ORIGINAL

09-063

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED
OCT 29 2009
HEALTH FACILITIES & SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Roseland Community Hospital
Street Address: 45 W. 111th Street
City and Zip Code: Chicago 60628
County: Cook Health Service Area Health Planning Area: A-03

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

Exact Legal Name: Roseland Community Hospital Association
Address: 45 W. 111th Street, Chicago, IL 60628
Name of Registered Agent: Mindy Mylecki
Name of Chief Executive Officer: Anthony Puorro
CEO Address: 45 W. 111th Street, Chicago, IL 60628
Telephone Number: (773) 995-3012

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

Type of Ownership

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

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

Primary Contact
[Person to receive all correspondence or inquiries during the review period]

Name: Anthony Puorro
Title: CEO
Company Name: Roseland Community Hospital
Address: 45 W. 111th Street, Chicago, IL 60628
Telephone Number: (773) 995-3012
E-mail Address: apuorro@roselandhospital.org
Fax Number: (773) 995-0152

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

Name: Billie J. Paige
Title: Consultant
Company Name: Shea, Paige & Rogal, Inc.
Address: 547 S. LaGrange Road, LaGrange, IL 60525
Telephone Number: (708) 482-4820
E-mail Address: stargazer23@msn.com
Fax Number: (708) 482-1091

Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance]

Name: Douglas Beck
Title: Director
Company Name: Roseland Community Hospital
Address: 45 W. 111th Street, Chicago, IL 60628
Telephone Number: (773) 995-3089
E-mail Address: dbeck@roselandhospital.org
Fax Number: (773) 995-1052

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Roseland Community Hospital Association
Address of Site Owner: 45 W. 111th Street, Chicago, IL 60628
Street Address or Legal Description of Site: SAME

APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

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

Exact Legal Name:
Address:

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

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

Organizational Relationships

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

APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements

[Refer to application instructions.]

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

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

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

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

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

DESCRIPTION OF PROJECT

1. Project Classification

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

Part 1110 Classification:	Part 1120 Applicability or Classification: [Check one only.]
☑ Substantive	☐ Part 1120 Not Applicable
☐ Non-substantive	☐ Category A Project
	☑ Category B Project
	☐ DHS or DVA Project

2. Project Outline

In the chart below, indicate the proposed action(s) for each clinical service area involved by writing the number of beds, stations or key rooms involved:

Clinical Service Areas	Establish	Expand	Modernize	Discontinue	No. of Beds, Stations or Key Rooms
Medical/Surgical, Obstetric, Pediatric and Intensive Care					
Acute/Chronic Mental Illness	30				
Neonatal Intensive Care					
Open Heart Surgery					
Cardiac Catheterization					
In-Center Hemodialysis					
Non-Hospital Based Ambulatory Surgery					
General Long Term Care					
Specialized Long Term Care					
Selected Organ Transplantation					
Kidney Transplantation					
Subacute Care Hospital Model					
Post Surgical Recovery Care Center					
Children's Community-Based Health Care Center					
Community-Based Residential Rehabilitation Center					
Long Term Acute Care Hospital Bed Projects					
Clinical Service Areas Other Than Categories of Service:					
• Surgery					
• Ambulatory Care Services (organized as a service)					
• Diagnostic & Interventional Radiology/Imaging					
• Therapeutic Radiology					
• Laboratory					
• Pharmacy					
• Occupational Therapy					
• Physical Therapy					
• Major Medical Equipment					
Freestanding Emergency Center Medical Services					
Master Design and Related Projects					
Mergers, Consolidations and Acquisitions					

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

3. Narrative Description

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

The Roseland Community Hospital project is for the addition of 30 acute mental illness beds. This is a new service for the hospital which currently has 162 beds. The project will include the renovation of 9,918 sq. ft. and will be funded by cash.

This is a substantive project because it would add a new service to the facility.

This is the new application for Roseland Community Hospital. Roseland has had to reapply because of unanticipated problems with the electrical and HVAC systems (due to the age of its building) which drove the costs to more than 5% of the approved project amount.

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-clinical components that are not related to the provision of health care, complete the second column of the table below. See 20 ILCS 3960 for definition of non-clinical. Note, the use and sources of funds must equal.

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NON-CLINICAL**	**TOTAL**
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts	2,900,000		2,900,000
Contingencies	180,000		180,000
Architectural/Engineering Fees	220,000		220,000
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)	100,000		100,000
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)	90,000		90,000
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	3,490,000		3,490,000
SOURCE OF FUNDS	**CLINICAL**	**NON-CLINICAL**	**TOTAL**
Cash and Securities	**740,000**		**740,000**
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages - Loan	**2,750,000**		**2,750,000**
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	**3,490,000**		**3,490,000**

NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

Land acquisition is related to project ☐ Yes ☑ No
Purchase Price: $_____
Fair Market Value: $_____

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

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

Estimated start-up costs and operating deficit cost is $ 696,671.

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:

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

Anticipated project completion date (refer to Part 1130.140): 04/30/11

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.

State Agency Submittals

Are the following submittals up to date as applicable:
☑Cancer Registry
☑APORS
☑All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
☑All reports regarding outstanding permits

Cost Space Requirements

Provide in the following format, the department/area GSF and cost. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
CLINICAL							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
AMI	3,490,000	0	10,973		10,973		
Total Clinical	3,490,000	0	10,973		10,973		
NON CLINICAL							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL	**3,490,000**		**10,973**		**10,973**		

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

Facility Bed Capacity and Utilization

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

FACILITY NAME: Roseland Community Hospital	**CITY: Chicago**				
REPORTING PERIOD DATES:	**From: 01/01/08**			**to: 12/31/08**	
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	132	4,708	20,742		132
Obstetrics	20	496	1,273		20
Pediatrics					
Intensive Care	10	238	1,998		10
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					30
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:	162	5,442	24,013		192

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

This Application for Permit is filed on the behalf of _____* 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

ANTHONY PUORRO
PRINTED NAME

CHIEF EXECUTIVE OFFICER
PRINTED TITLE

Notarization:
Subscribed and sworn to before me this 23 day of October 2009

Signature of Notary

Seal

OFFICIAL SEAL
MABEL Y JONES
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:04/20/10

SIGNATURE

RONALD L. KROL
PRINTED NAME

CHIEF FINANCIAL OFFICER
PRINTED TITLE

Notarization:
Subscribed and sworn to before me this 23 day of October 2009

Signature of Notary

Seal

*Insert EXACT legal name of the applicant

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

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

Criterion 1110.230 - Project Purpose, Background and Alternatives

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

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

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

3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**

4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT-10, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.

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

3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]

4. Cite the sources of the information provided as documentation.

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

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

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

PURPOSE OF PROJECT

As stated in the many letters of referral and support, this project is being proposed, as it was I Project 08-055, in order to fill a void on the far south side of Chicago. It is to respond to an unrelenting appeal from parents and other health care facilities as to placements for children and adolescents requiring inpatient mental illness treatment.

This was the purpose of Project 08-055 which this application replaces. We should also note that the situation for placement of young people continues to deteriorate in Planning Area A-03.

It was devastating that the age and condition of the Roseland building was such that a substantial addition of funds is required to bring the proposed unit up to code. Fortunately, since previously the area was not being used for patient care, there were no regulatory citations.

Nonetheless, because of the urgency to provide the best patient care, Roseland is prepared to expend its limited resources to complete this needed venture.

Example: the recent tragic murder of a high school student on the far south side of Chicago caused an outcry for such services.

It is a void that Roseland hopes to fill without impact on any other health care facilities (see support and referral letters in Attachment 12).

ALTERNATIVES TO THE PROJECT

Roseland Community Hospital considered the following alternatives:

- Do nothing.
- Affiliate with another hospital which has an acute mental illness unit specializing in adolescent and childhood mental illness
- Adding an acute mental illness service to Roseland Community Hospital

Do Nothing

Roseland considered and rejected this alternative. There continues to be a steady inquiry from both parents and other health care facilities as to whether Roseland has any knowledge of where adolescents and children who need inpatient mental illness treatment can be accommodation on the South Side of Chicago. Roseland has had to respond in the negative. To do nothing would just continue an what is becoming a most untenable situation (see support letters).

Affiliate With Another Hospital

The reason this application is before you is that there are no other hospitals that have an acute mental illness service can accommodate these patients. We receive calls from them as well (see support letters).

Add an Acute Mental Illness Service

The foregoing discussion of the first two options detail the reason that we have decided, through our experience, that there exists an unfulfilled need for additional acute mental illness beds on the South Side of Chicago. Therefore, because of that empirical experience, we have determined that a unit of 30 beds is appropriate and will provide the access that many in the community do not have. Even if a bed is available from time to time, most of the people we see or that communicate with us would travel an unacceptable distance in order to seek the treatment their children require. Therefore, many of these children are not receiving the appropriate inpatient service which they need (see support letters).

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

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

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

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

2. If the gross square footage exceeds the GSF standards in Appendix B, justify the discrepancy by documenting one of the following::

    a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;

    b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;

    c. The project involves the conversion of existing bed space that results in excess square footage.

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

PROJECT SERVICES UTILIZATION:

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

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B.

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

UNFINISHED OR SHELL SPACE: **N/A**

Provide the following information:

1. Total gross square footage of the proposed shell space;

2. The anticipated use of the shell space, specifying the proposed GSF tot be allocated to each department, area or function;

3. Evidence that the shell space is being constructed due to
    a. Requirements of governmental or certification agencies; or
    b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.

4. Provide:
    a. Historical utilization for the area for the latest five-year period for which data are available; and

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

1. In addition to addressing the Category of Service Review Criteria for ALL category of service projects [SECTION VII], applicants proposing to establish, expand and/or modernize Acute/Chronic Mental Illness must submit the following information:

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

Category of Service	# Existing Beds	# Proposed Beds	# to Establish	# to Expand	# to Modernize
☑ Acute Mental Illness			30		
☐ **Chronic Mental Illness**					

3. READ the applicable review criteria outlined below:

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.730(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.730(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.730(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.730(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.730(b)(5) - Planning Area Need - Service Accessibility	X		
1110.730(c)(1) - Unnecessary Duplication of Services	X		
1110.730(c)(2) - Maldistribution	X		
1110.730(c)(3) - Impact of Project on Other Area Providers	X		
1110.730(d)(1) - Deteriorated Facilities			X
1110.730(d)(2) - Documentation			X
1110.730(d)(3) - Documentation Related to Cited Problems			X
1110.730(d)(4) - Occupancy			X
1110.730(e(1)) - Staffing Availability	X	X	
1110.730(f) - Performance Requirements	X	X	X
1110.730(g) - Assurances	X	X	

SECTION VII. - CATEGORY OF SERVICE - REVIEW CRITERIA

1. This Section is applicable to all projects proposing establishment, expansion or modernization of ALL **categories of service that are subject to CON review**, as provided in the Illinois Health Facilities Planning Act [20 ILCS 3960], WITH THE EXCEPTION OF:

- General Long Term Care;
- Subacute Care Hospital Model;
- Postsurgical Recovery Care Center Alternative Health Care Model;
- Children's Community-Based Health Care Center Alternative Health Care Model; and
- Community-Based Residential Rehabilitation Center Alternative Health Care Model.

If the project involves any of the above-referenced categories of service, refer to " SECTION VIII.- Service Specific Review Criteria" for applicable review criteria, and submit all necessary documentation for each service involved..

2. READ THE APPLICABLE REVIEW CRITERIA FOR EACH OF THE CATEGORIES OF SERVICE INVOLVED.**[Refer to SECTION VIII regarding the applicable criteria for EACH action proposed, for EACH category of service involved.]**

3. **After identifying the applicable review criteria for each category of service involved (see the charts in Section VIII), provide the following information, AS APPLICABLE TO THE CRITERIA THAT MUST BE ADDRESSED:**

A. Planning Area Need - Formula Need Calculation:

1. **Complete the requested information for each category of service involved:**
Refer to 77 Ill. Adm. Code 1100 for information concerning planning areas, bed/station/key room deficits and occupancy/utilization standards.

Planning Area A-03

Category of Service	No. of Beds/Stations/Key Rooms Proposed	HFSRB Inventory Need or Excess	Part 1100 Occupancy/Utilization Standard
Acute Mental Illness	30	55 (need)	85%

Using the formatting above:

2. Indicate the number of beds/stations/key rooms proposed for each category of service.

3. Document that the proposed number of beds/stations/key rooms is in conformance with the projected deficit specified in 77 Ill. Adm. Code 1100.

4. Document that the proposed number of beds/stations/key rooms will be in conformance with the applicable occupancy/utilization standard(s) specified in Ill. Adm. Code 1100.

B. Planning Area Need - Service to the Planning Area Residents:

5. If establishing or expanding beds/stations/key rooms, document that the primary purpose of the project will be to provide necessary health care to the residents of the area in which the proposed project will be physically located (i.e., the planning or geographical service area, as applicable), for each category of service included in the project.

6. If expanding an existing category of service, provide patient origin information for all admissions for the last 12-month period, verifying that at least 50% of admissions were residents of the area. For all other projects, document that at least 50% of the projected patient volume will be from residents of the area.

APPEND DOCUMENTATION AS ATTACHMENT-20, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

C. Service Demand - Expansion of an Existing Category of Service

*** See Attachment 20**

Document "Historical Service Demand" and **either** "Projected Referrals" or "Project Service Demand - Based on Rapid Population Growth" :

1. Historical Service Demand

Category of Service	Board Occupancy/Utilzation Standards	Year One Indicate CY or FY	Year Two Indicate CY or FY
	[Indicate standards for the planning area.]		

a. As formatted above, document that the average annual occupancy/utilization rate has equaled or exceeded occupancy standards for the category of service, as specified in 77 Ill. Adm. Code 1100, for each of the latest two years;

b. If patients have been referred to other facilities in order to receive the subject services, provide documentation of the referrals, including: patient origin by zip code; name and specialty of referring physician; and name and location of the recipient hospital, for each of the latest two years

2. Projected Referrals

An applicant proposing to establish a category of service or establish a new hospital shall submit physician referral letters containing ALL of the information outlined in subsection(b)(4) of the criteria for the subject service(s).

3. Projected Service Demand – Based on Rapid Population Growth

If a projected demand for service is based upon rapid population growth in the applicant facility's existing market area (as experienced annually within the latest 24-month period), the projected service demand must be determined, as specified in the criterion titled "Projected Service Demand-Based on Rapid Population Growth" of the criteria for the subject service(s).

APPEND DOCUMENTATION AS ATTACHMENT-20, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

D. Service Demand - Expansion of an Existing Category of Service **N/A**

Document "Historical Service Demand" and **either** "Projected Referrals" or "Project Service Demand -
Based on Rapid Population Growth" :

1. Historical Service Demand

Category of Service	Board Occupancy/ Utilzation Standards	Year One Indicate CY or FY	Year Two Indicate CY or FY
	[Indicate standards for the planning area.]		

T. Financial Feasibility

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

REVIEW CRITERIA RELATING TO FINANCIAL FEASIBILITY (FIN)

Does the applicant (or the entity that is responsible for financing the project or is responsibl assuming the applicant's debt obligations in case of default) have a bond rating of "A" or bette 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 XXVI. **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**

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 (Projected)**
Enter Historical and/or Projected Years:	**2006**	**2007**	**2008**	**2012**
Current Ratio	.6	.6	.7	.7
Net Margin Percentage	-12.8	+2.8	5.5	14.4
Percent Debt to Total Capitalization	-560%	576%	144%	70
Projected Debt Service Coverage	N/A	N/A	N/A	9.2
Days Cash on Hand	3	23	32	67
Cushion Ratio	N/A	N/A	N/A	2.1

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.

REVIEW CRITERIA RELATING TO FINANCIAL FEASIBILITY (FIN)

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:

740,000 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.

2,750,000 Debt Financing (indicate type(s) loan)
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.

3,490,000 TOTAL FUNDS AVAILABLE

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.

APPEND DOCUMENTATION AS ATTACHMENT 75, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Start up costs funded by cash. $696,671 for seven months of operating deficit.

Roseland Hospital

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

Department/Area	A Cost/Square Foot New	B Cost/Square Foot Mod.	C Gross Sq. Ft. New	D Gross Sq. Ft. Circ.*	E Gross Sq. Ft. Mod.	F Gross Sq. Ft. Circ.*	G Const. $ (A x C)	H Mod. $ (B x E)	Total Cost (G + H)
AMI		264.29			10,973			$2,900,000	$2,900,000
Contingency		16.40			10,973			$180,000	$180,000
TOTAL		280.69			10,973	0		$3,080,000	$3,080,000

REVIEW CRITERIA RELATING TO ECONOMIC FEASIBILITY (ECON) (continued)

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.

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.

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.

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.

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.

ORGANIZATIONAL RELATIONSHIPS

Roseland Community Hospital is a general acute care hospital solely held by Roseland Community Hospital Association.

ATTACHMENT 3

Illinois Department of
Natural Resources
One Natural Resources Way · Springfield, Illinois 62702-1271
http://dnr.state.il.us

Rod R. Blagojevich, Governor
Sam Flood, Acting Director

July 25, 2007

Mr. John S. Cullinane
The Cullinane Law Firm
10411 Clayton Road, Suite A9
St. Louis, MO 63131

RE: Acute Mental Health Unit, Roseland Hospital, 45 W. 111th Street, Chicago, IL

Dear Mr. Cullinane:

Thank you for submitting site plans and requesting a floodplain determination for the proposed Mental Health Unit at Roseland Hospital in Chicago, Illinois in order to ensure compliance with Illinois Executive Order #V (E.O. V).

In brief, E.O. V requires that state agencies which plan, promote, regulate, or permit activities, as well as those which administer grants or loans in the State's floodplain areas, must ensure that all projects meet the standards of the state floodplain regulations or the National Flood Insurance Program (NFIP) whichever is more stringent. These standards require that new or substantially unproved buildings as well as other development activities be protected from damage by the 100-year flood. In addition, no construction activities in the floodplain may cause increases in flood heights or damages to other properties.

Based on the site location you have provided, we have determined that, this parcel is not located within a designated 100-year floodplain and therefore would not fall under the floodplain development requirements of E.O. V.

Should you have any questions or comments regarding this flood hazard determination, feel free to contact me at (217) 782-4428.

Sincerely,

Paul A. Osman, Manager
Floodplain Management Programs

[redacted]
ATTACHMENT 4

24

Illinois Historic
Preservation Agency

1 Old State Capitol Plaza • Springfield, Illinois 62701-1512 • Teletypewriter Only (217) 524-7128

Voice (217) 782-4836

www.illinois-history.gov

PLEASE REFER TO: IHPA LOG #004071307

Cook County
Chicago
45 West 111th Street
Establishment of a New Acute Mental Health Unit, Roseland Community Hospital

July 17, 2007

John S. Cullinane
The Cullinane Law Firm
10411 Clayton Road, Suite A9
Saint Louis, MO 63131

Dear Mr. Cullinane:

The Illinois Historic Preservation Agency is required by the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420, as amended, 17 IAC 4180) to review all state funded, permitted or licensed undertakings for their effect on cultural resources. Pursuant to this, we have received information regarding the referenced project for our comment.

Our staff has reviewed the specifications under the state law and assessed the impact of the project as submitted by your office. We have determined, based on the available information, that no significant historic, architectural or archaeological resources are located within the proposed project area.

According to the information you have provided concerning your proposed project, apparently there is no federal involvement in your project. However, please note that the state law is less restrictive than the federal cultural resource laws concerning archaeology. If your project will use federal loans or grants, need federal agency permits, use federal property, or involve assistance from a federal agency, then your project must be reviewed under the National Historic Preservation Act of 1966, as amended. Please notify us immediately if such is the case.

This clearance remains in effect for two (2) years from date of issuance. It does not pertain to any discovery during construction, nor is it a clearance for purposes of the IL Human Skeletal Remains Protection Act (20 ILCS 3440).

Please retain this letter in your files as evidence of compliance with the Illinois State Agency Historic Resources Preservation Act.

Sincerely,

Anne E. Haaker

Anne E. Haaker
Deputy State Historic
Preservation Officer

AEH

25

ATTACHMENT 5

Roseland Community Hospital

80 years of service and our commitment continues...

October 23, 2009

Mr. Michael Constantino
Illinois Health Facilities Planning Board
525 W. Jefferson Street
Springfield, IL 62761

Dr. Mr. Constantino,

This is to verify that no adverse action has been taken with respect to Roseland Hospital in the last three years. In addition, this letter authorizes the Illinois Health Facilities Planning Board and its employees to access information in order to verify any documentation or information submitted in response to our application. Additional access is allowed to obtain any documentation or information that the Planning Board or its employees find pertinent for the purposes of reviewing the background of the applicant.

Sincerely,

Anthony J. Puorro, FACHE, FHFMA
President and Chief Executive Officer

ATTACHMENT 10

45 W. 111th Street Chicago IL 60628 · Phone: 773.995.3000 · Fax: 773.995.1052

File Number 2655-882-4

To all to whom these Presents Shall Come, Greeting:

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

ROSELAND COMMUNITY HOSPITAL ASSOCIATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON MARCH 29, 1940, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

Authentication #: 0927201874

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

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 29TH *day of* SEPTEMBER *A.D.* 2009 .

Jesse White

SECRETARY OF STATE

ATTACHMENT 10

AMERICAN OSTEOPATHIC ASSOCIATION

BUREAU OF HEALTHCARE FACILITIES ACCREDITATION
HEALTHCARE FACILITIES ACCREDITATION PROGRAM

142 E. Ontario Street, Chicago, IL 60611-2864 ph 312 202 8258 | 800- 621 -1773 X 8258

September 18, 2009

Anthony Puorro
Chief Executive Officer
Roseland Community Hospital
45 West 111th Street
Chicago, IL 60628

Dear Mr Puorro :

The American Osteopathic Association's Bureau of Healthcare Facilities Accreditation Executive Committee, at its meeting on August 26, 2009 , reviewed the recertification survey report and granted **Full Accreditation with Interim Report,** with resurvey within 3 years and recommends that the CMS RO approve deemed status for:

Roseland Community Hospital
45 West 111th Street
Chicago, IL 60628

Program: Acute Care Hospital
CCN # 140068
HFAP ID: 164144
Survey Dates: 09/29/08 – 10/01/08
Effective Date of Accreditation: 10/01/08 - 10/01/2011

Condition Level Deficiencies: ☐ None
(Use crosswalk and CFR citiations, if applicable):
482.51
30.00.00 Surgical Services

For Interim Accreditation Actions Only:
Timeframe for response to deficiencies:
-

In reviewing your report, the Executive Committee made the observations that are contained on the enclosed sheets and requires that in Interim Report by your facility, indicating continued progress made toward correction of cited deficiencies, be received in the AOA Division of Healthcare Facilities Accreditation prior to October 15, 2009.

Sincerely,

George A. Reuther

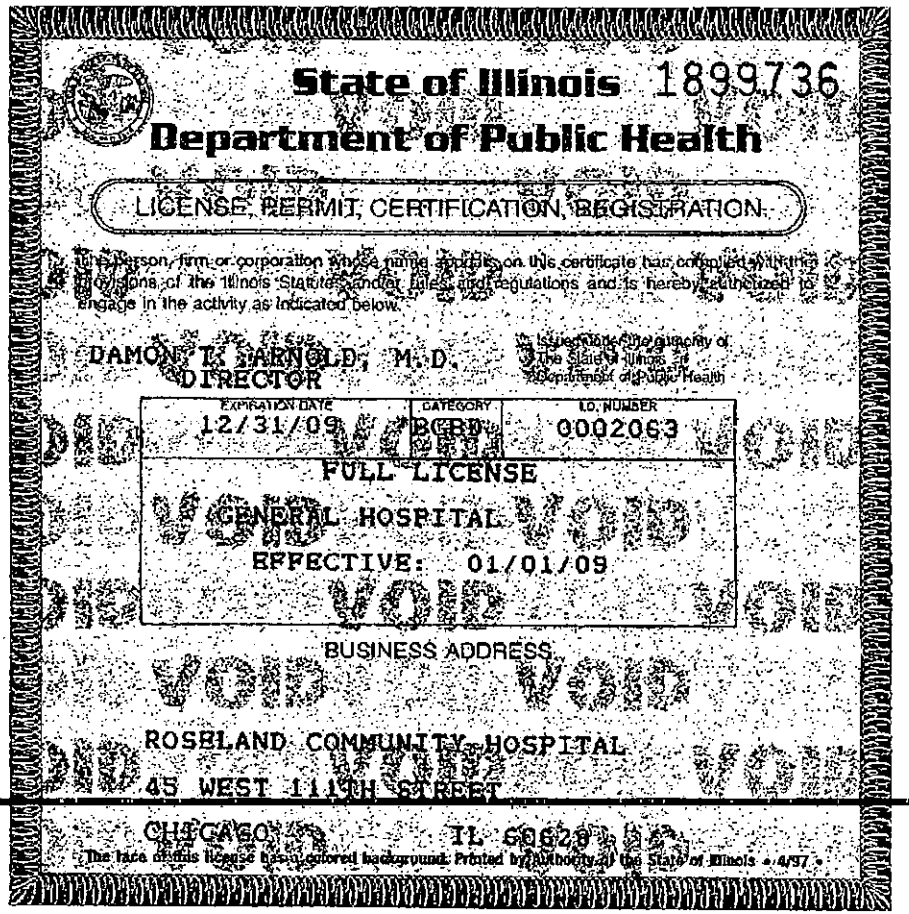
George A. Reuther
Secretary

GAR/pmh

Enclosure
cc: President, Governing Body
Chief of Staff
Laura Weber, Health Insurance Specialist, CMS
Region V, CMS

28

ATTACHMENT 10



State of Illinois 1899736

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

This person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes, under 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
12/31/09	BGBD	0002063

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/09

BUSINESS ADDRESS

ROSELAND COMMUNITY HOSPITAL
45 WEST 111TH STREET
CHICAGO IL 60628

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

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

↓

State of Illinois 1899736

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

ROSELAND COMMUNITY HOSPITAL

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/09	BGBD	0002063

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/09

11/01/08

ROSELAND COMMUNITY HOSPITAL
45 WEST 111TH STREET

CHICAGO IL 60628

FEE RECEIPT NO.

