

ORIGINAL

09-064

RECEIVED

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

NOV 06 2009

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION
HEALTH FACILITIES & SERVICES REVIEW BOARD

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	MetroSouth Medical Center		
Street Address:	12935 South Gregory Street		
City and Zip Code:	Blue Island, IL 60406		
County:	Cook	Health Service Area	VII
Health Planning Area:	A-04		

Applicant Identification

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

Exact Legal Name:	MSMC Investors, LLC
Address:	500 Mamaronek Avenue Harrison, NY 10528
Name of Registered Agent:	
Name of Chief Executive Officer:	Lawrence Krule, Managing Partner
CEO Address:	500 Mamaronek Avenue Harrison, NY 10528
Telephone Number:	212/662-5333

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

Type of Ownership

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

- o Corporations and limited liability companies must provide an Illinois certificate of good standing.
- o Partnerships must provide the name of the state in which 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:	Anne M. Murphy
Title:	Partner
Company Name:	Holland + Knight
Address:	131 S. Dearborn Street 30 th Floor Chicago, IL 60603
Telephone Number:	312/578-6544
E-mail Address:	anne.Murphy@hkllaw.com
Fax Number:	312/578-6666

Additional Contact

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

Name:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	675 North Court Suite 210 Palatine, IL 60067
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7004

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

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	MetroSouth Medical Center		
Street Address:	12935 South Gregory Street		
City and Zip Code:	Blue Island, IL 60406		
County:	Cook	Health Service Area	VII
		Health Planning Area:	A-04

Applicant Identification

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

Exact Legal Name:	Harrison Hospital Holdings, LLC
Address:	500 Mamaronek Avenue Harrison, NY 10528
Name of Registered Agent:	
Name of Chief Executive Officer:	Lawrence Krule, Managing Partner
CEO Address:	500 Mamaronek Avenue Harrison, NY 10528
Telephone Number:	212/662-5333

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

Type of Ownership

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

o Corporations and limited liability companies must provide an Illinois certificate of good standing.
o Partnerships must provide the name of the state in which 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:	Anne M. Murphy
Title:	Partner
Company Name:	Holland + Knight
Address:	131 S. Dearborn Street 30 th Floor Chicago, IL 60603
Telephone Number:	312/578-6544
E-mail Address:	anne.Murphy@hklaw.com
Fax Number:	312/578-6666

Additional Contact

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

Name:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	675 North Court Suite 210 Palatine, IL 60067
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7004

Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance]

Name:	Enrique Beckmann, MD
Title:	CEO
Company Name:	MetroSouth Medical Center
Address:	12935 South Gregory Street Blue Island, IL 60406
Telephone Number:	708/597-2000
E-mail Address:	Enrique_Beckmann@MetroSouthMedicalCenter.com
Fax Number:	

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Harrison Hospital Realty, LLC
Address of Site Owner:	500 Mamaronek Avenue Harrison, NY 10528
Street Address or Legal Description of Site:	12935 South Gregory Street Blue Island, IL 60406

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:	MSMC Investors, LLC	
Address:	500 Mamaronek Avenue Harrison, NY 10528	
<input type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership	
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental	
<input checked="" type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Other
<ul style="list-style-type: none">o Corporations and limited liability companies must provide an Illinois certificate of good standing.o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.		

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)]

<p>Part 1110 Classification:</p> <p><input type="checkbox"/> Substantive</p> <p><input checked="" type="checkbox"/> Non-substantive</p>	<p>Part 1120 Applicability or Classification: [Check one only.]</p> <p><input checked="" type="checkbox"/> Part 1120 Not Applicable</p> <p><input checked="" type="checkbox"/> Category A Project</p> <p><input type="checkbox"/> Category B Project</p> <p><input type="checkbox"/> DHS or DVA Project</p>
---	---

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				9	9
Acute/Chronic Mental Illness					
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 co-applicants propose to "discontinue" MetroSouth Medical Center's pediatric beds "category of service", which was reduced in scope by State Board action from 33 to 6 beds in April 22, 2009.

Low utilization of the pediatrics service pre-dates the hospital's July 2, 2008 change of ownership, with the average daily census dropping from 2.9 patients in 2006 to 1.9 in 2008. Essentially, the community has chosen to discontinue using the hospital's pediatric service, and, as a result, it is no longer practical that the hospital continue to offer this service. In addition, the applicants believe that because other nearby hospitals provide pediatric services, because formal referral agreements have been executed with two of those hospitals, and because the volume of pediatrics patients at MetroSouth is insufficient to assure that clinical staff is able to maintain optimal skill levels, the community is well-served by the proposed "discontinuation", and access to pediatric services will be maintained.

When the State Board approved the hospital's change of ownership in July, 2008 (the actual change of ownership occurred on July 30, 2008), the Board emphasized the importance of retaining the hospital's obstetrics, NICU and Emergency Department services, and as the co-applicants have noted in their *Annual Report* following the change of ownership, the provision of these three important services has not only been maintained, but enhanced. Over the 8-month period ending August 31, 2009 obstetrics admissions have increased by 9%, NICU admissions have increased by 130% and ED visits have increased by 5% over the same 8-months of 2008.

In addition, MetroSouth has continued to provide "safety net services" through all of its clinical programs. Since the change of ownership, the charity care policies of the previous owners have been retained; and during the timeframes identified above, Medicaid admissions have increased by 12% and on a cost basis, \$4M in charity care has been provided.

This is a "non-substantive" project, because it addresses the discontinuation of a "category of service", exclusively.

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			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	\$0	\$0	\$0
SOURCE OF FUNDS	CLINICAL	NON-CLINICAL	TOTAL
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	\$0	\$0	\$0

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

Related Project Costs

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

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

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

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

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

Project Status and Completion Schedules

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): within 30 days of State Board approval

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. **NOT APPLICABLE**

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

NOT APPLICABLE

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.**

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
CLINICAL							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON CLINICAL							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							

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**.

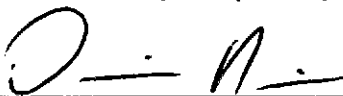
FACILITY NAME: MetroSouth Medical Center		CITY: Blue Island			
REPORTING PERIOD DATES: From: January 1 to: December 31, 2008					
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	319	9,333	45,550	None	319
Obstetrics	30	1,532	3,903	None	30
Pediatrics	6	181	680	-6	0
Intensive Care	28	1,211	6,195	None	28
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:	383	12,257	15,328	-6	377

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

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

This Application for Permit is filed on the behalf of MSMC INVESTORS, LLC 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
David Reis
PRINTED NAME

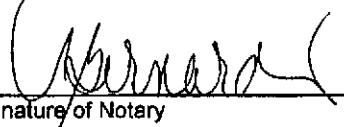
PRINTED TITLE



SIGNATURE
Laurine Krue
PRINTED NAME

PRINTED TITLE

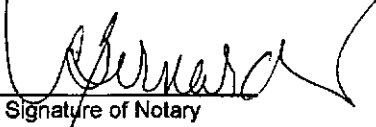
Notarization:
Subscribed and sworn to before me
this 30th day of November 2009



Signature of Notary

Seal
TERESA BERNARDI
Notary Public, State of New York
No. 01BE6187450
Qualified in Westchester County
Commission Expires May 19, 2012

Notarization:
Subscribed and sworn to before me
this 2nd day of November 2009



Signature of Notary

Seal
TERESA BERNARDI
Notary Public, State of New York
No. 01BE6187450
Qualified in Westchester County
Commission Expires May 19, 2012

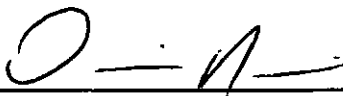
*Insert EXACT legal name of the applicant

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:


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

This Application for Permit is filed on the behalf of HARRISON HOSPITAL HOLDINGS, LLC* 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
David Reis

 PRINTED NAME



 SIGNATURE
Lawrence Krole

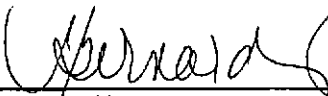
 PRINTED NAME

PRINTED TITLE _____

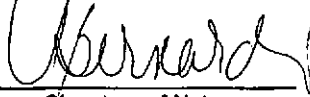
PRINTED TITLE _____

Notarization:
Subscribed and sworn to before me
this 3rd day of November 2009

Notarization:
Subscribed and sworn to before me
this 2nd day of November 2009



 Signature of Notary



 Signature of Notary

Seal

Seal

TERESA BERNARDI
 Notary Public, State of New York
 No. 01BE6187450
 Qualified in Westchester County
 Commission Expires May 19, 2012

TERESA BERNARDI
 Notary Public, State of New York
 No. 01BE6187450
 Qualified in Westchester County
 Commission Expires May 19, 2012

*Insert EXACT legal name of the applicant

SECTION II. DISCONTINUATION

This Section is applicable to any project that involves discontinuation of a health care facility or a category of service. **NOTE:** If the project is solely for discontinuation and if there is no project cost, the remaining Sections of the application are not applicable.

Criterion 1110.130 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any that are to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.
6. For applications involving the discontinuation of an entire facility, certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 60 days following the date of discontinuation.

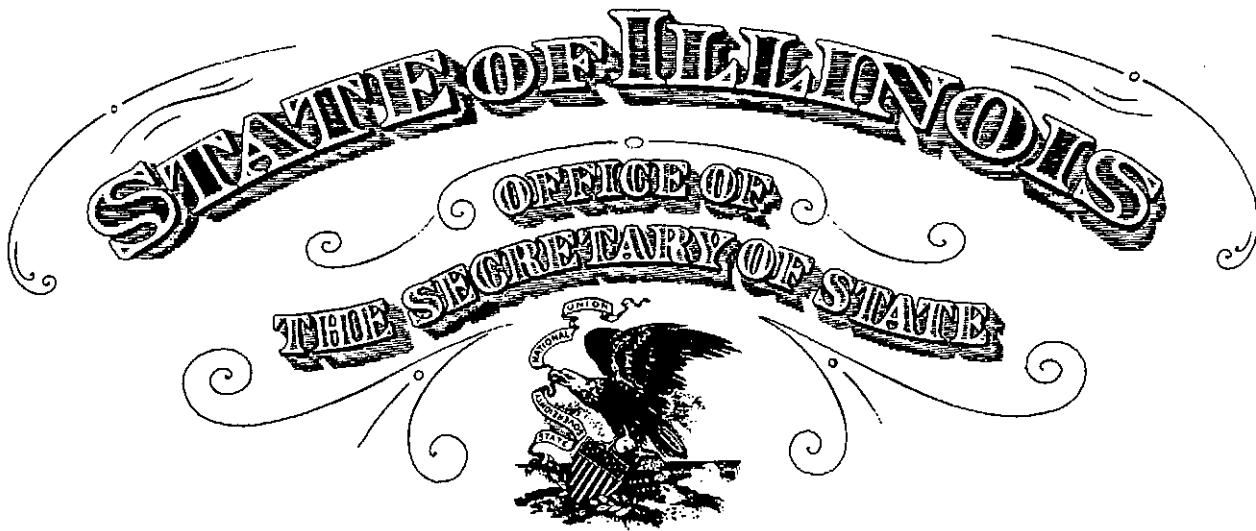
REASONS FOR DISCONTINUATION

The applicant shall state the reasons for discontinuation and provide data that verifies the need for the proposed action. See criterion 1110.130(b) for examples.

IMPACT ON ACCESS

1. Document that the discontinuation of each service or of the entire facility will not have an adverse effect upon access to care for residents of the facility's market area.
2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility.
3. Provide copies of impact statements received from other resources or health care facilities located within 45 minutes travel time, that indicate the extent to which the applicant's workload will be absorbed without conditions, limitations or discrimination.

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



To all to whom these Presents Shall Come, Greeting:

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

MSMC INVESTORS, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON MAY 27, 2008, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.



In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 30TH day of SEPTEMBER A.D. 2009

Jesse White

SECRETARY OF STATE

Authentication #: 0927302616

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

ATTACHMENT 1



To all to whom these Presents Shall Come, Greeting:

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

HARRISON HOSPITAL HOLDINGS, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON MAY 27, 2008, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.



Authentication #: 0929601762

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 23TH day of OCTOBER A.D. 2009 .

Jesse White

SECRETARY OF STATE

ATTACHMENT 1

SITE CONTROL

The attached Certificate of Liability Insurance held by Harrison Hospital Holdings, LLC (which was named as a co-applicant in the change of ownership Permit issued by the State Board on July 2, 2008) is provided as evidence of site control.

