MERCY
HEALTH SYSTEM

Malcolm Baldrige National Quality Award
Award Recipient

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July 26, 2011

Mr. Michael Constantino
Illinois Department of Public Health
525 West Jefferson Street
Springfield, IL 62761

RE: Mercy Crystal Lake Hospital and Medical Center, Inc ("**Mercy**" or the "**Applicant**") - Project #10-089 (the "**Project**")

Dear Mr. Constantino:

This letter responds to your written request, dated July 18, 2011, wherein you requested (I) a detailed response to the safety net impact statement submitted to the State Agency on June 2, 2011 by Joe Ourth, counsel to several competing hospitals, including Advocate Good Shepherd Hospital, Sherman Hospital and St. Alexius Medical Center; (II) a detailed response to the 2010 McHenry County Community Health Study (the "**Study**") conducted by the University of Illinois (including how the proposed hospital will address the community problems and issues that were identified by the Study), certain, self serving details of which were noted by Mr. Ourth, again counsel to several competing hospitals, including Advocate Good Shepherd Hospital, Sherman Hospital and St. Alexius Medical Center; and (III) a detailed response of how the decrease in the rate of growth in the population in McHenry County will affect the size and the viability of the proposed hospital.

I. MERCY'S RESPONSE TO THE SAFETY NET IMPACT STATEMENT:

While we will address the issues raised by the Safety Net Impact Statement (the "**Statement**") generally, we are hesitant to address the specifics contained therein for two reasons. First, as Mercy has modified its application to provide for a much smaller hospital project, the underlying assumptions contained in the Statement are no longer valid. Thus, the ultimate conclusions reached therein are also not valid. Despite our Project modification, the conclusions Mercy originally reached regarding the safety net impact of our Project (summarized again below) remain unchanged – the Project will not have a material impact on other area providers.

Second, it is unclear how much of the charity care services referenced in the Statement, at least with respect to the safety net impact of the Project on Advocate Healthcare, relate to true, altruistic charity care services provided by Advocate, and how much relate to the charity care services Advocate is forced to provide as a result of settling a class action lawsuit related to its charity care efforts and collection practices. In the fall of 2008, Advocate executed a settlement agreement that was designed to settle [illegible] ged, among other things, that Advocate Health Car[illegible] insured patients excessive, unconscionable, unfair [illegible] l procedures, products and prescription drugs recei[illegible] erated by Advocate." This included Advocate's op[illegible] s Advocate Good Shepherd Hospital. A copy of t[illegible] xhibit A. As part of this settlement, Advocate w[illegible] e and retain a charity care ombudsman to assist wi[illegible] ide charity care to certain uninsured and underinsu[illegible] certain uninsured patients, and also refund payment[illegible] ts. It is unclear how much of the charity care claime[illegible] t was actually provided as a result of this settlement[illegible] t of Advocate's charitable mission.

Simply put, the Statemen[illegible] xius Medical Center and Advocate Good Shepherd [illegible] **Competing Hospital"** and, collectively, the **"Competing Hospitals"**), is an example of fear without the facts. The Competing Hospitals cite the Illinois General Assembly amendment to the Illinois Health Facilities Planning Act (the **"Act"**) as the basis for *fear* of the potential impact a new project could have on "other providers' ability to cross-subsidize safety net services to the community." However, the *facts* included in the Statement appear to be a bit disingenuous. For example, the Statement cites the 4,063 historical referrals referenced in the Certificate of Need (**"CON"**) application that could be taken out of existing hospitals. However, the Competing Hospitals do not mention or include in the Statement the fact that of those discharges (referrals) only ten percent (10.8%) of those referrals came from existing facilities outside of McHenry County, and specifically of the 438 discharges outside of McHenry County, all but 32 (406 in total) were from Advocate Good Shepherd Hospital in Barrington, Illinois. The other two hospitals (referred to in the Statement as "Concerned Hospitals") were not identified as having referrals (discharges) taken away from them.

In an effort to limit and ultimately reduce the "claimed" impact on not just the "Concerned Hospitals" but all of the existing hospitals within the 30-minute market contour and McHenry County, Mercy has proposed reducing the size of the proposed hospital almost fifty percent (50%) - from the overall total of 128 beds down to 70 beds. This modification of the original CON application does not change Mercy's commitment to recruit much needed physicians and specialists to the area. It should also be known that the proposed Project will be a general, acute care hospital offering primary and secondary, community-based services to the local service area

surrounding the facility. It does not plan to offer tertiary care services and will work closely with other area hospitals, which provide these services, to coordinate a seamless transfer of patients requiring this level of care. Therefore, Mercy fully expects to be, and to fill, the referral network in southern McHenry County that will assist residents (many of whom require safety net services) to find the appropriate service to fit their needs and, as such, will continue making referrals to the appropriate existing hospitals.

The Statement, in order to put tangible numbers to the concept of potential impact on "Concerned Hospitals," identified 5,270 "lost inpatients" and therefore, potential lost net revenue and potential lost contributions to "cross subsidized" interests. As stated previously, however, this Statement does not take into account the proposed reduction of beds from 128 down to only 70 beds. In addition, it questions the need for safety net resources in the A-10 Planning Area and specifically in the geographic service are of Crystal Lake, Algonquin, Cary and Lake in the Hills (page 5 of the Statement) – despite the fact that the Study (discussed in greater detail below) expressly states that such services are needed in McHenry County. Together, these four communities have a current estimated population of 164,000 residents. Attached as Exhibit B is a population density map of McHenry County again illustrating that for all of the communities with existing hospitals in McHenry County, the most populated areas are not currently served. Mercy respectfully asserts that the underserved and under privileged within the proposed market area are equally deserving of service and in-fact more deserving of services from area hospitals than those of cross-subsidized population in other areas of the State.

Although the issue of Safety Net Services is important, in a joint statement before the Illinois Task Force on Health Planning Reform, the United Stated Department of Justice (**"DOJ"**) and Federal Trade Commission (**"FTC"**) warned of the dangers of using the CON process solely to ensure safety net resources and cross-subsidization of services. A copy of the joint statement is attached as Exhibit C. The DOJ and FTC state that "incumbent hospitals often argue that they should be protected against additional competition so that they can continue to cross-subsidize care provided to uninsured or underinsured patients." The DOJ and FTC note that often the incumbent hospitals argue that a new hospital project would deprive them of revenue that otherwise could be put to charitable use. This is the argument and rationale the "Concerned Hospitals" posit in the Statement. However, it is the DOJ's and FTC's contention that this rationale can often lead to the CON laws being used by the incumbent hospitals (e.g., the "Concerned Hospitals") to "impede the entry of new health care providers that consumers might enjoy (such as independent ambulatory surgery centers, freestanding radiology or radiation-therapy providers, and single- or multi-specialty physician owned hospitals) for the express purpose of preserving the market power of incumbent providers." One excerpt from the joint statement best summarizes Mercy's response to the issue raised by the "Concerned Hospitals" in their Safety Net Impact Statement:

> "We fully appreciate the laudatory public-policy goal of providing sufficient funding for the provisions of important health care services – at community

> hospitals and elsewhere – to those who cannot afford them, and for whom government payments are either unavailable or too low to cover the cost of care. But at the same time, we want to be clear that the imposition of regulatory barriers to entry as an indirect means of funding indigent care may impose significant costs on all health care consumers – consumers who might otherwise benefit from additional competition in health care markets."

