern Illinois become critical access hospitals with a very limited number of beds and short lengths of stay, the number of beds needed at the remaining hospitals for Obstetrics services and for those patients needing more intensive care continues to rise. The hospital can no longer afford to go on by-pass for even a short period of time as there is no place else for the patient to go for care within a reasonable travel time.

These additional beds are also essential for the recruitment of new physicians to the area. Again new physicians are needed in the specialty services which often involve ICU care and in Obstetrics where Southern Illinois has always had a problem recruiting and retaining Obstetricians which results in many hospitals over the years closing their services due to having no physicians. The location of this new facility will also improve access to mothers coming from different parts of the planning area to deliver their babies.

SECTION VII. REVIEW CRITERIA RELATING TO ALL MODERNIZATION PROJECTS (MOD)

This section is applicable to all projects proposing modernization. Modernization includes, but is not limited to: expanding a department, acquiring major medical equipment, remodeling, or constructing additions or new buildings.

A. Specific Information Requirements

Indicate if the following areas or departments are to be modernized and provide the information as applicable.

1 AMBULATORY CARE (Include all outpatient clinics) -- Is this area being modernized? Yes ☐ No ☒

If yes, provide:

a. The number of visits for each of the last three years:

Year	____	____	____
Number	____	____	____

b. The number of treatment/examination rooms: Existing _____ Proposed _____

2. AMBULATORY SURGERY TREATMENT CENTERS-- Is this area being modernized? Yes ☐ No ☒

If yes, provide:

a. The number of procedures for each of the last three years:

Year	____	____	____
Number	____	____	____

b. The number of visits for each of the last three years:

Year	____	____	____
Number	____	____	____

c.. The number of operating rooms for each of the last three years:

Year	____	____	____
Number	____	____	____

3. CARDIAC CATHETERIZATION -- Is this area being modernized? Yes ☒ No ☐

If yes, provide the number of inpatient, outpatient, and total procedures (patient visits) performed on adults and on pediatric patients for each of the past three years:

	ADULT			PEDIATRIC **not applicable**			
Year	2005	2006	2007	Year	____	____	____
Inpatient	873	915	700	Inpatient	____	____	____
Outpatient	376	349	387	Outpatient	____	____	____
Total	1,249	1,264	1,087	Total	____	____	____

4. EEG DEPARTMENT OR AREA -- Is this area being modernized? Yes ☒ No ☐

If yes, provide the number of inpatient, outpatient, and total procedures for each of the past three years:

Year	2005	2006	2007
Inpatient	158	154	182
Outpatient	106	142	137
Total	264	296	319

5. EKG DEPARTMENT OR AREA -- Is this area being modernized? Yes ☒ No ☐

If yes, provide the number of inpatient, outpatient, and total procedures for each of the past three years:

Year	2005	2006	2007
Inpatient	12,726	11,819	12,643
Outpatient	8,798	8,531	8,073
Total	21,560	20,350	20,716

6. HEMODIALYSIS SERVICES -- Is this area being modernized? Yes ☒ No ☐

If yes, provide the following information:

a. The number of treatment stations: existing 4 proposed 4
b. The number of treatments performed for each of the last three years:

Year	2005	2006	2007
Treatments	1,217	1,367	1,430

7. LABOR-DELIVERY-RECOVERY -- Is this area being modernized? Yes ☒ No ☐

If yes, provide the following information:

a. The number of

Labor rooms	____
Delivery/birthing rooms	____
Recovery stations	____
LDR's	5*
LDRP rooms	6**

* Number of existing rooms
** Number of Proposed Rooms

b. The number of procedures and deliveries for each of the last three years:

Year	2005	2006	2007
Procedures	____	____	____
Deliveries	689	724	781

8. LABORATORY SERVICES -- Is this area being modernized? Yes ☒ No ☐

If yes, provide the number of equivalent full-time employees (FTE's) employed in the laboratory 36

9. MAGNETIC RESONANCE IMAGING -- Is this area being modernized? Yes ☐ No ☒
MRI will be located in Medical Office Building and is discussed in that CON.

If yes, provide the following information for each of the last three years:

Year			
Number of visits			
Number of scans			

10. NURSERY (other than neonatal intensive care units) -- Is this area being modernized? Yes ☒ No ☐

If yes, provide the following for each of the last three years:

Year	2005	2006	2007
Number of newborns	689	724	787
Number of patient days	1,178	1,253	1,330

11. OCCUPATIONAL THERAPY -- Is this area being modernized? Yes ☒ No ☐

If yes, provide the following information for each of the last three years:

Year	2005	2006	2007
Inpatient treatments	7,050	7,793	7,308
Outpatient treatments	993	753	718
Number of visits	8,043	8,546	8,026

12. PHYSICAL THERAPY -- Is this area being modernized? Yes ☒ No ☐

If yes, provide the following information for each of the last three years.

Year	2005	2006	2007
Inpatient treatments	17,033	17,368	17,029
Outpatient treatments	4,116	3,818	4,325
Total treatments	21,149	21,186	21,354
Number of visits	21,149	21,186	21,354

13. PULMONARY FUNCTION -- Is this area being modernized? Yes ☒ No ☐

If yes, provide the following information for each of the last three years.

Year	2005	2006	2007
Inpatient procedures	196	173	151
Outpatient procedures	997	793	828
Total procedures	1,193	966	979
Number of visits	1,193	966	979

14. RECOVERY (SURGICAL) -- Is this area being modernized? Yes ☐ No ☐

If yes, provide the existing and proposed number of stations by type:

	Existing	Proposed
Inpatient		9
Outpatient Stage 1		
Outpatient Stage II		

15. RESPIRATORY THERAPY -- Is this area being modernized? Yes ☒ No ☐

If yes, provide the following information for each of the last three years.

Year	2005	2006	2007
Inpatient treatments	79,781	79,797	90,681
Outpatient treatments	2,520	3,225	2,329
Total treatments	82,301	83,022	93,010
Number of visits	82,301	83,022	93,010

16. DIAGNOSTIC RADIOLOGY -- Is this area being modernized? Yes ☒ No ☐

If yes, provide the following information classifying procedure rooms as general or special according to the type of machines employed.

General machines are:
-Radiographic
-Fluoroscopic
-Radiographic/Flouroscopic
-Tomographic (linear)

Special machines are:
-Angiographic
-CT Scanner
-Mammography
-Sonographic (ultrasound)
-Tomographic (multi-directional)

a. Provide the number of existing and proposed general procedure rooms by machine type.

b. Provide the number of existing and proposed special procedure rooms by machine type.

APPEND DOCUMENTATION AS ATTACHMENT MOD-1A AFTER THE LAST PAGE OF THIS SECTION.

17, EMERGENCY SERVICES -- Is this area being modernized? Yes ☒ No ☐

If yes, provide the following information:

a. The number of existing and proposed treatment/examination rooms;
b. A list of any of the above rooms that are or will be used for purposes other than general treatment;
c. The number of visits for each of the last three years.

APPEND DOCUMENTATION AS ATTACHMENT MOD-1B AFTER THE LAST PAGE OF THIS SECTION.

18. INPATIENT BED AREA -- Is this area being modernized? Yes ☒ No ☐

If yes, provide the following information:

a. The number of existing and proposed private rooms, semi-private rooms, and three or more occupancy rooms (by category of service for each type of room) for the entire facility and for the project;

b. Line drawings showing the configuration of the unit(s) being modernized.

APPEND DOCUMENTATION AS ATTACHMENT MOD-1C AFTER THE LAST PAGE OF THIS SECTION.

19. NUCLEAR MEDICINE -- Is this area being modernized? Yes ☒ No ☐

If yes, provide the following information:
A list of the existing and proposed major pieces of equipment;

a. The existing and proposed number of procedure rooms;
b. The number of inpatient, outpatient, and total procedures done for each of the last three years;
c. A breakdown of the procedures into types of procedures and machine time/procedure for the last year.

APPEND DOCUMENTATION AS ATTACHMENT MOD-1D AFTER THE LAST PAGE OF THIS SECTION.

20. RADIATION THERAPY -- Is this area being modernized? Yes ☐ No ☒

If yes, provide the following information:

a. The number of treatments and the number of "courses of treatment" for each of the last three years;
b. A list of the existing and proposed pieces of megavoltage equipment.

APPEND DOCUMENTATION AS ATTACHMENT MOD-1E AFTER THE LAST PAGE OF THIS SECTION.

21. SURGERY -- Is this area being modernized? Yes ☒ No ☐

If yes, provide the following information:

a. The existing and proposed number of procedure rooms. Indicate the use of these rooms such as general, open heart, eye, endoscopy, and cystology. Indicate how many rooms are dedicated solely to outpatient surgery, solely to inpatient surgery, and how many are used for both.
b. The inpatient, outpatient, and total hours of utilization (including clean-up and set-up time) for each of the last three years;
c. The total hours of utilization (including clean-up and set-up time) for each type of procedure room for each of the last three years;
d. The number of inpatient, outpatient, and total surgical visits for each type of surgical specialty for each of the last three years.

APPEND DOCUMENTATION AS ATTACHMENT MOD-1F AFTER THE LAST PAGE OF THIS SECTION.

22. OTHER DEPARTMENTS OR AREAS – Are any other areas being modernized? Yes ☒ No ☐

If yes, identify the area(s) and provide workload data for each area for each of the last three years.

APPEND DOCUMENTATION AS ATTACHMENTS MOD-1G, MOD-1H, MOD-1I, MOD 1J, etc. AFTER THE LAST PAGE OF THIS SECTION.

DIAGNOSTIC RADIOLOGY

Room Type	No. Of Rooms Existing	Proposed	Volume 2005	2006	2007
General X-ray/ Fluoroscopy	3	6*	33,545	31,686	31,835
Mammography	2	3**	6,548	6,702	7,207
Ultrasound	3	5***	7,040	7,342	8,273
Angiography	1	1	1,108	1,103	1,105
CT	2	2****	12,469	10,996	12,592

* 3 of the general X-ray units will be located in the new hospital and 3 will be located in the outpatient imaging center in the proposed MOB

**All three of the Mammography Units will be located in the Women's Center in the MOB and will be discussed in that CON.

*** 2 of the ultrasound units will be located in the hospital and three will be located in the MOB.

**** 1 CT will be located in the hospital and 1 will be located in the MOB

EMERGENCY SERVICES

The existing facility currently has 14 treatment rooms and is proposing to have 18 treatment rooms.

The historical volume for this department is shown on the following table.

Year	Volume -Visits
2005	23,952
2006	24,072
2007	24,679

ATTACHMENT MOD-1B

INPATIENT BED AREA

None of the existing inpatient bed units are being modernized. They are all being replaced in a new hospital. The new replacement hospital will have 100% private beds.

Schematic drawings for the new hospital are appended to the application.

ATTACHMENT MOD-1C

NUCLEAR MEDICINE

The existing facility has 3 rooms and the new replacement facility is also proposing to have 3 rooms. The existing facilities historical volume is shown on the following table:

Year	Volume - Procedures
2005	3,914
2006	3,208
2007	3,521

Good Samaritan
Chargemaster for Dept 4204
Printed 6/10/08@10:10 am.

NOTES:
changing collimators takes a long time for higher energy treatments
Myocardial procedures require IV start times prior to treatment beginning

ATTACHMENT MOD-1D

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PROCEDURES

FIM_CODE	PATIENT TRMT TIME IN HOURS	2007 Volume	Extended Time	SIM_DESC	SIM_DPT	HCPCS_ CODE	Categories of Care	Often have to change collimators for these procedures	UB_COD E	VAR_PRC_1	REV_CODE	ALT_CDS
420478100	0.5	107	53.50	NM THYROID UPTAKE	RAD	78000	Endocrine		341	201	4204	WP
420478010	1	107	107.00	NM THYROID SCAN ONLY	RAD	78010	Endocrine		341	525	4204	WP
420478070	3	13	39.00	NM PARATHYROID	RAD	78070	Endocrine		341	1208	4204	WP
420478195	3	29	87.00	NM LYMPHATICS LYMPH GLAND IMAGING	RAD	78195	Tumor		341	2193	4204	WP
420478216	1.25	2	2.50	NM LIVER SPLEEN SCAN	RAD	78216	GI		341	1257	4204	WP
420478220	1.5	60	90.00	NM HEPATOBILIARY SCAN	RAD	78220	GI		341	1284	4204	WP
420478223	3	318	954.00	NM HEPATOBILIARY FUNCTION SCAN	RAD	78223	GI		341	1562	4204	WP
420478284	2.5	16	40.00	NM GASTRIC EMPTYING STUDY	RAD	78284	GI		341	1467	4204	WP
420478278	2	14	28.00	NM GI BLOOD LOSS	RAD	78278	GI		341	900	4204	WP
420478290	3	1	3.00	NM MECKELS SCAN	RAD	78290	GI		341	1028	4204	WP
420478300	3	20	60.00	NM BONE SCAN LIMITED AREA	RAD	78300	Skeletal		341	760	4204	WP
420478306	3	450	1,350.00	NM BONE SCAN TOTAL BODY	RAD	78306	Skeletal		341	1181	4204	WP
420478315	3	86	258.00	NM BONE IMAGING 3 PHASE	RAD	78315	Skeletal		341	1191	4204	WP
420478320	3	11	33.00	NM BONE SCAN W/SPECT	RAD	78320	Skeletal		341	2054	4204	WP
420478461	3	2	6.00	NM MYOCARDIAL REDISTRIBUTION MULT	RAD	78461	Cardiology		341	1131	4204	WP
420478464	3	2	6.00	NM MYOCARDIAL SPECT STRESS OR RES	RAD	78464	Cardiology		341	1023	4204	WP
420478465	1.5	630	945.00	NM MYOCARDIAL SPECT MULTI	RAD	78465	Cardiology		341	2727	4204	WP
420478466	6	1	6.00	NM MYOCARDIAL IMAGING INFARCT	RAD	78466	Cardiology		341	686	4204	WP
420478472	1	116	116.00	NM CARDIAC BLOOD POOL	RAD	78472	Cardiology		341	1932	4204	WP
420478478	1	632	632.00	NM MYOCARDIAL PERF W/WALL MOTION	RAD	78476	Cardiology		341	558	4204	WP
420478460	1	832	832.00	NM MYOCARDIAL PERF W/EJECTION FRA	RAD	78460	Cardiology		341	558	4204	WP
420478580	1	104	104.00	NM LUNG PERFUSION	RAD	78580	Pulmonary		341	1082	4204	WP
420478587	1	103	103.00	NM LUNG VENTILATION MULTI PROJ	RAD	78587	Pulmonary		341	760	4204	WP
420478704	1	16	16.00	NM RENAL W/FUNCTION	RAD	78707	Urology		341	1214	4204	WP
420478726	1.5	25	37.50	NM RENAL W/PHARMAC INTERVENTION	RAD	78708	Urology		341	1214	4204	WP
420478800	4	1	4.00	NM TUMOR LOCALIZATION LIMITED	RAD	78800	Tumor	xx	341	1800	4204	WP
420478801	4	1	4.00	NM TUMOR LOCALIZATION MULTIPLE	RAD	78801	Tumor	xx	341	1666	4204	WP
420478802	3	5	15.00	NM TUMOR LOCALIZATION WHOLE BODY	RAD	78802	Tumor	xx	341	1797	4204	WP
420478806	3	6	18.00	NM ABSCESS LOCALIZATION WHOLE BOD	RAD	78806	Infection	xx	341	4340	4204	WP
420479001	1	6	6.00	NM HYPERTHYROIDISM THERAPY INITIA	RAD	79005	Therapy		342	1811	4204	WP
420479100	1	1	1.00	NM P-32 THERAPY	RAD	79101	Therapy		342	1374	4204	WP
420408375	1	4	4.00	NM HELICOBACTER PYLORI BREATH	RAD	83014	GI		300	600	4204	WP
		3,521	5,760.50									

SURGERY

Specialty	Number of Rooms		Hours of Surgery - Inpatient			Hours of Surgery - Outpatient		
	Present	Proposed	2005	2006	2007	2005	2006	2007
Cardiovascular	1	1	142	575	952	8	24	47
General	7	4	3,479	2,376	4,187	4,456	5,503	6,519
Urology / Cystoscopy	1	1	203	288	536	405	501	846

In addition to the surgery rooms offered in the hospital 3OR's and two minor procedure rooms will be provided in the ASTC which is proposed to be located in the Medical Office Building adjacent to the new replacement hospital and will be discussed in a separate CON application..

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Pharmacy

The pharmacy is meant to serve only the patients of the hospital, therefore the only apparent measure of need is the utilization of the hospital. The following table shows the number of inpatient admissions and the number of outpatient visits for each of the last three years.

Year	Inpatient Admissions	Patient Days Total	Outpatient Visits
2005	7,237	31,422	59,445
2006	7,440	31,270	76,683
2007	7,965	32,610	78,127(at the hospital)

Endoscopy

The applicant currently has 2 endoscopy rooms, and will continue to have 2 endoscopy rooms in the new facility. The utilization for the endoscopy Service is shown below:

Year	Hours of Utilization
2005	1,498
2006	1,329
2007	1,336

ATTACHMENT MOD-1H

Infusion Services

The Infusion services volume for each of the last three years is shown below

Year	Volume
2005	5,262
2006	4,704
2007	6,351

ATTACHMENT MOD-1I

Cardiac Rehabilitation

The cardiac rehabilitation voulme for each of the last three years is shown below.

Year	Volume
2005	1,362
2006	1,412
2007	1,765

ATTACHMENT MOD-1J

Speech Therapy

The volume for this department is as follows:

	2005	2006	2007
Inpatient	2,058	2,482	2,007
Outpatient	1,374	1,239	1,015
Total	3,432	3,721	3,002

ATTACHMENT MOD-1K

B Criterion 1110.420.b, Modern Facilities

A criterion must be claimed for EACH department or area to be modernized. The justification for each department or area must be on a separate page. Choose the criterion or criteria which most clearly approximates the reason for proposing the modernization.

At least ONE of the following two criteria must be claimed for EACH department or area proposed for modernization.

1. Read criterion 1110.420.b.1. **This criterion cannot be used to justify any increase in square footage. If expansion of a department is proposed, criterion 1110.420.b.2 must be claimed.**

   Indicate if this criterion is claimed and submit the following:

   a. the age of the building or piece of equipment;

   b. the downtime experienced on the piece of equipment for each of the last three years;

   c. the cost of repair experienced on the piece of equipment for each of the last three years;

   d. a detailed explanation of why and how it was determined that the building or piece of equipment was deteriorated and needs to be replaced;

      (a) provide copies of any licensing, certification, or fire protection citations.

APPEND DOCUMENTATION AS <u>ATTACHMENT MOD-2</u> AFTER THE LAST PAGE OF THIS SECTION.

2. Read Criterion 1110.420.b.2. Identify if this criterion is claimed and submit the following information:

   a. a detailed explanation of why and how it was determined that expansion of the department or area was necessary;

   b. a discussion of the alternatives considered to expanding the department (e.g. increasing the hours or days of operation) and why the alternatives were rejected.

APPEND DOCUMENTATION AS <u>ATTACHMENT MOD-3</u> AFTER THE LAST PAGE OF THIS SECTION.

C. Criterion 1110.420.c, Major Medical Equipment

Read Criterion 1110.420.c and provide documentation that the equipment will achieve or exceed the applicable target utilization levels specified in Appendix B of Part 1110 within 12 months after becoming operational.

APPEND DOCUMENTATION AS <u>ATTACHMENT MOD-4</u> AFTER THE LAST PAGE OF THIS SECTION.

Criterion 1110.420.b.2, Necessary Expansion

This criterion is chosen for all of the services in the new Replacement Hospital because it best describes the reasons why the hospital is being proposed for replacement. In general the hospital is inadequately sized and configured to serve the needs of the hospital's patients in an efficient and cost effective manor. While the building itself is old and its infrastructure is in need of replacement, that is only part of the information used to decide to replace the building. There is a need to provide more space so that patients can be treated in private rooms, the individual departments such as Emergency, Diagnostic Imaging, Surgery, etc. are undersized to accommodate the equipment used in today's health care environment, and are not designed to serve the increasing outpatient utilization in their present configuration. These conditions can not be addressed in the present location as the site is too small and does not lend itself to expansion beyond its current configuration.

The individual departments involved in this department are discussed in detail in the following pages.

A. Pharmacy

The pharmacy is proposed to be used to supply all pharmaceutical supplies required for the treatment of inpatients and for the use by outpatients who are seen by the physicians at the hospital or in the Emergency Department. This department will not be a retail pharmacy.

The department will be located on the Garden or lowest level of the hospital in close proximity to the material management department with convenient vertical access to the emergency department , surgery, and the bed units.

This department is an essential part of the provision of inpatient care as well as to the provision of emergency care. It is a department which is included in every new hospital and as such is needed in this hospital.

B. Central Sterile Supply

This department will be located on the Garden level of the hospital and will have direct vertical access to the cardiac catheterization Labs, The Surgery, and the outpatient services (endoscopy, and minor procedure) departments. The department will also be located in close proximity vertically to the Emergency Department.

The department will be responsible for providing sterile packs to the various departments in the hospital. The department will also house the sterilization equipment used to sterilize instruments and other re-usable supplies to these departments.

Again this department is an integral part of all hospitals. Even with today's reliance on disposable supplies the sterilization of equipment and supplies must be done, and this department is also responsible for preparing the packages of disposal for use in the other departments of the hospital.

C. Outpatient Testing

This department will be located on the first floor adjacent to the main entrance to the hospital. This will be where the patients go for their pre-admission testing, to have blood drawn, to answer questions, provide medical histories, etc,.before they are admitted to the hospital, for any type of elective procedure, whether it be inpatient or outpatient. All of the testing here will be done on an outpatient basis.

This department provides a central location for patients who are coming into the hospital, many for the first time, to be met and escorted to the various departments where the testing will actually take place.

This department will have small rooms where blood can be drawn or where patients can answer the medical questions they or the hospital may have in privacy which is not now available at the existing hospital Absent this department, patients would have to find their way to the various departments for their tests, and in many cases would have to answer the same questions multiple times. With this department the patient can have a much less stressful visit for these pre-admission tests while providing all of the information necessary to admit the patient for their actual procedure at a single location.

The requirements for privacy advanced by HIPAA require that the hospital provides private spaces for the taking of the pre-admission information. This department will allow that to be provided in an efficient manner.

D. Outpatient Prep and Recovery

This department is where outpatients requiring special procedures such as endoscopy, bronchoscopy, cardiac catheterization, etc, are prepared for the procedure and come back to for recovery. This department is outside of the PACU and stage two recovery areas for surgery. It basically consists of small rooms with a dressing area, a recliner or a space for a stretcher. These areas are monitored by the nursing staff and the patients are directly discharged from this area.

In 2007 the hospital had 1,330 outpatient endoscopy patients; 1,087 Catheterization patients and 712 angiography patients, in addition the applicant also has a contract with Archway Associates of Saint Louis to perform lithotripsy procedures and in 2007, 184 of those procedures were performed. All of the endoscopy patients a large percentage of the cardiac cath patients, many of the angiography patients and all of the lithotripsy patients will pass through this department many going into surgery, and again for recovery before they can be released to go home. This department by its nature has daily peaks and valleys in terms of occupancy with the early morning hours being the busiest and weekends being very quiet. Therefore the department must be built large enough to accommodate the busy times.

Again this department is an integral part of any modern health care facility with a strong outpatient department.

E. Infusion Center

This department will have five treatment stations on the first floor of the hospital and will be on a hallway that directly connects to the Medical Office Building This unit will be isolated somewhat from the rest of the hospital as many times the patients receiving care in this area have compromised immune systems which would make it dangerous for them to be in close contact with other hospital patients.

This department will also be located on an outside wall of the hospital in order to provide the patients with exterior views . These patients are sometimes in the treatment rooms for several hours and this view to the outside is essential in their treatment.

The historical volume for this department for 2007 total 6,351 visits for an average of 24.4 visits per day 260 work days per year (5 days per week X 52 weeks). This volume would mean that, based upon an average time of 1.5 hours per patient, including setting up the room before each patient would mean that the rooms would be occupied 92% of the time.

The five rooms proposed are necessary to support the existing volume of infusions and that volume has increased from 5,262 visits in 2005 to 6,351 visits in 2007, and it is expected to continue to increase as the patients' age and new forms of chemotherapy are developed.

F. Outpatient Procedure Rooms.

This department will house the four procedure rooms, two rooms will be set-up to perform endoscopy procedures, one room will be used for pulmonary function testing and one room will be used for minor procedures not done in the surgery requiring only local anesthesia.

The existing facility performed a total of 1,336 hours of endoscopy in 2007 which was a 13% increase from the year before. It is projected that the volume will surpass the 1,500 hours of utilization level which justifies a second room by 2010 based upon a conservative increase of 4% per year. This increase is based upon the increase in population projected for the area approximately 2.2% over those 3 years, the increase in the population age 65 and over up which is projected to increase by 10% over those same three years. When these two population increases are taken into consideration along with an increase in the use of colonoscopies as a screening test the 4% increase in volume is very conservative.

The pulmonary function testing volume has remained relatively constant between 966 procedures and 1,193 procedures over the last three years with the volume in 2007 at 979 procedures. This volume supports the need for one room for this procedure.

The one room proposed for minor procedures is new and no historical volume is available, however, based upon discussions with our physicians it was determined that one room was need to allow these procedures to be performed outside of the physicians' offices.

G. Cardiac Catheterization

The hospital currently has two Cardiac Catheterization units in the existing building and the new replacement hospital will also have two cardiac catheterization laboratories. The applicant's 2007 volume totaled 1,087 visits. Based upon the State standard for Cardiac Catheterization of 400 procedures per machine the applicant can justify up to 3 laboratories.

H. Diagnostic Radiology

The applicant is proposing to have 1 angiography room, 1 Radiographic /Fluoroscopic Unit, 1 General X-ray Unit, Chest X-ray Unit, 2 ultrasound units, and 1 CT Scanner in this department in the hospital. The hospital is proposing to have an outpatient Imaging Department in the MOB which will be discussed in that application.

The applicant's 2007 workload for general X-ray units total 12,389 exams for inpatients which, based upon the State standard of 6,500 procedures justifies only two of the three general units proposed by the applicant. However, each of the three units proposed to be located in the hospital serves a different purpose and all three are needed to support the applicant's inpatient and Emergency Department workload. The units, while capable of doing some of the same procedures, are much more efficient when used in their standard configuration.. The hospital will have a total of 5 ultrasound rooms counting the three units in the outpatient imaging department and the combined total volume for 2007 was 8,273 exams, which based upon the State Norm of 2000 exams per piece of equipment justifies 4.2 or 5 rooms.

The applicant's 2007 CT volume totaled 3,864 procedures performed on inpatients and 8,728 performed on outpatient. These volumes together justify up to 6.2 or 7 units based upon the State standard of 2,000 procedures per unit per year. The applicant is proposing to have 1 unit in the hospital and 1 unit in the MOB.

The applicant is proposing to have 1 angiography room in the hospital and none in the MOB. The 2007 hospital volume totaled 1,105 procedures, which based upon the State Norm of 400 procedures per machine would justify up to 3 angiography rooms in the hospital.

I. Cardiac Diagnostic Testing

The applicant is proposing to have 5,131 GSF to house this unit, which will have space for stress testing, echocardiography testing, general EKG testing, storage space for the cardiology equipment and support space for the staff of the diagnostic cardiology department.

The workload for this department for 2007 totaled 20,716 procedures both inpatient and outpatient. With the hospitals busy cardiology department including two cardiac catheterization labs and an open heart surgery program, this space is needed to meet the patients needs for both pre and post surgery and catheterization testing. Patients are routinely followed up subsequent to Open Heart Surgery and following therapeutic catheterizations.

Utilizing this department to determine which patients might need a catheterization or surgery is equally important to the follow-up care. If a catheterization can be avoided utilizing other less invasive testing methods, both time and money can be saved and the patient can avoid the risks associated with an invasive procedure.

This department, in conjunction with the cardiac catheterization service and the Open Heart Surgery Program offers the full range of cardiac care in one location convenient to the population of the planning area.

J. Nuclear Medicine

The hospital currently has three pieces of nuclear medicine equipment and will have three pieces of equipment in the new facility.

The proposed plan is to have two identical dual camera nuclear medicine rooms (A and B) that would perform the majority of all requested studies (79%) utilization of each room. We have proposed a third room ©) with only a single camera nuclear medicine machine system that would be configures for specialty studies (20%). These are longer duration studies that require a change in columnator configurations and calibration. These changes add 30 minutes each to the set-up and take-down of the configuration if the studies were performed on the routine (room A&B) system. By having Room C configured and calibrated will eliminate the set-up and take-down time for the 1.4 procedures performed per day.

The space difference is negligible as evidenced by the fact that the State Norm for Nuclear Medicine calls for 1,135 GSF per room which would allow the hospital to have 2,270 GSF for two units and the hospital is proposing to house the three units in only 2,140 GSF.

It is the most cost effective and efficient alternative available to the applicant to utilize the three units rather than the two the State Standard would allow. Note if only the special camera and one of the other two units was utilized the one unit would be operating at more than 100% occupancy.

K. Emergency Department

The existing facility currently has 14 treatment rooms and is proposing to have 18 treatment rooms.

The historical volume for this department is shown on the following table.

Year	Volume -Visits
2005	23,952
2006	24,072
2007	24,679

Of the 18 treatment rooms proposed 1 room is dedicated to trauma patients with a second room for backup. The proposed back-up trauma room would be used for general emergency treatment unless the trauma room is being used. Then this proposed second room would be used as a back-up trauma room. Another room is designed for privacy for use as a Women's crisis treatment room (Rape Victims or domestic abuse). A third room will not be set up specifically for treatment but will be used as a dedicated Behavioral Holding Room (a safe room to lock a disruptive patient in until the police can arrive.).

In all, three rooms will be dedicated and will not be used for routine treatment rooms.

Based upon the State Standard of 2,000 visits per room per year the 2007 workload justifies 13 rooms. However, as has been put forth in several of the applications considered by the IHFPB in the last two years, a more commonly accepted standard is 1,500 visits per room per year which would justify 17 rooms at the applicant facility, based upon the 2007 workload. Even if all of the specialty rooms are counted except for the single holding room where no treatment is actually taking place, the applicant is proposing to have only 17 treatment rooms which is consistent with the 1,500 procedure standard .

L. EMS Facilities

This area consists of a small 390 GSF area which will be utilized by the EMS call system and EMS personnel when they are at the hospital making their reports and awaiting the return of their equipment or picking up supplies. It will be located adjacent to the Emergency Department, but will not be used for patient care or treatment.

M. Observation Beds

This area consists of four rooms with a capacity for two beds in each room. These beds will be utilized for the observation of patients who have not yet been admitted to the hospital. These patients are currently placed in inpatient beds on the patient floor or they are held in the ER treatment rooms until a bed can be found or they are released.

The patients will not be held for more than 23 hours in these rooms and they will be monitored by staff which can also be used in the ER if needed.

The establishment of this unit will allow for shorter waiting times in the ER and reduce the expense of transporting patients to the bed floors when they may or may not be admitted. This unit will also help the hospital to keep from having to go onto diversion (by-pass) due to lack of staff or available beds by maintaining open beds on the patient floors rather than utilizing them for these observation patients.

This unit is especially helpful when the hospital discontinues the pediatric unit because many times pediatric patients are admitted for very short stays and the observation unit could be used to monitor these patients and prevent them from being admitted when they can be stabilized and sent home for care.

The patient observation days for 2007 were as follows: 509 MS, 36 Peds, 4 ICU, and 88 in OB. This does not include any patients who were held in the Emergency room for observation. These patients could now be cared for in the observation unit with no disruption on the patient floor and with better resources for testing at there immediate disposal. This location also allows the Emergency Room physicians to continue to monitor the patients and be close at hand in case of an emergency involving the patient.

The four rooms are in one pod which makes it easy to segregate the patients as needed for isolation or differences in age or sex of the patient. The State Board does not publish utilization standards for this type of bed, but this unit appears to be the ideal size to handle virtually any observation scenario.

N. Surgery

The hospital is proposing to have 4 General Surgery Rooms, one dedicated Open Heart Surgery Room, and one dedicated Cystoscopy room. The ASTC in the adjacent MOB is projecting to perform 6,295.5 hours of surgery which if removed from the hospitals 2007 volume would leave 6,701.5 Hours to be performed in the hospital based upon the State Standard of 1,500 hours of surgery per year per room this workload would justify 4.46 or 5 rooms needed. However, if the two dedicated rooms and their volumes are removed from the hours of surgery the applicant's 2007 workload would be 4,320 hours which would justify three of the four rooms proposed.

As has been discussed elsewhere in the application the population of the planning area is projected to grow by 3.5 % between now and the opening of this hospital with another 2.5 % over the first three years of operation of the new hospital with the population over the age of 65 to grow at nearly twice that rate. If one only considers the smaller growth in the overall population the applicant's workload would be above the State standard (5,533 hours ÷1,500 hours per year per room = 3.02 or 4 rooms needed.) by the second year after project completion. It is unreasonable to build a new hospital which will already be inadequately sized within a two year period.

ATTACHMENT MOD-3

O. Surgical Prep and Stage II Recovery

This department will be used for the patients who come into the hospital the day of their surgery. The patients will be shown to a small room where they change from their street clothes into the gowns they will wear when they are transported to surgery. They will then be prepared for surgery with IV's started and any other pre-anesthesia medication administered. They will also meet here with their physician, or his representative and with a member of the anesthesiology department to go over what is going to be done and to answer any final questions they may have before surgery.

The patients will be transported from this area into surgery where they will have their procedure performed and then they will go to the PACU for stage one recovery and either be sent to their hospital room for stage two recovery or if they area an outpatient they will come back to this department for stage II recovery.

This department will have 11 bays which is less than two bays for each of the 6 OR's. These bays will be highly utilized throughout the morning when patients will be arriving, and again when the patients come into Stage II recovery. The PACU will have only 9 recovery rooms, so the two recovery areas will have a total of 20 bays for 6 operating rooms the Illinois Department of Public Health Establishes a recommended level of 4 bays per OR, which is above the applicant's 3.3 bays per OR, this can be accomplished due to the fact that most of the outpatient surgery will be performed in the ASTC in the adjacent MOB. The ASTC has its own recovery and prep area.

P. Recovery

The applicant is proposing to have a stage one recovery area with 8 bays and one isolation bay. This is very near the minimum number of recovery stations allowed by licensure and again can be accomplished due to the fact that the majority of the outpatient procedures, which normally have the quickest turn over in the OR's are done in the ASTC in the adjacent MOB. The ASTC has its own recovery area totally separate from the hospital based PACU.

A stage I recovery area is mandated for a hospital which performs surgery. Therefore, this unit is required and based upon licensure standards the 9 recovery stations are needed.

Q. Hemodialysis - Inpatient

The applicant is proposing to have an inpatient dialysis unit with 4 stations in a total of 1,200 GSF. The 2007 workload totaled 1,430 treatments.

The patients cared for in this unit will be patients who come into the hospital already on dialysis and those patients who because of kidney failure during their hospital stay require dialysis treatment. Dialysis treatment takes several hours for each treatment and a schedule of treatment must be maintained for patients once treatment is started. There must also be back-up equipment available in case of an emergency.

Based upon a 6 day per week schedule the 2007 volume would mean that on average 4.6 patients per day utilize the 4 stations proposed. However, inpatient dialysis does not maintain the same type of schedule that a freestanding dialysis unit would have, as people leave the hospital and go back to their regular dialysis facilities, the utilization of these units go up and down. Many times these units are utilized by two patients in the same day, or in some cases not utilized at all that day. The department must have sufficient capacity to handle the peak workloads. After reviewing the historical utilization patterns at the hospital it was determined that the four units would be the number required to meet the peak utilization times.

R. Respiratory Therapy

The applicant is proposing to place this department on the second floor of the new hospital directly below the patient bed floors. This department will occupy 1,344 GSF which is used primarily for the storage of supplies and equipment and for work space for the Respiratory Therapists. The majority of the treatments take place in the patient rooms.

In 2007 the department was responsible for 93,010 treatments. The majority, 90,681 were performed on inpatients with the remaining 2,329 performed on outpatients. The outpatients are treated within the department in most instances, so some treatment space is required.

The State Norm for is 20.5 procedures per GSF. The 2007 workload at the hospital would, based upon this standard justify 4,537 GSF which is substantially more than the applicant proposes. This can only be accomplished by the ability to maintain some equipment in the patient rooms since all of the new patient rooms will be private and by efficiently utilizing the space in the unit.

S. Physical Therapy

The applicant is proposing to have this department located on the third floor of the hospital between the Rehabilitation bed unit and the Medical Surgical Bed unit on that floor.

This department will be used solely for inpatients and is needed to support the proposed Rehabilitation Service. While, it will also serve the inpatient rehabilitation needs of the hospital's other inpatients, its primary purpose is to provide space for the rehabilitation of patients in the Comprehensive Rehabilitation unit.

In 2007 the inpatient workload for this department total 17,029 visits which based upon the State standard of 7.5 visits per GSF would justify 2,270.5 GSF while the applicant is proposing to have only 1,200 GSF. The difference is in the fact that the State Norm includes the outpatient space which is normally larger due to the need for changing rooms, and larger exercise spaces as the patients progress, and in this hospital that space is to be provided in the outpatient rehabilitation department in the MOB.

The hospital's proposed Comprehensive Rehabilitation Bed Unit requires that the applicant have an active Physical Therapy Department and an Occupational Therapy Department. The existing hospital provides both of those services and the new hospital will also have those services available.

T. Occupational Therapy

The applicant is proposing to located this department immediately adjacent to the Physical Therapy Department in 444 GSF. This department will be used solely for the inpatients of the hospital and will be separate from the outpatient Occupational Therapy area which is located in the MOB which is attached to the hospital.

This unit is required in order to provide "Comprehensive Rehabilitation Services" as proposed by the applicant. The square footage proposed is the minimum amount of space needed to provide this service and is supplemented on an outpatient basis by the department in the MOB. This unit provides basic occupational therapy with the more comprehensive program provided through the outpatient unit.

The inpatient program is designed to provide services which will enable the patient to be discharged where they will then be provided further services on an outpatient basis.

U. ICU Beds

The applicant is proposing to increase the number of inventoried ICU beds from 10 to 16. The IHFPB Inventory of Health Care Facilities shows that a need for one additional bed in the applicant's F-004 Planning Area.

The 2007 workload for this department totaled 3,128 patient days. Based upon the Board's target occupancy of 60% this volume supports the need for 14.2 or 15 beds.

The population of this planning area is projected to increase by 7.1% between 2005 and 2015. This amounts to 3.5% over the next 4 years which is when the first full year of operation will be complete this would increase the number of patient days by 109 days which would then justify 14.78 beds. In 2007, the applicant also went on diversion/bypass 20 times for periods ranging from1hr and 55 minutes up to 88hrs and 25 minutes. The total time on diversion was 26.5 days . A log of that by-pass time is appended to this attachment. This by-pass affects the ICU in several ways, when the Medical Surgical Unit is full, the ICU can not move patients out to monitored beds and free space in the ICU and on the other side when the ICU is full the ambulances which bring patients to the hospital must be diverted to other facilities which means that patients are not being admitted through the ER or normally for any type of elective surgery that might require ICU care initially.

The applicant averaged 2.47 patients being admitted to ICU per day so if the facility was on bypass for 26.5 days it could be projected that the facility would have admitted an additional 66 Patients which with an average length of stay of 3.46 days this would have resulted in another 228 patient days. When those patient days are added to the 2007 patient days the total patient days would be 3,358 patient days which at the target occupancy would support the need for 15.3 or 16 beds, which is the number the applicant proposes to have.

ATTACHMENT MOD-3

V. Rehabilitation Beds

The proposed project while technically classified as the establishment of a new category of service because the applicant will be licensed as a new facility, is in reality a replacement for an existing service in the old facility which is being replaced as a part of this application. The existing facility has 23 beds , while the new facility will have only 10 beds. There is only one other provider of rehabilitation services in the applicant's planning area which is all of HSA V. (See the appended map to see the location of the two facilities). The two facilities are 42.72 miles and 48 minutes travel time from each other and both are located in the middle of the HSA one to the North and 1 to the South in close proximity to Interstate 57. (See the second map showing HSA V.)

Herrin Hospital does not have any admission restrictions to their facility, but the travel time is excessive for the residents of the northern half of HSA V.

If the applicant were to discontinue the service totally a need for 9 additional beds would be created. The proposed reduction in beds from 23 to 10 reduces the number of excess beds in the planning area to 1 bed.

Based upon the historical utilization the applicant and the Board's 85% occupancy target the facility can justify 9.1 or 10 beds. Since this is the existing facility's historical utilization it appears reasonable to assume that these are the patients who would not have reasonable geographic access to Herrin Hospital if the existing facility's beds were not replaced at the new facility.

The State Board has established a minimum unit size of 15 beds for this service, however, given the rural nature of this planning area and the utilization experienced by the existing facility over several years, it does not appear that a 15 bed unit would be appropriately utilized while the proposed 10 bed unit would be.

ATTACHMENT MOD-3

W. OB Beds/ LDR

The facility will have 6 LDRP beds, 2 Post-Partum Beds and one Ante-Partum bed for a total of 9 beds which will be inventoried as Obstetric beds. The LDRP beds (Labor/Delivery/Recovery/Post-Partum) beds will be the primary location in which the patients will be admitted. The patient will be admitted to an LDRP bed where they will stay through labor, delivery, recovery, and until they are ready for discharge. The two post-partum beds and the ante-partum beds will we used for patients who have not delivered and are being admitted for medical reasons, or patients who have had C-sections are recovering from the surgery.

The 2007 workload, 1,861patient days supports the need for 9 beds based upon the Board's target occupancy of 60%. (1,861÷365 = 5.2 patients per day ÷.60 =8.7 or 9 beds needed)

The beds are further justified under the variance to computed bed need shown on ATTACHMENT ACUTE-2.

X. C-section Site

The hospital is proposing one operating room for c-sections which will be located on the Fourth Floor of the new hospital adjacent to the LDRP and the Obstetric Unit. The total GSF for this area is 1,018 GSF.

In 2007 the volume of C-sections totaled 228 out of the 787 total deliveries at the hospital. This volume supports the need for one C-section room, which is what the applicant is proposing.

An operating room in which C-sections can be performed is an integral part of the hospitals provision of Obstetric Services and locating that room immediately adjacent to the rest of the OB services is the best way quality care can be delivered in an efficient and safe manor.

The proposed room will only be used for C-sections and will not be used for any other surgical procedure which means that its volume should not be used to justify any space in the OR nor should room capacity in the OR be considered as available for this service.

Illinois Hospital licensure requires that a C-section suite be available unless Operating Rooms can be shown to be immediately available for use. Since the surgery department is located on another floor the C-section suite is required and it must meet surgical standards.

The IHFPB guidelines allow for 2,078 GSF per Operating Room. The applicant is proposing to have only 1,018 GSF for this departmental area since it will be able to share some support space with the LDRP unit.

Y. New Born Nursery

The new born nursery will be located on the fourth floor immediately adjacent to the Obstetric and LDRP units, as is required by Illinois State Hospital Licensure.

While the patient rooms will have space for the baby to room-in with the mother the nursery will be used for respite times for the mothers or if the baby needs additional care.

ATTACHMENT MOD-3

Z. Medical Surgical Beds

The proposed project calls for the discontinuation of a 106 bed Medical Surgical Service and the replacement of those beds by a 99 bed service in the new replacement hospital.

A map showing all of the facilities within 30 minutes travel time of the proposed facility and those facilities in the applicant's planning area is appended to this Attachment. It is important to note that Franklin Hospital in Benton, while within 30 minutes travel time is in another planning area for this service. The map also shows the only other non-planning area facility that is located between 30 and 45 minutes travel time of the proposed facility, that is Hamilton Memorial Hospital, in Mcleansboro, which is also in another planning area.

Only one other facility in the Planning area is within 30 minutes travel time of the proposed facility, that is Crossroads Community Hospital also located in Mt. Vernon.

The applicant's 2007 workload for Medical Surgical and Pediatric beds totaled 24,802 patient days, which results in an average daily census of 67.95 patients. Based upon the State Board's target occupancy rate of 75% for modernization of facilities with between 26 and 99 beds the 2007 workload justifies 91 beds. Based upon the 80% utilization target for new facilities the workload justifies 85 beds.

The applicant's peak census for 2007 was 99 beds which is also the number of beds proposed in the new hospital. The peak census for Pediatrics was 5. Together the peak census was 104 beds. This is important because all pediatric cases will be cared for in Medical/Surgical beds in the new replacement hospital.

In 2007, the applicant also went on diversion/bypass 20 times for periods ranging from1hr and 55 minutes up to 88hrs and 25 minutes. A log of that by-pass time is appended to this attachment. This by-pass effects not only the Medical Surgical Unit but also the ICU. When the Medical Surgical Unit is full, the ICU can not move patients out to monitored beds and free space in the ICU and on the other side when the ICU is full the ambulances which bring patients to the hospital must be diverted to other facilities which means that patients are not being admitted through the ER or normally for any type of elective surgery that might require ICU care initially.

The bypass issue is a situation the hospital feels it must address in the new hospital as it critically impacts the ability to insure prompt care to the area residents.

The applicant proposes to have all private rooms in the facility which will allow for better utilization of the facilities beds by eliminating problems with isolation or with patient mix by age or sex. This is especially important now that pediatric patients are being treated in Medical Surgical beds, as it is inappropriate to mix pediatric and adolescent

patients with adults.

The other facilities in the planning area do not appear to have admission restrictions, but they are with the exception of Crossroads Hospital a substantial distance away and would result in hardships for the patients and their families to have to use facilities so remote from where they live.

Good Samaritan Regional Health Center has been for a number of years a regional resource for programs such as cardiac catheterization, open heart surgery and Rehabilitation beds. The other facilities within either the 30 minute travel time or the forty-five minute travel time do not either offer the service (rehab and open heart) or have the capacity (cardiac catheterization) to accommodate the facility's historical workload were the facility to not be replaced.

The proposed location of the new facility is on property next to Interstate 57 which will dramatically improve the access to the hospital by the planning area residents. The existing hospital is located in a residential area and is not on one of the main roads in the community which makes it difficult to locate for any patient who is not familiar with Mt. Vernon itself.

The hospital has always maintained a generous charity care program and does not deny access to any patient regardless of their ability to pay. This policy will continue at the facility.

The proposed 99 beds are needed to support the facility's peak census as it now exists and to prevent the hospital from having to go on diversion/bypass, even if no growth in the population occurs. The Illinois Department of Public Health Center for Health Statistics predicts that the total population of the planning area is projected to grow by 7.1% between 2005 and 2015, while the population age 65 and over is projected to grow by 33.9% during that same time period. The only population which is projected to decrease during that time is the 0-14 age group which is the pediatric patients for which the applicant is proposing to discontinue the dedicated unit. The number of medical surgical patient days for the area is projected to increase by 12,100 days in the age 65 and over group for that time period and by 464 in the 15-64 age group

Based on the 2005 utilization data, as published in the Planning Board's Inventory of Health Care Facilities dated March 11, 2008, the applicant treated 43.36% of the patient days in the planning area. If that market share remains the same in 2012 the first year after project completion the applicant's patient days would increase by 3,672 patient days which at the 80% occupancy target supports the need for 13 beds which more than justifies the difference between the number of beds the 2007 volume currently supports and the number of beds the applicant is proposing to have.