Client#: 14231

MSMC

ACORD™ CERTIFICATE OF LIABILITY INSURANCE		DATE (MM/DD/YYYY) 07/31/2009
PRODUCER Kinloch Partners, Inc., NJ Suite 310 300 Executive Dr. West Orange, NJ 07052	THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.	
INSURED Harrison Hospital Holdings, LLC c/o Metro South Medical Center 12935 South Gregory Blue Island, IL 60406	INSURERS AFFORDING COVERAGE INSURER A: See Description INSURER B: Zurich American Insurance Compa INSURER C: Nat'l Union Fire Ins. Co. of PI INSURER D: Zurich American Insurance INSURER E:	NAIC # 16535 19445 16535

COVERAGES

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

INSR ADD'L LTR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS								
	GENERAL LIABILITY <input type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC				EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COMP/OP AGG \$								
D	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input checked="" type="checkbox"/> ALL OWNED AUTOS <input checked="" type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS <input checked="" type="checkbox"/> Comprehensive <input checked="" type="checkbox"/> Collision	BAP379301801	07/30/09	07/30/10	COMBINED SINGLE LIMIT (Ea accident) \$1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ AUTO ONLY - EA ACCIDENT \$ OTHER THAN AUTO ONLY: EA ACC \$ AGG \$								
	GARAGE LIABILITY <input type="checkbox"/> ANY AUTO												
A	EXCESS/UMBRELLA LIABILITY <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE DEDUCTIBLE RETENTION \$	UHL002836001	07/30/09	07/30/10	EACH OCCURRENCE \$See AGGREGATE \$Description \$ \$ \$								
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below	WC09672167	07/30/09	07/30/10	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>WC STATUTORY LIMITS</td> <td>OTHER</td> </tr> <tr> <td>E.L. EACH ACCIDENT</td> <td>\$1,000,000</td> </tr> <tr> <td>E.L. DISEASE - EA EMPLOYEE</td> <td>\$1,000,000</td> </tr> <tr> <td>E.L. DISEASE - POLICY LIMIT</td> <td>\$1,000,000</td> </tr> </table>	WC STATUTORY LIMITS	OTHER	E.L. EACH ACCIDENT	\$1,000,000	E.L. DISEASE - EA EMPLOYEE	\$1,000,000	E.L. DISEASE - POLICY LIMIT	\$1,000,000
WC STATUTORY LIMITS	OTHER												
E.L. EACH ACCIDENT	\$1,000,000												
E.L. DISEASE - EA EMPLOYEE	\$1,000,000												
E.L. DISEASE - POLICY LIMIT	\$1,000,000												
C	OTHER Directors & Officers / EPL Crime/Fiduciary	048429006	07/30/09	07/30/10	See Description								

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

Additional Named Insureds
 MSMC Investors, LLC
 MSMC Homecare LLC
 MSMC Hospice LLC
 (See Attached Descriptions)

CERTIFICATE HOLDER Capital Source Bank ISAOA , ATIMA HSB Portfolio Manager 4445 Willard Avenue 12th Floor Chevy Chase, MD 20815	CANCELLATION 10 Days for Non-Payment SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL <u>30</u> DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES. AUTHORIZED REPRESENTATIVE <i>Jason Confort</i>
---	--

16

IMPORTANT

If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

DISCLAIMER

The Certificate of Insurance on the reverse side of this form does not constitute a contract between the issuing insurer(s), authorized representative or producer, and the certificate holder, nor does it affirmatively or negatively amend, extend or alter the coverage afforded by the policies listed thereon.

DESCRIPTIONS (Continued from Page 1)

MSMC Realty LLC
Transition Hospital Partners, LLC

Directors & Officers/Employment Practices/ Fiduciary
\$10,000,000 Shared Limit

Crisis Management (D&O Only)- \$25,000
Investigative Cost (D&O Only)- \$150,000
Voluntary Compliance Loss (Fiduciary Only)- \$100,000
HIPAA Penalties (Fiduciary Only) - \$25,000

Retentions

Each Non-Indemnifiable - \$0.00
Each Indemnifiable Claim - \$50,000
Each EPLI Claim - \$100,000
Each Indemnifiable Fiduciary Claim - \$5,000

Crime

- Employee Theft - \$2,000,000 / \$25,000 Deductible
- Forgery or Alteration - \$2,000,000 / \$25,000 Deductible
- Inside the Premises (Theft of Money or Securities) - \$2,000,000 / \$25,000 Deductible
- Inside the Premises (Robbery or Safe Burglary of Other Property) - \$2,000,000 / \$25,000 Deductible
- Outside the Premises - \$2,000,000 / \$25,000 Deductible
- Computer Fraud - \$2,000,000 / \$25,000 Deductible
- Funds Transfer Fraud - \$2,000,000 / \$25,000 Deductible
- Money Orders and Counterfeit Paper Currency - \$2,000,000 / \$25,000 Deductible

Hospital General Liability - Occurrence
Hospital Professional Liability - Claims Made

SIR: 7 Mil Per Claim
SIR Aggregate: 20 Mil Per Policy

Insurers Affording Coverage - Insurer A

Excess Layers

1st Layer: Arch Specialty Insurance Company, NAIC# 21199
Policy No. UHL0028360-01, Term 7/30/09 to 7/30/10

2nd Layer: Allied World Assurance Company, NAIC# 19489
Policy No. C010035002, Term 7/30/09 to 7/30/10

3rd Layer: Steadfast Insurance Company, NAIC# 26387
Policy No. HPC967206701, Term 7/30/09 to 7/30/10

4th Layer: Lloyds of London, NAIC# 15792
Policy No. C090941, Term 7/30/09 to 7/30/10

5th Layer: Lexington Insurance Company, NAIC# 19437
Policy No. 6795623, Term 7/30/09 to 7/30/10

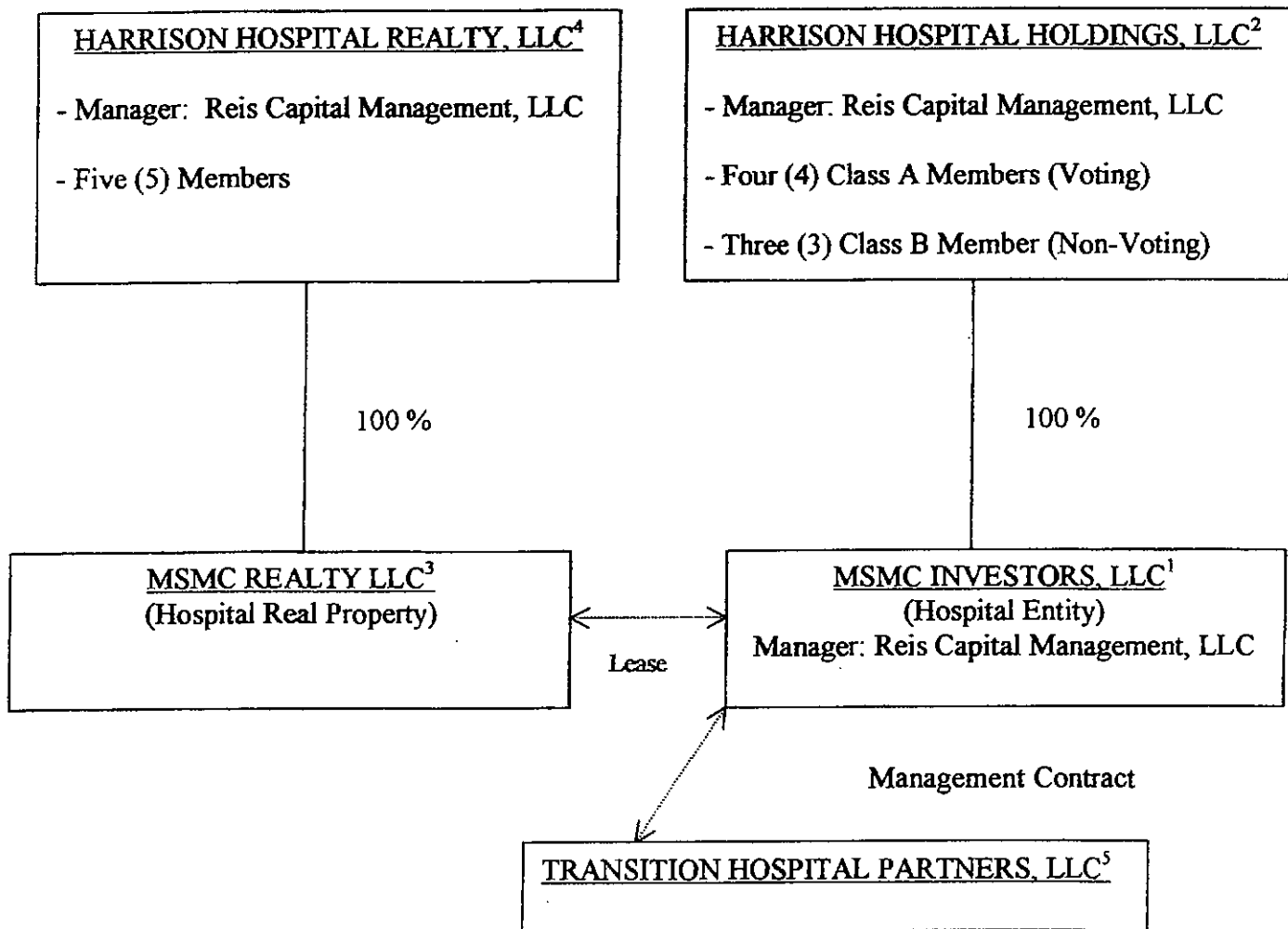
6th Layer: Swiss Re International SE, NAIC# 25364
Policy No. MH742671, Term 7/30/09 to 7/30/10

7th Layer: Admiral Insurance Company, NAIC# 24856
Policy No. CEHIL10116070802, Term 7/30/09 to 7/30/10

DESCRIPTIONS (Continued from Page 1)

Capital Source Bank ISAOA, ATIMA is included as Additional Insureds, A.T.I.M.A.

ORGANIZATIONAL CHART



NOTES TO ORGANIZATIONAL CHART

1. MSMC Investors, LLC (MSMC Investors) will be the hospital operating entity and license holder. MSMC Investors is a manager-managed LLC. Reis Capital Management, LLC (RCM) is the Manager. In this role, RCM has broad powers and authority. With the exception of certain enumerated decisions, RCM has unilateral authority to operate MSMC Investors. MSMC Investors is 100% owned by Harrison Hospital Holdings, LLC (HHH, LLC), which is the sole Member. Based on the foregoing, HHH and RCM are co-applicants. There is no debt being assumed by MSMC Investors or any other related party in order to effectuate the change of ownership transaction.
2. HHH is a manager-managed LLC. Reis Capital Management, LLC (RCM) is the Manager. In this role, RCM has broad powers and authority. With the exception of certain decisions, RCM has unilateral authority to operate HHH. There are 4 Class A Members of HHH, none of which controls HHH. There are 3 non-voting Class B Members, none of which controls HHH. No Class A or Class B Member: (a) owns 50% or more of HHH, (b) holds 50% or more of the voting securities or other voting rights of HHH, (c) has the unilateral right to amend HHH's governance documents or appoint a governing body for HHH, (d) has the unilateral power to require or approve the use of funds or assets of HHH, or (e) has unilateral control over HHH governance or operational decision-making.
3. MSMC Realty, LLC (MSMC Realty) will hold the hospital real property, and will lease this real property to MSMC Investors. MSMC Realty will not possess any control over MSMC Investors; it will have no involvement in hospital operations or the provision of care through the hospital or MSMC Investors, will hold no voting securities of MSMC Investors, and will exert no operational or governance control over MSMC Investors.
4. Harrison Hospital Realty, LLC owns 100% of MSMC Realty.
5. Transition Hospital Partners, LLC (Transition Hospital) will enter into a management contract with MSMC Investors. Transition Hospital Partners will not possess any control over MSMC Investors.



Illinois State Water Survey



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

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

Requester: Jacob M. Axel, Axel & Associates, Inc.
Address: 675 North Court, Suite 210
City, state, zip: Palatine, IL 60067 Telephone: (847) 776-7101

Site description of determination:
Site address: St. Francis Hospital Blue Island campus: 12831-12935 S. Gregory St., 12850-13001 S. Irving Ave., 12921-12955 S. Western Ave., 2329 Union St., 2310 York St.
City, state, zip: Blue Island, IL
County: Cook Sec $\frac{1}{4}$: W $\frac{1}{2}$ of NW $\frac{1}{4}$ Section: 31 T. 37 N. R. 14 E. PM: 3rd
Subject area: Parcels within area bounded by S. Western Ave. on the west, the METRA Railroad on the east, New St. on the south, and Walnut St. (extended) on the north.