Finally, this Statement references the 2010 McHenry County Community Health Study by stating: "according to the 2010 McHenry County Health Community Study, residents found availability of health care to be one of the positive characteristics of living in McHenry County." As is discussed in greater detail below, the Study identifies as priorities access to information, referrals to services and transportation within McHenry County, especially since there are numerous communities without continuity of care. The Study also illustrated a disagreement between the end users of health care services (e.g., the residents and survey respondents) and the key informants (e.g., the health care providers that served as key informant and financial contributors to the study (e.g., Centegra Health System, Advocate Good Shepherd Hospital, and Sherman Hospital). The *resident* respondents identify gaps to information and referrals and ultimately barriers to care while the *competing hospital* key informants stated there were abundant resources available. Furthermore, the Study never asked the question of whether there should be a new hospital in McHenry County or if so, where it should be located.

It appears that the existing hospital providers have their market share and serve who they want to serve. However, when one reads the Study and reviews the enclosed population dot matrix map of McHenry County, there is an apparent underserved area. Unlike the existing area hospital providers, Mercy wants to serve these patients.

To be clear, for the reasons set forth in Mercy's application and forth the reasons set forth below, Mercy is confident the only impact that the Project will have on the safety net services provided in the area will be a positive one:

- The Project addresses Medical/Surgical/Pediatric bed need in Planning Area A-10, now and in the future. Unmet bed need has increased rapidly since 2002, when IDPH estimated a surplus of 35 Medical/Surgical and Pediatric beds in McHenry County. Between 2002 and 2008, the net increase in Medical/Surgical and Pediatric beds increased by 118 beds. By 2020, based on population projections, Planning Area A-10 will have a bed need of 131 Medical/Surgical and Pediatric beds, significantly higher than the 70 bed complement proposed by Mercy.

Planning Area A-10: Medical/Surgical & Pediatrics								
Year	Out Migration	Percent Change	Net Migration	Percent Change	Adjusted Beds Needed		Existing Beds	
2002	9,148	-	7,257	-	153	-	188	-35
2005	10,477	14.5%	8,455	16.5%	197	28.8%	218	-21
2008	11,091	5.9%	8,876	5.0%	289	46.7%	206	83
2015	11,091	-	8,876	-	295	-	206	89
2020	11,091	-	8,876	-	337	-	206	131

- Providing primary and secondary hospital care. The proposed Mercy Crystal Lake Hospital and Medical Center will be a general, acute care hospital offering community-based services to the local service area surrounding the facility. It does not plan to offer tertiary care services and will work closely with area hospitals, which provide these services, to coordinate transfer of patients requiring this level of care.

- Addressing physician need in McHenry County. As of January 1, 2011, Mercy Health System employed 76 full-time and 11 part-time physicians in northern Illinois, a major contribution of physician providers to the area. Mercy plans to add 45 new physicians in Crystal Lake, which will assist in addressing the calculated physician need in McHenry County of nearly 50 physicians in March of 2010. These physicians will play a vital role in the future health of residents of McHenry County.

Mercy has also projected that, notwithstanding the increased admissions currently occurring as a result of the Patient Protection and Affordable Care Act of 2010, in years one and two of operations of the Project, admissions will be further impacted at a rate of 5 percent first year and 3 percent second year over current rates. Mercy projects that other planning/market area facilities (including the "Concerned Hospitals") will see a similar impact. In combination of these factors, Mercy is confident that its Project will not lower the utilization of other area providers below the occupancy standards specified in 77 Ill. Adm. Code 1100. Further, the data and projections of Mercy indicate that its project will not lower, to a further extent, the utilization of other area hospitals that are currently (during the latest 12-month period) operating below the occupancy standards. Given the above, Mercy projects that the Project will not have a material impact on the ability of other area providers ability to provide safety net services in McHenry County.

II. MERCY'S RESPONSE TO THE 2010 MCHENRY COUNTY COMMUNITY HEALTH STUDY:

The stated purpose of the "independent"[1] 2010 McHenry County Community Health Study is:

> "The "health" of a community extends far beyond the traditional view focused on select health measures and availability of medical resources. Rather, a healthy community encompasses a broad range of community characteristics that define the ingredients of a healthy place to live."

Given the broad purpose of the Study, the Applicant principally views the Study as an invaluable tool for the public to identify historical and existing issues in McHenry County. It is critical to note, however, that the Study was not limited to health care and its delivery system in McHenry County. Rather, the Study assessed the overall quality of life of McHenry County residents. More importantly, this Study was never intended to gauge whether a new hospital was needed or even wanted by the residents in McHenry County. Nor did the Study assess what size of hospital or location would best serve the residents of McHenry County. What the Study attempted to do was identify broad themes in terms of "gaps in" or "barriers to" needs and services. In no way did the Study attempt to suggest how to fill in the gaps.[2]

Before addressing certain of the issues raised in the Study, it is important to note again that the primary health care service provider in McHenry County is Centegra Health System (**"Centegra"**). Centegra controls 93% of the hospital beds in McHenry County. Centegra is prominently named as "key informant" to this Study. Additional "key informants" include the hospital providers that have been most vocal in opposing Mercy's proposed project, namely Advocate Good Shepherd and Sherman Hospital. Key informants also helped fund the Study. Of note, while named as "key informants" to the Study, both are located outside of the county they are supposed to be "key informants" in. The only other hospital provider in McHenry County, Mercy Harvard Memorial Hospital, a Critical Access Hospital in the northeastern quadrant of McHenry County was not part of the Study.

The issues identified by the Study covered nearly every facet of life and every need (or lack thereof) for all segments of the population in McHenry County. Of all the wide ranging issues discussed in the Study, the issue that Mercy found most compelling as related to the Project (e.g.,

[1] We acknowledge and appreciate the information contained in the letter dated July 18, 2011 submitted to the Board (apparently on her own initiative) by Deborah Lischwe, lead researcher for the Study. This letter provides information on various aspect of the Study, includes a helpful overview of the methodology of the Study. The letter also, rather interesting, concludes by highlighting the two self serving "findings" that the Competing Hospitals highlighted from the survey. Since the Study itself did not focus on these "findings," we assume that was just a coincidence and not an attempt to support the position of the key informants who fund the Study (e.g., the Competing Hospitals) over the needs of the residents the Study was commissioned to help.

the establishment of a hospital in Crystal Lake), is that disadvantaged in McHenry County are not aware or not able to obtain health care services, and this disadvantaged population lacks a referral network for such services. Mercy's integrated delivery system is uniquely qualified to address these two issues.

The Study raised four primary and four secondary priorities for McHenry County. The primary priorities are:

1. Information and referral system;
2. Access to dental care for low-income population;
3. Access to mental health and substance abuse services; and
4. Obesity and nutrition.

The secondary priorities identified in the Study are:

1. Cardiovascular Disease;
2. Diversity of Population/Lack of Integration;
3. Environment - Open Space and Groundwater Protection; and
4. Lack of Public Transportation.

From both sets of priorities, Mercy contends that the proposed project will alleviate issues with Information and referral systems, access to mental health and substance abuse services, obesity and nutrition, cardiovascular disease, diversity of population/lack of integration, and lack of public transportation.

Specifically, the Applicant is proposing not only the establishment of a new hospital but the establishment of a new hospital with a medical office building in the community of Crystal Lake. This is important as the southeastern portion of the County has no direct access to acute care without traveling out of the local communities of Crystal Lake, Cary, Algonquin, and Lake in the Hills. The proposed Project offers a fully integrated health care delivery system which completely aligns our physicians and other health care professionals as well as the hospital services. The proposed area is the most densely populated area of McHenry County which has no public transportation between communities. The area is also home to the largest concentration of low income individuals in McHenry County. As mentioned earlier, the Project proposes to bring into McHenry County 45 additional physicians and specialists.