29

JULY 14 89

89320948

THE GRANTOR NHS REDEVELOPMENT CORPORATION

a corporation created and existing under and by virtue of the laws of the State of Illinois and duly authorized to transact business in the State of Illinois, for and in consideration of the sum of Ten ($10.00) dollars and other good and valuable consideration in hand paid, and pursuant to authority given by the Board of Directors of said corporation, CONVEYS and WARRANTS to ROSELAND COMMUNITY HOSPITAL ASSOCIATION 45 W. 111th Street Chicago, Illinois GRANTEE'S ADDRESS

the following described Real Estate situated in the County of COOK in the State of Illinois, to wit:

Lot 84 and the East Half of Lot 83 of the Vanden Berg's Addition, being a Subdivision of the South Half of Lot 57 and Lot 58 (Except the South 165 Feet) in School Trustee's Subdivision of Section 16, Township 37 North, Range 14, East of the Third Principal Meridian, according to the plat thereof recorded in the Recorder's Office of Cook County, Illinois on December 22, 1892 as document 1789928 in Cook County, Illinois

89320948

Permanent Real Estate Index Number(s): 25-16-430-011

Address(es) of Real Estate: 23 West 110th Place, Chicago, Illinois 60628

In Witness Whereof, said Grantor has caused its corporate seal to be hereto affixed, and has caused its name to be signed to these presents by its Vice President, and attested by its Assistant Secretary, this 4th day of June, 1989.

NHS REDEVELOPMENT CORPORATION

IMPRINT CORPORATE SEAL HERE

By: Judith L. Baker Vice President

Attest: Scott Lancelot Assistant Secretary

State of Illinois, County of COOK ss. I, the undersigned, a Notary Public, in and for the County and State aforesaid, DO HEREBY CERTIFY, that Judith L. Baker personally known to me to be the Vice President of the NHS Redevelopment Corporation corporation, and Scott Lancelot personally known to me to be the Assistant Secretary of said corporation, and personally known to me to be the same persons whose names are subscribed to the foregoing instrument, appeared before me this day in person and severally acknowledged that as such Vice President and Assistant Secretary, they signed and delivered the said instrument and caused the corporate seal of said corporation to be affixed thereto, pursuant to authority given by the Board of Directors of said corporation, as their free and voluntary act and as the free and voluntary act and deed of said corporation, for the uses and purposes therein set forth.

IMPRINT NOTARIAL SEAL HERE

Given under my hand and official seal this 4th day of June, 1989

Commission expires June 10, 1990 Notary Public

This instrument was prepared by Paul L. Lacanoli, 33 N. LaSalle, Chicago, Illinois 60602

Mail to: John Cullinane, Esq. Tabbert, Cullinane & Brook 135 S. LaSalle St. 35th Flr. Chicago, Illinois 60603

Send subsequent tax bills to: Roseland Community Hospital Assoc. 45 W. 111th Street Chicago, Illinois 60628

RECORDER'S OFFICE BOX NO. ____

89320948

Exempt under provisions of Paragraph ____ Section 4, Real Estate Transfer Tax Act. Date: ____ Buyer, Seller or Representative

RECORDER'S STAMP

185 92 R.O

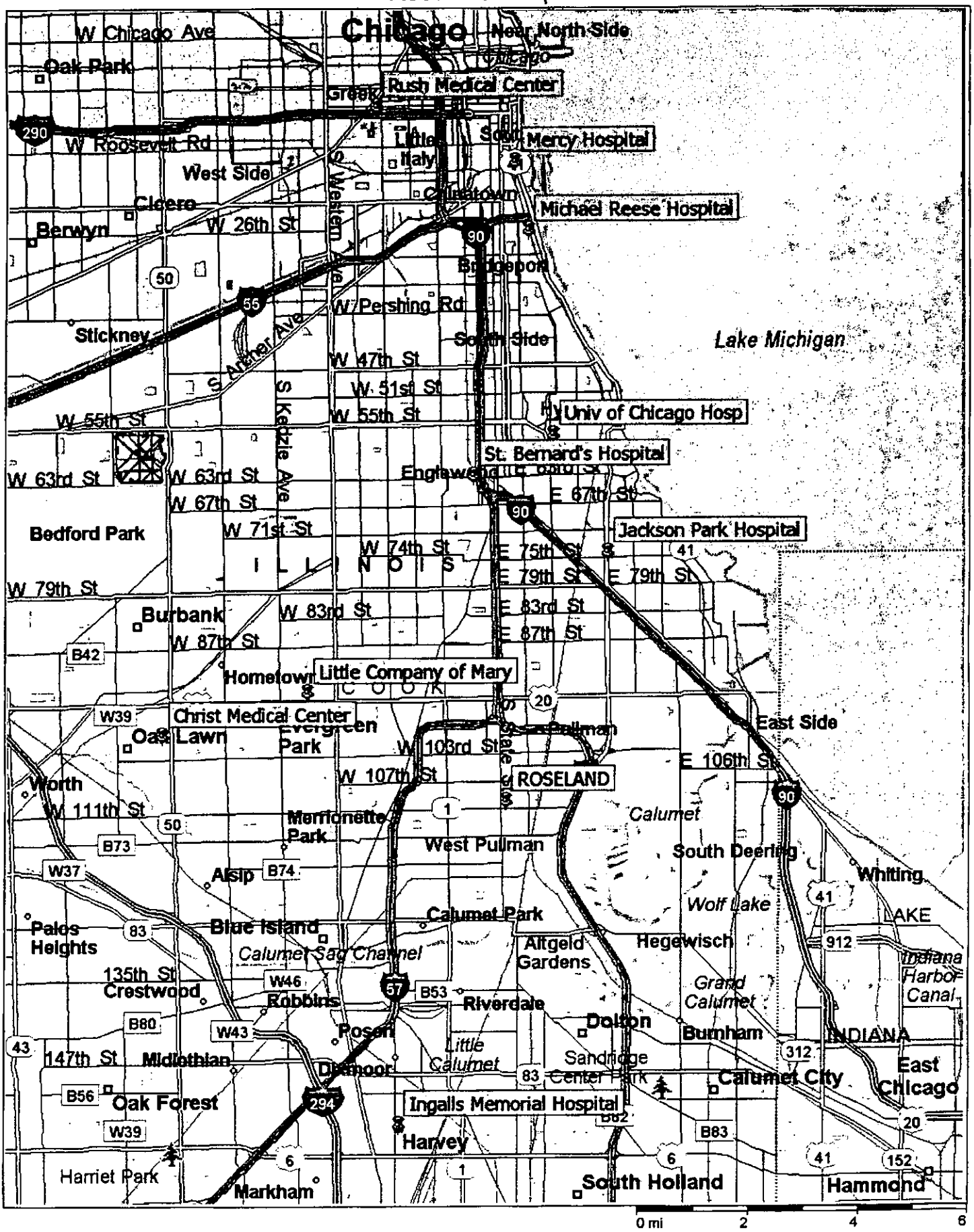
ROSELAND COMMUNITY HOSPITAL
45 W. 111TH STREET, CHICAGO, IL

TRAVEL TIMES & DISTANCE
PLANNING AREA A-03

		TRAVEL TIME (in minutes)	DISTANCE (in miles)
1.	Jackson Park Hospital Foundation 7531 S. Stony Island Chicago, IL 60649	15	6.18
2.	Mercy Hospital & Medical Center 2525 S. Michigan Ave. Chicago, IL 60616	23.75	11.20
3.	St. Bernard Hospital 326 W. 64th Street Chicago, IL 60621	17.50	6.41
4.	Rush University Medical Center 1653 W. Congress Parkway Chicago, IL 60612	28.75	14.75
5.	Advocate Christ Medical Center 4440 W. 95th Street Oak Lawn, IL 60453	22	7.67
6.	Ingalls Memorial Hospital 1 Ingalls Drive Harvey, IL 60426	18	9.29
7.	Little Company of Mary Hospital 2800 W. 95th Street Evergreen Park, IL 60805	16	5.47

ATTACHMENT 11

Roseland Hospital



ATTACHMENT 11

COST BENEFIT ANALYSIS

If Roseland Community Hospital does nothing, the cost to the community will be of significant, if not quantifiable magnitude. The large number of patients who need this service will remain untreated in the inpatient setting which physicians and comm.-munity providers state they need and they will remain a burden on their families and to themselves.

Revenues from installing this service at the hospital will cover its costs and provide a profit to the applicant allowing the hospital to continue to enhance and upgrade its service to the community.

As you will see from the financial spreadsheet which we have included in this application, this new service will provide the additional wherewithal to continue to move Roseland from an endangered hospital in a community desperately needing service to become, once again, the community hospital its history demonstrates.

ATTACHMENT 12

SIZE OF PROJECT

The project consists of 30 beds in 10,973 GSF, or 365.77 GSF per bed. The State standard is 588 GSF per acute mental illness bed. Therefore, the project is 222.23 GSF smaller than the State standard.

While the space is for child and adolescents who need in-patient behavioral treatment, Roseland is a General Acute care Hospital which already has private treatment space available in proximity to the unit, so additional space within the service will note be necessary.

ATTACHMENT 13

ROSELAND COMMUNITY HOSPITAL
BEHAVIORAL HEALTH UNIT - ADOLESCENTS
FINANCIAL MODEL

Volume:	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Year 1	Year 2	Year 3
Admissions	15	30	45	42	50	49	49	49	58	60	60	54	561	720	744
Length of Stay	13.0	13.0	13.0	13.0	13.0	13.0	13.0	13.0	13.0	13.0	13.0	13.0	13.0	13.0	13.0
Total Patient Days	195	390	585	548	650	637	637	637	754	780	780	702	7,293	9,360	9,672
Medical Assistance Days	185	371	556	519	618	605	605	605	716	741	741	667	6,928	8,892	9,188
Other Patient Days	10	20	29	27	33	32	32	32	38	39	39	35	365	468	484
ADC	7	13	20	18	22	21	21	21	25	26	26	23	20	26	26
Reimbursement rates:															
Medical Assistance	$550	$550	$550	$550	$550	$550	$550	$550	$550	$550	$550	$550	$550	$550	$550
Other	$575	$575	$575	$575	$575	$575	$575	$575	$575	$575	$575	$575	$575	$575	$575
Revenue:															
Medical Assistance	$101,888	$203,775	$305,663	$285,285	$339,625	$332,833	$332,833	$332,833	$393,985	$407,550	$407,550	$366,795	$3,810,593	$4,890,600	$5,053,620
Other	$5,606	$11,213	$16,819	$15,698	$18,688	$18,314	$18,314	$18,314	$21,678	$22,425	$22,425	$20,183	$209,674	$269,100	$278,070
Total Projected Revenue	$107,494	$214,988	$322,481	$300,983	$358,313	$351,146	$351,146	$351,146	$415,643	$429,975	$429,975	$386,978	$4,020,266	$5,159,700	$5,331,690
Staffing (FTE's):															
Medical Director	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0		1.0	1.0
Psychiatrist	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0		1.0	1.0
Program Director	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0		1.0	1.0
Nurse Manager	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0		1.0	1.0
Unit Clerk	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0		3.0	3.0
Registered Nurse	4.9	9.8	14.6	13.7	16.3	15.9	15.9	15.9	18.9	19.5	19.5	17.6		19.2	19.9
Licensed Practical Nurse	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		2.0	2.0
Social Worker	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0		3.0	3.0
Total Staffing	10.9	15.8	20.6	19.7	22.3	21.9	21.9	21.9	24.9	25.5	25.5	23.6		31.2	31.9
Hourly Wage:															
Medical Director	$96.15	$96.15	$96.15	$96.15	$96.15	$96.15	$96.15	$96.15	$96.15	$96.15	$96.15	$96.15		$96.15	$96.15
Psychiatrist	$84.13	$84.13	$84.13	$84.13	$84.13	$84.13	$84.13	$84.13	$84.13	$84.13	$84.13	$84.13		$84.13	$84.13
Program Director	$36.06	$36.06	$36.06	$36.06	$36.06	$36.06	$36.06	$36.06	$36.06	$36.06	$36.06	$36.06		$36.06	$36.06
Nurse Manager	$33.65	$33.65	$33.65	$33.65	$33.65	$33.65	$33.65	$33.65	$33.65	$33.65	$33.65	$33.65		$33.65	$33.65
Unit Clerk	$12.02	$12.02	$12.02	$12.02	$12.02	$12.02	$12.02	$12.02	$12.02	$12.02	$12.02	$12.02		$12.02	$12.02
Registered Nurse	$24.04	$24.04	$24.04	$24.04	$24.04	$24.04	$24.04	$24.04	$24.04	$24.04	$24.04	$24.04		$24.04	$24.04
Licensed Practical Nurse	$14.42	$14.42	$14.42	$14.42	$14.42	$14.42	$14.42	$14.42	$14.42	$14.42	$14.42	$14.42		$14.42	$14.42
Social Worker	$24.04	$24.04	$24.04	$24.04	$24.04	$24.04	$24.04	$24.04	$24.04	$24.04	$24.04	$24.04		$24.04	$24.04
Total Staffing															
Labor Expenses:															
Medical Director	$16,667	$16,667	$16,667	$16,667	$16,667	$16,667	$16,667	$16,667	$16,667	$16,667	$16,667	$16,667	$200,000	$200,000	$200,000
Psychiatrist	$14,583	$14,583	$14,583	$14,583	$14,583	$14,583	$14,583	$14,583	$14,583	$14,583	$14,583	$14,583	$175,000	$175,000	$175,000
Program Director	$6,250	$6,250	$6,250	$6,250	$6,250	$6,250	$6,250	$6,250	$6,250	$6,250	$6,250	$6,250	$75,000	$75,000	$75,000
Nurse Manager	$5,833	$5,833	$5,833	$5,833	$5,833	$5,833	$5,833	$5,833	$5,833	$5,833	$5,833	$5,833	$70,000	$70,000	$70,000
Unit Clerk	$2,083	$2,083	$2,083	$2,083	$2,083	$2,083	$2,083	$2,083	$2,083	$2,083	$2,083	$2,083	$25,000	$75,000	$75,000
Registered Nurse	$20,313	$40,625	$60,938	$56,875	$67,708	$66,354	$66,354	$66,354	$78,542	$81,250	$81,250	$73,125	$759,688	$961,644	$993,699
Licensed Practical Nurse	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$60,000	$60,000
Social Worker	$4,167	$4,167	$4,167	$4,167	$4,167	$4,167	$4,167	$4,167	$4,167	$4,167	$4,167	$4,167	$50,000	$150,000	$150,000
Total Staffing	$69,896	$90,208	$110,521	$108,458	$117,292	$115,938	$115,938	$115,938	$128,125	$130,833	$130,833	$122,708	$1,354,688	$1,766,644	$1,798,699
Fringe Benefits	$13,979	$18,042	$22,104	$21,292	$23,458	$23,188	$23,188	$23,188	$25,625	$26,167	$26,167	$24,542	$270,938	$353,329	$359,740
Purchased Service - Mgt. Fee	$25,000	$25,000	$25,000	$25,000	$25,000	$25,000	$25,000	$25,000	$25,000	$25,000	$25,000	$25,000	$300,000	$300,000	$300,000
Food	$975	$1,950	$2,925	$2,730	$3,250	$3,185	$3,185	$3,185	$3,770	$3,900	$3,900	$3,510	$36,465	$46,800	$48,380
Pharmaceuticals	$5,850	$8,700	$17,550	$16,380	$19,500	$19,110	$19,110	$19,110	$22,620	$23,400	$23,400	$21,060	$215,790	$280,800	$290,160
Utilities	$2,500	$2,500	$2,500	$2,500	$2,500	$2,500	$2,500	$2,500	$2,500	$2,500	$2,500	$2,500	$30,000	$30,000	$30,000
Office Supplies	$390	$780	$1,170	$1,092	$1,300	$1,274	$1,274	$1,274	$1,508	$1,560	$1,560	$1,404	$14,586	$16,720	$19,344
Medical Supplies	$1,950	$3,900	$5,850	$5,460	$6,500	$6,370	$6,370	$6,370	$7,540	$7,800	$7,800	$7,020	$72,930	$93,600	$96,720
Linen	$975	$1,950	$2,925	$2,730	$3,250	$3,185	$3,185	$3,185	$3,770	$3,900	$3,900	$3,510	$36,465	$46,800	$48,360
Depreciation	$11,333	$11,333	$11,333	$11,333	$11,333	$11,333	$11,333	$11,333	$11,333	$11,333	$11,333	$11,333	$135,996	$135,996	$135,996
Interest Expense	$15,583	$15,357	$15,129	$14,901	$14,672	$14,442	$14,210	$13,977	$13,744	$13,509	$13,273	$13,037	$171,834	$137,571	$101,371
Total Operating Expenses	$148,431	$179,720	$217,007	$209,876	$228,055	$225,524	$225,292	$225,059	$245,535	$249,902	$249,666	$235,624	$2,639,691	$3,210,260	$3,228,749
Net Operating Margin	-$40,937	$35,268	$105,474	$91,107	$130,258	$125,622	$125,854	$126,087	$170,108	$180,073	$180,309	$151,354	$1,380,575	$1,949,440	$2,102,941

35

ATTACHMENT 14

PROJECTED PATIENT DAYS

Projected patient days for the first two years after the additional beds open are:

Year 1: 7,293 *
Year 2: 9,360 *

The projections for the first year are based on the referral volume contained both in the referral letters and the service agreements.

- See: Roseland Community Hospital Financial Model

ATTACHMENT 14

EMERGENCY ROOM BY ZIP CODE

ATTACHMENT 19

EMERGENCY ROOM BY ZIP CODE

08 10:3 2:48 (ZIPCODERPT) PAGE 1

PATIENT NUMBER	PATIENT ZIP CODE
60628	1
60619	1
60628	1
60827	2
G0827	1
0	1
2806	1
6031978	1
6478	1
15205	1
19144	1
20469	1
21133	1
22026	1
23608	1
27909	1
30060-168	1
30274	1
30311	1
32507	1
33127	1
33612	1
353713	1
35802	1

37217	1
38128	1
38463	1
38663	1
38748	1
39069	1
39209	1
39648	1
43232	1
43620	1
44306	1
45840	1
46226	1
46234	1
46236	1
46304	1
46307	1
46311	4
46312	1
46319	20
46320	9
46321	9
463213	1
46323	1
46324	2
46325	7

46327	1
46341	5
46360	1
46368	1
46375	4
46383	1
46394	1
46402	6
46403	2
46404	8
46406	6
46407	2
46408	5
46409	4
46410	2
46421	6
46516	1
46544	1
46601	2
46628	2
47274	1
47904	1
47905	1
47909	1
47948	1
48075	2

48146	1
48228	1
48238	1
48607	1
48911	1
48912	1
48933	1
49043	1
49424	1
49501	1
49507	1
50010	1
50314	1
50316	1
50317	1
52001	1
52240	4
52248	1
52601	2
53081	2
53105	1
53140	1
53206	1
53208	1
53210	1
53212	1

53215	1
53218	1
53224	2
53400	1
53403	1
53511	1
53548	1
53704	1
53713	1
53719	7
54303	1
54603	1
55075	2
55102	1
55104	1
55106	2
55109	4
55117	2
55119	2
55125	1
55343	1
55404	2
55405	2
55407	2
55409	1
55413	2

55425	1
55428	1
55429	1
55430	1
55434	1
55746	1
55811	1
55947	1
56303	2
59847	2
60	1
60000	2
60004	1
60015	3
60056	3
60064	1
60067	2
60074	1
60085	2
60087	4
6009	1
60090	1
60099	1
60101	2
60102	2
60104	1

60107	2
60108	4
60110	1
60120	7
60123	1
60131	1
60133	1
60139	2
60148	3
60152	1
60153	1
60162	6
60163	1
601832	1
60193	1
60194	1
60201	2
60203	3
60280	1
60302	2
60304	1
60317	4
60333	1
60402	2
60405	2
60406	1

60407	42
60409	2
60410	167
60411	1
60412	61
60413	2
60415	1
60417	9
60418	3
60419	1
60421	157
60422	2
60423	6
60425	1
60426	10
60427	164
60428	4
60429	28
60430	27
60432	9
60434	4
60435	1
60436	2
60438	3
60440	33
60441	6

60442	2
60443	2
60445	16
6.04E+08	5
60446	1
60449	2
60450	1
60451	1
60452	1
60453	2
60454	6
60455	2
60456	1
60457	2
60458	1
60459	2
60461	1
60462	2
60465	7
60466	1
60467	21
60469	2
60470	5
60471	2
60472	14
60473	12

60475	46
60477	4
60478	10
60481	31
60501	1
60502	3
60505	1
60506	5
60508	7
60516	1
60517	1
60527	1
60528	2
605433	1
60551	1
60559	1
60585	1
606	2
60601	6
60602	4
60603	2
60604	3
60605	5
60607	4
60608	8
60609	11

60610	73
60612	10
60613	38
60614	5
606147	7
60615	1
60616	59
60617	34
60618	336
60619	11
6062	486
60620	1
60621	696
60622	226
60623	17
606237	42
60624	1
60625	50
606258	9
60626	1
60627	11
60628	101
60628-401.	14,671
60628-423	3
60628-622	1
60628CJ	1

6.06E+09	1
60629	1
6063	86
60630	1
60632	1
60633	11
60634	35
60636	2
60637	207
60638	194
60639	18
60640	10
60641	26
60642	4
60643	4
60643-501	1,713
60644	1
60645	47
60647	1
60648	14
60649	6
60651	201
60652	26
60653	50
60654	83
60655	2

60657	10
60658	8
60659	1
60660	3
60660615	12
60661	1
606628	2
60673	1
606827	1
60692	4
60699	1
60727	1
60728	1
60801	1
60803	1
60804	11
60805	4
6082	12
60824	1
60826	1
60827	1
60828	1,218
60843	3
608827	1
60901	1
60914	4

60915	1
60964	4
61032	1
61100	1
61102	1
61104	2
61108	1
61110	1
61201	1
61354	1
61701	1
61761	2
61777	2
61802	1
61821	1
61832	1
61866	9
61999	4
62025	1
62201	2
62522	1
62526	1
62702	1
62703	2
62828	2
62864	1

	62901	1
	62948	3
	66283	1
	68107	1
	68278	2
	85023	1
	85051	1
	85208	1
	89032	1
	89119	1
	90037	2
	90805	1
	94619	1
	94801	1
	99336	1
		1
FINAL		22,361

END OF REPORT ***

INPATIENT BY ZIP CODE

INPATIENT BY ZIP CODE

7:16 (ZIPCODERPT) PAGE 1

PATIENT ZIP CODE	
60426	1
60628	1
3291929	1
18360	1
30135	1
30804	1
33612	1
37900	1
39661	1
46312	3
46320	5
46350	1
46360	1
46394	1
46402	3
46403	2
46404	4
46407	2
46615	1
48601	1
49014	1
52057	1
52405	1
52655	1
52806	1

53209	1
53215	1
55104	1
55107	1
55411	1
60064	2
60085	2
60087	1
60104	16
60120	1
60130	1
60133	2
60148	8
60153	9
60201	1
60287	1
60406	16
60409	58
60411	12
60417	3
60419	42
60425	4
60426	47
60428	14
60429	8
60430	1

60438	10
60439	2
60440	2
60443	4
60457	6
60458	3
60459	1
60461	2
60466	6
60471	1
60472	6
60473	10
60475	2
60478	7
60504	1
60505	2
60506	2
60601	3
60603	2
60605	16
60607	6
60608	5
60609	32
60610	8
60612	20
60613	3

60614	11
60615	34
60616	52
60617	112
60619	201
60620	209
60621	93
60622	6
60623	29
60624	29
606258	1
60626	27
60627	10
60628	3,009
60628-423	2
60629	30
60630	5
60632	24
60633	17
60634	4
60636	82
60637	140
60638	11
60639	17
60640	32
60641	11

60643	393
60644	70
60645	5
60646	1
60647	9
60648	3
60649	100
60651	85
60652	18
60653	110
6065328	1
60655	3
60657	3
60659	6
60660	4
606827	1
60692	3
60803	1
60804	4
60805	1
60827	274
60828	1
60901	3
60915	4
60953	5
61081	1

OUTPATIENT BY ZIP CODE

46394	1
46403	1
46404	1
46406	4
46410	7
46516	1
60016	3
60026	1
60068	1
60077	1
60085	2
60107	1
60108	4
60110	1
60115	2
60123	1
60133	1
60153	1
60154	3
60172	3
60193	1
60208	1
60301	1
60302	1
60304	3
60308	4

60328	1
60333	1
60401	4
60403	2
60406	166
60409	204
60411	70
60412	1
60413	1
60415	34
60417	17
60418	2
60419	147
60421	1
60422	6
60423	9
60425	38
60426	140
60428	43
60429	36
60430	23
60435	2
60436	1
60438	42
60439	1
60440	1

60441	11
60442	8
60443	19
60445	62
60446	1
60448	5
60449	1
60451	3
60452	36
60453	211
60455	30
60456	11
60457	18
60458	17
60459	56
60461	4
60462	29
60463	16
60465	26
60466	41
60467	11
60469	21
60471	24
60472	28
60473	79
60475	3

60477	39
60478	38
60480	6
60482	18
60487	5
60490	1
60491	2
60493	1
60504	1
60505	1
60513	1
60517	1
60525	7
60527	4
60543	1
60546	1
60559	4
60586	7
606	1
60601	3
606028	2
60604	2
60605	1
60607	1
60608	10
60609	26

60611	1
60612	5
60613	3
60615	30
60616	26
60617	258
60618	1
60619	298
6061928	1
60620	459
6.06E+08	1
60621	122
60622	2
606228	2
60623	8
60624	8
606258	2
60626	3
60627	33
60628	5,284
60628-423	1
60629	134
60630	3
60632	43
60633	64
60635	1

60636	142
60637	101
60638	42
60639	3
60640	3
60641	2
606411	1
60642	1
60643	1,020
6.06E+08	1
606436	1
60644	12
60645	3
60646	2
60647	5
60648	1
60649	139
6.06E+08	1
60651	13
60652	120
60653	54
60655	192
60656	1
60657	1
60658	8
60660	3

60690	1
60692	5
60728	1
60802	10
60803	210
60804	3
60805	103
60825	1
60827	870
60828	1
608287	1
60901	1
60909	1
60940	2
61008	1
61102	2
6126	1
61777	1
61832	2
62864	1
72301	1
90827	1
	11,929

ACUTE MENTAL ILLNESS- REFERRAL VOLUME

As you will notice from the support letters, referral letters, and service agreements, there is universal sentiment that an acute mental illness unit at Roseland Hospital serving children and adolescents is sorely needed on the South Side of Chicago. The potential volumes because of that need are staggering! The following will detail the referrals that Roseland can expect from hospitals, physicians, service agencies and the Department of Children and Family Services. (Also it should be noted, where gross numbers were noted for referrals, we have taken no more than half the total number who are designated to be south side referrals.) There are three large community agencies who have sent in signed agreements for coordinated care for AMI child and adolescent patients, of which Ada S. McKinley Community Services is the largest. Again, we have attempted to be conservative in our interpretation of these numbers. They are listed below.