The property described above IS NOT located in a Special Flood Hazard Area or a shaded Zone X floodzone.
Floodway mapped: N/A Floodway on property: No
Sources used: FEMA Flood Insurance Rate Map (FIRM, attached); tax parcel map 37-14-31C (2006); provided parcel list.
Community name: City of Blue Island, IL Community number: 170064
Panel/map number: 17031C0645 F Effective Date: November 6, 2000
Flood zone: X [unshaded] Base flood elevation: N/A ft NGVD 1929

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

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

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

Questions concerning this determination may be directed to Bill Saylor (217/333-0447) at the Illinois State Water Survey. Questions concerning requirements of Governor's Executive Order 5 (2006), or State floodplain regulations, may be directed to John Lentz (847/608-3100 x2022) at the IDNR Office of Water Resources.

William Saylor
William Saylor, CFM IL-02-00107, Illinois State Water Survey

Title: ISWS Surface Water & Floodplain Information Date: 1/11/2008

Post-it [®] Fax Note	7671	Date	1/11/2008	# of pages	3
To	Jack Axel	From	Bill	ATTACHMENT 4	
Co./Dept.	AS&A-319	Co.	ISWS		



**Illinois Historic
Preservation Agency**

FAX (217) 782-8161

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

Cook County
Blue Island

CON - Discontinuation of Pediatric Services, MetroSouth Medical Center
12935 Gregory St.
IHPA Log #021101509

October 27, 2009

Jacob Axel
Axel & Associates, Inc.
675 North Court, Suite 210
Palatine, IL 60067

Dear Mr. Axel:

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

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

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

If you have any further questions, please contact me at 217/785-5027.

Sincerely,

Anne E. Haaker

Anne E. Haaker
Deputy State Historic
Preservation Officer

DISCONTINUATION
GENERAL INFORMATION REQUIREMENTS

MetroSouth Medical Center proposes to discontinue its pediatrics category of service, consisting of six (6) beds, as of adjustments to the IDPH *Inventory* made by the State Board on April 22, 2009.

No other categories of service, other clinical service or non-clinical service will be impacted by the proposed discontinuation.

The discontinuation will occur within thirty days of the receipt of the requested Permit from the IHFSRB, and all required notifications will be made prior to the discontinuation.

The pediatrics unit will be used to allow the conversion of semi-private medical/surgical rooms into private rooms, and no equipment of any significance is involved in the discontinuation.

The medical records of past pediatrics patients will be maintained by MetroSouth Medical Center, initially in hard copy form, and then digitally recorded, as is the case with all medical records at MetroSouth. There are no plans to destroy any medical

records, and they will be routinely retrievable, as is the case with all of MetroSouth's medical records.

REASONS FOR DISCONTINUATION

The proposed discontinuation is the result of the following: 1) low utilization, 2) the availability of alternative providers, 3) the inefficient allocation of personnel as a result of the low utilization, 4) the inefficient allocation of other resources as a result of the low utilization, 5) the gross over-bedding in the area, and 6) the costs associated with providing a service with such low utilization.

During 2008, MetroSouth Medical Center admitted 181 pediatrics patients, and experienced an average daily census of 1.9 patients. During the 12-month period ending June 30, 2009, only 163 pediatrics patients were admitted, an average of 3.1 admissions per week.

There are four other providers of pediatrics services located within ten miles of MetroSouth, and on average, based on 2008 IDPH data, the combined approved pediatrics beds at those four hospitals exceeds the average daily census by 79.4. Stated another way, on average, within ten minutes of MetroSouth there are 79-80 unoccupied pediatrics beds. Clearly there is sufficient supply to meet any area need, and as confirmed in the letters from area hospitals contained in ATTACHMENT 9C, the hospitals are willing to accept the patients.

Last, with the discontinuation of this under-utilized service, MetroSouth will be able to allocate and utilize its resources, including staffing, in a more efficient manner.

IMPACT ON ACCESS

The proposed discontinuation of the pediatrics category of service at MetroSouth Medical Center will not have any adverse effect upon access to care for residents of the planning area, that being IDPH-designated Planning Area A-04.

The table on the following page identifies each acute care hospital located within a 45-minute drive of MetroSouth Medical Center (MapQuest, adjusted), approved to operate a pediatrics unit.

		Pediatrics		%
		Beds	ADC	Occupancy
Adventist Hinsdale Hospital	Hinsdale	19	17.4	91.6%
Advocate Christ Medical Center*	Oak Lawn	45	39.7	88.2%
Advocate Good Samaritan Hospital	Downers Grove	16	8.7	54.5%
Elmhurst Memorial Hospital	Elmhurst	6	1.9	30.9%
Ingalls Memorial Hospital*	Harvey	49	3.2	6.4%
Jackson Park Hospital	Chicago	8	0.0	0.0%
John Stroger	Chicago	40	11.1	27.8%
Little Company of Mary Hospital*	Evergreen Park	20	3.2	16.2%
Loretto Hospital	Chicago	10	0.0	0.0%
Loyola U. Medical Center	Maywood	34	20.0	58.7%
MacNeal Memorial Hospital	Berwyn	10	3.9	38.7%
Mercy Hospital	Chicago	37	3.1	8.3%
Mount Sinai Medical Center	Chicago	31	10.8	34.8%
Norwegian American Hospital	Chicago	5	3.6	71.9%
Palos Community Hospital*	Palos Heights	15	3.5	23.0%
Provena St. Joseph Hospital	Joliet	13	7.3	56.2%
Rush University Medical Center	Chicago	28	14.2	50.8%
Silver Cross Hospital	Joliet	8	3.7	46.3%
South Shore Hospital	Chicago	6	0.0	0.0%
St. Anthony Hospital	Chicago	12	5.7	47.2%
St. Bernard Hospital	Chicago	28	1.5	5.4%
St. James Hospital and Health Center*	Chicago Heights	10	0.2	1.8%
St. Mary of Nazareth	Chicago	14	6.7	47.7%
U. of Chicago Medical Center	Chicago	61	49.2	80.7%
U. of Illinois Medical Center	Chicago	<u>44</u>	<u>15.3</u>	<u>34.7%</u>
		569	233.9	41.1%

*located in IDPH-designated Planning Area A-04

Source: 2008 IDPH *Hospital Profiles*

As noted in the table above, there are 25 hospitals located within a 45-minute drive of MetroSouth that provide pediatric services, with four of those hospitals being located in IDPH-designated Planning Area A-04, which encompasses the southern Cook County suburbs. Cumulatively, during 2008, the 25 hospitals' pediatrics beds operated at 41.1% occupancy rate, compared to the IDPH's area-wide occupancy target rate of 90% (the hospital-specific occupancy target for programs of less than 100 beds is 80%). The four other pediatrics services located in Planning Area A-04 operate a total of 124 beds,

with a 2008 combined average daily census of 46.3 patients, resulting in a cumulative occupancy rate of 37.3%. Only one of the four providers operates with an occupancy rate over 16.2%, that being Advocate Christ Medical Center, which operated at 88.2% occupancy in 2008. The four hospitals located in Planning Area A-04 are all located within 12-31 minutes (MapQuest, adjusted), and as such, access to care should not be appreciably restricted due to travel issues.

In addition, MetroSouth has and will maintain formal pediatric transfer agreements with two nearby hospitals: Advocate Christ Medical Center and St. James Hospital and Health Center, both located in Planning Area A-04. Copies of these transfer agreements are attached, and it is envisioned that these agreements would be used primarily in conjunction with transfers from MetroSouth Medical Center's Emergency Department.

Consistent with the requirements of Part 1110.130c, letters were sent to all acute care hospitals located within 45 minutes of MetroSouth, requesting comment concerning the proposed discontinuation's impact on their facility. Copies of the template letter used, as well as the certified mail receipts are attached. As of the filing of this application, fifteen replies have been received. Five of the responding hospitals indicated that the discontinuation would not have an impact on their facility and that they "would be willing to admit these patients without conditions, limitations or discrimination"; eight hospitals indicated that the discontinuation would have no impact, one hospital indicated that they "would be willing to admit these patients without conditions, limitations or

discrimination” without indicating whether or not the discontinuation would have an impact on their hospital, and one hospital (Ingalls Memorial) indicated that the proposed discontinuation “... would negatively impact not only Ingalls Memorial Hospital but also the families and communities of Blue Island and its surrounding areas”. Ingalls did indicate that they would accept patients, however. According to IDPH data, Ingalls Memorial is authorized to operate 49 pediatrics beds, and in 2008 experienced an average daily census of 3.2 patients and an occupancy rate of 6.4%. Ingalls Memorial is located 4.8 miles/12 minutes (MapQuest, adjusted) from MetroSouth.

Copies of the responses are attached, and should additional responses be received, they will be forwarded to the State Agency.

In conclusion, and as a result of the low occupancy rates experienced by area pediatrics programs (only three of the 25 programs located within a 45-minute drive met the IDPH target utilization level in 2008) as well as the transfer agreements maintained by MetroSouth, the proposed discontinuation will not have an adverse effect on the ability of area residents to access pediatrics services.

**TRANSFER AGREEMENT
BETWEEN
METROSOUTH MEDICAL CENTER
ADVOCATE HEALTH AND HOSPITALS CORPORATION
d/b/a ADVOCATE CHRIST MEDICAL CENTER
AND HOPE CHILDREN'S HOSPITAL**

This Agreement is made and effective as of the 28th day of July, 2009, between Advocate Health and Hospitals Corporation d/b/a Advocate Christ Medical Center and Hope Children's Hospital, an Illinois not-for-profit corporation ("MEDICAL CENTER"), and MetroSouth Medical Center, an Illinois for-profit corporation ("FACILITY").

WHEREAS, both parties to this agreement desire to assure continuity of care and treatment appropriate to the needs of each patient in the MEDICAL CENTER and the FACILITY, and to use the skills, resources and physical plant of both patient care at both the acute and post-acute stages of illness.

NOW, THEREFORE, IN CONSIDERATION of the mutual advantage occurring to the parties hereto, the MEDICAL CENTER and FACILITY hereby covenant and agree with each other as follows:

1. Autonomy. The Board of Directors of the MEDICAL CENTER and the Board of Directors of the FACILITY shall continue to have exclusive control of the management, assets and affairs of their institutions, and neither party by virtue of this Agreement shall assume any liability for any debts or obligations which have been or which may be incurred by the other party to this Agreement.
2. Transfer of Patients. Whenever the attending physician of any patient confined in the MEDICAL CENTER or in the FACILITY shall determine that a transfer of such patient from one of these institutions to the other is medically appropriate, the parties shall take whatever steps may be necessary to effect such a transfer in their admissions policies to patients requiring such transfer, subject to availability of bed space, and provided that all the usual conditions for admission are met. Each party shall give notice to the other party, as far in advance as possible, of responsibility of the institution and attending physician initiating transfer to arrange for appropriate and safe transportation. Further, it shall be their responsibility for arranging for the care of the patient during transfer. These responsibilities will cease when the patient has been physically admitted at the designation designated.
3. Medical Center Admissions Priority. In establishing its preference in admission policies for patients subject to transfer from the FACILITY in accordance with Article II, the MEDICAL CENTER shall be guided by its usual admission requirements.

In accordance with criteria for admission:

- A. Patients declared as emergencies by their attending physicians shall be admitted to the MEDICAL CENTER without delay.
- B. Patients not strictly emergent, but requiring early admission to the MEDICAL CENTER, shall be placed on the MEDICAL CENTER's urgent list.
- C. Elective cases shall be booked for future admission to the MEDICAL CENTER according to the established routine of the MEDICAL CENTER.

4. Facility Admissions Priority. In establishing its preference in admission policies for patients subject to transfer from the MEDICAL CENTER in accordance with Article II, the FACILITY shall be guided by the following plan:

- A. To admit the patient from the MEDICAL CENTER as promptly as possible, provided general admission requirements established by the institution are met.
- B. To give priority to re-admission of patients transferred from the FACILITY to the MEDICAL CENTER.

5. Interchange of Information. The parties shall interchange all pertinent medical records and other information which may be necessary or useful in the care and treatment of patients transferred between the parties or which may be relevant to determining whether such parties can be adequately cared for otherwise than in either the MEDICAL CENTER or FACILITY. All such information shall be provided by the transferring institution in advance, where possible, and in any event at the time of the transfer, and shall be recorded on a referral form which shall be mutually agreed upon by the parties. This information shall include but not be limited to current medical findings, diagnosis, rehabilitation potential, and a brief summary of the course of treatment followed in the MEDICAL CENTER or the care of the patient, ambulation status and pertinent administrative and social information.

6. Transfer of Personal Effects. Procedures for affecting the transfer of patients and their personal effects and valuables shall be developed and adhered to by both parties. These procedures will include, but are not limited to, the provision of information concerning such valuables, money, and personal effects transferred with the patient so that a receipt may be given and received for same.