The proposed Project will address head on both the primary and secondary priorities identified in the Study. In addition to the primary and secondary priorities identified above, the clear issues that are delineated through the Study are that 44.4% of the respondents (those surveyed) indicated that they are not aware of the availability of health care services. Compounding the issue is that transportation between communities is not available without personal transportation or costly taxi-cab services. However, there is also a disagreement between the replies from the

"key informants" (e.g., the area hospital providers that funded the Study (the Competing Hospitals)) and the respondents (the public residents surveyed). The "key informants" believe that there is an abundance of social and health care services in McHenry County, but the respondents are not aware of such services and do not have access to them through referral networks. Therefore, the problem is clear. The existing monopolistic providers have the market that is desires and the hospital providers outside of the County also have the portion of the market that they desire. This leaves an entire segment of the population, Public Aid recipients and uninsured persons and those populations without personal transportation, without access to care in McHenry County.

MERCY'S CALL TO ACTION:

It is the intent of Mercy Crystal Lake Hospital and Medical Center, Inc. to address several of the Study's stated priorities when this Project is approved and ultimately operational.

- As it relates to Information and Referral Systems, it is the intent of Mercy to provide a Mercy Help Line in McHenry County. This Help Line would be a free source of information and services available in McHenry County. It would also serve as a free source of information regarding health services available in the region.

- Mercy currently provides a variety of health education and screening activities in McHenry County including programs directed at obesity and nutrition. With the opening of the proposed hospital, Mercy plans to significantly expand these offerings in the primary market area of the project. More importantly, the Mercy Bariatric Surgery program currently exists at Mercy Harvard Hospital. With the opening of the Applicant's project, Mercy will expand this program to the Mercy Crystal Lake Hospital and Medical Center, Inc.

- Mercy is committed to expanding our health screening and education activities as noted. We intend to provide a high priority on health screenings that will identify and refer for treatment those individuals at risk for cardiovascular disease.

- The Study highlighted that a better public transportation system is needed in McHenry County. To address this priority, Mercy proposes to establish a Mercy-In-Motion program and provide a low cost option for individuals needing transportation to clinic or hospital appointments. The service will be provided on a scheduled appointment basis with access available through the Mercy Help Line we have proposed to establish.

III. MERCY'S RESPONSE OF HOW THE DECREASE IN POPULATION IN MCHENRY COUNTY WILL AFFECT THE SIZE AND THE VIABILITY OF THE PROPOSED HOSPITAL.

The 2010 Census did not indicate that the population in McHenry County had decreased, rather it illustrated that the growth in McHenry County over the last decade was perhaps "robust" rather than "staggering." The 2010 Census reported 308,760 persons residing in McHenry County. This represents a reduction of 32,517 persons, or a 9.5% decrease, from the population estimates used by the Applicant originally. McHenry County continues, however, to be among the fastest growing counties in Illinois. In fact, the 2010 Census showed that from 2000 to 2010 the population in McHenry County grew by almost 19%, compared to the State of Illinois average of approximately 3%.

The change in population allowed the Applicant the following opportunities:

- Reevaluate the size and scope of the Project.
- Reevaluate the marketplace and in particular any potential negative impacts a project of the size and scope of the original proposal would have on other existing providers.
- Reassess our ability to positively impact the existing safety net services in the A-10 planning region.

The original proposal by the Applicant was based upon the State norm for a 100-bed minimum facility. The Applicant in fact stated on page 182 of the application, item f(1) as submitted for State review, that we believe that this minimum number is dated and no longer reflects the current needed number of beds to build a hospital. Consequently, given recent actions by the Board related to that State norm and in light of all of the arguments for a smaller facility at less cost, we are proposing a modification to our application to allow for the Board to consider a 70-bed hospital proposal in Crystal Lake.

Among the positive impacts of this proposal is a significant reduction in any negative impact on physician referrals and admissions to other area provider facilities. From the capital cost savings as well as the reduction in operations expenses associated with the smaller facility, we believe that this creates a further set of opportunities to collaborate with other hospital based and other not-for-profit service providers to improve safety net services in the planning region.

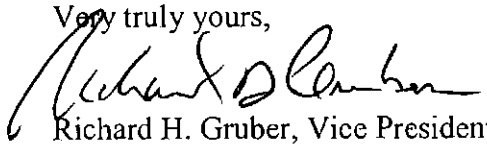
* * * *

Finally, the Applicant would like to address the comments made by Mr. Eaker at the June 28, 2011 Board meeting regarding Mercy's level of charity care for FY 2009. During the June 28th meeting, Mercy informed the Board that Mercy's charity care provided in FY 2009 amounted to 1.5% of net revenues. While Mr. Eaker stated he felt 1.5% of net revenue was "low" for charity

care, we noted that such amount was higher than any other hospital provider located in McHenry County. Mercy recently completed its 2011 Community Benefit analysis and it revealed that for FY 2010, Mercy provided approximately $13 Million in charity care, and almost $85 Million in total charitable community benefit services. The charity care provided by Mercy in FY 2010 amounted to 2.4% of Mercy's net revenue, much greater than 1.5% of net revenue amount we cited for FY 2009. Mercy takes its commitment to the residents of McHenry County seriously, and hopes Mr. Eaker and the Board view this recent increase in charity care as an example of Mercy's commitment to the community. Mercy will not turn away any patient because of her or his ability to pay for medical treatment at any Mercy facility, whether such facility is a hospital or medical clinic. Further, it is Mercy's intention to provide the same level of charity care at the proposed Crystal Lake facility that Mercy historically provides on a system-wide basis.

Mercy submitted its CON application for the Project almost eight months ago (in December 2010), and during this journey the entire Mercy organization has been committed, and remains committed, to answering each and every question the Board and its staff asks of us. We know your resources are limited and Mercy appreciates the time and energy the Board and Board staff has put into reviewing our Project. We appreciate your consideration and attention to this matter and the residents of McHenry County.

Very truly yours,



Richard H. Gruber, Vice President
Mercy Health System Corporation

EXHIBIT A

Settlement Agreement

IN THE CIRCUIT COURT OF COOK COUNTY
COUNTY DEPARTMENT, LAW DIVISION

VANESSA CRISTIANI, *et al.*,	§	
	§	
Plaintiffs,	§	
	§	Case No. 03 L 014635
v.	§	
	§	
ADVOCATE HEALTH SYSTEMS CARE NETWORK, INC., *et al.*,	§	
	§	
	§	
Defendants.	§	

CLASS ACTION SETTLEMENT AGREEMENT AND RELEASE

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CLASS ACTION SETTLEMENT AGREEMENT AND RELEASE

Plaintiffs, Vanessa Cristiani, Tiffany Montgomery, Chris Hauser, Frank Vacha, Jeffrey P. Wojcik, Curtis Moore, Adam Beebe, Tina LaValliere, Margaret Loncar, Ravell McDonald, Thomas Pemberton, Nicolas Rodriguez, Terrence Rogers, Michael Szykowny, Santos Gordils, Lillie McLinton, and Vincent Petrozza, (collectively, "the Named Plaintiffs") on behalf of themselves and the Settlement Class (as defined below), and Defendants Advocate Health Care Network and Advocate Health and Hospitals Corporation (collectively, "Advocate"), hereby enter into this Class Action Settlement Agreement and Release ("Agreement"), providing for complete and final settlement of claims herein described against Advocate, pursuant to the terms and conditions set forth below, and subject to the approval of the court in *Cristiani et al., v. Advocate Health Care Network. et al.*, Case No. 03 L 014635, Circuit Court of Cook County (hereinafter "the Case").