Projected Annual Referrals Roseland Community Hospital

Ada S. McKinley Community Services – 956

St. Anthony Hospital – 5

The Alliance on Mental Illness of Greater Chicago – 13

Community Mental Health Council – 240

Illinois Department of Children and Family Services – 40

EmCare – 30

Mercy Hospital – 36

Metropolitan Family Services – 240

Mount Sinai Hospital – 24

Provident Hospital – 36

Dr. Sanette C. Varnodomus 10

University of Illinois Hospital at Chicago – 10

Total Referrals - 1940

ACUTE MENTAL ILLNESS- REEERRAL VOLUME

As you will notice from the support letters, referral letters, and service agreements, there is universal sentiment that an acute mental illness unit at Roseland Hospital serving children and adolescents is sorely needed on the South Side of Chicago. The potential volumes because of that need are staggering! The following will detail the referrals that Roseland can expect from hospitals, physicians, service agencies and the Department of Children and Family Services. (Also it should be noted, where gross numbers were noted for referrals, we have taken no more than half the total number who are designated to be south side referrals.) There are three large community agencies who have sent in signed agreements for coordinated care for AMI child and adolescent patients, of which Ada S. McKinley Community Services is the largest. Again, we have attempted to be conservative in our interpretation of these numbers. They are listed below.

Projected Annual Referrals Roseland Community Hospital

Ada S. McKinley Community Services – 956

St. Anthony Hospital – 5

The Alliance on Mental Illness of Greater Chicago – 13

Community Mental Health Council – 240

Illinois Department of Children and Family Services – 40

EmCare – 30

Mercy Hospital – 36

Metropolitan Family Services – 240

Mount Sinai Hospital – 24

Provident Hospital – 36

Dr. Sanette C. Varnodomus 10

University of Illinois Hospital at Chicago – 10

Total Referrals - 1940

ATTACHMENT 20

Provident Hospital of Cook County
500 East 51st Street, Chicago, Illinois 60615
312.572.2000 * TDD 312.572.1738

Todd H. Stroger
President
Board of Cook County Commissioners

Sidney A. Thomas
Chief Operating Officer

Cook County Bureau of Health Services

April 22, 2008

Mr. Ian McFadden
President/CEO
Roseland Community Hospital
45 West 111th Street
Chicago, IL 60628

Dear Mr. McFadden:

I have personal knowledge of the shortage of pediatric psychiatric beds on the Far South Side. This is a densely populated area and has one of the highest incidences for psychiatric emergencies for youth in the State of Illinois. DCFS data suggests that many of these patients are referred to hospital programs in other services areas at some distance away as a result of this shortage. This poses great challenges to these vulnerable youth to obtain and to complete treatment and, of course, to their families.

Last year, our agency referred many pediatric patients to inpatient psychiatric units in Chicago area hospitals. If Roseland Community Hospital had operated a unit to the kind it is proposing to develop during this past year, our agency likely would have possibly referred pediatric psychiatric patients.

Our agency is grateful to Roseland Community Hospital for recognizing and stepping forward to meet the obvious need for this new inpatient pediatric psychiatric unit. Please let me know if we can provide any other assistance in this process.

Sincerely,

Pierre E. Wakim, DO
Chairman
Department of Emergency Medicine

ATTACHMENT 20

UNIVERSITY OF ILLINOIS AT CHICAGO

Department of Psychiatry (MC 747)
1747 West Roosevelt Road
Chicago, Illinois 60608

August 30, 2007

Ian McFadden
President and CEO
Roseland Community Hospital
45 W. 111th Street
Chicago, IL 60628

Dear Mr. McFadden,

I am a child psychiatrist and I have worked with youth with mental health needs within Chicago's metropolitan area for many years. I am writing to offer my support for your plan to open a child and adolescent program at Roseland Community Hospital. There is lack of quality mental health services for youth and their families in the Roseland community. A large gap in services in this community is the absence of an inpatient psychiatric program for children and adolescents. Currently, the families must travel far outside their communities to find services. This has created a barrier for the youth and families that I treat.

There is a great need for an inpatient child and adolescent psychiatric program on Chicago's far south side. Many inpatient psychiatric programs have closed or downsized in the recent past. The need for community based programs for patients of color is critical, if the disparity of services along racial lines is to be addressed. This community is in dire need of more inpatient psychiatric beds and specialized services for youth. I would be very happy to refer my patients in need of acute care to your new program.

Karen Taylor-Crawford, MD, DABPN
Director of Disruptive Behaviors Clinic (DBC) School-Age Program, Board Certified Child Psychiatrist

Assistant Professor of Clinical Psychiatry
University of Illinois at Chicago
Institute for Juvenile Research (MC 747)
Department of Psychiatry
Colbeth Child Psychiatry Clinic
1747 West Roosevelt Road, Room 155
Chicago, IL 60608-1264

St. James HOSPITAL and Health Centers

CHICAGO HEIGHTS
1423 Chicago Road, Chicago Heights, Illinois 60411-3483
708/756-1000

OLYMPIA FIELDS
20201 S. Crawford Avenue, Olympia Fields, Illinois 60461-1010
708/747-4000

May 2, 2008

Mr. Ian McFadden
President and Chief Executive Officer
Roseland Community Hospital
45 West 111th Street
Chicago, Illinois 60628

Dear Mr. McFadden:

It is my understanding that Roseland Community Hospital is planning to develop an inpatient pediatric/adolescent psychiatric unit at its facility on Chicago's far south side. This is a much needed project that has the enthusiastic support of St. James Hospital and Health Centers in Chicago Heights and Olympia Fields. Child and adolescent psych is an underserved service and Roseland Community Hospital's initiative in addressing the need is commendable.

As President of St. James, I can attest to the shortage of pediatric/adolescent psychiatric beds on the south side. There is a large population of these patients in our areas that present in hospital emergency departments. Many of these hospitals, such as St. James, are not properly equipped to provide the level of specialized service necessary to assist them. It is my hope that Roseland Community's proposed inpatient pediatric psychiatric unit can fill this significant void.

St. James is grateful to Roseland Community Hospital for being proactive in addressing this obvious need and wholeheartedly supports your application for a Certificate of Need. Please do not hesitate to contact us if we can provide any other assistance with this process.

Sincerely,

Seth C. R. Warren
President

On this 2nd day of May, 2008, before me personally appeared Seth Warren and signed the foregoing instrument in the above stated capacity as his/her free act and deed.

"OFFICIAL SEAL"
RITAMARIE LEONARD
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 12/16/2010

Ritamarie Leonard, Notary Public

My Commission Expires: 12-16-2010

Saint Anthony HOSPITAL
Dedicación, nuestro compromiso

2875 West 19th Street | 773.484.1000
Chicago, Illinois 60623 | www.saintanthonyhospital.org

May 1, 2008

Ian McFadden
President/Chief Executive Officer
Roseland Community Hospital
45 West 111th Street
Chicago, Illinois 60628

Dear Mr. McFadden:

Thank you for sharing Roseland Community Hospital's plan to develop an inpatient pediatric psychiatric unit at its facilities on Chicago's far south side. This project has the enthusiastic support of Saint Anthony Hospital and will help fill a long-standing gap in these kinds of services.

As Chief Operating Officer of Saint Anthony Hospital, I have personal knowledge of the shortage of pediatric psychiatric beds. This is a densely populated area and has one of the highest incidences for psychiatric emergencies for youth in the State of Illinois. Saint Anthony Hospital's data suggests that many of these patients are referred to hospital programs in other service areas at some distance away as a result of this shortage. This poses great challenges to these vulnerable youth to obtain and to complete treatment and, of course, to their families.

Last year, our hospital referred approximately five pediatric patients to inpatient psychiatric units in Chicago area hospitals. In addition, we think it is very likely that area Screening, Assessment and Support Services (SASS) agencies would refer to this new unit and welcome this additional resource because it is difficult to find resources on the city's far south side

Our hospital is grateful to Roseland Community Hospital for recognizing and stepping forward to meet the obvious need for this new inpatient pediatric psychiatric unit. Saint Anthony Hospital fully supports the Hospital's application for a Certificate of Need. Please let us know if we can provide any other assistance in this process.

Sincerely,

Gwenn Rausch

Gwenn Rausch
Chief Operating Officer

On this 2nd day of May, 2008 before me personally appeared Gwenn Rausch and signed the foregoing instrument in the above stated capacity as his/her free act and deed.

Jewerystine Sampson, Notary Public

My Commission Expires: 5/17/2010

"OFFICIAL SEAL"
Jewerystine Sampson
Notary Public, State of Illinois
My Commission Expires 05/17/2010

Promoting healthy families.
Building stronger communities.

30TH Anniversary Campaign for
Chicago Family Health Center

May 1, 2008

Mr. Ian McFadden
President/CEO
Roseland Community Hospital
45 West 111th Street
Chicago, IL 60628

Dear Mr. McFadden:

Chicago Family Health Center is pleased to support Roseland Community Hospital's plan to develop an inpatient pediatric psychiatric unit at its facilities on Chicago's Far South Side. This project will help fill a long-standing gap in these kinds of services.

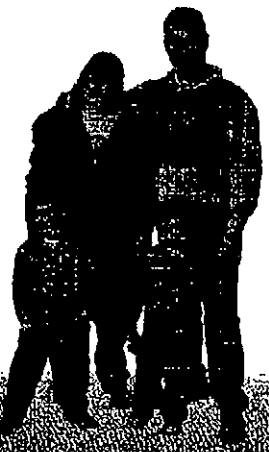
At Chicago Family Health Center, we are aware of the shortage of pediatric psychiatric beds on the Far South Side. This is a densely populated area and has one of the highest incidences for psychiatric emergencies for youth in the State of Illinois. Data suggests that many of these patients are referred to hospital programs in other service areas at some distance away as a result of this shortage. This poses great challenges to these vulnerable youth to obtain and to complete treatment and, of course, to their families.

Last year, our organization referred our pediatric patients to inpatient psychiatric units in Chicago area hospitals. Our referrals reside on the City's Far South Side, and are referred to Michael Reese Hospital for treatment. If Roseland Community Hospital had operated a unit to the kind it is proposing to develop during this past year, our organization likely would have referred this pediatric patient to your hospital. In addition, we think it is very likely that other area Screening, Assessment and Support Services (SASS) agencies would refer to this new unit and welcome this additional resource.

Our organization is grateful to Roseland Community Hospital for recognizing and stepping forward to meet the obvious need for this new inpatient pediatric psychiatric unit. Chicago Family fully supports the Hospital's application for a Certificate of Need. Please let us know if we can provide any other assistance in this process.

Sincerely,

Wendy Cox-Largent
Chief Executive Officer



9312 South Exchange Avenue, Chicago, Illinois 60617-4321 — T 773-768-5900 — F 773-768-6153 — www.chicagofamilyhealth.org

Provident Hospital of Cook County
500 East 51st Street
Chicago, Illinois 60615

April 23, 2008

Mr. Ian McFadden
President/CEO
Roseland Community Hospital
45 West 111th Street
Chicago, Il 60628

Dear Mr. McFadden:

Thank you for sharing Roseland Community Hospital's plan to develop an inpatient pediatric psychiatric unit at its facilities on Chicago's South Side. This project has the enthusiastic support of the Department of Pediatrics at Provident Hospital of Cook County.

The Department of Pediatrics has personal knowledge of the shortage of pediatric psychiatric beds on the South Side. This is a densely populated area and has one of the highest incidences for psychiatric emergencies for youth in the State of Illinois. Data suggests that many of these patients are referred to hospital programs in other service areas at some distance away, as a result of this shortage. This poses great challenges to these vulnerable youth and their families, and hinders completion of treatment.

Last year, our institution referred pediatric patients to inpatient psychiatric units in Chicago area hospitals. Of these pediatric patients residing on the City's South Side, the bulk of these patients were referred to Michael Reese, University of Illinois, and Little Company of Mary Hospital. If Roseland were to operate an inpatient pediatric psychiatric unit, we will refer patients as appropriate. In addition, we think it is very likely that area Screening, Assessment and Support Services (SASS) agencies would refer to this new unit and welcome this additional resource.

Our department is grateful to Roseland Community Hospital for recognizing and stepping forward to meet for this need for an inpatient pediatric psychiatric unit. I fully support the Hospital's application for a Certificate of Need.

Sincerely,

Gayle Kates

Gayle Kates, MD, Chairperson
Department of Pediatrics

Traci E. Powell, M.D. & Associates
Women's Mental Health Specialists

9415 S. Western Ave., Ste. 201A
Chicago, IL 60620
Telephone: (773) 779-9700
Fax: (773) 779-9732
www.forawoman.medem.com

May 1, 2008

Mr. Ian McFadden
President/CEO
Roseland Community Hospital
45 West 111th Street
Chicago, IL 60628

Dear Mr. McFadden,

Thank you for sharing Roseland Community Hospital's plan to develop an inpatient pediatric psychiatric unit at its facilities in Chicago. There has been a long standing need for such services and I am excited at this prospect.

As a practicing psychiatrist, I have personal knowledge of the shortage of pediatric psychiatric beds on the Far South Side. This is a densely populated area and has one of the highest incidences for psychiatric emergencies for youth in the State of Illinois. DCFS data suggests that many of these patients are referred to hospital programs in other service areas at some distance away as a result of this shortage. This poses great challenges to these vulnerable youth to obtain and to complete treatment and, of course, to their families.

Our office is grateful to Roseland Community Hospital for recognizing and stepping forward to meet the obvious need for this new inpatient pediatric psychiatric unit. DCFS fully supports the Hospital's application for a Certificate of Need. Please let us know if we can provide any other assistance in this process.

Sincerely,

Traci Powell, MD
Board Certified Psychiatrist

Ramesh Doshi, MD
Board Certified Psychiatric Medicine
13011 South 104th Ave, Palos Park, IL 60464
(708) 448-3300

May 1, 2008

Mr. Ian McFadden
President/CEO
Roseland Community Hospital
45 West 111th Street
Chicago, IL 60628

Dear Mr. McFadden:

Thank you for sharing Roseland Community Hospital's plan to develop an inpatient pediatric psychiatric unit at its facilities on Chicago's Far South Side. This project has the enthusiastic support of DCFS and will help fill a long-standing gap in these kinds of services.

I have personal knowledge of the shortage of pediatric psychiatric beds on the Far South Side. This is a densely populated area and has one of the highest incidences for psychiatric emergencies for youth in the State of Illinois. DCFS data suggests that many of these patients are referred to hospital programs in other service areas at some distance away as a result of this shortage. This poses great challenges to these vulnerable youth to obtain and to complete treatment and, of course, to their families.

While I do not have a large adolescent population in my practice, I do come across some and know of agencies which do deal with adolescent populations. With careful marketing attempts they can be easily persuaded to send their patients to Roseland. If Roseland Community Hospital had operated a unit to the kind it is proposing to develop during this past year, there is little doubt the unit would be operating at full capacity base on the referrals it would receive. In addition, we think it is very likely that area Screening, Assessment and Support Services (SASS) agencies would refer to this new unit and welcome this additional resource.

As member of the Roseland Hospital Medical Staff in the department of psychiatry, I am grateful to the Hospital for recognizing and stepping forward to meet the obvious need for this new inpatient pediatric psychiatric unit. I fully support the Hospital's application for a Certificate of Need. Please let us know if we can provide any other assistance in this process.

Sincerely,

Ramesh Dosi, M.D.

JACKSON PARK HOSPITAL AND MEDICAL CENTER
'TO SERVE AND TO GROW' 7531 STONY ISLAND AVENUE CHICAGO, ILLINOIS 60649 (773) 947-7800

May 5, 2008

Re: Pediatric Psychiatric Unit

Dear Mr. McFadden,

Thank you for sharing Roseland Community Hospital Plan to develop an Inpatient Pediatric Psychiatric Unit at its' facility on Chicago's far south side. This is a project that is long overdue for this area.

As a psychiatrist I have personal knowledge of the shortage of pediatric psychiatric beds on the far south side. This is a densely populated area which has one of the highest incidences for psychiatric emergencies involving youth in the State of Illinois. I obtained this knowledge first hand after working in the emergency room at Jackson Park Hospital, along with experiencing the challenge of locating inpatient psychiatric services for this population.

I am happy to support the plan for Roseland Community Hospital and grateful that they are recognizing and stepping forward to meet this obvious need. I fully support the hospital's application for a Certificate of Need. Please let me know if I can be of any further assistance in this process.

Sincerely,

Joyce R. Miller MD

Joyce R. Miller, M.D.

JRM/fh

Provident Hospital of Cook County
600 East 51st Street
Chicago, Illinois 60615

April 24, 2008

Mr. Ian McFadden
President and CEO
Roseland Community Hospital
45 West 111th Street
Chicago, Illinois 60628

Dear Mr. McFadden:

Thank you for sharing Roseland Community Hospital's plan to develop an inpatient pediatric psychiatric unit at its facilities on Chicago's far South Side. This project has the enthusiastic support of DCFS and will help fill a long-standing gap in these kinds of services.

As chair in the Department of Family and Community Medicine at Provident Hospital of Cook County, I have personal knowledge of the shortage of pediatric psychiatric beds on the Far South Side. This is a densely populated area and has one of the highest incidences for psychiatric emergencies for youth in the State of Illinois. DCFS data suggests that many of these patients are referred to hospital programs in other service areas at some distance away as a result of this shortage. This poses great challenges to these vulnerable youth to obtain and to complete treatment and, of course, to their families.

Last year our agency had difficulty finding inpatient psychiatric units for referrals into Chicago area hospitals. If Roseland Community Hospital had operated a unit to the kind it is proposing to develop during this past year, our agency would likely refer pediatric patients to your hospital to keep them near their families. In addition, we think it is very likely that area Screening, Assessment and Support Services (SASS) agencies would refer to this new unit and welcome this additional resource.

Our agency is grateful to Roseland Community Hospital for recognizing and stepping forward to meet the obvious need for this new inpatient pediatric psychiatric unit. I am happy to hear that DCFS fully supports the hospital's application for a Certificate of Need. Please let us know if we can provide any other assistance in this process.

Sincerely,

Crystal Cash, MD, Chair,
Department of Family and Community Medicine

On this ____ day of _____, 2008 before me personally appeared _____ and signed the foregoing instrument in the above stated capacity as his/her free act and deed.

My Commission Expires: _____, Notary Public

MERCY
MERCY HOSPITAL & MEDICAL CENTER
2525 SOUTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60616-2477
phone 312.567-2000

May 29, 2008

Mr. Ian McFadden
President/CEO
Roseland Community Hospital
45 West 111th Street
Chicago, IL 60628

Dear Mr. McFadden:

Thank you for sharing Roseland Community Hospital's plan to develop an inpatient pediatric psychiatric unit at its facilities on Chicago's Far South Side.

The Far South Side is a densely populated area and has a high incidence of psychiatric emergencies for youth in the State of Illinois. Data suggests that many of these patients are referred to hospital programs in other service areas at some distance away as a result of this shortage. This poses great challenges to these vulnerable youth to obtain and to complete treatment and, of course, to their families. With the pending closure of Michael Reese Hospital this need becomes even more acute. Mercy Hospital and Medical Center estimates three patient referrals a month to the proposed pediatric psychiatric unit.

Mercy Hospital and Medical Center supports Roseland Community Hospital for recognizing and stepping forward to meet the obvious need for this new inpatient pediatric psychiatric unit. Mercy Hospital and Medical Center fully supports the Hospital's application for a Certificate of Need. Please let us know if we can provide any other assistance in this process.

Sincerely,

Sister Sheila Lyne, RSM
President and Chief Executive Officer

SSL/ss

NORWEGIAN AMERICAN HOSPITAL
"...Committed to your health"

May 13, 2008

Ian E. McFadden, FACHE
President and Chief Executive Officer
Roseland Community Hospital
45 West 111th Street
Chicago, IL 60628

Dear Mr. McFadden,

Norwegian American Hospital posses no objection to the Roseland Community Hospital plans to open a 30 bed adolescent psychiatric unit and would encourage the Health Facilities Planning Board to approve a CON application for the same.

Sincerely,

Michael J. O'Grady, Jr.
President

/sd

EmCare
Emergency Medicine. Customer Driven.

May 2, 2008

Mr. Ian McFadden
President/CEO
Roseland Community Hospital
45 West 111th Street
Chicago, IL 60628

Dear Mr. McFadden:

Thank you for sharing Roseland Community Hospital's plan to develop an inpatient pediatric psychiatric unit at its facilities on Chicago's Far South Side. This project has the enthusiastic support of EmCare, Inc. and will help fill a long-standing gap in these kinds of services.

As Chief Executive Officer of EmCare, Inc. I have personal knowledge of the shortage of pediatric psychiatric beds on the Far South Side. This is a densely populated area and has one of the highest incidences for psychiatric emergencies for youth in the State of Illinois. EmCare, Inc. data suggests that many of these patients are referred to hospital programs in other service areas at some distance away as a result of this shortage. This poses great challenges to these vulnerable youth to obtain and to complete treatment and, of course, to their families.

Last year, our agency referred approximately 30 pediatric patients to inpatient psychiatric units in Chicago area hospitals. Of these pediatric patients residing on the City's Far South Side, the bulk of these patients were referred to other Non South Side Hospitals due to the absence on the in-patient beds. If Roseland Community Hospital had operated a unit to the kind it is proposing to develop during this past year, our agency likely would have referred approximately 30 of these pediatric patients to your hospital. In addition, we think it is very likely that area Screening, Assessment and Support Services (SASS) agencies would refer to this new unit and welcome this additional resource.

Our agency is grateful to Roseland Community Hospital for recognizing and stepping forward to meet the obvious need for this new inpatient pediatric psychiatric unit. EmCare, Inc. fully supports the Hospital's application for a Certificate of Need. Please let us know if we can provide any other assistance in this process.

Sincerely,

Douglas Webster DO

Name: Douglas Webster, D.O.
Title: Regional Chief Executive Officer

CC: Candace Mikulecky, COO Attorney in Fact

533 West North Avenue
Suite 102
Elmhurst, IL 60126

630-941-4330
800-732-1066
630-941-4333 FAX

SINAI

Sinai Health System California Avenue at 15th Street • Chicago, IL 60608 • (773)542-2000 • TTY (773)257-6289

Alan H. Channing
President/Chief Executive Officer
Office: 773-257-6434 — Fax: 773-257-6953
Email: chaalan@sinai.org

April 28, 2008

Mr. Ian McFadden
President/CEO
Roseland Community Hospital
45 West 111th Street
Chicago, IL 60628

Dear Mr. McFadden:

Thank you for sharing Roseland Community Hospital's plan to develop an inpatient pediatric psychiatric unit at its facilities on Chicago's Far South Side. Mount Sinai Hospital and the Sinai Health System recognize the tremendous need of child and adolescent behavioral health services.