ATTACHMENT MOD-3

AA. Hospice and Home Health

This area will be used primarily as office space and counseling space for the nurses and care givers in the Home Health and Hospice departments.

This unit will not be used to house patients and will have no bed space on the unit. It will have meeting rooms and spaces for the families of the patients to meet with the professional care givers who provide the care for the patients in their homes. It will also have materials for the patients and their families to refer to as they make decisions regarding their care.

The home health nurses and their supervisors will also be housed here as needed and the administrative portion of their care will be done here.

This department is located on the fifth floor of the hospital in an area which is otherwise administrative in nature.

This space is basically non-clinical in nature and could have been excluded from the Board's review, however, the decision was made that since it involves staff with direct patient care responsibility and in some instances meetings with the patient, that it would be treated as clinical space and justified in that fashion.

It is difficult to assign workload figures to this department because the patients served vary greatly, and nurses are used as needed.

SECTION VIII. REVIEW CRITERIA RELATING TO MEDICAL-SURGICAL, PEDIATRIC, OBSTETRICS, AND INTENSIVE CARE SERVICES (ACUTE)

The section is applicable to all projects proposing the addition of Medical/Surgical, Obstetric, Pediatric, or ICU beds.

A. Criterion 1110.530.a, Unit Size

Read the criterion and indicate if the existing or proposed facility is located within a MSA. Yes ☐ No ☒

B. Criterion 1110.530.b, Variances to Computed Bed Need

Read the criterion and, if applicable, address one of the following variances.

1. Criterion 1110.530.b.1, High Occupancy. Indicate if chosen and submit the following information:

    a. patient days and admissions for each of the last two years for the service involved;
    b. explain why it is not feasible to convert underutilized services to meet the identified demand;
    c. document that the number of beds proposed will not exceed the number needed to meet the target occupancy.
    d. if projections are utilized to support the need for beds, document the following:

        1) the projections are based upon population projections from the U.S. Bureau of the Census;
        2) the projections are for a period of not more than 5 years from the date the application is submitted;
        3) the projections are zip code based and age specific; and
        4) the projections are based upon the applicant's service area as defined by historical patient origin, and do not include any projected change in market share.

APPEND DOCUMENTATION AS <u>ATTACHMENT ACUTE-1</u> AFTER THE LAST PAGE OF THIS SECTION.

2. Criterion 1110.530.b.2, Medically Underserved Population. Indicate if chosen and submit the following information:

    a. a map showing the location of all other area providers;
    b. a list of the travel times to other area providers;
    c. a detailed description of the admission restrictions of the other area facilities;
    d. documentation that access is restricted in the planning area;
    e. documentation that the number of beds proposed will not exceed the number needed, at the target occupancy rate, to meet the health care needs of the population identified;
    f. an explanation of how the proposed project will improve the access to care;

APPEND DOCUMENTATION AS <u>ATTACHMENT ACUTE-2</u> AFTER THE LAST PAGE OF THIS SECTION.

Criterion 1110.530.b, Variances to Computed Bed Need

Criterion 1110.530.b.2, Medically Underserved Population

This criterion is being address for the Medical Surgical, Obstetric and ICU beds because the proposed project calls for the relocation of an existing hospital to a new site in the same community and Planning Area. The relocation to a new site requires the Board to consider this application as a new hospital rather than a replacement, and as such the only variance available in the Medical Underserved Population variance.

A. Medical Surgical Beds

The proposed project calls for the discontinuation of a 106 bed Medical Surgical Service and the replacement of those beds by a 99 bed service in the new replacement hospital.

A map showing all of the facilities within 30 minutes travel time of the proposed facility and those facilities in the applicant's planning area is appended to this Attachment. It is important to note that Franklin Hospital in Benton, while within 30 minutes travel time is in another planning area for this service. The map also shows the only other area facility that is within 45 minutes travel time of the proposed facility, that is Hamilton Memorial Hospital in Mcleansboro, which is also in another planning area.

Only one other facility in the Planning area is within 30 minutes travel time of the proposed facility, that is Crossroads Community Hospital also located in Mt. Vernon.

The applicant's 2007 workload for Medical Surgical and Pediatric beds totaled 24,802 patient days, which results in an average daily census of 67.95 patients. Based upon the State Board's target occupancy rate of 75% for modernization of facilities with between 26 and 99 beds the 2007 workload justifies 91 beds. Based upon the 80% utilization target for new facilities the workload justifies 85 beds.

The applicant's peak census for 2007 was 99 beds which is also the number of beds proposed in the new hospital. The peak census for Pediatrics was 5. This is important because all pediatric cases will be cared for in Medical/Surgical beds in the new replacement hospital.

In 2007, the applicant also went on diversion/bypass 20 times for periods ranging from 1 hr and 55 minutes up to 88hrs and 25 minutes. A log of that by-pass time is appended to this attachment. This by-pass effects not only the Medical Surgical Unit but also the ICU. When the Medical Surgical Unit is full, the ICU can not move patients out to monitored beds and free space in the ICU and on the other side when the ICU is full the ambulances which bring patients to the hospital must be diverted to other facilities which means that patients are not being admitted through the ER or normally for any type of elective surgery that might require ICU care initially.

The bypass issue is a situation the hospital feels it must address in the new hospital as it critically impacts the ability to insure prompt care to the area residents.

The applicant proposes to have all private rooms in the facility which will allow for better utilization of the facilities beds by eliminating problems with isolation or with patient mix by age or sex. This is especially important now that pediatric patients are being treated in Medical Surgical beds, as it is inappropriate to mix pediatric and adolescent patients with adults.

The other facilities in the planning area do not appear to have admission restrictions, but they are with the exception of Crossroads Hospital a substantial distance away and would result in hardships for the patients and their families to have to use facilities so remote from where they live.

Good Samaritan Regional Health Center has been for a number of years a regional resource for programs such as cardiac catheterization, open heart surgery and Rehabilitation beds. The other facilities within either the 30 minute travel time or the forty-five minute travel time do not either offer the service (rehab and open heart) or have the capacity (cardiac catheterization) to accommodate the facility's historical workload were the facility to not be replaced.

The proposed location of the new facility is on property next to Interstate 57 which will dramatically improve the access to the hospital by the planning area residents. The existing hospital is located in a residential area and is not on one of the main roads in the community which makes it difficult to locate for any patient who is not familiar with Mt. Vernon itself.

The hospital has always maintained a generous charity care program and does not deny access to any patient regardless of their ability to pay. This policy will continue at the facility.

The proposed 99 beds are need to support the facilities peak census as it now exists and to prevent the hospital from having to go on diversion/bypass, even if no growth in the population occurs. The Illinois Department of Public Health Center for Health Statistics predicts that the total population of the planning area is projected to grow by 7.1% between 2005 and 2015, while the population age 65 and over is projected to grow by 33.9% during that same time period. The only population which is projected to decrease during that time is the 0-14 age group which is the pediatric patients for which the applicant is proposing to discontinue the serve. The number of medical surgical patient days for the area is by 12,100 days in the age 65 and over group for that time period and by 464 in the 15-64 age group

Based on the 2005 utilization data, as published in the Planning Board's Inventory of Health Care Facilities dated March 11, 2008, the applicant treated 43.36% of the patient

days in the planning area. If that market share remains the same in 2012 the first year after project completion the applicant's patient days would increase by 3,813 patient days and by 4,362 in 2013 which is the second full year of operation which at the 80% occupancy target supports the need for 15 beds which justifies the difference between the number of beds the 2007 volume currently supports and the number of beds the applicant is proposing to have.

B. Obstetric Beds

The applicant is proposing to have 9 beds classified as OB beds. The facility will have a total of 6 LDRP rooms, 2 post-partum beds and one ante-partum beds.

The 2007 workload totaled 1,861patient days, which at the target occupancy for units between 1 and 10 beds of 60% supports the need for the 9 beds proposed by the applicant.

The Inventory of Health Care Facilities projects an excess of 13 beds in the applicant's planning Area F-004, However if the facility were to close their OB unit there would be no other facilities within 30 minutes travel time which offer OB services.

The need for the 9 beds proposed is a direct result of the volume of patients now seen at the existing hospital, the applicant is not projecting a larger need for beds, nor is there any expected impact on other facilities in the planning area. While the population of the planning area is projected to increase, the number of beds proposed are adequate to meet any immediate need for beds.

C. ICU Beds

The applicant is proposing to increase the number of inventoried ICU beds from 10 to 16. The IHFPB Inventory of Health Care Facilities shows that an need for one additional bed in the applicant's F-004 Planning Area.

The 2007 workload for this department totaled 3,128 patient days. Based upon the Board's target occupancy of 60% this volume supports the need for 14.2 or 15 beds.

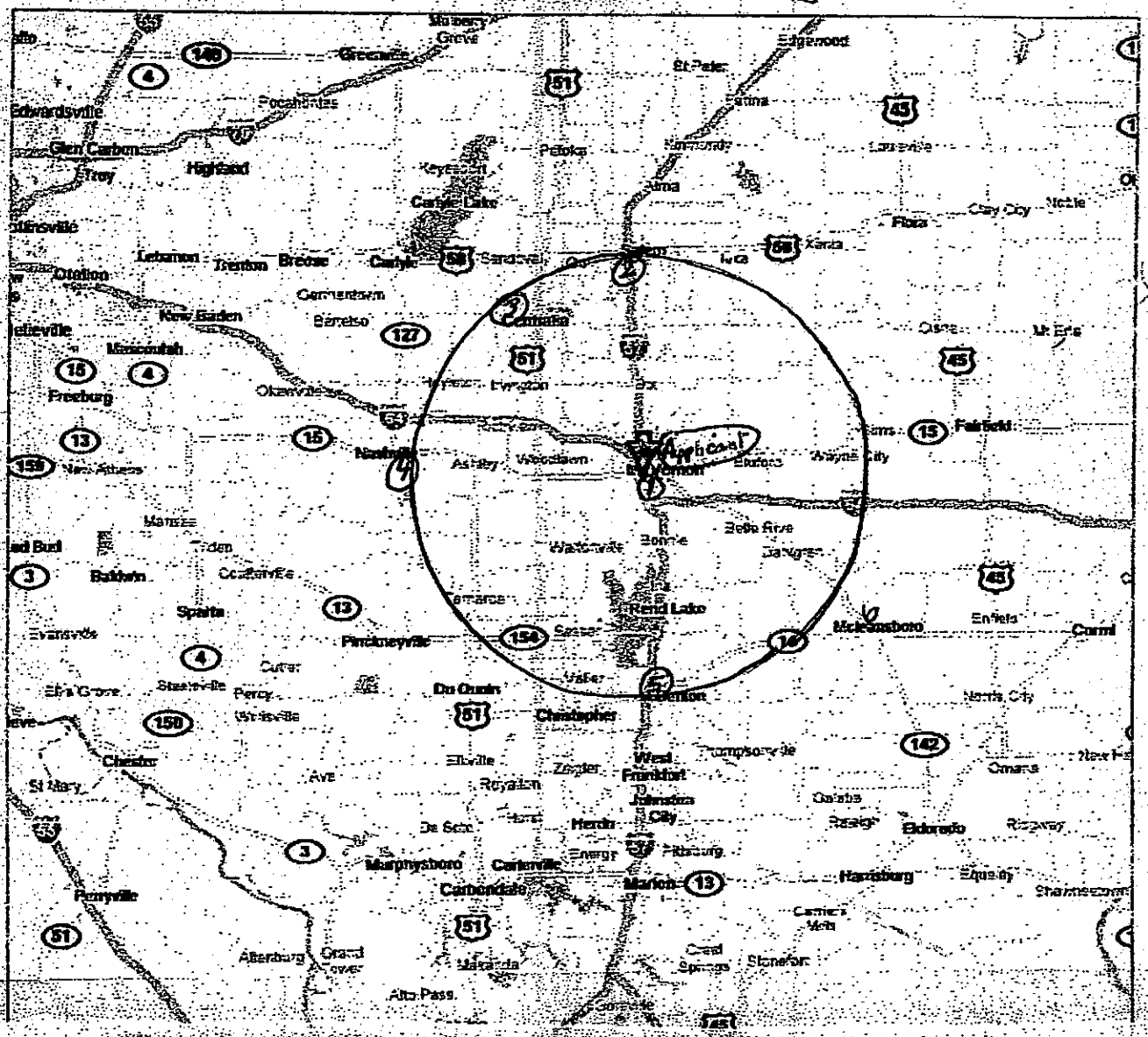
The population of this planning area is projected to increase by 7.1% between 2005 and 2015. This amounts to 3.5% over the next 4 years which is when the first full year of operation will be complete this would increase the number of patient days by 109 days which would then justify 14.78 beds. In 2007, the applicant also went on diversion/bypass 20 times for periods ranging from1hr and 55 minutes up to 88hrs and 25 minutes. The total time on diversion was 26.5 days . A log of that by-pass time is appended to this attachment. This by-pass effects the ICU in several ways, when the Medical Surgical Unit is full, the ICU can not move patients out to monitored beds and free space in the ICU and on the other side when the ICU is full the ambulances which bring patients to the hospital must be diverted to other facilities which means that patients

might require ICU care initially.

The applicant averaged 2.47 patients being admitted to ICU per day so if the facility was on bypass for 26.5 days it could be projected that the facility would have admitted an additional 66 Patients which with an average length of stay of 3.46 days this would have resulted in another 228 patient days. When those patient days are added to the 2007 patient days the total patient days would be 3,358 patient days which at the target occupancy would support the need for 15.3 or 16 beds, which is the number the applicant proposes to have.

Google maps

Address Veterans Memorial Dr & S 42nd St Mt Vernon, IL 62864



Illinois Hospitals Within ~30 Minutes Travel Time of the Applicant Facility

Hospital	Distance From Proposed Facility	Travel Time
1. Crossroads Community Hospital - Mt. Vernon	1.6 miles	5 minutes
2. Salem Township Hospital	26.1 miles	31 minutes
3. St. Mary's Hospital in Centralia	25.6 miles	31 minutes
4. Washington County Hospital in Nashville	31.3 miles	37 minutes
5. Franklin Hospital in Benton	24.4 miles	30 minutes

6. Hamilton Memorial 28.06 miles 41 minutes

Diversion/Bypass
2008

	Date/Time On		Date/Time Off		Length of Time on Diversion	Reason for Diversion
1	1/14/08	1525	1/15/08	1415	22 hrs. 50 min.	Staffing
2	1/20/08	2130	1/23/08	1315	63 hrs. 45 mins.	Staffing
3	2/3/08	2320	2/6/08	0550	54 hrs. 30 mins.	Critical/monitored bed availability
4	2/7/08	0100	2/7/08	1040	9 hrs 40 mins.	Staffing
5	2/26/08	1634	2/27/08	1908	26 hrs. 34 mins.	Bed availability
6	2/29/08	0654	2/29/08	1750	10 hrs. 56 mins.	Staffing/Census
7	3/14/08	2140	3/16/08	1920	45 hrs. 40 mins.	Staffing/bed availability
8	3/18/08	0620	3/19/08	0630	24 hrs. 10 mins.	Internal disaster – power outage
9	3/21/08	0932	3/21/08	1552	6 hrs. 20 mins.	Staffing
10	4/16/08	1734	4/17/08	1400	20 hrs. 26 mins.	Critical/monitored bed availability
11	4/21/08	1616	4/22/08	1419	22 hrs. 3 mins.	Critical/monitored bed availability
12	5/15/08	1900	5/16/08	1430	19 hrs. 30 mins.	Staffing
13						
14						
15						
16						
17						
18						
19						

Diversion/Bypass
2007

	Date/Time On		Date/Time Off		Length of Time on Diversion
1	01/02/07	2040	01/03/07	1454	18 hrs. 14 mins.
2	01/04/07	0806	01/05/07	1026	26 hrs. 20 mins.
3	01/08/07	1455	01/09/07	2132	30 hrs. 37 mins.
4	01/16/07	1045	01/16/07	1900	8 hrs. 15 mins.
5	02/13/07	0240	01/15/07	0600	51 hrs. 20 mins.
6	02/23/07	1740	02/24/07	1423	20 hrs. 43 mins.
7	02/26/07	1800	02/28/07	2000	50 hrs. 0 mins.
8	04/13/07	0435	04/15/07	0929	52 hrs. 54 mins.
9	04/24/07	0920	04/24/07	2218	12 hrs. 58 mins.
10	05/10/07	1405	05/12/07	0700	40 hrs. 55 mins.
11	06/12/07	1355	06/15/07	1410	73 hrs. 15 mins.
12	07/10/07	1115	07/11/07	1500	27 hrs. 45 mins.
13	07/23/07	1820	07/25/07	1005	39 hrs. 45 mins.
14	08/21/07	1415	08/22/07	1100	20 hrs. 45 mins.
15	08/23/07	0721	08/24/07	0028	17 hrs. 7 mins.
16	09/24/07	2215	09/05/07	1410	1 hr. 55 mins.
17	09/24/07	1820	09/28/07	1045	88 hrs. 25 mins.
18	10/03/07	1710	10/04/07	0757	14 hrs. 47 mins.
19	10/21/07	2231	10/30/07	2135	23 hrs. 4 mins.
20	12/3/07	2202	12/04/07	1515	17 hrs. 13 mins.

SECTION IX. REVIEW CRITERIA RELATING TO COMPREHENSIVE REHABILITATION SERVICES (REHAB)

This section is applicable to all projects proposing to establish or to add rehabilitation beds.

A. Criterion 1110.630.b, Access Variance to Computed Bed Need

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

1. A map showing the location of all of the other facilities in the planning area which offer inpatient rehabilitation services.

2. A list of the other rehabilitation programs in the planning area showing the distance and travel time to each.

3. A detailed description of the access restrictions, if any, for each of the area facilities.

4. Documentation that the number of beds proposed will not exceed the number needed, at the target occupancy rate, to meet the health care needs of the population identified as having restricted access.

APPEND DOCUMENTATION AS ATTACHMENT REHAB-1 AFTER THE LAST PAGE OF THIS SECTION.

B. Criterion 1110.630.c, Staffing Requirements

Read the criterion and for those positions described, provide the following information:

1. The name and qualifications of the person currently filling the job.

2. Letters of intent from potential employees.

3. Applications filed for a position.

4. Signed contracts with the required staff.

5. A detailed explanation of how the positions will be filled.

APPEND DOCUMENTATION AS ATTACHMENT REHAB-2 AFTER THE LAST PAGE OF THIS SECTION.

Criterion 1110.630.b, Access Variance to Computed Bed Need

The proposed project while technically classified as the establishment of a new category of service because the applicant will be licensed as a new facility, is in reality a replacement for an existing service in the old facility which is being replaced as a part of this application. The existing facility has 23 beds , while the new facility will have only 10 beds. There is only one other provider of rehabilitation services in the applicant's planning area which is all of HSA V. (See the appended map to see the location of the two facilities). The two facilities are 42.72 miles and 48 minutes travel time from each other and both are located in the middle of the HSA one to the North and 1 to the South in close proximity to Interstate 57. (See the second map showing HSA V.)

Herrin Hospital does not have any admission restrictions to their facility, but the travel time is excessive for the residents of the northern half of HSA V.

If the applicant were to discontinue the service totally a need for 9 additional beds would be created. The proposed reduction in beds from 23 to 10 reduces the number of excess beds in the planning area to 1 bed.

Based upon the historical utilization the applicant and the Board's 85% occupancy target the facility can justify 9.1 or 10 beds. Since this is the existing facility's historical utilization it appears reasonable to assume that these are the patients who would not have reasonable geographic access to Herrin Hospital if the existing facility's beds were not replaced at the new facility.

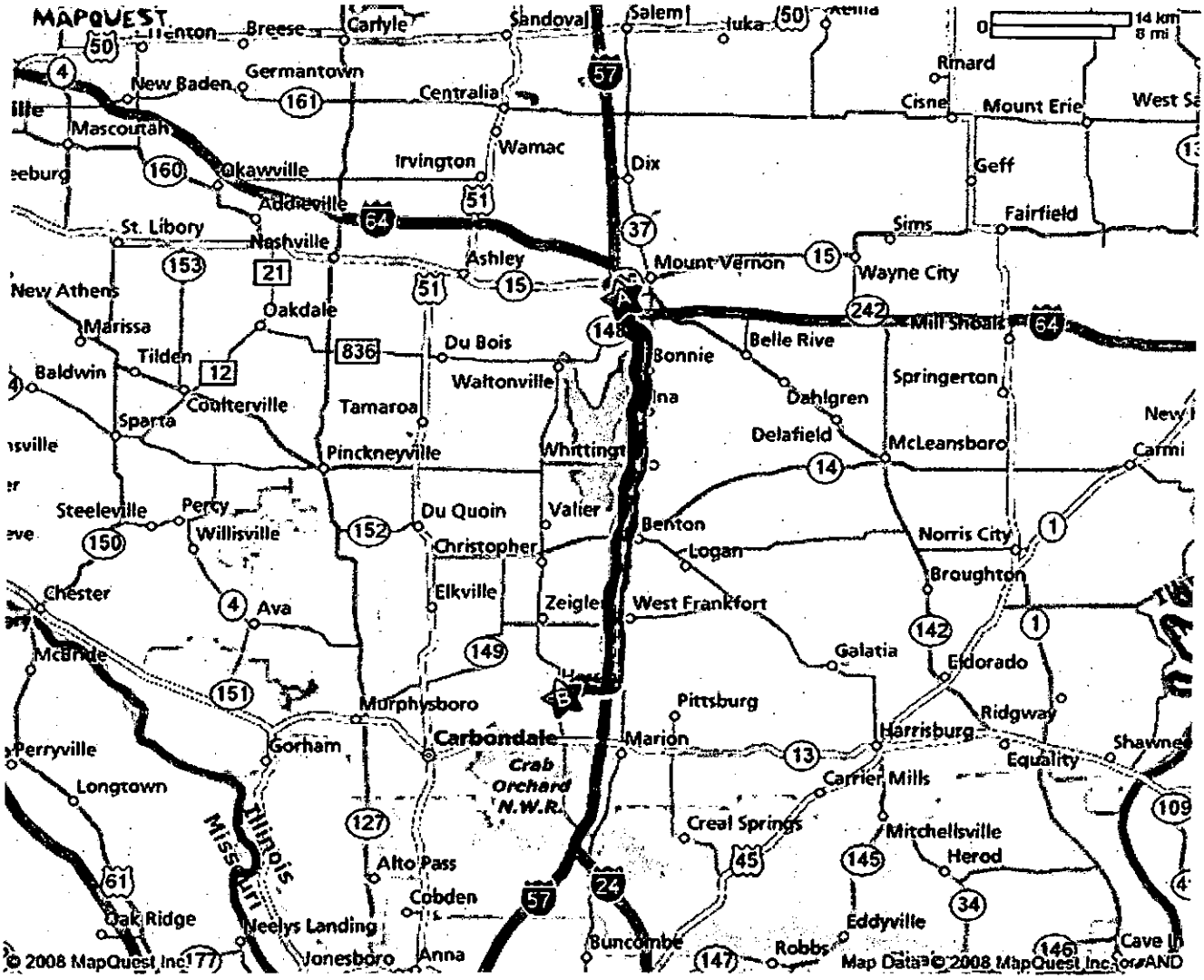
The State Board has established a minimum unit size of 15 beds for this service, however, given the rural nature of this planning area and the utilization experienced by the existing facility over several years, it does not appear that a 15 bed unit would be appropriately utilized while the proposed 10 bed unit would be.

ATTACHMENT REHAB-1

Estimated Time: 48 minutes Estimated Distance: 42.72 miles

B: Herrin Hospital: 201 S 14th St, Herrin, IL 62948, (618)942-2171

Total Time: 48 minutes Total Distance: 42.72 miles



A. The applicant Facility

B. Herrin Hospital

1.. The Applicant Facility

2.. Herrin Hospital

Criterion 1110.630.c, Staffing Requirements

The applicant currently operates a Comprehensive Rehabilitation Unit which is fully staffed and has either on premises or through contractual agreements access to all of the staff required by this review criterion. A list of the individuals and their qualifications for the positions listed in this criterion are shown below:

Medical Director- Dr. H.G. Thompson
Medical Director of Rehabilitation for 18 years at Good Samaritan Regional Health Center, Board Certified in Family Practice, and Board Certified in Geriatrics

Rehabilitation Nursing Supervisors:
Wendy Williams, RN, CRRN, Director
Angie Summers, RN CRRN, Assistant Clinical Manager

Physical Therapist
Madona Syxiengmay, RPT
Alice Martin, PTA
Lori Simmons, PTA

Occupational Therapist
Jenny Charlton, OTR/L
Amanda Gaines, COTA,
Shelly Macbeth, MOTR?L
Kinny Merchant, OTR/L

Social Worker
Nancy Lane, MSW

Speech Pathologist
Randi Rothschild, MS SLP

Psychologist
Lydia Williams, PHD

Vocational Counselor or Specialist
Department of Rehabilitation Services/ Jefferson County
Lisa Briak, Masters in Rehabilitation, CRC(Certified Rahbilitation Counselor)
Vocational Rehabilitation Counselor
Robin Matthews, MSW - Vocational Rehabilitation Counselor

Dietician
Yvette Peterson, RD

ATTACHMENT REHAB-2

Pharmacist

Monica Heinzman PharmD

Audiologist

David Lane, Audiologist

Prothetist or Orthotist:

J.E. Hanger, Inc.

Dentist:

Bruce Thackery, DMD

ATTACHMENT REHAB-2

SECTION XII. REVIEW CRITERIA RELATING TO OPEN HEART SURGERY (OHS)

This section is applicable to all projects proposing to establish the open heart surgery category of service.

A. Criterion 1110.1230.a, Peer Review

Read the criterion and submit a detailed explanation of your peer review program.

APPEND DOCUMENTATION AS ATTACHMENT OHS-1 AFTER THE LAST PAGE OF THIS SECTION.

B. Criterion 1110.1230.b, Establishment of Open Heart Surgery

Read the criterion and provide the following information:

1. The number of cardiac catheterizations (patients) performed in the latest 12-month period for which data is available.
2. The number of patients referred for open heart surgery following cardiac catheterization at your facility, for each of the last two years.

APPEND DOCUMENTATION AS ATTACHMENT OHS-2 AFTER THE LAST PAGE OF THIS SECTION.

C. Criterion 1110.1230.c, Unnecessary Duplication of Services

Read the criterion and address the following:

1. Contact all existing facilities within 90 minutes travel time of your facility which currently provide or are approved to provide open heart surgery to determine what the impact of the proposed project will be on their facility.
2. Provide a sample copy of the letter written to each of the facilities and include a list of the facilities sent letters.
3. Provide a copy of all of the responses received.

APPEND DOCUMENTATION AS ATTACHMENT OHS-3 AFTER THE LAST PAGE OF THIS SECTION.

D. Criterion 1110.1230.d, Support Services

Read the criterion and indicate on a service by service basis which of the services listed in this criterion are available on a 24-hour inpatient basis and explain how any services not available on a 24 hour inpatient basis can be immediately mobilized for emergencies at all times.

APPEND DOCUMENTATION AS ATTACHMENT OHS-4 AFTER THE LAST PAGE OF THIS SECTION.

E. Criterion 1110.1230.e, Staffing

Read the criterion and for those positions described under this criterion provide the following information:

1. The name and qualifications of the person currently filling the job.
2. Letters of interest from potential employees.
3. Application filed for a position.
4. Signed contracts with the required staff.
5. A detailed explanation of how you will fill the positions.

APPEND DOCUMENTATION AS ATTACHMENT OHS-5 AFTER THE LAST PAGE OF THIS SECTION.

Criterion 1110.1230.a, Peer Review

The proposed Open Heart Surgery Service is a replacement for the program currently provided by the hospital in its existing location.

The Peer Review Program which is currently in place in the existing hospital will continue to be used in the new hospital.

A copy of the Peer Review Program procedures are appended to this Attachment.

GOOD SAMARITAN REGIONAL HEALTH CENTER
MEDICAL STAFF

Policy Title: Medical Staff Quality Council
Date: January 2003
Revised: **December 2005, September 2006**

MEC Approval: _____
MEDICAL STAFF PRESIDENT
GOOD SAMARITAN REGIONAL HEALTH CENTER
(Medical Executive Committee Approval 9/11/06)

MEDICAL STAFF POLICY AND PROCEDURE

PURPOSE: To follow a consistent process for the evaluation and monitoring of the various dimensions of practitioner performance, which include technical quality of care, quality of service, resource utilization, peer and coworker relationships, and contributions to the hospital and the community. This will be accomplished through identification and timely resolution of peer review cases as part of the performance improvement process. To ensure that practitioners have a leadership role in peer review and performance activities to improve clinical and non clinical processes, practitioners participate in the development and ongoing evaluation of Medical Staff Performance Improvement activities. Performance data are aggregated for consideration by the Credentials Committee at reappointment.

Definitions: For the purpose of this policy, a peer is defined as any licensed M.D. or D.O. or D.D.S./D.M.D. with equivalent qualifications, i.e. physician, oral surgeon. A practitioner is defined as a licensed M.D. or D.O. or D.D.S./D.M.D., as well as licensed CRNAs, APNs, PAs, NPs, and credentialed RNs.

STATEMENT OF POLICY: Clinical and nonclinical peer review information and data generated by or at the request of a Medical Staff Department/Medical Staff or Hospital Committee and/or its leaders is used to evaluate and improve the quality of patient care and practitioner performance. The Medical Staff President, Department or Committee Chairperson, or other appointed Medical Staff Committee has the authority to conduct quality appraisal reviews as necessary, in accordance with the Bylaws.

Peer review cases should be screened within 30 days of identification; preliminary peer review done within 30 days after screening; and final Council disposition at the next regularly scheduled meeting. If there are questions of the practitioner about the case, the final Council determination/disposition should be done approximately 30-60 days after answers are provided. If no answers are provided, the Council may make its determination at the next regularly scheduled meeting thereafter.

Medical Executive Committee

The Medical Executive Committee (MEC) shall be ultimately responsible for monitoring/evaluating Medical Staff Department/services and for organizing the quality assurance activities of the Medical Staff as well as the mechanisms used to collect, evaluate & revise such activities.

Medical Staff Quality Council

1. **Composition/Terms.** Good Samaritan Regional Health Center Medical Staff Quality Council (MSQC) is composed of:

    a. A Chairperson appointed by the Medical Staff President and approved by the MEC;
    b. The Chairperson of each Department. Each Department Chairperson will hold a three year term. At the end of the three year term, the then-current Department Chairperson will fill the position for the next three year term;
    c. Two practitioner designees from each Medical Staff Department (appointed by the Medical Staff President);
    d. Administrative Medical Director (ex officio);
    e. Quality Appraisal Services staff representative(s);
    f. Vice President of Patient Care Services; and
    g. Hospital President
    h. Medical Director of Pathology for blood review (ad hoc)

Appointed members shall hold the position for a term of three years. The MSQC Chairperson shall be appointed for a three year minimum term. The MSQC Chairperson cannot be a current Department Chairperson. The Medical Staff President shall appoint replacements to fill any vacancy in the term of any appointed MSQC member. All such appointments shall be subject to the MEC's approval.

2. **Meetings.** The MSQC will meet on at least a monthly basis, or more frequently as needed, as determined by the MSQC Chairperson.

3. **Duties.**

    a. Processes or outcomes on which the Hospital collects data using Medical Staff approved criteria include, but are not limited to, the following:

        - Medical assessment and treatment of patients;
        - Use of medications;
        - Use of blood and blood components;
        - Use of operative and other procedures;
        - Efficiency of clinical practice patterns;
        - Significant departures from established patterns of clinical practice;
        - Complaints or grievances from patients, coworkers, or others directed towards practitioners;
        - Referrals made from root causes analyses of Sentinel Events, and
        - Adherence to Medical Staff Bylaws and policies.

b. These processes and outcomes are measured using the following classification of clinical indicators:

- Type 1: Rules, law, general principles of medicine. (A Type 1 indicator represents a rule, standard, generally recognized professional guideline or law. It should always be performed.)
- Type 2: Very unusual events that require professional judgment to determine deviation from the standard. (A Type 2 indicator represents a very unusual event within the hospital and would require analysis by peers in order to determine cause, effect, and severity.)
- Type 3: Rates (A Type 3 indicator exists only to cause a rate to be created and returned to the Department/Committee. No records need to be evaluated. These rates would be broken down by service, Department, or individual practitioner.)

c. The MSQC is responsible for review of all Type 2 cases. This is accomplished via performance improvement activities through individual clinical case review. Outcome variances of the processes reviewed and Medical Staff Risk Management/Patient Safety issues may be referred by the Medical Staff Committees/Departments to the MSQC for review and recommendations.

d. Pertinent policy and process information from the MSQC will be shared with the Medical Staff Departments for review.

e. When a case is being reviewed by the MSQC, appropriate standards of care, references from the literature, relevant clinical guidelines or other information from evidence-based medicine shall be taken into consideration.

PROCEDURE:

1. **Responsibility:**

a. **MSQC Chairperson:** Conducts the meetings, ensures oversight of clinical review processes in collaboration with the Quality Appraisal Services staff or his/her designee, and ensures that Medical Staff Performance Improvement Activities are conducted and reported to the MEC. The MSQC Chairperson will ensure that meeting minutes are submitted to the MEC for confirmation and/or further recommendations.

b. **MSQC Member:** Performs clinical reviews during the MSQC meetings, presents cases and opinion from the clinical review to the MSQC for categorization. MSQC members will ensure that MSQC meeting reports of action/recommendations are taken back to the respective Medical Staff Departments.

c. **Quality Review Nurse:** Performs initial clinical review utilizing the criteria established by each Medical Staff Department and/or MSQC. Refers clinical cases which are found to be variances from the criteria to the MSQC for peer review with the Clinical Review Summary form attached which identifies the reason for review.

d. **Quality Appraisal Services Staff:** Assists in the preparation of agendas in collaboration with the MSQC Chairperson, prepares medical records for Practitioner Review by attaching Clinical Review Summary sheets, and aggregates monthly clinical review activity for the MSQC.

Provides Committee with findings regarding Illinois Foundation for Healthcare Quality issues, issues related to patterns/trends, and provides reports, related to clinical review activities, to the Medical Staff Department Chairperson. The Vice President of Systems Improvement in collaboration with Quality Appraisal Services staff will report to the Board of Directors.

2. **Physician Nursing Liaison Committee:**

A Physician Nursing Liaison Committee is established as a subcommittee of the Medical Staff Quality Council to evaluate relationship issues between the medical staff and hospital staff. Complaints about practitioners that are behavioral in nature will be received by this committee and validated as outlined below:

a. Any complaint regarding practitioner behavior will be directed to the Medical Staff Office.

b. The appropriate Department Chairperson and Vice President of Patient Care will promptly notify the practitioner and investigate the complaint and determine if it is valid. In the absence of the respective Department Chairperson, the President of the Medical Staff will assume the responsibility of the investigation. If the President is unavailable, the President-elect will assume the responsibility. In the absence of the Vice President of Patient Care, the Administrator on Call will assume the responsibility.

c. If a complaint is valid, it will be considered as a variance from Type I Indicators and a Rule letter will be sent to the practitioner from the Quality Department indicating the variance and placed in the practitioner's quality file for tracking and trending.

d. Goal performance is 0 validated complaints in a rolling twelve month reporting period. Acceptable performance is 2 validated complaints in a rolling twelve month period. If more than two validated complaints about a practitioner are received in a rolling twelve month period, the Medical Staff Quality Council will review the complaints and recommend actions as deemed appropriate.

e. Complaints that are deemed invalid will be tracked by the Liaison Committee and if there is a trend recognized in the number of invalid complaints from an individual or individuals, the issue will be addressed appropriately.

f. If there are any conflicts of interest with the individuals designated to validate complaints, another reviewer will be named by the MSQC Chairperson.

g. If there is disagreement between the individuals designated to validate issues then a second opinion will be obtained from the President of the Medical Staff, or in their absence, the President-elect of the Medical Staff.

h. Issues will be addressed timely and will include input from the individuals identified in the complaint. Practitioners have the right to bring a challenge to the MSQC regarding the decision of the individuals validating the complaint.

2. **Procedure for Type 1 and Type 3 Indicators:**

a. Quality Appraisal Services will coordinate the accumulation of data for Indicators Type 1 and Type 3. Information and rates (numbers) shall be shared with the respective Department Chair at least quarterly for incorporation into a regular report to the Department. Rates or numbers are to be reviewed regularly against recognized benchmarks in order to determine overall practice variation within a specialty or within the institution.

b. Type 1 variations are deviations from accepted rules and expectations. A pattern in this area will not necessarily warrant an action or response. Ongoing problems reflected in patterns should be reported to the MSQC with all pertinent documentation. If a pattern continues it will be referred to the MEC.

c. Type 3 indicators identifying patterns of performance at variance with a benchmark or the norm shall be evaluated by the MSQC utilizing CQI techniques/tools. If analysis shows a pattern of deviation, it will be reviewed intensively and process improvement sought. Recommendations will be made to the MEC.

3. **Procedure for Type 2 Indicators:**

a. Quality Review Nurse identifies cases on a ongoing basis meeting the quality indicators as outlined by the Medical Staff and/or MSQC. The Quality Review Nurse reviews the records utilizing criteria as established by the Medical Staff. A Clinical Review Summary form (Attachment A or Attachment B) is initiated for those cases which do not demonstrate compliance with these criteria and is forwarded for review by the MSQC.

b. The case in question will be reviewed by an individual physician assigned each month on a rotating basis from the MSQC. The reviewing physician will determine if the case warrants presentation to the full committee. The physician reviewer will then prescore the case to be presented to the full committee as outlined in Attachment C. The physician of record will be notified in writing that their case is being reviewed by the committee and will have an opportunity to respond.

c. Each referred case is reviewed by the MSQC and assigned a category according to the definitions established by the Medical Staff as outlined in Attachment D.

4. **Process Following MSQC Review:**

a. If analysis shows deviation attributed to Hospital processes, findings and recommendations will be forwarded to the appropriate Hospital Department for review and response.

b. The practitioner will be notified in writing of the results of the review.

c. The MSQC may, in its sole discretion, elect to request a peer review by an independent third party peer reviewer when there is a need for clarification or confirmation of a suspected deviation from the standard of care, a conflict of interest (or a perception of conflict of interest) exists, or a specialty level review is warranted. Any time the care has been deemed inappropriate, the practitioner may request that the MSQC obtain an outside peer review. Independent third party peer reviewers shall be selected by the MSQC.

d. If further information or review is necessary, the MSQC may request the following actions:

- The involved practitioner will be notified and will be required to provide his/her rationale or justification either in writing within 30 days or by attending the next MSQC meeting; or

- Request an additional review by another practitioner in the Department.

e. If a practitioner fails to respond within 30 days, the MSQC will make a determination on the case with the information available, and the practitioner will be notified of the determination.

f. After reviewing all available information, the MSQC shall take action, as appropriate. MSQC actions shall include providing written follow-up to the practitioner and/or making a recommendation to the MEC regarding appropriate corrective action in response to issues identified during the review.

g. Written minutes of each MSQC meeting shall be maintained, and shall be submitted to the MEC at its next regularly scheduled meeting following each MSQC meeting.

5. **Confidentiality of Peer Review Information:**

a. The MSQC's activities are confidential peer review activities, and the confidentiality of any information or records generated by the MSQC will be respected. Quality Appraisal Services will maintain copies of all minutes, reports, worksheets and other data in a manner ensuring strict confidentiality. These files will be available to the MSQC Committee. A written Confidentiality Policy provides for restricted access to such documentation by qualified individuals.

b. Peer review records will be accessible only to those who are responsible for, or who participate in, MSQC-initiated peer review activity and to those responsible for surveying hospitals to ascertain the existence of an ongoing effective performance improvement efforts.

c. The confidential nature of the information will be maintained in accordance with the Illinois Medical Studies Act (735 ILCS 5/8-2101 - 2105).

Attachment A

St. Mary's-Good Samaritan, Inc. *Mt. Vernon Campus*

Quality/Risk Assessment *Department of* _____

Patient_____ M.R.#_____ Attending MD_____

Admitted:_____Disch:_____ Consulting MDs_____

Admitting Diagnosis:_____

Significant Medical History:_____

_____

Procedures:

_____

_____

Please check all that apply:

_____ Cardiac/respiratory arrest during or within 48 hours of invasive procedure or surgery

_____ Unplanned transfer to ICCU

_____ Unplanned readmission within 7 days of previous inpatient hospitalization

_____ Unplanned admission within 48 hours of outpatient surgery

_____ Unplanned organ injury during invasive procedure

_____ Unanticipated return to surgery

_____ Neurological deficit or CVA not present upon admission

_____ Renal failure not present upon admission

_____ Pulmonary embolus/thrombophlebitis not present upon admission

_____ CHF/pulmonary edema not present upon admission

_____ GI Bleed unrelated to primary diagnosis

_____ Other Complications:_____

Summary by R.N.: SEE ATTACHED SHEET

Peer Review:

Comments/conclusions of reviewing physician: _____

_____

_____

Are there any hospital based processes in need of improvement? If yes, please describe:

_____

_____

Should this case be presented verbally to the Department/Committee? ___ No ____ Yes

Signature: _____ Date: _____

Patient Expired:	Acute	Rehab
	Hospice	

Attachment B

St. Mary's-Good Samaritan, Inc. Mt. Vernon Campus
Mortality Review Department of _____

Name:_____Age:_____
MR#_____
Attending:_____ Surgeon:_____Consulting:_____
Admit Date:_____ Expiration Date:_____
Hospice?_____ Coroner's Case?_____ Perioperative Death?_____ ASA Class_____
Admission Diagnosis:_____
Significant History:_____
Did patient have a chronic end stage disease?_____
Surgery?_____
_____
Invasive Procedures:
_____
Was patient coded? ___ Yes ___ No ___ DNR_____
Was patient a donor? ___ Yes ___ No Was donor consent/declination signed on chart? ___ Yes ___ No
Did patient meet criteria for autopsy? ___ Yes ___ No Was autopsy performed? ___ Yes ___ No
Cause of death from physician documentation:
_____
_____
None on chart at time of review_____

Coments:_____
_____
_____
_____
_____

Section A:
___ Death expected given the patient's condition/prognosis upon admission & documented in H & P
___ Death expected given the evolution of the patient's condition during the course of inpatient stay & documented by the physician in the patient's chart
___ Death was a result of the implementation of an appropriately executed advanced directive

Section B: **(Automatic referral for peer review)**
___ Death within 48 hours of diagnostic/invasive procedure (not otherwise explained in Section A)
___ Death of patient unseen by attending physician/surgeon
___ Unanticipated Patient Death
___ Other: _____

Peer Review:

Comments/conclusions of reviewing physician:

_____

_____

Are there any hospital based processes in need of improvement? If yes, please describe:

_____

_____

Should this case be presented verbally to the Quality Council? **_____ No _____ Yes**

Signature: _____ Date: _____

Attachment C

Preliminary Physician Reviewer Scoring Form

Medical Record Number: _____

Physician Questions: _____

_____

Outcome:

____1. no adverse outcome
____2. minor/temporary adverse outcome (complete recovery expected)
____3. major/permanent adverse outcome (complete recovery NOT expected)
____4. death

Affect on patient care:

____1. Care not affected
____2. Increased level of monitoring/observation (e.g. vital sign checks)
____3. Additional treatment/intervention (e.g. IV fluids)
____4. Life sustaining treatment/intervention (e.g. intubation, pressor support, CPR, prolonged LOS)

Documentation:

____A. No issue with documentation
____B. Documentation is not present
____C. Documentation does not substantiate clinical course and treatment
____D. Documentation not timely to communicate with other caregivers
____E. Documentation illegible
____F. Other: _____

Problem identification:

____A. No issues with physician care
____B. Diagnosis
____C. Judgment
____D. Technique/skill
____E. Communication or implementation of treatment plan
____F. Policy compliance
____G. Supervision of house staff or AHPs
____H. Other: _____

Overall Physician Care:

____1. Care Appropriate
____2. Care questionable or unusual or controversial
____3. Care inappropriate

Exemplary Physician Care:

____1. Documentation Exemplary
____2. Care Exemplary

Are there system problems, processes, or nursing care issues that need to be addressed?

____ No
____ Yes
If yes, please describe: _____
_____
_____

Attachment D

CASE SCORING OPTIONS

Patient Outcome

1	No adverse outcome
2	Minor/temporary adverse outcome (complete recovery expected)
3	Major/permanent adverse outcome (complete recovery NOT expected)
4	Death

Affect on Patient Care

1	Care not affected
2	Increased level of monitoring/observation (e.g. vital sign checks)
3	Additional treatment/intervention (e.g. IV fluids)
4	Life sustaining treatment/intervention (e.g. intubation, pressor support, CPR, prolonged LOS)

Documentation (select all that apply):

A	No issue with documentation
B	Documentation is not present
C	Documentation does not substantiate clinical course and treatment
D	Documentation not timely to communicate with other caregivers
E	Documentation illegible
F	Other:

Physician Problem Identification (check all that apply):

A	No issues with physician care identified
B	Issue with physician diagnosis
C	Issue with physician judgment
D	Issue with physician technique/skill
E	Issue with physician communication or implementation of treatment plan
F	Issue with physician policy compliance
G	Issue with physician supervision of AHP or house staff
H	Other:

Overall Physician Care (check one):

1	Care appropriate
2	Care questionable or unusual or controversial
3	Care inappropriate

Exemplary Physician Care

A	Documentation exemplary
B	Care exemplary

Non-Physician Issues

Are there system problems, processes, or nursing care issues that need to be addressed?

_____ No

_____ Yes

If yes, please describe: _____

_____

Criterion 1110.1230.b, Establishment of Open Heart Surgery

This criterion reads as follows:

> "Establishment of Open Heart Surgery - Review Criterion. The applicant must document that a minimum of 200 open heart surgical procedures will be performed during the second year of operation or that 750 cardiac catheterizations were performed in the latest 12 month period for which data is available. Anticipated open heart surgical volume must be documented by historical referral volume of at least 200 patients directly referred following catheterization at the applicant facility to other institutions for open heart surgery for each of the last two years."

The applicant facility performed 74 Open Heart Surgery procedures in 2007, which does not meet the 200 procedure level required by this criterion. However, the criterion's second option to meet this criterion is that the applicant facility have performed more than 750 cardiac catheterizations in 2007. The hospital's cardiac catheterization volume for 2007 totaled 1,087 catheterizations which exceeds the number required by this criterion.

Due to the increase in Therapeutic Cardiac Catheterization and the resultant decrease in Open Heart Surgery Volume it is clear the applicant will not achieve the 200 procedure target level established by the Board. However, the program has been in place at the existing hospital for a number of years with high quality outcomes, and it is recommended that Open Heart Surgery be available in order to perform therapeutic catheterization. In 2007 the applicant performed 387 therapeutic catheterization, if only 1/3 of those patients would have had open heart surgery as they did in the past the applicant would have easily met the 200 procedure minimum.

Given the location of this facility, in an HSA where only two other hospitals provide this service, and both of those facilities are more than 45 minutes travel time from the proposed facility. Memorial Hospital of Carbondale is 64 minutes and 67.7 miles from the proposed facility and Heartland Regional Medical Center in Marion is 47 minutes and 45.7 miles from the proposed new hospital.

The applicant was originally approved for this service under a conditional permit and having met the requirements of the conditional permit those conditions were removed by the State Planning Board.

The volume of cardiac catheterizations supports the need to have an open heart surgery under the Board's rules, and the applicant's history of providing high quality care supports the continuation of this necessary service.