WHEREAS, the Named Plaintiffs have filed a class action against Advocate alleging that Advocate charged uninsured and underinsured patients excessive, unconscionable, unfair and otherwise unlawful prices for medical procedures, products and prescription drugs received at hospitals or other medical facilities operated by Advocate;

WHEREAS, Plaintiffs have asserted claims that Advocate violated the Illinois Consumer Fraud and Deceptive Business Practices Act ("ICFA"), and claims for Constructive Fraud, Unjust Enrichment, Breach of Contract, Unconscionability, and Declaratory Judgment;

WHEREAS, Advocate has vigorously denied and continues to vigorously deny all of the aforementioned claims, denies any and all allegations of wrongdoing, fault, liability or damage of any kind to Plaintiffs and the putative class, denies that it acted improperly or wrongfully in any way, and believes that this litigation has no merit;

WHEREAS, the parties to this Settlement Agreement have conducted a thorough examination and investigation of the facts and law relating to the matters set forth in the complaints filed in the Case;

WHEREAS, Advocate has concluded that settlement is desirable in order to avoid the time, expense and inherent uncertainties of defending protracted litigation and to resolve finally and completely the pending and potential claims of the Named Plaintiffs and all Settlement Class Members against Advocate;

WHEREAS, Named Plaintiffs and Class Counsel recognize the costs and risks of prosecuting this litigation and believe that it is in their interest, and in the interest of all Settlement Class Members, to resolve finally and completely the pending and potential claims of the Named Plaintiffs and the Settlement Class against Advocate;

WHEREAS, arm's-length, adversarial settlement negotiations have taken place between Class Counsel and Advocate over an extended period and, as a result, this Agreement has been reached, subject to notice to the Settlement Class and Court approval;

WHEREAS, the undersigned parties believe that this Settlement Agreement offers significant benefits to the Settlement Class and is fair, reasonable, adequate and in the best interest of all Settlement Class Members; and

WHEREAS, Advocate has agreed to class action treatment of the claims alleged in the Case solely for the purpose of effecting the compromise and settlement of those claims on a class basis as set forth herein, and makes no admissions whatsoever as to any matter in entering into this Agreement, including as to the merits of the case or the propriety of class action certification.

NOW, THEREFORE, the undersigned parties stipulate and agree that all claims of the Named Plaintiffs and Settlement Class Members against Advocate (defined below as "Settled Claims" and or "Released Claims") shall be fully and finally settled, discharged, released and resolved on the terms and conditions set forth below.

I. DEFINITIONS

As used in this Settlement Agreement, the following terms shall have the defined meanings set forth below. Where appropriate, terms used in the singular shall be deemed to include the plural and vice versa.

"Advocate" means Advocate Health Care Network and Advocate Health and Hospitals Corporation, together with their affiliates (including Advocate Illinois Masonic Medical Center) and all hospitals and health clinics owned and/or operated by Advocate and/or its affiliates during the Class Period, and all agents, employees, officers, sponsors, representatives, assigns, and successors.

"Advocate Hospitals" means the following hospitals operated by Advocate: Advocate Bethany Hospital, Advocate Christ Hospital, Advocate Good Samaritan Hospital, Advocate Good Shepherd Hospital, Advocate Illinois Masonic Medical Center, Advocate Lutheran General Hospital, Advocate South Suburban Hospital and Advocate Trinity Hospital, but does not include physicians or physician groups.

"Advocate Patients" means all patients who received in-patient or out-patient treatment or services at an Advocate Hospital during the Class Period, and any person who is a guarantor of the payment for such treatment or services.

"Case" means *Cristiani, et al. v. Advocate*, Case No. 03 L 014633, the Class action that was filed in the Circuit Court of Cook County, Illinois on behalf of uninsured and certain insured patients against Advocate.

"Claim Form" means the claim and release form, substantially in the form set forth in Exhibit H to this Settlement Agreement, which form must be timely and fully completed and

submitted by each Settlement Class Member who wishes to receive payment of cash restitution benefits under Section III.C of this Agreement.

"Charity Care" means Medically Necessary Services provided at an Advocate Hospital without charge or at a reduced rate to Advocate Patients who meet or are deemed to meet eligibility criteria set forth in Advocate's Charity Care Policy summary attached as Exhibit B to this Agreement.

"Charity Care Committee" refers to the relevant committee at each Advocate Hospital, or its nominee or other duly authorized body or agent, which is responsible for determining the eligibility of Advocate Patients for Charity Care under Advocate's Charity Care Policy summary attached as Exhibit B to this Agreement.

"Class Counsel," "Plaintiffs' Co-Lead Counsel," "Counsel for Plaintiffs and/or Counsel for the Class" means Thomas H. Geoghegan, Carol Nguyen, and Jorge Sanchez, Despres Schwartz & Geoghegan, 77 W. Washington, Ste. 1720, Chicago, IL 60602 ; Robert R. Cohen and Scott J. Frankel, Frankel & Cohen, 77 W. Washington, Ste. 1720, Chicago, IL 60602.

"Class Period" means November 19, 2000 through the date of entry of the Final Order, except for Illinois Masonic Medical Center, for which the Class Period commences July 1, 2001.

"Class Representatives" means the Named Plaintiffs in the Case.

"Class Settlement" means the terms of the settlement provided in this Agreement.

"Collection Action" means any activity by which an Advocate Hospital, a designated agent or assignee of the Hospital, or a purchaser of the patient account, requests payment for services from a patient or a patient's guarantor. Collection Actions include pre-admission or pretreatment deposits, billing statements, letters, electronic mail, telephone and personal contacts related to Hospital bills, court summonses and complaints, and any other activity relating to collecting a Hospital bill, and includes any referrals of bills to collection agencies or law firms to collect payment for services at an Advocate Hospital.

"Cost" means the Advocate Hospital's established usual and customary charges as set forth in its chargemaster at the time of initial billing, prior to application of any discount, multiplied (reduced) by the Hospital's ratio of costs to charges (also referred to as the Hospital's "cost to charge ratio"), taken from the Hospital's most recently submitted Medicare cost report.

"Cost to charge ratio" means the ratio of an Advocate Hospital's total cost of providing patient care to its total charges for patient care, as reported in its most recently submitted Medicare Cost Report.

"Court" means the Circuit Court of Cook County, Illinois.

"Defendants" means Advocate.

"Effective Date" means the date three business days after the date on which the Settlement and Final Order have become "Final" in that all of the following conditions have been satisfied: (1) the Final Order has been entered; and (2)(a) if an appeal, review or reconsideration is not sought from the Final Order, the expiration of the time for the filing or noticing of any appeal, petition for review or motion for reconsideration; (2)(b) if an appeal, review or reconsideration is sought from the Final Order, the date on which the Final Order is affirmed and is no longer subject to judicial review or the date on which the appeal, petition for review or motion for reconsideration is dismissed or denied and the Final Order is no longer subject to judicial review.

"Fairness Hearing" means the final hearing(s) scheduled by the Court in the Case, after proper notice, to determine whether to approve this Agreement.

"Family" means the patient, the patient's spouse, the patient's parents or guardians (in the case of a minor patient), and any dependents living in the patient's or his or her parents' or guardians' household.

"Family income" means the sum of a Family's gross income, however derived, reportable to the Internal Revenue Service.

"Federal Poverty Income Guidelines" means the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of 42 U.S.C. § 9902(2). *See, e.g.*, http://aspe.hhs.gov/poverty/08poverty.shtml, for the 2008 Guidelines.

"Final Order" means the last of the orders and final judgment of the Circuit Court of Illinois dismissing the Case with prejudice as to Advocate and approving this Agreement, substantially in the form of Exhibit C hereto.

"Gross Charge" is the price for a hospital service or supply listed on an Advocate Hospital's chargemaster.