As a significant inpatient provider of behavioral health services and a provider of ambulatory child and adolescent services Sinai Health System recognizes the critical need for these services throughout the Chicago area.

If such a unit were open at Roseland Community Hospital Sinai Health System would refer all appropriate patients. In addition, we think it is very likely that area Screening, Assessment and Support Services (SASS) agencies would refer to this new unit and welcome this additional resource.

Sinai Health System is grateful to Roseland Community Hospital for recognizing and stepping forward to meet the obvious need for this new inpatient pediatric psychiatric unit and fully supports the Hospital's application for a Certificate of Need. Please let us know if we can provide any other assistance in this process.

Sincerely,

Alan H. Channing

Rod R. Blagojevich
Governor

Erwin McEwen
Director

DCFS

Illinois Department of Children & Family Services

Mr. Ian McFadden
President/CEO
Roseland Community Hospital
45 West 111th Street
Chicago, IL 60628

Dear Mr. McFadden:

Thank you for sharing Roseland Community Hospital's plan to develop an inpatient pediatric psychiatric unit at its facilities on Chicago's Far South Side. This project has the enthusiastic support of DCFS and will help fill a long-standing gap in these kinds of services.

As the Assistant Director of DCFS, I have personal knowledge of the shortage of pediatric psychiatric beds on the Far South Side. This is a densely populated area and has one of the highest incidences for psychiatric emergencies for youth in the State of Illinois. DCFS data suggests that many of these patients are referred to hospital programs in other service areas at some distance away as a result of this shortage. This poses great challenges to these vulnerable youth to obtain and to complete treatment and, of course, to their families.

Last year, our agency referred approximately 197 pediatric patients to inpatient psychiatric units a total of 200 times in Chicago area hospitals. Of these pediatric patients residing on the City's Far South Side, the bulk of these patients were referred to Chicago Lakeshore Hospital, Children's Memorial Hospital, Hartgrove Hospital, Riveredge, Rush-Presbyterian-St.Luke's Hospital, Streamwood St. Elizabeth's, Streamwood St. Mary's and UIC-CARTS. Of the wards managed by Cook South, the majority of them were hospitalized at Hargrove and Riveredge, which are not on the south side of the city. If Roseland Community Hospital had operated a unit of the kind it is proposing to develop during this past year, our agency likely would have referred approximately 20% of these pediatric patients to your hospital. In addition, we think it is very likely that area Screening, Assessment and Support Services (SASS) agencies would refer to this new unit and welcome this additional resource.

Our agency is grateful to Roseland Community Hospital for recognizing and stepping forward to meet the obvious need for this new inpatient pediatric psychiatric unit. DCFS fully supports the Hospital's application for a Certificate of Need. Please let us know if we can provide any other assistance in this process.

Sincerely,

Velma Williams
Assistant Director

100 West Randolph, 6-200 • Chicago, Illinois 60601-3249
312-814-4650 • 312-814-8783 / TTY

March 1, 2008

Mr. Ian McFadden
President/CEO
Roseland Community Hospital
45 West 111th Street
Chicago, Illinois 60628

Dear Mr. McFadden:

I write to express my enthusiastic support for the Hospital's plan to develop a separate thirty (30) bed child and adolescent psychiatry unit. I believe this project deserves to be approved by the Illinois Health Facilities Planning Board and offer my support of the Hospital's application for a Certificate of Need.

As a pediatrician in your area, I am well aware of the need for additional mental health services and beds for children and adolescents. Over the past twelve (12) months, I have referred approximately 10 patients for these kinds of services, specifically to the following facility: Christ Hospital's Adolescent Unit. If this project comes to fruition, I would expect to refer approximately 10 patients to the new RCH child and adolescent psychiatric unit annually.

This would add a valuable and needed service to the Roseland community which I believe would be well utilized in its first year. Thank you for considering my thoughts on this important project.

Sincerely,

Suzanne R. Varnado MD

On this 3rd day of March, 2008 before me personally appeared Suzanne Varnado and signed the above and foregoing instrument as his/her free act and deed.

Notary Public

"OFFICIAL SEAL"
Renee L. Reed
Notary Public, State of Illinois
My Commission Exp. 06/19/2008

My Commission Expires: 6/19/2008

community MENTAL HEALTH council INC.

9704 SOUTH CONSTANCE AVENUE ♦ CHICAGO, ILLINOIS 60617 ♦ (773) 734-4033 ♦ FAX: (773) 734-6447 OR 5994
TTY: (773) 734-2440 ♦ WEBSITE: thecouncil-online.org
TOLL-FREE CRISIS (877) 311-3222

6239 SOUTH WESTERN AVENUE ♦ CHICAGO, ILLINOIS 60636 ♦ (773) 863-9749 ♦ FAX: (773) 863-9782
8541 SOUTH STATE STREET ♦ CHICAGO, ILLINOIS 60619 ♦ (773) 651-4954 ♦ FAX: (773) 651-5418
49 EAST 95th STREET ♦ CHICAGO, ILLINOIS 60619 ♦ (312) 745-3493 ♦ FAX: (312) 745-3519

"Restoring Hope and Health Through Wellness"

June 27, 2008

Mr. Ian McFadden
President and CEO
Roseland Community Hospital
45 East 111th Street
Chicago, Illinois 60628

Regarding: Inpatient Adolescent Psychiatric Unit

Dear Mr. McFadden:

The Community Mental Health Council, Inc. (CMHC) is in support of Roseland Community Hospital's efforts to open an inpatient Adolescent Psychiatric Unit.

We have been in collaborative partnerships with Roseland for many years and know that this is a much needed service to be provided to the community. As with other ventures Roseland has undertaken, we at CMHC know that this will be successful.

Sincerely,

Carl C. Bell, M.D.
President and CEO

CCB/apr

Enclosures

Cc: Juanita L. Redd, M.P.A., M.B.A.
Hayward Suggs, M.S., M.B.A.
Verbie Jones
LaWanda Aldridge

"SAVING LIVES..."

Sykes
2555 S. King Drive - LL
Chicago, Illinois 60616
Telephone 312.808.7205

Advocate Health Centers

Mr. Ian McFadden
President/CEO
Roseland Community Hospital
45 West 111th Street
Chicago, IL 60628

Dear Mr. McFadden:

Thank you for sharing Roseland Community Hospital's plan to develop an inpatient pediatric psychiatric unit at its facilities on Chicago's Far South Side. This project has the enthusiastic support of Advocate Health Centers (AHC) and will help fill a long-standing gap in these kinds of services.

As Vice President of Medical Management of AHC, I have personal knowledge of the shortage of pediatric psychiatric beds on the Far South Side. This is a densely populated area and has one of the highest incidences for psychiatric emergencies for youth in the State of Illinois. DCFS data suggests that many of these patients are referred to hospital programs in other service areas at some distance away as a result of this shortage. This poses great challenges to these vulnerable youth to obtain and to complete treatment and, of course, to their families.

As a provider of pediatric care, we are always in need of pediatric psychiatric referrals. In addition, we think it is very likely that area Screening, Assessment and Support Services (SASS) agencies would refer to this new unit and welcome this additional resource.

AHC is grateful to Roseland Community Hospital for recognizing and stepping forward to meet the obvious need for this new inpatient pediatric psychiatric unit. Advocate Health Centers fully supports the Hospital's application for a Certificate of Need. Please let us know if we can provide any other assistance in this process.

Sincerely,

Dianna Grant, M.D.

Name: Dr. Dianna Grant
Title: Vice President of Medical Managment

ROSELAND COMMUNITY HOSPITAL
45 W. 111TH STREET, CHICAGO, IL

HOSPITALS WITHIN 30-MINUTE DRIVE TIME

TRAVEL TIMES & DISTANCE

		TRAVEL TIME (in minutes)	DISTANCE (in miles)
1.	Children's Memorial Hospital 2300 N. Children's Plaza Chicago, IL 60614	30	17.99
2.	Northwestern Memorial Hospital 251 E. Huron Chicago, IL 60611	27	16.35
3.	Jackson Park Hospital Foundation 7531 S. Stony Island Chicago, IL 60649	12	6.18
4.	Mercy Hospital & Medical Center 2525 S. Michigan Ave. Chicago, IL 60616	19	11.20
5.	St. Bernard Hospital 326 W. 64th Street Chicago, IL 60621	14	6.41
6.	Advocate Christ Medical Center 4440 W. 95th Street Oak Lawn, IL 60453	22	7.67
7.	Ingalls Memorial Hospital 1 Ingalls Drive Harvey, IL 60426	18	9.29
8.	Little Company of Mary Hospital 2800 W. 95th Street Evergreen Park, IL 60805	16	5.47
9.	Palos Community Hospital 12251 80th Avenue Palos Heights, IL 60463	28	12.50

	TRAVEL TIME (in minutes)	DISTANCE (in miles)
10. Loretto Hospital 645 S. Central Chicago, IL 60644	28	19.59
11. Mt. Sinai Hospital Medical Center 2750 W. 15th Street Chicago, IL 60608	27	16.52
12. Norwegian American Hospital 1044 N. Francisco Chicago, IL 60622	30	18.07
13. Rush University Medical Center 1653 W. Congress Parkway Chicago, IL 60612	23	14.75
14. St. Mary of Nazareth Hospital 2233 W. Division Chicago, IL 60622	27	16.64
15. St. Anthony Hospital 2875 W. 19th Street Chicago, IL 60623	27	15.62
16. St. Elizabeth's Hospital 1431 N. Claremont Chicago, IL 60622	28	17.37
17. UHS Hartgrove Hospital 520 N. Ridgeway Chicago, IL 60624	28	18.38
18. University of Illinois Medical Center at Chicago 1740 W. Taylor Street Chicago, IL 60612	24	15.16

POPULATION OF CITY OF CHICGO – U.S. CENSUS DATA

2,896,016 of which approximately 15% are between the ages of 10-19.

ATTACHMENT 23

H. Staffing Availability

Roseland Community Hospital has entered into a management agreement with Chicago Lakeshore Hospital to provide the necessary personnel to staff the unit, including a Medical Director, Psychiatrist, Program Director and Nurse Manager. Any additional staff will be recruited by our Human Resources Department as needed. The remaining positions of RN, LPN, Unit Clerk and Social Worker will be recruited as needed from the existing pool of hospital professionals.

ASSURANCES

To Whom It May Concern:

This statement is provided by Roseland Community Hospital per Section VII, K of the Application for Permit.

Roseland Community Hospital hereby attests to the fact that, by the second year of operation after project completion, the applicant will achieve and maintain the occupancy/utilization standards specified in 77 Ill. Adm. Code 1100 for the Acute Mental Illness category of services involved in this proposal.

Anthony Puorro, CEO
Roseland Community Hospital

Dated: 10/26/09

ATTACHMENT 26

PARK NATIONAL BANK

August 19, 2009

Mr. Ron Krol
Chief Financial Officer
Roseland Community Hospital
45 West 111th Street
Chicago, IL 60628

Dear Ron:

Thank you for the opportunity to provide a financing proposal to Roseland Community Hospital for a $2,750,000 construction loan for the hospital's new Adolescent Behavioral Health program.

To expedite the review of your loan request, please return the following items:

- Fiscal year end audited financial statements for 2008 and 2009
- Budget for the proposed improvements;
- Interim company prepared 6/30/08 YTD and 6/30/09 YTD financial statements;
- Projected funding from Critical Hospital Adjustment Payments (CHAP), Direct Hospital Adjustments (DHA) and Safety Net Access Payment (SNAP) for 2009 & 2010.

In addition to the projection you already have provided us, please provide us with the specifics of the collateral you are considering pledging for the loan. We will discuss a proposed structure and the terms of your loan request after we have an opportunity to review the requested information.

We appreciate the relationship that we have shared over many years and the opportunity to assist the hospital well with its plans. If we can be of any other assistance please do not hesitate to call me.

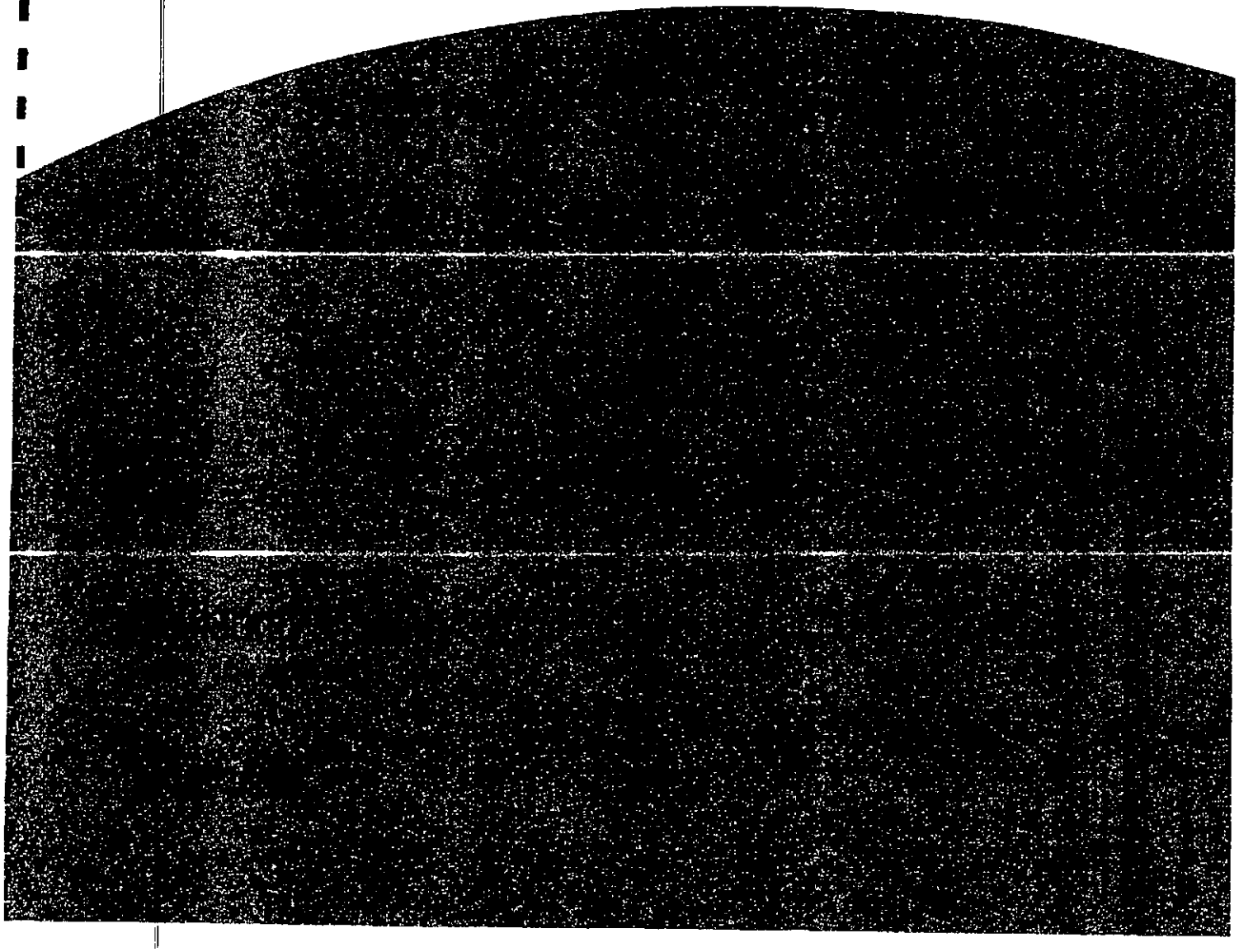
Best Regards,

Kenneth T. Robinson
Vice President
Commercial Banking

ATTACHMENT 75

Roseland Community Hospital

Financial Report
March 31, 2007



Contents

McGladrey & Pullen
Certified Public Accountants

INDEPENDENT AUDITOR'S REPORT ON THE FINANCIAL STATEMENTS

To the Board of Directors
Roseland Community Hospital Association
Chicago, Illinois

We have audited the accompanying balance sheets of Roseland Community Hospital Association as of March 31, 2007 and 2006, and the related statements of operations and changes in net assets (deficit) and cash flows for the years then ended. These financial statements are the responsibility of the Hospital's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Roseland Community Hospital Association as of March 31, 2007 and 2006, and the results of its operations and changes in net assets (deficit) and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

The 2007 financial statements have been prepared assuming that Roseland Community Hospital Association will continue as a going concern. As discussed in Note 2 to the financial statements, Roseland Community Hospital generated significant losses from operations in recent years, has a significant net working capital deficiency, and has a deficit net assets position. This raises substantial doubt about Roseland Community Hospital Association's ability to continue as a going concern. Management's plans in regard to these matters are described in Note 2. The financial statements do not include any adjustments that might result from the outcome of this uncertainty.

McGladrey & Pullen, LLP

Rockford, Illinois
January 24, 2008

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

BALANCE SHEETS
March 31, 2007 and 2006

ASSETS	2007	2006
Current Assets		
Cash	$ 492,872	$ 399,053
Assets limited as to use - current portion	1,000,384	544
Patient accounts receivable, net of allowances for uncollectible accounts of approximately $22,608,000 in 2007 and $14,902,000 in 2006	5,338,743	4,866,327
Due from third-party payors	191,200	67,207
Medicaid assessment revenue receivable	5,384,164	5,384,164
Pledges and other receivables	238,340	165,519
Inventories	156,744	162,546
Prepaid expenses	64,911	93,295
Total current assets	12,867,358	11,138,655
Assets Limited as to Use, net of current portion:		
Under malpractice funding agreement - held by trustee	234	15,417
By Board of Directors for capital improvements	2,955,398	54,265
	2,955,632	69,682
Cash restricted by Grantor for property and equipment	672,417	-
Investments	48,342	76,165
Property and equipment, net	7,055,181	7,317,164
Other long-term assets	94,609	206,327
	$ 23,693,539	$ 18,807,993

See Notes to Financial Statements.

LIABILITIES AND NET ASSETS (DEFICIT)	2007	2006
Current Liabilities		
Line of credit	$ 1,154,506	$ 2,790,000
Current installments of obligations under capital leases	221,493	203,065
Accounts payable	7,402,939	6,467,732
Due to third-party payors	7,824,315	5,789,456
Medicaid assessment tax payable	1,093,881	1,093,881
Accrued interest	363	544
Accrued expenses and other	2,256,189	1,864,306
Total current liabilities	19,953,686	18,208,984
Commitments and Contingencies (Notes 3, 7, 9, 10, 11, and 15)		
Obligations Under Capital Leases, net of current installments	171,632	393,125
Professional Liability	5,940,986	5,248,096
Total liabilities	26,066,304	23,850,205
Net Assets (Deficit)		
Unrestricted (deficit):		
Board designated	3,955,782	54,809
Undesignated	(9,006,967)	(6,702,912)
	(5,051,185)	(6,648,103)
Temporarily restricted	2,678,420	1,605,891
Total net assets (deficit)	(2,372,765)	(5,042,212)
	$ 23,693,539	$ 18,807,993

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS (DEFICIT)
Years Ended March 31, 2007 and 2006

	2007	2006
Revenues:		
Net patient service revenue	$ 48,262,376	$ 38,464,142
Medicaid hospital assessment revenue	7,178,885	6,479,794
Other operating revenue	713,401	866,534
Net assets released from restrictions, used for operations	11,159	198,705
	56,165,821	46,009,175
Expenses:		
Salaries and wages	17,871,937	17,903,469
Employee benefits	3,482,396	3,076,563
Physician compensation	2,296,748	2,877,760
Medicaid hospital assessment tax	1,458,508	1,520,709
Food	316,555	361,705
Utilities	787,253	715,485
Repairs and maintenance	393,103	649,081
Insurance	1,431,998	1,554,021
Supplies and other	11,217,212	12,614,637
Interest	376,432	254,137
Depreciation and amortization	654,646	707,415
Provision for uncollectible accounts	15,062,133	10,123,249
	55,348,921	52,358,231
Operating income (loss)	816,900	(6,349,056)
Nonoperating income:		
Investment income	2,533	20,783
Gain on sale of property and equipment	116,212	-
Other, net	661,273	447,691
	780,018	468,474
Excess (deficiency) of revenues over expenses	$ 1,596,918	$ (5,880,582)

(Continued)

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS (DEFICIT) (Continued)
Years Ended March 31, 2007 and 2006

	2007	2006
Unrestricted Net Assets (Deficit)		
Excess (deficiency) of revenues over expenses	$ 1,596,918	$ (5,880,582)
Contributions for property and equipment	-	246,219
Increase (decrease) in unrestricted net assets (deficit)	1,596,918	(5,634,363)
Change in Temporarily Restricted Net Assets (Deficit)		
Contributions and grant	1,083,688	-
Net assets released from restrictions	(11,159)	(198,705)
Increase (decrease) in temporarily restricted net assets (deficit)	1,072,529	(198,705)
Increase (decrease) in net assets (deficit)	2,669,447	(5,833,068)
Net assets (deficit), beginning of the year	(5,042,212)	790,856
Net assets (deficit), end of the year	$ (2,372,765)	$ (5,042,212)

See Notes to Financial Statements.

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

STATEMENTS OF CASH FLOWS
Years Ended March 31, 2007 and 2006

	2007	2006
Cash Flows from Operating Activities		
Increase (decrease) in net assets (deficit)	$ 2,669,447	$ (5,833,068)
Adjustments to reconcile increase (decrease) in net assets (deficit) to net cash provided by (used in) operating activities:		
Depreciation and amortization	654,646	707,415
Provision for uncollectible accounts	15,062,133	10,123,249
Gain on sale of property and equipment	(116,212)	-
Contributions for property and equipment	(1,083,688)	(246,219)
Increase (decrease) from changes in:		
Patient accounts receivable	(15,534,549)	(9,237,065)
Due from/to third-party payors	1,910,866	5,385,778
Medicaid assessment receivable and payable	-	(4,290,283)
Pledges and other receivables	(72,821)	231,585
Inventories	5,802	(20,473)
Prepaid expenses	28,384	210,736
Other long-term assets	111,718	(61,110)
Accounts payable	935,207	1,129,990
Accrued interest	(181)	(59,215)
Accrued expenses and other	391,883	120,103
Professional liability	692,890	481,096
Net cash provided by (used in) operating activities	5,655,525	(1,357,481)
Cash Flows from Investing Activities		
Purchases of assets limited as to use and investments	(11,518,782)	(2,957,434)
Proceeds from assets limited as to use and investments	7,660,815	4,700,849
Contributions received for property and equipment	1,083,688	246,219
Increase in cash restricted by Grantor for property and equipment	(672,417)	-
Proceeds from sale of long-term asset	316,138	-
Purchase of property and equipment, net	(592,589)	(917,625)
Net cash provided by (used in) investing activities	(3,723,147)	1,072,009
Cash Flows from Financing Activities		
Net proceeds from (payments on) line of credit	(1,635,494)	1,307,500
Repayment of long-term debt	-	(1,470,000)
Repayment of capital lease obligations	(203,065)	(204,889)
Net cash (used in) financing activities	(1,838,559)	(367,389)
Net increase (decrease) in cash	93,819	(652,861)
Cash, beginning of year	399,053	1,051,914
Cash, end of year	$ 492,872	$ 399,053

(continued)

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

STATEMENTS OF CASH FLOWS (Continued)
Years Ended March 31, 2007 and 2006

	2007	2006
Supplemental Disclosures of Cash Flow Information		
Cash paid for interest	$ 376,613	$ 313,352
Supplemental Schedule of Noncash Investing and Financing Activities		
Purchase of equipment in accounts payable	-	180,643

See Notes to Financial Statements.

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

Notes to Financial Statements

Note 1. Nature of Organization and Summary of Significant Accounting Policies

Nature of organization: Roseland Community Hospital Association (Hospital), a not-for-profit corporation, operates a short-term general acute care community hospital and various clinics. The Hospital provides general health care services to residents within its geographic service area, including inpatient, outpatient, emergency room, physician, and other services.

A summary of significant accounting policies follows:

Use of estimates: The preparation of financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates. The use of estimates and assumptions in the preparation of the accompanying financial statements is primarily related to the determination of the patient receivables and settlements with third-party payors and the accrual for professional liability. Due to uncertainties inherent in the estimation and assumption process, it is at least reasonably possible that changes in these estimates and assumptions in the near term would be material to the financial statements.

Cash: Throughout the year, the Hospital may have amounts on deposit with financial institutions in excess of those insured by the FDIC. Management does not believe this presents a significant risk to the Hospital.

Patient accounts receivable, provision for uncollectible accounts and due from/to third-party payors: The collection of receivables from third-party payors and patients is the Hospital's primary source of cash for operations and is critical to its operating performance. The primary collection risks relate to uninsured patient accounts and patient accounts for which the primary insurance payor has paid, but patient responsibility amounts (deductibles and co-payments) remain outstanding. Patient receivables, where a third-party payor is responsible for paying the amount, are carried at a net amount determined by the original charge for the service provided, less an estimate made for contractual adjustments or discounts provided to third-party payors.

Patient receivables due directly from the patients are carried at the original charge for the service provided less amounts covered by third-party payors and less an estimated allowance for doubtful receivables. Management estimates this allowance based on the aging of its accounts receivable and its historical collection experience for each payor type. Recoveries of receivables previously written off are recorded as a reduction of bad debt expense when received.