ATTACHMENT OHS-2

Criterion 1110.1230.c, Unnecessary Duplication of Services

This criterion reads as follows: "The applicant must document that the volume of any existing service within 90 minutes travel time from the applicant will not be reduced below 350 procedures annually for adults and 75 procedures annually for pediatrics. Documentation shall consist of proof of contact of all facilities within 90 minutes travel time currently providing open heart surgery to determine the projected impact the project will have on existing open heart surgery volume.

A letter was sent to each of the four facilities in Illinois which are within 90 minutes of the proposed new hospital site (Memorial Hospital in Belleville, St. Elizabeth's Hospital in Belleville, Memorial Hospital of Carbondale, in Carbondale, and Heartland Regional Medical Center located in Marion) describing the proposed project and requesting that they advise the applicant of any potential impact of the proposed project on their workload. Memorial Hospital of Carbondale responded that they did not anticipate any substantial impact on their Open Heart Surgery program.

Since this project is for the replacement of an existing facility with a well established Open Heart Surgery program it is believed that this project would not have any adverse impact on any of the existing programs, and would not reduce the volume at any of the existing hospitals.

ATTACHMENT OHS-3

St. Mary's Good Samaritan
Incorporated

Cosponsored by Felician Services, Inc. and SSM Health Care

December 7, 2007

Mr. Timothy F. Brady
Administrator
St. Elizabeth's Hospital
211 South Third Street
Belleville, IL 62220

RE: Good Samaritan Regional Health Center
Open Heart Surgery Service

Dear Mr. Brady:

Good Samaritan Regional Health Center is planning to relocate from its current site at 605 North 12th Street in Mount Vernon, Illinois to Veterans Memorial Drive and South 42nd Street in Mount Vernon, Illinois. Good Samaritan Regional Health Center provides open heart surgical services at the existing location, and intends to continue to provide open heart surgical services at the proposed relocated hospital.

This project involves relocation of an existing health care facility to a new site. Therefore, the Illinois Health Facilities Planning Board requires that we notify existing providers of the proposed program in order to determine any anticipated impact. Please advise Good Samaritan Regional Health Center if you believe this relocation will have any impact on your facility. You may direct any correspondence pertaining to this to:

Michael Warren
Vice President, Clinical Development
Good Samaritan Regional Health Center
605 North 12th Street
Mount Vernon, IL 62864

Thank you for your attention to this matter.

Sincerely,

Gerald W. Lefert
President and Chief Executive Officer
St. Mary's Good Samaritan, Inc.

605 North 12th Street
Mt Vernon, IL 62864
618.242.4600

www.smgsi.com

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SR. VICE PRESIDENT & ADMINISTRATOR
Stre MEMORIAL HOSPITAL OF CARBONDALE
or F 405 WEST JACKSON STREET
City CARBONDALE IL 62901

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Street HEARTLAND REGIONAL MEDICAL
or PO CENTER
City, 333 WEST DEYOUNG
MARION IL62959

PS Fo ... structions

Criterion 1110.1230.d, Support Services

All of the ancillary and support services required by this criterion will be provided on a 24 hour per day basis as they are in the existing hospital.

ATTACHMENT OHS-4

MEMORIAL HOSPITAL
OF CARBONDALE

January 15, 2008

VIA FEDERAL EXPRESS

Michael Warren
Vice President, Clinical Development
Good Samaritan Regional Health Center
605 North 12th Street
Mount Vernon, Illinois 62864

Re: Good Samaritan Regional Health Center
Open Heart Surgery Service
Cardiac Catheterization Service

Dear Mr. Warren:

We are in receipt of your letter wherein you describe how Good Samaritan Regional Health Center is planning to relocate from its current site at 605 North 12th Street in Mt. Vernon, Illinois to Veterans Memorial Drive and South 42nd Street, also in Mount Vernon. We understand that Good Samaritan Regional Health Center provides open heart surgical services as well as cardiac catheterization services at the existing location and that you intend to continue to provide these services at the proposed relocated hospital.

We do not anticipate any dramatic or substantial impact from this relocation on Memorial Hospital of Carbondale. Therefore, so long as Good Samaritan Regional Health Center meets the state's minimum utilization criteria for open heart surgery and cardiac catheterization services, we would be supportive of the proposed relocation and re-initiation of services at the new location.

If you have any questions regarding this letter, please do not hesitate to contact me.

Sincerely,

George Maroney
Senior Vice President and Administrator
Memorial Hospital of Carbondale

C: Jeffrey Mark, Executive Secretary, Illinois Health Facilities Planning Board

db

405 West Jackson Street | PO Box 10000
Carbondale, IL 62902-9000
TEL 618-549-0721
FAX 618-529-0449
www.sih.net

Criterion 1110.1230.e, Staffing

The applicant currently operates an Open Heart Surgery Program as well as a very active Cardiac Catheterization Program. Theses program will continue to be staffed by existing staff the required information regarding the individual staff is appended to this Attachment.

ATTACHMENT OHS-5

CURRICULUM VITAE

NAME: John Ward Watson, M.D.

DATE OF BIRTH: October 3,1958

SOCIAL SECURITY NUMBER: 243-96-9849

PLACE OF BIRTH: West Jefferson, North Carolina

MARITAL STATUS: Married, Lianne Lee, 1985

HOME ADDRESS: 170 Allison Way
Hollidaysburg, PA 16648
(814) 693-2457 Cell (~~717) 818-2862~~ 814-381-6602
(Email) heart4labs@atlanticbb.net

EDUCATION:

1976-1978: Appalachian State University, Boone, North Carolina

1978-1980: BA Wake Forest University, Winston-Salem, North Carolina

1980-1984: M.D. Bowman Gray School of Medicine, Winston-Salem, North Carolina

POSTDOCTORAL TRAINING:

1984-1985: Intern in Surgery, New Hanover Memorial Hospital, Wilmington, NC

1987-1988: Intern in Surgery, Wilford Hall USAF Medical Center, Lackland AFB, TX

1988-1991: Resident in Surgery, Wilford Hall USAF Medical Center, Lackland AFB, TX

1991-1992: Chief Resident in General Surgery, Wilford Hall USAF Medical Center

1992-1994: Fellow in Cardiothoracic Surgery, New England Deaconess Hospital, Boston, MA

PREVIOUS POSITIONS:

January 1995- January 1996: Staff Cardiothoracic Surgeon, Kessler Medical Center

January 1996- May 1999: Chief Cardiothoracic Surgery, Kessler Medical Center

July 1999-June 2000: Clinical Associate Cardiac Surgery, Cleveland Clinic Foundation, Cleveland, OH

August 2000 - January 2005 Chief of Cardiothoracic Surgery at Bon Secours Holy Family Hospital, Altoona, PA

February 2005 - January 2006 Cardiothoracic surgeon with Cardiac and Thoracic Surgery Associates

BOARD CERTIFICATION:

American Board of Surgery: September 22,1993 # 5910 Recertification 2004
American Board of Thoracic Surgery: June 7,1996 # 3858 Recertification 2005

MILITARY SERVICE:

1985-1999 Active Duty United States Air Force
Rank at time of separation: Lt. Col.

PREVIOUS ASSIGNMENTS:

1985-1987: Flight Surgeon, 56th TAC Training Wing, MacDill AFB, FL

LICENSURE:

North Carolina # 33910
Pennsylvania MD-071749-L

AWARDS AND HONORS:

"Iron Intern Award" Best performance as a general surgery intern, Presented by Chief Residents.

MEMBERSHIP IN PROFESSIONAL SOCIETIES:

Society of Air Force Clinical Surgeons
Candidate Group, American College of Surgeons
Affiliate Member, American College of Chest Physicians
Candidate Group, Society of Thoracic Surgeons
Fellow American College of Chest Physicians
Associate Fellow, American College of Surgeons
Fellow American College of Surgeons
Fellow Society of Thoracic Surgeons
Pennsylvania Medical Society

PUBLICATIONS:

1. Watson JW, Brown DR, Lally KP, et al. Complications of Extracorporeal MembraneOxygenation in Neonates. South Med J. 83: 1262 – 1265, 1990.

2. Watson JW, Smith VC, Schmidt, et al. Automatic Implantable Cardioverter Defibrillator: Early Experience at Wilford Hall Medical Center, South Med J, 1991

INVITED LECTURES:

"Complications of Extracorporeal Membrane Oxygenation in Neonates", Combined Pediatric and Surgery Conference, Santa Children's Hospital, San Antonio, Texas.

"Thoracic Trauma", Emergency Medical Technician Training Course, Kessler Medical Center, August 1997.

"Congenital Heart Disease", General Surgery Residents Lecture Series, Kessler MedicalCenter, USAF 1995-1998

"Cardiovascular Surgery, Part One "The Heart"". Physician Assistant Students, St. Francis College, Latrobe PA, September 2000

"Pulmonary Surgery", Physician Assistant Students, St. Francis College, Latrobe PA

"Cardiac and Pulmonary Surgery" Physician Assistant Students, St. Francis College, Latrobe PA, October 2001

PRESENTATIONS:

"Complications of Extracorporeal Membrane Oxygenation in Neonates", Surgery Section,Southern Medical Association, 83rd Annual Assembly, Washington D.C., November 1989.

Automatic Implantable Cardioverter Defibrillator: Early Experience at Wilford HallUSAF Medical Center" , Surgery Section, Southern Medical Association, 84th Scientific Assembly, Nashville, Tennessee, October, 1990.

Thoracic Surgical Oncology: Our Changing Specialty", 44th Annual Meeting, Society of Air Force Clinical Surgeons, April 1997.

"Myocardial Surgical Revascularization: Then and Now" , 45th Annual Meeting, Society of Air Force Clinical Surgeons, April 1998.

"Aortic Valve Disease and the Enlarged Ascending Aorta; "Is Aortic Root Replacement Necessary?" Research Day at The Cleveland Clinic. June 2000

Curriculum Vitae

John E. Codd, M.D.

Education:

St. Louis University School of Medicine-M.D. 1963
Gonzaga University, Spokane-B.A. 1958
Gonzaga High School, Spokane- 1954

Board Certification:

American Board of Thoracic Surgery, 1971
American Board of Surgery, 1970

Post-Graduate Training:

St. Louis University Hospital, Cardiovascular Fellow 1969-70
St. Louis University Hospital, Resident, 1968-69
St. Louis University Hospital, Assistant Resident, 1964-67
St. Louis University Hospital, Intern, 1963-64

Positions:

Professor of Surgery
Washington University School of Medicine
St. Louis, MO
January 2003 to present

President
St. Louis Heart Institute Cardiothoracic Surgeons, Inc.
St. Louis, MO
1984-2002

Director of Cardiovascular Surgical Services
DePaul Health Center
Bridgeton, MO
1984-2002

Director of Cardiovascular Surgical Services
St. Joseph Health Center
St. Charles, MO
1991-2002

Chairman, Department of Surgery
DePaul Health Center
Bridgeton, MO
1988-1990

St. Louis University School of Medicine
Professor of Surgery 1979-1984
Associate Professor of Surgery 1975-1979
Assistant Professor of Surgery 1971-1974

John Cochran V.A. Hospital
Chief of Cardiothoracic Surgery 1982-1984
Chief of Surgery 1981-1982
Chief, Unit II Surgery 1971-1974

Curriculum Vitae Cont'd

John E. Codd, M.D.

Positions:

Director of Cardiovascular Surgical Services
SMGSI Open Heart Program
Mt. Vernon, IL
September, 2005 to July, 2006

Surgeon, St. Mary's Good Samaritan Medical Group
Director, Vascular Clinic
Mt. Vernon, IL
December, 2006 to present

Military Service:

Major, USAF, March 1969
Active Duty, August 1969-1971

Awards and Achievements:

St. Louis Heart Institute Cardiovascular Surgeons, Inc.

- Established four ongoing cardiothoracic surgical programs in the St. Louis area
- Established two satellite programs, one in Jefferson City, MO and the other in Mt. Vernon, IL
- Co-author of 112 papers and presented at 76 major meetings
- Received grant support from the Veteran's Administration for Research in Organ Preservation for Transplantation

St. Louis University Hospital

- Awarded NIH Fellowship for Research in Organ Transplantation

Societies:

St. Louis Thoracic Surgical Society, President
American Medical Association
American Association for Thoracic Surgery
American College of Chest Physicians
American Federation of Clinical Research
American Heart Association, Council Member
American Society for Artificial Internal Organs
American Society of Transplant Surgeons
Association for Academic Surgery
Association of V.A. Cardiologists
Central Surgical Association
Fellow, American College of Surgeons
Regional Dialysis and Transplant Association Scientific Board
St. Louis Metropolitan Medical Society, Council Member
St. Louis Cardiology Club
St. Louis Surgical Society
St. Louis Thoracic Surgical Society
Sigma XI
Society of Thoracic Surgeons
Society of Transplant Surgeons
Southwestern Dialysis and Transplantation Association
Southwestern Surgical Congress
The International Cardiac Transplantation Society
The International Cardiovascular Society
Transplantation Society
Western Dialysis and Transplant Society
Western Surgical Association

TRAVES CRABTREE

PERSONAL DATA:

Date of Birth:	October 24, 1969
Place of Birth:	Carbondale, IL.
Office Address:	Department of Cardiothoracic Surgery Washington University School of Medicine 3rd Floor, Queeny Tower St. Louis, MO (314) 362-7327
Home Address:	11565 Tivoli Lane St. Louis, MO (314) 567-1460
Family:	Wife: Felicia Crabtree Children: Ellie (5), Abby (4), & Jakob (1)

SPECIFIC SURGICAL INTERESTS:

Off-pump coronary revascularization, mitral valve repair, aortic and aortic root surgery, arrhythmia surgery (ie. MAZE), noncardiac thoracic surgery, esophageal surgery, etc.

TRAINING:

Fellow in Cardiothoracic Surgery
Washington University Dept. of Surgery
July 2002-Present

Chief Resident in General Surgery
University of Virginia Dept. of Surgery
July, 2001-June, 2002

Resident in General Surgery
University of Virginia Dept. of Surgery
July, 1999-June, 2001

Surgical Infectious Disease Research Fellow
University of Virginia Dept. of Surgery
July, 1997-June, 1999

Resident in General Surgery
University of Virginia Dept. of Surgery
July, 1996-June, 1997

Intern in General Surgery
University of Virginia Dept. of Surgery
June, 1995-June, 1996

EDUCATION:

M.D., Southern Illinois University School of Medicine
Springfield, IL.
August, 1991-May, 1995

B.S., University of Illinois, Champaign-Urbana
Major: Biology
August, 1987-May, 1991

CME CREDITS

-Advanced Laparoscopic Techniques Course sponsored by SAGES. Cleveland, OH. Nov. 3-4, 2000.
-Ultrasound for Surgeons course sponsored by ACOS. Orlando, FL. Oct. 8-9, 1998.

HONORS/AWARDS:
RECENT:

-University of Virginia School of Medicine Resident Teaching Award-2002
-Pharmacia/Upjohn Academic Achievement Resident Award-2000
-John Horsley Memorial Prize for best publication among UVA medical alumni-2000
-Dean Edwin Pullen Anatomy Resident Teaching Award (1998-1999)
-Winner, Gold Medal Forum for best paper presented at the Southeastern Surgical Congress Annual Meeting, 1999.
-Kass Fellowship Award Recipient for the presentation at the 36th Annual Meeting of the Infectious Disease Society of America, Denver, CO. 1998.
-National Research Service Award Recipient, May 1998.

MEDICAL SCHOOL:

-UPJOHN Academic Achievement Award SIU Class of 1995 (Awarded to 1 student/yr by faculty selection)
- AOA (Selected in Junior Year)
- AOA President for SIU Class of 1995
-1st and 2nd Year Academic Honors for completion of Research Honors Project
-Chosen as SIU Student Representative to attend the 1994 80th Annual Clinical Congress of the American College of Surgeons
-Class Representative, 1st and 2nd year

UNDERGRADUATE:

-suma cum laude
-Bronze Tablet (Highest University Recognition for Academic Achievement)
-University Honorary Distinction for Independent Research
-Phi Beta Kappa
-School of Life Sciences' Scholarship for Independent Research

RESEARCH FUNDING:

-May 1998-July 1999: **National Research Service Award #1F32GM19423-01** from the National Institutes of Health. The Neutrophil Response to Hemolysin-producing E. coli.

RESEARCH AND PUBLICATIONS:

1. Sawyer RG, **Crabtree TD**, Gleason TG, Antevil JL, Pruett TL. Impact of solid organ transplantation and immunosuppression on fever, leukocytosis, and physiologic response during bacterial and fungal infections. Clin Transplant 1999;13:260-265.
2. **Crabtree TD**, Gleason TG, Pruett TL, Sawyer RG. Trends in nosocomial pneumonia in surgical patients as we approach the 21st century: a prospective analysis. Am Surg 1999;65:706-709.
3. **Crabtree TD**, Pelletier SJ, Gleason TG, Pruett TL, Sawyer RG. Clinical characteristics and antibiotic utilization in surgical patients with Clostridium difficile-associated diarrhea. Am Surg 1999;65:507-511.
4. Gleason TG, **Crabtree TD**, Pelletier SJ, Karchmer T, Raymond DP, Pruett TL, Sawyer RG. Infection with antibiotic-resistant gram positive cocci predicts a poorer prognosis than infection with antibiotic-sensitive strains. Arch Surg 1999;134:1033-1040.
5. **Crabtree TD**, Pelletier SJ, Gleason TG, Pruett TL, Sawyer RG. Analysis of aminoglycosides in the treatment of gram-negative infections in surgical patients. Arch Surg 1999;134:1300-1308.

6. Pelletier SJ, **Crabtree TD**, Gleason TG, Banas LE, Patel SR, Pruett TL, Sawyer RG. Waiting for microbiologic data to direct therapy against nosocomial infections does not worsen outcome in febrile surgical patients. Arch Surg 1999;134:1293-1299.
7. **Crabtree TD**, Pelletier SJ, Gleason TG, Pruett TL, Sawyer RG. Gender-dependent differences in outcome after the treatment of infection in hospitalized patients. JAMA 1999;282:2143-2148.
8. Pelletier SJ, **Crabtree TD**, Gleason TG, Raymond DP, Oh CK, Pruett TL, Sawyer RG. Characteristics of infectious complications associated with mortality after solid organ transplantation. Clin Transplant 2000;14:401-408.
9. Pelletier SJ, **Crabtree TD**, Gleason TG, PruettTL, and Sawyer RG. Bacteremia associated with central venous catheter infection is not an independent predictor of outcome. J Am Coll Surg 2000;190:671-680.
10. Pelletier SJ, Iezzoni JC, **Crabtree TD**, Hahn YS, Sawyer RG, Pruett TL. Prediction of graft fibrosis by clinical parameters and early macrovesicular steatosis after liver transplantation for hepatitis C virus. Liver Transpl 2000;6:44-53.
11. Claridge JA, **Crabtree TD**, Pelletier SJ, Butler K, Sawyer RG, Young JS. Persistant occult hypoperfusion is associated with a significant increase in infection rate and mortality in major trauma patients. J Trauma 2000;48:8-14.
12. Pelletier SJ, Raymond DP, **Crabtree TD**, Berg CL, Iezzoni JC, Hahn YS, Sawyer RG, Pruett TL. Hepatitis C-induced hepatitis allograft injury is associated with a pretransplant elevated viral replication rate. Hepatology 2000;32:418-426.
13. Pelletier SJ, Iezzoni JC, **Crabtree TD**, Raymond DP, Sawyer RG, Hahn YS, and Pruett TL. Pretransplant hepatitis C virus envelope diversity may be predictive of long-term outcome after liver transplantation. Hepatology 2000;32:375-381.
14. Jin L, Raymond DP, **Crabtree TD**, Houlgrave CW, Pelletier SJ, Pruett TL, Sawyer RG. Enhanced murine macrophage tumor necrosis factor receptor shedding by CpG in oligodeoxynucleotides. J Immunol 2000;165:5153-5160.
15. Raymond DP, **Crabtree TD**, Pelletier SJ, Gleason TG, Banas LE, Patel S, Pruett TL, Sawyer RG. Extremes of white blood cell count do not independently predict outcome among surgical patients with infection. Am Surg 2000;66:1124-1131.
16. **Crabtree TD**, Jin L, Raymond DP, Pelletier SJ, Houlgrave W, Gleason TG, Pruett TL, Sawyer RG. Preexposure of murine macrophages to CpG oligonucleotide results in a biphasic TNF-α response to subsequent LPS challenge. Infect Immun 2001;69:2123-2129.
17. Raymond DP, Pelletier SJ, **Crabtree TD**, Gleason TG, Pruett TL, Sawyer RG. Impact of bloodstream infection on outcomes among infected, hospitalized surgical patients. Ann Surg 2001;233:549-555.
18. **Crabtree TD**, Pelletier SJ, JL Antevil, Gleason TG, Pruett TL, and Sawyer RG. Cohort study of fever and leukocytosis as diagnostic and prognostic indicators in infected surgical patients. World J Surg 2001;25:739-744.
19. Sawyer RG, Raymond DP, Pelletier SJ, **Crabtree TD**, Gleason TG, Pruett TL. Implications of 2,457 consecutive surgical infections entering the year 2000. Ann Surg 2001;233:867-874.
20. Raymond DP, Pelletier SJ, **Crabtree TD**, Gleason TG, Hamm LL, Pruett TL, Sawyer RG. Impact of a rotating empiric antibiotic schedule on infectious mortality in an intensive care unit. Crit Care Med 2001;29:1101-1108.

21. Evans HL, Raymond DP, Pelletier SJ, **Crabtree TD**, Pruett TL, Sawyer RG. Diagnosis of intra-abdominal infection in the critically ill patient. Current Opinion in Critical Care 2001;7:117-21.
22. Raymond DP, Pelletier SJ, **Crabtree TD**, Schulman AM, Pruett TL, Sawyer RG. Surgical infection and the aging population. Am Surg 2001;67:827-832.
23. Evans HL, Raymond DP, Pelletier SJ, **Crabtree TD**, Pruett TL, Sawyer RG. Tertiary peritonitis (recurrent diffuse or localized disease) is not an independent predictor of mortality in surgical patients with intra-abdominal infection. Surgical Infections 2001;2:255-265.
24. Pelletier SJ, Raymond DP, **Crabtree TD**, Gleason TG, Pruett TL, Sawyer RG. Outcome analysis of intra-abdominal infection with resistant gram-positive organisms. Surgical Infections 2002;3:11-19.
25. **Crabtree TD**, Pelletier SJ, Raymond DP, Antevil JT, Gleason TG, Pruett TL, Sawyer RG. Effect of changes in surgical practice on the rate and detection of nosocomial infections: a prospective analysis. Shock 2002;17:258-262.
26. Pelletier SJ, Isaacs RB, Raymond DP, **Crabtree TD**, Spencer CE, Gleason TG, Pruett TL, Sawyer RG. Ethnic disparities in outcome from posttransplant infections. Shock, *in press*.
27. Jin L, Raymond DP, **Crabtree TD**, Pelletier SJ, Rudy CK, Pruett TL, Sawyer RG. Pre-exposure of murine macrophages to CpG ODN Results in NF-κB p50 homodimer-associated hypo-responsiveness. Surgery 2002;132(2):245-251.
28. Raymond DP, Pelletier SJ, **Crabtree TD**, Evans HL, Pruett TL, Sawyer RG. Impact of antibiotic resistant Gram negative bacilli infections on outcome in hospitalized patients. Crit Care Med 2003;31(4):1035-1041.
29. Pelletier SJ, Banas LE, Raymond DP, **Crabtree TD**, Gleason TG, Pruett TL, Sawyer RG. Effect of ethnicity on mortality after infection among hospitalized patients. (Submitted for publication).
30. **Crabtree T**, Smith M, Patterson A. Pulmonary Resection for Focal Lung Disease Secondary to Cystic Fibrosis (work in progress).
31. **Crabtree T**, Belle J, Patterson A, Cooper J, Meyers B. Utility of prophylactic minitracheostomy tube placement in lung resection patients at high risk for postoperative pulmonary complications: a randomized controlled trial (work in progress).

Abstracts

1. Raymond DP, Pelletier SJ, **Crabtree TD**, Pruett TL, Sawyer. Recurrent pneumonia in hospitalized surgical patients: risk factors and outcomes. Submitted to the Society of Critical Care Medicine 30th International Educational and Scientific Symposium, 2001.
2. Raymond DP, Pelletier SJ, **Crabtree TD**, Schulman AM, Pruett TL, Sawyer. Surgical Infection and the Aging Population. Submitted to the Annual Meeting of the Southeastern Surgical Congress, New Orleans, LA. Feb. 4-6, 20001.
3. Jin L, Raymond DP, Pelletier SJ, **Crabtree TD**, Rudy CK, Pruett TL, Sawyer RG. Effect of CpG oligonucleotide pre-exposure on NF-κB activity in response to endotoxin. Submitted to the 62nd Annual Meeting of the Society of University Surgeons, Chicago, IL. Feb. 8-10, 2001.

4. Sawyer RG, Raymond DP, Pelletier SJ, **Crabtree TD**, Gleason TG, Pruett TL. 12K @ Y2K: Implications of 2,457 consecutive surgical infections entering the year 2000. Submitted to the 2000 Meeting of the Southern Surgical Association.
5. Pelletier SJ, Raymond DP, **Crabtree TD**, Iezonni JC, Hahn YS, Sawyer RG, Pruett TL. Hepatitis C-induced hepatic allograft injury associated with a pretransplant elevated viral replication rate. Presented at the 61st Annual Meeting of the Society of University Surgeons, Toronto, Ontario, February 10-12, 2000.
6. Houlgrave CW, **Crabtree TD**, Pelletier SJ, Jin L, Sawyer RG, Pruett TL. Sublytic concentrations of active and inactive E. coli alpha-hemolysin inhibit IL-8 secretion by human neutrophils. Accepted for presentation at the 1st International Congress on Cytokines and Chemokines In Infectious Diseases, Bethesda, MD, September 8-10, 1999.
7. **Crabtree TD**, Pelletier SJ, Jin L, Houlgrave W, Pruett TL, Sawyer RG. CpG DNA motifs cause early endotoxin sensitivity followed by delayed, IL-10 mediated insensitivity in macrophages. Presented at the American College of Surgeons Meeting, San Francisco, CA, October, 1999.
8. Pelletier SJ, **Crabtree TD**, Gleason TG, Pruett TL, Sawyer RG. Bacteremia associated with central venous catheters is not an independent predictor of outcome. Presented at the American College of Surgeons Meeting, San Francisco, CA, October, 1999.
9. Raymond DP, **Crabtree TD**, Pelletier SJ, Gleason TG Banas LE, Patel S, Pruett TL, Sawyer, RG. Extremes of White Blood Cell Count Are Not Independently Predictive Of A Worse Outcome Among Surgical Patients With Infection. Accepted as a Gold Medal Forum Paper for the Annual Meeting of the Southeastern Surgical Congress, Lake Buena Vista, FL, Feb. 2000.
10. Pelletier SJ, Isaacs R, **Crabtree TD**, Gleason TG, Lobo P, Pruett TL, and Sawyer RG. Interracial differences in posttransplant infections. Accepted for presentation at the American Society of Transplantation Meeting, Chicago, IL, May, 1999. Published in *Transplantation* 1999;67:S94.
11. **Crabtree TD**, Pelletier SJ, Gleason TG, Sawyer RG, Pruett TL. Are aminoglycosides associated with increased mortality in surgical patients treated for gram negative infection? Accepted for presentation at the Surgical Infection Society Meeting, Seattle, WA, April 1999.
12. Gleason TG, **Crabtree TD**, Pelletier SJ, Raymond DP, Karchmer TB, Pruett TL, Sawyer RG. Infection with antibiotic-resistant gram positive cocci predicts a poorer prognosis than infection with antibiotic-sensitive strains. Presented at the Surgical Infection Society Meeting, Seattle, WA, April 1999.
13. Pelletier SJ, **Crabtree TD**, Gleason TG, Sawyer RG, Pruett TL. Waiting for microbiologic data to direct therapy against nosocomial infections does not worsen outcome in surgical patients. Presented at the Surgical Infection Society Meeting, Seattle, WA, April 1999.
14. **Crabtree TD**, Pelletier SJ, Gleason TG, Pruett TL, Sawyer RG. Prospective study of Clostridium difficile colitis in surgical patients. Presented at the Southeastern Surgical Congress, Tampa, FL, February, 1999. Winner of the Gold Medal Forum Award for best paper and presentation.
15. **Crabtree TD**, Zhou J, Houlgrave WC, Gleason TG, Pruett TL, Sawyer RG. Bacterial DNA Augments LPS Lethality But Induces Tolerance to LPS In Vitro. The 84th Annual Clinical Congress of the American College of Surgeons. 1998.

16. **Crabtree TD**, Gleason TG, Pruett TL, Sawyer RG. Trends in Nosocomial Pneumonia in Surgical Patients as we Approach the 21st Century: A Prospective Analysis. Abstract of the 41st Annual Meeting of the Midwest Surgical Association. 1998: paper #17.
17. **Crabtree TD**, Antevil JL, Gleason TG, Pruett TL, Sawyer RG. Prospective Study of Fever As A Diagnostic And Prognostic Indicator In Surgical Patients Treated For Suspected Infection. Abstract for the 18th Annual Meeting of the Surgical Infection Society. 1998: p. 46.
18. Raman, J., Divenere, S.W., **Crabtree, T.D.,** Trupin, S., M.D., Dawson, M.J. Demonstration of Biochemical Abnormalities in Placenta of Women with Abnormal Glucose Tolerance Using 31P NMR. Abstract of the 10th Annual Meeting of the Society of Magnetic Resonance in Medicine. 1991:Vol. 2, p. 642.
19. Xu, S., Raman, J., Divenere, S.W., **Crabtree, T.D.,** Trupin, S., Dawson, M.J. Biochemical Abnormalities in Placenta of Women with Abnormal Glucose Tolerance. Abstract of the Fourth Annual Cell & Molecular Biology/Molecular Biophysics Training Grant Research Symposium, Urbana, IL., Sept. 7, 1991.
20. **Crabtree, T.D.** In-vitro Studies of Normal Human Placental Tissue Using Phorphorus-31 Nuclear Magnetic Resonance Spectroscopy. Accepted for University Honorary Distinction for Independent Research at the University of Illinois. April, 1991. (Available upon request).
21. Pelletier SJ, **Crabtree TD**, Lillard T, McGory R, Ryan T, Sawyer RG, Hahn YS, Pruett TL. Increased preoperative quasispecies diversity may be predictive of long-term outcome after orthotopic liver transplantation for hepatitis C virus. Accepted for presentation at the American Society of Transplant Surgeons Meeting, Chicago, IL, May 1999.
22. Pelletier SJ, **Crabtree TD**, Lillard T, McGory R, Ryan T, Sawyer RG, Hahn YS, Pruett TL. Hepatitis C virus and liver transplantation: increased quasispecies diversity may predict recurrent hepatitis. Accepted for presentation at the 5th International Liver Transplantation Society Meeting, Pittsburgh, PA, August 1999.
23. Pelletier SJ, Iezzoni J, **Crabtree TD**, Sawyer RG, Hahn YS, Pruett TL. Clinical hepatitis after liver transplantation is predictive of hepatitis C virus-induced graft fibrosis. Accepted for presentation at the 6th International Symposium on Hepatitis C & Related Viruses Meeting, Bethesda, MD, June 1999.
24. Pelletier SJ, Raymond DP, **Crabtree TD**, Gleason TG, Pruett TL, Sawyer RG. Outcome analysis of intra-abdominal infection with resistant gram-positive organisms. Submitted to the Annual Meeting of the Southeastern Surgical Congress, Lake Buena Vista, FL, Feb. 2000.
25. Raymond DP, Pelletier SJ, **Crabtree TD**, Pruett TL, Sawyer RG. Blood stream infection is not an independent predictor of mortality in surgical patients. Presented at the 5th World Congress on Trauma, Shock, Inflammation, and Sepsis – Munich, Germany, February 29-March 4, 2000 and published in *Shock* 2000; 13: suppl. 1:136.
26. Pelletier SJ, Banas LE, Raymond DP, **Crabtree TD**, Gleason TG, Patel S, Pruett TL, Sawyer RG. Ethnicity independently predicts mortality associated with infection in surgical patients. Submitted to the 20th Annual Meeting of the Surgical Infection Society, Providence, RI, May, 2000.
27. Raymond DP, Pelletier SJ, **Crabtree TD**, Gleason TG, Hamm LL, Calfee DP, Pruett TL, Sawyer RG. Improvement in outcomes following the initiation of a rotating empiric

antibiotic schedule in an ICU. Accepted to the 20th Annual Meeting of the Surgical Infection Society, Providence, RI, May, 2000.

28. Raymond DP, Jin L, Pelletier SJ, **Crabtree TD**, Gleason TG, Pruett TL, Sawyer RG. Macrophage TNF-alpha receptor synthesis, expression, and shedding in response to CpG oligonucleotide exposure. Submitted for presentation at the American College of Surgeons Clinical Congress, Chicago, IL, October 22-27, 2000.

BOOKS

Crabtree TD, Foley E, Sawyer RG. Board Review Series: General Surgery. Lippincott Williams and Wilkins, Philadelphia, PA, (April 2000).

Crabtree TD, Foley E, Sawyer RG. Board Review Series: Surgical Specialties. Lippincott Williams and Wilkins, Philadelphia, PA, (May 2000).

BOOK CHAPTERS

Crabtree TD, Moon MR. Complications of Coronary Revascularization in Complications in Surgery by Doherty GM, Mulholland M (Eds). Lippincott Williams and Wilkins, Ann Arbor (2004).

Pruett TL, **Crabtree TD**, Pelletier SJ. Surgical Antiseptics Chapter in Disinfection, Sterilization, and Preservation, 5th Edition. By Seymour S. Block. Lippincott Williams and Wilkins, Media, PA, (2002).

Cephas G, **Crabtree TD**. Surgical Nutrition Chapter in Board Review Series: General Surgery. Ed. Crabtree TD, Foley E, Sawyer RG. Lippincott Williams and Wilkins, Philadelphia, PA (April 2000).

Crabtree TD. Liver Chapter in Board Review Series: General Surgery. Ed. Crabtree TD, Foley E, Sawyer RG. Lippincott Williams and Wilkins, Philadelphia, PA (April 2000).

Crabtree TD. Surgical Infections Chapter in Board Review Series: General Surgery. Ed. Crabtree TD, Foley E, Sawyer RG. Lippincott Williams and Wilkins, Philadelphia, PA (April 2000).

Crabtree TD. Hernias and Lesions of the Abdominal Wall Chapter in Board Review Series: General Surgery. Ed. Crabtree TD, Foley E, Sawyer RG. Lippincott Williams and Wilkins, Philadelphia, PA (April 2000).

NBME Part 1 Score:	Raw Score: 251	Percentile Ranking: 99th
NBME Part 2 Score:	Raw Score: 256	Percentile Ranking: 99th
Inservice exam	PGY-1	Percentile Ranking: 99th
	PGY-2	Percentile Ranking: 99th
	PGY-3	Percentile Ranking: 99th
General Surgery Qualifying Exam		Percentile Ranking: 99th

Board Certified in General Surgery after passing oral boards

RALPH JAMES DAMIANO, JR., M.D.

Washington University School of Medicine
Campus Box 8234
3108 Queeny Tower
St. Louis, MO 63110

314-362-7327 (office phone)
314-747-0917 (fax)
e-mail:
damianor@wustl.edu

Birthplace and Date:	White Plains, New York; 11/03/54
Marital Status	Married on May 12, 1979, to Diane Louise Fenzel Ellicott City, Maryland
Children:	Nicholas (b. 4/11/83) Cara (b. 10/9/85) Devon (b. 4/20/87)

MEDICAL LICENSURE:

Diplomate of National Board of Medical Examiners, March 1981

North Carolina Medical License #32678, August 1988
Virginia State Medical License #0101043574, March, 1989
Pennsylvania State Medical License #MD-058352L, March, 1996
Missouri State Medical License #2000 152 513, April, 2000
Illinois State Medical License #36111563, June, 2004

BOARD CERTIFICATION:

American Board of Surgery September, 1990
American Board of Thoracic Surgery June, 1992
American Board of Thoracic Surgery Recertified December, 2002

UNDERGRADUATE EDUCATION:

Dartmouth College, B.A., Summa cum laude
August 1972-June 1976

UNDERGRADUATE HONORS AND ACHIEVEMENTS:

Summa cum laude
Phi Beta Kappa
Rufus Choate Scholar, 1972-1976
President, Gamma Delta Chi Fraternity
Member, Interfraternity Council
Varsity Crew

MEDICAL SCHOOL:

Duke University School of Medicine
Durham, N.C.
August 1976-May 1980

MEDICAL SCHOOL HONORS AND ACHIEVEMENTS:

Alpha Omega Alpha
Social Vice President, Sophomore Class

POSTGRADUATE TRAINING:

July 1980 - June 1981:	Intern in Surgery Duke University Medical Center Durham, North Carolina
July 1981 - June 1982:	Junior Assistant Resident in Surgery Duke University Medical Center Durham, North Carolina
July 1982 - June 1984:	Research Fellow, Recipient of National Institute of Health National Research Service Award Duke University Medical Center Durham, North Carolina
July 1984 - June 1987:	Senior Assistant Resident in Surgery Duke University Medical Center Durham, North Carolina
July 1987 - June 1988:	Chief Resident in Surgery Duke University Medical Center Durham, North Carolina
July 1988 - June 1989:	Teaching Scholar in Cardiac Surgery Duke University Medical Center Durham, North Carolina

POSTGRADUATE HONORS AND AWARDS:

July 1982 - Junc 1984	United States Public Health Service Individual National Research Service Award National Institute of Health
July 1991 - July 1993	American College of Surgeons Faculty Fellowship Award "Electrophysiologic Consequences of Surgical Ischemia"
June 1997	Computerworld Smithsonian Award "Robotically Assisted Microsurgery for Coronary Bypass Grafting"

ACADEMIC APPOINTMENTS:

July 1989 - June 1995:	Assistant Professor of Surgery Director, Surgical Electrophysiology Medical College of Virginia Richmond, Virginia
July 1989 - June 1995:	Assistant Professor of Surgery McGuire Veterans Administration Hospital Richmond, Virginia
July 1991 - Mareh 1996:	Medical Director Richmond Memorial Hospital/MCV Heart Program Richmond, Virginia

ACADEMIC APPOINTMENTS (continued)

July 1995 - March 1996:	Associate Professor of Surgery Director, Surgical Electrophysiology Director, Cardiothoracic Surgical Research Laboratories Medical College of Virginia
July 1995 - March 1996:	Associate Professor McGuire Veterans Administration Hospital Richmond, Virginia
March 1996 - April 2000:	Professor of Surgery Chief, Division of Cardiothoracic Surgery Program Director Associate Director, Penn State Cardiovascular Center Milton S. Hershey Medical Center Penn State University Penn State Geisinger Health System Hershey, Pennsylvania
July 1996 - April 2000	Professor of Surgery and Cellular and Molecular Physiology Chief, Division of Cardiothoracic Surgery Associate Director, Penn State Cardiovascular Center Milton S. Hershey Medical Center Penn State University Penn State Geisinger Health System Hershey, Pennsylvania
January 1999 - April 2000	Co-Director Penn State Cardiovascular Center
April 2000 - Present	Professor of Surgery Chief of Cardiac Surgery Washington University School of Medicine St. Louis, Missouri
July 2000 – Present	John M. Shoenberg Professor of Surgery Chief of Cardiac Surgery Washington University School of Medicine St. Louis, Missouri

HOSPITAL APPOINTMENTS:

July 1989 - March 1996	Medical College of Virginia Richmond, Virginia
July 1989 - March 1996	McGuire VA Hospital Richmond, Virginia
July 1989 - March 1996	Richmond Memorial Hospital Richmond, Virginia

HOSPITAL APPOINTMENTS (continued)

May 1992 - March 1996	Henrico Doctors' Hospital Richmond, Virginia
March 1996 - April 2000	Milton S. Hershey Medical Center Hershey, Pennsylvania
April 2000 - Present	Barnes-Jewish Hospital St. Louis, Missouri

ORGANIZATIONS:

Eagle Scout
Phi Beta Kappa, 1976
Alpha Omega Alpha, 1980
Association for Academic Surgery, 1989
Richmond Academy of Medicine, 1990
David C. Sabiston, Jr., Surgical Society, 1989
Virginia Surgical Society, 1991
American College of Surgeons (Associate Fellow), 1991
Council on Cardiothoracic and Vascular Surgery of the American Heart Association., 1992
Society of Thoracic Surgeons, 1992
North American Society of Pacing and Electrophysiology, 1992
Richmond Surgical Society, 1993
Cardiac Surgery Biology Club, 1993
American Physiological Society, 1993
American College of Surgeons (Fellow), 1994
American Association for Thoracic Surgery, 1994
American Association for the Advancement of Science, 1994
Surgical Biology Club III, 1994
Southern Thoracic Surgical Association, 1994
Young Surgeons Society, 1995
Southern Surgical Association, 1995
Society for Thoracic Surgical Education, 1996
Thoracic Surgery Directors Association, 1996
Hinkle Society, 1996
Hershey Surgical Society, 1996
Socicty of Clinical Surgery, 1996
Society of University Surgeons, 1997
Pennsylvania Association of Thoracic Surgery, 1997
International Society of Minimally Invasive Cardiac Surgery, 1998
American Surgical Association, 2000
Erlanger-Graham Society, 2000
St. Louis Thoracic Surgical Society, 2001
American Heart Association (Fellow), 2002
Halstead Society, 2003
American College of Cardiology, 2003

COMMITTEES:

University:

October 1987 - June 1989	Patient Care Management Subcommittee of the Medical Center Information Systems Advisor Committee Duke University Medical Center
December 1989 - March 1996	Surgical Quality Assurance Committee Medical College of Virginia
January 1990 - March 1996	Intensive Care Unit Committee Richmond Memorial Hospital
January 1991 - March 1996	Surgical Quality Assurance Committee Richmond Memorial Hospital
September 1993 - March 1996	Research Committee MCV Heart Center Richmond, Virginia
August 1994 - March 1996	Chairman, Surgical Quality Assurance Committee Medical College of Virginia
August 1994 - May 1995	Faculty Practice Committee, Department of Surgery Medical College of Virginia
September 1994 - March 1996	Medical Staff Quality Assessment and Improvement Committee Medical College of Virginia
October 1994 - March 1996	Medical Staff Quality Improvement Committee Richmond Memorial Hospital
January 1995 - March 1996	J.B. Foote Foundation Grant Peer Review Board Medical College of Virginia
July 1995 - March 1996	M.D./Ph.D. Committee Medical College of Virginia
April 1996 - April 2000	Surgical Council Penn State University
April 1996 - April 2000	Executive Committee Penn State Cardiovascular Center
April 1996 - April 2000	Operating Room Committee Penn State University
April 1996 - April 2000	Research Committee Penn State Cardiovascular Center
April 1996 - April 2000	Cardiothoracic Service Board Penn State University
April, 1996 - April 2000	Medical Director, Perfusion Program Penn State University

COMMITTEES - University (continued)

September 1996 - November 1996	Search Committee for Chief, Internal Medicine Penn State University
September 1996 - January 1997	Medicare Task Force, Chairman Penn State University
January 1997 - January 1998	Albumin Task Force Penn State University
July 1997 - April 2000	Department of Surgery, Promotion & Tenure Committee Penn State University
July 1997 - April 2000	Residency Directors Committee Penn State Geisinger Health System
November 1997 - May 1998	Search Committee, Chair of Department of Anesthesia Penn State Geisinger Health System
November 1998 - March 1999	Fee for Service Compensation Advisory Committee Penn State Geisinger Health System
January 1999 - September 1999	Material Management Redesign Project Co-Chairman Penn State Geisinger Health System
January 1999 - April 2000	Executive Committee Penn State University College of Medicine
March 1999 - April 2000	Elected Member, Regional Council Penn State Geisinger Health System
August 1999 - April 2000	Ad-Hoc Bylaws Committee, Hershey Region Penn State Geisinger Health System
August 1999 - April 2000	Compensation Committee, Hershey Medical Center Penn State Geisinger Health System
September 1999 - April 2000	Research Advisory Committee, Department of Surgery Penn State Geisinger Health System
September 1999 - April 2000	Billing Advisory Committee Penn State University
April 2000 - Present	Venture Capital Committee Washington University School of Medicine
June 2000 – Present	Finance Committee, Division of Cardiothoracic Surgery Washington University School of Medicine

COMMITTEES – University (continued)

June 2000 – Present	Chairman, Cardiac Service Board Washington University School of Medicine/Barnes-Jewish Hospital
June 2000 – Present	Co-Chairman, Heart Services Leadership Committee Washington University School of Medicine/Barnes-Jewish Hospital
April 2001 – Present	Co-Chairman, OR Efficiency Task Force Washington University School of Medicine/Barnes-Jewish Hospital
November 2001 – Present	Program Director and Affiliate Liaison Skaggs Community Hospital Cardiac Surgery Program

State:

January 1995 - March 1996	American Heart Association VA Affiliate Peer Review Committee Richmond, Virginia
May 1999 - April 2000	PA Chapter of American College of Cardiology Expert Panel Response System
June 1999	Consultant, Chief of Cardiac Surgery; Lehigh Valley Hospital Search Committee Allentown, Pennsylvania
January 2002 – April 2002	Chairman, Search Committee Skaggs Community Hospital Chief of Cardiac Surgery Branson, Missouri
January 2003 – April 2004	Chairman, Search Committee Good Samaritan Hospital Chief of Cardiac Surgery Mt. Vernon, Illinois

National:

July 1993 - January 1995	Cardiac Electrical Problems Subcommittee Ad Hoc Committee for Cardiothoracic Surgical Practice Guidelines
August 1994 - January 2000	Coordinating Committee of Continuing Education for Thoracic Surgery (CCCETS) Chicago, Illinois
May 1995 - July 1997	Lead Advisory Board Ventritex Inc.; Sunnyvale, CA

COMMITTEES - National (continued)

January 1996	Ad hoc Member Surgery, Anesthesiology and Trauma Study Section Division of Research Grants National Institutes of Health
July 1996 - Present	Member, Anesthesiology Radiology and Surgery Peer Review Committee American Heart Association
November 1996 - Present	Advisory Board Computer Motion, Inc.; Goleta, CA
September 1997 - Present	Medical Advisory Board Kensey Nash Corporation; Exton, PA
October 1997 – December, 1999	Member, National American Heart Association Research Committee
December 1997 - December 1999	Examination Consultant Committee American Board of Thoracic Surgery; Evanston, IL
January 1998 - Present	Editorial Review Group Chair, Cardiothoracic Surgery Doody Publishing
January 1998 - January 1999	Surgeon Advisory Board US Surgical Corporation; Norwalk, CT
January 1998 - Present	Research Committee Thoracic Surgery Research Foundation
May 1998 - Present	Cardiac Surgery Advisory Board Medtronic, Inc.; Minneapolis, MN
June 1998	Congress Chairman Second Annual International Congress on Computers and Robotics in the Operating Room Santa Barbara, CA
July 1998 – June 2002	Member, Surgery and Biomedical Engineering Study Section Division of Research Grants National Institutes of Health
November 1998 - March 1999	Surgery Advisory Board 3M/Sarns Corp.; St. Paul, MN
November, 1999 - Present	Executive Committee Council on Cardiothoracic and Vascular Surgery American Heart Association
December, 1999 - Present	Clinical Advisory Committee Medical Image Computer & Computer Assisted Intervention 2000