"Medically Necessary Services" means services or supplies that are provided for the diagnosis, direct care, and treatment of a medical condition, meet the standards of good medical practice in the local area, are covered by and considered medically necessary by the Medicare and Medicaid programs, and are not mainly for the convenience of the patient or physician. Medically Necessary Services do not include cosmetic surgery or non-medical services, such as social, educational or vocational services; medical services that are experimental or part of a clinical research program; private medical or physician professional fees; and services and/or treatments not provided by Advocate.

"Notice" means the Court-approved form of notice of this Agreement to the Settlement Class, substantially in the form of Exhibit D hereto.

"Notice and Claims Administration Expenses" means all reasonable costs and expenses incurred in connection with preparing, printing, mailing and publishing the Notice, processing claims, and administering the Settlement.

"Ombudsperson" means the person appointed under Section III.A.7 of this Agreement.

"Parties" means the Named Plaintiffs and Defendants.

"Plaintiffs" means all Named Plaintiffs.

"Preliminary Approval Order" means the order of the Court, substantially in the form of Exhibit A to this Settlement Agreement, granting preliminary approval of this Settlement Agreement and authorizing the Notice.

"Publication Notice" means the notice, substantially in the form attached hereto as Exhibit D, that shall be published pursuant to Section IV.C.2 of this Agreement to give notice to the Settlement Class of this Settlement, unless otherwise agreed by the Parties and approved by the Court.

"Related Parties" means the Defendants and all of their past and present officers, directors, agents, designees, servants, sureties, attorneys, employees, parents, associates, controlling or principal shareholders, sponsors, members, general or limited partners or partnerships, subsidiaries, divisions, affiliates, insurers, and all predecessors or successors in interest, assigns, or legal representatives.

"Released Claims" means and includes any and all claims, demands, rights, damages, obligations, suits, debts, liens, contracts, agreements and causes of action of every nature and description whatsoever, ascertained or unascertained, suspected or unsuspected, existing or claimed to exist, including unknown claims, of the Plaintiffs and all Settlement Class Members that were or could have been brought against the Defendants and the Related Parties, or any of them, from the beginning of the Class Period to the Effective Date of the Settlement Agreement, based upon or related to any charges incurred, or any billing, pricing or Collection Action, in connection with any treatment or service received at any hospital or medical facility of any kind owned or operated by Advocate, including, without limitation, claims arising under the ICFA or the common law contract, quasi-contract or tort claims alleged or that could have been alleged in the Case. Released Claims do not include claims for personal injury or medical malpractice or other claims related to the quality or standard of care provided to patients.

"Released Parties" or "Released Party" means the Defendants and their Related Parties.

"Settlement Agreement" or "Agreement" means this Settlement Agreement and the exhibits attached hereto.

"Settlement Class" means all Advocate Patients from November 19, 2000 to the Effective date of this Agreement who were Uninsured Patients as defined in this Settlement Agreement at the time medical services were rendered, or who were not Uninsured Patients but whose obligations to Advocate, not payable by insurers or other third parties (including liability insurers or third party indemnitors) due to, for example, co-payments or deductibles, equal or exceed $5,000 in a calendar year.

"Settlement Class Members" means all persons who are members of the Settlement Class except for those persons who validly request exclusion from the Class Settlement (i.e., "opt out") as provided in the Notice and the Settlement Agreement.

"Settling Parties" or "Settling Party" includes all Named Plaintiffs, Settlement Class Members and the Defendants and their Related Parties.

"Uninsured Patient" means a patient who received medical services (inpatient or outpatient) at an Advocate Hospital and who was not covered in whole or in part under a policy of health insurance and is not a beneficiary under a public or private health insurance, health benefit, or other health coverage program (including, without limitation, private insurance, Medicare, Medicaid or Crime Victim Assistance), workers' compensation, accident liability insurance, or other third party liability.

II. REQUIRED EVENTS

Promptly after the execution of this Settlement Agreement by all of the undersigned:

A. Class Counsel shall take all necessary steps consistent with this Settlement Agreement to obtain preliminary and final judicial approval of the Class Settlement and the dismissal with prejudice of the Case. As part of the approval process, the parties agree to cooperate and use their best efforts to describe and establish the benefits of the Settlement to the Settlement Class.

B. To effectuate the requirements of Paragraph II.A above, Class Counsel, on behalf of the Settling Parties, shall submit the Settlement Agreement to the Court for Preliminary Approval, and the parties shall jointly move for one or more orders in substantially the same form as Exhibit A ("Preliminary Approval Order(s)"), which by their terms shall:

1. Preliminarily approve the terms of the Class Settlement;

2. Conditionally certify the Settlement Class for settlement purposes only;

3. Determine or approve the Notice to be given to the Settlement Class advising them of the Class Settlement and of the Fairness Hearing to be held to determine the fairness, reasonableness and adequacy of the Class Settlement;

4. Schedule the Fairness Hearing to review comments or objections regarding the Class Settlement, to consider the fairness, reasonableness and adequacy of the Class Settlement, to consider the application for an award of attorneys fees and reimbursement of expenses, and to consider whether the Court should issue a Final Order (in substantially the form attached as Exhibit C) approving the Class Settlement, dismissing the Case with prejudice as to Advocate and ruling upon whether in negotiating Plaintiffs' attorneys' fees and expenses there was a fair and reasonable balance of the interests of the plaintiffs and the plaintiffs' attorneys.

C. Class Counsel and Advocate will cooperate to undertake all reasonable actions in order to accomplish the above. In the event that the Court fails to grant Preliminary Approval or fails to issue a Final Order, Class Counsel and Advocate agree to use all reasonable efforts, consistent with this Settlement Agreement, to cure any defect identified by the Court.

D. Class Counsel and Advocate will use all reasonable efforts, consistent with this Settlement Agreement, to promptly obtain a Final Order.

III. SETTLEMENT TERMS

A. Charity Care and Uninsured Patient Discounts After the Effective Date.

1. Charity Care. As of the Effective Date of the Settlement, Advocate shall continue its prior policy and practice of offering Charity Care to all Uninsured Patients pursuant to the terms no less generous than those set forth in the Charity Care Policy summary attached as Exhibit B. Such terms shall be at least consistent with the terms below:

a. Advocate shall continue to provide full Charity Care to any Uninsured Patient who applies for Charity Care and satisfies the eligibility criteria in Exhibit B, including the requirement that the Patient's Family income is equal to or less than 200% of the Federal Poverty Income Guidelines.

b. Advocate shall continue to provide discounted Charity Care to any Uninsured Patient who applies for Charity Care and satisfies the eligibility criteria in Exhibit B, including the requirement that the Patient's Family income is more than 200% of the Federal Poverty Income Guidelines and equal to or less than 400% of those Guidelines. The discounts shall be equal to those Charges that exceed Advocate's Cost of providing the Medically Necessary Services, which shall be calculated as set forth in Exhibit B (Gross Charges for the services multiplied by the Advocate Hospital's Cost-to-Charge Ratio). As set forth in Exhibit B, the Uninsured

Patient's responsibility to pay any balance after the Charity Care discount is applied shall not exceed (i) 5% of the Patient's Family income for Patients whose Family income is equal to or less than 300% of the Federal Poverty Income Guidelines or (ii) 10% of the Patient's Family income for Patients whose Family income is equal to or less than 400% of the Federal Poverty Income Guidelines.

c. The terms of sub-paragraphs a and b above shall also apply to Settlement Class Members whose obligations to Advocate, due, for example, to co-payments or deductibles, equal or exceed $5,000 in a calendar year.

d. A summary of Advocate's Hospital Charity Assistance Policy shall be drafted in language reasonably calculated to be understood by the average patient and shall reasonably apprise persons of the essential terms of the Policy. The parties stipulate that the summary of Advocate's Charity Care Policy attached as Exhibit B satisfies this subparagraph.

e. Advocate is neither obligated to nor barred from implementing Charity Care standards or awarding Charity Care on terms more generous than those set forth herein.

f. Notwithstanding the foregoing, subject to federal or state laws regarding the provision of emergency assessment or treatment, this Agreement imposes no obligation on Advocate to admit, treat or provide Charity Care to any person in any of the following circumstances:

(i) The person requires major surgery, such as an organ transplant, the person has a chronic condition requiring regular recurring and extensive treatment, such as dialysis, or such other treatment as would place an unreasonably onerous financial burden on the Advocate Hospital and in Advocate's reasonable judgment is not a service typically provided as Charity Care by other tax-exempt hospitals or covered by health insurers. However, the Ombudsperson shall be notified in each such case and may request an explanation of the reasons for the denial from the Advocate Hospital's Charity Care Committee and may comment on the determination.