The past-due status of receivables is determined on a case-by-case basis depending on the payor responsible. Interest is generally not charged on past-due accounts.

Receivables or payables related to estimated settlements on various payor contracts, primarily Medicare, are reported as amounts due from or to third-party payors. Significant changes in payor mix, business office operations, economic conditions or trends in federal and state governmental health care coverage could affect the Hospital's collection of accounts receivable, cash flows and results of operations.

Inventories: Inventories of supplies are stated at the lower of cost (first-in, first-out) or market.

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

Notes to Financial Statements

Note 1. Nature of Organization and Summary of Significant Accounting Policies (Continued)

Investments and assets limited as to use: Assets limited as to use consist primarily of investment securities. Investments in money market accounts are measured at fair value which approximates cost. Investments in equity securities with readily determinable fair values and debt securities are carried at fair value. The fair values are estimated based on quoted market prices for those or similar investments. The change in net unrealized gains and losses in the value of investments is recognized as a change in net assets. Assets limited as to use include assets set aside by the Board of Directors (Board) for capital improvements and other purposes, over which the Board retains control and may at its discretion subsequently use for other purposes; assets held by a trustee to be used in accordance with requirements of a bond indenture agreement; assets held by a trustee to be used in accordance with the requirements of a line-of-credit agreement; and assets held by a trustee to be used in accordance with the requirements of a self-insurance trust agreement. Assets limited as to use that are required for obligations classified as current liabilities are reported in current assets. Assets limited as to use are classified as noncurrent assets to the extent they are not expected to be expended to satisfy obligations classified as current liabilities.

Investments are regularly evaluated for impairment. The Hospital considers factors affecting the investee, factors affecting the industry the investee operates within, and general debt and equity market trends. The Hospital considers the length of time an investment's fair value has been below carrying value, the near-term prospects for recovery to carrying value, and the intent and ability to hold the investment until maturity or market recovery is realized. If and when a determination is made that a decline in fair value below the cost basis is other than temporary, the related investment is written down to its estimated fair value and included in excess of revenues over expenses as a component of investment income.

Property and equipment: Property and equipment are stated at cost. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed on the straight-line method. Leased equipment under capital leases is amortized over the shorter of the lease term or estimated useful life. The estimated useful lives of depreciable property and equipment range from 5 to 25 years for land improvements, 10 to 40 years for buildings, and 3 to 20 years for furniture and fixtures. Amortization expense on assets acquired under capital leases is included with depreciation expense on owned assets. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

Gifts of long-lived assets, such as land, buildings, or equipment, are reported as unrestricted support and are included in the income or loss from operations unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

Other long-term assets: Included in this balance is a certificate of deposit which has been pledged in support of a loan for the benefit of Hospital Laundry Services, LLC, a shared laundry service company that provides services to the Hospital. The balance of the certificate of deposit for the years ended March 31, 2007 and 2006 was approximately $64,000 and $61,000, respectively.

Professional liability: The provision for professional liability includes estimates of the ultimate costs for known claims as well as claims incurred but not reported. The provision is actuarially determined.

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

Notes to Financial Statements

Note 1. Nature of Organization and Summary of Significant Accounting Policies (Continued)

Net patient service revenue: Agreements with third-party payors provide for payments to the Hospital at amounts different from its established rates. Payment arrangements include prospectively determined rates-per-discharge, discounted charges, or cost reimbursement methodologies. Net patient service revenues are reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods, as final settlements are determined.

Excess (deficiency) of revenues over expenses: The statements of operations and changes in net assets include excess (deficiency) of revenues over expenses which represents results of operations. Changes in unrestricted net assets, which are excluded from the results of operations, consistent with industry practice, include unrealized gains and losses on investments and contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purpose of acquiring such assets).

Operating income (loss): The statements of operations and changes in net assets include operating income (loss). Changes in unrestricted net assets, which are excluded from operating income (loss), include investment income, gains and losses from sales of long-term assets, and other revenue, net, which management views as outside of normal activity.

Charity care: The Hospital provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than established rates. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue.

Basis of presentation: The Hospital may classify its net assets into three categories, which are unrestricted, temporarily restricted, and permanently restricted.

Unrestricted net assets are reflective of revenues and expenses associated with the principal operating activities of the Hospital and are not subject to donor-imposed stipulations.

Temporarily restricted net assets are those whose use by the Hospital has been limited by donors to a specific time period or purpose.

Permanently restricted net assets have been restricted by donors to be maintained in perpetuity.

Donor-restricted gifts: Unconditional promises to give cash and other assets to the Hospital are reported at fair value at the date the promise is received. Conditional promises to give and indication of intentions to give are reported at fair value at the date the gift is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the statements of changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions in the accompanying financial statements.

Tax-exempt status: The Hospital is a not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code (IRC) and is exempt from Federal income taxes on related income pursuant to Section 501(a) of the Code.

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

Notes to Financial Statements

Note 2. Continuing Operations

The accompanying financial statements have been prepared on the basis of a going concern, which contemplates the realization of assets and discharge of liabilities in the ordinary course of business. The Hospital experienced significant losses from operations in recent years and has also experienced difficulty in generating sufficient cash flow to meet its obligations and sustain its operations during that time.

The Hospital engaged a consulting firm and began a process to reduce expenses, restructure operations and recruit new management team members. The effects of these changes began during the year and continue subsequently.

The Hospital's ability to sustain its operations is dependent upon its ability to (a) generate cash flow to meet its obligations on a timely basis, (b) obtain additional financing (as may be required), and (c) ultimately attain profitability. Management believes they will be able to sustain future operations through actions completed and planned, including but not limited to the following:

Governance and Management:

- In July 2007, the Hospital hired a permanent CFO, Anthony J. Puorro, FHFMA, FACHE, who brings a wealth of knowledge to the Hospital. Mr. Puorro is one of few healthcare professionals that have dual Fellowship status in both the American College of Healthcare Executives and Healthcare Financial Management Association. Mr. Puorro has extensive experience with turn-around hospital operations.
- Management continues to modify operations with an improved emphasis of quality registration. The Hospital has recently increased efforts regarding Medical Assistance applications for patients being treated at the Hospital.

Operational:

- The Hospital has received net funding of $5,720,000 from the Provider Tax pertaining to the State Fiscal Year 2007. These funds will provide the Hospital with the ability to continue modification of operations and additional funding for capital projects. (See also Note 3.)
- The Hospital is planning several capital projects including the construction of a new Emergency Room, several exterior renovations, the leasing of space in a new medical office building and the creation of an inpatient Behavioral Health Unit. The Hospital has evaluated the impact of these projects and believes they will have a positive impact on the Hospital's bottom line.

Management believes that these and other actions will favorably affect operating results; however, there can be no assurances that these actions will be sufficient to ensure the Hospital's long-term future.

The Hospital's existence is substantially dependent on its ability to consistently improve operations, generate positive cash flows and increase its working capital. Because the long-term funding of the State of Illinois Medicaid program, including the Medicaid Hospital Assessment Program, and the outcome of management's efforts to consistently achieve accreditation, profitable operations, positive cash flows and increased working capital cannot be determined, no adjustments to the accompanying financial statements relating to this uncertainty have been made.

Note 3. Net Patient Service Revenue and Subsequent Event

The Hospital has agreements with third-party payors which provide for reimbursement to the Hospital at amounts different from its established rates. Contractual adjustments under third-party reimbursement programs represent the difference between the Hospital's billings at list price and the amounts reimbursed by Medicare, Medicaid, Blue Cross, and certain other third-party payors; and any differences between estimated third-party reimbursement settlements for prior years and subsequent final settlements. Contractual adjustments under third-party reimbursement programs are accrued on an estimated basis in the period the related services are rendered and are adjusted in future periods as final settlements are determined. A summary of the basis of reimbursement with major third-party payors follows:

Medicare: The Hospital is paid for inpatient acute care and outpatient care services rendered to Medicare program beneficiaries under prospectively determined rates per discharge (Prospective Payment Systems). These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Inpatient non-acute services and defined capital and medical education costs related to Medicare beneficiaries are paid based upon a cost reimbursement method, established fee screens, or a combination thereof. The Hospital's classification of patients under Prospective Payment Systems and the appropriateness of the patient's admissions are subject to validation reviews. The Hospital is reimbursed for cost reimbursable items at tentative rates with final settlement determined after submission of annual reimbursement reports by the Hospital and audits by the Medicare fiscal intermediary.

Fiscal year 2008 will represent the first of a three-year phase-in period for implementation of revised Medicare Diagnosis Related Group (DRG) reimbursement system. This new payment methodology makes meaningful refinements to the current CMS classification system to increase recognition of severity of illness. However, there will be a limited impact on payments in specific DRGs because of the simultaneous implementation of incremental reforms for cost-based and severity-based payments. Management has not determined the reimbursement impact of this change in reimbursement for the Hospital.

Medicaid: The Hospital is reimbursed at prospectively determined rates for each Medicaid inpatient discharge. Outpatient services are reimbursed based on established fee screens. For inpatient acute care services, payment rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. The prospectively determined rates are not subject to retroactive adjustment. The Hospital also receives incremental Medicaid reimbursement for specific programs and services at the discretion of the State of Illinois Medicaid Program. Medicaid reimbursement may be subject to periodic adjustment, as well as to changes in existing payment levels and rates, based on the amount of funding available to the Medicaid program.

Subsequent to March 31, 2007 the Hospital received a letter from the Office of Inspector General (OIG) related to an integrity audit covering the period of May 1, 2004 through April 30, 2006. Because of the significant number of records requested that were not produced during the audit, the OIG identified overpayments of approximately $1,786,000 and issued a warning to the Hospital. If subsequent audits show no material decrease in the number of missing records, further sanctions including, but not limited to suspension or exclusion from the State of Illinois Medicaid Program are possible. The Hospital is in the process of appealing the findings of the audit and has included the liability in the due to third-party payor line in the balance sheet.

Blue Cross: The Hospital also participates as a provider of health care services under a reimbursement agreement with Blue Cross. The provisions of this agreement stipulate that services will be reimbursed at a tentative reimbursement rate and that final reimbursement for these services is determined after the submission of an annual cost report by the Hospital and a review by Blue Cross.

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

Notes to Financial Statements

Note 3. Net Patient Service Revenue and Subsequent Event (Continued)

Managed Care Organizations: The Hospital has also entered into reimbursement agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment under these agreements includes discounts from established charges and prospectively determined per diem rates.

A summary of gross and net patient service revenues for the years ended March 31, 2007 and 2006 follows:

	2007	2006
Gross patient service revenue	$ 134,223,248	$ 93,291,299
Physician service revenue	317,741	546,707
Less provision for contractual adjustments under third-party reimbursement programs, charity care, and other discounts and allowances	(86,278,613)	(55,373,864)
Net patient service revenue	$ 48,262,376	$ 38,464,142

Estimates for cost report settlements and contractual allowances can differ from actual reimbursements based on the results of subsequent reviews and cost report audits. Changes in third-party valuation allowances that relate to prior years are reported in revenue in excess of expenses in the consolidated statements of operations and changes in net assets. The impact of such items on revenue in excess of expenses was a decrease of approximately $971,000 and $1,268,000 for the years ended March 31, 2007 and 2006, respectively.

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The Hospital's management believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation, as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs.

During fiscal year 2007, the Medicaid Hospital Assessment Program (Program) was renewed for the period from August 2005 to June 30, 2008. Under the Program, the Hospital received additional Medicaid reimbursement from the State of Illinois (State) and paid a related assessment. Total reimbursement revenue recognized by the Hospital related to this Program amounted to $7,178,885 and $6,479,794 during the Hospital's years ended March 31, 2007 and 2006, respectively. Total assessments incurred by the Hospital related to this program amounted to $1,458,508 and $1,520,709 during the Hospital's years ended March 31, 2007 and 2006, respectively. Continuation of this program past June 2008 is uncertain at this time.

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

Notes to Financial Statements

Note 4. Concentrations of Credit Risk

The Hospital grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at March 31, 2007 and 2006 was as follows:

	2007	2006
Medicare	13 %	16 %
Medicaid	28	30
Managed care	14	10
Patients	42	40
Other	3	4
	100 %	100 %

Note 5. Assets Limited as to Use and Investments

The composition of assets limited as to use at March 31, 2007 and 2006 is as follows:

	2007	2006
Under bond indenture agreements - held by trustee, U.S. government obligations	$ 384	$ 544
Under line-of-credit agreement - held by trustee, Money market	1,000,000	-
Under malpractice funding agreement - held by trustee, U.S. government obligations	234	15,417
By Board for capital improvements:		
Money market	2,902,832	3,785
U.S. government obligations	52,566	50,480
Total assets limited or restricted as to use	3,956,016	70,226
Less current portion	1,000,384	544
	$ 2,955,632	$ 69,682

Investments consist of a money market account of $48,342 and $76,165 at March 31, 2007 and 2006, respectively.

Investment securities, in general, are exposed to various risks, such as interest rate, credit, and overall market volatility. Due to the level of risk associated with certain investment securities, it is reasonably possible that changes in the value of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the balance sheet.

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

Notes to Financial Statements

Note 6. Charity Care (Unaudited)

The Hospital maintains records to identify and monitor the level of charity care it provides. For the years ended March 31, 2007 and 2006, the Hospital provided approximately $3,646,000 and $3,951,000 of charity care, respectively, based on charges foregone for services rendered.

Note 7. Property and Equipment and Subsequent Event

A summary of property and equipment at March 31, 2007 and 2006 is as follows:

	2007	2006
Land	$ 380,477	$ 380,477
Land improvements	403,347	403,347
Buildings	5,980,389	6,328,127
Building improvements	5,050,423	5,054,454
Major movable and fixed equipment	10,757,585	10,671,553
Construction-in-progress	4,041,154	3,557,975
Equipment under capital lease	2,420,506	2,420,506
	29,033,881	28,816,439
Less accumulated depreciation and amortization, including amortization of equipment under capital lease of $2,093,143 in 2007 and $1,908,785 in 2006	21,978,700	21,499,275
	$ 7,055,181	$ 7,317,164

Construction-in-progress at March 31, 2007 and 2006 consisted primarily of costs incurred for various construction and renovation projects. The most significant project in process at March 31, 2007 is the expansion of the Hospital's emergency room from 4,500 square feet to 10,500 square feet. The emergency room project is currently on hold pending funding from future grants and other sources of funding. The estimated cost to complete the emergency room project is approximately $3,800,000 as of March 31, 2007.

Subsequent to March 31, 2007, the Hospital entered into a contract related to the emergency room project in the amount of approximately $1,556,000 and was also approved for a long-term low interest loan through the Illinois Health Facility Planning Board's Hospital Basic Services Preservation Act in the amount of $2,200,000. The rate will be determined upon execution of the note. The Hospital's original application was for $5,000,000; however, the application is under review for this additional amount. This loan is to be used for improvements to the Hospital's emergency room. At the date of this report, the client had not drawn any amounts under this loan.

Note 8. Note Payable, Pledged Assets and Subsequent Event

The Hospital has a revolving line-of-credit agreement with a bank which provides for total borrowings of up to $2,800,000. The line is collateralized by substantially all assets of the Hospital. The agreement expired June 30, 2007. Interest is paid monthly at the prime rate (8.25% at March 31, 2007) plus 1%. The outstanding balance on this line was $1,154,506 at March 31, 2007. Subsequent to March 31, 2007, the Hospital paid off the line-of-credit.

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

Notes to Financial Statements

Note 9. Lease Obligations

The Hospital has entered into capital lease obligations at varying rates of interest from 7% to 12%, which are collateralized by leased equipment.

Future minimum lease commitments under capital leases for equipment as of March 31, 2007 are as shown below:

Years Ending March 31,	
2008	$ 245,899
2009	129,251
2010	51,481
Total required minimum lease payments	426,631
Less amount representing interest	33,506
Net present value of minimum lease payments	393,125
Less current portion	221,493
Long-term portion	$ 171,632

The Hospital also leases equipment under operating leases. Minimum annual rental payments are as follows:

Year Ending March 31,	
2008	$ 80,605
2009	57,488
	$ 138,093

Rent expense for the years ended March 31, 2007 and 2006 was approximately $554,000 and $605,000, respectively.

Note 10. Pension Plan

The Hospital has a voluntary defined contribution pension plan (Plan) covering substantially all employees who work at least 1,000 hours annually, are over age 21, and have at least two years of service. Hospital contribution requirements under the terms of the Plan are computed at 2% of an eligible employee's first $20,000 of salary and 4% of salary earned thereafter. Eligible employees may elect to contribute 2% of their first $20,000 of salary and 4.7% of salary earned thereafter, thereby increasing the Hospital's contribution requirements to 3% and 6%, respectively. Beginning in 1997, participants may also elect to make additional voluntary contributions which are not matched by the Hospital. Pension expense under the terms of the plan of approximately $750,000 and $217,000 for the years ended March 31, 2007 and 2006, respectively, is included in employee benefits expense in the accompanying financial statements. Pension expense is funded on a current basis.

During the year ended March 31, 2007, the Hospital became aware of an underfunding of this pension liability in the amount of approximately $400,000, including interest and penalties. This amount is included in accrued expenses and employee benefits expense in the accompanying financial statements.

Note 11. Self-Insurance – Accrued Professional Liability and General Liability

The Hospital is involved in litigation under various matters arising in the ordinary course of business. Substantially all claims related to incidents occurring prior to 1976 are covered by commercial insurance. Effective for the periods since 1976 the Hospital has adopted a self-insurance program for professional (medical malpractice) and general liability claims. For various years in this time frame, the Hospital has also obtained excess medical malpractice insurance coverage from commercial insurance carriers.

In connection with its self-insurance program, the Hospital engaged the services of a professional consultant for actuarial evaluations of self-insured funding requirements and designated attorneys to handle legal matters relating to professional and general liability claims. The Hospital also established a trust fund with an independent trust agent for the proper administration and protection of the assets designated for professional and general liability claims.

Under the trust agreement, the trust fund assets are only to be used for the self-insurance program and are not available for the general operations of the Hospital.

The ultimate cost of asserted and unasserted self-insured claims identified under the Hospital's incident reporting system, as well as estimates of claims incurred but not reported, are accrued based on estimation methodologies that incorporate the Hospital's past experience, as well as other considerations including the nature of each claim or incident and relevant trend factors. Accrued professional and general liability claim losses have been discounted at 6% for 2007 and 2006. The portion of the accrual for estimated professional and general liability claims expected to be paid within one year of the balance sheet date is not readily determinable and, therefore, the entire accrual amount is classified as a noncurrent liability. An accrual for possible losses attributable to incidents that may have occurred, but that have not been identified under the incident reporting system is included in this liability. If accrued malpractice losses had not been discounted, the estimated liability would be approximately $834,000 and $1,033,000 higher than the amounts recorded in the balance sheets as of March 31, 2007 and 2006, respectively.

Self-insured professional and general liability expense of approximately $1,082,000 in 2007 and $1,185,000 in 2006 has been included with insurance expense in the accompanying statements of operations and changes in net assets.

At this time, there is no excess insurance coverage.

Note 12. Investment in Limited Partnership and Subsequent Event

The Hospital contributed $150,000 during 1992 as a limited partner in the Morgan Park Professional Centre Limited Partnership. As a limited partner, the Hospital's liability is limited to the amount of its contributions and it has no responsibility for managing partnership affairs. Partnership operations began in July 1992. The Hospital's investment, which is accounted for on the equity method, is included in other long-term assets in the accompanying balance sheets. The Hospital's proportionate share of the partnership's operations included net income of approximately $207,000 and $91,000 in 2007 and 2006, respectively, which is included with other nonoperating income in the accompanying statements of operations and changes in net assets. During 2007, the Hospital sold its investment in Morgan Park.

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

Notes to Financial Statements

Note 13. Temporarily and Permanently Restricted Net Assets

As of March 31, 2007, temporarily restricted net assets consisted of $2,625,081 for emergency room renovations; $14,594 for capital campaign fundraising costs; and, $38,745 for other programs. As of March 31, 2006, temporarily restricted net assets consist of $1,545,081 for emergency room renovations; $11,159 for bioterrorism; $10,906 for capital campaign fundraising costs; and, $38,745 for other programs.

There are no permanently restricted net assets as of March 31, 2007 and 2006.

Note 14. Functional Expenses

The Hospital provides general health care services to residents within its geographic location. Expenses related to providing these services were as follows for the years ended March 31, 2007 and 2006:

	2007	2006
Health care services	$ 39,297,734	$ 37,314,166
General and administrative	16,051,187	15,044,065
	$ 55,348,921	$ 52,358,231

Certain costs have been allocated among the health care services and general and administrative expenses.

Note 15. Commitments and Contingencies

Medicare Reimbursement: Further changes in Medicare reimbursement as a result of the Centers for Medicare & Medicaid Services' (CMS) implementation of the provisions of future Medicare legislation may have an adverse effect on the Hospital's net patient service revenue.

Medicaid Reimbursement: Due to the Hospital's relatively high Medicaid patient volume, the Hospital receives additional reimbursement ($9,102,848 in 2007 and $5,566,163 in 2006) in the form of critical hospital adjustment payments (CHAP), direct hospital adjustments (DHA) and safety net access payments (SNAP), the majority of which is provided by the Illinois Medicaid program. The amount of additional reimbursement from the Illinois Medicaid program which will be made to hospitals in the future is uncertain, and future legislative changes to reimbursements provided to hospitals could have a material adverse effect on the Hospital's operating results.

Medicaid Hospital Assessment Program: As described in Note 3, CMS approved State legislation for the Program relating to the period through June 2008. Receipt and timing of such future Program payments is dependent on future actions of the State. No receivable or payable for amounts applicable to periods after March 31, 2007 have been recorded.

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

Notes to Financial Statements

Note 15. Commitments and Contingencies (Continued)

Litigation: The Hospital is involved in litigation arising in the normal course of business. With the exception of one matter, in consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the Hospital's financial position or results of operations. The Hospital is the defendant in a matter for which the jury verdict was overturned by the judge. A new trial on damages has been ordered by the judge. Legal counsel and management estimate that the probable outcome of this matter will be material to the Hospital's financial position. This matter was considered by the actuary and management in determining the professional liability accrual. Legal counsel has estimated that this case will settle for an amount between $1,000,000 and $2,000,000.

Regulatory Investigation: The U.S. Department of Justice, other federal agencies and the Illinois Department of Public Aid routinely conduct regulatory investigations and compliance audits of health care providers. The Hospital is subject to these regulatory efforts. Management is currently unaware of any regulatory matters which may have a material effect on the Hospital's financial position or results from operation.

Note 16. Pending Adoptions of New Accounting Principles

In July 2006, the FASB issued Interpretation No. 48 (FIN 48), *Accounting for Uncertainty in Income Taxes – an interpretation of SFAS No. 109, Accounting for Income Taxes.* FIN 48 clarifies the accounting for uncertainty in income taxes recognized in an enterprise's financial statements in accordance with SFAS No. 109, *Accounting for Income Taxes.* FIN 48 prescribes a comprehensive model for recognizing, measuring, presenting and disclosing in the financial statements tax positions taken or expected to be taken on a tax return. FIN 48 is effective for fiscal years beginning after December 15, 2006. The Hospital is currently evaluating the impact of FIN 48 on its financial statements.

In September 2006, the FASB issued SFAS No. 157, *Fair Value Measurements.* SFAS No. 157 defines fair value, establishes a framework for measuring fair value and expands disclosures about fair value measurements. The requirements of SAFS No. 157 are effective for financial statements issued for fiscal years beginning after November 15, 2007. The Hospital is currently evaluating the impact of SFAS No. 157 on its financial statements.

Roseland Community Hospital

Financial Report
March 31, 2006

Contents

McGladrey & Pullen

Certified Public Accountants

INDEPENDENT AUDITOR'S REPORT ON THE FINANCIAL STATEMENTS

To the Board of Directors
Roseland Community Hospital Association
Chicago, Illinois

We have audited the accompanying balance sheets of Roseland Community Hospital Association, as of March 31, 2006 and 2005, and the related statements of operations and changes in net assets and cash flows for the years then ended. These financial statements are the responsibility of the Hospital's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Roseland Community Hospital Association as of March 31, 2006 and 2005, and the results of its operations and changes in net assets and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

The 2006 financial statements have been prepared assuming that Roseland Community Hospital Association will continue as a going concern. As discussed in Note 2 to the financial statements, Roseland Community Hospital generated a significant loss from operations in the year ended March 31, 2006, has a net working capital deficiency, and has decreasing levels of net assets. This raises substantial doubt about Roseland Community Hospital Association's ability to continue as a going concern. Management's plans in regard to these matters are described in Note 2. The financial statements do not include any adjustments that might result from the outcome of this uncertainty.

In accordance with *Government Auditing Standards*, we have also issued our report dated April 30, 2007, on our consideration of Roseland Community Hospital Association's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our audit.