7. Final Financial Arrangements. Charges for services performed by either party for patients transferred from the other party pursuant to this Agreement shall be collected by the party rendering such services directly from the patient, third party payors or from other sources normally billed. Neither party shall have any liability to the other for such charges, except to the

extent that such liability would exist separate and apart from the Agreement. Nor shall either party receiving a transferred patient be responsible for collecting any previously outstanding account receivable due the other party from such patient.

8. Insurance. Each party shall maintain professional and public liability insurance coverage in the amount of One Million Dollars (\$1,000,000.000) per occurrence or claim made with respect to the actions of its employees and agents connected with or arising out of services provided under this Agreement.

9. Independent Contractor. Nothing contained in this Agreement shall constitute or be construed to create a partnership, joint venture, employment, or agency relationship between the parties and/or their respective successors and assigns, it being mutually understood and agreed that the parties shall provide the services and fulfill the obligations hereunder as independent contractors. Further, it is mutually understood and agreed that nothing in this Agreement shall in any way affect the independent operation of either HOSPITAL or FACILITY. The governing body of HOSPITAL and FACILITY shall have exclusive control of the management, assets, and affairs at their respective institutions. No party by virtue of this Agreement shall assume any liability for any debts or obligations of a financial or legal nature incurred by the other, and neither institution shall look to the other to pay for service rendered to a patient transferred by virtue of this Agreement.

10. Nondiscrimination. The parties agree to comply with Title VI of the Civil Rights Act of 1964, all requirements imposed by regulations issued pursuant to that title, section 504 of the Rehabilitation Act of 1973, and all related regulations, to insure that neither party shall discriminate against any recipient of services hereunder on the basis of race, color, sex, creed, national origin, age or handicap, under any program or activity receiving Federal financial assistance.

11. Term and Termination. This Agreement shall commence on July 28, 2009, and shall automatically be renewed annually for one year periods unless terminated according to this Section 10. This Agreement may be terminated by either party at any time upon the giving of at least sixty (60) day's prior written notice. Notwithstanding any notice which may have been given, however, this Agreement shall be automatically terminated whenever either party shall have its license to operate revoked, suspended or non-renewed.

12. Notices. All notices required to be served under this Agreement may be served on any of the parties hereto personally or may be served by sending a letter duly addressed by registered or certified mail. Notices to be served on MEDICAL CENTER shall be served at or mailed to: Advocate Christ Medical Center and Hope Children's Hospital, attention President, with a copy to Chief Legal Officer, Advocate Health and Hospitals Corporation 2025 Windsor Drive, Oak Brook, Illinois 60521. Notices to be served on FACILITY shall be served at or mailed to: MetroSouth Medical Center, attention Executive Vice President, 12935 South Gregory, Blue Island, Illinois 60406, unless otherwise instructed.

13. Advertising and Publicity. Neither party shall use the name of the other party in any promotional or advertising material unless review and approval of those intended use shall be first be obtained from the party whose name is to be used.

14. Nonexclusive Clause. Nothing in this Agreement shall be construed as limiting the right of either party to affiliate or contract with any other MEDICAL CETNER or FACILITY, or either a limited or general basis, while this Agreement is in effect.

15. Amendment. This Agreement may be amended, modified, or supplemented by agreement of both parties, but no such modification, amendment, or supplement shall be binding on either party unless and until the same is attached hereto in writing and signed by authorized officials of both parties.

16. Governing Law. All questions concerning the validity or construction of this Agreement shall be determined in accordance with the laws of Illinois.

IN WITNESS WHEREOF, this Agreement has been executed by MEDICAL CENTER and FACILITY on the date first written above.

ADVOCATE HEALTH AND HOSPITALS CORPORATION
d/b/a ADVOCATE CHRIST MEDICAL CETNER AND HOPE CHILDREN'S
HOSPITAL

By: K. W. Finkbeiner
President

METROSOUTH MEDICAL CENTER

By: [Signature]
Executive Vice President

28943

METROSOUTH MEDICAL CENTER

TRANSFER AGREEMENT

THIS TRANSFER AGREEMENT ("Agreement") is entered into as of the first day of July 2009 ("Effective Date") by and between MSMC Investors, a Delaware Corporation, d/b/a MetroSouth Medical Center ("Transferring Facility"), and Sisters of St. Francis Health Services, Inc. d/b/a St. James Hospital and Health Centers, an Indiana non-profit corporation ("Receiving Hospital") (each a "Party" and collectively the "Parties").

RECITALS

WHEREAS, Transferring Facility operates a general acute care hospital in Blue Island, Illinois; and

WHEREAS, Transferring Facility receives from time to time patients ("Patient" or "Patients") who are in need of pediatric services ("Specialty") not available at Transferring Facility, but available at Receiving Hospital; and

WHEREAS, Receiving Hospital operates general acute care hospitals in Chicago Heights and Olympia Fields, Illinois, and is willing to receive Patients from Transferring Facility in order to provide Specialty services; and

WHEREAS, the Parties wish to establish transfer arrangements in order to assure continuity of care and accessibility of services to Patients.

NOW, THEREFORE, for and in consideration of the terms, conditions, covenants, agreements and obligations contained herein, it is hereby mutually agreed by the Parties as follows:

ARTICLE I.

Patient Transfers

1.1. Acceptance of Patients. Upon recommendation of an attending physician and pursuant to the provisions of this Agreement, Receiving Hospital agrees to admit a Patient as promptly as possible, provided customary admission requirements are met, State and Federal laws and regulations are met, and Receiving Hospital has the capacity to treat the Patient. Notice of the transfer shall be given by Transferring Facility as far in advance as possible. Receiving Hospital shall give prompt confirmation of whether it can provide health care appropriate to the Patient's medical needs. Receiving Hospital agrees to exercise its best efforts to provide for prompt admission of transferred Patients.

1.2. Appropriate Transfer. It shall be the Transferring Facility's responsibility to arrange for, at no cost to Receiving Hospital, appropriate care and safe transportation of the Patient during a transfer. The Transferring Facility shall ensure that the transfer is an "appropriate transfer" under the Emergency Medical Treatment and Active Labor Act, as may be

amended from time to time ("EMTALA"), and carried out in accordance with all applicable laws and regulations.

(a) Prior to any Patient transfer to the Receiving Hospital, Transferring Facility shall provide sufficient information as far in advance as possible, and in any event prior to the Patient leaving Transferring Facility for transport, to allow the Receiving Hospital to determine whether it can provide the necessary Patient care and whether the anticipated transport time to Receiving Hospital is reasonable considering the Patient's medical needs, medical condition and proximity of other hospitals to Transferring Facility and the services offered by such alternative facilities. Prior to Patient transfer, the transferring physician or designee shall contact and secure acceptance by a receiving physician at Receiving Hospital who shall attend to the medical needs of the Patient and who will accept responsibility for the Patient's medical treatment at Receiving Hospital

(b) The Patient's medical record shall contain a physician's order to transfer, and the attending physician recommending the transfer shall communicate directly with Receiving Hospital's patient admissions, or, in the case of an emergency services patient who has been screened and stabilized for transfer, with the Receiving Hospital's Emergency Department.

(c) In addition to a Patient's medical records and the physician's order to transfer, Transferring Facility shall provide Receiving Hospital with a transfer authorization form executed by or on behalf of Patient and all information regarding a Patient's medications, and clear direction as to who may make medical decisions on behalf of the Patient, with copies of any power of attorney for medical decision making or, in the absence of such document, a list of next of kin, if feasible, to assist the Receiving Hospital in determining appropriate medical decision makers in the event a Patient is or becomes unable to do so on his or her own behalf.

1.3. Transfer Log. The Transferring Facility shall keep an accurate and current log of all Patients transferred to the Receiving Hospital and the disposition of such Patient transfers.

1.4. Admission to the Receiving Hospital from Transferring Facility. When a Patient's need for admission is determined by his/her attending physician, Receiving Hospital shall admit the Patient in accordance with the provisions of this Agreement as follows:

(a) Patients determined to be emergent by the attending physician shall be admitted, subject to bed, space, qualified personnel and equipment availability, provided that all usual conditions of admission to Receiving Hospital are met.

(b) All other Patients shall be admitted according to the established routine of Receiving Hospital.

1.5. Standard of Performance. Each Party shall, in performing its obligations under this Agreement, provide Patient care services in accordance with the same standards as services provided under similar circumstances to all other Patients of such Party, and as required by federal and state laws and Medicare/Medicaid certification standards. Each Party shall maintain

all legally required certifications and licenses from all applicable governmental and accrediting bodies, and shall maintain full eligibility for participation in Medicare and Medicaid.

1.6. Billing and Collections. Each Party shall be entitled to bill Patients, payors, managed care plans and any other third party responsible for paying a Patient's bill for services rendered to Patients by such Party and its employees, agents and representatives under this Agreement, and neither Party will have any liability to the other Party for such charges. Each Party shall be solely responsible for all matters pertaining to the billing and collection of such charges. The Parties shall reasonably cooperate with each other in the preparation and completion of all necessary forms and documentation and the determination of insurance coverage and managed care requirements for each transferred Patient. Each Party shall have the sole final responsibility for all forms, documentation, and insurance verification.

1.7. Personal Effects. Personal effects of any transferred Patient shall be delivered to the transfer team or admissions department of the Receiving Hospital. Personal effects include money, jewelry, personal papers and articles for personal hygiene.

ARTICLE II.

Medical Records

Subject to applicable confidentiality requirements, the Parties shall exchange all information which may be necessary or useful in the care and treatment of the transferred Patient or which may be relevant in determining whether such Patient can be adequately cared for by the other Party. All such information shall be provided by the Transferring Facility in advance, where possible, and in any event, no later than at the time of the transfer. The Transferring Facility shall send a copy of all Patient medical records that are available at the time of transfer to the Receiving Hospital. Other records shall be sent as soon as practicable after the transfer. The Patient's medical record shall contain evidence that the Patient was transferred promptly, safely and in accordance with all applicable laws and regulations. Each Party shall, and shall cause its employees and agents to protect the confidentiality of all Patient information (including, but not limited to, medical records, electronic data, radiology films, laboratory blocks, slides and billing information), and comply with all applicable state and federal laws and regulations protecting the confidentiality of Patients' records, including the Health Insurance Portability and Accountability Act of 1996 and the corresponding Standards for Privacy of Individually Identifiable Health Information regulations, each as amended from time to time (collectively, "HIPAA").

ARTICLE III.

Term and Termination

3.1. Term. The initial term of this Agreement shall begin on the Effective Date and continue for a period of one (1) year. **Thereafter, this Agreement shall automatically renew for successive one (1) year terms unless terminated pursuant to this Article.** The initial term and all renewal terms shall collectively be the "Term" of this Agreement.

3.2. Termination. This Agreement may be terminated as follows:

(a) Termination Without Cause. Either Party may terminate this Agreement, at any time without cause, upon ninety (90) days prior written notice to the other Party.

(b) Termination for Cause. The Parties shall have the right to immediately terminate this Agreement for cause upon the happening of any of the following:

- (i) If either Party determines that the continuation of this Agreement would endanger Patient care.
- (ii) Violation by the other Party of any material provision of this Agreement, provided such violation continues for a period of thirty (30) days after receipt of written notice by the other Party specifying the violation.
- (iii) A general assignment by the other Party for the benefit of creditors; the institution by or against the other Party, as debtor, of proceedings of any nature under any law of the United States or any state, whether now existing or currently enacted or amended, for the relief of debtors, provided that in the event such proceedings are instituted against the other Party remain unstayed or undismissed for thirty (30) days; the liquidation of the other Party for any reason; or the appointment of a receiver to take charge of the other Party's affairs, provided such appointment remains undischarged for thirty (30) days. Such termination of the provisions of this Agreement shall not affect obligations which accrued prior to the effective date of such termination.
- (iv) Exclusion of either Party from participation in the Medicare or Medicaid programs or conviction of either Party of a felony related to the provision of health care services.
- (v) Except with respect to a change from one accrediting body to another, either Party's loss or suspension of any certification, license, accreditation (including JCAHO accreditation or other applicable accreditation), or other approval necessary to render Patient care services.
- (vi) In the event of insufficient coverage as defined in Article V herein, or lapse of coverage.

ARTICLE IV.

Non-Exclusive Relationship

This Agreement shall be non-exclusive. Either Party shall be free to enter into any other similar arrangement at any time, and nothing in this Agreement shall be construed as limiting the

right of either Party to affiliate or contract with any other hospital, nursing home, home health agency, school or other entity on either a limited or general basis while this Agreement is in effect. Neither Party shall use the other Party's name or marks in any promotional or advertising material without first obtaining the written consent of the other Party. In entering into this Agreement, neither Party is acting to endorse or promote the services of the other Party.

ARTICLE V.

Certification and Insurance

5.1. Licenses, Permits, and Certification. Each Party represents to the other that it and all of its employees, agents and representatives possess and shall maintain in valid and current status during the term of this Agreement all required licenses, permits and certifications enabling each Party to provide the services set forth in this Agreement.