(ii) The Patient refuses or fails to cooperate with reasonable requests of Advocate to cooperate in providing, in a timely and forthright manner, information regarding any available third party coverage, such as financial information and documents needed to apply for third party coverage through government or other programs (e.g., Medicare, Medicaid, Kid Care, Family Care, Crime Victims funds, etc.) or to secure payment from third parties (including insurers) in liability matters. Patient cooperation

also includes providing information to or filing documents with such potential third party payers where necessary to apply for and potentially secure such payments. However, the Ombudsperson shall be notified in each such case and may request an explanation of the reasons for the denial from the Advocate Hospital's Charity Care Committee and may comment on the determination.

(iii) The person was personally steered or referred to an Advocate Hospital by any entity or individual for the purpose of disrupting the orderly operation of or provision of care by the Advocate Hospital or of causing an unreasonable disturbance.

(g) If Advocate learns that a substantial number of applicants for Charity Care are Uninsured Patients because they declined to participate in a health coverage plan offered by an employer, or, if self-employed, declined to obtain health coverage through such business, Advocate may discuss with the Ombudsperson and Plaintiffs' Counsel potential modifications of this Agreement to address the issue and, if agreement is not reached, petition the Court for an appropriate modification. However, Advocate will not delay or condition the approval of any individual application based on whether the applicant declined to participate in a health coverage plan offered by an employer, nor will the application form make such an inquiry, or application process or delay or condition the approval of any individual application, to learn or inquire whether a specific individual declined to participate in a health coverage plan offered by an employer, unless and until the Court approves a an appropriate modification of this Agreement to authorize such condition or inquiry into whether the applicant declined to participate in a health coverage plan offered by an employer.

2. Application Form for Charity Care.

a. Commencing on the Effective Date of the Settlement, Advocate shall give every Uninsured Patient who seeks or receives services at an Advocate Hospital, at the earliest practicable time of service, a charity care application in the form attached hereto as Exhibit E. A copy of a Summary of Advocate's Charity Care Policy in the form attached hereto as Exhibit B shall be attached to Exhibit E. Advocate must translate and distribute the Charity Care application forms and the Summary of the Charity Care policy in accordance with the Fair Patient Billing Act. Advocate shall also include a copy of the charity care application form and the Summary of the Charity Care Policy (i) in the initial bill it sends to any Uninsured Patient, (ii) to any Advocate Patient who asks for a copy of the application or the policy, or (iii) to any Advocate Patient whose obligations to Advocate, due, for example, to co-payments or deductibles, equal or exceed $5,000 in a calendar year.

b. Pursuant to said application, an Uninsured Patient shall have the option of providing any one or more of the following to establish his or her Family income, if such documents are available: (1) a copy of his or her most recent federal income tax return, or (2) a copy of his or her W-2 form, if such person is employed, and 1099 Forms, or (3) a copy of the most recent pay stub. If there is more than one employed person in the Patient's Family, each such person must submit one of the documents described in the preceding sentence. Regardless of whether documents are provided with the application, the applicant shall sign a statement certifying the monthly or yearly income of the Family. The applicant shall also authorize Advocate to verify the certification of the Patient's Family income by obtaining copies of such Patient's or Family member's most recent income tax returns from the Illinois Department of Revenue or the United States Internal Revenue Service. Advocate may request the applicant to sign IRS Form 4506 (Request for Copy of Tax Return) and IRS Form 4506-T, Request for Transcript of Tax Return). Advocate is not required to obtain copies of such income tax returns before making Charity Care determinations, but may rescind or modify such a determination pursuant to subparagraph c. below if such returns demonstrate that the applicant has provided materially false information.

c. If an applicant for Charity Care provides materially false information in support of the application, Advocate may, in the case of intentional provision of materially false information, deny the application or future applications from such Patients. In the case of materially false information provided in the absence of bad faith, Advocate will base its determination upon the corrected information. If Charity Care has already been granted based upon materially false information, Advocate may deem the prior grant of Charity Care void, in which case Advocate retains all legal and equitable rights to seek payments from such Patients to which it may be entitled. In such cases, if the provision of materially false information was unintentional, Advocate will revise the determination based upon the corrected information.

d. Pursuant to said Charity Care application, applicants shall be informed (via the application form attached as Exhibit E) that they may elect to provide Advocate with additional documentation regarding their income, outstanding debts or other circumstances which would show financial hardship as to support a request for Charity Care equal to or greater than the amounts to which they are eligible pursuant to this Agreement.

e. An application for Charity Care under this section may be made at any time before or after Medically Necessary Services are rendered to the Uninsured Patient at any Advocate Hospital.

f. An application for Charity Care under this section that is approved shall be presumed effective for six months after the date the application was submitted. If the income of the family unit of such Patient materially improves during the six month period, the Patient shall notify Advocate and Advocate may base its decision to provide further Charity Care after the date of the material change in the income of the family unit. A Patient's failure to disclose a material improvement in Family income voids any provision of Charity Care by Advocate after the material improvement occurs, and nothing in this Agreement diminishes any legal and equitable rights Advocate may have to seek payments from such Patients, and Advocate may deny any future applications for Charity Care from such Patients if the material omission was intentional.

3. Determination of Eligibility for Charity Care.

a. Beginning on the Effective Date of the Settlement, determination of eligibility for Charity Care shall be made by the Advocate Hospital's Charity Care Committee or its nominee based on the application for Charity Care attached as Exhibit E.

b. Advocate's Charity Care Committee shall not reject an Uninsured Patient's application for Charity Care as incomplete based on failure to provide documentation, if the Uninsured Patient has provided at least one of the documents as provided above in paragraph 2.b and listed in the approved application form attached as Exhibit B and has signed the verification and authorization set forth therein, or in the case of a patient unable to provide such documents, who has signed the verification and authorization, provided, however, that if Advocate subsequently learns that the information verified by the applicant is materially false, it may take the remedial actions set forth above in paragraph 2c. Advocate shall take reasonable steps to aid or assist an applicant to complete an application.

c. Advocate shall make best efforts to notify the Uninsured Patient who applied for Charity Care in writing of the Charity Care Committee's determination not later than 45 days after Advocate receives the fully completed application for Charity Care, after Advocate has denied the application because it is incomplete, or after the process for securing any payments from third parties (such as insurers) has been completed. If the application is denied, the applicant should be informed the reason(s) the application was denied, including whether the denial is based on incompleteness of the application. Advocate shall inform an applicant whose application for Charity Care has been denied in whole or in part (including denials based on incompleteness) that he or she has 45 days to appeal the decision of the Charity Care Committee to the Ombudsperson, and how to file such an appeal. A sample letter advising the applicant of such a right of appeal from the unfavorable determination of the Charity Care Committee is attached as Exhibit F. Such

letter shall be translated into the non-English languages applicable to the Advocate Hospital by the Fair Patient Billing Act.