McGladrey & Pullen, LLP

Rockford, Illinois
April 30, 2007

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

BALANCE SHEETS
March 31, 2006 and 2005

ASSETS	2006	2005
Current Assets		
Cash	$ 399,053	$ 1,051,914
Assets limited as to use	544	1,465,593
Patient accounts receivable, net of allowances for uncollectible accounts of approximately $14,902,000 in 2006 and $11,319,000 in 2005	4,866,327	5,752,511
Due from third-party payors	67,207	4,339,818
Medicaid assessment revenue receivable	5,384,164	-
Pledges and other receivables	165,519	397,104
Inventories	162,546	142,073
Prepaid expenses	93,295	304,031
Total current assets	11,138,655	13,453,044
Assets Limited as to Use, net of current portion:		
Under malpractice funding agreement - held by trustee	15,417	3,067
By Board of Directors for capital improvements	54,265	276,885
	69,682	279,952
Investments	76,165	144,261
Property and Equipment, net	7,317,164	6,926,311
Other Long-Term Assets	206,327	145,217
	$ 18,807,993	$ 20,948,785

See Notes to Financial Statements.

LIABILITIES AND NET ASSETS	2006	2005
Current Liabilities		
Line of credit	$ 2,790,000	$ 1,482,500
Current portion of long-term debt	-	1,470,000
Current installments of obligations under capital leases	203,065	198,057
Accounts payable	6,467,732	5,157,099
Due to third-party payors	5,789,456	4,676,289
Medicaid assessment tax payable	1,093,881	-
Accrued interest	544	59,759
Accrued expenses and other	1,864,306	1,744,203
Total current liabilities	18,208,984	14,787,907
Commitments and Contingencies (Notes 9, 11, and 15)		
Obligations Under Capital Leases, net of current installments	393,125	603,022
Professional Liability	5,248,096	4,767,000
Total liabilities	23,850,205	20,157,929
Net Assets (Deficit)		
Unrestricted (deficit):		
Board designated	54,809	1,742,478
Undesignated	(6,702,912)	(2,756,218)
	(6,648,103)	(1,013,740)
Temporarily restricted	1,605,891	1,804,596
Total net assets (deficit)	(5,042,212)	790,856
	$ 18,807,993	$ 20,948,785

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS (DEFICIT)
Years Ended March 31, 2006 and 2005

	2006	2005
Revenues:		
Net patient service revenue	$ 38,464,142	$ 43,556,828
Medicaid hospital assessment revenue	6,479,794	3,937,043
Other operating revenue	866,534	915,420
Net assets released from restrictions, used for operations	198,705	122,006
	46,009,175	48,531,297
Expenses:		
Salaries and wages	17,903,469	17,703,454
Employee benefits	3,076,563	2,966,428
Physician compensation	2,877,760	2,287,769
Medicaid hospital assessment tax	1,520,709	1,533,768
Food	361,705	357,815
Utilities	715,485	850,921
Repairs and maintenance	649,081	596,707
Insurance	1,554,021	2,917,718
Supplies and other	12,614,637	11,314,230
Interest	254,137	205,947
Depreciation and amortization	707,415	821,455
Provision for uncollectible accounts	10,123,249	9,690,817
	52,358,231	51,247,029
Operating (loss)	(6,349,056)	(2,715,732)
Nonoperating income:		
Investment income	20,783	149,630
Other, net	447,691	127,994
	468,474	277,624
(Deficiency) of revenues over expenses	$ (5,880,582)	$ (2,438,108)

(Continued)

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS (DEFICIT) (Continued)
Years Ended March 31, 2006 and 2005

	2006	2005
Unrestricted Net Assets (Deficit)		
(Deficiency) of revenues over expenses	$ (5,880,582)	$ (2,438,108)
Net change in unrealized gains and losses on assets limited as to use	-	(142,945)
Contributions for property and equipment	246,219	-
(Decrease) in unrestricted net assets (deficit)	(5,634,363)	(2,581,053)
Change in Temporarily Restricted Net Assets (Deficit)		
Contributions	-	1,030,444
Net assets released from restrictions	(198,705)	(122,006)
Increase (decrease) in temporarily restricted net assets (deficit)	(198,705)	908,438
(Decrease) in net assets (deficit)	(5,833,068)	(1,672,615)
Net assets, beginning of the year	790,856	2,463,471
Net assets (deficit), end of the year	$ (5,042,212)	$ 790,856

See Notes to Financial Statements.

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

STATEMENTS OF CASH FLOWS
Years Ended March 31, 2006 and 2005

	2006	2005
Cash Flows from Operating Activities		
(Decrease) in net assets	$ (5,833,068)	$ (1,672,615)
Adjustments to reconcile (decrease) in net assets		
to net cash provided by (used in) operating activities:		
Depreciation and amortization	707,415	821,455
Provision for uncollectible accounts	10,123,249	9,690,817
Net change in unrealized gains and losses on assets limited as to use	-	142,945
Contributions for property and equipment	(246,219)	-
Increase (decrease) from changes in:		
Patient accounts receivable	(9,237,065)	(10,834,167)
Due from/to third-party payors	5,385,778	1,441,111
Medicaid assessment receivable and payable	(4,290,263)	-
Pledges and other receivables	231,585	151,495
Inventories	(20,473)	42,780
Prepaid expenses	210,736	97,372
Other long-term assets	(61,110)	(37,848)
Accounts payable	1,129,990	465,209
Accrued interest	(59,215)	(11,600)
Accrued expenses and other	120,103	(153,567)
Professional liability	481,096	261,001
Net cash provided by (used in) operating activities	(1,357,481)	404,388
Cash Flows from Investing Activities		
Purchases of assets limited as to use and investments	(2,957,434)	(4,236,448)
Proceeds from assets limited as to use and investments	4,700,849	5,325,972
Contributions received for property and equipment	246,219	-
Purchase of property and equipment, net	(917,625)	(1,954,257)
Net cash provided by (used in) investing activities	1,072,009	(864,733)
Cash Flows from Financing Activities		
Net proceeds from line of credit	1,307,500	1,482,500
Repayment of long-term debt	(1,470,000)	(305,000)
Repayment of capital lease obligations	(204,889)	(246,718)
Net cash provided by (used in) financing activities	(367,389)	930,782
Net increase (decrease) in cash	(652,861)	470,437
Cash, beginning of year	1,051,914	581,477
Cash, end of year	$ 399,053	$ 1,051,914

(continued)

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

STATEMENTS OF CASH FLOWS (Continued)
Years Ended March 31, 2006 and 2005

	2006	2005
Supplemental Disclosures of Cash Flow Information		
Cash paid for interest	$ 313,352	$ 217,547
Supplemental Schedule of Noncash Investing and Financing Activities		
Property and equipment financed with capital leases	-	324,762
Purchase of equipment in accounts payable	180,643	-

See Notes to Financial Statements.

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

Notes to Financial Statements

Note 1. Nature of Organization and Summary of Significant Accounting Policies

Nature of organization: Roseland Community Hospital Association (Hospital), a not-for-profit corporation, operates a short-term general acute care community hospital and various clinics. The Hospital provides general health care services to residents within its geographic service area, including inpatient, outpatient, emergency room, physician, and other services.

A summary of significant accounting policies follows:

Use of estimates: The preparation of financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates. The use of estimates and assumptions in the preparation of the accompanying financial statements is primarily related to the determination of the patient receivables and settlements with third-party payors and the accrual for professional liability. Due to uncertainties inherent in the estimation and assumption process, it is at least reasonably possible that changes in these estimates and assumptions in the near term would be material to the financial statements.

Cash: Throughout the year, the Hospital may have amounts on deposit with financial institutions in excess of those insured by the FDIC. Management does not believe this presents a significant risk to the Hospital.

Patient accounts receivable, provision for uncollectible accounts and due from/to third-party payors: The collection of receivables from third-party payors and patients is the Hospital's primary source of cash for operations and is critical to its operating performance. The primary collection risks relate to uninsured patient accounts and patient accounts for which the primary insurance payor has paid, but patient responsibility amounts (deductibles and co-payments) remain outstanding. Patient receivables, where a third-party payor is responsible for paying the amount, are carried at a net amount determined by the original charge for the service provided, less an estimate made for contractual adjustments or discounts provided to third-party payors.

Patient receivables due directly from the patients are carried at the original charge for the service provided less amounts covered by third-party payors and less an estimated allowance for doubtful receivables. Management estimates this allowance based on the aging of its accounts receivable and its historical collection experience for each payor type. Recoveries of receivables previously written off are recorded as a reduction of bad debt expense when received.

The past-due status of receivables is determined on a case-by-case basis depending on the payor responsible. Interest is generally not charged on past-due accounts.

Receivables or payables related to estimated settlements on various payor contracts, primarily Medicare, are reported as amounts due from or to third-party payors. Significant changes in payor mix, business office operations, economic conditions or trends in federal and state governmental health care coverage could affect the Hospital's collection of accounts receivable, cash flows and results of operations.

Inventories: Inventories of supplies are stated at the lower of cost (first-in, first-out) or market.

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

Notes to Financial Statements

Note 1. Nature of Organization and Summary of Significant Accounting Policies (Continued)

Investments and assets limited as to use: Assets limited as to use consist primarily of investment securities. Investments in money market accounts are measured at fair value which approximates cost. Investments in equity securities with readily determinable fair values and debt securities are carried at fair value. The fair values are estimated based on quoted market prices for those or similar investments. The change in net unrealized gains and losses in the value of investments is recognized as a change in net assets. Assets limited as to use include assets set aside by the Board of Directors (Board) for capital improvements and other purposes, over which the Board retains control and may at its discretion subsequently use for other purposes; assets held by a trustee to be used in accordance with requirements of a bond indenture agreement; and assets held by a trustee to be used in accordance with the requirements of a self-insurance trust agreement. Assets limited as to use that are required for obligations classified as current liabilities are reported in current assets. Assets limited as to use are classified as noncurrent assets to the extent they are not expected to be expended to satisfy obligations classified as current liabilities.

Investments are regularly evaluated for impairment. The Hospital considers factors affecting the investee, factors affecting the industry the investee operates within, and general debt and equity market trends. The Hospital considers the length of time an investment's fair value has been below carrying value, the near-term prospects for recovery to carrying value, and the intent and ability to hold the investment until maturity or market recovery is realized. If and when a determination is made that a decline in fair value below the cost basis is other than temporary, the related investment is written down to its estimated fair value and included in excess of revenues over expenses as a component of investment income.

Property and equipment: Property and equipment are stated at cost. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed on the straight-line method. Leased equipment under capital leases is amortized over the shorter of the lease term or estimated useful life. The estimated useful lives of depreciable property and equipment range from 5 to 25 years for land improvements, 10 to 40 years for buildings, and 3 to 20 years for furniture and fixtures. Amortization expense on assets acquired under capital leases is included with depreciation expense on owned assets. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

Gifts of long-lived assets, such as land, buildings, or equipment, are reported as unrestricted support and are included in the income or loss from operations unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

Professional liability: The provision for professional liability includes estimates of the ultimate costs for known claims as well as claims incurred but not reported. The provision is actuarially determined.

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

Notes to Financial Statements

Note 1. Nature of Organization and Summary of Significant Accounting Policies (Continued)

Net patient service revenue: Agreements with third-party payors provide for payments to the Hospital at amounts different from its established rates. Payment arrangements include prospectively determined rates-per-discharge, discounted charges, or cost reimbursement methodologies. Net patient service revenues are reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods, as final settlements are determined.

Deficiency of revenues over expenses: The statements of operations and changes in net assets include deficiency of revenues over expenses which represents results of operations. Changes in unrestricted net assets, which are excluded from the results of operations, consistent with industry practice, include unrealized gains and losses on investments and contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purpose of acquiring such assets).

Operating loss: The statements of operations and changes in net assets include an operating loss. Changes in unrestricted net assets, which are excluded from operating loss, include investment income and other revenue, net, which management views as outside of normal activity.

Charity care: The Hospital provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than established rates. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue.

Basis of presentation: The Hospital may classify its net assets into three categories, which are unrestricted, temporarily restricted, and permanently restricted.

Unrestricted net assets are reflective of revenues and expenses associated with the principal operating activities of the Hospital and are not subject to donor-imposed stipulations.

Temporarily restricted net assets are those whose use by the Hospital has been limited by donors to a specific time period or purpose.

Permanently restricted net assets have been restricted by donors to be maintained in perpetuity.

Donor-restricted gifts: Unconditional promises to give cash and other assets to the Hospital are reported at fair value at the date the promise is received. Conditional promises to give and indication of intentions to give are reported at fair value at the date the gift is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the statements of changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions in the accompanying financial statements.

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

Notes to Financial Statements

Note 1. Nature of Organization and Summary of Significant Accounting Policies (Continued)

Tax-exempt status: The Hospital is a not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code (IRC) and is exempt from Federal income taxes on related income pursuant to Section 501(a) of the Code.

Reclassifications: Certain 2005 amounts have been reclassified to conform to the 2006 presentation. These reclassifications had no effect on the 2005 change in net assets.

Note 2. Continuing Operations

The accompanying financial statements have been prepared on the basis of a going concern, which contemplates the realization of assets and discharge of liabilities in the ordinary course of business. The Hospital experienced an operating loss during the year ended March 31, 2006, and is experiencing difficulty in generating sufficient cash flow to meet its obligations and sustain its operations.

The Hospital engaged a consulting firm and began a process to reduce expenses, restructure operations and recruit new management team members.

The Hospital's ability to sustain its operations is dependent upon its ability to (a) generate cash flow to meet its obligations on a timely basis, (b) obtain additional financing (as may be required), and (c) ultimately attain profitability. Management believes they will be able to sustain future operations through actions completed and planned, including but not limited to the following:

Governance and Management:

- The Hospital achieved Healthcare Facilities Accreditation Program (HFAP) accreditation. The Hospital has implemented a culture of improved clinical quality and patient safety that not only satisfied the concerns of the Federal Centers for Medicare & Medicaid Services (CMS), but also has provided a platform for improved patient outcomes throughout the entire continuum of care.
- In July 2006, the Hospital hired a permanent CEO, Ian McFadden, who brings a wealth of knowledge to the Hospital. Mr. McFadden, a health care executive from Brentwood, Kentucky, was selected as the Hospital's new CEO after a six-month nationwide search. He previously served as the senior consultant for FTI Cambio Health Solutions and the Chief Operating Officer of the Alameda County Medical Center, a 588-bed teaching hospital in Oakland, California.
- Management secured an affordable health insurance plan option and other benefit enhancements for employees to improve employee satisfaction and to assist in employee recruiting and retention efforts.

Operational:

- The Hospital borrowed $3,000,000 in the first quarter of fiscal year 2006 and paid it off from the proceeds from the Medicaid Hospital Assessment Program. The Hospital established a $2,000,000 line of credit in the third quarter of fiscal year 2006. This line has been fully drawn down to meet working capital needs. In the fourth quarter of fiscal year 2006, the Hospital increased the $2,000,000 line of credit by $800,000, for a total borrowing of $2,800,000 to meet working capital needs. This line of credit is being paid with proceeds from the Medicaid Hospital Assessment Program.

Note 2. Continuing Operations (Continued)

- Added key service lines to provide essential health care services to the community including pediatric services, occupational and physical therapy, infectious disease services, orthopedic services and Magnetic Resonance Imaging (MRI) capabilities, and Sleep Study.
- Due to the re-instatement of the HFAP accreditation, the Hospital was able to again service existing and new managed care contracts that the Hospital is currently serving as a Participating Provider.
- The Hospital entered into an arrangement with Chicago Family Health Center, which has opened a comprehensive community health center on the 2nd floor of the Hospital. This clinic offers greater access to affordable, comprehensive primary health care to residents of the Roseland, Riverdale, Auburn-Gresham and West Pullman communities. All services are provided without regard to ability to pay and a sliding scale fee program is available for uninsured patients.

Management believes that these and other actions will favorably affect operating results; however, there can be no assurances that these actions will be sufficient to ensure the Hospital's long-term future.

The Hospital's existence is substantially dependent on its ability to consistently improve operations, generate positive cash flows and to increase its working capital. Because the long-term funding of the State of Illinois Medicaid program, including the Medicaid Hospital Assessment Program, and the outcome of management's efforts to consistently achieve accreditation, profitable operations and positive cash flows and increased working capital cannot be determined, no adjustments to the accompanying financial statements relating to this uncertainty have been made.

Note 3. Net Patient Service Revenue and Subsequent Event

The Hospital has agreements with third-party payors which provide for reimbursement to the Hospital at amounts different from its established rates. Contractual adjustments under third-party reimbursement programs represent the difference between the Hospital's billings at list price and the amounts reimbursed by Medicare, Medicaid, Blue Cross, and certain other third-party payors; and any differences between estimated third-party reimbursement settlements for prior years and subsequent final settlements. Contractual adjustments under third-party reimbursement programs are accrued on an estimated basis in the period the related services are rendered and are adjusted in future periods as final settlements are determined. A summary of the basis of reimbursement with major third-party payors follows:

Medicare: The Hospital is paid for inpatient acute care and outpatient care services rendered to Medicare program beneficiaries under prospectively determined rates per discharge (Prospective Payment Systems). These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Inpatient non-acute services and defined capital and medical education costs related to Medicare beneficiaries are paid based upon a cost reimbursement method, established fee screens, or a combination thereof. The Hospital's classification of patients under Prospective Payment Systems and the appropriateness of the patient's admissions are subject to validation reviews. The Hospital is reimbursed for cost reimbursable items at tentative rates with final settlement determined after submission of annual reimbursement reports by the Hospital and audits by the Medicare fiscal intermediary.

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

Notes to Financial Statements

Note 3. Net Patient Service Revenue and Subsequent Event (Continued)

Medicaid: The Hospital is reimbursed at prospectively determined rates for each Medicaid inpatient discharge. Outpatient services are reimbursed based on established fee screens. For inpatient acute care services, payment rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. The prospectively determined rates are not subject to retroactive adjustment. The Hospital also receives incremental Medicaid reimbursement for specific programs and services at the discretion of the State of Illinois Medicaid Program. Medicaid reimbursement may be subject to periodic adjustment, as well as to changes in existing payment levels and rates, based on the amount of funding available to the Medicaid program.

Blue Cross: The Hospital also participates as a provider of health care services under a reimbursement agreement with Blue Cross. The provisions of this agreement stipulate that services will be reimbursed at a tentative reimbursement rate and that final reimbursement for these services is determined after the submission of an annual cost report by the Hospital and a review by Blue Cross.

Managed Care Organizations: The Hospital has also entered into reimbursement agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment under these agreements includes discounts from established charges and prospectively determined per diem rates.

A summary of gross and net patient service revenues for the years ended March 31, 2006 and 2005 follows:

	2006	2005
Gross patient service revenue	$ 93,291,299	$ 98,625,649
Physician service revenue	546,707	682,431
Less provision for contractual adjustments under third-party reimbursement programs, charity care, and other discounts and allowances	(55,373,864)	(55,751,252)
Net patient service revenue	$ 38,464,142	$ 43,556,828

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The Hospital's management believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation, as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs.

In February 2007, CMS approved State of Illinois (State) legislation for a Medicaid Hospital Assessment Program (Program) relating to the three-year period from September 2005 to May 2008. Under the Program, the Hospital received additional Medicaid reimbursement from the State and paid a related assessment. Total reimbursement revenue recognized by the Hospital related to this Program amounted to $5,384,164 during the Hospital's year ended March 31, 2006. Total assessments incurred by the Hospital related to this program amounted to $1,093,881 during the Hospital's year ended March 31, 2006.

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

Notes to Financial Statements

Note 4. Concentrations of Credit Risk

The Hospital grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at March 31, 2006 and 2005 was as follows:

	2006	2005
Medicare	16 %	12 %
Medicaid	30	25
Managed care	10	14
Patients	40	45
Other	4	4
	100 %	100 %

Note 5. Assets Limited as to Use and Investments

The composition of assets limited as to use at March 31, 2006 and 2005 is as follows:

	2006	2005
Under bond indenture agreements - held by trustee, U.S. government obligations	$ 544	$ 1,465,593
Under malpractice funding agreement - held by trustee, U.S. government obligations	15,417	3,067
By Board for capital improvements:		
Money market	3,785	118,294
U.S. government obligations	50,480	158,591
Total assets limited or restricted as to use	70,226	1,745,545
Less current portion	544	1,465,593
	$ 69,682	$ 279,952

Investments consist of a money market account of $76,165 and $144,261 at March 31, 2006 and 2005, respectively.

Investment securities, in general, are exposed to various risks, such as interest rate, credit, and overall market volatility. Due to the level of risk associated with certain investment securities, it is reasonably possible that changes in the value of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the balance sheet.

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

Notes to Financial Statements

Note 6. Charity Care (Unaudited)

The Hospital maintains records to identify and monitor the level of charity care it provides. For the years ended March 31, 2006 and 2005, the Hospital provided approximately $3,951,000 and $3,050,000 of charity care, respectively, based on charges foregone for services rendered.

Note 7. Property and Equipment

A summary of property and equipment at March 31, 2006 and 2005 is as follows:

	2006	2005
Land	$ 380,477	$ 380,477
Land improvements	403,347	400,667
Buildings	6,328,127	5,981,354
Building improvements	5,054,454	5,054,454
Major movable and fixed equipment	10,671,553	10,512,374
Construction-in-progress	3,557,975	2,968,339
Equipment under capital lease	2,420,506	2,420,506
	28,816,439	27,718,171
Less accumulated depreciation and amortization, including amortization of equipment under capital lease of $1,908,785 in 2006 and $1,696,365 in 2005	21,499,275	20,791,860
	$ 7,317,164	$ 6,926,311

Construction-in-progress at March 31, 2006 and 2005 consisted primarily of costs incurred for various construction and renovation projects. The most significant project in process at March 31, 2006 is the expansion of the Hospital's emergency room from 4,500 square feet to 10,500 square feet. The emergency room project is currently on hold pending funding from future grants and other sources of funding. The estimated cost to complete the emergency room project is approximately $3.9 million as of March 31, 2006.

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

Notes to Financial Statements

Note 8. Note Payable, Long-Term Debt, Pledged Assets and Subsequent Event

The Hospital has a revolving line-of-credit agreement with a bank which provides for total borrowings of up to $2,800,000. The line is collateralized by substantially all assets of the Hospital. The agreement expires June 30, 2006 and has been subsequently extended through June 30, 2007. It has since been paid. Interest is paid monthly at the prime rate (7.75% at March 31, 2006) plus 1%. The outstanding balance on this line was $2,790,000 and $1,482,500 at March 31, 2006 and 2005, respectively.

A summary of long-term debt at March 31, 2006 and 2005 follows:

	2006	2005
First Mortgage Revenues Refunding and Improvement Bonds, Series 1978, paid in full	$ -	$ 1,470,000
Less current portion	-	1,470,000
Long-term portion	$ -	$ -

Note 9. Lease Obligations

The Hospital has entered into capital lease obligations at varying rates of interest from 7% to 12%, which are collateralized by leased equipment.

Future minimum lease commitments under capital leases for equipment as of March 31, 2006 are as shown below:

Years Ending March 31,	
2007	$ 245,899
2008	245,899
2009	129,251
2010	51,502
Total required minimum lease payments	672,551
Less amount representing interest	76,361
Net present value of minimum lease payments	596,190
Less current portion	203,065
Long-term portion	$ 393,125

Note 9. Lease Obligations (Continued)

The Hospital also leases equipment under operating leases. Minimum annual rental payments are as follows:

Years Ending March 31,

2007	$ 41,575
2008	3,955
	$ 45,530

Rent expense for the years ended March 31, 2006 and 2005 was approximately $605,000 and $544,000, respectively.

Note 10. Pension Plan

The Hospital has a voluntary defined contribution pension plan (Plan) covering substantially all employees who work at least 1,000 hours annually, are over age 21, and have at least two years of service. Hospital contribution requirements under the terms of the Plan are computed at 2% of an eligible employee's first $20,000 of salary and 4% of salary earned thereafter. Eligible employees may elect to contribute 2% of their first $20,000 of salary and 4.7% of salary earned thereafter, thereby increasing the Hospital's contribution requirements to 3% and 6%, respectively. Beginning in 1997, participants may also elect to make additional voluntary contributions which are not matched by the Hospital. Pension expense under the terms of the plan of approximately $217,000 and $404,000 for the years ended March 31, 2006 and 2005, respectively, is included in employee benefits expense in the accompanying financial statements. Pension expense is funded on a current basis.

Note 11. Self-Insurance – Accrued Professional Liability and General Liability

The Hospital is involved in litigation under various matters arising in the ordinary course of business. Substantially all claims related to incidents occurring prior to 1976 are covered by commercial insurance. Effective for the periods since 1976 the Hospital has adopted a self-insurance program for professional (medical malpractice) and general liability claims. For various years in this time frame, the Hospital has also obtained excess medical malpractice insurance coverage from commercial insurance carriers.

In connection with its self-insurance program, the Hospital engaged the services of a professional consultant for actuarial evaluations of self-insured funding requirements and designated attorneys to handle legal matters relating to professional and general liability claims. The Hospital also established a trust fund with an independent trust agent for the proper administration and protection of the assets designated for professional and general liability claims.

Under the trust agreement, the trust fund assets are only to be used for the self-insurance program and are not available for the general operations of the Hospital.

The ultimate cost of asserted and unasserted self-insured claims identified under the Hospital's incident reporting system, as well as estimates of claims incurred but not reported, are accrued based on estimation methodologies that incorporate the Hospital's past experience, as well as other considerations including the nature of each claim or incident and relevant trend factors. Accrued professional and general liability claim losses have been discounted at 6% for 2006 and 2005. The portion of the accrual for estimated professional and general liability claims expected to be paid within one year of the balance sheet dates is not readily determinable, and therefore, the entire accrual balance is classified as a noncurrent liability.