COMMITTEES - National (continued)

March 2000	Consultant, Robert Wood Johnson School of Medicine University of Medicine and Dentistry of New Jersey Search Committee for Chief of Cardiothoracic Surgery
April 2000 - Present	Scientific Advisory Board Atricure, Inc., West Chester, OH
April 2000 - Present	Scientific Advisory Board AFx, Inc.; Fremont, CA
June 2000 – Present	Co- Chairman, Cardiothoracic Residents Committee American Association for Thoracic Surgery
September 2000 – Present	Surgical Advisory Board Terumo Cardiovascular; St. Paul, Minnesota
June 2001 – July 2003	Chairman, Cardiothoracic Residents' Committee American Association for Thoracic Surgery
October 2001 – Present	Committee on Video-Based Education American College of Surgeons
April 2002 – Present	Research Advisory Committee American Association for Thoracic Surgery
November 2002 – Present	Treasurer, Society of Clinical Surgery
November 2002 – June 2003	Program Committee International Society of Minimally Invasive Surgery
January 2003 – Present	Ad Hoc Research Advisory Committee American Association for Thoracic Surgery
January 2003 – Present	International Advisory Board World Heart Foundation
September, 2003 – Present	Chairman, Education Subgroup AATS Retreat
January 2004 – Present	Board of Directors International Society of Minimally Invasive Surgery
January 2004 – April 2004	Program Chairman Adult Cardiac Surgery Symposium AATS
April 2004 – Present	Program Chairman Cardiac Surgery Biology Club
May 2004 – Present	Program Committee American Association for Thoracic Surgery

COMMITTEES - National (continued)

May 2004 – Present	Chairman, Postgraduate Course Advisory Committee American Association for Thoracic Surgery
December 2004 – Present	Member, Workforce on Annual Meeting/TechCon Society of Thoracic Surgeons

GRADUATE STUDENT TRAINING:

Jitendra Palmar, FRCS	1989-1990	Consultant in Cardiothoracic Surgery Walsgrave Hospital Coventry, England
Michael K. Belz, M.D.	1990-1991	Department of Medicine Medical College of Virginia
Brian K. Holdaway, M.D.	1991-1992	Department of Medicine Medical College of Virginia
Neri M. Cohen, M.D., Ph.D.	1991-1993	Department of Surgery Medical College of Virginia Present Position: Assistant Professor of Surgery Medical College of Virginia
Steven L. Maskal, M.D.	1993-1995	Department of Surgery Medical College of Virginia
Gary L. Harrington, M.D.	1993-1995	Department of Surgery Medical College of Virginia
Jennifer S. Lawton, M.D.	1994-1996	Department of Surgery Medical College of Virginia Present Position: Assistant Professor of Surgery Washington University School of Medicine
A. Mark Jayawant, M.D.	1995-1997	Department of Surgery Medical College of Virginia
Dong-Ping Hua, M.D.	1995-1997	Department of Surgery Renji Hospital Shanghai, China
Edward Stephenson, M.D.	1996-1998	Department of Surgery Hershey Medical Center Present Position: Assistant Professor of Surgery Penn State University
Christopher Ducko, M.D.	1997-1999	Department of Surgery Hershey Medical Center
Eric Hoenicke, M.D.	1998-2000	Department of Surgery Hershey Medical Center

GRADUATE STUDENT TRAINING (CONTINUED):

Robert Strange, M.D.	1999-2001	Department of Surgery Hershey Medical Center
Sunil Prasad, MD	2000-2002	Department of Surgery Washington University School of Medicine
Michael Diodato, MD	2001-2003	Department of Surgery Washington University School of Medicine
Sydney Gaynor, MD	2002-2004	Department of Surgery Washington University School of Medicine
Yosuke Ishii, MD	2002-2004	Department of Surgery Washington University School of Medicine
Sinichi Mizutani, MD	2002-2004	Department of Surgery Washington University School of Medicine
Greg Byrd, BA	2003-2005	Department of Surgery Washington University School of Medicine
Sandip Prasad, BA	2003-2004	Department of Surgery Duke University Medical School
Spencer Melby, MD	2004-2006	Department of Surgery Washington University School of Medicine
Ashraf Al-Dadah	2004-2005	Department of Surgery Washington University School of Medicine

THESIS COMMITTEES:

Kathy W. Kuelz	MS	Biomedical Engineering	1991
Christopher J.Hyatt	MS	Biomedical Engineering	1992
Sylvia Frerk	MS	Biomedical Engineering	1993
David H Keeler	MS	Biomedical Engineering	1993
Samir S. Shah	MS	Biomedical Engineering	1994
Lahn M. Fendelender	MS	Biomedical Engineering	1995
Suresh Gurunathan	MS	Biomedical Engineering	1996
Robert Shaffer	MS	Physiology	1996
Greg Byrd	MS	Physiology	2004

GUEST REVIEWER:

American Journal of Physiology
Annals of Thoracic Surgery
Circulation
Journal of Cardiac Surgery
Pacing and Clinical Electrophysiology
American Heart Journal
European Journal of Cardiothoracic Surgery

GUEST REVIEWER (continued):

Heart Surgery Forum
Journal of the American College of Surgeons

EDITORIAL BOARDS:

Journal of Thoracic and Cardiovascular Surgery
Journal of Laparoendoscopic and Advanced Surgical Techniques
Asian Cardiovascular and Thoracic Annals
Journal of Cardiovascular Surgery
New Surgery: Molecular Basis of Surgical Disease and New Technology
Journal of Surgical Research

EDITORIAL POSITIONS:

December 1998 - Present	Journal of Thoracic & Cardiovascular Surgery: Associate Editor
January 1998 - Present	Cardiothoracic Surgery, Doody Publishing Editorial Review Group Chair

RESEARCH FUNDING:

Agency	Title	Amount	Period of Support	Role
John B. Foote Grant-in-Aid	Physiological Consequences of Bundle Branch Block	$ 7,875	1/90 - 12/90	PI
VCU Grant-in-Aid	Effect of Bundle Branch Block on Ventricular Function and Fibrillation	7,000	1/90 - 12/90	PI
Virginia Commonwealth University	Electrophysiologic Consequences of Ventricular Distention	6,972	1/91- 12/91	PI
Telectronics Pacing Systems, Inc.	Electrophysiological Consequences of Acute Ventricular Distention	8,000	7/90- 6/92	PI
American College of Surgeons	Electrophysiological Consequences of Surgical Ischemia	60,000	7/91- 6/93	PI
The Upjohn Company	The Efficacy of Gelfoam Sterole Powder Paste as a Bone Hemostatic Agent During Cardiopulmonary Bypass Surgery	94,000	9/91- 9/93	PI
NIH National Research Service Award	Electrophysiological Consequences Consequences of Surgical Ischemia	59,800	9/90 - 8/92	Sponsor
American Heart Assoc. (Va. Affiliate)	Role of Ventricular Fibrillation During Internal Defibrillation	55,000	7/92- 6/94	Collab Invest

RESEARCH FUNDING (continued)

Agency	Title	Amount	Support	Role
Virginia Commonwealth Small Grant Award	Electrophysiological Predictors of Postoperative Atrial Fibrillation	5,645	7/93-6/94	PI
American Heart Assoc. (Va. Affiliate)	Hyperpolarized Cardiac Arrest During Surgical Ischemia: A New Approach to Myocardial Protection	54,770	7/93-6/95	PI
NIH National Research Service Award	Hyperpolarized Cardiac Arrest During Surgical Ischemia	59,800	10/93-9/95	Sponsor
Ventritex, Inc.	New Defibrillation Techniques Using Real-time VF Waveform Analysis	56,720	4/94-3/95	Collab Invest
American Heart Assoc. (Va. Affiliate)	Defining a Vulnerable Period of Defibrillation	65,000	7/94-6/96	Collab Invest
NIH National Research Service Award	Pathophysiology of Surgical Ischemia and Cardioplegia	59,800	9/94-8/96	Sponsor
NIH RO1	Hyperpolarized Arrest During Surgical Global Ischemia	1,004,000	4/95-3/99	PI
Whitaker Foundation	Probabilistic Nature of Defibrillation	179,998	4/95-3/98	Collab Invest
NIH National Research Service Award	The Physiology of Hyper-polarized Cardioplegic Arrest	60,500	7/95-6/97	Sponsor
A.D. Williams Research Fellowship	Hyperpolarizing Cardiac Arrest with Nicorandil	2,000	6/95-9/95	Sponsor
Ventritex, Inc.	A New Defibrillation Technique Using Real-time VF Waveform Analysis	67,270	7/95-6/96	Collab Invest
Carbomedics, Inc.	Tissue overgrowth on biolite coated and uncoated annuloplasty rings	50,000	7/97-6/98	PI
Penn State University	Physiology of Hyperpolarized Arrest	10,000	7/97-6/98	Sponsor
Penn State University	Cell Volume Regulation During Cardioplegia	10,000	7/97-6/98	Sponsor
Penn State University	Waldhausen Research Fellowship	29,000	7/97-	Sponsor
Computer Motion	Robotically-assisted Microsurgery	80,000	10/96-7/98	PI

RESEARCH FUNDING (continued)

Agency	Title	Amount	Period of Support	Role
NIH National Research Service Award	The Effect of Cardioplegia on Myocyte Volume Regulation	59,800	1/98-12/00	Sponsor
Medtronic, Inc.	Minimally Invasive MAZE Procedure	40,000	3/98-6/99	PI
Kensey-Nash Corp.	Novel Anastomotic Devices	10,000	1/99-12/99	PI
Penn State University	The Effect of Cardioplegia On Myocyte Volume Regulation	4,500	7/99-6/00	PI
Penn State University	Novel Strategies in Donor Heart Preservation	10,000	7/99-6/00	PI
Computer Motion	Beating Heart Endoscopic CABG	10,000	7/99-6/00	PI
NIH National Research Service Award	Human Myocyte Volume Regulation	59,800	7/99-6/01	Sponsor
Medtronic, Inc.	Minimally Invasive Cardiac Surgery Training Grant	30,000	2/00-1/01	Sponsor
Boston Scientific, Inc.	Endoscopic Epicardial Ablation	55,000	1/00-12/01	PI
US Surgical Corp.	Minimally Invasive Cardiac Surgery	200,000	1/00 - 11/01	PI
Medtronic, Inc.	Pulmonary Outcomes after Beating Heart Surgery	100,000	7/00 - 6/03	PI
Enable, Inc.	Minimally Invasive Arrhythmia Ablation	80,000	7/00 - 6/02	PI
NIH R44	Minimally Invasive Maze Procedure	$760,000	7/01-6/04	PI
AMed, Inc.	The Use of Right Heart Bypass to Facilitate Endoscopic CABG	$6,000	10/01-12/01	PI
NIST ATP Grant #00-00-4466	Dual-Phase Small Caliber Vascular Prosthesis	$582,610	1/02-12/04	PI
Heartstent	Evaluation of Aorto-Coronary Conduit	$55,000	11/01-6/02	PI

RESEARCH FUNDING (continued)

Agency	Title	Amount	Period of Support	Role
NIH R01 HL32257	Surgical Treatment of Cardiac Arrhythmias	$1,143,194	4/00 07/03	Co-PI
Computer Motion Inc.	A Prospective Randomized Study to Investigate the Use of the Zeus Robotic Surgical System for Assisting in the Anastomosis of LIMA to LAD in CABG	$305,409	07/01-09/02	PI
Computer Motion Inc.	A prospective randomized study to investigate the use of the ZEUS system for endoscopic harvesting of the left internal mammary artery (LIMA) in subjects undergoing a coronary artery bypass graft (CABG) procedure	$177,225	07/01 - 09/02	PI
Computer Motion Inc.	A prospective, multi-center study to investigate the use of the ZEUS MicroWrist Robotic Surgical System to assist in the anastomosis of the left internal mammary artery (LIMA) to the left anterior descending artery (LAD) in a coronary artery bypass graft (CABG) procedure	$150,255	07/02 - 07/03	PI
AtriCure	Use of the AtriCure Bipolar Coagulation System to Create Linear Lesions during Cardiac Surgery	$69,574	01/02 - 01/04	PI
Converge Medical Inc.	Study to Evaluate Safety and Performance of the Sutureless Anastomotic System (SAS) for creating coronary anastomoses	$114,533	11/02 - 09/03	PI
Guidant	Investigational Plan for the Guidant Syncrus™ Internal Cardioversion System	$119,850	07/02 - 09/03	PI
Medtronic	Effects on the Pulmonary System of Placing a Patient on Cardiopulmonary Bypass	$110,501	07/01 - present	PI
Howard Hughes Medical Institute	Research Training Fellowship	$26,500	07/03-06/04	Mentor
NIH 2 401 HL032257-21	Surgical Treatment of Cardiac Arrhythmias	$1,530,000	08/03-07/07	PI

RESEARCH FUNDING (continued)

Agency	Title	Amount	Period of Support	Role
AtriCure, Inc.	RESTORE-SR: A prospective, multi-center study with case-matched controls to evaluate the safety and efficacy of the AtriCure bipolar System for the treatment of Continuous Atrial Fibrillation as adjunct therapy to elective open-heart surgery	$366,700	05/04-11/06	Co-PI
MCRI (On-X)	Thromboembolic Related Complications—Randomized Trial of Previous and Current Generation Mechanical Prostheses	$274,275	03/04-3/11	Co-PI
NIH 1 F32 HL78136-01	Research Training Fellowship	$40,000	07/04-06/06	Mentor

BIBLIOGRAPHY

Publications

1. Damiano RJ, Ungerleider RM, Lofland GK, Williams JM, Quick G, Cox JL: Reversal of flow through chronic coronary collateral vessels. J Surg Res 30:544, 1981.

2. Jones DP, Damiano RJ, Cox JL, Wolfe WG: The effect of altitude-induced hypoxia on regional myocardial blood flow. J Thorac Cardiovasc Surg 82:216, 1981.

3. Damiano RJ, Jr., Asano T, Smith PK, Douglas JM, Jr., Ferguson TB, Jr., Cox JL: Right ventricular isolation: electrophysiologic and hemodynamic effects. Surg Forum 34:270, 1983.

4. Damiano RJ, Jr., Asano T, Smith PK, Ferguson TB, Small KW, Cox JL: Functional consequences of right ventricular isolation. Surg Forum 35:348-50, 1984.

5. Blanchard SM, Damiano RJ, Jr., Asano T, Cox JL, Lowe JE: Distant and local effects on unipolar epicardial recordings. IEEE Frontiers of Engineering and Computing in Health Care - 1984, pp 220-223, 1984.

6. Cox JL, Bardy GH, Damiano RJ Jr., German LD, Fedor JM, Kisslo JA, Packer DL, Gallagher JJ: Right ventricular isolation procedures for non-ischemic ventricular tachycardia. J Thorac Cardiovasc Surg 90:212-224, 1985.

7. Damiano RJ, Jr., Tripp HF, Jr., Asano T, Small KW, Ideker RE, Cox JL: Effect of right ventricular isolation and unilateral sympathectomy on ventricular fibrillation threshold: surgical approaches to ventricular fibrillation. Surg Forum 36:230-232, 1985.

8. Blanchard SM, Damiano RJ, Jr., Smith WM, Ideker RE, Lowe JE: Estimating electrograms between unipolar electrode sites. IEEE Frontiers of Engineering and Computing in Health Care - 1985, pp 1128-1131, 1985.

9. Damiano RJ, Jr., Smith PK, Tripp JF, Jr., Asano T, Small KW, Lowe JE, Ideker RE, Cox JL: The effect of chemical ablation of the endocardium on ventricular fibrillation threshold. Circulation 74:645-652, 1986.

10. Tripp HF, Lewis W, Veronee C, Damiano RJ, German LD, Lowe JE: Effects of acute tachycardia on left ventricular high energy compound metabolism and subsequent tolerance to ischemia. J Thorac Cardiovasc Surg 92: 931-935, 1986.

11. McCann RL, Makhoul R, Damiano R: Diagnosis of arteriovenous fistula by venous oxygen saturation: case report. J Vasc Surg 3:921-923, 1986.

12. Ferguson TB, Jr., Damiano RJ, Jr., Smith PK, Buhrman WC, Cox JL: The electrophysiologic effects of calcium channel blockade during standard hyperkalemic, hypothermic cardioplegic arrest. Ann Thorac Surg 41:622-629, 1986.

13. Damiano RJ, Jr., Asano T, Smith PK, Ferguson TB, Jr., Douglas JM, Jr., Cox JL: Electrophysiologic effects of surgical isolation of the right ventricle. Ann Thorac Surg 42:65-69, 1986.

14. Damiano RJ, Jr., and Sabiston DC, Jr.: Cardiac neoplasms in Essentials of Surgery. (Ed.) David C. Sabiston, Jr., W.B. Saunders, Philadelphia, pp 1163-1169, 1987.

15. Damiano RJ, Jr., Tripp HF, Jr., Asano T, Small KW, Jones RH, Lowe JE: Left ventricular dysfunction and dilatation resulting from chronic supraventricular tachycardia. J Thorac Cardiovasc Surg 94:135-143, 1987.

16. Damiano RJ, Jr., Rotolo FS, Postlethwait RW, Myers WC: Adenocarcinoma of the stomach: Changing patterns over the last 4 decades. Ann Surg 205: 1-8, 1987.

17. Blanchard SM, Damiano RJ, Asano T, Smith WM, Ideker RE, Lowe, JE: The effects of distant cardiac electrical events on local activation in unipolar epicardial electrograms. IEEE Trans Biomed Eng 34(7):539-546, 1987.

18. Ferguson TB, Jr., Smith LS, Smith PK, Damiano RJ, Jr., Cox JL: Electrical activity of the heart during hyperkalemic hypothermic cardioplegic arrest: site of origin and relationship to specialized conduction tissue. Ann Thorac Surg 43:373-379, 1987.

19. Damiano RJ, Jr., Blanchard SM, Asano T, Cox JL, Lowe JE: Effects of distant potentials on unipolar electrograms in an animal model utilizing the right ventricular isolation procedure. J Am Coll Cardiol 11:1100-1109, 1988.

20. Damiano RJ, Jr., Asano T, Smith PK, Ferguson TB, Cox JL: Hemodynamic consequences of right ventricular isolation: the contribution of the right ventricular free wall to cardiac performance. Ann Thorac Surg 46:324-330, 1988.

21. Damiano RJ, Jr., Asano T, Smith PK, Ferguson TB, Jr., Cox JL: Right ventricular free wall isolation: Effects on regional myocardial blood flow. Ann Thorac Surg 46:391-395, 1988.

22. Damiano RJ, Jr.: Principles of Cardiac Arrhythmias, 4th Edition, Edited by Chung, EK, Ann Surg 210:682-683, 1989.

23. Damiano RJ, Jr.: The cardiovascular system in Surgical Intensive Care: A Practical Guide. (Ed) Lyerly HK. Year Book Medical Publishers, Chicago, pp. 43-122, 1989.

24. Blanchard SM, Smith WM, Damiano RJ, Jr., Molter DW, Ideker RE, Lowe JE: Four digital algorithms for activation detection from unipolar epicardial electrograms. IEEE Trans Biomed Eng 36(2):256-261, 1989.

25. Blanchard SM, Damiano RJ, Jr., Smith WM, Ideker RE, Lowe JE: Interpolating unipolar epicardial potentials from electrodes separated by increasing distances. PACE 12:1938-1955, 1989.

26. Fyfe DA, Lowe JE, Damiano RJ, Jr., Christopher TD: Hemodynamic function in arrhythmias, in Pediatric Arrhythmias: Electrophysiology and Pacing. (Ed) Gillette PC and Garson A. W.B. Saunders, Philadelphia, pp 501-575, 1990.

27. Bauernfeind RA, Welch WJ, Damiano RJ: Paroxysmal supraventricular tachycardia in Cardiac Arrhythmias: Their Mechanism, Diagnosis and Management (3rd Ed). Mandel WJ (ed). Lippincott, Philadelphia, 1990.

28. Damiano RJ, : Surgical treatment of nonischemic ventricular tachycardia. Cardiac Surgery: State of the Art Reviews. 4:233-246, 1990.

29. Santamore WP, Damiano RJ, Yamaguchi S, Taher M: Dynamic biventricular interaction during systole (review article) Coronary Artery Disease. 1:298-306, 1990.

30. Damiano RJ, Jr., Cox JL, Lowe JE, Santamore WP: Left ventricular pressure effects on right ventricular pressure and volume outflow. Catheterization and Cardiovascular Diagnosis 19:269-278, 1990.

31. Damiano RJ, Jr., Asano T, Smith PK, Cox JL: Effect of the right ventricular isolation procedure on ventricular vulnerability to fibrillation. J Am Coll Cardiol 15:730-6, 1990.

32. Damiano RJ, Jr., Asano T, Smith PK, Ferguson TB, Cox JL: Functional consequences of the right ventricular isolation procedure. J Thorac Cardiovasc Surg 100:569-579, 1990.

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170. Mizutani S, Bloch JB, Prasad SM, Diodato MD, Schuessler RB, Damiano RJ Jr., Lawton JS: The ATP-sensitive potassium channel ameliorates cell swelling secondary to hyperkalemic cardioplegia. Ann Thorac Surg, in press.

171. Gill I, Karmanukian H, Damiano RJ Jr., Landolfo K, Zenati M: Robotic assisted coronary artery bypass grafting: Prospective randomized multicenter trial. Circulation, in press.

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174. Maniar HS, Prasad SM, Prasad SM, Chu CM, Damiano RJ Jr. Comparison of skill training with robotic systems and traditional endoscopy: Implications on training and adoption. J Surg Res, in press

175. Diodato MD, Shah NR, Prasad SM, Racen EL, Mizutani S, Lawton JS, Damiano RJ Jr.: Progress towards a more physiologic approach to donor heart preservation: The advantages of hyperpolarized arrest. Submitted, J Heart Lung Transplant

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178. Mizutani S, Prasad SM, Sellitto AD, Schuessler RB, Damiano RJ Jr., Lawton JS: Alterations in myocyte volume and function in response to osmotic stress: Role of the K_{ATP} channel. In Press, Circulation.

179. Parekh K, Meyers BF, Patterson GA, Guthrie TJ, Trulock EP, Damiano RJ, Moazami N: Outcome of lung transplantation for patients requiring concomitant cardiac surgery. In press. J Thorac Cardiovasc Surg

180. Lau CL, Hoganson DM, Meyers BF, Damiano RJ, Patterson GA. Use of the Urchin heart stabilizer in lung transplantation. Ann Thorac Surg. In press.

181. Kreisel D, Bailey M, Lindsay BD, Damiano RJ Jr: A minimally invasive surgical treatment for inappropriate sinus tachycardia In press. J Thorac Cardiovasc Surg

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183. Ishii Y, Kronegold RT, Virmani R, Rivera EA, Gaynor SL, Diodato MD, Goldman SM, Prechtel EJ, Schuessler RB, Damiano RJ Jr: Excellent one month patency with a novel bio-engineered small caliber vascular graft. Submitted, Circulation.

184. Prasad SM, Byrd GD, Flagg TP, Gomes J, Damiano RJ Jr, Nichols CG, Lawton JS: The sarcolemmal KATP channel underlies the regulation of hyperkalemic cardioplegia-induced myocyte swelling and reduced contractility. Submitted, J Thoracic Cardiovasc Surg

185. Moazami N, Affleck DG, Moon MR, Pasque MK, Lawton JS, Bailey MS, Damiano RJ Jr: Morbidity and mortality of cardiac surgery following renal transplantation. Submitted, J Card Surg

186. Gaynor SL, Byrd GD, Diodato MD, Ishii Y, Lee AM, Prasad SM, Gopal J, Berube D, Schuessler RB, Damiano RJ Jr.: Microwave ablation for atrial fibrillation: Dose response curves in the cardioplegia-arrested and beating heart. Submitted, Ann Thorac Surg

187. Gaynor SL, Lawton JS, Gleva MJ, Damiano RJ Jr., Moon MR: Laser assistance for extraction of chronically implanted endocardial leads: Infectious versus non-infectious indications. Submitted.

188. Gaynor SL, Byrd GD, Diodato MD, Ishii Y, Lee AM, Prasad SM, Gopal J, Berube D, Schuessler RB, Damiano, RJ Jr.: Dose response curves for microwave ablation in the cardioplegia arrested porcine heart. Submitted, Heart Surg Forum

189. Ishii Y, Kronengold RT, Virmani R, Rivera EA, Goldman SM, Prechtel EJ, Schuessler RB, Damiano RJ Jr: A novel bioengineered drug-eluting small caliber vascular graft. Submitted

190. Mitzutani S, Al-Dadah AS, Bloch JB, Prasad SM, Diodato MD, Schuessler RB, Damiano RJ Jr., Lawton JS: Opening the ATP-sensitive potassium channel ameliorates cell swelling and reduced contractility secondary to hyperkalemic cardioplegia. Submitted, Circ Res

191. Moon MR, Pasque MK, Munfakh NA, Melby SJ, Lawton JS, Moazami N, Codd JE, Crabtree TD, Damiano RJ Jr: Prosthesis-patient mismatch following aortic valve replacement: Impact of age and body size on late survival. Submitted.

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Abstracts

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37. Geis WP, Svanidze O, Kelly T, Tabai H, Stratoulias C, Damiano RJ Jr. Endoscopic coronary artery surgery: geometric considerations, access routes, visual views, and robotic enhancement. International Society for Minimally Invasive Cardiac Surgery. Minneapolis, MN. June, 1998.

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40. Stephenson ER, Jayawant AMA, Ducko CT, Damiano RJ Jr. Cardioplegia temperature and its effect on myocyte volume regulation. Circulation 98: I 3223, 1998.

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49. Damiano RJ Jr., Tabaie HA, Mack MJ, Edgerton JR, Mullangi C, Graper P, Prasad S. Initial prospective multicenter trial of robotically-assisted coronary artery bypass grafting. Society of Thoracic Surgeons, January 2001. New Orleans, Louisiana.

50. Klingensmith M. Prasad S, Maniar H, Soper N, Damiano RJ Jr. The effect of robotic assistance on learning curves for basic laparoscopic skills. Association for Surgical Education, March 2001. Opryland, Tennessee.

51. Prasad S, Maniar HS, Schuessler R, Damiano RJ Jr. Epicardial ablation of the beating heart: Progress towards an off-pump MAZE procedure. International Society of Minimally Invasive Cardiac Surgeons, June 2001. Munich, Germany.

52. Prasad S, Maniar H, Damiano RJ Jr. Robotic surgical training: Learning curves in surgeons and nonsurgeons. Poster Presentation. International Society of Minimally Invasive Cardiac Surgeons, June 2001. Munich, Germany.

53. Prasad S, Maniar HS, Schuessler RB, Damiano RJ Jr. Transmural epicardial radiofrequency ablation on the beating heart: progress towards a minimally invasive operation for atrial fibrillation. American College of Surgeons, October 2001. New Orleans, Louisiana.

54. Prasad SM, Maniar HS, Camillo CJ, Schuessler RB, Boineau JP, Sundt TM III, Cox JL, Damiano RJ: The Cox-Maze III Procedure for atrial fibrillation: Long-term efficacy in patients undergoing lone versus concomitant procedures. American Association of Thoracic Surgery, May, 2002.

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62. Mizutani S, Bloch J, Diodato M, Schuessler R, Damiano R, Lawton J: Pinacidil ameliorates myocyte swelling secondary to traditional hyperkalemic cardioplegia. J Am Coll Surg197(S3):S20, 2003.

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64. Absi TS, VanVickle-Chavez J, Sundt TM III, Moon M, Damiano RJ Jr, Thompson RW: Gene expression in ascending aortic aneurysms associated with normal and bicuspid valves. Circulation 108(17):IV-480, 2003.

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67. Moon MR, Sicard GS, Bailey MS, Damiano RJ Jr: Late functional status following elective thoracic aortic replacement. Poster session. Aortic Surgery Symposium IX. April 22, 2004, New York, New York.

68. Mizutani S, Prasad SM, Sellitto AD, Schuessler RB Damiano RJ Jr, Lawton JS: The role of the mitochondrial K_{ATP} channel in myocyte osmotic stress. Circulation Suppl III 110:III-504-III505, 2004.

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70. Ishii Y, Virmani R, Gaynor SL, Diodato MD, Goldman SM, Prechtel EJ, Kronegold RT, Damiano RJ Jr.: A novel bioengineered small caliber vascular graft incorporating sirolimus. Circulation Suppl III 110:III-753, 2004.

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INVITED LECTURESHIPS

1. Surgical Approach to Ventricular Arrhythmias: Procedures and Results. Immediate Issues in Cardiology: MCV Cardiology Conference, Williamsburg, Virginia. May 7, 1989.

2. Surgical Management of Ventricular Tachycardia. Update in Cardiology, Virginia Heart Institute, Richmond, Virginia. October 12, 1989.

3. Surgical Treatment of Arrhythmias. Special Topics in Critical Care Nursing Conference. MCV Department of Nursing, Richmond, Virginia. March 28, 1990.

4. Surgical Implantation of Dual Chamber Pacing Systems. Implantation and Evaluation of an Implantable Cardioverter/Defibrillator. Postgraduate Colloquium on Pacing and Arrhythmia Control. Telectronics Pacing Systems. Cancun, Mexico. May 8-11, 1990.

5. New Surgical Approaches to the Treatment of Cardiac Arrhythmias. Sudden Cardiac Death. Practical Issues in Primary Care, MCV Continuing Education, Virginia Beach, Virginia. August 11, 1990.

6. Surgical Treatment of Arrhythmias. Update 1990, Cardiac Arrhythmias; Virginia Heart Institute, Richmond, Virginia. September 21, 1990.

7. Surgical Management of Sudden Cardiac Death. The Eastern Surgical Society Annual Meeting, Richmond, Virginia. April 19, 1991.

8. Surgical Approaches to Ventricular Arrhythmias. Implantation and Evaluation of Implantable Cardioverter Defibrillators. Cardiovascular Hemodynamics of Stress, Rest, and Exercise. Sudden Death Symposium, Telectronics Pacing Systems, Sydney, Australia. October 1-11, 1990.

9. Cardiac Mapping. Surgical Approaches to Ventricular Arrhythmias. January Pacing Seminar. Telectronics Pacing Systems, Snowmass, Colorado. January 24-25, 1991.

10. Surgical Implantation of Dual Chamber Pacing Systems. Update on Lead Technology. Postgraduate Colloquium on Pacing and Arrhythmia Control. Telectronics Pacing Systems. San Antonio, Texas. April 22-25, 1991.

11. State of the Art Lecture: Implantable Cardioverter Defibrillators. Postgraduate Course, Society of Thoracic Surgery. San Francisco, California. February 17, 1992.

12. Intraoperative mapping. Surgery for Ventricular Arrhythmias. ICD's as a Bridge to Transplantation. Postgraduate Colloquium on Pacing and Arrhythmia Control. Telectronics Pacing Systems. Orlando, Florida. February 19-20, 1992.

13. Surgical Implantation of Dual Chamber Pacing Systems. Extraction of Chronic Pacing Leads. Surgical Complications of Pacing. Surgery for Ventricular Arrhythmias. Postgraduate Colloquium on Pacing and Arrhythmia Control. Telectronics Pacing Systems. Orlando, Florida. February 18-20, 1993.

14. The Role of KATP Channels in Myocardial Stunning. Frontiers in Perioperative Myocardial Stunning. Gensia Pharmaceuticals. San Diego, CA. September 10, 1993.

15. Coronary Artery Surgery 1994: Current State-of-the Art. Mary Washington Hospital Medical Staff Grand Rounds. Fredericksburg, VA. December 17, 1993.

16. Implantation of Dual Chamber Pacemakers. Complications of Pacemaker Insertion: Non Thoracotomy Defibrillators. 37th Postgraduate Colloquium on Pacing and Arrhythmia Control. Telectronics Pacing Systems. San Diego, CA. January 13-14, 1994.

17. Aortic Dissections: Current Management. Southside Regional Hospital Surgical Grand Rounds. Petersburg, VA. October 3, 1995.

18. The Electrophysiology of Ischemia and Cardioplegia: Implications for Myocardial Protection. Surgical Biology Club III. New Orleans, LA. October 22, 1995.

19. The Rise and Fall of Arrhythmia Surgery: Lessons Learned from Surgical Extinction. Surgery Grand Rounds, Hershey Medical Center. June 13, 1996.

20. Cardiac Defibrillation: Why is it probabilistic? Division of Bioengineering Seminar Series, Penn State University, State College, PA. June 18, 1996.

21. The Electrophysiology of Ischemia and Cardioplegia. Surgical Research Conference, Hershey Medical Center, September 11, 1996.

22. The Role of Potassium Channel Openers in Myocardial Protection. How-to-Session, American Heart Association , New Orleans, LA. November 13, 1996

23. Invited discussant: The University of Alabama, Birmingham. Experience with left ventricular assist devices. Southern Surgical Assoc. West Palm Beach, Fla. December 3, 1996.

24. Is there an Alternative to Potassium Cardioplegia? Surgery Grand Rounds. Medical University of South Carolina, Charleston, SC, January 21, 1997.

25. Lessons learned from surgical extinction. Cardiology Grand Rounds. Hershey Medical Center, March 3, 1997.

26. Invited discussant: Improved event free survival following transmyocardial laser revascularization versus medical management in patients with unreconstructable coronary artery disease. American Assoc. of Thoracic Surgery. Washington, D.C. May 6, 1997

27. Innovative new techniques in the surgical treatment of arrhythmias. Symposium Chairman. North American Society of Pacing and Electrophysiology. New Orleans, LA. May 8, 1997.

28. Minimally invasive microsurgery in the year 2000. Program Moderator. Computers and Robotics in the OR2000. Santa Barbara, CA. June 20, 1997

29. Hemostasis in Cardiac Surgery. Dinner Conference. St. Lukes Hospital. Kansas City, MO. July 31, 1997.

30. Computers and robotics in minimally invasive cardiac surgery. Cardiac Symposium. California Center for Cardiothoracic Surgery. Thousand Oaks, CA. September 6, 1997.

31. Robotics in surgery. Susquehanna Chapter of IEEE. Hershey, PA. September 9, 1997.

32. New surgical approaches to the management of CAD. 16th Annual Lion-Hearted Meeting. Hershey, PA September 12, 1997.

33. Future Innovations for CABG: Robotic Surgery. Utrecht MICABG Course. Utrecht, Netherlands. September, 26, 1997.

34. Robotic Surgery: Potential impact on closed chest CABG on the beating heart. Utrecht MICABG Workshop III. Utrecht, Netherlands. September 27, 1997.

35. Cell swelling and cardioplegia: A new etiology for postoperative myocardial dysfunction. Surgical Biology Club III. Chicago, IL. October 12, 1997.

36. Myocardial protection during cardiac surgery. Department of Cellular and Molecular Biology Seminar. Penn State College of Medicine, Hershey, PA October 28, 1997.

37. Hyperpolarizing cardioplegia: advantages over traditional solutions. Cardiovascular Seminar. American Heart Assoc. Orlando, FL November 10, 1997

38. Robotics and Operatory Environmental Control. New Era Cardiac Care: Minimally Invasive Techniques. Palm Springs, CA. January 9, 1998.

39. Will robotic assistance enable us to perform totally endoscopic CABG? Facts and Myths of Minimally Invasive Cardiac Surgery. Current Trends in Thoracic Surgery IV. New Orleans, LA. January 24, 1998.

40. Minimally invasive cardiac surgery: the dawning of a new era. Cardiovascular Center Grand Rounds. Penn State Geisinger Health System. Hershey, PA March 2, 1998.

41. Robotically assisted microsurgery: the next frontier in the development of minimally invasive cardiac surgery. Fifth Annual Heart and Lung Surgery Update. Lehigh Valley Hospital. Allentown, PA. March 28, 1998.

42. Robotically assisted endoscopic coronary artery bypass grafting. Board of Visitors, Milton S. Hershey Medical Center. Hershey, PA, April 30, 1998.

43. he future of robotics in cardiovascular surgery. Medtronic Senior Advisory Board. Boston, MA, May 2, 1998.

44. New surgical and catheter ablation techniques to treat atrial fibrillation. Chairperson. North American Society of Pacing and Electrophysiology. San Diego, CA, May 7, 1998.

45. Enabling endoscopic coronary artery bypass grafting. 2nd International Congress on Computers and Robotics in the Operating Room. Santa Barbara, CA. June 18, 1998.

46. Computer-assisted endoscopic CABG. Latest Techniques in Minimally Invasive Cardiac Surgery. Brussels, Belgium. September 19, 1998.

47. Minimally invasive coronary artery bypass surgery. Moderator. Latest Techniques in Minimally Invasive Cardiac Surgery. Brussels, Belgium. September 19, 1998.

48. Total endoscopic multivessel coronary revascularization. Transcatheter Cardiovascular Therapeutics X. Washington, DC. October 9, 1998.

49. Minimally invasive cardiac surgery. Cardiovascular Disease: Prevention and Disease Management for Women: Rural Women's Health Initiative. Penn State University. November 3, 1998.

50. Assist devices and the total artificial heart. 3 M Surgeons Advisory Board. Wonewok, Minnesota. November 6, 1998.

51. Robotics in minimally invasive coronary artery bypass. The Magic of Minimally Invasive Thoracic Surgery. Cincinnati, OH. November 13, 1998.

52. Endoscopic coronary artery bypass grafting: a clinical reality. Cardiology Grand Rounds, Hershey Medical Center, Hershey, PA, December 14, 1998.

53. The cardiac operating room in the next millennium: Innovative new technology for minimally invasive CABG. Moderator. Evolving Techniques and Technologies in Minimally Invasive Cardiac Surgery. San Antonio, TX. January 23, 1999.

54. Robotically-assisted CABG: The U.S. experience at The Future of Cardiac Surgery. The Possibility are Realities. Medtronic, Inc. San Antonio, TX. January 24, 1999.

55. Endoscopic Coronary Artery Bypass Grafting: From concept to Reality. Surgical Grand Rounds, Hershey, PA. February 11, 1999.

56. Total endoscopic multivessel revascularization. Cardiovascular Interventions 1999. Tampa, FL. February 26, 1999.

57. Robotically-assisted cardiac surgery: the US Experience. Cobe Cardiovascular Summit. Keystone, CO. March 19, 1999.

58. Endoscopic coronary artery bypass grafting: Cardiac Surgery Biology Club. New Orleans, LA. April 18, 1999.

59. Minimally invasive cardiac surgery. Mini-Medical School. Hershey Medical Center, Hershey, PA. April 20, 1999.

60. Robotique et chirurgie coronaire. Amicale des Cardiologues de Paris et sa RÉgion. Paris, France. May 20, 1999.

61. Robotic Coronary Surgery. Keynote address. International Society for Minimally Invasive Cardiac Surgery. Paris, France. May 22, 1999.

62. Minimally invasive cardiac surgery: Is there a there there? US Bancorp Piper Jaffray Conference, Minneapolis, MN. June 17, 1999.

63. The emergency of robotics in minimally invasive cardiac surgery. Third International Congress on Computers and Robotics in the OR 2000. July 15, 1999.

64. Advanced Technologies in the OR 2000 (Moderator). Third International Congress on Computers and Robotics in the OR 2000. July 15, 1999.

65. The Mighty Zeus: The Role of Computers and Robotics in the Operating Room of the Future. Challenges in Critical Care. PA Chapter of Society of Critical Care Medicine. Hotel Hershey, Hershey, PA. August 27, 1999.

66. Session Chairman. Off-pump closed chest CABG. Fifth Utrecht MICABG Workshop, Utrecht, Netherlands. September 3, 1999.

67. Closed chest, off-pump coronary artery bypass grafting: The Zeus(Experience. Fifth Utrecht MICABG Workshop. Utrecht, Netherlands. September 3, 1999.

68. Computer-assisted coronary bypass grafting: an enabling technology for endoscopic microsurgery. Society for Minimally Invasive Therapy. Boston, MA. September 17, 1999.

69. Visiting Professor: Endoscopic coronary artery bypass grafting: From concept to reality. Barnes Jewish Hospital, Washington University, St. Louis, MO. October 1, 1999.

70. Minimally Invasive Cardiac Surgery and Microsurgical Robotics. At "Emerging Technologies in Laparoscopic Surgery", General Session. American College of Surgeons. San Francisco, October 11, 1999.

71. Robotics in Cardiac Surgery. Surgical Grand Rounds. University of Medicine and Dentistry, New Jersey, New Brunswick, New Jersey. October 30, 1999.

72. Endoscopic coronary artery bypass grafting. Southern Thoracic Surgical Association. Rio Mar, Puerto Rico. November 3, 1999.

73. Moderator. Preconditioning and Myocardial Protection. American Heart Association. Atlanta, Georgia, November 9, 1999.

74. Endoscopic coronary artery bypass grafting: Initial clinical experience. Visiting Professor. London Health Sciences Center, London, Ontario. November 19, 1999.

75. Minimally invasive coronary artery bypass grafting. Advanced Critical Care Update Symposium. Hershey, PA. December 15, 1999.

76. Robotically-assisted cardiac surgery. Cardiology Grand Rounds. Temple University. Philadelphia, PA. December 17, 1999.

77. Setting up the operating room of the future. 6th Annual Current Techniques & Technologies. Fort Lauderdale, FL, January 29, 2000.

78. Robotic assistance for endoscopic CABG: Early clinical experience. 6th Annual Current Techniques & Technologies. Fort Lauderdale, FL. January 29, 2000.

79. Minimally invasive cardiac surgery: The evolution of a revolution. Bear Stearns West Coast Cardiovascular Symposium. San Francisco, CA. February 10, 2000.

80. Robotic coronary artery bypass grafting: initial clinical experience. Robotics in Cardiac Surgery: The First North American Perspective. Ohio State University. February 11, 2000.

81. Endoscopic Cardiac Surgery: early clinical experience. Cardiology Grand Rounds. Washington University, St. Louis. Barnes Jewish Hospital. February 23, 2000.

82. Robotically assisted coronary artery bypass grafting. Cardiothoracic Surgery Grand Rounds, UCLA. Los Angeles. February 28, 2000.

83. Minimally invasive cardiac surgery: where is it all going? Susquehanna Chapter of American Assoc. Critical Care Nurses. Hershey medical Center. Hershey, PA. March 2, 2000.

84. Robotically-assisted coronary artery bypass grafting. Adult Cardiac Surgery Symposium. American Association for Thoracic Surgery. Toronto, Ontario, Canada. April 30, 2000.

85. Update on surgical robotics. Cardiac Surgery Biology Club. American Association for Thoracic Surgery. Toronto, Ontario, Canada. April 30, 2000.

86. The next frontier in cardiac surgery: creating the digital surgeon. MICS and Its Future. Medtronic Fellows Course. Medtronic PRL. Minneapolis, Minnesota. May 18, 2000.

87. Surgical approaches to off pump CABG. MICS and Its Future. Medtronic Fellows Course. Medtronic PRL. Minneapolis, Minnesota. May 18, 2000.

88. Robotic cardiac surgery; past, present and future. Third International Congress on Computers and Robotics. Santa Barbara, California. July 20, 2000.

89. Visiting Professor: The next frontier in cardiac surgery: Creating the digital surgeon. University of Alabama. Birmingham Cardiovascular Society. September 7, 2000.

90. Beating heart surgery: from sternotomy to endoscopy. 9th Annual Contemporary Cardiothoracic Surgery course. St. Louis, Missouri. September 23, 2000.

91. Robotically –assisted cardiac surgery: present state of the art. 9th Annual Contemporary Cardiothoracic Surgery course. St. Louis, Missouri. September 23, 2000.

92. Robotically-assisted coronary artery bypass. Missouri Chapter of the American College of Cardiology. St. Louis, Missouri. October 7, 2000.

93. Moderator: Is off-pump coronary bypass superior to on-pump? American College of Surgeons, Chicago, Illinois. October 23, 2000.

94. Moderator: Cardiothoracic Surgical Forum Session I: Innovations/neonatal-congenital. American College of Surgeons, Chicago, Illinois. October 23, 2000.

95. Current status of the Zeus robotic system in cardiac surgery. Innovative Techniques in Cardiac Surgery. What is the Future? American College of Surgeons, Chicago, Illinois. October 27, 2000.

96. Robotically-assisted cardiac surgery: present state of the art. Ehrenhaft Lecture. University of Iowa, Iowa City, Iowa. October 28, 2000.

97. Beating heart surgery: A to Z. Course Director. Medtronic Minimally Invasive Surgery. St. Louis, Missouri. November 10, 2000.

98. Moderator: Current Trends in Surgical Revascularization. American Heart Association, New Orleans, Louisiana. November 14, 2000.

99. Robotics in open heart surgery. Update 2000. American College of Chest Physicians, Cancun, Mexico. December 6, 2000.

100. Total arterial revascularization. Update 2000. American College of Chest Physicians, Cancun, Mexico. December 6, 2000.

101. Minimally invasive coronary surgery: a look into the future. Internal Medicine Grand Rounds. Washington University School of Medicine, St. Louis, Missouri. January 25, 2001.

102. Robotic assisted cardiac surgery. Minimally Invasive Surgery in the New Millennium, Washington University Institute for Minimally Invasive Surgery. St. Louis, Missouri, January 26, 2001.

103. Myocardial revascularization using robotics. Postgraduate Program. Society of Thoracic Surgeons, New Orleans, Louisiana. January 28, 2001.

104. Moderator. Adult cardiac surgery scientific session. Society of Thoracic Surgeons, New Orleans, Louisiana. January 29, 2001.

105. Computer Motion Update: Robotics. New Technology Symposium. Society of Thoracic Surgeons, New Orleans, Louisiana. January 29, 2001.

106. Visiting Professor. University of Toronto, Toronto General Hospital. Toronto, Ontario, Canada. February 8, 9, 2001.

107. Advances in coronary bypass surgery. Cardiology Resident Conference. Washington University School of Medicine. St. Louis, Missouri. February 13, 2001.

108. Robotics and minimally invasive cardiac surgery. Visiting Professor, Surgery Grand Rounds. St. Francis Medical Center, Pittsburgh, Pennsylvania. March 16, 2001.

109. Robotics and coronary surgery: Hype or hope? Invited lecture. American College of Cardiology. Orlando, Florida. March 20, 2001.

110. The present status of robotics in cardiac surgery. Visiting Professor. Visionaries in Medicine and Science Series of the Age of Innovation. Newark Beth Israel Medical Center. Newark, New Jersey. April 4, 2001.

111. Robotic cardiac surgery: Human skill meets high-tech precision. Mini-Medical School, Washington University School of Medicine. St. Louis, Missouri. April 12, 2001.

112. Robotically-assisted coronary bypass grafting: An enabling technology for endoscopic cardiac surgery. 12th Annual Cardiology Spring Fling. Barnes-Jewish Hospital, St. Peters. St. Peters, Missouri. April 19, 2001.

113. Update on robotic cardiac surgery. Society of American Gastrointestinal Endoscopic Surgeons. St. Louis, Missouri. April 20, 2001.

114. The future of minimally invasive cardiac surgery: Can we compete with angioplasty? Medical Grand Rounds, St. Luke's Hospital. Chesterfield, Missouri. April 24, 2001.

115. Robotic cardiac surgery. Middle East Medical Assembly. American University of Beirut. Beirut, Lebanon. May 11, 2001.

116. Robotic cardiac surgery. Middle East Medical Assembly. American University of Beirut. Beirut, Lebanon. May 11, 2001.

117. Robotic cardiac surgery: Present state of the art. Medical Grand Rounds. DePaul Medical Center, St. Louis, Missouri. June 22, 2001.