d. In the event of an appeal pursuant to the preceding subparagraph, the Ombudsperson may contact the Uninsured Patient ex parte as he or she reasonably deems necessary or appropriate in order to obtain additional information or documentation from such person. The Ombudsperson shall have authority to counsel any Uninsured Patient when appropriate and to assist any Uninsured Patient in the completion of the application. Advocate shall designate a manager at each Advocate Hospital to serve as the principal contact for the Ombudsperson at that Hospital ("Hospital Contact"). Additionally, Advocate shall designate its Director of Corporate Ethics or other appropriate officer to serve as principal contact for the Ombudsperson on a system-wide level ("System Contact"). The Ombudsperson may contact the Hospital Contact to obtain information or documentation that the Ombudsperson reasonably deems appropriate or relevant for a final decision. Advocate staff shall cooperate with all requests for non-privileged information within Advocate's possession, custody or control that the Ombudsperson has reasonably determined to be necessary and appropriate.

e. The review of the Ombudsperson of an appeal shall be based on the criteria set forth in the Charity Care Policy summary attached as Exhibit B and the terms of this Agreement. Following such review, the Ombudsperson shall make a written determination of the eligibility of the Uninsured Patient for Charity Care, with a copy to the Charity Care Committee and the System Contact. If the relevant Advocate Hospital Charity Care Committee disagrees with the determination, it shall notify the Ombudsperson and the System Contact of its disagreement within ten business days of the Ombudsperson's determination, and, within fourteen business days thereafter, the committee or its nominee and the Ombudsperson shall meet and confer in good faith to attempt to reach an agreed disposition of the appeal. If Advocate does not provide notice of its disagreement with the determination of the Ombudsperson within ten business days of the determination, the determination shall be final and binding. If Advocate does provide such notice and an agreed resolution is reached with the Ombudsperson, that resolution shall be final and binding. If no agreed resolution is reached, Advocate's determination shall be final and binding. The Uninsured Patient who submitted the appeal shall be notified in writing in plain language of the result of the appeal process within ten business days of the resolution, with a copy of the notice provided to the Ombudsperson.

f. The Ombudsperson shall maintain records concerning the foregoing appeal process and include information concerning the process in the reports he or she prepares pursuant to paragraph III.A.7.b of this Agreement. If the Ombudsperson believes that an Advocate Hospital is engaging in a pattern or practice of, or

otherwise substantially, failing to process, evaluate and decide charity applications in compliance with this Agreement, he or she shall notify the System Contact, Advocate Counsel and Class Counsel of this conclusion and the reasons therefor. In such circumstances, plaintiffs may move the Court to make the Ombudsperson, rather than Advocate, the final arbiter of the above appeals process, and if the Court should determine that Advocate has been engaging in the pattern or practice or other substantial non-compliance with this Agreement's requirements for processing, evaluating and determining charity applications, the Court may modify this Agreement to provide that the Ombudsperson has final arbitral authority for such determinations. However, technical violations or isolated instances of non-compliance shall not constitute a pattern or practice or substantial non-compliance with this Agreement.

g. The Ombudsperson shall treat as strictly confidential the identities and financial information concerning Charity Care applicants and applications (as well as the identities of Advocate employees involved in the application process and Advocate's business procedures) and shall not disclose such information to any third party without Advocate's written consent or order of court.

4. Financial Counseling. As of the Effective Date of the Settlement, Advocate shall continue to provide financial counseling to Uninsured Patients regarding their patient accounts and free assistance with Charity Care applications, as described below, as needed to all Uninsured Patients seeking treatment at Advocate Hospitals. The ability to obtain and the provision of such financial counseling shall be communicated to Advocate Patients in plain, simple English (or Spanish where appropriate), subject to the Emergency Medical Treatment and Labor Act ("EMTALA") and other applicable legal requirements. Advocate shall provide reasonable training to Advocate Hospital financial counselors regarding Charity Care availability and how to provide assistance to patients. Financial counseling shall include information concerning the following:

a. The right to apply for any available third party coverage through government or other programs (e.g., Medicare, Medicaid, Kid Care, Family Care, third party liability, Crime Victims funds, etc.), or to secure third party payments in liability matters;

b. The right to apply for Charity Care, an application for Charity Care, and assistance in completing an application for Charity Care in order to receive Charity Care, including providing all required information and documentation;

c. The right of appeal to the Ombudsperson from a denial of an application for Charity Care due to ineligibility or failure to complete the application.

5. Notice of Charity Care

a. At each of its hospitals, Advocate shall post signs and provide brochures regarding the availability of Charity Care in a manner consistent with the Fair Patient Billing Act, 210 ILCS 88/15.

b. Advocate shall provide copies of the Charity Care Policy summary attached as Exhibit B and the Charity Care application form attached as Exhibit E to every Uninsured Patient at the time of treatment at, or prior to discharge from, an Advocate hospital. In addition, Advocate shall include such forms in the initial bill for Medically Necessary Services rendered and sent to a patient by Advocate after treatment.

c. Advocate shall post a link in a prominent place on its website to a notice that Charity Care is available at its facilities. The notice must include a description of the Charity Care Policy and application process and provide electronic access to a full copy of the Charity Care Policy summary and application form. The notice must be in the same languages as the signs that are required in paragraph a above.

d. All of the notifications required by this Sections 5(b) and (c) above must include contact information for the filing of any appeals or complaints with the Ombudsperson.

6. Bills and Collection Actions.

a. Advocate shall comply with the Fair Patient Billing Act regarding the issuance of bills. Advocate shall not require payment for any bill for Medically Necessary Services rendered to any Uninsured Patient until at least 60 days after the date of discharge or receipt of outpatient care for such Services.

b. Advocate shall not bill or attempt to collect fees from an Uninsured Patient who has applied for Charity Care and whose eligibility determination is pending.

c. If an Uninsured Patient first applies for Charity Care after a Collection Action has been initiated, Advocate or any designated agent, assignee, or contractor shall suspend all Collection Actions until an eligibility determination is made as to the patient's application for Charity Care. In addition, if the patient is determined to be eligible for Charity Care, Advocate, or any designated agent, assignee or contractor shall request in a timely manner that any credit reporting agencies remove any adverse information reported and appearing on the patient's credit report as a result of the Collection Action.

d. Advocate shall offer Uninsured Patients a reasonable payment plan consistent with the requirements of the Fair Patient Billing Act to satisfy any payment obligations remaining after a final determination has been made on their application for Charity Care.