Note 11. Self-Insurance – Accrued Professional Liability and General Liability (Continued)

Self-insured professional and general liability expense of approximately $1,185,000 in 2006 and $1,440,000 in 2005 has been included with insurance expense in the accompanying statements of operations and changes in net assets.

At this time, there is no excess insurance coverage.

Note 12. Investment in Limited Partnership and Subsequent Event

The Hospital contributed $150,000 during 1992 as a limited partner in the Morgan Park Professional Centre Limited Partnership. As a limited partner, the Hospital's liability is limited to the amount of its contributions and it has no responsibility for managing partnership affairs. Partnership operations began in July 1992. The Hospital's investment, which is accounted for on the equity method, is included in other long-term assets in the accompanying balance sheets. The Hospital's proportionate share of the partnership's operations included net income of approximately $91,000 in 2006 and $50,500 in 2005, which is included with other nonoperating income in the accompanying statements of operations and changes in net assets. Subsequent to March 31, 2006, the client sold their investment in Morgan Park for a gain of approximately $510,000. At December 31, 2005, total assets (consisting primarily of property and equipment) of the Morgan Park Professional Centre Limited Partnership were approximately $1.4 million and total liabilities (primarily long-term debt) were approximately $1.2 million. For the year ended December 31, 2005, revenues and expenses were approximately $305,000 and $236,000, respectively.

Note 13. Temporarily and Permanently Restricted Net Assets

As of March 31, 2006, temporarily restricted net assets consist of $1,545,081 for emergency room renovations; $11,159 for bioterrorism; $10,906 for capital campaign fundraising costs; and, $38,745 for other programs. As of March 31, 2005, temporarily restricted net assets consist of $1,545,081 for emergency room renovations; $117,410 for bioterrorism; $98,705 for capital campaign fundraising costs; and, $43,400 for other programs.

There are no permanently restricted net assets as of March 31, 2006 and 2005.

Note 14. Functional Expenses

The Hospital provides general health care services to residents within its geographic location. Expenses related to providing these services were as follows for the years ended March 31, 2006 and 2005:

	2006	2005
Health care services	$ 37,314,166	$ 36,522,245
General and administrative	15,044,065	14,724,784
	$ 52,358,231	$ 51,247,029

Certain costs have been allocated among the health care services and general and administrative expenses.

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

Notes to Financial Statements

Note 15. Commitments and Contingencies

Medicare Reimbursement: For the years ended March 31, 2006 and 2005, the Hospital recognized approximately $28,066,000 and $30,639,000, respectively, of gross patient service revenues from services provided to Medicare beneficiaries. Changes in Medicare reimbursement as a result of the Centers for Medicare and Medicaid Services' (CMS) implementation of the provisions of future Medicare legislation may have an adverse effect on the Hospital's net patient service revenue.

Medicaid Reimbursement: For the years ended March 31, 2006 and 2005, the Hospital recognized approximately $30,797,000 and $30,586,000, respectively, of gross patient service revenues provided to Medicaid patients. Due to the Hospital's relatively high Medicaid patient volume, the Hospital receives additional reimbursement ($5,566,163 in 2006 and $8,176,122 in 2005) in the form of critical hospital adjustment payments (CHAP), direct hospital adjustments (DHA) and safety net access payments (SNAP), the majority of which is provided by the Illinois Medicaid program. The amount of additional reimbursement from the Illinois Medicaid program which will be made to hospitals in the future is uncertain, and future legislative changes to reimbursements provided to hospitals could have a material adverse effect on the Hospital's operating results.

Medicaid Hospital Assessment Program: As described in Note 3, CMS approved State legislation for the Program relating to the period through May 2008. Receipt and timing of such future Program payments is dependent on future actions of the State. No receivable or payable for amounts applicable to periods after March 31, 2006 have been recorded.

Litigation: The Hospital is involved in litigation arising in the normal course of business. In consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the Hospital's financial position or results of operations.

Regulatory Investigation: The U.S. Department of Justice, other federal agencies and the Illinois Department of Public Aid routinely conduct regulatory investigations and compliance audits of health care providers. The Hospital is subject to these regulatory efforts. Management is currently unaware of any regulatory matters which may have a material effect on the Hospital's financial position or results from operation.

McGladrey & Pullen

Certified Public Accountants

INDEPENDENT AUDITOR'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

To the Board of Directors
Roseland Community Hospital Association
Chicago, Illinois

We have audited the financial statements of Roseland Community Hospital Association (the Hospital) as of and for the year ended March 31, 2006, and have issued our report thereon dated April 30, 2007. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

Internal Control Over Financial Reporting

In planning and performing our audit, we considered the Hospital's internal control over financial reporting in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and not to provide an opinion on the internal control over financial reporting. However, we noted certain matters involving the internal control over financial reporting and its operation that we consider to be reportable conditions. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of the internal control over financial reporting that, in our judgment, could adversely affect the Hospital's ability to initiate, record, process, and report financial data consistent with the assertions of management in the financial statements. Reportable conditions are described in the accompanying Schedule of findings and responses as items 06-1 through 06-6.

A material weakness is a reportable condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements caused by error or fraud in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control that might be reportable conditions and, accordingly, would not necessarily disclose all reportable conditions that are also considered to be material weaknesses. However, of the reportable conditions described above, we consider items 06-1, 06-3, 06-4, 06-5, and 06-6 to be material weaknesses.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Hospital's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of the financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards* and which are described in the accompanying schedule of findings and responses as items 06-6 and 06-7.

We noted certain matters that we reported to management of Roseland Community Hospital Association in a separate letter dated April 30, 2007.

This report is intended for the information and use of the Board of Directors, management, and federal and state awarding agencies and is not intended to be and should not be used by anyone other than these specified parties.

McGladrey & Pullen, LLP

Rockford, Illinois
April 30, 2007

Roseland Community Hospital Association

SCHEDULE OF FINDINGS AND RESPONSES
Year Ended March 31, 2006

06-1: Billing and Accounts Receivable

Criteria or Specific Requirement: A good system of controls includes proper internal review and monitoring of patient billings and related documentation and a proper system for estimating contractual allowances at time of billing.

Condition and Context: The Hospital does not perform internal reviews of patient bills to ensure that proper quantities and levels of service are entered into the billing system. The Hospital also records contractual allowances at the time of payment versus determining an estimate for the contractual allowance and recording at time of billing. The contractual allowance would then be adjusted if needed at time of payment for any difference between the estimate and the actual contractual allowance.

Effect: Multiple errors were discovered in patient accounts receivable related to improper quantities and level of service entered into the billing system. These errors resulted in improper reimbursement for accounts receivable.

Cause: Limitations in the software package prevents contractual adjustments from being taken at the time of billing.

Recommendation: We recommend that the Audit Committee, Compliance Committee and management develop a process to internally audit patient bills, both inpatient and outpatient, on a routine basis, to ensure that such errors do not occur in the future. In practice, many health systems and hospitals utilize nurse auditors in this role. We also recommend that the Hospital incorporate quantity and dollar value thresholds into their billing software in order to detect errors prior to processing daily receivables batches. Also the procedure for recording contractual allowances should be revised so that the Hospital's system records the estimated contractual allowances at the time of billing with subsequent adjustment at the time of payment.

Management's Response: Management will explore the feasibility of acquiring contract management software that will afford RCH with the ability to calculate contractual adjustments at the time of billing. In the interim, a system to review patient bills, particularly high dollar accounts, will be established.

06-2: Payroll

Criteria or Specific Requirement: A good internal control structure involves maintaining proper segregation of duties in the payroll process as well as proper approvals of time worked by employees. In addition, exit interview should be performed in order to detect any other payroll related issues.

Condition and Context: Our review of controls in payroll revealed a few issues. We observed that the payroll coordinator is responsible for printing and distributing the payroll checks without the check sequence being accounted for by a person independent of payroll. We also observed that departmental managers are not required to review the time of employees in their department. Payroll is required to be locked down prior to processing, which is done by either the departmental manager or the payroll coordinator, and there is no way to retroactively determine whether or not the manager locked down the time-sheet. Last, we noted exit interviews are not conducted for terminated employees prior to departure.

This situation is mitigated to some extent by several procedures, which involve payroll reviews by members of management. First, department managers review labor distribution reports, which list total hours by employee and total dollars, for each payroll. Second, beginning in January 2005, a "change in status report" was reviewed each pay period. Payroll expense is also reviewed monthly by the Hospital's chief financial officer and Finance Committee.

Effect: As a result of this lack of controls, it is possible that the Hospital could pay a fictitious employee or improperly pay a current employee.

Roseland Community Hospital Association

SCHEDULE OF FINDINGS AND RESPONSES
Year Ended March 31, 2006

06-2: Payroll (Continued)

Cause: Additional control procedures are necessary, including the distribution of department expense reports containing line item detail comparing actual labor expenses to budget.

Recommendation: We recommend the following: 1.) someone outside of the payroll department distribute payroll checks; 2.) all employee time sheets are reviewed by their respective department manager prior to processing; and 3.) exit interviews be conducted for all terminated employees.

Management's Response: Management will explore the feasibility of software applications designed to generate monthly reporting of labor costs in detail in order for Department Managers to effectively review labor costs.

06-3: Approval of Expense Reports

Criteria or Specific Requirement: A proper approval process should be maintained for expense reports to ensure improper expenses are not paid by the Hospital.

Condition and Context: During our testing of expense reports, we noted that the chief executive officer is reviewing and approving the expenses submitted by the chief financial officer, both of which are contracted from the management consulting firm.

Effect: The current approval process increases the risk of inappropriate expenses being paid by the Hospital.

Cause: Lack of an independent review process leading to the processing of expenses could result in inappropriate expenses being processed.

Recommendation: We recommend that all invoices from the management consulting firm for expense reimbursement be submitted with supporting receipts and reviewed by the Board of Directors for approval.

Management's Response: The Hospital will employ the CEO and CFO beginning in 2006.The review of the process of approving expenditures will lead to a recommendation from management for additional controls.

06-4: Fixed Asset Tracking

Criteria or Specific Requirement: To ensure proper accounting for fixed assets, a formal fixed asset tagging and tracking system should be maintained.

Condition and Context: We observed that Roseland does not currently tag and track fixed assets.

Effect: This minimizes the Hospital's ability to identify assets that are impaired, put out of service, or disposed of.

Cause: Specific tagging of fixed assets will require an investment of time.

Recommendation: We recommend that the Hospital consider the use of a formal fixed asset tagging and tracking system.

Management's Response: A in depth review of the amount of resources necessary to accomplish the tagging of fixed assets will be performed by management leading to a recommendation on the methodology for increased control.

Roseland Community Hospital Association

SCHEDULE OF FINDINGS AND RESPONSES
Year Ended March 31, 2006

06-5: Chief Financial Officer Position

Criteria or Specific Requirement: A proper financial management structure in a Hospital is important to ensure complex accounting and financial issues are handled properly and that a high level of decision making and review is maintained.

Condition and Context: The chief financial officer position was vacant during the year and the Administrative Director, Controls and Accountability, was performing the duties of the chief financial officer.

Effect: The Hospital could have issues in many areas such as finance accounting, personnel and morale without having the proper management structure in place.

Cause: Possible poor fiscal management, including inaccurate reporting of the financial condition of the hospital.

Recommendation: We recommend that a chief financial officer be hired as soon as possible.

Management's Response: Subsequent to the period under audit a chief financial officer was hired.

06-6: Unclaimed Property

Criteria or Specific Requirement: In order to comply with state law, the Hospital is required to remit any unclaimed property in a timely manner.

Condition and Context: The Hospital had approximately $240,000 of unclaimed property at June 30, 2006 that should have been remitted to the State of Illinois.

Effect: The failure to submit unclaimed property in a timely manner could potentially result in penalties and fees assessed at the Hospital.

Cause: Establishment of ineffective protocol to identify and report unclaimed property.

Recommendation: We recommend that the Hospital submit all unclaimed property to the state of Illinois in a timely manner.

Management's Response: Management will review this issue and develop the protocol to properly identify and report unclaimed property.

06-7: Timely Submission of Reports

Criteria or Specific Requirement: In order to comply with the requirement of the Office of Management and Budget (OMB) compliance supplements related to reporting, the Hospital must submit their audit reports within 180 days of year-end.

Condition and Context: Due to delays experienced during the audit, the audit reports were not completed in a timely manner.

Effect: The audit reports were not submitted within 180 days of year-end.

Roseland Community Hospital Association

SCHEDULE OF FINDINGS AND RESPONSES
Year Ended March 31, 2006

06-7: Timely Submission of Reports (Continued)

Cause: Due to delays experienced in collecting provider tax monies from the State of Illinois, the Hospital was unable to pay audit fees in a timely manner resulting in a delay in the performance of the audit.

Recommendation: We recommend that management ensure proper funds are available to ensure the audit report is completed and submitted in a timely manner.

Management's Response: Increased emphasis will be placed on payment to satisfy regulatory reporting requirements.

McGladrey & Pullen
Certified Public Accountants

Financial Report
March 31, 2008

ATTACHMENT 75

Contents

McGladrey & Pullen
Certified Public Accountants

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors
Roseland Community Hospital Association
Chicago, Illinois

We have audited the accompanying balance sheets of Roseland Community Hospital Association as of March 31, 2008 and 2007, and the related statements of operations and changes in net assets (deficit) and cash flows for the years then ended. These financial statements are the responsibility of the Hospital's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Roseland Community Hospital Association as of March 31, 2008 and 2007, and the results of its operations and changes in net assets (deficit) and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

The accompanying financial statements have been prepared assuming that Roseland Community Hospital Association will continue as a going concern. As discussed in Note 2 to the financial statements, Roseland Community Hospital has experienced difficulty in generating sufficient cash flow to meet its obligations and sustain operations, and is dependent on the Illinois Medicaid Hospital Assessment Program in order to generate operating income. This raises substantial doubt about Roseland Community Hospital Association's ability to continue as a going concern. Management's plans in regard to these matters are also described in Note 2. The financial statements do not include any adjustments that might result from the outcome of this uncertainty.

McGladrey & Pullen, LLP

Rockford, Illinois
November 7, 2008

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

BALANCE SHEETS
March 31, 2008 and 2007

ASSETS	2008	2007
Current Assets		
Cash	$ 1,176,859	$ 492,872
Assets limited as to use	313,046	1,000,384
Patient accounts receivable, net of allowances for uncollectible accounts of approximately $15,606,000 in 2008 and $22,608,000 in 2007	4,956,400	5,338,743
Due from third-party payors	1,273,805	191,200
Medicaid assessment revenue receivable	5,384,166	5,384,164
Pledges and other receivables	186,782	238,340
Inventories	224,160	156,744
Prepaid expenses	87,191	64,911
Total current assets	13,602,409	12,867,358
Assets limited as to use, net of amounts required to meet current obligations	3,618,196	2,955,632
Cash restricted by grantor for property and equipment	619,947	672,417
Investments	-	48,342
Property and equipment, net	8,591,487	7,055,181
Other long-term assets	137,505	94,609
	$ 26,569,544	$ 23,693,539

See Notes to Financial Statements.

LIABILITIES AND NET ASSETS (DEFICIT)	2008	2007
Current Liabilities		
Line of credit	$ -	$ 1,154,506
Current installments of obligations under capital leases	121,513	221,493
Accounts payable	9,913,330	7,402,939
Due to third-party payors	6,189,514	7,824,315
Medicaid assessment tax payable	1,093,881	1,093,881
Accrued expenses and other	2,482,327	2,256,552
Total current liabilities	19,800,565	19,953,686
Obligations Under Capital Leases, net of current installments	50,119	171,632
Professional Liability	5,828,780	5,940,986
Total liabilities	25,679,464	26,066,304
Commitments and Contingencies (Notes 3, 9, 10, 11, and 15)		
Net Assets (Deficit)		
Unrestricted (deficit)	(1,791,084)	(5,051,185)
Temporarily restricted	2,681,164	2,678,420
Total net assets (deficit)	890,080	(2,372,765)
	$ 26,569,544	$ 23,693,539

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS (DEFICIT)
Years Ended March 31, 2008 and 2007

	2008	2007
Revenues:		
Net patient service revenue	$ 50,965,143	$ 48,262,376
Medicaid hospital assessment revenue	7,178,889	7,178,885
Other operating revenue	843,005	713,401
Net assets released from restrictions, used for operations	-	11,159
	58,987,037	56,165,821
Expenses:		
Salaries and wages	17,810,401	17,871,937
Employee benefits	3,268,832	3,482,396
Physician compensation	2,838,750	2,296,748
Medicaid hospital assessment tax	1,458,508	1,458,508
Food	364,683	316,555
Utilities	798,379	787,253
Repairs and maintenance	375,803	393,103
Insurance	635,140	1,431,998
Supplies and other	13,240,295	11,217,212
Interest	191,766	376,432
Depreciation and amortization	697,764	654,646
Provision for uncollectible accounts	14,146,939	15,062,133
	55,827,260	55,348,921
Operating income	3,159,777	816,900
Nonoperating income:		
Investment income	7,287	2,533
Gain on sale of property and equipment	-	116,212
Other, net	93,037	661,273
	100,324	780,018
Excess of revenues over expenses	$ 3,260,101	$ 1,596,918

(Continued)

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS (DEFICIT) (Continued)
Years Ended March 31, 2008 and 2007

	2008	2007
Unrestricted Net Assets		
Excess of revenues over expenses	$ 3,260,101	$ 1,596,918
Increase in unrestricted net assets	3,260,101	1,596,918
Change in Temporarily Restricted Net Assets		
Contributions and grant	2,744	1,083,688
Net assets released from restrictions	-	(11,159)
Increase in temporarily restricted net assets	2,744	1,072,529
Increase in net assets	3,262,845	2,669,447
Net deficit, beginning of the year	(2,372,765)	(5,042,212)
Net assets (deficit), end of the year	$ 890,080	$ (2,372,765)

See Notes to Financial Statements.

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

STATEMENTS OF CASH FLOWS
Years Ended March 31, 2008 and 2007

	2008	2007
Cash Flows from Operating Activities		
Increase in net assets	$ 3,262,845	$ 2,669,447
Adjustments to reconcile increase in net assets (deficit) to net cash provided by operating activities:		
Depreciation and amortization	697,764	654,646
Provision for uncollectible accounts	14,146,939	15,062,133
Gain on sale of property and equipment	-	(116,212)
Contributions for property and equipment	-	(1,083,688)
Increase (decrease) from changes in:		
Patient accounts receivable	(13,764,596)	(15,534,549)
Due from/to third-party payors	(2,717,406)	1,910,866
Pledges and other receivables	51,556	(72,821)
Inventories	(67,416)	5,802
Prepaid expenses	(22,280)	28,384
Other long-term assets	(42,896)	111,718
Accounts payable	2,197,345	935,207
Accrued expenses and other	225,775	391,702
Professional liability	(112,206)	692,890
Net cash provided by operating activities	3,855,424	5,655,525
Cash Flows from Investing Activities		
Purchases of assets limited as to use and investments	(12,904,491)	(11,518,782)
Proceeds from assets limited as to use and investments	12,977,607	7,660,815
Contributions received for property and equipment	-	1,083,688
(Increase) decrease in cash restricted by grantor for property and equipment	52,470	(672,417)
Proceeds from sale of long-term asset	-	316,138
Purchase of property and equipment, net	(1,921,024)	(592,589)
Net cash (used in) investing activities	(1,795,438)	(3,723,147)
Cash Flows from Financing Activities		
Net payments on line of credit	(1,154,506)	(1,635,494)
Repayment of capital lease obligations	(221,493)	(203,065)
Net cash (used in) financing activities	(1,375,999)	(1,838,559)
Net increase in cash	683,987	93,819
Cash, beginning of year	492,872	399,053
Cash, end of year	$ 1,176,859	$ 492,872

(Continued)

150

ROSELAND COMMUNITY HOSPITAL ASSOCIATION

STATEMENTS OF CASH FLOWS (Continued)
Years Ended March 31, 2008 and 2007

	2008	2007
Supplemental Disclosures of Cash Flow Information		
Cash paid for interest	$ 191,766	$ 376,613
Supplemental Schedule of Noncash Investing and Financing Activities		
Purchase of equipment in accounts payable	313,046	-

See Notes to Financial Statements.

Note 1. Nature of Organization and Summary of Significant Accounting Policies

Nature of organization: Roseland Community Hospital Association (Hospital), a not-for-profit corporation, operates a short-term general acute care community hospital and various clinics. The Hospital provides general health care services to residents within its geographic service area, including inpatient, outpatient, emergency room, physician, and other services.

A summary of significant accounting policies follows:

Use of estimates: The preparation of financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates. The use of estimates and assumptions in the preparation of the accompanying financial statements is primarily related to the determination of the patient receivables and settlements with third-party payors and the accrual for professional liability. Due to uncertainties inherent in the estimation and assumption process, it is at least reasonably possible that changes in these estimates and assumptions in the near - term would be material to the financial statements.

Cash: Throughout the year, the Hospital may have amounts on deposit with financial institutions in excess of those insured by the FDIC. This concentration exposes the Hospital to custodial credit risk.

Patient accounts receivable, provision for uncollectible accounts and due from/to third-party payors: The collection of receivables from third-party payors and patients is the Hospital's primary source of cash for operations and is critical to its operating performance. The primary collection risks relate to uninsured patient accounts and patient accounts for which the primary insurance payor has paid, but patient responsibility amounts (deductibles and co-payments) remain outstanding. Patient receivables, where a third-party payor is responsible for paying the amount, are carried at a net amount determined by the original charge for the service provided, less an estimate made for contractual adjustments or discounts provided to third-party payors.

Patient receivables due directly from the patients are carried at the original charge for the service provided less amounts covered by third-party payors and less an estimated allowance for doubtful receivables. Management estimates this allowance based on the aging of its accounts receivable and its historical collection experience for each payor type. Recoveries of receivables previously written off are recorded as a reduction of bad debt expense when received.

The past-due status of receivables is determined on a case-by-case basis depending on the payor responsible. Interest is generally not charged on past-due accounts.

Receivables or payables related to estimated settlements on various payor contracts, primarily Medicare and Blue Cross, are reported as amounts due from or to third-party payors. Significant changes in payor mix, business office operations, economic conditions or trends in federal and state governmental health care coverage could affect the Hospital's collection of accounts receivable, cash flows and results of operations.

Inventories: Inventories of supplies are stated at the lower of cost (first-in, first-out) or market.

Note 1. Nature of Organization and Summary of Significant Accounting Policies (Continued)

Investments and assets limited as to use: Assets limited as to use consist primarily of investment securities. Investments in money market accounts are measured at fair value which approximates cost. Investments in equity securities with readily determinable fair values and debt securities are carried at fair value. The fair values are estimated based on quoted market prices for those or similar investments. The change in net unrealized gains and losses in the value of investments is recognized as a change in net assets. Assets limited as to use include assets set aside by the Board of Directors (Board) for capital improvements and other purposes, over which the Board retains control and may at its discretion subsequently use for other purposes; assets held by a trustee to be used in accordance with requirements of a bond indenture agreement; assets held by a trustee to be used in accordance with the requirements of a line-of-credit agreement; and assets held by a trustee to be used in accordance with the requirements of a self-insurance trust agreement. Assets limited as to use that are required for obligations classified as current liabilities are reported in current assets. Assets limited as to use are classified as noncurrent assets to the extent they are not expected to be expended to satisfy obligations classified as current liabilities.

Investments are regularly evaluated for impairment. The Hospital considers factors affecting the investee, factors affecting the industry the investee operates within, and general debt and equity market trends. The Hospital considers the length of time an investment's fair value has been below carrying value, the near-term prospects for recovery to carrying value, and the intent and ability to hold the investment until maturity or market recovery is realized. If and when a determination is made that a decline in fair value below the cost basis is other than temporary, the related investment is written down to its estimated fair value and included in excess of revenues over expenses as a component of investment income.

Assets limited as to use consist of investments set aside by the Board for capital improvements. Assets limited as to use also include a nominal amount (less than $1,000) designated by the Board and held by trustee for professional liability claims.

Property and equipment: Property and equipment are stated at cost. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed on the straight-line method. Leased equipment under capital leases is amortized over the shorter of the lease term or estimated useful life. The estimated useful lives of depreciable property and equipment range from 5 to 25 years for land improvements, 10 to 40 years for buildings, and 3 to 20 years for furniture and fixtures. Amortization expense on assets acquired under capital leases is included with depreciation expense on owned assets. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

Gifts of long-lived assets, such as land, buildings, or equipment, are reported as unrestricted support and are included in the income or loss from operations unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

Other long-term assets: Included in this balance is a certificate of deposit which has been pledged in support of a loan for the benefit of Hospital Laundry Services, LLC, a shared laundry service company that provides services to the Hospital. The balance of the certificate of deposit at March 31, 2008 and 2007 was approximately $107,000 and $64,000, respectively.

Professional liability: The provision for professional liability includes estimates of the ultimate costs for known claims as well as claims incurred but not reported. The provision is actuarially determined. The Hospital is completely self-insured for all claims.

Note 1. Nature of Organization and Summary of Significant Accounting Policies (Continued)

Net patient service revenue: Agreements with third-party payors provide for payments to the Hospital at amounts different from its established rates. Payment arrangements include prospectively determined rates-per-discharge, discounted charges, or cost reimbursement methodologies. Net patient service revenues are reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods, as final settlements are determined.