5.2. Insurance. Each Party shall maintain during the term of this Agreement, at its sole cost and expense, general liability and professional liability insurance in such amounts as are reasonable and customary in the industry to guard against those risks which are customarily insured against in connection with the operation of activities of comparable scope and size. A written certificate of such coverage shall be provided to each Party, upon request, together with a certification that such coverage may not be canceled without at least thirty (30) days notice to the other Party. Each Party shall notify the other Party within ten (10) days of any material change or cancellation in any policy of insurance required to be secured or maintained by such Party. In the event the form of insurance held by a party is claims made, such Party warrants and represents that it will purchase appropriate tail coverage for claims, demands, or actions reported in future years for acts of omissions during the Term of this Agreement. In the event of insufficient coverage as defined in this Article, or lapse of coverage, the non-breaching Party reserves the right to immediately and unilaterally terminate this Agreement.

5.3. Notification of Claims. Each Party shall notify the other in writing, by certified mail, of any action or suit filed and shall give prompt notice of any claim made against either by any person or entity which may result in litigation related in any way to this Agreement.

ARTICLE VI.

Indemnification

Each Party shall indemnify and hold harmless the other Party from and against any and all manner of claims, demands, causes of action, liabilities, damages, costs, and expenses (including costs and reasonable attorney's fees) arising from or incident to the performance of such Party's duties hereunder, except for negligent, grossly negligent, reckless or willful acts or omissions of the other Party. Notwithstanding anything to the contrary, a Party's obligations with respect to indemnification for acts described in this article shall not apply to the extent that such application would nullify any existing insurance coverage of such Party or as to that portion of any claim of loss in which an insurer is obligated to defend or satisfy.

ARTICLE VII.

Compliance With Laws

At all times, both Parties shall comply with all federal, state and local laws, rules and regulations now in effect or later adopted relating to the services to be provided hereunder and that may be applicable to the Parties including, but not limited to, laws, rules and regulations regarding confidentiality, disclosure and retention of Patient records, such as the regulations promulgated under HIPAA. A Party shall promptly notify the other Party if it receives notice of any actual or alleged infraction, violation, default or breach of the same. Neither Transferring Facility or Receiving Hospital, nor any employee, officer, director or agent thereof, is an "excluded person" under the Medicare rules and regulations.

Transferring Facility represents, warrants and covenants to Receiving Hospital that Transferring Hospital, prior to the first Patient transfer made under this Agreement and at all times thereafter during the term of the Agreement, will be licensed to operate a hospital in Illinois and will be a participating facility in Medicare and Medicaid. Receiving Hospital represents, warrants and covenants to Transferring Facility that Receiving Hospital is, and will be at all times during the term of this Agreement, licensed to operate a general acute care hospital, an approved provider of services required by the Specialty, a participant in Medicare and Medicaid.

ARTICLE VIII.

Miscellaneous

8.1. Non-Referral of Patients. Neither Party is under any obligation to refer or transfer Patients to the other Party, and neither Party will receive any payment for any Patient referred or transferred to the other Party. A Party may refer or transfer Patients to any facility based on its professional judgment and the individual needs and wishes of the Patients.

8.2. Relationship of the Parties. The Parties expressly acknowledge that in performing their respective obligations under this Agreement, they are acting as independent contractors. Transferring Facility and Receiving Hospital are not and shall not be considered joint venturers or partners, and nothing herein shall be construed to authorize either Party to act as general agent for the other. Neither Party, by virtue of this Agreement, assumes any liability for any debts or obligations of either a financial or legal nature incurred by the other Party. Each Party shall disclose in its respective dealings that they are separate entities.

8.3. No Third Party Rights. This Agreement shall not be construed under any circumstance to confer any rights or privileges on any third parties, and neither Party shall be under any obligation to any third party by reason of this Agreement or any term thereof.

8.4. Notices. All notices that may be given under this Agreement shall be in writing, addressed to the receiving Party's address as set forth below or otherwise designated in writing from time to time, and shall be delivered by hand, traceable courier service, or sent by certified or registered mail, return receipt requested:

To Transferring Facility:

MetroSouth Medical Center
12935 South Gregory Street
Blue Island, IL 60406
Attn: Executive Vice President of Finance
Fax No.: 708-389-9480

To Receiving Hospital: St. James Hospital & Health Centers
1423 Chicago Road
Chicago, Heights, IL 60411
Attn: President
Fax No. 708-756-6863

All notices shall be deemed to have been given, if by hand or traceable courier service, at the time of the delivery to the receiving Party at the address set forth above or to such other address as the receiving Party may designate by notice hereunder, or if sent by certified or registered mail, on the 2nd business day after such mailing.

8.5. Assignment. Neither Party may assign its rights or delegate its obligations under this Agreement without the prior written consent of the other, except that either Party may assign all or part of its rights and delegate all or part of its obligations under this Agreement to any entity controlled by or under common control with such Party.

8.6. Entire Agreement; Amendment. This Agreement contains the entire agreement of the Parties with respect to the subject matter hereof and may not be amended or modified except in a writing signed by both Parties. All continuing covenants, duties, and obligations contained herein shall survive the expiration or termination of this Agreement.

8.7. Governing Law. This Agreement shall be governed by and construed according to the laws of the State of Illinois without regard to the conflict of laws provisions thereunder.

8.8. Headings. The headings of articles and sections contained in this Agreement are for reference purposes only and will not affect in any way the meaning or interpretation of this Agreement.

8.9. Non-discrimination. Neither Party shall discriminate against any individuals on the basis of race, color, sex, age, religion, national origin, or disability in providing services under this Agreement.

8.10. Severability. If any provision of this Agreement, or the application thereof to any person or circumstance, shall be held to be invalid, illegal or unenforceable in any respect by any court or other entity having the authority to do so, the remainder of this Agreement, or the application of such affected provision to persons or circumstances other than those to which it is held invalid or unenforceable, shall be in no way affected, prejudiced or disturbed, and each provision of this Agreement shall be valid and shall be enforced to the fullest extent permitted by law.


8.11. Successors and Assigns. This Agreement shall be binding upon, and shall inure to the benefit of the Parties hereto, their respective successors and permitted assigns.

8.12. Waiver. No covenant or condition of this Agreement can be waived, except to the extent set forth in writing by the waving Party.

8.13. Counterparts. This Agreement may be executed in two (2) counterparts, each of which shall be deemed an original, but all of which, when taken together, shall constitute one and the same Agreement.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed and delivered as of the day and year written above.


TRANSFERRING FACILITY

Signature:  Date: 08/31/09

Name: Barbara Groux

Title: Executive Vice President of Finance

RECEIVING HOSPITAL

Signature:  Date: 7/14/09
Seth C.R. Warren, President

LETTERHEAD

Sent via Certified Mail / Delivery Receipt Requested

September 21, 2009

«Title» «First» «Last» «Degree»
«Suffix»
«Hosp»
«Street_1»
«City», «State» «Zip»

Re: Application for Permit to Discontinue Pediatric Services

Dear «Title» «Last»,

MetroSouth Medical Center intends to file an Application for Permit with the Illinois Health Facilities and Services Review Board to "discontinue" its 33-bed pediatrics service.

Consistent with Section 1110.130.c of the IHFSRB's rules, and in order to document that this "discontinuation" will not have an adverse impact upon access to pediatrics services, we would appreciate it if you could please identify:

- 1) what, if any, impact this "discontinuation" will have on your hospital, and,
- 2) whether you would be willing to admit these patients without conditions, limitations or discrimination.

Please indicate your response(s) below and return a copy of this letter in the self addressed, stamped envelope provided.

Thank you for your prompt attention to this matter.

Enrique Beckmann, MD, PhD
President & Chief Executive Officer

- This discontinuation will have no impact on our hospital.*
- This discontinuation will have the following impact on our hospital:*

- We would be willing to admit these patients without conditions, limitations or discrimination.*

ATTACHMENT 9 C

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Guy Medaglia
 President & CEO
 St. Anthony Hospital
 2875 West 19th Street
 Chicago, IL 60623-3501

2. Article Number
(Transfer from service label)

91 7108 2133 3934 6160 3365

PS Form 3811, February 2004

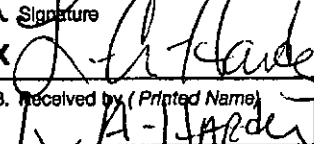
Domestic Return Receipt

102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X


 Agent Addressee

B. Received by (Printed Name)



C. Date of Delivery

D. Is delivery address different from item 1? Yes
If YES, enter delivery address below: No

3. Service Type

 Certified Mail Express Mail Registered Return Receipt for Merchandise Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes**SENDER: COMPLETE THIS SECTION**

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Sr. Elizabeth Van Straten
 President
 St. Bernard Hospital & Hlth Ctr
 326 West 64th Street
 Chicago, IL 60621

2. Article Number
(Transfer from service label)

91 7108 2133 3934 6160 3327

PS Form 3811, February 2004

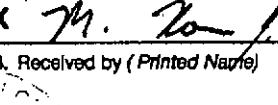
Domestic Return Receipt

102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X


 Agent Addressee

B. Received by (Printed Name)



C. Date of Delivery

9/24/09

D. Is delivery address different from item 1? Yes
If YES, enter delivery address below: No

3. Service Type

 Certified Mail Express Mail Registered Return Receipt for Merchandise Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes**SENDER: COMPLETE THIS SECTION**

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Ms. Margaret McDermott
 Exec Vice Pres & CEO
 St. Elizabeth Hospital
 1431 North Claremont Avenue
 Chicago, IL 60622-1791

2. Article Number
(Transfer from service label)

91 7108 2133 3934 6160 3358

PS Form 3811, February 2004

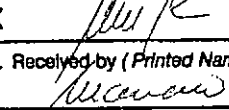
Domestic Return Receipt

102595-02-M-1540

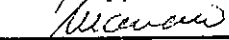
COMPLETE THIS SECTION ON DELIVERY

A. Signature

X


 Agent Addressee

B. Received by (Printed Name)



C. Date of Delivery

9/24/09

D. Is delivery address different from item 1? Yes
If YES, enter delivery address below: No

3. Service Type

 Certified Mail Express Mail Registered Return Receipt for Merchandise Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes

ATTACHMENT 9 C

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Jeffrey Brickman, FACHE
Regional President & CEO
Provena St. Joseph Med.Ctr.
333 North Madison Street
Joliet, IL 60435-6595

2. Article Number
(Transfer from service label)

91 7108 2133 3934 6160 3181

PS Form 3811, February 2004

Domestic Return Receipt

102585-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature *[Signature]* Agent
 Addressee

B. Received by (Printed Name) *Jim LaSala* C. Date of Delivery *9-24-09*

D. Is delivery address different from item 1? Yes
If YES, enter delivery address below: No

SEP 24 2009

3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee) Yes

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Anthony Puorro
Interim President & CEO
Roseland Community Hosp.
45 West 111th Street
Chicago, IL 60628-5296

2. Article Number
(Transfer from service label)

91 7108 2133 3934 6160 3372

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature *[Signature]* Agent
 Addressee

B. Received by (Printed Name) C. Date of Delivery *9/24/09*

D. Is delivery address different from item 1? Yes
If YES, enter delivery address below: No

3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee) Yes

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Dr. Larry Goodman, MD
President & CEO
Rush University Med.Ctr.
1653 West Congress Parkway
Chicago, IL 60612-3864

2. Article Number
(Transfer from service label)

91 7108 2133 3934 6160 3266

PS Form 3811, February 2004

COMPLETE THIS SECTION ON DELIVERY

A. Signature *[Signature]* Agent
 Addressee

B. Received by (Printed Name) C. Date of Delivery

D. Is delivery address different from item 1? Yes
If YES, enter delivery address below: No

3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee) Yes

ATTACHMENT 9 C

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Sr. Sheila Lyne, RSM
 President
 Mercy Hosp & Med Ctr
 2525 South Michigan Avenue
 Chicago, IL 60616

2. Article Number
 (Transfer from service label)

91 7108 2133 3934 6160 3297

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

- A. Signature Agent Addressee
X J. Seligman
- B. Received by (Printed Name) Agent Addressee
 C. Date of Delivery
 SEP 24 2009
- D. Is delivery address different from item 1? Yes
 If YES, enter delivery address below: No

3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.
4. Restricted Delivery? (Extra Fee) Yes

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Michael O'Grady
 President & CEO
 Norwegian American Hospital
 1044 North Francisco Avenue
 Chicago, IL 60622-2794