118. Robotic Surgery and CABG with the Zeus System. International Society for Minimally Invasive Cardiac Surgery. Munich, Germany. June 28, 2001.

119. New Approaches in Arrhythmia Surgery. International Society for Minimally Invasive Cardiac Surgery. Munich, Germany. June 29, 2001.

120. The Operating Room of the Future. Anesthesiology Grand Rounds. Washington University School of Medicine, St. Louis, Missouri. July 25, 2001.

121. Who needs new toys—Arterial grafting is the final answer. Emerging Therapies in Cardiovascular Disease. Kauii, Hawaii. August 3, 2001.

122. No slips and no errors: The Maze Procedure. Emerging Therapies in Cardiovascular Disease. Kauii, Hawaii. August 3, 2001.

123. Is there really a robot in the future? Emerging Therapies in Cardiovascular Disease. Kauii, Hawaii. August 3, 2001.

124. New Frontiers in Minimally Invasive Cardiac Surgery. ICHE Annual Summer Symposium. Poplar Bluff, Missouri. August 25, 2001

125. Robotic Cardiac Surgery. Department Heads Meeting. Barnes-Jewish Hospital, St. Louis, Missouri. September 7, 2001.

126. Robotically-Assisted Cardiac Surgery: The Beginning of a New Era. BJC Healthcare Case Managers' Conference. St. Louis, Missouri. September 25, 2001.

127. Emerging Atrial Fibrillation Ablation Technologies. Second International Forum on Emerging Alternatives vs. Traditional Treatments. Orlando, Florida. October 26, 2001.

128. Moderator, Poster Session. Advances in Surgical Treatment of Ischemic Heart Disease. American Heart Association. Anaheim, California. November 13, 2001.

129. Minimally Invasive Coronary Surgery: Can We Compete with Angioplasty? Medical Grand Rounds, St. Joseph's Hospital. St. Charles, Missouri. November 29, 2001.

130. The Role of Robotics in Cardiac Surgery. The David Boyd Lecture. Lahey Clinic, Burlington, Massachusetts. December 5, 2001.

131. Minimally Invasive Coronary Artery Bypass Grafting: Can We Compete with Angioplasty? Heart Center Grand Rounds. Duke Medical Center. Durham, North Carolina. December 12, 2001.

132. Robotics in Cardiac Surgery: The Zeus Experience in Coronary Surgery. New Era Cardiac Care 2002. Dana Point, California. January 5, 2002.

133. Atrial Fibrillation (Moderator) STS/AATS Tech-Con 2002. Fort Lauderdale, Florida. January 27, 2002

134. Surgical Treatment of Atrial Fibrillation. Invited Lecture. Edwards Lifesciences. STS, Fort Lauderdale, Florida. January 28, 2002.

135. Robotics in Coronary Bypass Grafting: Present State of the Art. Coalescent Surgical Educational Symposium. Las Vegas, Nevada. February 9, 2002.

136. Robotics in Cardiac Surgery: The Road to Salvation or a Dead End? CREF 2002. Pathophysiology and Techniques Cardiopulmonary Bypass. San Diego, California. February 22, 2002.

137. Emerging Therapy for Atrial Fibrillation. Cardiac Surgery Symposium for Thoracic Surgery Residents. St. Jude Medical. Minneapolis, Minnesota. March 8, 2002.

138. Robotics in Cardiac Surgery: Where Are We Going? Academy of Surgery of Detroit. Detroit, Michigan. April 11, 2002.

139. Robots Doing Heart Surgery: The New Era. Annual Heart Research Center Lecture, Oregon Health and Science University. Portland, Oregon. April 26, 2002.

140. Surgical Treatment of Atrial Fibrillation. Cardiothoracic Surgical Grand Rounds. Visiting Professor. Oregon Health and Science University. Portland, Oregon. April 27, 2002.

141. Developing the Academic Surgeon—A Symposium. Co-Chairman. 82nd Annual Meeting of the AATS. Washington, DC. May 4, 2002.

142. Surgery for Atrial Fibrillation. 82nd Annual Meeting of the AATS. Edwards Lifesciences. Washington, DC. May 6, 2002.

143. Moderator, C. Walton Lillehei Resident Forum Session. 82nd Annual Meeting of the AATS. Washington, DC. May 7, 2002.

144. Surgical Isolation of the Pulmonary Veins: Techniques, Results, Indications. Mini-course 9: Catheter Ablation of Atrial Fibrillation. NASPE. San Diego, California. May 8, 2002.

145. Robotic Cardiac Surgery; Human Skill Meets High Tech Precision. Washington University School of Medicine Mini-Med School. St. Louis, Missouri. May 16, 2002.

146. Ischemic Mitral Regurgitation: Evaluation, Clinical Implications and Treatment Options. Course Director. St. Louis, Missouri. June 1, 2002.

147. Second Annual Surgical Treatment of Atrial Fibrillation Conference. Conference Director. New York New York. June 19, 2002.

148. An Overview of Current Alternative Energy Sources for the Treatment of Atrial Fibrillation. Second Annual Surgical Treatment of Atrial Fibrillation Conference. New York, NY June 20, 2002

149. Bipolar Radiofrequency Ablation: Initial Clinical Experience. Second Annual Surgical Treatment of Atrial Fibrillation Conference. New York, NY June 20, 2002.

150. Atrial Fibrillation Session. Moderator. International Society of Minimally Invasive Surgery. New York, New York. June 22, 2002.

151. Ischemic Mitral Regurgitation. Grand Rounds Dinner. Cape Girardeau, Missouri. August 29, 2002.

152. Surgical Management of Atrial Fibrillation. Practical Management of Arrhythmias. Washington University School of Medicine CME Conference. St. Louis, Missouri. September 14, 2002.

153. Maze Procedure: Which is the Best Energy Device? Controversies in Adult Cardiac Surgery. Promedica International. Alfredo Trento, Program Director. Los Angeles, California. October 4, 2002.

154. Totally Endoscopic CABG. Controversies in Adult Cardiac Surgery. Promedica International. Alfredo Trento, Program Director. Los Angeles, California. October 4, 2002.

155. Cardiac Surgery Video Session. Coordinator and Presiding Officer. American College of Surgeons. San Francisco, California. October 7, 2002.

156. The Maze IV Procedure for Atrial Fibrillation: A Simplified Operation using Bipolar Radiofrequency Ablation. Cine Clinic. American College of Surgeons. San Francisco, California. October 9, 2002.

157. New Technologies for Surgical Ablation of Atrial Fibrillation. Atrial Fibrillation: Mechanisms and Management. Symposium. Aurora Health Care. Milwaukee, Wisconsin. October 17, 2002.

158. Recent Advances in the Surgical Treatment of Atrial Fibrillation. Visiting Professor, Case Western Reserve Hospital. Cleveland, Ohio. November 5, 2002.

159. Moderator. Novel Methods of Myocardial Revascularization Session. American Heart Association. Chicago, Illinois. November 18, 2002.

160. Recent Advances in Coronary Artery Surgery. Medical Grand Rounds. Phelps County Hospital. Rolla, Missouri. December 11, 2002.

161. Recent Advances in the Surgical Treatment of Arrhythmias. Missouri Chapter, American College of Cardiology Regional Meeting. St. Louis, Missouri. December 12, 2002.

162. Minimally Invasive Cardiac Surgery: A New Era has Begun. Sicilian Cultural Association of St. Louis. St. Louis, Missouri. January 9, 2003

163. The Future of Robotics in Cardiac Surgery: How the Information Technology Will Transform Our Specialty. Universität Müchen, Cardiac Surgery in the Future—What Can Be Expected. Munich, Germany. January 18, 2003.

164. Surgical Treatment of Atrial Fibrillation. Mitral Valve Repair XII. Los Angeles, California. January 28, 2003.

165. Computer Assisted Coronary Surgery. Society of Thoracic Surgeons. Computer Motion Booth. San Diego, California. January 31, 2003.

166. The Cox-Maze Procedure for Atrial Fibrillation. Team Approach to Pediatric Cardiac Disease. Vail, Colorado. March 4, 2003.

167. Cardiac Bypass Surgery Done the Robotic Way. Washington University Mini-Med School. St. Louis, Missouri. March 20, 2003.

168. Robotic Cardiac Surgery: The Information Age Enters the Operating Room. Rotary Club of St. Louis; St. Louis, Missouri. March 27, 2003.

169. Surgical Treatment of Atrial Fibrillation. AtriCure Course; Miami, Florida. April 12, 2003

170. Developing the Academic Surgeon Symposium. Co-Moderator and Program Organizer. American Association for Thoracic Surgery; Boston, Massachusetts. May 3, 2003.

171. New Tools for Atrial Fibrillation Surgery. Postgraduate Course Lecture. American Association for thoracic Surgery; Boston, Massachusetts. May 4, 2003.

172. New Energy Sources for Atrial Fibrillation. Recent Advanced in the Management of Valvular Heart Disease. Moderator and Program Organizer. St. Louis, Missouri. May 17, 2003.

173. Robotic Myocardial Revascularization in the OR of the 21st Century. Society of Cardiac Surgeons Annual Meeting. Quebec, Canada. June 9 – 10, 2003.

174. The Cox-Maze Procedure: The gold Standard and Its Shortcomings. Third Annual Surgical Treatment of Atrial Fibrillation. Moderator and Program Organizer. San Francisco, California. June 18 – 19, 2003.

175. Surgical Treatment of Atrial Fibrillation. Atricure Training Seminar. St. Louis, Missouri. July 19, 2003.

176. Recent Advances in the Surgical Treatment of Atrial Fibrillation. Visiting Professor. Cardiology Grand Rounds, Torrance Memorial Medical Center. Torrance, California. July 21, 2003.

177. Alternative Energy Sources for the Surgical Ablation of Atrial Fibrillation. Atrial Fibrillation Summit. Cleveland Clinic Foundation. August 1, 2003.

178. The Role of Robotics in the Operating Room of the 21st Century. Tech Connect 2003. St. Louis, Missouri. October 1, 2003.

179. Ablation Therapy for Atrial Fibrillation. Visiting Professor, University of Pittsburgh. Weekly Cardiothoracic Residents' Conference. Pittsburgh, Pennsylvania. October 15, 2003

180. Surgery for Atrial Fibrillation: Old and New Techniques/Indications. Invited Lecture. American Heart Association. Orlando, Florida. November 10, 2003.

181. How to Make a Robot Work for You. Moderator. American Heart Association. Orlando, Florida. November 10, 2003.

182. Molecular Aspects of Myocardial Protection. Moderator. American Heart Association. Orlando, Florida. November 11, 2003.

183. Alternative Energy Sources for Atrial Fibrillation. Epicardial Ablation on the Beating Heart: Progress Towards an Off-Pump Maze Procedure. Current Status of Mitral Valve Surgery. Hong Kong, China. November 13, 2003.

184. Robotics in Cardiac Surgery: The Road to Salvation or a Dead End? 14th Annual International Surgical Symposium. Hong Kong, China. November 15, 2003.

185. Surgery for Atrial Fibrillation: Present Status and Future Directions. Annual Lehman Lecture, University of Virginia. Charlottesville, Virginia. November 23, 2003.

186. Minimally Invasive Cardiac Surgery: An Update. Medical Grand Rounds. Christian Hospital Northeast. St. Louis, Missouri. January 9, 2004.

187. Surgery for Atrial Fibrillation. Visiting Professor. Grand Rounds, Loyola University School of Medicine. Chicago, Illinois. January 15, 2004.

188. Fourth Annual Surgical Treatment of Atrial Fibrillation. Course Organizer. San Antonio, Texas. January 23, 24, 2004.

189. Invited Lectures: a) Perioperative Management and Long Term Results of Atrial Fibrillation Surgery. b) Ablation Devices for Atrial Fibrillation: How Do We Judge the New Technology? c) The Future of Atrial Fibrillation Surgery. Fourth Annual Surgical Treatment of Atrial Fibrillation. San Antonio, Texas. January 23, 2004.

190. Atrial Fibrillation. Moderator. STS/AATS Tech-Con 2004. San Antonio, Texas. January 25, 2004.

191. Invited Lecture. New Energy Sources for Atrial Fibrillation Ablation. National Cardiovascular Center. Osaka, Japan. February 15, 2004.

192. a) Robotics in Cardiac Surgery: How Do We Judge New Technology. b) Surgical Treatment of Atrial Fibrillation: Progress Towards a Minimally Invasive Approach. c) Developing an Academic Career: From the Bottom to the Top. 34th Annual Meeting of the Japanese Society for Cardiovascular Surgery. Fukuoka, Japan. February 20, 2004.

193. An Assessment of the New Technology of AF Ablation. Atrial Fibrillation: Emerging Techniques. New Orleans, Louisiana. March 6, 2004

194. Atrial Anatomy for the Ablating Physiologist: American College of Cardiology. New Orleans, Louisiana. March 7, 2004.

195. Minimally Invasive Cardiac Surgery: How Do We Assess the Risk of Heart Operations. Washington University Mini-Medical School. St. Louis, Missouri. April 1, 2004.

196. Chronic Atrial Fibrillation Associated with Mitral Valve Regurgitation: Surgical Options and Results. Advanced Cardiac Techniques in Surgery. New York, New York. April 21, 2004.

197. Navigating the NIH: A Guide to the Grant Review Process. Granstmanship Courrse. 84th Annual Meeting of the American Association for Thoracic Surgery. Toronto, Ontario, Canada. April 24, 2004.

198. Future Directions in Atrial Fibrillation Surgery. Cardiac Surgery Biology Club Annual Meeting. Toronto, Ontario, Canada. April 24, 2004.

199. Chairman. Adult Cardiac Surgery Symposium. 84th Annual Meeting of the American Association for Thoracic Surgery. Toronto, Ontario, Canada. April 25, 2004.

200. New Surgical Approaches to Atrial Fibrillation. Advances in the Surgical Treatment of Atrial Fibrillation. Toronto, Ontario, Canada. April 26, 2004.

201. Course Organizer and Co-Chairman. Recent Advances in the Management of Valvular Heart Disease. St. Louis, Missouri. May 8, 2004.

202. A Rational Surgical Approach to Atrial Fibrillation. Grand Rounds. Birmingham, Alabama. July 15, 2004.

203. Moderator: Surgical Treatment of Atrial Fibrillation. International Society of Minimally Invasive Surgery. London, United Kingdom. June 25, 2004.

204. Course Director. Clinical Training Seminar of the Bipolar Radiofrequency Approach to Ablation. St. Louis, Missouri. July 22, 2004.

205. Course Director. Clinical Training Seminar of the Bipolar Radiofrequency Approach to Ablation. St. Louis, Missouri. September 18, 2004.

206. Minimally Invasive Cardiac Surgery: How Do We Decrease Operative Risk? Medicine Grand Rounds, Patient First Medical Group. Washington, Missouri. September 24, 2004.

207. New Approaches for Surgical Atrial Fibrillation Ablation with Open Heart Surgery. Atrial Fibrillation Summit. Cleveland Clinic, Cleveland, Ohio. October 2, 2004.

208. How Helpful are the New Energy Options in the Mini-Maze Procedure? Controversies in Adult Cardiac Surgery. Santa Monica, California. October 7, 2004.

209. A New Modification of the Cox-Maze Procedure Utilizing Bipolar Radiofrequency Ablation. American College of Surgeons, Video Session. New Orleans, Louisiana. October 11, 2004.

210. Minimally Invasive Surgery for Atrial Fibrillation: What Do We Need to Know? Minimally Invasive Cardiac Surgery Symposium. Sapporo, Japan. October 20, 2004

211. How Helpful Are the New Energy Options for the Mini-Maze Procedure? 57th Annual Meeting of Japanese Association for Thoracic Surgery. Sapporo, Japan. October 21, 2004

212. The Future of Arrhythmia Surgery. Keynote Address. Japanese Association for Thoracic Surgery. Sapporo, Japan. October 22, 2004.

213. Advances in Surgical Devices. New Arrhythmia Technologies Retreat. Indian Lakes Resort, Illinois. October 30, 2004.

214. Visiting Professor. Beth Israel Deaconess Medical Center, Harvard Medical School. Boston, Massachusetts. November 17, 2004

215. Minimally Invasive Cardiac Surgery. Holiday Inn. Carlinville, Illinois. November 30, 2004.

Curriculum Vitae

Nader Moazami, M.D.

Updated: October 6, 2004

Personal Information:

Sex:	Male
Date of Birth:	March 8, 1966
Citizenship:	U.S.
Home Address:	52 Claverach Dr. Clayton, MO 63105 (314) 725-3894
Office Address:	Division of Cardiothoracic Surgery Queeny Tower, Suite 3108 One Barnes-Jewish Hospital Plaza St. Louis, MO 63110-1013 (314) 362-8008 – FAX: (314) 747-4216 E-mail: moazamin@msnotes.wustl.edu

Education:

Undergraduate:
New York University, New York, NY
Dates of Attendance: 1984-1988
Degree: B.A., Biochemistry (Honors), Magna Cum Laude, Phi Beta Kappa

Medical School:
Columbia University, College of Physicians & Surgeons, New York, NY
Dates of Attendance: 1988-1992
Degree: M.D. (AOA)

General Surgery Internship and Residency:
Columbia-Presbyterian Medical Center, New York, NY
Dates of Attendance: 1992-1998
Chief Resident: 7/19/98-6/1999
Thoracic Organ Procurement Team: 1995-1996

Cardiothoracic Surgery Fellowship:
Cleveland Clinic Foundation, Dept. of Thoracic and Cardiovascular Surgery, Cleveland, OH
Dates of Attendance: 1998-2001
Chief Resident: 7/2000 – 7/2001

Academic Position: Assistant Professor of Surgery
Director of Cardiac Transplantation
Washington University School of Medicine
Department of Surgery
Division of Cardiothoracic Surgery
August 2001 – Present

Memberships:
American Heart Association - Board Member - Local Chapter,
November 2002 – Present
Association for Academic Surgery - Active Member -
November 15, 2002 – December 31, 2004
International Society for Heart & Lung Transplantation
January 1, 2004 – Present
Society of Thoracic Surgeons – Member
January 28, 2004 – Present
Mid-America Transplant Services – Medical Affairs,
Executive Committee Member
February 2, 2004 – Present
Heart Failure Society of America – Member
May 10, 2004 – Present

Honors & Awards:
Alpha Omega Alpha Honor Medical Society
Phi Beta Kappa (Junior)
Research Grant, NIH
Research Grant, Dept. of Surgery, Columbia University
Research Grant, CarboMedics, Inc.
Clinical Trials Award, Presbyterian Hospital, New York
Research Grant, Vascutech, Inc.
Raven-Lippincott Award for Best Presentation at ASAIO
Blakemore Research Award
Jerome S. Coles Scholar
Gregor-Brown Award in Chemistry
Merck Award in Chemistry
Distinguished Research Award
Dean's List
Dean's Student Award

Board Certification:
American Board of Surgery #44600, November 2, 1999
American Board of Thoracic Surgery #6821, June 6, 2003

Professional Activities:

Review Manuscript Articles for:

1. Journal of Thoracic and Cardiovascular Surgery
2. Journal of Heart and Lung Transplantation
3. International Society of Heart and Lung Transplantation

Research Experience:

1. Mount Sinai Hospital, Dept. of Biochemistry, New York
   Dates: 1986, 1987
   Director: Diana S. Beattie, Ph.D.
   Subject: Oxidative phosphorylation

2. New York University, New York
   Dates: 1987-1988
   Director: Charles T. Grubmeyer, Ph.D.
   Subject: Protein chemistry and mechanisms of enzyme action
   Thesis: Modification of an Essential Residue at the Active Site of Histidinol Dehydrogenase

3. NIH Grant: Columbia-Presbyterian Hospital, Dept. of Surgery, New York
   Dates: 1989-1990
   Director: Michael R. Treat, M.D.
   Subject: Application of Lasers to Tissue Welding
   New York University, Dept. of Biochemistry, Honors Program in Biochemistry

4. Research Fellow: Div. of Cardiothoracic Surgery, Dept. of Surgery, Columbia Univ.
   Dates: 1995-1996
   Director: Mehmet C. Oz, M.D.
   Subjects: Ventricular assist devices, Percutaneous aortic valve replacement, Strategies to modify ventricular remodeling

Bibliography:

1. Grubmeyer CT, Insinga S, Bhatia M, **Moazami N**. Salmonella typhimurium histidinol dehydrogenase: complete reaction stereochemistry and active site mapping. Biochemistry 1989; 28(20):8174-80.

2. **Moazami N**, Oz MC, Bass LS, Treat MR. Reinforcement of colonic anastomoses with a laser and dye-enhanced fibrinogen. Arch Surg 1990; 125(11):1452-4.

3. Bass LS, **Moazami N**, Poscidio J, Oz MC, LoGerfo P, Treat MR. Changes in type I collagen following laser welding. Lasers Surg Med 1992; 12(5):500-5.

4. **Moazami N**, Bessler M, Argenziano M, Choudhri AF, Cabreiza SE, Oz MC. Transluminal aortic valve placement: A feasibility study with a newly designed collapsible aortic valve. ASAIO J 1996; 42(5):M381-385.

5. Roberts JK, Mohr JP, **Moazami N**, Oz MC. Microembolic signals in patients with left ventricular assist devices. Stroke 1996; 27(10):1915-6.

6. Argenziano M, **Moazami N**, Thomashaw B, Edsall J, Chun Y, Prager KM, Gorenstein LA, Rose EA, Steinglass KM, Ginsburg ME. Extended indications for lung volume reduction surgery in advanced emphysema. Ann Thorac Surg 1996; 62(6):1588-97.

7. Argenziano M, **Moazami N**, Catanese KA, Gardocki MT, Clavenna MW, Rose EA, Scully BE, Levin HR, Oz MC. Diagnosis and management of LVAD endocarditis. Cardiovascular Engineering 1997; 2(1):11-15.

8. Goldstein DJ, **Moazami N**, Seldomridge JA, Laio H, Ashton RC, Naka Y, Pinsky DJ, Oz MC. Circulatory resuscitation with left ventricular assist device support reduces interleukins 6 and 8 levels. Ann Thorac Surg 1997; 63(4), 971-974.

9. **Moazami N**, Argenziano M, Roberts K, Catanese KA, Mohr JP, Rose EA, Oz MC. Asymptomatic microembolism in patients with long-term left ventricular assist support. ASAIO Journal 1997; 43(3), 177-180.

10. Argenziano M, Catanese KA, **Moazami N**, Gardocki MT, Weinberg AD, Clavenna MW, Rose EA, Scully BE, Levin HR, Oz MC. The influence of infection on survival and successful transplantation in patients with left ventricular assist devices. J Heart Lung Transplant 1997; 16(8):822-31.

11. **Moazami N**, Schimenti B, Argenziano M, Oz MC. Minimally invasive saphenectomy for coronary artery bypass surgery. Surgical Rounds 1997; 20(3):94-8.

12. **Moazami N**, Argenziano M, Williams M, Cabreiza SB, Oz MC, Nowygrod R. Photo-oxidized bovine arterial grafts: short-term results. ASAIO J 1998; 44(1):89-93.

13. Argenziano M, Chouhri AF, **Moazami N**, Rose EA, Smith CR, Levin HR, Smerling AJ, Oz MC. Randomized, double-blind trial of inhaled nitric oxide in LVAD recipients with pulmonary hypertension. Ann Thorac Surg 1998; Feb 65(2):340-5.

14. **Moazami N**, Argenziano M, Levin H, Rose EA, Oz MC, Burkhoff D. Inflow valve regurgitation during left ventricular assist device support may interfere with reverse ventricular remodeling. Ann Thorac Surg 1998; 65(3):628-31.

15. Argenziano M, Dean D, **Moazami N**, Williams M. Goldstein DJ, Cabreriza SE, Burkhoff D, Rose EA, Oz MC, Dickstein ML. Inhaled nitric oxide is not a myocardial

depressant in a porcine model of heart failure. J Thorac Cardiovasc Surg 1998; 115(3):700-8.

16. Argenziano M, Choudhri AF, **Moazami N**, Rose EA, Smith CR, Levin HR, Smerling AJ, Oz MC. Randomized, double-blind trial of inhaled nitric oxide in LVAD recipients with pulmonary hypertension. Ann Thorac Surg 1998;65(2):340-5.

17. Farman J, Goldstein DJ, Sugalski MT, **Moazami N**, Amory S. Bouveret's syndrome: diagnosis by helical CT scan. Clin Imaging 1998; Jul-Aug. 22(4):240-2.

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20. **Moazami N**, Itescu S, Williams MR, Argenziano M, Levin H, Weinberg H, Burke E, Rose EA, Oz MC. Platelet transfusions are associated with the development of anti-major histocompatibility complex class I antibodies in patients with left ventricular assist support. J Heart Lung Transplant 1998; 17(9):876-80.

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22. Smedira NG, **Moazami N**, Golding CM, McCarthy PM, Apperson-Hansen C, Blackstone EH, Cosgrove DM. Clinical experience with 202 adults receiving extracorporeal membrane oxygenation for cardiac failure: survival at five years. J Thorac Cardiovasc Surg. 2001; 122(1):92-102.

23. **Moazami N**, Smedira NG, McCarthy PM, Katzan I, Sila CA, Lytle BW, Cosgrove DM. Safety and Efficacy of Intraarterial Thrombolysis for Perioperative Stroke after Cardiac Operation. Ann Thorac Surg 2001; 72(6):1933-1937; discussion 1937-8.

24. **Moazami N**, Smedira NG. Temporary Mechanical Support. J Card Surg 2001;16(3):193-202.

25. **Moazami N**, Rice TW, Rybicki LA, Adelstein DJ, Murthy SC, DeCamp MM, Barnett GH, Chidel MA, Suh JH, and Blackstone EH. Stage III non-small cell lung cancer and metachronous brain metastases. J Thorac Cardiovasc Surg. 2002;124(1):113-122.

26. **Moazami N**, Damiano RJ, Bailey M, Hess R, Lawton JS, Moon M R, and Pasque MK. Nesiritide (BNP) In The Management of Post-Operative Cardiac Patients. Ann Thorac Surg 2003;75(6):1974-76.

27. Force SD, Lau CL, **Moazami N**, Trulock EP, and Patterson GA. Bilateral Lung Transplantation and Pulmonary Artery Reconstruction in a Patient with Chronic Obstructive Pulmonary Disease and a Giant Pulmonary Artery Aneurysm. J Thorac Cardiovasc Surg. 2003;126(3):864-866.

28. **Moazami N** and Hill L. Right Ventricular Dysfunction in Patients with Acute Inferior MI: Role of RV Mechanical Support. Thorac Cardiovasc Surg 2003;51(5):290-292.

29. **Moazami N**, Moon MR, Lawton JS, Bailey M, and Damiano RJ. Axillary artery cannulation for extracorporeal membrane oxygenator support in adults: An approach to minimize complications. J Thorac Cardiovasc Surg 2003;126(6):2097-8.

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32. Rovner A, Thanigaraj S, Rogers JG, **Moazami N**, Lasala JM. Spontaneous Multivessel Coronary Artery Dissection in a Young Asymptomatic Patient. J Inter Card 2004;17(2):123-7.

33. Shah NR, Rogers JG, Ewald GA, Pasque MK, Geltman EM, Bailey MS, and **Moazami N**. Survival of patients removed from the heart transplant waiting list. J of Thorac Cardiovasc Surg 2004;127(5):1481-5.

34. Moon MR, Barner HB, Bailey MS, Lawton JS, **Moazami N**, Pasque MK, and Damiano RJ. Long-term neurologic hand complications after radial artery harvesting using conventional cold and harmonic scalpel techniques. Ann Thorac Surg; 2004;78(2):535-8.

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36. **Moazami N** and Barner H. Complications of coronary artery bypass surgery. Chapter – Blackwell Futura Publishing Company, Editor Alex G. Little, MD. ISBN: 0-87993-427-1. 2004, Chapter 15, p 257-279.

37. **Moazami N**, Pasque MK, Moon MR, Herren RL, Bailey MS, Lawton JS, and Damiano RJ Jr. Mechanical Support for Isolated Right Ventricular Failure in Patients After Cardiotomy. J Heart Lung Transplant. 2004; 23(5).

38. **Moazami N**, Diodato MD, Moon MR, Lawton JS, Pasque MK, Herren RL, Guthrie TJ, and Damiano RJ. Does functional mitral regurgitation improve with isolated aortic valve replacement? J Card Surg. 2004; 19(5):444-8.

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40. Shah NR, Goldstein JA, Balzer DT, Lasala JM, and **Moazami N**. Transcatheter Repair of Recurrent Postinfarct Ventricular Septal Defects. Ann Thorac Surg; 2004(78) (Submitted 2/04).

41. Fernandez FG, Jaramillo A, Ewald G, Rogers J, Pasque MK, Mohanakumar T, **Moazami N**. Blood Transfusions Decrease the Incidence of Acute Rejection in Cardiac Allograft Recipients. Ref. JHLT-D-04-00128R1 (Accepted – J of Heart and Lung Transplantation – 7/04).

42. **Moazami N**, Ewald G, Moorehead S, Bourge RC, Brown RN, Wagoner LE, Boehmer JP, Kasper EK, O'Donnell J, Rayburn BK, Czerska B, and the Cardiac Transplant Research Database @ U. of Alabama, Birmingham, AL. Does type or constituent of preservation solutions influence early graft failure after cardiac transplantation? A multi-institutional study. (Submitted – J of Heart and Lung Transplantation – 6/04).

43. **Moazami N,** Moon MR, Pasque MK, Lawton JS, Bailey M, and Damiano RJ. Strategies for temporary mechanical support: Should ECMO be abandoned for treatment of cardiogenic shock in adults? (Submitted – ASAIO Journal – 8/04).

44. **Moazami N.** Ventricular Assist Devices: Past, Present and the Future. (Submitted – Business Briefing: US Cardiology 2004) 7/04.

45. Jaramillo A, Cambell LG, Ramachandran S, Liu W, Shipley JM, Rogers JG, **Moazami N**, Itohara S, Senior RM. Different Roles for Matrix Metalloproteinase-9 in the Pathogenesis of Cardiac Allograft Rejection. (Submitted – Am J of Transplantation) 8/04.

46. **Moazami N**, Affleck DG, Moon MR, Pasque MK, Lawton JS, Bailey MS, Damiano RJ Jr. Morbidity and Mortality of Cardiac Surgery Following Renal Transplantation. (Submitted – Ann Thorac Surg 9/04).

47. **Moazami N**, Pasque MK. An Approach to LVAD Explantation during Heart Transplantation. (Submitted – Ann Thorac Surg 9/04).

48. **Moazami N**, OZ MC. Natriuretic Peptides in the Perioperative Management of Cardiac Surgery Patients. (Submitted - Ann Thorac Surg 9/04).

Presentations:

1. **Moazami N**, Argenziano M, Levin H, Rose EA, Oz MC, Burkhoff D. Inflow valve regurgitation interferes with reverse LV remodeling during LVAD support. American Heart Association, 69th Annual Scientific Sessions. New Orleans, 1996.

2. **Moazami N**, Argenziano M, Roberts K, Catanese C, Levin H, Rose E, Oz MC. Asymptomatic microembolism inpatients with long-term left ventricular assist support. American Society of Artifical Internal Organs, Washington DC, May 1996.

3. **Moazami N**, Bessler M, Argenziano M, Choudhri AF, Cabreiza SE, Oz MC. Transluminal aortic valve placement: a feasibility study with a newly designed collapsible aortic valve. American Society of Artificial Internal Organs, Washington DC, May 1996.

4. **Moazami N**, Smedira NG, McCarthy PM, Golding CM, Lytle BW, Cosgrove DM. Clinical experience with 229 adults on ECMO: Survival at 5 years. American Association for Thoracic Surgery, 80th Annual Meeting, Toronto, Canada, May 2000.

5. **Moazami N**, Smedira NG, McCarthy PM, Golding CM, Lytle BW, Blackstone EH, and Cosgrove DM. Extracorporeal Life Support in Adults. The Fifth International Conference on Circulatory Support Devices for Severe Cardiac Failure. New York City, September 2000.

6. **Moazami N**, Katzan I, Smedira NG, McCarthy PM, Lytle BW, Delos M, Cosgrove DM. Safety and Efficacy of Intra-arterial Thrombolysis for Perioperative Stroke after Cardiac Surgery. The 37th Annual Meeting of the Society of Thoracic Surgeons Meeting. New Orleans, Louisiana. January 2001.

7. **Moazami N**, Rice TW, DeCamp MM, Murthy S, Blackstone EH. Aggressive Therapy of Stage III Non-small cell lung cancer and metachronous brain metastases. Presented at the 81st Annual Meeting of the American Association for Thoracic Surgery, San Diego, California, May 2001.

8. **Moazami N,** Diodato MD, Moon MR, Pasque MK, Lawton JS, Herren RL, Bailey MS, and Damiano RJ Jr. "Does Functional Mitral Regurgitation Improve with Isolated Aortic Valve Replacement?" American College of Cardiology – 52nd Annual Scientific Session, Chicago, IL. March 31-April 1, 2003.

9. **Moazami N**, Pasque MK, Moon MR, Herren RL, Bailey MS, Lawton JS, and Damiano RJ Jr. Mechanical Support for Isolated Right Ventricular Failure in Post-Cardiotomy Patients. ISHLT, Vienna, April 8-13, 2003.

10. **Moazami N**. "Outcomes of patients removed from the heart transplant waiting list". American Transplant Congress, Washington, DC. June 3, 2003.

11. **Moazami N,** Affleck DG, Jackson, Hill L, De Wet C, Avidan M, Tymkew H, Moon M, and Damiano R. Inhaled prostacyclin is a safe and effective alternative to nitric oxide for treatment of pulmonary hypertension and right heart failure after cardiothoracic surgery. Western Thoracic Surgical Association Meeting, Carlsbad, CA. June 19, 2003.

12. Kuhn K, **Moazami N,** Shelton K, Weber M. Ventricular Assist Devices: Parts for the Heart. ISHLT San Diego, CA. March 2004.

13. **Moazami N**, Ewald G, Moorehead S, Bourge RC, Brown RN, Wagoner LE, Boehmer JP, Kasper EK, O'Donnell J, Rayburn BK, Czerska B, and the Cardiac Transplant Research Database @ U. of Alabama, Birmingham, AL. Does type or constituent of preservation solutions influence early graft failure after cardiac transplantation? A multi-institutional study. American Transplant Congress, Boston, MA. May 2004.

14. **Moazami N,** Moon M, Pasque M, Lawton J, Bailey M, and Damiano R. Strategies for Temporary Mechanical Support: Should ECMO Be Abandoned for Treatment of Cardiogenic Shock in Adults? Presented at the 50th Anniversary of The American Society of Artificial Internal Organs, Washington DC, June 2004.

Teaching:

1. 2002 Cardiology Spring Fling – CME – Host: Barnes-Jewish St. Peters Hospital. Dr. Moazami's presentation "Progress and Future Perspectives in Mechanical Circulatory Support", April 4, 2002.

2. Host: Missouri Chapter of the American College of Cardiology. Dr. Moazami's presentation "Surgical Therapies for Heart Failure", November 14, 2002, Columbia, MO.

3. Abiomed, Inc. – BVS 5000 – Bi-Ventricular Support System Training Seminar. Dr. Moazami taught cardiothoracic surgeons, anesthesiologists, nephrologists, pulmonologists, intensivists, cardiologists, and operating room staff, in the

metropolitan St. Louis area on the design, operation, and clinical use of the BVS 5000. Also performed an acute implant in two animal models for bi-ventricular support. Washington University Clinic Research Science Laboratory. November 19, 2002.

4. Host: Washington University Continuing Medical Education. Current Concepts in Congestive Heart Failure Symposium. Dr. Moazami's presentation "Mechanical Circulatory Support: Are we ready for permanent VADS?" December 7, 2002.

5. Abiomed, Inc. – Implantation of the Abiomed BVS and AB Ventricle. Dr. Moazami taught cardiothoracic surgeons and cardiologists in the metropolitan St. Louis area on the scope, implantation, and clinical use of the AB Ventricle. This lab lecture and presentation was held in the Clinical Science Research area of Washington University School of Medicine on September 25, 2004.

Films:

1. **Moazami N**, Argenziano M, Gorenstein LA, Steinglass KM, Ginsburg ME. The clamshell technique for bilateral volume reduction pneumectomy. New York Society for Thoracic Surgery, November 1995.

Curriculum Vitae

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Pre-Medical Education: B.S., Cellular and Molecular Biology, 1981
University of Michigan
Ann Arbor, Michigan

Medical Education: M.D., 1985
University of Michigan
Ann Arbor, Michigan

Graduate Clinic and Research Experience:

1985 – 1986 Intern in General Surgery
University of Kentucky Hospital
Lexington, Kentucky

1986 – 1988 Resident in General Surgery
University of Kentucky Hospital
Lexington, Kentucky

1988 – 1989 Research Fellow-Laboratory of Willard M. Dagger, M.D.
Department of Surgery, Division of Cardiovascular Surgery
Massachusetts General Hospital
Boston, Massachusetts

Graduate, Clinic and Research Experience continued:

1989 – 1990 Resident in General Surgery
Department of Surgery
University of Kentucky Hospital
Lexington, Kentucky

1990 – 1991 Administrative Chief Resident
Department of Surgery, General Surgery
University of Kentucky Hospital
Lexington, Kentucky

1991 – 1993 Resident in Cardiothoracic Surgery
Department of Surgery
Medical College of Virginia Hospitals
Richmond, Virginia

Academic Positions:

2001 – present Associate Professor of Surgery
Washington University School of Medicine
St. Louis, Missouri

1999 – 2001 Associate Professor of Surgery
Section of Cardiothoracic Surgery
Louisiana State University School of Medicine
New Orleans, Louisiana

1993 – 1999 Assistant Professor of Surgery
Section of Cardiothoracic Surgery
Louisiana State University School of Medicine
New Orleans, Louisiana

Board Certifications:

American Board of Thoracic Surgery
Certificate No. 5537, 1994

American Board of Surgery
Certificate No. 37899, 1992

National Board of Medical Examiners
Certificate No. 09871R, 1986

Medical Licensure:

State of Missouri
License No. 200128232, issued 2001

State of Louisiana
License No. 09871R, issued 1993

Medical Licensure continued:

State of Kentucky
License No. 24634, issued 1986

State of Michigan
License No. 4301050786, issued 1987

Awards and Honors:

William J. Branstrom Freshman Prize
University of Michigan, 1979

James B. Angell Scholar
University of Michigan, 1980 and 1981

Class Honors
University of Michigan, 1979, 1980, and 1981

School of Literature, Science & Arts Academic Scholarship
University of Michigan, 1979, 1980 and 1981

Highest Distinction Graduate
University of Michigan, 1981

Phi Beta Kappa Honor Society

Schemm Academic Scholarship
University of Michigan Medial School
Ann Arbor, Michigan

Alpha Omega Alpha Honor Medical Society Membership
1984 to present

Frederick A. Coller Surgical Scholar Award, 1989
University of Kentucky

Resident Paper Award, 2nd Prize, 1990
American College of Surgeons
Kentucky Chapter

Ben Eiseman Surgical Scholar Award, 1990
University of Kentucky

Hospital Appointments:

7/2001-present Christian Hospital Northeast
St. Louis, MO

7/2001-present Barnes-Jewish Hospital
St. Louis, MO

Hospital Appointments continued:

1993-2001	University Hospital (MCLA) New Orleans, Louisiana
1993-2001	West Jefferson Medical Center Marrero, Louisiana
1994-2001	Toure Infirmary New Orleans, Louisiana
1995-2001	Meadowcrest Hospital Gretna, Louisiana
1996-2001	Kenner Regional Medical Center Kenner, Louisiana
1996-2001	Memorial Medical Center New Orleans, Louisiana
1996-2001	East Jefferson General Hospital Metairie, Louisiana
1998-2001	Doctors Hospital of Jefferson Metairie, Louisiana
1999-2001	Tulane University Medical Center New Orleans, Louisiana

Research:

1988-1989 Laboratory of William Daggett, M.D.
Professor, Department of Surgery, Massachusetts
- General Hospital

Boston, Massachusetts
- Myocardial protection of the hypertrophied heart
- Myocardial preservation using various cardioplegic solutions in the isolated rat heart model
- Myocardial oxygen consumption studies using the isolated, cross perfused dog heart model

1979-1982 Laboratory of Stanley J. Watson, M.D., Ph.D.
Professor, Department of Neuroscience
University of Michigan Medical School
- Opiate receptor kinetics
- Autoradiograph localization of opiate receptor in rat C.N.S.
- Study of the ontogenic development of opioid peptides in the rate C.N.S., using immunocytochemistry

Professional Society Memberships:

American Medical Association	1982
Fellow, American College of Chest Physicians	1994
Fellow, American College of Surgeons	1995
Louisiana Chapter, American College of Surgeons	1995
New Orleans Surgical Society	1995
Society of Thoracic Surgeons	1995
Southeastern Surgical Congress	1995
Southern Medical Association	1995
Southern Thoracic Surgical Association	1995

Publications:

1. Khachaturian H., Alessi N.E., Munfakh N.A., Watson, S.J.: Ontogeny of opioid and related peptides in the rat C.N.S. and pituitary: An Immunocytochemical Study, Life Science, 1983; 38 Supp I: 61-64.

2. Khachaturian H., Alessi N.E., Lewis M.E., Munfakh N.A., Fitzsimmons M., Watson S.J.: Development of Hypothalamic Opioid Neurons: A Combined Immunocytochemical and 3-H Thymidine Autoradiographic Study, Neuropeptides, 1985; Feb (4-6): 477-480.

3. Endean E.D., Schwarcz T.H., Barker, D.E., Munfakh N.A., Wilson-Nealy R., Hyde G.L.: Hip Disarticulation: Factors Affecting Outcome. J Vasc Surg. 1991: 14(3): 398-404.

4. Steinberg, J.B., Doherty N.E., Munfakh, N.A., Geffin G.A., Titus J.S., Hoaglin D.C., Denenberg A.F., Daggett W.M.: Oxygenation Cardioplegia: The Metabolic and Functional Effects of Glucose and Insulin, Ann Thorac Surg., 1991, 51(4): 620-629.

5. Munfakh N.A., Steinberg J.B., Titus J.S., Denenberg A.G., O'Keefe D.D., Daggett W.M., Geffin G.A.: Protection of the Hypertrophied Myocardium by Crystalloid Cardioplegia, J Surg Res, 1991, 51(6): 447-456.

6. Allyn J.W., Teplick R., Steinberg J.B., Munfakh N.A., Geffin G.A., Titus J.S., Daggett W.M.: Norepinephrine increases the economy of pressure development in isolated canine hearts, Am J Physiol, 1993; 263, H7150H721.

7. Schwartz R.W., Munfakh N.A., Zwang T.N., Strodel W.E., Lee E., Thompson N.W.: Non-functioning cystic neuroendocrine neoplasms of the Pancreas. Surgery, 1994; 115: 645-9.

8. Webb W., Harrison L., Helmcke F., Camino A., Munfakh N.A., Heck H., Moulder P.: Carbon dioxide field flooding minimizes residual intracardiac air after open heart operations. Anns of Thorac Surg, 1997; 64:1489-91.

9. Crumb W.J., Pigott J.D., Nenova N., Munfakh N.A., Harrison L.H., Heck H.A., Clarkson C.W., Roca T.P.: Fatty acid block of the transient outward current in the adult human atrium. J Pharm & Exp Thera 1999; 289:386-91.

10. Carmeci C., Munfakh N.A., Brooks J.W., Abdominal Apoplexy. So Med J, 1998; 91: 273-74.

Publications continued:

11. Nevov N.I., Crumb W.J., Munfakh N.A., Pigott J.D., Clarkson C.W.: Unique Effects of Extracellular Potassium on the Human Atrial Transient Outward Current. Submitted to American Journal of Physiology.

12. Tan C.W., Munfakh N.A., Helmcke F., Abourame A., Caspi J., Glancy D.L.: Congenital Cardiovascular malformations. Submitted to American Journal of Cardiology.

13. Caspi J., Zalstein E., Zucker N., Appelbaum A., Harrison L.H., Munfakh N.A., Ferguson T.B. Jr., Heck H., Stopa A., White M., Fontenot E.: Surgical management of tetralogy of Fallot in the first year of life. Ann Thorac Surg 1999;68:1344-349.

14. Caspi, J., Pettitt, T., Fontenot, E., Stopa, A., Heck, H., Munfakh, N., Ferguson, T.B., Harrison, L.: The beneficial hemodynamic effects of selective patent vertical vein following repair of obstructed total anomalous pulmonary venous drainage in infants. European Journal of Cardio-Thoracic Surgery 20 (2001) 830-834

Abstracts:

1. Munfakh N.A., Steinberg J.B., Geffin G.A., O'Keefe D.D., Daggett W.M.: Protection of the Hypertrophic Myocardium by Crystalloid Cardioplegia. The Association for Academic Surgery, Nov., 1990.

2. Steinberg J.B., Doherty N.E., Munfakh N.A., Geffin G.A., Titus J.S., Hoaglin D.C., Deneberg A.G., Daggett W.M.: The Addition of Glucose and Insulin to Oxygenated Cardioplegia Solution. International Society of Heart Research, Aug., 1990.

3. Allyn J.W., Teplick R., Steinberg J.B., Munfakh N.A., Geffin G.A., Daggett W.M.: Norephinephrine does not Result in Oxygen-Wasting in Isolated Canine Hearts. Society of Cardiovascular Anesthesiology, May, 1990.

4. Khachaturian H., Munfakh N.A., Alessi N.E., Watson S.J.: Comparative Otogeny of Three Opioid Systems in the rat C.N.S., International Narcotics Research Conference, Garmish, W. Germany, June 1983.

5. Khachaturian H., Alessi N.E., Lewis M.E., Munfakh N.A., Watson S.J.: Ontogeny of Opioid and Related Peptides in the Rat Brain and Pituitary, Society of Neuroscience, 1983.

Presentations:

1. Munfakh N.A., Khachaturian H., Watson S.J.: an ontogenic approach to the question of multiple substance localization within the same hypothalamic neurons. Presented to the Medical Student Research Forum, University of Michigan Medical School, September, 1982.

2. Munfakh N.A., Schwatz R.W, Barker D.E., Hyde G.L.,: A 22 Year Experience with Hip Disarticulation. Presented to the Kentucky Surgical Society, Cincinnati, OH, May 1987.

3. Munfakh N.A., Steinberg J.B., Geffin G.A., O'Keefe D.D., Daggett, W.M., "Protection of the Hypertrophied myocardium by Crystalloid Cardioplegia". Presented to the Association for Academic Surgery, Houston, TX, November 1990.

4. Damiano R.J., Munfakh N.A., Ellenbogen K.A., Wood M.A., Stambler B.S., Spratt J.A., and Wechsler A.S.: "Implantable Cardioverter Defibrillators (ICD) and Concomitant Cardiac Surgical Procedures: Efficacy, Morbidity and Mortality". Presented to Virginia Surgical Society, 1993.

Presentations continued:

5. Munfakh N.A., Harrison L.H., Webb W.R.: "Mitral Valve Repair". Presented to the Louisiana Chapter of the American College of Surgeons, New Orleans, LA. January 1996.

6. Munfakh, N.A.: "Use of TEE in Assessing the Patient for Mitral Valve Repair – the Surgeons Perspective". Presented to ECHO, New Orleans, LA. April 1997.