Excess of revenues over expenses: The statements of operations and changes in net assets include excess of revenues over expenses which represents results of operations. Changes in unrestricted net assets, which are excluded from the results of operations, consistent with industry practice, include unrealized gains and losses on investments and contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purpose of acquiring such assets).

Operating income: The statements of operations and changes in net assets include operating income. Changes in unrestricted net assets, which are excluded from operating income, include investment income, gains and losses from sales of long-term assets, and other revenue, net, which management views as outside of normal activity.

Charity care: The Hospital provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than established rates. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue.

Basis of presentation: The Hospital may classify its net assets into three categories, which are unrestricted, temporarily restricted, and permanently restricted.

Unrestricted net assets are reflective of revenues and expenses associated with the principal operating activities of the Hospital and are not subject to donor-imposed stipulations.

Temporarily restricted net assets are those whose use by the Hospital has been limited by donors to a specific time period or purpose.

Permanently restricted net assets have been restricted by donors to be maintained in perpetuity.

Donor-restricted gifts: Unconditional promises to give cash and other assets to the Hospital are reported at fair value at the date the promise is received. Conditional promises to give and indications of an intention to give are reported at fair value at the date the gift is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the statements of changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions in the accompanying financial statements.

Tax-exempt status: The Hospital is a not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code (IRC) and is exempt from Federal income taxes on related income pursuant to Section 501(a) of the Code.

Note 2. Continuing Operations

The accompanying financial statements have been prepared on the basis of a going concern, which contemplates the realization of assets and discharge of liabilities in the ordinary course of business. The Hospital has experienced difficulty in generating sufficient cash flow to meet its obligations and sustain its operations in recent years. The Hospital is also dependent on the Illinois Medicaid Hospital Assessment Program in order to generate operating income.

The Hospital engaged a consulting firm in a prior year and began a process to reduce expenses, restructure operations and recruit new management team members. The effects of these changes continue.

The Hospital's ability to sustain its operations is dependent upon its ability to (a) generate cash flow to meet its obligations on a timely basis, (b) obtain additional financing (as may be required), and (c) maintain profitability. Management believes they will be able to sustain future operations through actions completed and planned, including but not limited to the following:

- Management has implemented several cost saving measures as well as revenue cycle initiatives that are designed to improve cash flow. Best of Breed benchmarks have been utilized to compare actual Hospital results and provide management with a tool to evaluate processes.

- Management continues to modify operations with an improved emphasis on the registration process. The Hospital has increased efforts to determine Medicaid eligibility of patients; making certain that Medical Assistance applications are completed timely for all eligible patients. Increased resources have been devoted to this process.

- The Hospital has received net funding of approximately $5,720,000 from the Illinois Medicaid Hospital Assessment Program in both fiscal years 2007 and 2008. These funds will provide the Hospital with the ability to continue modification of operations and additional funding for capital projects.

Management believes that these and other actions will favorably affect operating results; however, there can be no assurances that these actions will be sufficient to ensure the Hospital's long-term future.

The Hospital's existence is substantially dependent on its ability to consistently improve operations, generate positive cash flows and increase its working capital. Because the long-term funding of the State of Illinois Medicaid program, including the Medicaid Hospital Assessment Program, and the outcome of management's efforts to consistently achieve accreditation, profitable operations, positive cash flows and increased working capital cannot be determined, no adjustments to the accompanying financial statements relating to this uncertainty have been made.

Note 3. Net Patient Service Revenue and Subsequent Event

The Hospital has agreements with third-party payors which provide for reimbursement to the Hospital at amounts different from its established rates. Contractual adjustments under third-party reimbursement programs represent the difference between the Hospital's billings at list price and the amounts reimbursed by Medicare, Medicaid, Blue Cross, and certain other third-party payors; and any differences between estimated third-party reimbursement settlements for prior years and subsequent final settlements. Contractual adjustments under third-party reimbursement programs are accrued on an estimated basis in the period the related services are rendered and are adjusted in future periods as final settlements are determined. A summary of the basis of reimbursement with major third-party payors follows:

Medicare: The Hospital is paid for inpatient acute care and outpatient care services rendered to Medicare program beneficiaries under prospectively determined rates per discharge (Prospective Payment Systems). These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Inpatient non-acute services and defined capital and medical education costs related to Medicare beneficiaries are paid based upon a cost reimbursement method, established fee screens, or a combination thereof. The Hospital's classification of patients under Prospective Payment Systems and the appropriateness of the patient's admissions are subject to validation reviews. The Hospital is reimbursed for cost reimbursable items at tentative rates with final settlement determined after submission of annual reimbursement reports by the Hospital and audits by the Medicare fiscal intermediary.

Fiscal year 2008 represented the first of a three-year phase-in period for implementation of revised Medicare Diagnosis Related Group (DRG) reimbursement system. This new payment methodology makes meaningful refinements to the current CMS classification system to increase recognition of severity of illness. However, there will be a limited impact on payments in specific DRGs because of the simultaneous implementation of incremental reforms for cost-based and severity-based payments. Management has not determined the reimbursement impact of this change in reimbursement for the Hospital.

Medicaid: The Hospital is reimbursed at prospectively determined rates for each Medicaid inpatient discharge. Outpatient services are reimbursed based on established fee screens. For inpatient acute care services, payment rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. The prospectively determined rates are not subject to retroactive adjustment. The Hospital also receives incremental Medicaid reimbursement for specific programs and services at the discretion of the State of Illinois Medicaid Program. Medicaid reimbursement may be subject to periodic adjustment, as well as to changes in existing payment levels and rates, based on the amount of funding available to the Medicaid program.

On November 6, 2007, the Hospital received a letter from the Office of Inspector General (OIG) related to an integrity audit covering the period of May 1, 2004 through April 30, 2006. Because of the significant number of records requested that were not produced during the audit, the OIG identified overpayments of approximately $1,786,000 and issued a warning to the Hospital. If subsequent audits show no material decrease in the number of missing records, further sanctions including, but not limited to suspension or exclusion from the State of Illinois Medicaid Program are possible.

Subsequent to March 31, 2008, the Hospital received a letter from OIG reducing the overpayment amount to $1,099,290. The amount was reduced because the Hospital was able to provide some of the documents that could not be obtained during the original audit. The Hospital is in the process of appealing the findings of the audit and has included the reduced liability in the due to third-party payor line in the balance sheet.

Note 3. Net Patient Service Revenue and Subsequent Event (Continued)

Blue Cross: The Hospital also participates as a provider of health care services under a reimbursement agreement with Blue Cross. The provisions of this agreement stipulate that services will be reimbursed at a tentative reimbursement rate and that final reimbursement for these services is determined after the submission of an annual cost report by the Hospital and a review by Blue Cross.

Managed care organizations: The Hospital has also entered into reimbursement agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment under these agreements includes discounts from established charges and prospectively determined per diem rates.

A summary of gross and net patient service revenues for the years ended March 31, 2008 and 2007 follows:

	2008	2007
Gross patient service revenue	$ 149,462,507	$ 134,223,248
Physician service revenue	302,730	317,741
Less provision for contractual adjustments under third-party reimbursement programs, charity care, and other discounts and allowances	(98,800,094)	(86,278,613)
Net patient service revenue	$ 50,965,143	$ 48,262,376

Estimates for cost report settlements and contractual allowances can differ from actual reimbursements based on the results of subsequent reviews and cost report audits. Changes in third-party valuation allowances that relate to prior years are reported in revenue in excess of expenses in the consolidated statements of operations and changes in net assets. The impact of such items on revenue in excess of expenses was an increase of approximately $315,000 and a decrease of approximately $971,000 for the years ended March 31, 2008 and 2007, respectively.

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near-term. The Hospital's management believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation, as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs.

During fiscal year 2007, the Medicaid Hospital Assessment Program (Program) was renewed for the period from August 2005 to June 30, 2008. Under the Program, the Hospital received additional Medicaid reimbursement from the State of Illinois (State) and paid a related assessment. Total reimbursement revenue recognized by the Hospital related to this Program amounted to $7,178,889 and $7,178,885 during the Hospital's years ended March 31, 2008 and 2007, respectively. Total assessments incurred by the Hospital related to this program amounted to $1,458,508 in each of the Hospital's years ended March 31, 2008 and 2007. Continuation of this program beyond June 2008 is uncertain at this time. The Illinois Healthcare and Family Services, Illinois Hospital Association, and Association of Safety Net Hospitals have worked together to develop a replacement Program which has been approved by the Illinois legislature and is subject to approval by the Center for Medicare and Medicaid Services (CMS). Final approval of the Program is expected by management of the Corporation, but cannot be assured.

Note 4. Concentrations of Credit Risk

The Hospital grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at March 31, 2008 and 2007 was as follows:

	2008	2007
Medicare	12 %	13 %
Medicaid	46	28
Managed care	14	14
Patients	26	42
Other	2	3
	100 %	100 %

Note 5. Assets Limited as to Use and Investments

The composition of assets limited as to use at March 31, 2008 and 2007 is as follows:

	2008	2007
Under bond indenture agreements - held by trustee, U.S. government obligations	$ 402	$ 384
Under line-of-credit agreement - held by trustee, Money market	-	1,000,000
Under malpractice funding agreement - held by trustee, U.S. government obligations	3	234
By Board for capital improvements:		
Money market	2,958,230	2,902,832
U.S. government obligations	54,575	52,566
Certificate of deposit	918,032	-
Total assets limited or restricted as to use	$ 3,931,242	$ 3,956,016

Investments consist of a money market account of $48,342 at March 31, 2007.

Note 6. Charity Care (Unaudited)

The Hospital maintains records to identify and monitor the level of charity care it provides. For the years ended March 31, 2008 and 2007, the Hospital provided approximately $3,600,000 and $3,646,000 of charity care, respectively, based on charges foregone for services rendered.

Note 7. Property and Equipment and Subsequent Event

A summary of property and equipment at March 31, 2008 and 2007 is as follows:

	2008	2007
Land	$ 380,477	$ 380,477
Land improvements	403,347	403,347
Buildings	6,252,501	5,980,389
Building improvements	6,526,154	5,050,423
Major movable and fixed equipment	11,077,383	10,757,585
Construction-in-progress	4,207,583	4,041,154
Equipment under capital lease	2,420,506	2,420,506
	31,267,951	29,033,881
Less accumulated depreciation and amortization, including amortization of equipment under capital lease of $2,277,500 in 2008 and $2,093,143 in 2007	22,676,464	21,978,700
	$ 8,591,487	$ 7,055,181

Construction-in-progress at March 31, 2008 and 2007 consisted primarily of costs incurred for various construction and renovation projects. The most significant project in process at March 31, 2008 is the expansion of the Hospital's emergency room from 4,500 square feet to 15,000 square feet. The estimated cost to complete the emergency room project is approximately $3,875,000 as of March 31, 2008.

Subsequent to March 31, 2008, the Hospital entered into a $5,000,000 note payable with interest at a rate of prime minus 0.5%. The State of Illinois has pledged $5,000,000 of its assets as collateral against the note and the Hospital has pledged $400,000 of its assets as collateral against the note. This loan is to be used for the Hospital's emergency room project. Principal is to be paid monthly, beginning in April 2009. Interest is to be paid monthly beginning in July 2008. The note matures in June 2011.

Note 8. Note Payable, Pledged Assets and Subsequent Event

The Hospital had a revolving line-of-credit agreement with a bank which provided for total borrowings of up to $2,800,000. The line was collateralized by substantially all assets of the Hospital. The agreement expired June 30, 2007. The outstanding balance on this line was $1,154,506 at March 31, 2007. The Hospital paid off the line-of-credit during the year ended March 31, 2008.

Subsequent to March 31, 2008, the Hospital entered into a $913,204 bank note payable with interest at a rate of prime. The Hospital has pledged $913,204 of its assets as collateral against the note. The principal balance is due in June 2009 and interest payments are due monthly, starting in June 2008.

Note 9. Lease Obligations

The Hospital has entered into capital lease obligations at varying rates of interest from 7% to 12%, which are collateralized by leased equipment.

Future minimum lease commitments under capital leases for equipment as of March 31, 2008 are as shown below:

Years Ending March 31,	
2009	$ 129,251
2010	51,501
Total required minimum lease payments	180,752
Less amount representing interest	9,120
Net present value of minimum lease payments	171,632
Less current portion	121,513
Long-term portion	$ 50,119

The Hospital also leases equipment under operating leases. Minimum annual rental payments are $57,500 for 2009.

Rent expense for the years ended March 31, 2008 and 2007 was approximately $622,000 and $554,000, respectively.

Note 10. Pension Plan

The Hospital has a voluntary defined contribution pension plan (Plan) covering substantially all employees who work at least 1,000 hours annually, are over age 21, and have at least two years of service. Hospital contribution requirements under the terms of the Plan are computed at 2% of an eligible employee's first $20,000 of salary and 4% of salary earned thereafter. Eligible employees may elect to contribute 2% of their first $20,000 of salary and 4.7% of salary earned thereafter, thereby increasing the Hospital's contribution requirements to 3% and 6%, respectively. Beginning in 1997, participants may also elect to make additional voluntary contributions which are not matched by the Hospital. Pension expense under the terms of the plan of approximately $312,000 and $750,000 for the years ended March 31, 2008 and 2007, respectively, is included in employee benefits expense in the accompanying financial statements. An underfunding in the amount of approximately $425,000 and $400,000, including interest and penalties, for the years ended March 31, 2008 and 2007, respectively, is included in accrued expenses and employee benefits expense in the accompanying financial statements.

Note 11. Self-Insurance – Accrued Professional Liability and General Liability

The Hospital is involved in litigation under various matters arising in the ordinary course of business. Substantially all claims related to incidents occurring prior to 1976 are covered by commercial insurance. Effective for the periods since 1976 the Hospital has adopted a self-insurance program for professional (medical malpractice) and general liability claims. For various years in this time frame, the Hospital has also obtained excess medical malpractice insurance coverage from commercial insurance carriers.

In connection with its self-insurance program, the Hospital engaged the services of a professional consultant for actuarial evaluations of self-insured funding requirements and designated attorneys to handle legal matters relating to professional and general liability claims. The Hospital also established a trust fund with an independent trust agent for the proper administration and protection of the assets designated for professional and general liability claims.

Under the trust agreement, the trust fund assets are only to be used for the self-insurance program and are not available for the general operations of the Hospital.

The ultimate cost of asserted and unasserted self-insured claims identified under the Hospital's incident reporting system, as well as estimates of claims incurred but not reported, are accrued based on estimation methodologies that incorporate the Hospital's past experience, as well as other considerations including the nature of each claim or incident and relevant trend factors. Accrued professional and general liability claim losses have been discounted at 6% for 2008 and 2007. The portion of the accrual for estimated professional and general liability claims expected to be paid within one year of the balance sheet date is not readily determinable and, therefore, the entire accrual amount is classified as a noncurrent liability. An accrual for possible losses attributable to incidents that may have occurred, but that have not been identified under the incident reporting system is included in this liability. If accrued malpractice losses had not been discounted, the estimated liability would be approximately $752,000 and $834,000 higher than the amounts recorded in the balance sheets as of March 31, 2008 and 2007, respectively.

Self-insured professional and general liability expense of approximately $244,000 in 2008 and $1,082,000 in 2007 has been included with insurance expense in the accompanying statements of operations and changes in net assets.

At this time, there is no excess insurance coverage.

Note 12. Investment in Limited Partnership

The Hospital contributed $150,000 during 1992 as a limited partner in the Morgan Park Professional Centre Limited Partnership. As a limited partner, the Hospital's liability is limited to the amount of its contributions and it has no responsibility for managing partnership affairs. Partnership operations began in July 1992. The Hospital's investment, which is accounted for on the equity method, is included in other long-term assets in the accompanying balance sheets. During 2007, the Hospital sold its investment in Morgan Park. The Hospital's proportionate share of the partnership's operations included net income of approximately $207,000 in 2007, which is included with other nonoperating income in the accompanying statements of operations and changes in net assets.

Note 13. Temporarily and Permanently Restricted Net Assets

As of March 31, 2008, temporarily restricted net assets consisted of $2,625,081 for emergency room renovations; $17,338 for capital campaign fundraising costs; and, $38,745 for other programs. As of March 31, 2007, temporarily restricted net assets consisted of $2,625,081 for emergency room renovations; $14,594 for capital campaign fundraising costs; and, $38,745 for other programs.

There are no permanently restricted net assets as of March 31, 2008 and 2007.

Note 14. Functional Expenses

The Hospital provides general health care services to residents within its geographic location. Expenses related to providing these services were as follows for the years ended March 31, 2008 and 2007:

	2008	2007
Health care services	$ 39,637,355	$ 39,297,734
General and administrative	16,189,905	16,051,187
	$ 55,827,260	$ 55,348,921

Certain costs have been allocated among the health care services and general and administrative expenses. There were no fundraising expenses.

Note 15. Commitments and Contingencies

Medicaid reimbursement: Due to the Hospital's relatively high Medicaid patient volume, the Hospital receives additional reimbursement ($7,887,718 in 2008 and $9,102,848 in 2007) in the form of critical hospital adjustment payments (CHAP), direct hospital adjustments (DHA) and safety net access payments (SNAP), the majority of which is provided by the Illinois Medicaid program. The amount of additional reimbursement from the Illinois Medicaid program which will be made to hospitals in the future is uncertain, and future legislative changes to reimbursements provided to hospitals could have a material adverse effect on the Hospital's operating results.

Litigation: The Hospital is involved in litigation arising in the normal course of business. With the exception of one matter, in consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the Hospital's financial position or results of operations. The Hospital is the defendant in a matter for which the jury verdict was overturned by the judge. A new trial on damages has been ordered by the judge. Legal counsel and management estimate that the probable outcome of this matter will be material to the Hospital's financial position. This matter was considered by the actuary and management in determining the professional liability accrual. Legal counsel has estimated that this case will settle for an amount between $1,000,000 and $2,000,000.

Contingency: Financial Accounting Standards Board Interpretation No. 47, *Accounting for Conditional Asset Retirement Obligations* (FIN 47) clarified when an entity is required to recognize a liability for a conditional asset retirement obligation. The Hospital has a legal obligation to remove hazardous materials from its facilities in the event the facilities are renovated or replaced. Such hazardous materials include asbestos. Management believes there is an indeterminate settlement date for the asset retirement obligations because of the range of time over which the Hospital may settle the obligation is unknown. However, management does not believe that the estimate of the liability related to these assets retirement obligations is a material amount at March 31, 2008 and 2007.

Note 15. Commitments and Contingencies (Continued)

Regulatory environment including fraud and abuse matters: The health care industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government activity continues with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the Hospital is in compliance with fraud and abuse, as well as other applicable government laws and regulations. While no regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

Illinois Hospital Uninsured Patient Discount Act: On May 30, 2008, the Illinois legislature passed a bill titled the "Hospital Uninsured Patient Discount Act" (the Act). This Act will require hospitals to provide certain mandated discounts from charges to the uninsured in Illinois. Charges are to be discounted to 135% of cost. Furthermore, a hospital may not collect more than 25% of an uninsured family's gross income in any one year. The Act became law on September 23, 2008 and the provisions applying to hospitals begin on April 11, 2009. The Hospital is in the process of determining the impact of this Act and is developing procedures in order to implement the Act.

CMS RAC program: Congress passed the Medicare Modernization Act in 2003, which among other things established a demonstration of the Medicare Recovery Audit Contractor (RAC) program. The RAC's identified and corrected a significant amount of improper overpayments to providers. In 2006, Congress passed the Tax Relief and Health Care Act of 2006 which authorized the expansion of the RAC program to all 50 states. CMS is in the process of rolling out this program nationally. As such, the Hospital may be subject to such an audit at some time in the future.

Note 16. Pending Adoptions of New Accounting Principles

In July 2006, the Financial Accounting Standards Board ("FASB") issued Interpretation No. 48 (FIN 48), *Accounting for Uncertainty in Income Taxes – an Interpretation of SFAS No. 109, Accounting for Income Taxes*. FIN 48 clarifies the accounting for uncertainty in income taxes recognized in an enterprise's financial statements in accordance with FASB Statement No. 109, *Accounting for Income Taxes*. FIN 48 prescribes a comprehensive model for recognizing, measuring, presenting and disclosing in the financial statements tax positions taken or expected to be taken on a tax return. In February 2008, the FASB delayed the effective date of FIN 48 for certain nonpublic companies to annual financial statements ending June 30, 2009. The adoption of FIN 48 is not expected to have a material impact on the Hospital's financial position, results of operations or cash flows.

In September 2006, the FASB issued SFAS No. 157, *Fair Value Measurements*. SFAS No. 157 defines fair value, establishes a framework for measuring fair value and expands disclosures about fair value measurements. The requirements of SAFS No. 157 are effective for financial statements issued for fiscal years beginning after November 15, 2007. In February 2008, the FASB issued FASB Staff Position (FSP) No. 157-2, *Effective Date of FASB Statement No. 157*. FSP 157-2 defers the effective date of SFAS No. 157 to fiscal years beginning after November 15, 2008, and interim periods within those fiscal years, for nonfinancial assets and nonfinancial liabilities, except for those items that are recognized or disclosed at fair value in the financial statements on a recurring basis. The Hospital has not fully evaluated the impact, if any, of adoption of this pronouncement on its financial statements.

Roseland Community Hospital

80 years of service and our commitment continues...

October 8, 2009

Mr. Michael Constantino
Illinois Health Services and Facilities Review Board
525 W. Jefferson Street
Springfield, IL 62761

RE: Roseland Community Hospital

Dear Mr. Constantino:

The undersigned, being authorized representatives of the applicant, hereby attest that 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 will be more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional debt, term, financing costs and other factors.

Anthony J. Puorro
Signature

Anthony J. Puorro
Printed Name

President & CEO
Printed Title

Dian M. Powell
Signature

Dian M. Powell
Printed Name

Chair Bd of Dir
Printed Title

STATE OF ILLINOIS)
) ss
COUNTY OF Cook)

SUBSCRIBED AND SWORN TO
before me this 23rd day of
October, 2009.

Mabel Y Jones
Notary Public

OFFICIAL SEAL
MABEL Y JONES
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:04/20/10

ATTACHMENT 76

45 W. 111th Street Chicago IL 60628 · Phone: 773.995.3000 · Fax: 773.995.1052

PROJECTED OPERATING COSTS

FY 2011

Salaries:	$1,766,644
Benefits:	353,239
Supplies:	112,320
Total Operating Costs:	$2,232,203
Patient Days:	9,360
Operating Costs per Day:	$ 238.48

EFFECT OF THE PROJECT ON CAPITAL COSTS

FY 2011

Interest Exp.:	$ 368,300
Depreciation:	1,480,000
Total Capital Costs:	$ 1,848,300
Equivalent Patient Days:	44,571
Capital costs per Equivalent Patient Days:	$ 41.46

ATTACHMENT 76

SAFETY NET IMPACT STATEMENT

Roseland Community Hospital is the Safety Net Hospital for the Roseland Community on the far south side of Chicago located at 45 W. 111th Street. As you will note, we have received support from other safety net hospitals in our area, e.g., Mercy, Jackson Park, St. James, as well as Provident Hospital of the Cook County Health System.

For the past three fiscal years, Roseland has provided the following charity care and received the following Medicaid reimbursement:

Information from Public Health Annual Survey

	2006	2007	2008
Charity Care Cost:	$ 1,093,406	$ 1,080,000	$ 990,000
Medicaid Revenue:	$30,796,632	$20,316,319	$26,460,655

ATTACHMENT 77

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

INDEX OF ATTACHMENTS

ATTACHMENT NO.		PAGES
1	Applicant Identification	
2	Site Ownership	
3	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	23
4	Flood Plain Requirements	24
5	Historic Preservation Act Requirements	25
6	Description of Project	
7	Project and Sources of Funds Itemization	
8	Cost Space Requirements	
9	Discontinuation	
10	Background of the Applicant	26-32
11	Purpose of the Project	
12	Alternatives to the Project	33
13	Size of the Project	34
14	Project Service Utilization	35-36
15	Unfinished or Shell Space	
16	Assurances for Unfinished/Shell Space	
17	Master Design Project	
18	Mergers, Consolidations and Acquisitions	
	Categories of Service:	
19	Planning Area Need	37-68
20	Service Demand – Establishment of Category of Service	69-88
21	Service Demand – Expansion of Existing Category of Service	
22	Service Accessibility – Service Restrictions	
23	Unnecessary Duplication/Maldistribution	89-91
24	Category of Service Modernization	
25	Staffing Availability	92
26	Assurances	93
	Service Specific:	
27	Comprehensive Physical Rehabilitation	
28	Neonatal Intensive Care	
29	Open Heart Surgery	
30	Cardiac Catheterization	
31	In-Center Hemodialysis	
32	Non-Hospital Based Ambulatory Surgery	
	General Long Term Care:	
33	Planning Area Need	
34	Service to Planning Area Residents	
35	Service Demand-Establishment of Category of Service	
36	Service Demand-Expansion of Existing Category of Service	
37	Service Accessibility	
38	Description of Continuum of Care	
39	Components	
40	Documentation	
41	Description of Defined Population to be Served	
42	Documentation of Need	
43	Documentation Related to Cited Problems	
44	Unnecessary Duplication of Service	
45	Maldistribution	

INDEX OF ATTACHMENTS