2. Article Number
 (Transfer from service label)

91 7108 2133 3934 6160 3334

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

- A. Signature Agent Addressee
X Ador Jimenez
- B. Received by (Printed Name) Agent Addressee
 C. Date of Delivery
 9/24/09
- D. Is delivery address different from item 1? Yes
 If YES, enter delivery address below: No

3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.
4. Restricted Delivery? (Extra Fee) Yes

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Sr. Margaret Wright, President
 Palos Community Hospital
 12251 South 80th Avenue
 Palos Heights, IL 60463-1256

2. Article Number
 (Transfer from service label)

91 7108 2133 3934 6160 3211

COMPLETE THIS SECTION ON DELIVERY

- A. Signature Agent Addressee
X W. Wright
- B. Received by (Printed Name) Agent Addressee
 C. Date of Delivery
 9-23-09
- D. Is delivery address different from item 1? Yes
 If YES, enter delivery address below: No

3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.
4. Restricted Delivery? (Extra Fee) Yes

ATTACHMENT 9 C

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Alan Channing
 President & CEO
 Mount Sinai Hospital
 California Avenue at 15th Street
 Chicago, IL 60608-1797

2. Article Number
(Transfer from service label)

91 7108 2133 3934 6160 3259

Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature


 Agent Addressee

B. Received by (Printed Name)

Alan Channing

C. Date of Delivery

D. Is delivery address different from item 1? Yes
If YES, enter delivery address below: No

3. Service Type

 Certified Mail Express Mail Registered Return Receipt for Merchandise Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes**SENDER: COMPLETE THIS SECTION**

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Dr. Paul Whelton, MD
 President & CEO
 Loyola Univ Medical Ctr
 2160 South First Avenue
 Maywood, IL 60153-5599

2. Article Number
(Transfer from service label)

91 7108 2133 3934 6160 3105

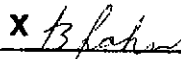
PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature


 Agent Addressee

B. Received by (Printed Name)

D. Is delivery address different from item 1? Yes
If YES, enter delivery address below: No

3. Service Type

 Certified Mail Express Mail Registered Return Receipt for Merchandise Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes**SENDER: COMPLETE THIS SECTION**

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

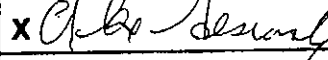
Mr. Brian Lemon
 Chief Executive Officer
 MacNeal Hospital
 3249 South Oak Park Avenue
 Berwyn, IL 60402-0715

2. Article Number
(Transfer from service label)

91 7108 2133 3934 6160 3136

COMPLETE THIS SECTION ON DELIVERY

A. Signature


 Agent Addressee

B. Received by (Printed Name)

D. Is delivery address different from item 1? Yes
If YES, enter delivery address below: No

3. Service Type

 Certified Mail Express Mail Registered Return Receipt for Merchandise Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes

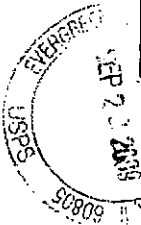
ATTACHMENT 9 C

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Dennis Reilly, Pres.
 Little Co. of Mary Hospital
 2800 West 95th Street
 Evergreen Park, IL 60805



2. Article Number
(Transfer from service label)

91 7108 2133 3934 6160 3426

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature Agent
 Addressee
Dan Finnegan
 B. Received by (Printed Name) C. Date of Delivery
 Dan Finnegan 9-23-09
 D. Is delivery address different from item 1? Yes
 If YES, enter delivery address below: No

3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.
 4. Restricted Delivery? (Extra Fee) Yes

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Dr. Peter Friedell, MD
 Chief Executive Officer
 Jackson Park Hosp & Med Ctr
 7531 South Stony Island Avenue
 Chicago, IL 60649

2. Article Number
(Transfer from service label)

91 7108 2133 3934 6160 3419

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature Agent
 Addressee
P. Friedell
 B. Received by (Printed Name) C. Date of Delivery
 P. Friedell 9-23-09
 D. Is delivery address different from item 1? Yes
 If YES, enter delivery address below: No

3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.
 4. Restricted Delivery? (Extra Fee) Yes

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Steven Drucker, FACHE
 President & CEO
 Loretto Hospital
 645 South Central Avenue
 Chicago, IL 60644-9987

2. Article Number
(Transfer from service label)

91 7108 2133 3934 6160 3402

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature Agent
 Addressee
S. Drucker
 B. Received by (Printed Name) C. Date of Delivery
 S. Drucker 9/22/09
 D. Is delivery address different from item 1? Yes
 If YES, enter delivery address below: No

3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.
 4. Restricted Delivery? (Extra Fee) Yes

ATTACHMENT 9 C

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Leo Ronza
 President & CEO
 Elmhurst Memorial Hospital
 200 Bertan Avenue
 Elmhurst, IL 60126-2989

2. Article Number
(Transfer from service label)

91 7108 2133 3934 6160 3112

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature Agent
 Addressee
 B. Received by (Printed Name) Agent
 Addressee
 C. Date of Delivery
 D. Is delivery address different from item 1? Yes
 If YES, enter delivery address below: No

3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee) Yes

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Wayne Lerner, DPH
 President
 Holy Cross Hospital
 2701 West 68th Street
 Chicago, IL 60629-1883

2. Article Number
(Transfer from service label)

91 7108 2133 3934 6160 3389

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature Agent
 Addressee
 B. Received by (Printed Name) Agent
 Addressee
 C. Date of Delivery
 D. Is delivery address different from item 1? Yes
 If YES, enter delivery address below: No

3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee) Yes

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Kurt Johnson
 President & CEO
 Ingalls Memorial Hospital
 One Ingalls Drive
 Harvey, IL 60426-3558

2. Article Number
(Transfer from service label)

91 7108 2133 3934 6160 3150

COMPLETE THIS SECTION ON DELIVERY

A. Signature Agent
 Addressee
 B. Received by (Printed Name) Agent
 Addressee
 C. Date of Delivery
 D. Is delivery address different from item 1? Yes
 If YES, enter delivery address below: No

3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee) Yes

ATTACHMENT 9 C

SENDER: COMPLETE THIS SECTION

- Complete Items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. David Fox, President
 Advocate Good Samaritan Hosp.
 3815 Highland Avenue
 Downers Grove, IL 60515-1590

2. Article Number
 (Transfer from service label)

COMPLETE THIS SECTION ON DELIVERY

A. Signature Agent Addressee
 X *[Signature]*

B. Received by (Printed Name) *P. Curran* C. Date of Delivery *9/29*

D. Is delivery address different from item 1? Yes
 If YES, enter delivery address below: No

3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee) Yes

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

SENDER: COMPLETE THIS SECTION

- Complete Items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Dr. Ann Errichetti, MD
 President
 Advocate So. Suburban Hosp.
 17800 South Kedzie Avenue
 Hazel Crest, IL 60429-0989

2. Article Number
 (Transfer from service label)

COMPLETE THIS SECTION ON DELIVERY

A. Signature Agent Addressee
 X *[Signature]*

B. Received by (Printed Name) *KAIP* C. Date of Delivery *9-23-09*

D. Is delivery address different from item 1? Yes
 If YES, enter delivery address below: No

3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee) Yes

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

SENDER: COMPLETE THIS SECTION

- Complete Items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Jonathan Bruss
 President
 Advocate Trinity Hospital
 2320 East 93rd Street
 Chicago, IL 60617-3983

2. Article Number
 (Transfer from service label)

COMPLETE THIS SECTION ON DELIVERY

A. Signature Agent Addressee
 X *[Signature]*

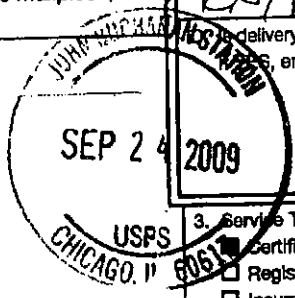
B. Received by (Printed Name) *KAIP B* C. Date of Delivery

D. Is delivery address different from item 1? Yes
 If YES, enter delivery address below: No

3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee) Yes

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540



ATTACHMENT 9 C

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. David Crane
 Chief Executive Officer
 Adventist Hinsdale Hospital
 120 North Oak Street
 Hinsdale, IL 60521-3829

2. Article Number
 (Transfer from service label) 91 7108 2133 3934 6160 3235

COMPLETE THIS SECTION ON DELIVERY

A. Signature
 X M. Pice Agent Addressee

B. Received by (Printed Name) C. Date of Delivery

D. Is delivery address different from item 1? Yes
 If YES, enter delivery address below: No

3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee) Yes

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Rick Wright
 Chief Executive Officer
 Adventist LaGrange Mem. Hosp.
 5101 South Willow Springs Road
 LaGrange, IL 60525-2679

2. Article Number
 (Transfer from service label) 91 7108 2133 3934 6160 3242

COMPLETE THIS SECTION ON DELIVERY

A. Signature
 X [Signature] Agent Addressee

B. Received by (Printed Name) C. Date of Delivery
Mike Schultz 9-22

D. Is delivery address different from item 1? Yes
 If YES, enter delivery address below: No

3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee) Yes

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Kenneth Lukhard
 President
 Advocate Christ Med. Ctr.
 4440 West 95th Street
 Oak Lawn, IL 60453-2699

2. Article Number
 (Transfer from service label) 91 7108 2133 3934 6160 3198

COMPLETE THIS SECTION ON DELIVERY

A. Signature
 X [Signature] Agent Addressee

B. Received by (Printed Name) C. Date of Delivery
DAN MCCREARY SEP 21 2004

D. Is delivery address different from item 1? Yes
 If YES, enter delivery address below: No

3. Service Type
 Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee) Yes

ATTACHMENT 9 C

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Ms. Margaret McDermott
 Exec Vice Pres & CEO
 St. Mary of Nazareth Hospital
 2233 West Division Street
 Chicago, IL 60622-3087

2. Article Number

(Transfer from service label)

91 7108 2133 3934 6160 3341

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

[Signature]

- Agent
 Addressee

B. Received by (Printed Name)

[Signature]

C. Date of Delivery

9/24/09

D. Is delivery address different from item 1? Yes

If YES, enter delivery address below: No

3. Service Type

- Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee)

Yes

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Dr. James Madara, MD
 Chief Executive Officer
 University of Chicago Med Ctr
 5841 South Maryland Ave, M/C 1114
 Chicago, IL 60637-1470

2. Article Number

(Transfer from service label)

91 7108 2133 3934 6160 3396

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

[Signature]

- Agent
 Addressee

B. Received by (Printed Name)

[Signature]

C. Date of Delivery

9-24-09

D. Is delivery address different from item 1? Yes

If YES, enter delivery address below: No

3. Service Type

- Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee)

Yes

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. John DeNardo
 CEO, Healthcare System
 Univ of IL Med Ctr at Chicago
 1740 West Taylor Street
 Suite 1400, M/C 693
 Chicago, IL 60612-7236

2. Article Number

91 7108 2133 3934 6160 3280

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

[Signature]

- Agent
 Addressee

B. Received by (Printed Name)

[Signature]

C. Date of Delivery

[Signature]

D. Is delivery address different from item 1? Yes

If YES, enter delivery address below: No

3. Service Type

- Certified Mail Express Mail
 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee)

Yes

ATTACHMENT 9 C

SENDER: COMPLETE THIS SECTION

- Complete Items 1, 2, and 3. Also complete Item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Paul Pawlak
 President & CEO
 Silver Cross Hospital
 1200 Maple Road
 Joliet, IL 60432-1497

2. Article Number
(Transfer from service label)

91 7108 2133 3934 6160 3174

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

 Agent Addressee

B. Received by (Printed Name)

C. Date of Delivery

D. Is delivery address different from item 1? Yes
If YES, enter delivery address below: No

3. Service Type

 Certified Mail Express Mail Registered Return Receipt for Merchandise Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes**SENDER: COMPLETE THIS SECTION**

- Complete Items 1, 2, and 3. Also complete Item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Jesus Ong, President
 South Shore Hospital
 8012 South Crandon Avenue
 Chicago, IL 60617

2. Article Number
(Transfer from service label)

91 7108 2133 3934 6160 3310

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

 Agent Addressee

B. Received by (Printed Name)

C. Date of Delivery

D. Is delivery address different from item 1? Yes
If YES, enter delivery address below: No

3. Service Type

 Certified Mail Express Mail Registered Return Receipt for Merchandise Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes

SENDER: COMPLETE THIS SECTION

- Complete Items 1, 2, and 3. Also complete Item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Seth Warren, President
 St. James Hosp & Hlth Ctr
 20201 South Crawford Avenue
 Olympia Fields, IL 60461-1080

2. Article Number
(Transfer from service label)

91 7108 2133 3934 6160 3204

PS Form 3811, February 2004

Domestic Return Receipt

102585-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X  Agent Addressee

B. Received by (Printed Name)

B. Warren

C. Date of Delivery

09/23/09

D. Is delivery address different from Item 1? YesIf YES, enter delivery address below: No

3. Service Type

 Certified Mail Express Mail Registered Return Receipt for Merchandise Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes**SENDER: COMPLETE THIS SECTION**

- Complete Items 1, 2, and 3. Also complete Item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Seth Warren, President
 St. James Hosp & Hlth Ctr
 1423 Chicago Road
 Chicago Heights, IL 60411-3400

2. Article Number
(Transfer from service label)

91 7108 2133 3934 6160 3143

PS Form 3811, February 2004

Domestic Return Receipt

102585-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X MOG

 Agent Addressee

B. Received by (Printed Name)

MOG

C. Date of Delivery

9-24-09

D. Is delivery address different from Item 1? YesIf YES, enter delivery address below: No

3. Service Type

 Certified Mail Express Mail Registered Return Receipt for Merchandise Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes



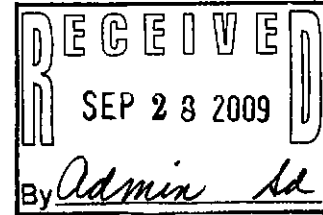
MetroSouth
MEDICAL CENTER

12935 South Gregory Street, Blue Island, IL 60406-2428
T (708) 597-2000 · W MetroSouthMedicalCenter.com

Sent via Certified Mail / Delivery Receipt Requested

September 21, 2009

Mr. Jeffrey Brickman, FACHE
Regional President & CEO
Provena Saint Joseph Medical Center
333 North Madison Street
Joliet, IL 60435-6595



Re: Application for Permit to Discontinue Pediatric Services

Dear Mr. Brickman,

MetroSouth Medical Center intends to file an Application for Permit with the Illinois Health Facilities and Services Review Board to "discontinue" its 33-bed pediatrics service.