7. Munfakh, N.A.: "Mitral Valve Repair – the Surgeon's Perspective". Presented to ECHO, New Orleans, LA. April, 1998.

8. Munfakh, N.A.: "Aortic and Mitral Valvuloplasty: timing of the Surgery and the Role of Intraoperative TEE". Presented to ECHO New Orleans, New Orleans, LA. April 1999.

9. Munfakh, N.A., "Mitral Valve Repair" presented to San Antonio Cardiology Society, American Heart Association, San Antonio, TX, January 2000.

10. Munfakh, N.A., "Mitral Valve Repair – Surgical Perspective" presented to ECHO New Orleans, LA. June 2, 2001, New Orleans, LA.

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1980 — Lincoln Land Community College, Springfield, IL
Associate Degree in Nursing

Experience:

02/2006 - present — St.Mary'sGoodSamaritan Regional Health Center, Mount Vernon, IL
CVOR Coordinator/RNFA
Duties include but not limited to cost containment and process improvement for all aspects for the cardiac surgery service line. Increase cost effectiveness and improve level of professionalism to optimize surgeon and patient satisfaction. Streamline service line to become more efficient use of resources and staff. Provide education and leadership in a supervisory capacity and as a clinical coach. Provide input on staff evaluations in anticipation of transfer of that responsibility. Evaluate revise and write policies and procedures in collaboration with the director of the department. Maintain relationship with vendors to facilitate surgeon and patient needs. RNFA for on and off pump CABG, complex cardiovascular, thoracic procedures, vein harvesting utilizing endoscopic and "no touch bridge" technique. Perform all surgical roles in cardiac surgery and RNFA, scrub and circulate general surgical and obstetrical procedures.

01/2004 – 02/2006 — Blessing Hospital, Quincy, IL
CVOR Nurse Manager/RNFA
New heart and vascular center, responsibilities include staff education and staff development. Overseeing construction and preparing two new CVOR suites for procedures. The new department and surgical suites guided successfully through JCAHO and IDPH inspections. Development of policies and procedures and development of performance improvement initiatives, manage and prepare project, capital and operational budgets, monitor charges and billing for accuracy and proper budgetary assignment and tracking. Oversee all aspects of three cost centers: CVOR, Perfusion and Cardiac Anesthesia. Maintain departments within budgets while implementing 5.25% budgetary reductions for the final quarter of the 2005 fiscal year. Maintain relationship with vendors of supplies, equipment and

aide in negotiating pricing. Perform RNFA duties for on and off pump CABG, complex cardiovascular, thoracic, and vascular procedures. Perform permanent pacemaker/automatic internal defibrillator insertion and peripheral vascular procedures. Vein harvested for conduit during coronary artery bypass grafting utilizing the "no touch bridge" technique. Performing all surgical roles in CVOR, including mentoring/teaching all roles including vein harvesting and wound closure.

07/1993-11/2003 Memorial Medical Center, Springfield, IL
Responsibilities include on and off pump CABG, complex cardiovascular, thoracic, vascular and peripheral vascular procedures. Vein harvesting for coronary bypass utilizing the "no touch bridge" technique, additional experience in LVAD, RVAD, VATS, ICD and pacemaker procedures. Ability to function in all CVOR surgical roles including charge nurse, preceptor, and training duties in CVOR.

10/1990-07/1993 St. John's Hospital, Springfield, IL
RNFA Cardiac Surgery
Responsibilities include on and off pump CABG, complex cardiovascular, thoracic, vascular and peripheral-vascular procedures. Additional experience in VATS, ICD, PPM, IABP and blood salvaging systems. Ability to function in all cardiac surgery surgical roles.

11/1989-09/1990 St. Francis Medical Center, Monroe, LA
Registered Nurse Cardiac Surgery
Responsibilities include scrub, circulate and charge nurse duties in cardiac surgery. Additional duties for blood salvaging systems and IABP insertion and monitoring in cardiac surgery, Registered Nurse in CVRU as a bridge nurse for the immediate postoperative phase.

06/1987-11/1989 St. John's Hospital, Springfield, IL
Registered Nurse Cardiac Surgery
Duties included scrub, circulating, blood salvaging systems, and IABP.

01/1987-06/1987 Intracorp, Springfield, IL
Medical Case Management/Rehabilitation Specialist

06/1983-01/1987 St. John's Hospital, Springfield, IL
Registered Nurse CPU
Responsibilities included telemetry interpretation, patient care, preceptor, and charge nurse on a 69 bed cardiopulmonary step down unit.

05/1980-06/1983 St. John's Hospital, Springfield, IL
Registered Nurse 6 Neuro IMC
Responsibilities included patient care on 21 bed general/surgical neurology floor with 6 bed IMC craniotomies and major head traumas. Duties also included charge nurse for entire floor of Neurology and EENT.

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Centralia, IL
General Studies

Nashville State Technical Institute
Nashville, TN
Surgical Technology, Certificate
Related courses: microbiology, anatomy & physiology, pharmacology, chemistry, medical terminology, and introduction to surgical technology.

Rend Lake College
Ina, IL
LPN and General Studies
Incomplete (LPN), Completed

Experience: Good Samaritan Hospital
Mt. Vernon, IL
January 3, 2005- present
Certified Surgical Technologist
Open Heart Certified Surgical Technologist, August 1, 2005 to present

St. Mary's Good Samaritan Hospital
Centralia, IL
October 2001 - December 31, 2004
Certified Surgical Technologist, Surgical Technologist Preceptor, and Surgical Information Systems Computer Coordinator.

Activities: Association of Surgical Technologists
High Honors Student
President of Parent Teacher Organization

References available on request.

Kristina Marie Feig
301 Leafland Avenue
Centralia, Illinois 62801
(618)533-1965

References:

Van Bates, surgical technology instructor
Nashville, TN 37221
(615) 353-3340

Mark Walker, Certified Registered Nurse First Assistant
1031 Monroe
Carlyle, IL 62231
(618) 594-8028

Tracy Walton, Registered Nurse
515 East Third Street
Centralia, IL 62801
(618)532-6750

Kyle E. Bevis
Registered Nurse Open Heart Circulator

Currently circulating Cardiothoracic surgery including Coronary Artery Bypass Grafting, Aortic and Mitral Valve Replacements, Thoracic surgery, Aneurysm repairs and other vascular procedures.

I started working in General Surgery in 1979 as a circulating nurse. I transferred to the Open Heart Team when the program began in March 2001. I was sent to DePaul Hospital and St. Josephs Hospital in St. Louis, Missouri for on the job training in their heart program. We also received multiple inservices for training purposes.
In November 2001, I went to Oakwood Heritage Hospital , Michigan for First Assistant training program. Following this program, I assisted on cardiothoracic cases for approximately 5 years. I then transferred to the Open Heart Circulator position.

Kathleen J Kretzer
Registered Nurse Open Heart Scrub

Currently scrubbing Cardiothoracic surgery including Coronary Artery Bypass Grafting, Aortic and Mitral Valve Replacements, Thoracic surgery, Aneurysm repairs and other vascular procedures.

I started working in General Surgery in 1992 as a circulating nurse, crossed trained for scrubbing after attending a scrub technique class. I then transferred to the Open Heart Team in August of 2002. I was trained on the job with an experienced scrub. I was sent to St. Joseph Hospital for on the job training. I attended classes for operating the Intra-Aortic Balloon Pump. I was inserviced by the Perfusionist.

Heather L. Pace
Registered Nurse Open Heart Circulator

Currently circulating Cardiothoracic surgery including Coronary Artery Bypass Grafting, Aortic and Mitral Valve replacements, Thoracic surgery, Aneurysm repairs and other vascular procedures.

I started as a circulator in General Surgery in Febuary 2001. I then transferred to the Open Heart team in April 2003. I was trained on the job with an experienced circulator for approximately twenty cases and then started circulating cases and taking call. During my training, I attended classes for operating the Intra-Aortic Balloon Pump. I also attended a Basic EKG class and was inserviced by the perfusionist.

****CONFIDENTIAL RESUME****

SANDY GUPTA, BS, MT, CCP
7147 Sue Lane
Rockford, IL 61111
Home: (815) 633-0670
Email: Sandhya1002@hotmail.com

OBJECTIVE: To obtain a position as a staff perfusionist.

EDUCATION:

The Johns Hopkins School of Perfusion Technology, Baltimore, MD, 7/92 to 12/93. Cumulative GPA 4.0/4.0.

University of Illinois, Chicago, IL, 12/90. B.S., Medical Laboratory Technology. Cumulative GPA 5.0/5.0, Dean's List. Certified Medical Technologist.

College of Lake County, Grayslake, IL. 1987-89. A.S. Medical Laboratory Technician (MLT), Cumulative GPA 4.0/4.0, Highest Honors.

University of Wisconsin, Milwaukee, WI, 1979-81. Microbiology, Immunology, and Human Parasitology. GPA 4.0/4.0

EXPERIENCE:

- Rockford Surgical Services, Rockford, IL, May 2003 – Present, Perfusionist, Clinical responsibilities include adult cardiopulmonary bypass, IABP, blood gases, ACT, record keeping, QC, and on call responsibilities.

- Ingalls Memorial Hospital, Harvey, IL, 1994-May 2003, Perfusionist.
- Columbus Cabrini Hospital, Chicago, IL, 1994-1998, Perfusionist.
  Clinical responsibilities include adult cardiopulmonary bypass, VADS, IABP, autotransfusion, blood gases, hemodynamic monitoring, ACT, QC, correlation studies, proficiency testing, PTCA standby, and on-call responsibilities.

- The Johns Hopkins Hospital, Baltimore, MD, 7/92-12/93
  Clinical experience included adult and pediatric perfusion, hemodynamic monitoring, blood gases and ACT, circulatory arrest, LA-FA bypass, IABP, VADS, ECMO, CPS, hemoconcetration, autotransfusion, heart and liver transplants, and isolated limb perfusion.
  Clinical Perfusion Affiliations:
  Medical College of Virginia, Richmond, VA, July 1993
  Northwestern Memorial Hospital, Chicago, IL August 1993

- Abbott Laboratories, Abbott Park, IL, Feb 91-July 92, Research & Development Technologist. Responsible for developing protocols, blood typing, research projects, documentation, and quality control.

CERTIFICATION:

Licensed Perfusionist, IL, 2002, #214-000071
Certified Clinical Perfusionist, 1995, National Percentile Rank 98%
Medical Technology Registry #184257, 1991, National Percentile Rank 99.98%
Medical Laboratory Technician Registry #040866, 1989, National record high score.

HONORS:

Outstanding Achievement Award, University of Illinois, 1991
Medical Technology Faculty Scholarship, University of Illinois, 1990
Outstanding Scholar Award, College of Lake County, IL, 1989

REFERENCES: Available upon request.

CURRICULUM VITAE

Frank M. Eaton, M.D.

Current Position:

Medical Director of Anesthesia
St. Mary's Good Samaritan Hospital
Mt. Vernon, IL

Medical Director of Anesthesia
St. Mary's Good Samaritan Hospital
Centralia, IL

President
Southern Illinois Anesthesiology, Ltd.

Personal Information:

17726 N. Hails Ln.
Mt. Vernon, IL 62864
Home Phone (618) 755-0094
Home Fax (618) 755-0095
Office Phone (618) 241-1137

Born November 25, 1959
Married (Michelle, 5/93)
Children (Kyle Christopher, 4/18/94
Evan Mitchell, 3/12/97)
Social Security #441-70-1642

Education:

1978-82	B.S. in Chemical Engineering with Honors University of Oklahoma, Norman, Oklahoma
1982-86	M.D. University of Oklahoma, Oklahoma City, Oklahoma

Postgraduate Training

1986-87	Internship, Rotating Saint Louis University Health Sciences Center, St. Louis, Missouri
1986-90	Resident, Anesthesiology Saint Louis University Health Sciences Center, St. Louis, Missouri

Board Certification and Licensure:

Diplomat, National Board of Medical Examiners, 1987
Diplomat, American Board of Anesthesiology, 1991
Missouri, R2K06
Illinois, 036-103229

Previous Professional Experience:

1990-1991	Instructor Department of Anesthesiology Saint Louis University Health Sciences Center
1991-2000	Assistant Professor Department of Anesthesiology Saint Louis University Health Sciences Center
2000	Associate Professor Department of Anesthesiology Saint Louis University Health Sciences Center
2000-pres	Medical Director of Anesthesia St. Mary's Good Samaritan Hospital Mt. Vernon, IL
2005-pres	Medical Director of Anesthesia St. Mary's Good Samaritan Hospital Centralia, IL

Clinical Staff Appointments:

1990-2000	Attending Anesthesiologist Saint Louis University Health Sciences Center St. Louis, Missouri
1990-1996	Attending Anesthesiologist John Cochran VA Medical Center St. Louis, Missouri
1990-2000	Attending Anesthesiologist Cardinal Glennon Children's Hospital St. Louis, Missouri
2000-pres	Attending Anesthesiologist St. Mary's Good Samaritan Hospital Mt. Vernon, IL
2005-pres	Attending Anesthesiologist St. Mary's Good Samaritan Hospital Centralia, IL

Professional Society Memberships:

American Society of Anesthesiologists
International Spine Intervention Society
Missouri Society of Anesthesiologists
Illinois Society of Anesthesiologists
St. Louis Society of Anesthesiologists
Association of Anesthesia Clinical Directors
Society for Technology in Anesthesia
Jefferson County Medical Society

Honorary Societies, Honors and Awards

1990 Chief Resident, Department of Anesthesiology
Saint Louis University Health Sciences Center

Professional Services:

Past Teaching Responsibilities at Saint Louis University Health Sciences Center

Anesthesiology Resident Curriculum
- Basic Science Seminars, 1990-2000
- Core Anesthesiology Lectures, 1990-2000
- Advanced Subspecialty Lectures, 1990-2000

Anesthesiology Resident Clinical Supervision, 1990-2000

Publications:

Papers

Eaton, FM, Mai-Lombardo, J, The Challenge: Improving OR Turnover Time, Surgical Services Management, September, 1997.

Eaton FM, Krucylak PE, Foroughi V, Baudendistel LJ: A Real-Time Status Monitor as a Tool for Operating Room Management. The Internet Journal of Anesthesiology 1998; Vol2N1: http://www.ispub.com/journals/IJA/Vol2N1/real.htm . Published January 1, 1998; Last Updated January 1, 1998.

Published Abstracts

Krucylak, PE, Foroughi,V, Eaton, FM, Baudendistel, LJ, Anesthesia Data Management Systems as a Tool for Total Quality Management of Operating Rooms, IARS, March, 1997.

Eaton, FM, Krucylak, PE, Foroughi, V, Baudendistel, LJ, A Real-Time Status Monitor as a Tool for Operating Room Management, ASA, October, 1997.

Exhibits

Krucylak, PE, Foroughi,V, Eaton, FM, Baudendistel, LJ, Anesthesia Data Management Systems as a Tool for Total Quality Management of Operating Rooms, IARS, March, 1997.

Poster Presentations

Eaton, FM, Krucylak, PE, Foroughi, V, Baudendistel, LJ, A Real-Time Status Monitor as a Tool for Operating Room Management, ASA, October, 1997.

Fisch, C, Eaton, FM, Foroughi, V, A Fully Integrated Surgical Information Management System. Midwest Anesthesiology Residents Conference, Chicago, Illinois. April, 1997.

Research Interests

- Computers in Anesthesia
- Use of automated database systems in operating room management
- Automated anesthesia records as a tool for TQM

Committee Memberships and Directorships

Departmental:

1990-2000	Coordinator Morbidity and Mortality Conference Department of Anesthesiology Saint Louis University Health Sciences Center
1992-1995	Co-Director of Clinical Services Department of Anesthesiology Saint Louis University Health Sciences Center
1992-1998	Director, Quality Improvement Department of Anesthesiology Saint Louis University Health Sciences Center
1995-1996	Director of Clinical Services Department of Anesthesiology Saint Louis University Health Sciences Center
1995-2000	Director of Medical Informatics Department of Anesthesiology Saint Louis University Health Sciences Center
1993-1996	Member, Clinical Competency Committee Department of Anesthesiology Saint Louis University Health Sciences Center
1995-1996	Member, Research Committee Department of Anesthesiology Saint Louis University Health Sciences Center
1998- 2000	Director, Clinical Quality Improvement Department of Anesthesiology Saint Louis University Health Sciences Center
1998- 2000	Member, Steering Committee Department of Anesthesiology Saint Louis University Health Sciences Center

Hospital:

1992-1995	Member, Operating Room Committee Saint Louis University Health Sciences Center
1994-1997	Member, Patient Services Committee Saint Louis University Health Sciences Center
1995-1997	Member, Quality Improvement Committee Saint Louis University Health Sciences Center
1996	Member, Ad Hoc Committee on Operating Room Scheduling Saint Louis University Health Sciences Center
1995-1999	Chairman, Operating Room Committee Saint Louis University Health Sciences Center
1997-2000	Member, Clinical Quality Management Committee Saint Louis University Health Sciences Center
1997-2000	Member, Executive Committee Saint Louis University Health Sciences Center
1998-2000	Member, Ad Hoc Committee on Operating Room Utilization Saint Louis University Hospital
1999-2000	Chairman, Credentials Committee Saint Louis University Hospital
1999-2000	Vice-President, Medical Staff Saint Louis University Hospital

2000- pres	Member, OB Committee St. Mary's Good Samaritan Hospital Mt. Vernon, IL
2000- pres	Member, Critical Care Committee St. Mary's Good Samaritan Hospital Mt. Vernon, IL
2000- pres	Member, Nursery Committee St. Mary's Good Samaritan Hospital Mt. Vernon, IL
2000- pres	Member, Orthopedics Team St. Mary's Good Samaritan Hospital Mt. Vernon, IL
2000- pres	Member, Heart Team St. Mary's Good Samaritan Hospital Mt. Vernon, IL
2000- pres	Member, Ad Hoc Group on OR Management St. Mary's Good Samaritan Hospital Mt. Vernon, IL
2003-pres	Member, Credentials Committee St. Mary's Good Samaritan Hospital Mt. Vernon, IL
2005-pres	Member, OB Committee St. Mary's Good Samaritan Hospital Centralia, IL

Waqqas Khan MD

130 Breezy Hills Cove
Grand Forks, ND 58201
701.795.0268
wkhan@altru.org

CERTIFICATION:

FMGEMS 1990
FLEX 1991
Board Eligible in Pediatrics-1993
Diplomate American Boards in Anesthesiology - 2001

TRAINING:

March 1997 – January 1999
Resident in Anesthesiology - Northwestern Memorial Hospital, Chicago.

July 1993 – January 1995
Resident in Anesthesiology – Cook County Hospital, Chicago

June 1990 – June 1993
Resident in Pediatrics – University of Illinois at Chicago

EMPLOYMENT

August 2000-Current
Staff Anesthesiologist, Altru hospital, Grand Forks, ND
Instructor, Department of Surgery
University of North Dakota Medical School, Grand Forks

July 1999- June 2000
Staff Anesthesiologist - Mount Sinai Hospital, Chicago
Instructor in Anesthesiology-Finch University of Health Sciences, Chicago

March 1999- June 1999
Staff Anesthesiologist – Northwestern Memorial Hospital, Chicago
Instructor in Anesthesiology – Northwestern University, Chicago

March 1995 – February 1997
Staff Pediatrician – Illinois Masonic Medical Center, Chicago

EDUCATION

1983 – 1989 Nishtar Medical College, Multan, Pakistan
1980 – 1982 Gordon College, Rawalpindi, Pakistan
1974 – 1980 St. Mary's Cambridge School, Rawalpindi, Pakistan

INTERESTS

Reading, Writing, Squash, Tennis, Skiing, Hunting

Kent Fair CRNA

Objective

Providing anesthesia for surgical procedures, including cardiac and chest surgery

Education

University of Illinois
Barnes School of Nursing
Barnes/Washington University School of Nurse Anesthesia

Positions Held

St. Mary's Hospital, Centralia, Illinois 1976-1978
Randell, Gonzales, Guzman
Anderson Hospital, St. Elizabeth's Hospital 1978-1985
Jewish Hospital of St. Louis 1985-1994
Washington University Department of Anesthesia 1994-1997
Anesthesia Associates of Belleville
Memorial Hospital 1997-2001
St. Mary's/ Good Samaritan Hospital 2001-2003
Southern Illinois Anesthesiology
St. Mary's/ Good Samaritan 2003-present

References

Dr.John Watson, Cardiac Surgeon
Dr. Kal White, Anesthesiologist
Dr. Waqqas Khan, Anesthesiologist

Primary Business Address
1011 Wilshire Dr.
Mount Vernon, Illinois
62864

Phone: 618-242-4150
Cell: 618-237-0737
E-mail: wottu@charter.net

Kent Fair CRNA

Professional Organizations
American Association of Nurse Anesthetists
Southern Illinois Anesthesia Association

Accreditation
Council on Recertification of Nurse Anesthetists
Recertification No. 27112 7/31/2008

Volunteer Experience
Cardiac Surgery
Hospital Sacre Coeur
Milot, Haiti

Licenses and Certificates
Illinois RN 041-171927
Illinois APN 209-000375

ANESTHESIA PRIVLEDGES

Regional Techniques
Spinal, Epidural: thoracic, lumbar, labor.
Nerve Blocks
Axillary, supraclavicular, scalene.
Femoral, ankle.

General
All general anesthetics, including, thoracic, cardiac, and major vascular

Monitoring
Skilled in placement and use of all monitoring devices, including, Swan-Ganz placement, central line placement, and arterial lines.
Tranesophageal Echocardiography
Echo study and monitoring

CURRICULUM VITAE

JONATHAN SORENSON, CRNA, DNSc
4204 ARAGON COURT
SWANSEA, ILLINOIS 62226
TELEPHONE/FAX (618) 234-9284
PAGER (618) 338-2511
CELLULAR (618) 407-1815

SUMMARY OF EXPERIENCE

Over nineteen years experience in the health care field including direct patient care, clinical management of patients and administration of anesthesia services. Background includes over ten years experience administering regional and general anesthesia to all ASA Classifications of patients. Experienced in organizing the capital needs for an anesthesia department. Revised and adapted a QA/QI tracking system for Touchette Regional Hospital's anesthesia department, as well as anesthesia assessment and discharge documentation. Active in the revision of established policies and procedures, along with the creation of new policies regarding labor anesthesia services.

EDUCATION

2002 Doctor of Nursing Science (DNSc)
University of Tennessee Health Science Center Memphis.
Graduation December , 2002

1991 Masters' in Nursing Science
University of Texas Health Science Center, Houston.
Granted an Air Force Scholarship while attending anesthesia School in a civilian program. As a Graduate Nurse Anesthetist, Preceptored senior anesthesia students at M.D. Anderson Cancer Center and Southeast Memorial Hospital.
Served as a representative for the anesthesia program to the Graduate curriculum for the University of Texas Health Science Center, Houston.

1986 Bachelors' in Nursing Science
Pacific Lutheran University, Tacoma, Washington.

EMPLOYMENT HISTORY

08/05 Staff CRNA (Relief Services)
Greenville Regional Hospital, Greenville, Illinois

08/04-present Faculty Program of Nurse Anesthesia
Barnes-Jewish College of Nursing
Responsibilities included didactic preparation of first year students to prepare them for entry into the clinical arena for delivery of anesthesia. Cadaver lab instruction for anatomy and physiology instruction.

08/03-03/04 Interim Program Coordinator-Nurse Anesthesia Specialization
Southern Illinois University Edwardsville

07/03-12/03 Assistant Professor Nurse Anesthesia Program
University of Tennessee Health Science Center Memphis
Responsible for the cardiovascular/vascular anesthesia content for the nurse anesthesia program. Assisted in the development of course syllabi and various anesthesia related courses

07/02-08/03 Assistant Program Coordinator-Nurse Anesthesia Specialization
Southern Illinois University Edwardsville
Duties include the overseeing of clinical students in various clinical settings, as well as didactic responsibilities. Records maintained in accordance with the guidelines of the Council of accreditation.

01/02-12/04 Staff Nurse Anesthetist
Belleville Memorial Hospital, Belleville, Illinois
Responsible for the administration of regional and general anesthesia to a diverse population. Cardiac as well as obstetrical services performed in an autonomous environment.

03/99-01/02 Chief Nurse Anesthetist/Anesthesia Department Manager
Touchette Regional Hospital, Centreville, Illinois.
Responsible for staffing and administrative duties for the Department of Anesthesia. Quality Improvement, budgeting and peer evaluations are implemented and maintained. Anesthesia liaison to hospital administration as well as other departments.

EMPLOYMENT HISTORY—(continued)

04/98-06/02 Clinical Instructor Southern Illinois University at Edwardsville.
Clinical Coordinator at Touchette Regional Hospital.
Responsibilities to include didactic instruction to senior, junior and freshmen anesthesia students. Restructing of core curriculum to enhance the learning experience. Clinical instruction of senior and junior anesthesia students. Main emphasis on regional anesthesia and anesthesia administration in small community hospital settings.

05/95-present Sorenson Anesthesia Services P.C.
Locums Tenens Illinois and Missouri.

01/02-12/04 Belleville Memorial Hospital
Anesthesia Associates of Belleville
Staff Nurse Anesthetist.

02/95-01/02 Staff CRNA
Touchette Regional Hospital, Centreville, Illinois.
Capable in the administration of general anesthesia to all ASA classification of surgical patients with a strong background in OB anesthesia. Regional techniques to include: (1) spinal, (2) epidural, (3) interscalene, (4) supraclavicular, (5) caudal, (6) scapular, (7) intercostal, (8) axillary, (9) femoral, (11) peribulbar/retrobulbar, and, (12) ankle blocks. Proficient in central venous access and line placement, as well as the placement of arterial catheters. Active participation in numerous neonatal resuscitations. ACLS Instructor/Provider working closely with nursing inservice.

10/94-02/95 Contract CRNA
Scott Air Force Base, Illinois.
Responsibilities included the administration of anesthetics to a wide variety of surgical and non-surgical procedures. Proficient in the administration of general as well as regional Techniques which include spinals, epidurals, and nerve blocks.

EMPLOYMENT HISTORY—(continued)

11/91-
10/94 Staff CRNA
United States Air Force, Scott AFB, Illinois.
Responsibilities included the administration of anesthetics on A wide variety of surgical and non-surgical procedures. Proficient in the administration of general and various regional techniques. Qualified in the placement of invasive lines. Taught EKG and central venous access and monitoring to nurse intern students. Taught basic and advanced airway management to EMT students. ACLS Instructor/Provider at Scott Medical Center and in the Azores.

06/91-
10/91 Locum Tenens CRNA
Houston, Texas.
Administration of general and regional anesthetics in hospital outpatient surgery centers.

01/94-
04/94 Staff RN-Agency Nursing Critical Care Specialties
Houston, Texas
Intensive Care Units, Post Anesthesia Care Units and Emergency Departments.

01/89-
12/89 Staff RN
Southwest Memorial Hospital, Houston, Texas
Emergency Department and Post Anesthesia Care Unit.

12/86-
12/88 Staff RN
St. Joseph Hospital, Tacoma, Washington.
Staff nurse Post Anesthesia Care Unit. Taught emergency airway Management to new employees. Preceptored senior nursing Student for a semester in the Post Anesthesia Care Unit.

CERTIFICATIONS

American Association of Nurse Anesthetists #42052
ACLS Instructor/Provider

LICENSURE

Registered Professional Nurse-Illinois #041-272021
Registered Advanced Practice Nurse-Illinois #209-000414
Registered Advanced Practice Nurse-Missouri #129825
Advanced Nurse Practitioner-Texas 549856
Registered Nurse-Washington #RN00090831
Registered Nurse-Oregon #96006246

PRESENTATIONS

American Association of Nurse Anesthetist—Assembly of School Faculty—2003
(Poster Presentation--Dissertation)
Southern Nurses' Research Society-2003
(Poster Presentation—Dissertation)
Illinois Association Nurse Anesthetists—Fall 2001
(Fast Trach™ Laryngeal Mask Airway)
Missouri Association of Nurse Anesthetists—Spring 2001
(Brachial Plexus Blockade)
Illinois Association Nurse Anesthetist—Fall 1999
(Hands On Session—Lower Extremity Blockade)

14205 N McRaven Ln.
Mt. Vernon, IL 62864

Phone 618-204-5283
E-mail brooksgreger@hotmail.com

Brooks Ross Greger II

SOC Sec #
462-91-8040

Objective

To obtain a position as a CRNA that will allow me to utilize my clinical and educational experience while actively gaining new knowledge.

Education

2004-2006 Texas Wesleyan University Fort Worth, TX
Master of Science in Nurse Anesthesia
Expected Graduation December 15, 2006

1997-2002 University of Central Arkansas Conway, AR
Bachelor of Science in Nursing
Graduated as member of Kappa Rho Chapter of Sigma Theta Tau Honors Society of Nursing

Work experience

2005-present Texas Tech Health Science Center Lubbock, TX
Graduate Student
Perform post-operative anesthetic assessments on in-house patients

2002-2004 Baylor University Medical Center Dallas, TX
Registered Nurse
Worked in Surgical/Transplant ICU

1999-2002 Conway Regional Medical Center Conway, AR
Nursing Assistant
Performed EKGs, phlebotomy, telemetry tech, post-cardiac cath care, nursing assistance

References

David Fincher, CRNA – Clinical Coordinator for Nurse Anesthesia Residency at Texas Tech University Medical Center. 806-743-2981

James Roberts, M.D. of Anesthesiology – O.R. Director. 806-775-8300

Jack Bolton, M.D. of Anesthesiology – 806-775-8300

Ron Banister, M.D. of Anesthesiology – 806-775-8300

Professional memberships

American Association of Nurse Anesthetists 2004-present

Accreditations and licenses

State of Texas Nursing License 2002-present

Advanced Cardiac Life Support 2002-present

Basic Life Support 1999-present

Pediatric Advanced Life Support 2004-present

Anesthesia Clinical Rotations

Texas Tech University Medical Center of Lubbock

- Specialty rotations in pediatric, vascular, neuro, OBGYN, and general surgery anesthesia

Plaza Medical Center of Fort Worth

- Specialty rotation in cardiothoracic anesthesia

Waqqas Khan MD

130 Breezy Hills Cove
Grand Forks, ND 58201
701.795.0268
wkhan@altru.org

CERTIFICATION:
FMGEMS 1990
FLEX 1991
Board Eligible in Pediatrics-1993
Diplomate American Boards in Anesthesiology - 2001

TRAINING:
March 1997 – January 1999
Resident in Anesthesiology - Northwestern Memorial Hospital, Chicago.

July 1993 – January 1995
Resident in Anesthesiology – Cook County Hospital, Chicago

June 1990 – June 1993
Resident in Pediatrics – University of Illinois at Chicago

Aug 03 - Present - Southern Illinois Anesthesiology, PTD

EMPLOYMENT
August 2000-Current - Jul-03
Staff Anesthesiologist, Altru hospital, Grand Forks, ND
Instructor, Department of Surgery
University of North Dakota Medical School, Grand Forks

July 1999- June 2000
Staff Anesthesiologist - Mount Sinai Hospital, Chicago
Instructor in Anesthesiology-Finch University of Health Sciences, Chicago

March 1999- June 1999
Staff Anesthesiologist – Northwestern Memorial Hospital, Chicago
Instructor in Anesthesiology – Northwestern University, Chicago

March 1995 – February 1997
Staff Pediatrician – Illinois Masonic Medical Center, Chicago

EDUCATION
1983 – 1989 Nishtar Medical College, Multan, Pakistan
1980 – 1982 Gordon College, Rawalpindi, Pakistan
1974 – 1980 St. Mary's Cambridge School, Rawalpindi, Pakistan

INTERESTS
Reading, Writing, Squash, Tennis, Skiing, Hunting

Waqqas Khan MD

130 Breezy Hills Cove
Grand Forks, ND 58201
701.795.0268
wkhan@altru.org

CERTIFICATION:

FMGEMS 1990
FLEX 1991
Board Eligible in Pediatrics-1993
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Resident in Pediatrics – University of Illinois at Chicago

EMPLOYMENT

August 2000-Current
Staff Anesthesiologist, Altru hospital, Grand Forks, ND
Instructor, Department of Surgery
University of North Dakota Medical School, Grand Forks

July 1999- June 2000
Staff Anesthesiologist - Mount Sinai Hospital, Chicago
Instructor in Anesthesiology-Finch University of Health Sciences, Chicago

March 1999- June 1999
Staff Anesthesiologist – Northwestern Memorial Hospital, Chicago
Instructor in Anesthesiology – Northwestern University, Chicago

March 1995 – February 1997
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EDUCATION

1983 – 1989 Nishtar Medical College, Multan, Pakistan
1980 – 1982 Gordon College, Rawalpindi, Pakistan
1974 – 1980 St. Mary's Cambridge School, Rawalpindi, Pakistan

INTERESTS

Reading, Writing, Squash, Tennis, Skiing, Hunting

Scott Alan Boss

406 Huron Avenue
Lubbock, Texas
79416

Phone (806)784-0103
E-mail
scottieboss@sbcglobal.net

Objective

Permanent staff position as Certified Registered Nurse Anesthetist.

Summary of qualifications

A varied background of experience and skills developed over my work history, have enabled me to effectively perform in the following ways:

Establishing and maintaining cooperative and productive rapport with others

Clinical knowledge as a Registered Nurse in the ER, OR, Critical Care settings

Technical skills in research, data gathering, software program development and evaluation methods

Familiarity with interpreting and disseminating policy, procedures, rules and guidelines

Conscientious and thorough work ethic by way of reliable and accountable personal performance

Education

2004- Dec 2006 Master of Science in Nurse Anesthesia; Texas Wesleyan University; Fort Worth, Texas

1995-1998 Master of Arts in Public Management; Midwestern State University, Wichita Falls, Texas

1996-1999 Bachelor of Science in Nursing; Midwestern State University, Wichita Falls, Texas

1986-1989 Bachelor of Arts Political Science and Public Administration; Midwestern State University, Wichita Falls, Texas

Professional experience

2005-2006 Texas Tech University Medical Center Lubbock, Texas

Resident Registered Nurse Anesthetist:

Provision of anesthetic care at Level I Trauma Center under supervision, to include: pre- and post-operative assessments, regional blocks, central/invasive line insertion and monitoring, pediatric, obstetric, general anesthesia, monitored anesthetic care, and PACU monitoring. Specialties included: General, Vascular, Orthopedic, Pediatric, OB/GYN, Pain Management, Neurosurgery, Kidney transplantation, ENT, Trauma, Genitourinary, and Ophthalmology.

2006 Plaza Medical Center Fort Worth, Texas

Resident Registered Nurse Anesthetist:

Provision of anesthetic care at private hospital care provider under supervision, to include: pre- and post-operative assessments, regional blocks, central/invasive line insertion and monitoring, general anesthesia, and monitored anesthetic care. Specialties included: Cardio-Pulmonary, Plastics, Neurosurgery, General, Orthopedic, Vascular, Cardiac Catheter Lab, and Cardioversions.

2004 United Regional Healthcare System Wichita Falls, Texas

ICU / CCU Staff Registered Nurse:

Assessing and implementing critical care needs of patients with life-threatening injuries of chronic and acute origins. Training in administering critical care medications, ACLS protocols, ventilatory patients, ICP and IABP monitoring, hemodynamics, external pacemakers, recovery of postoperative CABG, craniotomy, trauma, pulmonary and vascular procedures

2002-2003 United Regional Healthcare System Wichita Falls, Texas

OR Clinical Applications Coordinator:

Development and coordination of OR operational activities related to creation and maintenance of doctor's preference cards. Responsible for establishing and maintaining rapport with surgeons/assistants. Development and transfer of updated OR information system and electronic documentation. Training of OR staff in usage of operating systems. Calculation and tabulation of monthly surgery stats to financial officer. Oversight of OR schedulers to intercept errors.

2001- 2002 United Regional Healthcare System Wichita Falls, Texas

ICU / CCU Staff Registered Nurse:

Assessing and implementing critical care needs of patients with life-threatening injuries of chronic and acute origins. Training in administering critical care medications, ACLS protocols, ventilatory patients, ICP and IABP monitoring, hemodynamics, external pacemakers, recovery of postoperative CABG, craniotomy, trauma, pulmonary and vascular procedures

2000-2001 United Regional Healthcare System Wichita Falls, Texas

Operating Room Registered Nurse:

Responsible for assessing patients perioperatively for care needs.

Monitored and Staff assisted in maintaining surgical asepsis for operative procedures.

Prepared, planned, and coordinated logistic organization of procedure specifics and evening surgery schedule, supervising eight personnel.

Performed quality improvement goals and tracking reports to surgery director.

1999-2000 Graham Regional Medical Center Graham, Texas

ER / ICU / Medical / Surgical Staff Registered Nurse

Provided care for 26 bed Medical / Surgical inpatient facility; triage, acute treatment, stabilization of ER clientele at 7 bed Level IV Trauma facility.

Provided critical care needs for postoperative patients including hemodynamics monitoring, ACLS protocols, ventilatory assisted patients, etc.

Supervised three LVNs and one aide.

Resolved staffing issues, secured transport / transfer of critical patients, and provided training to subordinates.

Other Skills

Extensive computer experience involving database management and graphics applications including: Microsoft Office, Lotus, MS-DOS, WordPerfect 5.1, FoxPro 2.6, Harvard Graphics, Excel, iPath, Surgiserver, Powerpoint, etc. Trained in various research and audit techniques, statistical measures, and technical writing skills.

Accreditations

Cardiopulmonary Resuscitation, Advanced Cardiac Life Support, Pediatric Advance Life Support, Advanced Trauma Life Support, and Trauma Nursing Core Curriculum. Additional training in case management (TDMHMR), serious incident investigation techniques (TX DPRS), Prevention and Management of Aggressive Behavior (TDMHMR).

Licensure

Licensed Registered Nurse in the state of Texas

Extracurricular activities

Phi Sigma Kappa Fraternity: President, Secretary, Chairman of Community Service, Alumni, and Social Committees; Intramural Football, Softball, Soccer, Tennis, Flickerball, Greek Week.

MSU Nursing Program: Program Evaluation Committee student representative 1998
MSU Nursing Program: Curriculum Committee student representative 1999

Volunteer work for Founder's Lions Club, Cub Scout Pack 122, Habitat for Humanity, Wichita Falls Citizens' Traffic Advisory Committee, and Helen Farabee Mental Health Public Advisory Committee

Awards received

Pi Sigma Alpha National Political Science Honor Society
Sigma Theta Tau International Nursing Honor Society
Phi Sigma Kappa, Sigma Tetarton Chapter Alumni of the Year 1990
Arthur E Beyer Scholarship Recipient
Parrish-Abbott Scholarship Recipient
W.T. Waggoner Scholarship Recipient
Texas Association of Operating Room Nurses Scholarship Recipient 1999
Priddy Foundation Scholarship Recipient
Texas Nurses Association Scholarship Recipient 1999
Texas Nurses Association Individual Achievement Award 1999

References

Professional and personal references available upon request

David E. Lees CRNA

RR1 box 270A
Marshall, Mo 65340
660 831 1608
dleescrna@yahoo.com

Summary: **Curriculum Vitae**

Experience:

Lees Anesthesia Services PC — Marshall, Mo
Nurse Anesthetist — May 1998 to Present

- Independent practice of anesthesia.
- Providing permanent and temporary anesthesia coverage.

Marshall Anesthesiology — Marshall Mo
CRNA Partner — May 1998 to Present

- Provide anesthesia in a department with two other Certified Registered Anesthetists.
- Participate in providing anesthetic techniques of General, Regional and Monitored Anesthesia Care for a monthly case load of 220 procedures.
- Participate in a busy pain clinic providing diagnostic and therapeutic nerve blocks.
- Competent in placing invasive monitors.

Anesthesiology Associates Of Akron INC. — Akron Ohio
Staff CRNA — July 1988 to May 1998

- Active in cardiothoracic anesthesia cases.
- Large anesthesia care team.
- 12,000 anesthetics per year.
- Level 1 trauma experience.
- Invasive monitoring placement.
- Busy Epidural service for Obstetrics.
- Interests include complicated plastic surgery cases, ENT, and orthopedics.

Mercy Medical Center — Springfield Ohio
CRNA member Trauma Team — February 1986 to July 1988

- Member of a group of Active duty U.S. Airforce CRNA's that provided after hours coverage for this level II trauma center relating to anesthesia.

United States Air Force — Wright-Patterson AFB Ohio
Captain, CRNA — October 1984 to August 1988

- Provided anesthesia service of busy military hospital with the

Additional Training:

- 2004 Regional Anesthesia workshop University of Iowa.
- 2004 ACLS and BLS Neonatal resusitation course updated.
- Continuing Education 40 credits every two years.
- 1985 Training for Hyperbararic Medicine Diving Wright-Patterson AFB Ohio.

Awards:

- 1984 Received Hilda Salomen Award Best Case Study "Anesthesia for Superior Vena Cava Obstruction Syndrome." Pennsylvania Association Of Nurse Anesthetists.
- 1979 Phi Theta Kappa Honor Fraternity.

License:

- 2001 Licensed as a Professional Registered Nurse, State of Illinois.
- 2001 Licensed Advanced Practice Nurse, State of Illinois.
- 1998 Licensed as a Professional Registered Nurse, State Of Missouri.
- 1998 Recognized Registered Professional Nurse eligible to practice as an Advanced Practice Nurse Anesthetist State of Missouri.
- 1996 recognized Professional Registered Nurse Certificate of Authority as a Advanced Practice Nurse Anesthetist State of Ohio.
- 1985 Licensed as a Professional Registered Nurse, State of Ohio.
- 1981 Licensed as a Professional Registered Nurse, in the Commonwealth of Pennsylvania.
- 1984 Certified Nurse Anesthetist by the Council on Certification American Association of Nurse Anesthetists.
- Continually meet requirements to recertify through the Council on Recertification.

Affiliations: American Association of Nurse Anesthetists.

References: Available upon request

following subspecialties, General Surgery, Neurosurgery, Vascular, Orthopedics, Plastic, ENT, and Urology.
- member Hyperbararic Dive Team, inside observer for treatment dives.
- Commissioned Officer US Air Force, Honorable Discharge

McKeesport Hospital McKeesport Pa
RN July 1981 to September 1982
- Staff Registered Nurse Medical Surgical managed 3-11 nursing needs on Medical, Surgical floor.
- Surgical intensive care experience managing acute and long term surgical patients, also experienced trauma nursing including; ventilators and invasive monitoring.

Decatur Ambulance Service Decatur IL
EMT-A September 1977 to June 1979
- Responded to trauma and other emergency calls.
- Provided life support and transport before Paramedic services were available.

United States Navy U.S. Naval Air Station Jacksonville FL
HM2, E5 June 1969 to June 1973
- Advancement to Hospital corpsman 2nd class in twenty four months.
- Worked as a ward corpsman in a large Naval Hospital during Viet Nam era caring for wounded active duty men and also a large population of retired military and dependents.
- Held sick call Naval Air Station Dispensary.
- On the job training as xray technician.
- On the job training as pharmacy technician.
- Petty Officer in charge of medical storeroom, ordered and maintained supplies for Naval Dispensary.
- Stood Petty Officer of the Day watch.
- Honorable Discharge.

Education:

Mckeesport Hospital School of Nurse Anesthesia and California University of Pennsylvania Mckeesport PA
Bachelors of Science Nurse Anesthesia

St. Margaret's Memorial Hospital Pittsburgh, PA
Diploma Nursing

Richland Community College Decatur IL
Associate of Science

DAVID PETER RAKEY CRNA
531 NORTH TYLER
TRENTON, IL 62293-1073

HOME 618-224-2747
WORK 618-257-5162

SS# 492-60-0569 DOB 12-11-52
AANA # 028853 RECERTIFICATION EXPIRES 07-04
IL APN # 209-001244 EXPIRES 5-04
IL RN # 041-287433 EXPIRES 5-04

EDUCATION:

BARNES HOSPITAL SCHOOL OF NURSING
8-71 THRU 9-73 DIPLOMA

BARNES HOSPITAL SCHOOL OF NURSE ANESTHESIA
10-75 THRU 10-77 DIPLOMA

EXPERIENCE:

JEWISH HOSPITAL OF ST. LOUIS
216 SOUTH KINGSHIGHWAY
ST. LOUIS, MO 63110
STAFF CRNA 10-77 THRU 8-96

BELLEVILLE MEMORIAL HOSPITAL
4500 MEMORIAL DRIVE
BELLEVILLE, IL 62222
PRACTICE GROUP: ANESTHESIA ASSOCIATES OF BELLEVILLE
STAFF CRNA 9-96 THRU PRESENT

DEPENDENTS:

RUTH LYONS RAKEY DOB 9-16-60 SS# 323-60-6985
AARON MARK JONDRO DOB 8-21-85 SS# 350-76-4829

HEALTH HISTORY

DAVID P. RAKEY
CURRENT: HYPERTENSION, RX ZESTRIL 10 MG QD
NON-SMOKER
AGE 50 5' 9" 210LB

SURGICAL: 4-93 RADICAL NECK FOR CA OF TONSIL
POST-OP RADIATION THERAPY X 6 WEEKS

RUTH RAKEY
CURRENT: GOOD HEALTH, NO MEDS
NON-SMOKER
AGE 42 5"9" 153LB

MEDICAL: 3-02 PNEUMONIA, TX WITH ANTIBIOTICS

SURGICAL: 1-00 VAGINAL HYSTERECTOMY
10-99 BREAST BIOPSY; BENIGN

AARON JONDRO
CURRENT: GOOD HEALTH, NO MEDS
NON-SMOKER
AGE 17 5' 11" 230"

SURGICAL: TONSILECTOMY 8-02

CURRENT FAMILY PHYSICIAN (INTERNIST)
BRAD RINGHOFFER
4 PARK PLAZA
SWANSEA, IL
618-277-7500

HEALTH HISTORY

DAVID P. RAKEY
CURRENT: HYPERTENSION, RX ZESTRIL 10 MG QD
NON-SMOKER
AGE 50 5' 9" 210LB

SURGICAL: 4-93 RADICAL NECK FOR CA OF TONSIL
POST-OP RADIATION THERAPY X 6 WEEKS

RUTH RAKEY
CURRENT: GOOD HEALTH, NO MEDS
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AGE 42 5"9" 153LB

MEDICAL: 3-02 PNEUMONIA, TX WITH ANTIBIOTICS

SURGICAL: 1-00 VAGINAL HYSTERECTOMY
10-99 BREAST BIOPSY; BENIGN

AARON JONDRO
CURRENT: GOOD HEALTH, NO MEDS
NON-SMOKER
AGE 17 5' 11" 230"

SURGICAL: TONSILECTOMY 8-02

CURRENT FAMILY PHYSICIAN (INTERNIST)
BRAD RINGHOFFER
4 PARK PLAZA
SWANSEA, IL
618-277-7500

SECTION XIII. REVIEW CRITERIA RELATING TO CARDIAC CATHETERIZATION (CATH)

This section is applicable to all projects proposing to establish or modernize a cardiac catheterization category of service or to replace existing cardiac catheterization equipment.

A. Criterion 1110.1330.a, Peer Review

Read the criterion and submit a detailed explanation of your peer review program.

APPEND DOCUMENTATION AS ATTACHMENT CATH-1 AFTER THE LAST PAGE OF THIS SECTION.

B. Criterion 1110.1330.b, Establishment or Expansion of Cardiac Catheterization Service

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

1. A map (8 1/2" x 11") showing the location of the other hospitals within the planning area.
2. The number of cardiac catheterizations performed for the last 12 months at each of the hospitals shown on the map.
3. Provide the number of patients transferred directly from the applicant's hospital to another facility for cardiac catheterization services in each of the last three years.