Consistent with Section 1110.130.c of the IHFSRB's rules, and in order to document that this "discontinuation" will not have an adverse impact upon access to pediatrics services, we would appreciate it if you could please identify:

- 1) what, if any, impact this "discontinuation" will have on your hospital, and,
- 2) whether you would be willing to admit these patients without conditions, limitations or discrimination.

Please indicate your response(s) below and return a copy of this letter in the self addressed, stamped envelope provided.

Thank you for your prompt attention to this matter.


Enrique Beckmann, MD, PhD
President & Chief Executive Officer

This discontinuation will have no impact on our hospital.

This discontinuation will have the following impact on our hospital:

We would be willing to admit these patients without conditions, limitations or discrimination.

ATTACHMENT 9 C



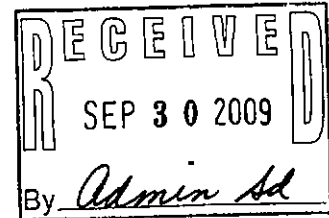
MetroSouth
MEDICAL CENTER

12935 South Gregory Street, Blue Island, IL 60406-2428
T (708) 597-2000 · W MetroSouthMedicalCenter.com

Sent via Certified Mail / Delivery Receipt Requested

September 21, 2009

Sr. Sheila Lyne, RSM
President
Mercy Hospital & Medical Center
2525 South Michigan Avenue
Chicago, IL 60616



Re: Application for Permit to Discontinue Pediatric Services

Dear Sr. Lyne,

MetroSouth Medical Center intends to file an Application for Permit with the Illinois Health Facilities and Services Review Board to "discontinue" its 33-bed pediatrics service.

Consistent with Section 1110.130.c of the IHFSRB's rules, and in order to document that this "discontinuation" will not have an adverse impact upon access to pediatrics services, we would appreciate it if you could please identify:

- 1) what, if any, impact this "discontinuation" will have on your hospital, and,
- 2) whether you would be willing to admit these patients without conditions, limitations or discrimination.

Please indicate your response(s) below and return a copy of this letter in the self addressed, stamped envelope provided.

Thank you for your prompt attention to this matter.

Enrique Beckmann, MD, PhD
President & Chief Executive Officer

This discontinuation will have no impact on our hospital.

This discontinuation will have the following impact on our hospital:

We would be willing to admit these patients without conditions, limitations or discrimination.

ATTACHMENT 9 C



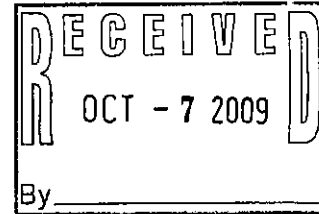
MetroSouth
MEDICAL CENTER

12935 South Gregory Street, Blue Island, IL 60406-2428
T (708) 597-2000 · W MetroSouthMedicalCenter.com

Sent via Certified Mail / Delivery Receipt Requested

September 21, 2009

Mr. Anthony Puorro
~~Interim~~ President & CEO
Roseland Community Hospital
45 West 111th Street
Chicago, IL 60628-5296



Re: Application for Permit to Discontinue Pediatric Services

Dear Mr. Puorro,

MetroSouth Medical Center intends to file an Application for Permit with the Illinois Health Facilities and Services Review Board to "discontinue" its 33-bed pediatrics service.

Consistent with Section 1110.130.c of the IHFSRB's rules, and in order to document that this "discontinuation" will not have an adverse impact upon access to pediatrics services, we would appreciate it if you could please identify:

- 1) what, if any, impact this "discontinuation" will have on your hospital, and,
- 2) whether you would be willing to admit these patients without conditions, limitations or discrimination.

Please indicate your response(s) below and return a copy of this letter in the self addressed, stamped envelope provided.

Thank you for your prompt attention to this matter.

Enrique Beckmann, MD, PhD
President & Chief Executive Officer

This discontinuation will have no impact on our hospital.

This discontinuation will have the following impact on our hospital:

We would be willing to admit these patients without conditions, limitations or discrimination.

ATTACHMENT 9 C

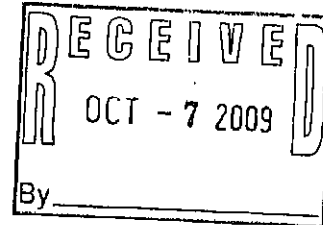


**LOYOLA
MEDICINE**

Loyola University Health System

Paul K. Whelton, MB, MD, MSc
President and Chief Executive Officer,
Loyola University Health System
Vice President for the Health Sciences,
Loyola University Chicago
Office: (708) 216-3215 • Fax: (708) 216-6227
E-mail: pwhelton@lumc.edu

September 29, 2009



Dr. Enrique Beckmann
President & Chief Executive Officer
MetroSouth Medical Center
12935 South Gregory Street
Blue Island, Ill 60406-2428

Re: Discontinuation of Pediatric Unit at MetroSouth Medical Center

Dear Dr. Beckmann:

Thank you for your letter dated September 21, 2009 informing us of MetroSouth's Application for Permit to discontinue pediatric services. It is anticipated that this discontinuation will have a minimal impact on our facility. Should patients affected by this closure need admission for appropriate medical care at Loyola University Hospital, they will be admitted without regard to race, color, gender, age, ethnicity, religion or ability to pay.

Yours sincerely,

Paul K. Whelton, M.B., M.D., M.Sc.
President and Chief Executive Officer
Loyola University Health System
Loyola University Medical Center

We also treat the human spirit.®

REC'D SEP 28 2009



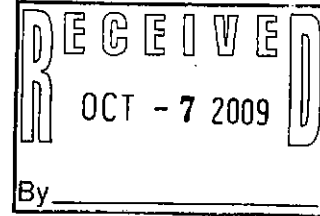
MetroSouth
MEDICAL CENTER

12935 South Gregory Street, Blue Island, IL 60406-2428
T (708) 597-2000 · W MetroSouthMedicalCenter.com

Sent via Certified Mail / Delivery Receipt Requested

September 21, 2009

Dr. Larry Goodman, MD
President & CEO
Rush University Medical Center
1653 West Congress Parkway
Chicago, IL 60612-3864



Re: Application for Permit to Discontinue Pediatric Services

Dear Dr. Goodman,

MetroSouth Medical Center intends to file an Application for Permit with the Illinois Health Facilities and Services Review Board to "discontinue" its 33-bed pediatrics service.

Consistent with Section 1110.130.c of the IHFSRB's rules, and in order to document that this "discontinuation" will not have an adverse impact upon access to pediatrics services, we would appreciate it if you could please identify:

- 1) what, if any, impact this "discontinuation" will have on your hospital, and,
- 2) whether you would be willing to admit these patients without conditions, limitations or discrimination.

Please indicate your response(s) below and return a copy of this letter in the self addressed, stamped envelope provided.

Thank you for your prompt attention to this matter.

Enrique Beckmann, MD, PhD
President & Chief Executive Officer

This discontinuation will have no impact on our hospital.

This discontinuation will have the following impact on our hospital:

We would be willing to admit these patients without conditions, limitations or discrimination.

ATTACHMENT 9 C



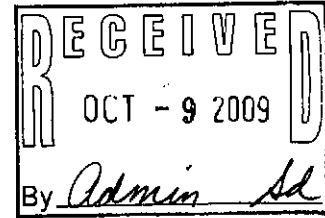
MetroSouth
MEDICAL CENTER

12935 South Gregory Street, Blue Island, IL 60406-2428
T (708) 597-2000 · W MetroSouthMedicalCenter.com

Sent via Certified Mail / Delivery Receipt Requested

September 21, 2009

Mr. Wayne Lerner , DPH
President
Holy Cross Hospital
2701 West 68th Street
Chicago, IL 60629-1883



Re: Application for Permit to Discontinue Pediatric Services

Dear Mr. Lerner,

MetroSouth Medical Center intends to file an Application for Permit with the Illinois Health Facilities and Services Review Board to "discontinue" its 33-bed pediatrics service.

Consistent with Section 1110.130.c of the IHFSRB's rules, and in order to document that this "discontinuation" will not have an adverse impact upon access to pediatrics services, we would appreciate it if you could please identify:

- 1) what, if any, impact this "discontinuation" will have on your hospital, and,
- 2) whether you would be willing to admit these patients without conditions, limitations or discrimination.

Please indicate your response(s) below and return a copy of this letter in the self addressed, stamped envelope provided.

Thank you for your prompt attention to this matter.

Enrique Beckmann, MD, PhD
President & Chief Executive Officer

This discontinuation will have no impact on our hospital.

This discontinuation will have the following impact on our hospital:

We would be willing to admit these patients without conditions, limitations or discrimination.

ATTACHMENT 9 C



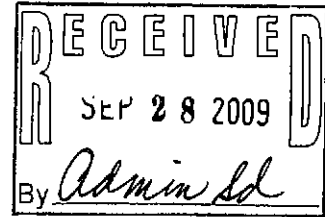
MetroSouth
MEDICAL CENTER

12935 South Gregory Street, Blue Island, IL 60406-2428
T (708) 597-2000 • W MetroSouthMedicalCenter.com

Sent via Certified Mail / Delivery Receipt Requested

September 21, 2009

Mr. Jesus Ong
President
South Shore Hospital
8012 South Crandon Avenue
Chicago, IL 60617



Re: Application for Permit to Discontinue Pediatric Services

Dear Mr. Ong,

MetroSouth Medical Center intends to file an Application for Permit with the Illinois Health Facilities and Services Review Board to "discontinue" its 33-bed pediatrics service.

Consistent with Section 1110.130.c of the IHFSRB's rules, and in order to document that this "discontinuation" will not have an adverse impact upon access to pediatrics services, we would appreciate it if you could please identify:

- 1) what, if any, impact this "discontinuation" will have on your hospital, and,
- 2) whether you would be willing to admit these patients without conditions, limitations or discrimination.

Please indicate your response(s) below and return a copy of this letter in the self addressed, stamped envelope provided.

Thank you for your prompt attention to this matter.

Enrique Beckmann, MD, PhD
President & Chief Executive Officer

- This discontinuation will have no impact on our hospital.
- This discontinuation will have the following impact on our hospital:

- We would be willing to admit these patients without conditions, limitations or discrimination.

*SOUTH SHORE HOSPITAL DOES NOT PROVIDE PEDIATRICS
INPATIENT CARE*

ATTACHMENT 9 C

62 [Signature] 9-25-09



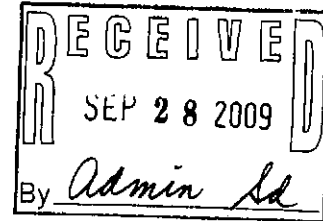
MetroSouth
MEDICAL CENTER

12935 South Gregory Street, Blue Island, IL 60406-2428
T (708) 597-2000 · W MetroSouthMedicalCenter.com

Sent via Certified Mail / Delivery Receipt Requested

September 21, 2009

Sr. Elizabeth Van Straten
President
Saint Bernard Hospital & Health Care Center
326 West 64th Street
Chicago, IL 60621



Re: Application for Permit to Discontinue Pediatric Services

Dear Sr. Van Straten,

MetroSouth Medical Center intends to file an Application for Permit with the Illinois Health Facilities and Services Review Board to "discontinue" its 33-bed pediatrics service.

Consistent with Section 1110.130.c of the IHFSRB's rules, and in order to document that this "discontinuation" will not have an adverse impact upon access to pediatrics services, we would appreciate it if you could please identify:

- 1) what, if any, impact this "discontinuation" will have on your hospital, and,
- 2) whether you would be willing to admit these patients without conditions, limitations or discrimination.

Please indicate your response(s) below and return a copy of this letter in the self addressed, stamped envelope provided.

Thank you for your prompt attention to this matter.

Enrique Beckmann, MD, PhD
President & Chief Executive Officer

This discontinuation will have no impact on our hospital.

This discontinuation will have the following impact on our hospital:

We would be willing to admit these patients without conditions, limitations or discrimination.

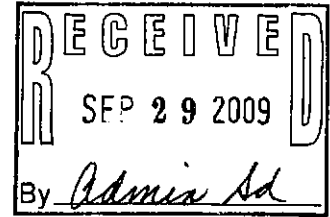
ATTACHMENT 9 C



Palos Community Hospital

12251 S. 80th Avenue Palos Heights, Illinois 60463 (708) 923-4000

Executive Offices



September 25, 2009

Enrique Beckmann, M.D., PhD
President & Chief Executive Officer
MetroSouth Medical Center
12935 South Gregory Street
Blue Island, Illinois 60406-2428

Dear Mr. Beckmann:

In response to your recent letter regarding the discontinuation of the pediatric category of service, it is not anticipated that it will have a significant impact on Palos Community Hospital as we assume you have minimal pediatric census. We also have experienced declines in pediatric utilization over the past several years and recognize that many pediatric hospitalizations require the specialization and resources that become increasingly hard for a community hospital to provide.

Sincerely,

Timothy J. Brosnan
Vice President, Planning and Community Relations

TJB:gmk

ATTACHMENT 9 C

4f



MetroSouth
MEDICAL CENTER

12935 South Gregory Street, Blue Island, IL 60406-2428
T (708) 597-2000 · W MetroSouthMedicalCenter.com

Sent via Certified Mail / Delivery Receipt Requested

September 21, 2009

Mr. Brian Lemon
Chief Executive Officer
MacNeal Hospital
3249 South Oak Park Avenue
Berwyn, IL 60402-0715

RECEIVED
SEP 30 2009
By Admin Sr

RECEIVED
SEP 23 2009

Re: Application for Permit to Discontinue Pediatric Services

Dear Mr. Lemon,

MetroSouth Medical Center intends to file an Application for Permit with the Illinois Health Facilities and Services Review Board to "discontinue" its 33-bed pediatrics service.

Consistent with Section 1110.130.c of the IHFSRB's rules, and in order to document that this "discontinuation" will not have an adverse impact upon access to pediatrics services, we would appreciate it if you could please identify:

- 1) what, if any, impact this "discontinuation" will have on your hospital, and,
- 2) whether you would be willing to admit these patients without conditions, limitations or discrimination.

Please indicate your response(s) below and return a copy of this letter in the self addressed, stamped envelope provided.

Thank you for your prompt attention to this matter.

Enrique Beckmann, MD, PhD
President & Chief Executive Officer

BSD
9/25/09

This discontinuation will have no impact on our hospital.

This discontinuation will have the following impact on our hospital:

We would be willing to admit these patients without conditions, limitations or discrimination.

ATTACHMENT 9 C

65



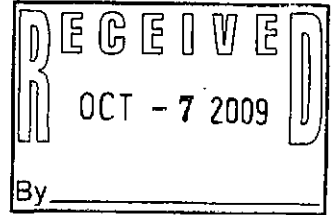
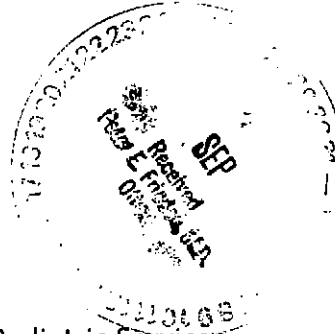
MetroSouth
MEDICAL CENTER

12935 South Gregory Street, Blue Island, IL 60406-2428
T (708) 597-2000 · W MetroSouthMedicalCenter.com

Sent via Certified Mail / Delivery Receipt Requested

September 21, 2009

Dr. Peter Friedell, MD
Chief Executive Officer
Jackson Park Hospital & Medical Center
7531 South Stony Island Avenue
Chicago, IL 60649



Re: Application for Permit to Discontinue Pediatric Services

Dear Dr. Friedell,

MetroSouth Medical Center intends to file an Application for Permit with the Illinois Health Facilities and Services Review Board to "discontinue" its 33-bed pediatrics service.

Consistent with Section 1110.130.c of the IHFSRB's rules, and in order to document that this "discontinuation" will not have an adverse impact upon access to pediatrics services, we would appreciate it if you could please identify:

- 1) what, if any, impact this "discontinuation" will have on your hospital, and,
- 2) whether you would be willing to admit these patients without conditions, limitations or discrimination.

Please indicate your response(s) below and return a copy of this letter in the self addressed, stamped envelope provided.

Thank you for your prompt attention to this matter.

Enrique Beckmann, MD, PhD
President & Chief Executive Officer

This discontinuation will have no impact on our hospital.

This discontinuation will have the following impact on our hospital:

We would be willing to admit these patients without conditions, limitations or discrimination.

ATTACHMENT 9 C



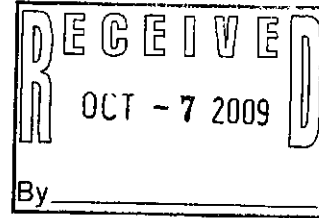
MetroSouth
MEDICAL CENTER

12935 South Gregory Street, Blue Island, IL 60406-2428
T (708) 597-2000 • W MetroSouthMedicalCenter.com

Sent via Certified Mail / Delivery Receipt Requested

September 21, 2009

Mr. Steven Drucker, FACHE
President & CEO
Loretto Hospital
645 South Central Avenue
Chicago, IL 60644-9987



Re: Application for Permit to Discontinue Pediatric Services

Dear Mr. Drucker,


MetroSouth Medical Center intends to file an Application for Permit with the Illinois Health Facilities and Services Review Board to "discontinue" its 33-bed pediatrics service.

Consistent with Section 1110.130.c of the IHFSRB's rules, and in order to document that this "discontinuation" will not have an adverse impact upon access to pediatrics services, we would appreciate it if you could please identify:

- 1) what, if any, impact this "discontinuation" will have on your hospital, and,
- 2) whether you would be willing to admit these patients without conditions, limitations or discrimination.

Please indicate your response(s) below and return a copy of this letter in the self addressed, stamped envelope provided.

Thank you for your prompt attention to this matter.


Enrique Beckmann, MD, PhD
President & Chief Executive Officer

This discontinuation will have no impact on our hospital.

This discontinuation will have the following impact on our hospital:

We would be willing to admit these patients without conditions, limitations or discrimination.

ATTACHMENT 9 C



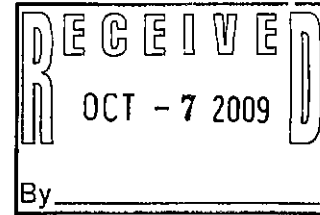
MetroSouth
MEDICAL CENTER

12935 South Gregory Street, Blue Island, IL 60406-2428
T (708) 597-2000 · W MetroSouthMedicalCenter.com

Sent via Certified Mail / Delivery Receipt Requested

September 21, 2009

Mr. Rick Wright
Chief Executive Officer
Adventist LaGrange Memorial Hospital
5101 South Willow Springs Road
LaGrange, IL 60525-2679



Re: Application for Permit to Discontinue Pediatric Services

Dear Mr. Wright,

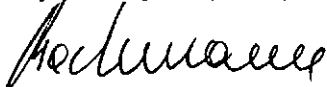
MetroSouth Medical Center intends to file an Application for Permit with the Illinois Health Facilities and Services Review Board to "discontinue" its 33-bed pediatrics service.

Consistent with Section 1110.130.c of the IHFSRB's rules, and in order to document that this "discontinuation" will not have an adverse impact upon access to pediatrics services, we would appreciate it if you could please identify:

- 1) what, if any, impact this "discontinuation" will have on your hospital, and,
- 2) whether you would be willing to admit these patients without conditions, limitations or discrimination.

Please indicate your response(s) below and return a copy of this letter in the self addressed, stamped envelope provided.

Thank you for your prompt attention to this matter.


Enrique Beckmann, MD, PhD
President & Chief Executive Officer

Beckmann

This discontinuation will have no impact on our hospital.

This discontinuation will have the following impact on our hospital:

We would be willing to admit these patients without conditions, limitations or discrimination.

ATTACHMENT 9 C



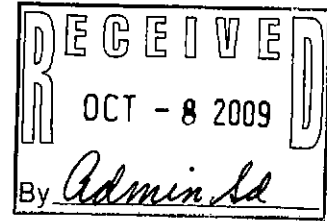
MetroSouth
MEDICAL CENTER

12935 South Gregory Street, Blue Island, IL 60406-2428
T (708) 597-2000 · W MetroSouthMedicalCenter.com

Sent via Certified Mail / Delivery Receipt Requested

September 21, 2009

Mr. Paul Pawlak
President & CEO
Silver Cross Hospital
1200 Maple Road
Joliet, IL 60432-1497



Re: Application for Permit to Discontinue Pediatric Services

Dear Mr. Pawlak,

MetroSouth Medical Center intends to file an Application for Permit with the Illinois Health Facilities and Services Review Board to "discontinue" its 33-bed pediatrics service.

Consistent with Section 1110.130.c of the IHFSRB's rules, and in order to document that this "discontinuation" will not have an adverse impact upon access to pediatrics services, we would appreciate it if you could please identify:

- 1) what, if any, impact this "discontinuation" will have on your hospital, and,
- 2) whether you would be willing to admit these patients without conditions, limitations or discrimination.

Please indicate your response(s) below and return a copy of this letter in the self addressed, stamped envelope provided.

Thank you for your prompt attention to this matter.

Enrique Beckmann, MD, PhD
President & Chief Executive Officer

- This discontinuation will have no impact on our hospital.
- This discontinuation will have the following impact on our hospital:

We would be willing to admit these patients without conditions, limitations or discrimination.

ATTACHMENT 9 C

**Ingalls.**

Ingalls Health System

One Ingalls Drive
Harvey, IL 60426
708.333.2333

October 8, 2009

Enrique Beckmann, M.D., PhD
President and Chief Executive Officer
MetroSouth Medical Center
12935 S. Gregory Street
Blue Island, IL 60406-2428

*Re: Application for Permit to Discontinue
Pediatric Services*

Dear Dr. Beckmann:

This correspondence is in response to your letter dated September 21, 2009. The discontinuation of Pediatric Services at MetroSouth Medical Center would negatively impact not only Ingalls Memorial Hospital ("Ingalls"), but also the families and communities of Blue Island and its surrounding areas. Families should have local options for general hospital care for their children, without having to drive to tertiary care centers or the few children's specialty hospitals in the Chicago metro area. While Ingalls will accept all patients who may be forced to drive from Blue Island to Harvey for pediatric care, it is not the best alternative. Families may decide not to seek care due to distance (e.g., they have no car available) and lack of familiarity with a different community many miles away from their homes. We are concerned that families will not have needed emergency care and that EMS will be forced to bypass MetroSouth to find another location for a pediatric 911 transport. Adequate resources should be provided to the community of Blue Island; therefore, we oppose the closure of a needed primary care service.

Sincerely,

Kurt E. Johnson
President and CEO

SAFETY NET IMPACT STATEMENT

The proposed "discontinuation" of pediatric services at MetroSouth Medical Center will not impact the availability of safety net services to the south suburban community served by the hospital.

Use of the pediatric service has been minimal, with the average daily census in 2008 being less than two patients per day. As discussed in ATTACHMENT 9C, there are pediatric services at nearby hospitals that have the capacity to accommodate pediatric patients that would be admitted to MetroSouth if the pediatric service was continued, and those other hospitals will accept the pediatric patients, without any form of discrimination or limitation. In addition, formal transfer agreements with two nearby hospitals providing pediatric services have been signed, to address the inpatient care of pediatric patients presenting themselves to the MetroSouth Emergency Department. Because of the low utilization of MetroSouth's pediatric service, the impact of the "discontinuation" will be minimal on other area providers.

During calendar 2008, \$37,711,545 in terms of net revenue was provided to Medicaid recipients and \$19,305,501 in terms of net revenue was provided to private pay/charity care patients.