APPEND DOCUMENTATION AS ATTACHMENT CATH-2 AFTER THE LAST PAGE OF THIS SECTION.

C. Criterion 1110.1330.c, Unnecessary Duplication of Services

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

1. Copies of the letter sent to all facilities within 90 minutes travel time which currently provide cardiac catheterization. This letter must contain a description of the proposed project and a request that the other facility quantify the impact of the proposal on its program.
2. Copies of the responses received from the facilities to which the letter was sent.

APPEND DOCUMENTATION AS ATTACHMENT CATH-3 AFTER THE LAST PAGE OF THIS SECTION.

D. Criterion 1110.1330.d, Modernization of Existing Cardiac Catheterization Laboratories

Read the criterion and, if applicable, submit the number of cardiac catheterization procedures performed for the latest 12 months.

APPEND DOCUMENTATION AS ATTACHMENT CATH-4 AFTER THE LAST PAGE OF THIS SECTION.

E. Criterion 1110.1330.e, Support Services

Read the criterion and indicate on a service by service basis which of the listed services are available on a 24 hour basis and explain how any services not available on a 24 hour basis will be available when needed.

APPEND DOCUMENTATION AS ATTACHMENT CATH-5 AFTER THE LAST PAGE OF THIS SECTION.

F. Criterion 1110.1330.f, Laboratory Location

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

APPEND DOCUMENTATION AS ATTACHMENT CATH-6 AFTER THE LAST PAGE OF THIS SECTION.

G. Criterion 1110.1330.g, Staffing

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

APPEND DOCUMENTATION AS ATTACHMENT CATH-7 AFTER THE LAST PAGE OF THIS SECTION.

H. Criterion 1110.1330.h, Continuity of Care

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

APPEND DOCUMENTATION AS ATTACHMENT CATH-8 AFTER THE LAST PAGE OF THIS SECTION.

I. Criterion 1110.1330.i, Multi-institutional Variance

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

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

APPEND DOCUMENTATION AS ATTACHMENT CATH-9 AFTER THE LAST PAGE OF THIS SECTION.

Criterion 1110.1330.a, Peer Review

The existing hospital currently provides cardaic catheterization services with an establish Peer Review Program which will be continued in the new facility. A copy of the Peer Review Program is appended to this atttachment.

ATTACHMENT CATH-1

ST. MARY'S GOOD SAMARITAN, INC.

Policy No. _____

POLICY: **Cath Lab Quality Reviews**

POLICY SUBJECT: Review of all Cath Lab statistics and adverse treatment events for quality peer review.

Implemented: August, 2000

Departments Involved: Quality Appraisal Services
Medical Staff

Revised:

Reviewed: April, 2007

Administrative Approval:
Michelle Darnell, V.P. Systems Improvement

PURPOSE: To follow a consistent process for the evaluation and monitoring of the quality of practitioner performance, this includes technical quality of care and quality of service. This will be accomplished through identification and timely resolution of peer review cases as part of the performance improvement process.

POLICY: Clinical and nonclinical peer review information and data generated by or at the request of the Cardiac Catheterization Lab is used to evaluate and improve the quality of patient care and practitioner performance.

PROCEDURE:

1. Based upon criteria established by the Cath Lab and approved by the MSQC, cases are identified for peer review during a quarterly Cath Lab Quality Committee meeting.

2. For those cases meeting the case selection criteria, a summary of the case is composed by the Cath Lab RN.

3. This summary is presented to the Cath Lab Quality Committee by the involved physician.

4. A committee determination of case categorization is made.

5. Statistical information and case review information is forwarded to the Medical Staff Quality Committee which is the oversight committee for the Medical Staff Peer Review Process.

ST. MARY'S GOOD SAMARITAN, INC.

Policy No. _____

POLICY: **Open Heart Program Quality Reviews**

POLICY SUBJECT: Review of the Open Heart Program statistics and adverse treatment events for quality peer review.

Implemented: March, 2001

Departments Involved: Quality Appraisal Services
Medical Staff

Revised: October, 2005

Reviewed: April, 2007

Administrative Approval:
Michelle Darnell, V.P. Systems Improvement

PURPOSE: To follow a consistent process for the evaluation and monitoring of the quality of practitioner performance, this includes technical quality of care and quality of service. This will be accomplished through identification and timely resolution of peer review cases as part of the performance improvement process.

POLICY: Clinical and nonclinical peer review information and data generated by or at the request of the Cardiac Catheterization Lab is used to evaluate and improve the quality of patient care and practitioner performance.

PROCEDURE:

1. Based upon criteria established by the Open Heart Program Team, cases are identified for peer review during a quarterly Open Heart Quality Committee meeting.

2. For those cases meeting the case selection criteria, a summary of the case is composed by the Cardiovascular Thoracic Surgery Office.

3. This summary is presented to the Open Heart Quality Committee by the involved physician. A committee determination of case categorization is made.

4. In addition to the Cardiology and Cardiothoracic physician members, the committee includes a representative from Washington University Hospital in St. Louis, Missouri.

5. Statistical information and case review information is forwarded to the Medical Staff Quality Committee which is the oversight committee for the Medical Staff Peer Review Process.

#39 & 43

St. Mary's Good Samaritan, Inc

National Quality Data Base Membership

- **Good Samaritan's Cardiac Cath Lab is a reporting member of the American College of Cardiology Quality Data Base.**

- **Good Samaritan Regional Health Center's Open Heart Program is a reporting member of the STS Open Heart Surgery Quality Data Base.**

Criterion 1110.1330.b, Establishment or Expansion of Cardiac Catheterization Service

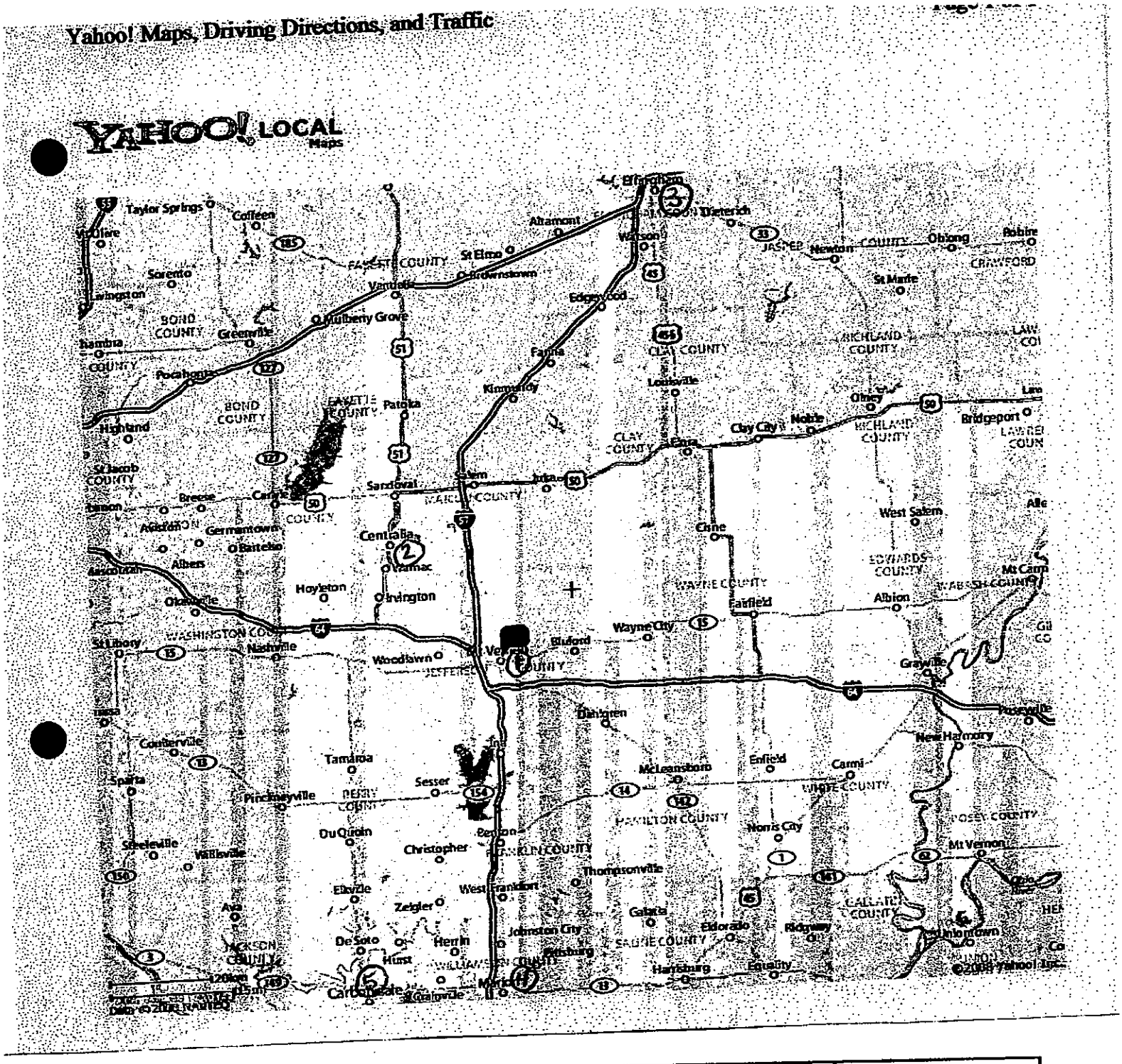
This project is technically for the establishment of a new category of service because the project is for the construction of a new health care facility. However, as was stated earlier in the application the project is actually for the replacement of an existing hospital which has operated a busy cardiac catheterization program for several years. The facility's 2007 volume total 1,087 cardiac catheterizations which is well in excess of the 400 procedure level established by the Board. In order to justify the two laboratories proposed for this project the applicant's workload would need to be 800 procedures. The 2007 volume nearly doubles that volume.

Since this is an existing program which is being replaced at a location within the same community the project will not have a negative impact on any of the existing programs. St. Mary's Hospital in Centralia is a related program which refers many of its interventional procedures to the applicant facility due to the availability of Open Heart Surgery back-up.

St. Anthony's hospital is located more than an hour away from the proposed facility and has not opened a program which was approved more than 5 years ago. It does not appear to be reasonable to hold another facility accountable for this long period of inactivity.

The applicant's historical utilization clearly indicates the ability to meet the Board's target utilization rates from the time the facility is opened.

Yahoo! Maps, Driving Directions, and Traffic



	Facility	Distance (miles)	Travel Time (Minutes)	Volume
1.	Applicant	N/A	N/A	1,087 (2007)
2.	St. Mary's Centralia	24.95	31	
3.	St. Anthony's Hospital Effingham	68.28	69	0*
4.	Heartland Regional Medical Center - Marion	45.71	48	1,073 (2006)
5	Memorial Hospital Carbondale	57.07	63	2,898 (2006)

* Permit to establish Cardiac Cath approved in 2002 program never started.

Criterion 1110.1330.c, Unnecessary Duplication of Services

The applicant has sent letters to all of the facilities in the planning area who are approved to offer cardiac catheterization services. A copy of the letter and a list of the facility's to which it was sent is appended to this application. Memorial Hospital of Carbondale responded that they do not anticipate any substantial impact from the relocation of the hospital on their facility workload..

None of the existing facilities which are currently operating cardiac catheterization programs have volumes below 200 procedures and because the applicant currently provides cardiac catheterization services and the new facility is being constructed in the same community, the proposed project will not have a negative impact on any other program in the planning area. The referral patterns are expected to remain the same as they were with the existing site.

ATTACHMENT CATH-3

December 7, 2007

St. Mary's Good Samaritan
Incorporated

Cosponsored by Felician Services, Inc. and SSM Health Care

Mr. George Maroney
Senior Vice President and Administrator
Memorial Hospital of Carbondale
405 West Jackson Street
Carbondale, IL 62901

RE: Good Samaritan Regional Health Center
Cardiac Catheterization Service

Dear Mr. Maroney:

Good Samaritan Regional Health Center is planning to relocate from its current site at 605 North 12th Street in Mount Vernon, Illinois to Veterans Memorial Drive and South 42nd Street in Mount Vernon, Illinois. Good Samaritan Regional Health Center provides cardiac catheterization services at the existing location, and intends to continue to provide cardiac catheterization services at the proposed relocated hospital.

This project involves relocation of an existing health care facility to a new site. Therefore, the Illinois Health Facilities Planning Board requires that we notify existing providers of the proposed program in order to determine any anticipated impact. Please advise Good Samaritan Regional Health Center if you believe this relocation of cardiac catheterization services will have any impact on your facility. You may direct any correspondence pertaining to this to:

Michael Warren
Vice President, Clinical Development
Good Samaritan Regional Health Center
605 North 12th Street
Mount Vernon, IL 62864

Thank you for your attention to this matter.

Sincerely,

Gerald W. Lefert
President and Chief Executive Officer
St. Mary's Good Samaritan, Inc.

605 North 12th Street
Mt. Vernon, IL 62864
618.242.4600

www.smgsi.com

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

GEORGE MARONEY
SENIOR VICE PRESIDENT AND
ADMINISTRATOR
MEMORIAL HOSPITAL OF CARBONDALE
405 WEST JACKSON STREET
CARBONDALE IL 62901

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☒ Agent ☐ Addressee

B. Received by (Printed Name) Lewis Hasemore C. Date of Delivery 12/20/07

D. Is delivery address different from item 1? ☒ Yes
If YES, enter delivery address below: ☐ No

P.O. Box 10,000
CARBONDALE IL 62902

3. Service Type
☐ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7002 2410 0002 8364 4599

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

BRUCE MERRELL
PRESIDENT
ST. MARY'S HOSPITAL
400 NORTH PLEASANT
CENTRALIA IL 62801

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☒ Agent ☐ Addressee

B. Received by (Printed Name) Robbie Hegwood C. Date of Delivery 12-20

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☐ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7002 2410 0002 8364 4612

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

DANIEL J. WOODS
EXECUTIVE VICE PRESIDENT AND
ADMINISTRATOR
ST. ANTHONY'S MEMORIAL HOSPITAL
503 NORTH MAPLE STREET
EFFINGHAM IL 62401

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery 12-20-07

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☐ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7002 2410 0002 8364 4605

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

TIMOTHY E. SCHMIDT
CHIEF EXECUTIVE OFFICER
HEARTLAND REGIONAL MEDICAL
CENTER
333 WEST DEYOUNG
MARION IL 62959

2. Article Number (Transfer from service label) 7002 2410 0002 8364 4582

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) Steven Dragovan C. Date of Delivery 12-20

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☐ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

MEMORIAL HOSPITAL
OF CARBONDALE

January 15, 2008

VIA FEDERAL EXPRESS

Michael Warren
Vice President, Clinical Development
Good Samaritan Regional Health Center
605 North 12th Street
Mount Vernon, Illinois 62864

Re: Good Samaritan Regional Health Center
Open Heart Surgery Service
Cardiac Catheterization Service

Dear Mr. Warren:

We are in receipt of your letter wherein you describe how Good Samaritan Regional Health Center is planning to relocate from its current site at 605 North 12th Street in Mt. Vernon, Illinois to Veterans Memorial Drive and South 42nd Street, also in Mount Vernon. We understand that Good Samaritan Regional Health Center provides open heart surgical services as well as cardiac catheterization services at the existing location and that you intend to continue to provide these services at the proposed relocated hospital.

We do not anticipate any dramatic or substantial impact from this relocation on Memorial Hospital of Carbondale. Therefore, so long as Good Samaritan Regional Health Center meets the state's minimum utilization criteria for open heart surgery and cardiac catheterization services, we would be supportive of the proposed relocation and re-initiation of services at the new location.

If you have any questions regarding this letter, please do not hesitate to contact me.

Sincerely,

George Maroney
Senior Vice President and Administrator
Memorial Hospital of Carbondale

C: Jeffrey Mark, Executive Secretary, Illinois Health Facilities Planning Board

db

405 West Jackson Street | PO Box 10000
Carbondale, IL 62902-9000
TEL 618-549-0721
FAX 618-529-0449
www.sih.net

Criterion 1110.1330.d, Modernization of Existing Cardiac Catheterization Laboratories

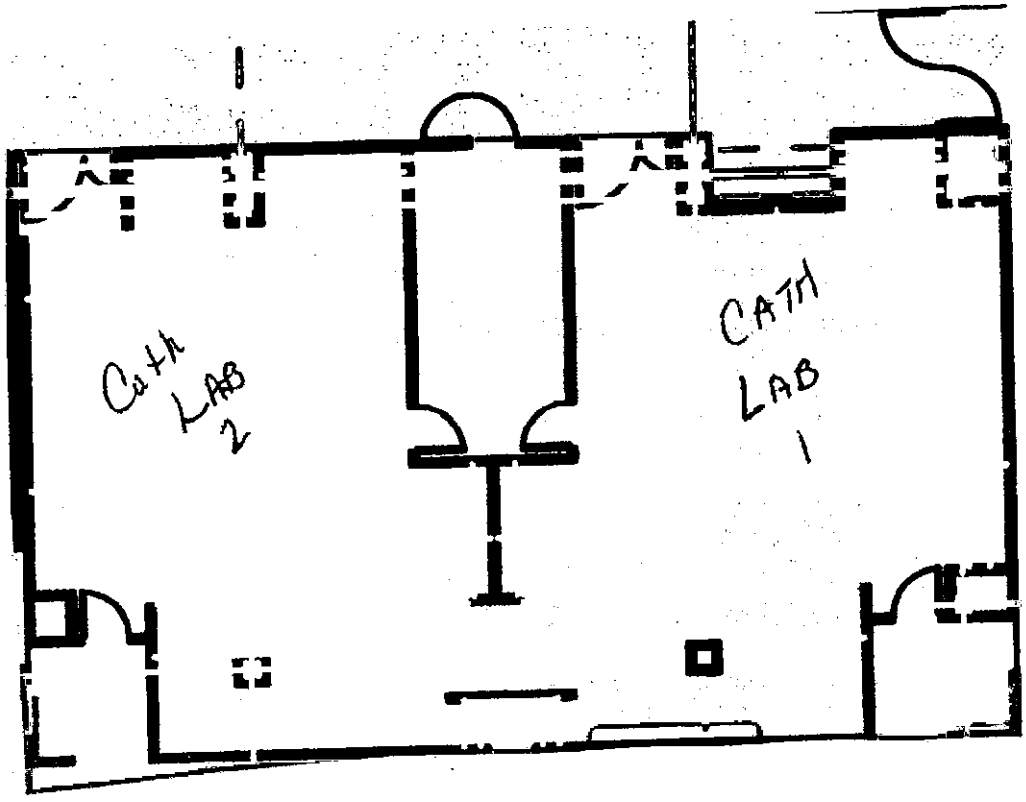
Technically this criterion is not applicable to this project since the proposed project is for the establishment of a new facility rather than a modernization. However if the Board determines that this criterion is applicable the applicant's historical workload of 1,087 procedures in 2007 meets all of the Board's standards for appropriate utilization for 2 laboratories.

Criterion 1110.1330.e, Support Services

All of the support services listed are currently available in the existing facility and will continue to be available when the new facility opens.

Criterion 1110.1330.f, Laboratory Location

The proposed project calls for two catheterization laboratories to be located adjacent to one another on the first floor of the new replacement hospital. This location will make it easier for the outpatients to access the laboratories as well as allow for the most efficient use of staff. Having the two laboratories adjacent to one another allows for easy access to supplies and it eliminates unnecessary duplication of space and supplies.


CATH LAB 2
CATH LAB 1

Criterion 1110.1330.g, Staffing

The existing facility currently provides cardiac catheterization and will continue to provide the same level of service at the new replacement facility. The staff in place now will simply move to the new facility when it opens. The staff names and their qualifications are shown in the documents appended to this attachment.

ATTACHMENT CATH-7

BRIAN C. JONES, M.D.

Cardiovascular Specialists of Illinois, Ltd.
605 North 12th Street
Mount Vernon, Illinois 62864
(618) 241-1350

PROFESSIONAL EXPERIENCE

GOOD SAMARITAN
REGIONAL HEALTH CENTER — MOUNT VERNON, ILLINOIS

Active Staff, November 2000 to present, interventional cardiologist
Cardiac catheterization, Angioplasty, Rest and Stress Echocardiography, Permanent Pacemakers

MERCY HOSPITAL OF PITTSBURGH — PITTSBURGH, PENNSYLVANIA

Active Staff, March 1992 to October 2000, interventional cardiologist
Cardiac catheterization, Angioplasty (including balloon angioplasty, directional atherectomy, rotational atherectomy, extraction atherectomy, stenting), Rest and Stress Echocardiography
Founding Member, Mercy Heart Institute
Member, Quality Oversight Committee, Mercy Heart Institute, 1993 to October 2000
Member, Catheterization Laboratory Quality Oversight Committee, 1998 to October 2000

OHIO VALLEY GENERAL HOSPITAL — McKEES ROCKS, PENNSYLVANIA

Active Staff, March 1992 to October 2000, consulting cardiologist
Permanent pacemakers, Echocardiography
Chairman, Pharmacy and Therapeutics Committee, 1999 to October 2000

BETHESDA HOSPITAL — ZANESVILLE, OHIO

Active Staff, August 1986 to March 1992, invasive cardiologist
Director, Cardiac Catheterization Services, 1986 to 1991
Cardiac catheterization, Permanent pacemakers, Rest and Stress Echocardiography
Chairman, Emergency Department and Special Care Committee, 1990 to 1991

GOOD SAMARITAN MEDICAL CENTER — ZANESVILLE, OHIO

Active Staff, August 1986 to March 1992, consulting cardiologist
Permanent pacemakers, Rest and Stress Echocardiography

PROFESSIONAL TRAINING

DIVISION OF CARDIOLOGY
UNIVERSITY OF FLORIDA — GAINESVILLE, FLORIDA

Clinical and American Heart Association Research Fellow, July 1985 to June 1986
Clinical Fellow, July 1983 to June 1985

MEDICAL UNIVERSITY OF
SOUTH CAROLINA — CHARLESTON, SOUTH CAROLINA

Resident in Internal Medicine, July 1981 to June 1983
Intern in Medicine, July 1980 to June 1981

EDUCATION

UNIVERSITY OF NORTH CAROLINA
AT CHAPEL HILL — CHAPEL HILL, NORTH CAROLINA
Doctor of Medicine, May 11, 1980
Bachelor of Science in Medicine, May 15, 1977

THEODORE ROOSEVELT HIGH SCHOOL — KENT, OHIO
Diploma, June 2, 1974

RESEARCH

SCIMED LIFE SYSTEMS — PITTSBURGH, PENNSYLVANIA
Co-Investigator, RADIUS Stent, 1996 to 1997

TELECTRONICS PACING SYSTEMS — ZANESVILLE, OHIO
Investigator, META Pacemaker, 1988

AMERICAN HEART ASSOCIATION — GAINESVILLE, FLORIDA
Clinician Scientist, Echocardiographic Quantitation of Coronary Perfusion, 1985 to 1986

McNEIL PHARMACEUTICAL — GAINESVILLE, FLORIDA
Junior Investigator, Bepridil, 1984-1986

PUBLICATIONS

Geiser, Connetta, Limacher, Stockton, Oliver, and Jones, "A Second-generation Computer-based Edge Detection Algorithm for Short-axis, Two-dimensional Echocardiographic Images: Accuracy and Improvement in Interobserver Variability," *J Amer Society of Echocardiography* 3:79-90, Mar-Apr, 1990.

BOARD CERTIFICATIONS

AMERICAN BOARD OF INTERNAL MEDICINE
Diplomate in Cardiovascular Disease, November 20, 1985
Diplomate in Internal Medicine, September 14, 1983

MEDICAL LICENSURE

State of Illinois, October 10, 2000
Commonwealth of Pennsylvania, February 24, 1992
State of Ohio, August 14, 1986
State of Florida, July 6, 1983
State of South Carolina, July 20, 1981

PROFESSIONAL ASSOCIATIONS

American College of Cardiology, Fellow
Society for Cardiac Angiography and Interventions, Fellow

AMR EL-SHAFEI, M.D.
400 South 14th Street, Suite 1011
St. Louis, Missouri 63103

Education:

9/1985 – 12/1991	Medical School Cairo University Hospital Cairo, Egypt
1/92 – 2/92	Break
3/92 – 2/93	Internship Cairo University Hospitals Cairo, Egypt
3/93 – 2/96	Cardiology Residency Cairo University Hospitals Cairo, Egypt
3/96 – 6/96	Assistant Lecturer Cardiology Department Cairo University Hospitals Cairo, Egypt
7/96 – 6/99	Internal Medicine Residency St. Louis University St. Louis, MO
7/99 – 6/02	Cardiology Fellowship St. Louis University St. Louis, MO
7/02 – 12/02	Cardiac Imaging Fellowship / Cardiac MRI St. Louis University / Washington University St. Louis, MO

Honors:

- Medical School: Graduated with "Excellent with Honors" December 1991
- Appreciation Certificate from The Egyptian Medical Syndicate for obtaining Master Degree (M.Sc.) in Cardiovascular Medicine with "Excellent" grade, November 1995
- The abstract titled "D-lactate Encephalopathy" won first prize in the ACP – Missouri Chapter among the abstracts dent from St. Louis University

- Kinsella award 1999 / 2000: the best graduating resident from the Department of Medicine at St. Louis University Hospital
- "Fellow of the Year" from the division of Cardiology, St. Louis University Hospital for the year 2000
- Selected as the "Chief of Cardiology Fellow" for the year 2000-2001

1996 – 1997	Internship St. Louis University Hospital St. Louis, MO
1993 – 1996	Cardiology Fellowship Cairo University Hospitals Cairo, Egypt
1992 – 1993	Internship Cairo University Hospitals Cairo, Egypt
7/1997 –8/1/1997	Electrophysiology Cleveland Clinic Foundation Cleveland, OH
1985 – 1991	Medical School Cairo University Hospitals Cairo, Egypt

Licensure and Certification:

State of Missouri medical license
American Board of Internal Medicine with a sub-specialty in Cardiovascular Disease.

Memberships

Egyptian Medical Syndicate
Egyptian Hypertension League
Egyptian Society of Cardiology
American College of Physicians
American Medical Association
American College of Cardiology

Naeem A. Khan, M.D., S.C., F.A.C.C., F.A.C.P., F.A.C.I.P., F.C.C.P.

Diplomate American Board of **Cardiovascular Disease**
Diplomate American Board of Internal Medicine
Fellow Council of Clinical Cardiology **American Heart Association**

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Centralia, Illinois 62801

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618-532-8574

TEACHING AND ACCOMPLISHMENTS:

1. Clinical Instructor in Medicine, Barnes Jewish Hospital, Washington University Medical School.

2. Society of Anesthesiology of Southern Illinois.

3. Professional Edication of Staff Physicians at St. Mary's Hospital, through lectures, discussions and consultations. Over 200 Cardiology consultations per year.

4. Edication and teaching of surrounding physicians and technicians in M-Mode and 2-D and Doppler color flow echocardiography (color dopper flow since 1988). M-Mode 2-dimensional since 1982. Exercise stress echocardiography since 1986. Persantine Thallium studies since 1986. Dobutamine and pharmacological stess echocardiograms since 1990. Transesophageal echo since 1987, all vascular duplex doppler, carotid, peripheral vascular and transcranial dopplers since 1995.

5. Lectures arranged through American Heart Association for public education to groups such as Stroke Club, etc.

6. Lectures to American Association of Retired Persons, when needed.

7. Lectures to local community Lions Club, Ladies Club, Shriners Club as needed.

8. Electrocardiography and Cardiovascular topics to local nurses at St. Mary's Hospital since 1982.

9. Technicians in cardiovascular services, vascular sonographers, echocardiogram sonographers, monitor technician nurses for holter, electrocardiogram and stress.

10. Introduced Stress Thallium and Persantine Thallium Nuclear Cardiology Studes, stress and pharmacological Nuclear Thallium studies at St. Mary's Hospital since 1982.

11. Introduced Stress echocardiography 1986, and Dobutamine Echocardiogram as well as interpreting these tests for surrounding hospitals and helping the community since 1986.

12. Introduced venous and arterial duplex doppler ultrasonography to the area as well as interpreting these tets for surrounding hospitals again helping the community since 1985.

Naeem A. Khan, M.D., S.C., F.A.C.C., F.A.C.P., F.A.C.I.P., F.C.C.P.
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PROFESSIONAL ORGANIZATIONS, MEMBERSHIPS AND FELLOWSHIPS:

FELLOW AMERICAN COLLEGE OF PHYSICIANS, 1998

FELLOW AMERICAN COLLEGE OF CARDIOLOGY, 1990

FELLOW AMERICAN COLLEGE OF INTERNATIONAL PHYSICIANS, 1987

FELLOW COUNCIL OF CLINICAL CARDIOLOGY, AMERICAN HEART ASSOC., 1990

FELLOW AMERICAN COLLEGE OF CHEST PHYSICIANS, 1991

FELLOW COUNCIL OF GERIATRIC CARDIOLOGY (AMERICAN COLLEGE OF CARDIOLOGY), 1992

FELLOW SOCIETY OF CARDIAC ANGIOGRAPHY AND INTERVENTIONS

MEMBER AMERICAN SOCIETY OF ECHOCARDIOGRAPHY

MEMBER, AMERICAN MEDICAL ASSOCIATION

MEMBER, AMERICAN GERIATRIC SOCIETY

MEMBER, SOCIETY OF NUCLEAR CARDIOLOGY

MEMBER, PAKISTAN MEDICAL COUNCIL

MEMBER, AMERICAN MEDICAL ASSOCIATION

MEMBER, AMERICAN COLLEGE OF CARDIOLOGY, ILLINOIS CHAPTER

MEMBER MARION COUNTY MEDICAL SOCIETY, 1982 TO PRESENT

PRESIDENT MARION COUNTY MEDICAL SOCIETY, 1996-1997

MEMBER, PAKISTAN DOCTOR ASSOCIATION OF USA

Naeem A. Khan, M.D., S.C., F.A.C.C., F.A.C.P., F.A.C.I.P., F.C.C.P.

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CV FOR NUCLEAR CARDIOLOGY

1. COURSES-MARCH/APRIL 1982, ADVANCES IN NUCLEAR CARDIOLOGY, 4 DAY COURSE APPROXIMATELY 30 HOURS IN 1982 UNDER DIRECTION OF DR. BARRY VARRETT, YALE UNIVERSITY, NEW HAVEN, CONNECTICUT.

2. NUCLEAR CARDIOLOGY UPDATES AND COURSES AT THE AMERICAN COLLEGE OF CARDIOLOGY INCLUDING ATTENDING LECTURES ON RESEARCH, 1984-86-87-88-90-91-92-93-94-95-96-97 AND 98.

3. CONTEMPORARY NUCLEAR CARDIOLOGY 19 CREDIT HOURS OCTOBER 7 TO ØCTOBER 9, 1996 AT THE HEART HOUSE LEARNING CENTER, AMERICAN COLLEGE OF CARDIOLOGY, BETHESDA, MARYLAND. PROGRAM #745. (UNDER DIRECTION OF DR. GERALD POHOST, DIRECTOR OF CARDIOLOGY, UNIVERSITY OF ALABAMA).

4. STATE OF THE ART REVIEW, CASE STUDIES. PRACTICAL CONCENTRATION. DIRECTOR OF THE PROGRAM, GERALD POHOST, M.D., DANIEL S. BERMAN, M.D., F.A.C.C., DIRECTOR OF NUCLEAR CARDIOLOGY, NIH, BETHESDA, MARYLAND.

5. 1966, ANAHEIM, CALIFORNIA, MARCH OF 1966, 8 HOURS, ADVANCES IN NUCLEAR CARDIOLOGY.

6. 1995, ACC CONVENTION, 3 HOURS UPDATING NUCLEAR CARDIOLOGY.

7. 1997, ATTENDED LECTURES IN NUCLEAR CARDIOLOGY AND RESEARCH PAPERS PRESENTED AT ANNUAL CONVENTION, AMERICAN COLLEGE OF CARDIOLOGY, NEW ORLEANS.

8. 1998, ATTENDED LECTURES ON RESEARCH NUCLEAR CARDIOLOGY, ATTENDED LECTURES IN NUCLEAR CARDIOLOGY, 1998 AT ATLANTA, AMERICAN COLLEGE OF CARDIOLOGY CONVENTION, APRIL, 1998.

9. 1998, ASSOCIATES IN MEDICAL PHYSICS, LLC, NUCLEAR LICENSING COURSE FOR PHYSICIANS, 200 H OURS, CLEVELAND, OHIO.

10. 1998 "THIRD ASNC TUTORIAL IN NUCLEAR CARDIOLOGY", NEW ORLEANS, LA, SEPTEMBER 11-13-16 HOURS.

11. 1 WEEK CLINICAL FELLOWSHIP IN NUCLEAR CARDIOLOGY WITH DR. BARRY SIEGEL, WASHINGTON UNIVERSITY, ST. LOUIS, MO, NOVEMBER 2 - NOVEMBER 6, 1998. EXTENSIVE EXPOSURE TO NUCLEAR CARDIOLOGY CASES, DISCUSSION, INCLUDING MUGGA STUDIES, PLANAR AND SPECT-PHARMACOLOGICAL STRESS STUDIES. REVIEW OF TEACHING FILES, AND CORRELATION OF ANGIOGRAPHIC STUDIES OF NUCLEAR CARDIOLOGY.

Naeem A. Khan, M.D., S.C., F.A.C.C., F.A.C.P., F.A.C.I.P., F.C.C.P.

Diplomate American Board of **Cardiovascular Disease**
Diplomate American Board of Internal Medicine
Fellow Council of Clinical Cardiology **American Heart Association**

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CV FOR NUCLEAR CARDIOLOGY

1. NUCLEAR CARDIOLOGY AT THE POST GRADUATE CARDIOVASCULAR INSTITUTE, PESHAWAR, PAKISTAN UNDER THE GUIDANCE OF DR. AZIZ-MUFTI, M.D., F.A.C.C. WHO IS A BOARD CERTIFIED CARDIOLOGIST, ASSISTANT PROFESSOR AT THE SAME INSTITUTION AT KHYBAR MEDICAL COLLEGE AND ALSO HAS DONE 1 YEAR OF NUCLEAR CARDIOLOGY FELLOWSHIP AT THE UNIVERSITY OF ALABAMA.

2. REVIEWED CASES, SPECT AND PLANAR THALLIUM STUDIES.

3. IN CARDIOLOGY FELLOWSHIP, 1980-1982, PERFORMED AND INTERPRETED OVER 200 NUCLEAR CARDIOLOGY CASES UNDER THE CARE OF DIRECTOR OF NUCLEAR CARDIOLOGY RESEARCH AND CLINICAL PROGRAM, PROFESSOR BUNYAD HAIDAR DURING A COURSE OF 18 MONTHS IN NON-INVASIVE CARDIOLOGY. APPROXIMATELY 4 MONTHS WAS SPENT IN NUCLEAR CARDIOLOGY BOTH IN RESEARCH, PERFORMING INTERPRETATIONS AND PERFORMANCE OF TEH TESTS OVER A PEROID OF 2 YEARS, 1980 TO 1982, APPROXIMATELY 500 HOURS IN NUCLEAR CARDIOLOGY.

Naeem A. Khan, M.D., S.C., F.A.C.C., F.A.C.P., F.A.C.I.P., F.C.C.P.
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Teaching Appointments:

Clinical Instructor in Medicine at Jewish Hospital, Washington University School of Medicine, St. Louis, Missouri, 1990-present.

Instructor and lecturer to hospital staff physician members.

Association of Anesthesia, Southern Illinois Nursing Staff in local community hospital.

Associate Professor of Cardiology, Southern Illinois University 1998.

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CURRICULUM VITAE (PAGE THREE)

Hospital Committees:

Member Credential Committee, St. Mary's Hospital 1983 til present. Also served As Member of Quality Assurance Utilization Review, Credential and Critical Care And Pharmacy Committee.

General Secretary St. Mary's Hospital Medical Staff 1990-1991

Member Executive Committee St. Mary's Hospital 1987-1991

Organizations, Memberships and Fellows:

Fellow American College of Physicians, 1988

Fellow American College of International Physicians, 1987

Fellow American College of Cardiology, 1990

Fellow American College of Chest Physicians, 1991

Fellow Council of Geriatric Cardiology (American College of Cardiology), 1992

Member, American Society of Echocardiography

Member, American Medical Association and Marion County Medical Society

Member, American Geriatric Society

Member, Pakistan Medical Council

Member, American Society of Nuclear Cardiology, 1998

Fellow Society Cardiac Angiography and Intervention, 1998

Fellow American College of Angiology, 1999

Naeem A. Khan, M.D., S.C., F.A.C.C., F.A.C.P., F.A.C.I.P., F.C.C.P.
Diplomate American Board of **Cardiovascular Disease**
Diplomate American Board of Internal Medicine
Fellow Council of Clinical Cardiology **American Heart Association**

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618-532-8574

Flex examination (1977)

Medical Residence – PG I, PG, II and PG III at Worcester, Massachusetts – Affiliated with University of Massachusetts Medical School, Worcester, Massachusetts (June 1977-June 1980)

Passed Board Internal Medicine – Diplomate American Board of Internal Medicine 1980

Cardiology Fellowship at University Hospital University of Medicine and Dentistry of New Jersey at Newark, New Jersey (June 1980-June 1982)

Chief of Subspecialty Fellows (1981-1982) University Hospital – University Hospital – University of New Jersey Subspecialty Fellowship Program

Passed boards in Cardiovascular Medicine ABIM November, 1989. Diplomate American Board of Cardiovascular Diseases

Post Training Appointments:

Presently in private practice with admitting and consulting privileges at:

1) St. Mary's Hospital., Centralia. IL, 1982-present
2) Consulting privileges at Salem Hospital, Salem, IL, 1982-present
3) Clinical Instructor in medicine at Jewish Hospital, Washington University, 1990-present
4) Chief of Internal Medicine 1988-1989 at St. Mary's Hospital, Centralia, IL

Special Committees:

Appointed Special Commission of Governor Thompson "Governor Commission For Insurance of the Elderly" 1988-89 (one of 5 physician members appointed In the State of Illinois

Naeem A. Khan, M.D., S.C., F.A.C.C., F.A.C.P., F.A.C.I.P., F.C.C.P.

Diplomate American Board of **Cardiovascular Disease**
Diplomate American Board of Internal Medicine
Fellow Council of Clinical Cardiology **American Heart Association**

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CURRICULUM VITAE

PREMEDICAL:

Edwards College-Peshaway, Pakistan-High 1st Division, graduated 1968

MEDICAL COLLEGE:

Khyber Medical College-Pashawar, Pakistan (1968-1973)

Honors- Second position in final year of Medical College among approximately 150 students

Board Certification - American Board of Internal Medicine
American Board of Cardiovascular Diseases

HONORS OBTAINED:

1. Second position among 150 students in final year Medical College
2. Chief of University Subspecialty Fellows 1982 at University Hospital, University of Medicine and Dentistry of New Jersey at Newark, New Jersey

House Job:

Six months in surgery and six months in medicine-Lady Reading Hospital-Peshawar, Pakistan (December 1973-November 1974)

In charge of medical ward and outpatient services- Shahnaz-Pahlavi Hospital, Bidjar, Iran (January 1975-November 1976)

Post Graduate Training in USA:

Passed ECFMG-Education Commission for Foreign Medical Graduates (January-1976)

Rotating Surgical Internship at Roger William Hospital, Providence, Rhode Island, Affiliated to Brown Medical College (June 1976-June 1977)

3) *Fellow Society for Cardiac Angiography and Interventions*

4) *Fellow Council on Clinical Cardiology*

5) *Fellow Society on Geriatric Cardiology*

6) *Member American College of Physicians*

7) *Member Southern Medical Association*

8) *Member Jefferson County Medical Society, Jefferson County, IL*

CME PROGRAMS GIVEN:

1) *"EKG: Designs and Patterns". July 21, 1999. Good Samaritan Regional Health Center, Mt. Vernon, Illinois.*

2) *"Upbeat in Cardiology". March 25, 1999. Given at Medical Staff meeting of Crossroads Community Hospital, Mt. Vernon, Illinois.*

3) *"CHF, what should we do? What can we do?". Symposium for primary care physicians at Holiday Inn, Mt. Vernon, Illinois. March 13, 1999.*

4) *"Case Records from Good Samaritan Regional Health Center," Mt. Vernon, Illinois. Given at the Quarterly Medical Staff Meeting on 12/01/98.*

5) *"Coronary Artery Disease and the Oddballs." September 4, 1997, Good Samaritan Regional Health Center, Mt. Vernon, Illinois.*

6) *"Acute MI: Can we do better?" October 23, 1996, Holiday Inn, Mt Vernon, Illinois. Sponsored by Southern Illinois University School of Medicine, Springfield, Illinois.*

7) *"Molecular Cardiology" January 25, 1995, Ramada Hotel, Mt. Vernon, IL Sponsored by Southern Illinois University.*

8) *"Molecular Cardiology--Trends of the Future". Presented at King Edward Medical College, Lahore, Pakistan, on December 14, 1994. Program sponsored by New Britain General Hospital, Connecticut.*

9) *"Signal Averaged EKG". Presented at the Eleventh Annual Symposium of King Edward Medical College, Lahore, Pakistan, on December 19, 1990. Program sponsored by New Britain General Hospital, Connecticut.*

10) *"Current Status of Management of Hypertension". Presented at the International Symposium, Lahore, Pakistan, on December 21, 1990. Program sponsored by King Edward Alumni Association of North America.*

RESEARCH/PUBLICATIONS:

Coronary Vasodilator Reserve:
Comparison of the Effects of Papaverine and Adenosine on Coronary Flow, Ventricular Function and Myocardial Metabolism (CIRCULATION 1991; 83: 294-303).

Chest Pains with Patent Coronary Arteries:
Syndrome "X" or Doctor "X"?
(CLINICAL RESEARCH: Vol. 37 p 841A 1989).

Doppler Echocardiographic Determinants of Clinical Outcome in Non-rheumatic Atrial Fibrillation: A Multivariate Discriminant Analysis. (CLINICAL RESEARCH: Vol 37 p 839, 1989).

Letter to the editor, New England Journal of Medicine, on clinical problem solving "Diverted by the Chief Complaint", November 23, 1995.

APPOINTMENTS:

1) *Clinical Assistant Professor, Department of Medicine, SIU School of Medicine, Springfield, Illinois. July 1995-onwards.*

2) *Chairman Department of Medicine, Good Samaritan Regional Health Center, Mt. Mt. Vernon, IL. January 1996-December 1996.*

3) *Member Executive Committee, Good Samaritan Regional Health Center, Mt. Vernon, IL. January 1996-December 1996.*

4) *Director Cardiac Cath Lab, Good Samaritan Regional Health Center, Mt. Vernon, IL. July 1992-onwards.*

5) *Chairman CCU Committee, Good Samaritan Regional Health Center, Mt. Vernon, IL. January 94-onwards.*

6) *Member Credentials Committee, Council on Geriatric Cardiology. 1995 to 1998.*

7) *Medical Director, American Heart Association of Illinois, Jefferson County Division, 1992-onwards.*

8) *ACLS Course Director since 1993.*

FELLOWSHIP/MEMBERSHIPS:

1) *Fellow American College of Cardiology*

2) *Fellow American College of Chest Physicians*

Mohammed Haseeb, M.D., F.A.C.C.

Cardiovascular Diseases

05 North 12th Street
Mt. Vernon, IL 62864

Phone (618) 244-2525
Fax (618) 244-3666

EDUCATIONAL QUALIFICATIONS:

1998	*Testamur, ASEeXAM*	
1991	*Board Certification in Cardiovascular Disease*	
1987	*Board Certification in Internal Medicine*	
1981	*BSc (English)*	*Punjab University, Lahore, Pakistan*
1980	*MBBS*	*King Edward Medical College, Lahore, Pakistan*
1973	*HSSC*	*Forman Christian College, Lahore, Pakistan*

TRAINING & EXPERIENCE:

7/92 Onward — *Director of Cardiology and Director of Cardiac Cath Lab, Good Samaritan Regional Health Center, Mt. Vernon, IL*

7/89 to 6/92 — *Chief of Cardiology, Paul B. Hall Regional Medical Center, Paintsville, KY*

7/87 to 6/89 — *Fellow in Cardiology*
SUNY Health Science Center at Brooklyn, Brooklyn Hospital, Brooklyn, N.Y.

7/85 to 6/87 — *PG II & PG III Internal Medicine*
University of Wisconsin, Mount Sinai Medical Center, Milwaukee

7/84 to 6/85 — *PG I Internal Medicine*
Woodhull Hospital, Brooklyn, State University of New York, Downstate Medical Center, NY

10/81 to 9/82 — *Instructor in Anatomy*
King Edward Medical College
Lahore, Pakistan

7/80 to 7/81 — *House Officer in Cardiology, Mayo Hospital*
Lahore, Pakistan

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CURRICULUM VITAE

Saiyed Aon Ali Mohib, M.D.

Personal Information:

Residence: 5201 Atlantic blvd. Apt 170.
Jacksonville, FL32207.
Tel. (904) 399 0359 (H) / (904) 631 4808 (M)

Office address: Section of Cardiology /Dept of Medicine.
633 W 8th street.
Jacksonville, FL 32209.
Tel. (904) 244 3066.

Email: aonmohib@hotmail.com.

Birth Date: March 6, 1973.

Place of Birth: Quetta, Pakistan.

Marital Status: Married.

Education:

07/00- present Cardiovascular disease fellowship. (Currently chief fellow)
University of Florida at Jacksonville
Section of Cardiology /Dept of Medicine.
633 W 8th street.
Jacksonville, FL 32209.
Tel. (904) 244 3066.

07/97- 06/00 Internal Medicine Residency
Department of Medicine, M/C 787
University of Illinois at Chicago
840 S. Wood St.
Chicago, IL 60612

11/95- 06/97 Externship in Internal Medicine.
Aga Khan University
Karachi, Pakistan.

10/90- 10/95 Medical school.
Aga Khan University Medical College
Karachi, Pakistan.

06/88- 08/90 Government College Lahore. (Pre- Medicine)

06/88 Senior Cambridge examinations. (High school)

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QUALIFICATIONS:

Degrees.

American Boards in Internal medicine	2000
USMLE	Step I, II and III certified.

M.B, B.S (Pakistan). November 1995.

Research experience.

1. Currently involved in a retrospective look at sex based differences in outcomes in-patients undergoing Transmyocardial Laser Revascularisation (TMR) at our institution. The STS national database is used in our data analysis.
2. Sub investigator in the THRIVE multi center study. The aim of the study is to evaluate the efficacy of a recently approved oral anti thrombin in the treatment of DVTs and pulmonary embolisms.
3. Presented reviews on CAD in women and thrombolysis in the elderly. Both were part of the requirements of the cardiology fellowship training.
4. Evaluating the correlation between NYHA class and scores on depression scales in-patients being treated at the University of Florida at Jacksonville at this time.
5. Involved in a study prospectively evaluating the efficacy of the UltraFast CT scan as a predictor of future coronary events. Study was conducted in the University of Illinois with George Kondos, M.D as the PI.
6. Involved in a pilot study of evaluate the efficacy of the rollover test as a predictor of future eclampsia. This was part of the medical school training requirement in Pakistan.
7. Reviewed the trends of fungal infections in immune compromised patients admitted to the Aga Khan University between 1985- 1995. We demonstrated difference in the type of opportunistic infections in tuberculosis patients as compared to other etiologies of compromised immunity.
8. Conducted a KAP survey to obtain epidemiological data concerning rabies in Chanesar Goth (an urban squatter settlement in Karachi, Pakistan.
9. Evaluated the trends of bacterial/ fungal super infections in ulcerative colitis .Also looked at the time course between diagnosis and malignant transformation of the disease. Patients were followed for a period of 10 yrs.

Procedures (anticipated total at the time of fellowship completion).

1. Heart catheterizations.	400.
2. Transthoracic echocardiograms.	1200.
3. Transesophageal echocardiograms.	100.
4. Swan- Ganz placement.	200.
5. Temporary pacemakers.	50.
6. Stress tests .	1500 supervised and read. Includes stress echo and. nuclear perfusion imaging tests.
7. Holter interpretations.	500.

Anticipate being certified in nuclear cardiology by the time of graduation from cardiology fellowship in 6/03.

Memberships.

1. American College of Cardiology.
2. American Heart Association.
3. Pakistan Medical and Dental Council.

Career aims Private practice as an invasive (non-interventional) cardiologist for the next five yrs. Will explore options regarding subspecialty training at that time.

#442

St. Mary's Good Samaritan
Incorporated

Mt. Vernon Campus
Cardiac Catheterization Labs
Staff Roster

Name	Title	Position
Dale Pearce	RN	Director Cardiac Cath Lab
Bill Sandweg	RT	Supervisor Cath Lab
Michelle Smith	RN	Staffing Coordinator
Bonnie Maurer	RN	Staff RN Cath Lab
Christina Arnold	RN	Staff RN Cath Lab
Janet Kissner	RN	Staff RN Cath Lab
Jeanne Simons	RN	Staff RN Cath Lab
Lana Herman	RN	Staff RN Cath Lab
Lenita Miller	RN	Staff RN Cath Lab
Monica Allen	RN	Staff RN Cath Lab
Pamela Crabtree	RN	Staff RN Cath Lab
Steven Berkemeier	RN	Staff RN Cath Lab
Julie Garrison	RT	Scrub Tech Cath Lab
Linda Borowiak	RT	Scrub Tech Cath Lab
Elizabeth Frazier	RT	Scrub Tech Cath Lab
Sharon Moore	RT	Scrub Tech Cath Lab
Sandy Jones	Secretary	Secretary/Database Clerk

Criterion 1110.1330.h, Continuity of Care

The existing facility currently provides Open Heart Surgery Services and those services are proposed to be provided in the new hospital, therefore, no transfer agreement is required. The new replacement hospital will provide the full range of cardiac services on site.

ATTACHMENT CATH-8

Criterion 1110.1330.i, Multi-institutional Variance

This criterion is not applicable to this project.

ATTACHMENT CATH-9

SECTION XXIV. REVIEW CRITERIA RELATING TO FINANCIAL FEASIBILITY (FIN)

SSM Health Care Corporation
SSM Regional Health Services
Good Samaritan Regional Health Center

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

Does the applicant (or the entity that is responsible for financing the project or is responsible for assuming the applicant's debt obligations in case of default) have a bond rating of "A" or better? Yes ☒ No ☐.

If yes is indicated, submit proof of the bond rating of "A" or better (that is less than two years old) from Fitch's, Moody's or Standard and Poor's rating agencies and go to Section XXX. If no is indicated, submit the most recent three years' audited financial statements including the following:

1. **Balance sheet**
2. **Income statement**
3. **Change in fund balance**
4. **Change in financial position**

APPEND THE REQUIRED DOCUMENTS AS ATTACHMENT FINANCIALS AND PLACE AFTER ALL OTHER APPLICATION ATTACHMENTS INCLUDING THE REMAINING ATTACHMENTS FOR THIS SECTION AND FOR SECTION XXX.

A. Criterion 1120.210.a, Financial Viability

1. Viability Ratios

If proof of an "A" or better bond rating has not been provided, read the criterion and complete the following table providing the viability ratios for the most recent three years for which audited financial statements are available. Category B projects must also provide the viability ratios for the first full fiscal year after project completion or for the first full fiscal year when the project achieves or exceeds target utilization (per Part 1100), whichever is later.

Provide Data for Projects Classified as:	Category A or Category B (last three years)			Category B
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. Insert the worksheets after this page.

2. Variance

Compare the viability ratios provided to the Part 1120 Appendix A review standards. If any of the standards for the applicant or for any co-applicant are not met, provide documentation that a person or organization will assume the legal responsibility to meet the debt obligations should the applicant default. The person or organization must demonstrate compliance with the ratios in Appendix A when proof of a bond rating of "A" or better has not been provided.

APPEND DOCUMENTATION AS <u>ATTACHMENT FIN-1</u> AFTER THE LAST PAGE OF THIS SECTION.

B. Criterion 1120.210.b, Availability of Funds

If proof of an "A" or better bond rating has not been provided, read the criterion and document that sufficient resources are available to fund the project and related costs including operating start-up costs and operating deficits. Indicate the dollar amount to be provided from the following sources:

_____ Cash & Securities

Provide statements as to the amount of cash/securities available for the project. Identify any security, its value and availability of such funds. Interest to be earned or depreciation account funds to be earned on any asset from the date of application submission through project completion are also considered cash.

_____ Pledges

For anticipated pledges, provide a letter or report as to the dollar amount feasible showing the discounted value and any conditions or action the applicant would have to take to accomplish goal. The time period, historical fund raising experience and major contributors also must be specified.

_____ Gifts and Bequests

Provide verification of the dollar amount and identify any conditions of the source and timing of its use.

_____ Debt Financing (indicate type(s) _____)

For general obligation bonds, provide amount, terms and conditions, including any anticipated discounting or shrinkage) and proof of passage of the required referendum or evidence of governmental authority to issue such bonds;
For revenue bonds, provide amount, terms and conditions and proof of securing the specified amount;
For mortgages, provide a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated;
For leases, provide a copy of the lease including all terms and conditions of the lease including any purchase options.

_____ Governmental Appropriations

Provide 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, provide a resolution or other action of the governmental unit attesting to such future funding.

_____ Grants

Provide a letter from the granting agency as to the availability of funds in terms of the amount, conditions, and time or receipt.

_____ Other Funds and Sources

Provide verification of the amount, terms and conditions, and type of any other funds that will be used for the project.

_____ TOTAL FUNDS AVAILABLE

APPEND DOCUMENTATION AS ATTACHMENT FIN-2 AFTER THE LAST PAGE OF THIS SECTION.

C. Criterion 1120.210.c, Operating Start-up Costs

If proof of an "A" or better bond rating has not been provided, indicate if the project is classified as a Category B project that involves establishing a new facility or a new category of service? Yes ☒ No ☐. If yes is indicated read the criterion and provide in the space below the amount of operating start-up costs (the same as reported in Section I of this application) and provide a description of the items or components that comprise the costs. Indicate the source and amount of the financial resources available to fund the operating start-up costs (including any initial operating deficit) and reference the documentation that verifies sufficient resources are available.

Since the applicant is proposing to move staff and supplies directly from the old hospital to the new no start-up costs are anticipated

SECTION XXV. REVIEW CRITERIA RELATING TO ECONOMIC FEASIBILITY (ECON)

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

A. Criterion 1120.310.a, Reasonableness of Financing Arrangements

Is the project classified as a Category B project? Yes ☒ No ☐. If no is indicated this criterion is not applicable. If yes is indicated, has proof of a bond rating of "A" or better been provided? Yes ☒ No ☐. If yes is indicated this criterion is not applicable, go to item B. If no is indicated, read the criterion and address the following:

Are all available cash and equivalents being used for project funding prior to borrowing? ☐ Yes ☐ No

If no is checked, provide a notarized statement signed by two authorized representatives of the applicant entity (in the case of a corporation, one must be a member of the board of directors) that attests to the following:

1. a portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order that the current ratio does not fall below 2.0 times; or

2. 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.

APPEND DOCUMENTATION AS ATTACHMENT ECON-1 AFTER THE LAST PAGE OF THIS SECTION.

B. Criterion 1120.310.b, Conditions of Debt Financing

Read the criterion and provide a notarized statement signed by two authorized representatives of the applicant entity (in the case of a corporation, one must be a member of the board of directors) that attests to the following as applicable:

1. The selected form of debt financing the project will be at the lowest net cost available or if a more costly form of financing is selected, that form is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional debt, term (years) financing costs, and other factors;

2. All or part of the project involves the leasing of equipment or facilities and the expenses incurred with such leasing are less costly than constructing a new facility or purchasing new equipment.

APPEND DOCUMENTATION AS ATTACHMENT ECON-2 AFTER THE LAST PAGE OF THIS SECTION.

C. Criterion 1120.310.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).

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

*Include the percentage (%) of space for circulation

2. For each piece of major medical equipment included in the proposed project, the applicant must certify one of the following:

   a. that the lowest net cost available has been selected; or

   b. that the choice of higher cost equipment is justified due to such factors as, but not limited to, maintenance agreements, options to purchase, or greater diagnostic or therapeutic capabilities.

APPEND DOCUMENTATION AS ATTACHMENT ECON-3 AFTER THE LAST PAGE OF THIS SECTION.

3. List the items and costs included in preplanning, site survey, site preparation, off-site work, consulting, and other costs to be capitalized. If any project line item component includes costs attributable to extraordinary or unusual circumstances, explain the circumstances and provide the associated dollar amount. When fair market value has been provided for any component of project costs, submit documentation of the value in accordance with the requirements of Part 1190.40.

APPEND DOCUMENTATION AS ATTACHMENT ECON-4 AFTER THE LAST PAGE OF THIS SECTION.

D. Criterion 1120.310.d, Projected Operating Costs

Read the criterion and provide in the space below the facility's projected direct annual operating costs (in current dollars per equivalent patient day or unit of service, as applicable) for the first full fiscal year of operation after project completion or for the first full fiscal year when the project achieves or exceeds target utilization pursuant to 77 Ill. Adm. Code 1100, whichever is later. If the project involves a new category of service, also provide the annual operating costs for the service. Direct costs are the fully allocated costs of salaries, benefits, and supplies. Indicate the year for which the projected operating costs are provided. **The direct operating cost per equivalent patient day for 2011 is $1,680.70**

E. Criterion 1120.310.e, Total Effect of the Project on Capital Costs

Is the project classified as a category B project? Yes ☒ No ☐. If no is indicated, go to item F. If yes is indicated, provide in the space below the facility's total projected annual capital costs as defined in Part 1120.130.f (in current dollars per equivalent patient day) for the first full fiscal year of operation after project completion or for the first full fiscal year when the project achieves or exceeds target utilization pursuant to 77 Ill. Adm. Code 1100, whichever is later. Indicate the year for which the projected capital costs are provided. **Good Samaritan Regional Health Center's Capital Cost per Equivalent Patient Day is $311.14.**

F. Criterion 1120.310.f, Non-patient Related Services

Is the project classified as a category B project and involve non-patient related services? Yes ☐ No ☒. If no is indicated, this criterion is not applicable. If yes is indicated, read the criterion and document that the project will be self-supporting and not result in increased charges to patients/residents or that increased charges are justified based upon such factors as, but not limited to, a cost benefit or other analysis that demonstrates the project will improve the applicant's financial viability.

APPEND DOCUMENTATION AS ATTACHMENT ECON-5 AFTER THE LAST PAGE OF THIS SECTION.

SSM HEALTH CARE

May 29, 2008

Mr. Jeffrey S. Mark
Executive Secretary
Health Facilities Planning Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

RE: Financing Arrangements

Dear Mr. Mark:

We, Sister Mary Jean Ryan, FSM, member of the Board of Directors of SSM Health Care Corporation, and June L. Pickett, Corporate Secretary of SSM Health Care Corporation, hereby certify that the selected form of debt financing will be at the lowest net cost available to us.

Sincerely,

Sr. Mary Jean Ryan, fsm
Sister Mary Jean Ryan, FSM
Board of Directors
SSM Health Care Corporation

June L. Pickett
June L. Pickett
Corporate Secretary
SSM Health Care Corporation

SUBSCRIBED and SWORN to before me this 2nd day of June, 2008.

Ingrid M. Vogel
Notary Public

SUBSCRIBED and SWORN to before me this 2nd day of June, 2008.

Ingrid M. Vogel
Notary Public

INGRID M. VOGEL
Notary Public - Notary Seal
State of Missouri, St Charles County
Commission # 07394416
My Commission Expires Jul 24, 2011

ATTACHMENT ECON-2

477 N. Lindbergh Blvd.
St. Louis, MO 63141-7832
www.ssmhc.com

(314) 994 7800 *phone*
(314) 994 7900 *fax*

CLINICAL - 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)	
Pharmacy	319.01		2,070				660,358		660,358
Central Sterile Supply	319.01		2,495				795,938		795,938
Outpatient Testing	319.01		2,317				739,154		739,154
Outpatient Prep & Recovery	319.01		5,897				1,881,222		1,881,222
Infusion Center	319.01		1,665				531,157		531,157
Outpatient Procedure Rooms	319.01		2,535				808,699		808,699
Cardiac Catheterization	319.01		2,478				790,515		790,515
Diagnostic Radiology	319.01		6,275				2,001,809		2,001,809
Cardiac Diagnostic Testing	319.01		5,132				1,637,177		1,637,177
Nuclear Medicine	319.01		2,140				682,689		682,689
Emergency	319.01		10,762				3,433,222		3,433,222
EMS Facilities	319.01		390				124,415		124,415
Observation Beds	319.01		2,724				868,993		868,993
Surgery	319.01		10,780				3,438,964		3,438,964
Surgery Prep	319.01		4,020				1,282,434		1,282,434
Recovery	319.01		2,265				722,565		722,565
Hemodialysis	319.01		1,200				382,816		382,816

ATTACHMENT ECON-3

Respiratory Therapy	319.01		1,344				428,754		428,754
Physical Therapy	319.01		1,200				382,816		382,816
Occupational Therapy	319.01		444				141,642		141,642
ICU Beds	319.01		11,658				3,719,058		3,719,058
Rehab Beds	319.01		7,112				2,268,823		2,268,823
OB Beds	319.01		2,771				883,986		883,986
LDR	319.01		6,305				2,011,379		2,011,379
C-section Suite	319.01		1,018				324,756		324,756
New Born Nursery	319.01		1,219				388,877		388,877
Medical Surgical Beds	319.01		57,265				18,459,709		18,459,709
Hospice/Home Health	319.01		6,513				2,077,734		2,077,734
Contingency	$32.21		162,594				$5,237,742		$5,237,742
TOTALS							$57,107,403		$57,107,403

*Include the percentage (%) of space for circulation

There is no single piece of equipment which exceeds the capital expenditure minimum

ATTACHMENT ECON-3

Criterion 1120.310.c, Reasonableness of Project and Related Costs

These cost are for the total project cost not just the non-clinical section:

Preplanning Cost consist of the following
Contract Manager Preconstruction Fee $511,194
Project Definition Reimbursables – $50,000

Site Survey and Soil Investigation consist of the following

Geotechnical Study – $30,000
Site Survey – $30,000

Site Preparation consists of a single contract to grade site, establish roads and curbs – $7,947,717

Off-site Work – Demolition of existing Facility $1,500,000

Consulting and Other Fees Consist of the following:

AV Consulting – $14,700
Codes Consulting – $75,000
Food Service Consulting – $75,000
Shielding Consulting – $30,000
Legal Fees – $30,000
CON consulting – $120,000
Other Consultants –$100,000
Architectural Models – $20,000
State Fees –$22,000
Physicist Testing – $25,000
Moving Company – $355,394
Training and In-service –54,098

ATTACHMENT ECON-4

STANDARD &POOR'S

PUBLIC FINANCE

SSM Health Care System, Missouri

Primary Credit Analysts:
Brian T Williamson
Chicago
(1) 312-233-7009
brian_williamson@
standardandpoors.com

Secondary Credit Analysts:
Kevin Holloran
Dallas
(1) 214-871-1412
kevin_holloran@
standardandpoors.com

RatingsDirect Publication Date
Jan. 3, 2008

Credit Profile

Missouri Hlth & Educl Facs Auth, Missouri

SSM Hlth Care Sys, Missouri

Missouri Hlth & Ed Facs Auth (SSM Health Care System)

Long Term Rating	AA-/Stable	Affirmed

Rationale

Standard & Poor's Ratings Services affirmed its 'AA-' rating on **Missouri Health and Education Facilities Authority's** series 2002A and 2005B bonds and its 'AA-' underlying rating (SPUR) on various issuer's bonds, all issued for **SSM Health Care System** (SSMHC).

The rating reflects:

- A solid balance sheet characterized by 233 days' cash on hand, leverage of 38%, and a cash-to-debt ratio of 142% as of Sept. 30, 2007;
- Strong operating levels with a 3.8% operating margin as of the nine months ended Sept. 30, 2007 compared with 2.5% for the same period in 2006;
- A solid business base in diversified markets located primarily in St. Louis, Madison, Wis., and Oklahoma City; and
- Strong health system management.

Offsetting credit factors include the very competitive markets in which SSMHC's primary facilities are located; the potential for new debt in 2008 to fund capital expenditures; SSMHC's ability to close a deal to sell the hospital located in Blue Island, Ill; and construction risk associated with projects at various hospitals in the system.

SSMHC owns, manages, and is affiliated with 20 acute care and two nursing homes in four states: Missouri, Illinois, Wisconsin, and Oklahoma. With more than 5,000 affiliated physicians, 24,000 employees, and 5,002 licensed beds, SSMHC provides a wide range of services, including rehabilitation, pediatrics, home health, hospice, residential, and skilled

nursing care. SSMHC's health-related businesses include information systems and support services such as materials management and home care. SSMHC also owns an interest in Dean Health Insurance, Inc., which, through a wholly owned subsidiary, operates a group model health maintenance organization throughout southern Wisconsin.

For fiscal years ended Dec. 31, 2006 and 2005, SSMHC posted operating margins of 2.6% and 3.4%. These margins were down as it compared to operations for fiscal 2003 and 2004. The majority of the decline was due to challenges in Oklahoma City and Blue Island markets. As management has focused on all of its markets there has been a good turnaround in the St. Louis and Oklahoma City markets. Management continues to focus on cutting cost and increasing its utilization in all markets. For the nine months ended Sept. 30, 2007, SSMHC posted a 3.8% operating margin compared with 2.5% for the same period in 2006. An example of this can he seen when comparing 17 facilities that SSMHC reported for the period ended Sept. 30, 2007, compared with fiscal year-end 2006. In fiscal 2006, five of the aforementioned 17 facilities were operating at an acceptable level. For the first nine months of fiscal 2007, 11 of the 17 facilities are now operating at an acceptable level. The improved performance of the six facilities continued to add to the stronger performance of SSMHC. The balance sheet has remained relatively stahle over the past couple of years. At Sept. 30, 2007, days' cash on hand was equal to 233 days, leverage was 38%, and rhe cash-to-debt ratio was 142%.

In the near future, SSMHC has plans to ramp up capital spending as it addresses facility maintenance. With the increased capital spending, SSMHC plans to issue new debt in fiscal 2008 but plans are not finalized. SSMHC does have some debt capacity but the new debt will be reviewed at a later date.

Outlook

The stable outlook reflects SSMHC's solid business position in the markets in which it operates, coupled with the expectation of stable financial performance. The stable outlook also takes into account Standard & Poor's expectation that SSMHC should be able to manage any minor setbacks during the construction projects at its various facilities. Standard & Poor's anticipates that SSMHC's management will continue to strengthen the health system's balance sheet and maintain the positive strides that have been made in its various markets.

Blue Island, Ill.

SSM Health Care has signed a letter of intent with Transition Healthcare Company, to purchase St. Francis Hospital and SSM Home Care's Blue Island home health and hospice operations. The letter of intent is a non-binding agreement that can lead to a purchase and sale agreement. Although the agreement does not guarantee the sale of the hospital, it is an official indication that SSM Health Care and Transition Healthcare Company are negotiating exclusively and that no other group is involved in the process.

Debt Derivative Profile And Indexed Put Bonds

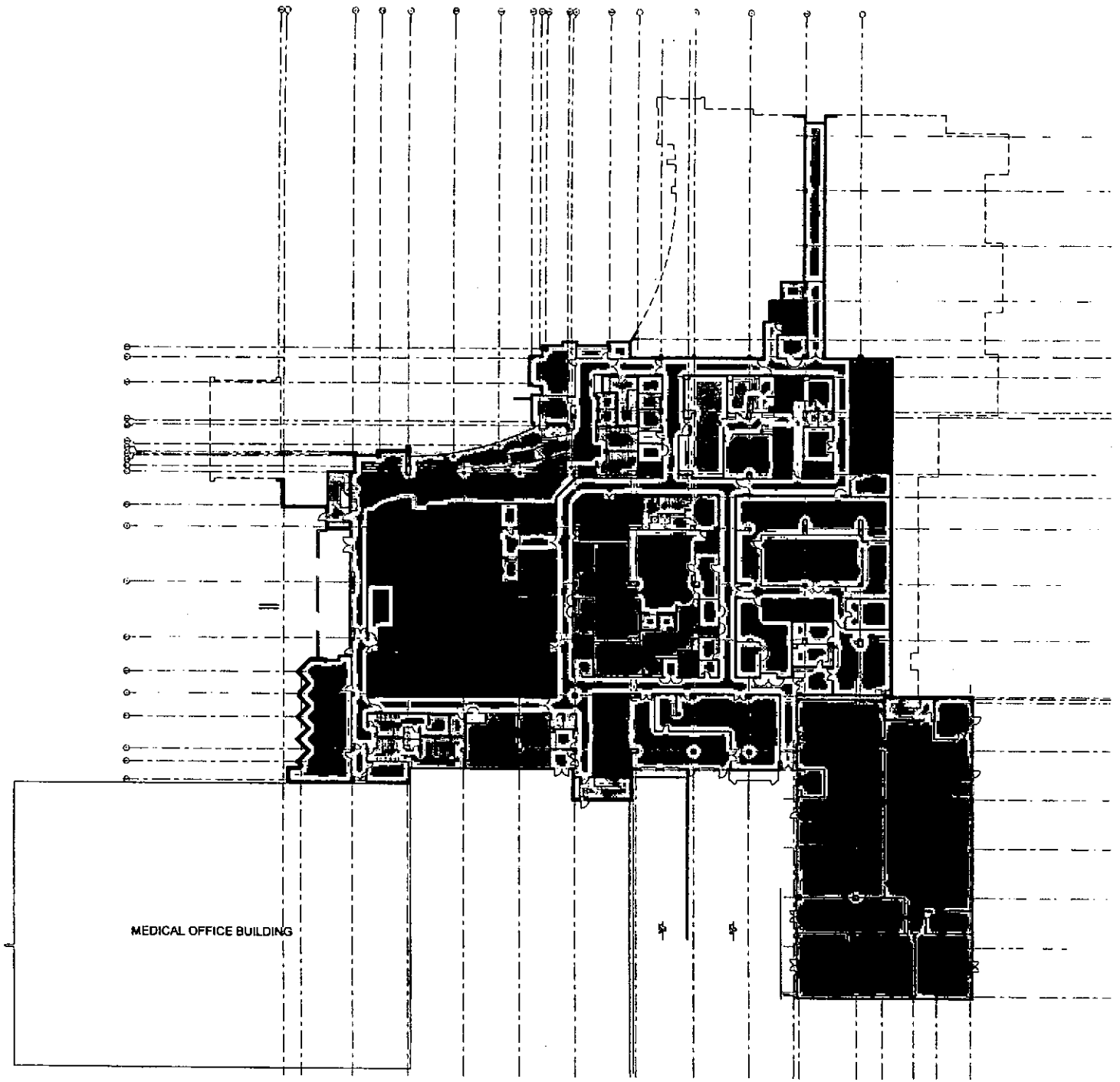
SSMHC has entered into seven swaps, of which six were floating-to-fixed-rate swaps on a total notional amount of $674.3 million and one was a fixed-to-floating swap on a notional amount of $50.0 million. UBS AG (AA) and Citibank N.A. (AA+) are the counterparties on all the interest rate swaps. Standard & Poor's assigned SSMHC a Debt Derivative Profile (DDP) score of '2' on a scale of

'1' to '4', with '1' representing the lowest risk and '4' the highest. The overall DDP score of '2' indicates that SSMHC's swaps do not pose significant additional risk to the credit quality. This is mainly a result of low counterparty risk, low termination risk, and good management oversight of the swap. The biggest risk for SSMHC is basis risk if interest rates rise in the future. The total net variable-rate debt exposure is approximately 27%.

With the indexed variable-rate put bond structure, SSMHC faces renewal risk in August 2010. The choices would be to:

- Renew the index put bonds, if the option is available;
- Convert to another variable-rate alternative, if the option is available;
- Refinance with the then-current market fixed rates; or
- Pay off the outstanding debt.

However, the bondholder may put the bonds early if a credit event occurs, including bankruptcy or payment default; taxability of the bonds; or the withdrawal or lowering of the rating on SSMHC's debt to 'A-' or below. SSMHC's current credit strength, evidenced by the 'AA-' rating, provides flexibility at this time. However, should the rating on SSMHC's debt decline to the 'A' category, it will have less financial flexibility and could experience a drop in unrestricted cash balances if the bonds are put (if the rating drops to 'A-') at a time when its credit profile is declining, putting added pressure on the rating. Standard & Poor's will continue to monitor the rating on SSMHC's debt through annually scheduled reviews and will incorporate any credit effect resulting from the series 2005B bond issue in the overall long-term rating.



Color Legend

- Vertical Circulation
- General Circulation
- Public Waiting / Public Toilets
- Administration
- Staff Facilities
- Materials Management
- Mechanical / Electrical / Plumbing
- Housekeeping
- Dietary
- Cafeteria
- Maintenance
- Hospice & Home Health
- Pharmacy
- Central Sterile Processing
- Information Technology
- Clinical Engineering
- Tunnel to Future Expansion
- Energy Center

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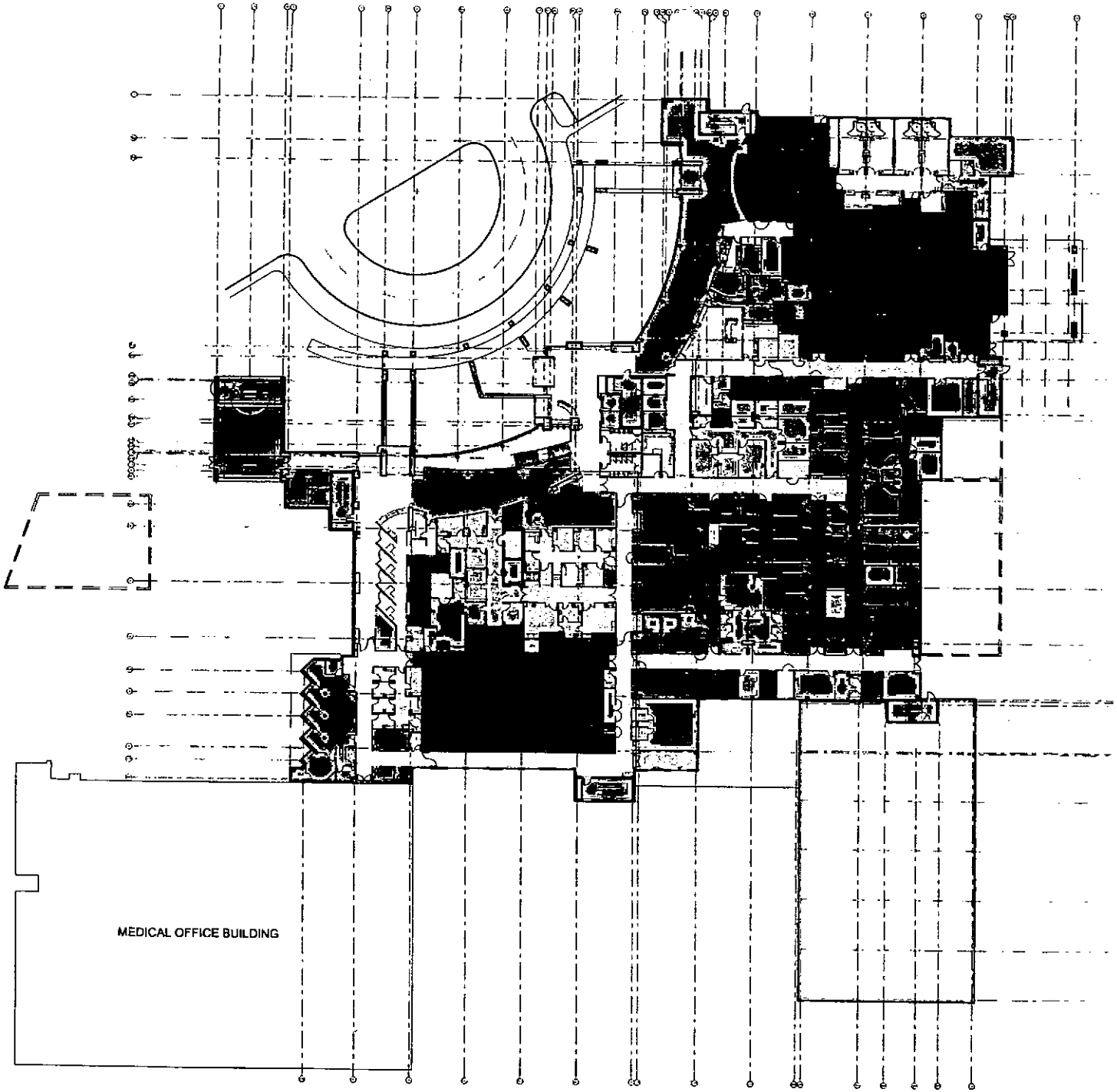
St. Mary's Good Samaritan
Incorporated

New Good Samaritan Regional Health Center

Garden Level Hospital Floor Plan

April 2008

BSA LifeStructures



Color Legend
Vertical Circulation
General Circulation
Public Waiting / Public Toilets
Administration
Staff Facilities
Materials Management
Mechanical / Electrical / Plumbing
Housekeeping
Admitting / Registration
Outpatient Testing
Outpatient Prep. & Recovery
Infusion Center
Ambulatory Care
Cardiac Catheterization Labs
Chapel / Pastoral Care
Employee Health
Diagnostic Radiology
Cardiac Diagnostic Testing
Nuclear Medicine
Gift Shop / Volunteers
Emergency
EMS Services
Pediatric Beds
Coffee Shop

382

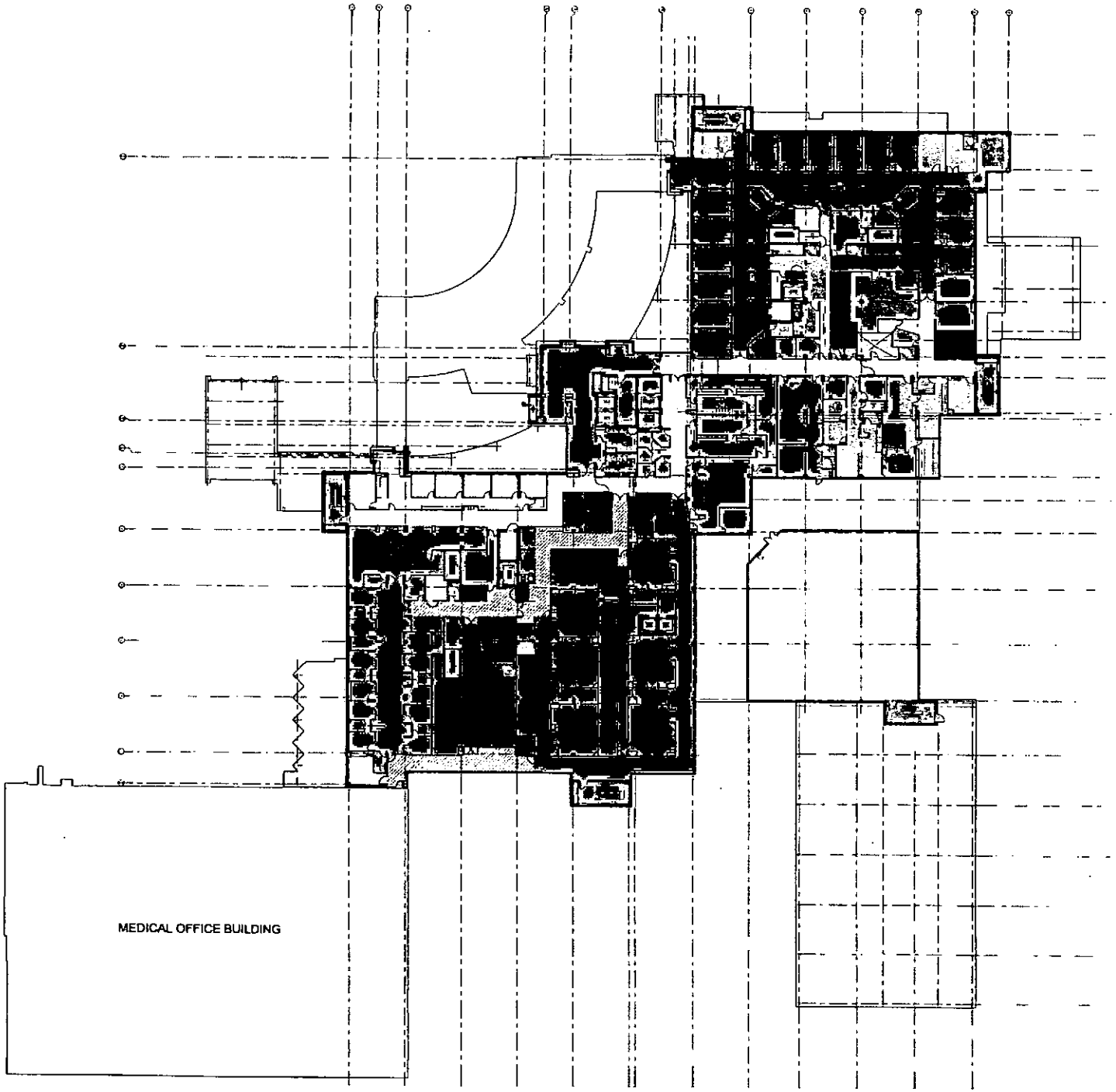
St. Mary's Good Samaritan Incorporated

New Good Samaritan Regional Health Center

First Level Hospital Floor Plan

April [illegible]08

BSA LifeStructures



Color Legend

- Vertical Circulation
- General Circulation
- Public Waiting / Public Toilets
- Administration
- Staff Facilities
- Materials Management
- Mechanical / Electrical / Plumbing
- Housekeeping
- Surgery
- Surgery Prep.
- Surgery Recovery (PACU)
- Nursing Administration
- Clinical Engineering
- Semi / Restricted Corridor
- Hemodialysis
- Intensive Care Beds
- Respiratory Therapy

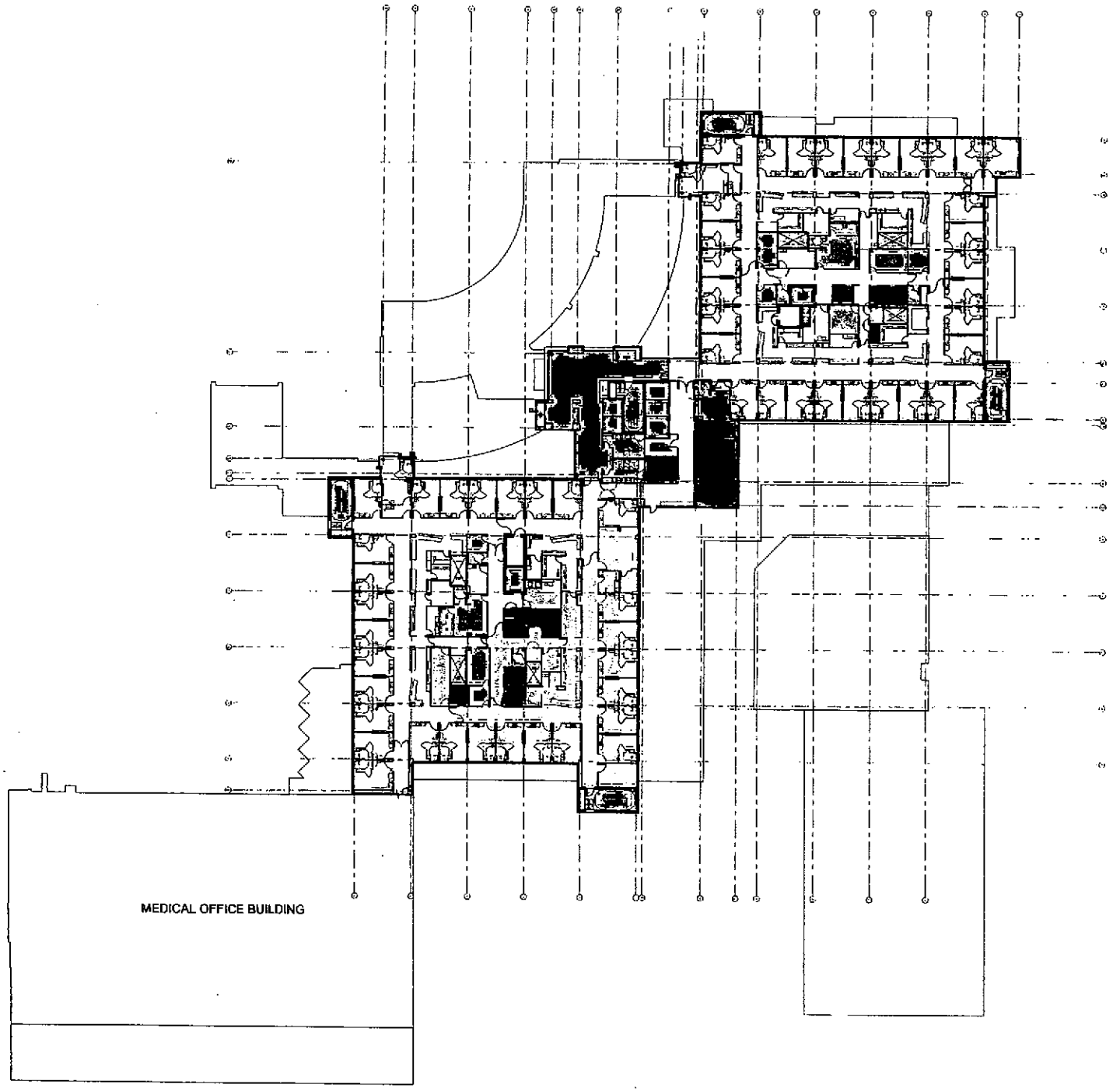
383

New Good Samaritan Regional Health Center

Second Level Hospital Floor Plan

June 12, 2008

BSA LifeStructures



Color Legend

- Vertical Circulation
- General Circulation
- Public Waiting / Public Toilets
- Administration
- Staff Facilities
- Materials Management
- Mechanical / Electrical / Plumbing
- Housekeeping
- Rehabilitation Beds
- Inpatient Physical Therapy
- Inpatient Occupational Therapy
- Medical / Surgical Beds

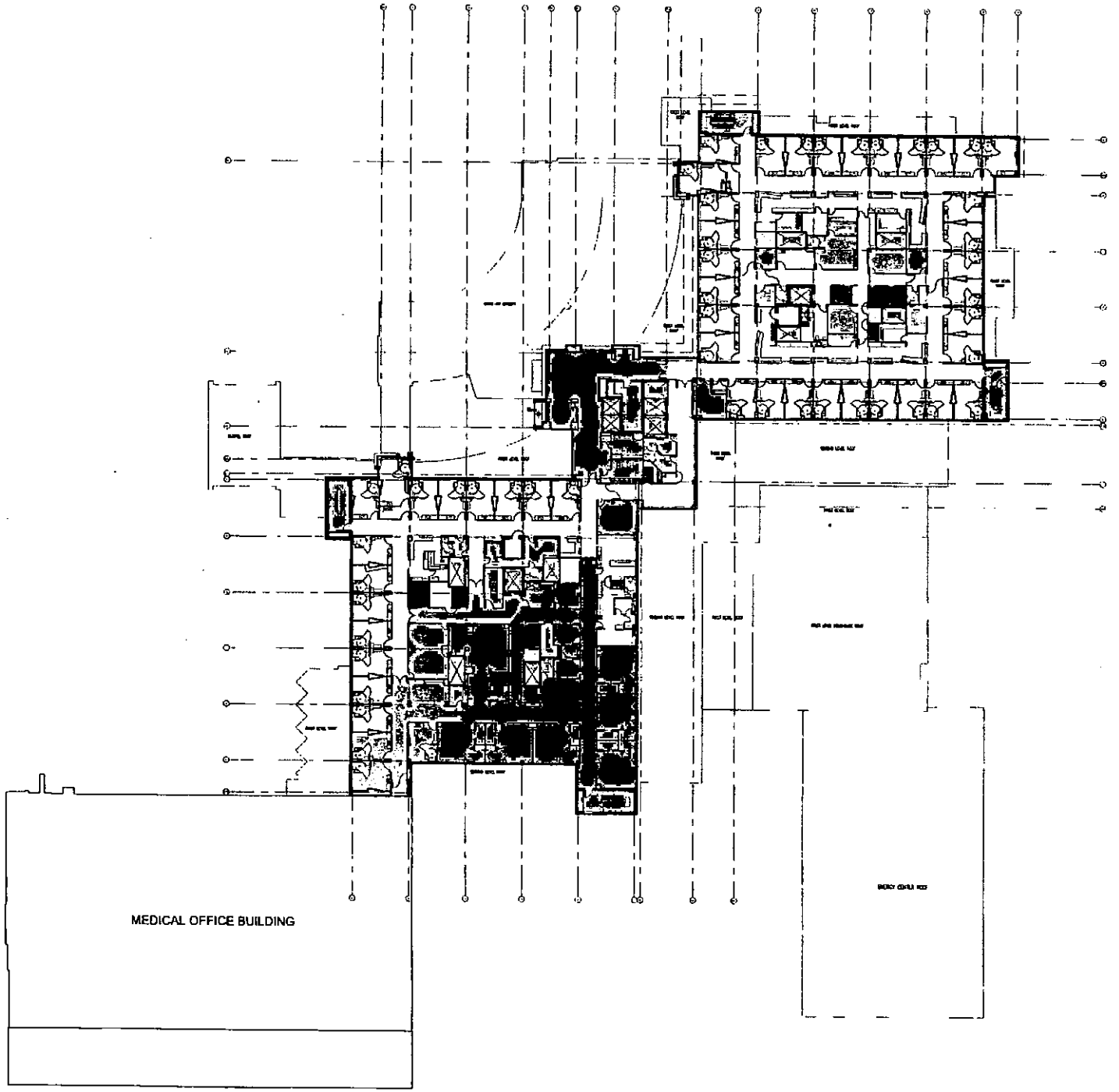
St. Mary's Good Samaritan Incorporated

New Good Samaritan Regional Health Center

Third Level Hospital Floor Plan

April [illegible]008

BSA LifeStructures



Color Legend

- Vertical Circulation
- General Circulation
- Public Waiting / Public Toilets
- Administration
- Staff Facilities
- Materials Management
- Mechanical / Electrical / Plumbing
- Housekeeping
- Obstetric Beds
- LDRP Rooms
- C-Section
- Newborn Nursery
- Medical & Surgical Beds

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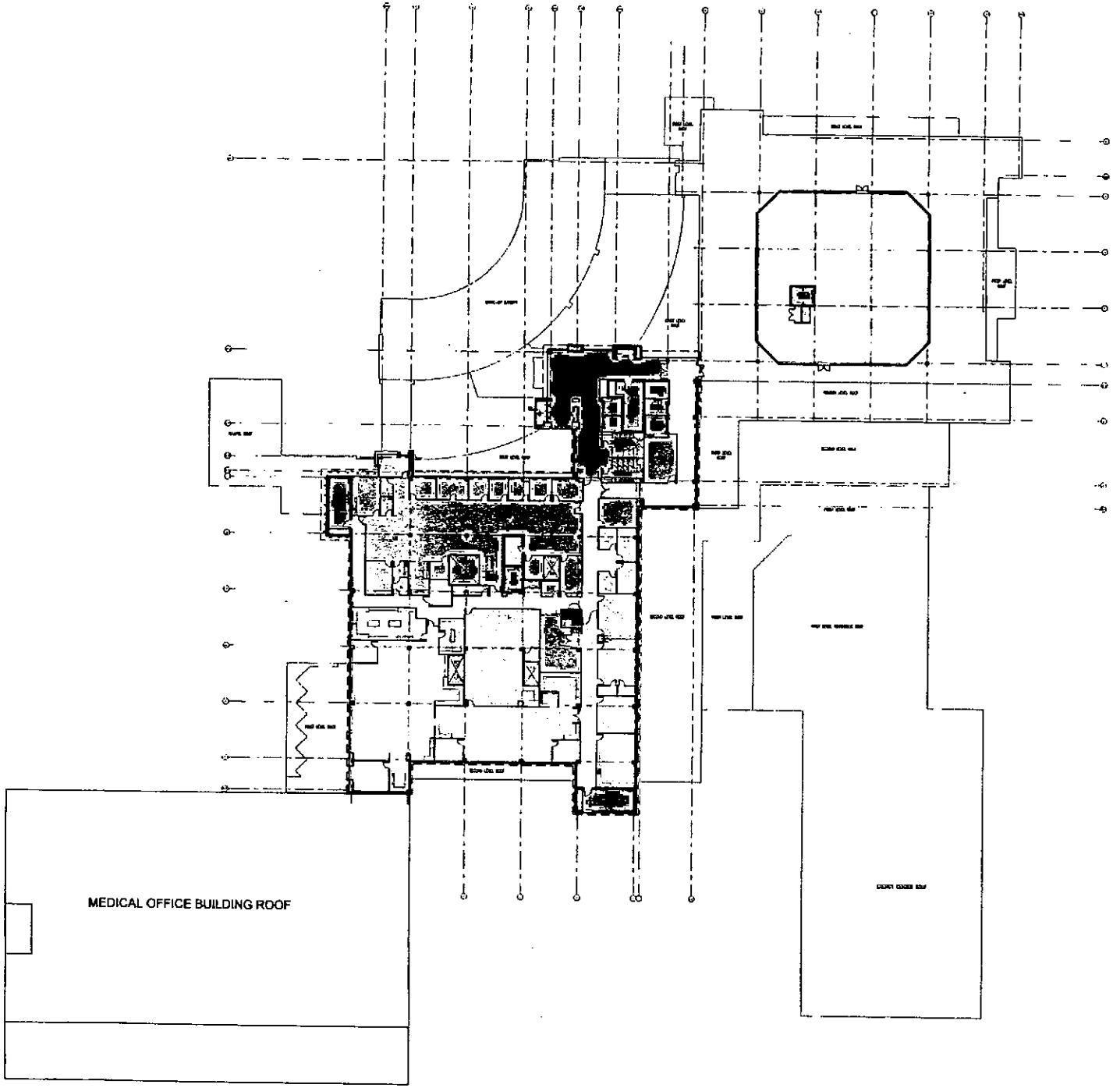
St. Mary's Good Samaritan Incorporated

New Good Samaritan Regional Health Center

Fourth Level Hospital Floor Plan

June 12, 2008

BSA LifeStructures



Color Legend

- Vertical Circulation
- General Circulation
- Public Waiting / Public Toilets
- Materials Management
- Mechanical / Electrical / Plumbing
- Housekeeping
- Hospice & Home Health
- Patient Accounts

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St. Mary's Good Samaritan incorporated

New Good Samaritan Regional Health Center

Fifth Level Hospital Floor Plan

April [illegible]8

BSA LifeStructures