7. Ombudsperson.

a. As of the Effective Date of the Settlement, Advocate shall retain and reasonably compensate an Ombudsperson, whose duties are described herein. The parties have agreed that Kathleen Hobbins shall serve in the position of Ombudsperson at the rate of $50 per hour and shall keep accurate, contemporaneous time records of hours worked. The Parties anticipate that after the first eight weeks of his or her employment, the Ombudsperson will usually work on a part-time basis (i.e., half time or less). The Ombudsperson shall certify that he or she is not affiliated with or acting on behalf or for the benefit of any party to this action or any labor organization. If Ms. Hobbins becomes unable to serve, a new Ombudsperson shall be selected by Advocate and Class Counsel or, if they cannot agree, by the Court from a list of up to three names submitted by each of Advocate and Class Counsel. The rate of compensation shall be appropriate to a professional in third party administration unless Advocate and the Ombudsperson agree to a different amount. The agreement with the Ombudsperson shall provide that he or she will act in conformity with this Agreement, including the provisions requiring confidentiality of the identities and financial circumstances of applicants for Charity Care. The agreement will also attach a description of roles and responsibilities in substantially the same form as Exhibit G hereto. The Ombudsperson may be removed by agreement of Advocate and Class Counsel, or by Advocate for misconduct or good cause, subject to review by the Court.

b. In addition to other duties and responsibilities set out in Section III.A.3 above and Exhibit G, the Ombudsperson shall assist Advocate to facilitate its compliance with the terms of the Settlement Agreement, which may include identifying areas in which Advocate may not be complying with the Agreement and making suggestions to cure any non-compliance. The Ombudsperson may investigate on his or her own initiative any complaints by Advocate Patients relating to the dissemination of applications for charity care or to the procedures for processing of applications for Charity Care. The scope of any such investigation shall be limited to whether or not Advocate is complying with this Agreement. The Ombudsperson shall submit a confidential report to Advocate and Class Counsel on an annual basis as to performance by Advocate of its obligations under the Settlement Agreement and recommend changes in the program to the parties. The Ombudsperson may include in such report information concerning the appeals process, including the extent, if any, to which Advocate and the Ombudsperson were unable to resolve any disagreements over the Ombudsperson's

recommended disposition of any appeals, and whether, in the Ombudsperson's opinion, such disagreements reflect a material failure on the part of Advocate to comply with this Agreement.

c. The Ombudsperson shall consider any appeals from any denial of eligibility for full or partial Charity Care and the Ombudsperson's recommendations shall be final and binding subject to paragraph III.A.3.e above. Advocate shall provide the Ombudsperson with a quarterly report setting for the number and disposition of all Charity Care applications.

d. The Ombudsperson and Advocate shall strive to work in a collaborative fashion. The role of the Ombudsperson is not to be confrontational or partisan, but rather to provide assistance and feedback to Advocate to advance the mutual goal of the Parties to ensure that the Charity Care process function smoothly, efficiently, fairly and in compliance with this Agreement.

e. Advocate sball cooperate with the Ombudsperson and shall provide the Ombudsperson with all non-privileged information and documentation within its possession, custody or control that the Ombudsperson reasonably requests to perform the Ombudsperson's duties. The Ombudsperson shall be authorized to contact directly the pertinent Hospital Contacts for information he or she reasonably deems appropriate to perform his or her duties, and Advocate shall direct the Hospital Contacts and other staff members to be responsive to such requests.

8. Auditor. Advocate shall hire and compensate an independent auditor, whom the parties agree shall be Ernst & Young or the public auditing firm responsible for auditing Advocate's financial statements. The auditor shall issue annual reports containing the information set forth below during the term of this Agreement regarding the information audited. The report shall also indicate whether Advocate is in substantial compliance with the Settlement Agreement. Advocate shall cooperate with the Auditor and provide the auditor with all information and documentation the Auditor deems necessary to issue reports. Each report must include following information for the applicable fiscal year.

- The total number of applications for Charity Care submitted to Advocate.
- The total number of applications for Charity Care approved by Advocate, separately itemizing approved applications for full Charity Care and discounted Charity Care.
- The total number of applications denied by Advocate and the reasons for such denials.
- The total number of incomplete applications and the reasons for the same.
- A detailed description of Advocate's Charity Care application process.
- Advocate's most recent complete consolidated audited annual financial statements.

9. Discounted Pricing for Uninsured Patients. As of the Effective Date of the Settlement, except as provided below, Uninsured Patients who receive treatment at Advocate Hospitals will receive, without having to submit an application, and independent of Charity Care determinations, an Uninsured Patient Discount on Medically Necessary Services on the following basis. Uninsured Patients shall receive a discount of no less than 20% from the Gross Charges and an additional 10 percent discount for paying a bill in full within 30 days after a bill is rendered. These discounts will be available to all Uninsured Patients regardless of income level. Advocate shall have the right to provide larger discounts in its sole discretion. This provision shall become null and void at Advocate's election if Medicare determines that the granting of such discounts negatively affects Advocate's Medicare reimbursement. Subject to the provisions of the Health Care Services Lien Act, 770 ILCS 23/1, the foregoing discount for Uninsured Patients does not apply to Advocate Patients whose injury is compensable pursuant to worker's compensation, automobile insurance or other liability insurance or a tort judgment.

10. Cooperation. Nothing in this Agreement is intended to diminish the patient responsibilities of Class Members pursuant to Section 45 of the Fair Patient Billing Act, 210 ILCS 88/45.

11. Record Keeping. During the pendency of this Agreement, for any and all Advocate Hospitals, Advocate hereby agrees to retain the following records: Records of applications for Charity Care and determinations. Each applicant shall be entitled upon written request to inspect and/or obtain a full copy of his or her Charity Care application file.

12. Scope of Agreement and Retention of Jurisdiction. The terms and requirements of this Section III of this Settlement Agreement shall expire on that date four (4) years from the Effective Date of this Settlement Agreement, except that Advocate may move the Court to terminate this Section III after three years from the Effective Date upon a showing that it has substantially complied with the terms and provisions of Section III. The terms and requirements of this Section III shall not apply to any acute care hospital that is not currently owned or operated by Advocate, any such hospital after it is subsequently sold or no longer operated by Advocate, or any hospital whose property tax, sales tax or income tax exemption is revoked or denied. Nothing in this Settlement Agreement shall require Advocate to take any action, or to refrain from taking any action, that would controvert in any way the provisions of any statute, regulation or other law of any kind now existing or that may be enacted in the future. The Parties hereby agree that Advocate shall remain free to take whatever action may be required to ensure compliance with any statutes, regulations or laws, whether in existence now or coming into existence at some future time, even if such action may violate the terms of this Settlement Agreement, and Advocate shall not be held liable or subject to any claim for relief under the terms of this Settlement Agreement for any such action. Following the Effective Date, and during the term of this Settlement Agreement, the Court shall retain jurisdiction over the Parties to this Settlement Agreement for purposes of interpreting or enforcing this Agreement.

B. Applications for Charity Care for Outstanding Bills for Medically Necessary Services Provided Prior to the Effective Date of Settlement.

All Settlement Class Members who currently have outstanding bills or unsatisfied judgments with Advocate as of the Effective Date of this Settlement, for Medically Necessary Services received during the Class Period, who apply for Charity Care shall receive Charity Care determinations under the terms set forth in Section A based on their current Family income. Advocate shall send notice to any Settlement Class Member from whom it is still seeking to recover money on an outstanding bill or judgment. Such notice shall inform the Settlement Class Member that he or she may apply for Charity Care as to such outstanding amount. The Notice shall provide an application form either the same as or substantially similar to that set forth in Exhibit E. (Advocate may satisfy these provisions by including Exhibit E with mailed copies of the Notice attached hereto as Exhibit D.) Eligibility for Charity Care shall be determined as set forth in Section III.A above. Advocate shall suspend any collection actions against any such Class Members pending determination of their applications for Charity Care. Advocate shall dismiss with prejudice any pending collection lawsuits against any Class Members whose Charity Care applications are granted in full, and take reasonable steps to correct and/or expunge any adverse credit reports on any Class Members whose applications for charity care are granted.

C. Restitution

1. Subject to Section III.C.2 below, Advocate will reimburse any Settlement Class Member who was an Uninsured Patient and eligible for Charity Care at the time the Settlement Class Member received Medically Necessary Services for any payment made to Advocate for such Services if and to the extent such payments exceed the amount, if any, owing to Advocate after application of the Charity Care discount. Restitution shall be limited to payments made for services that were rendered from November 19, 2000 through December 31, 2004. Advocate shall determine the eligibility of the Settlement Class Members as to the right and amount of refunds for payments for services rendered in this period, subject to review by the Ombudsperson. Advocate shall provide Notice as provided in Section IV below to all Settlement Class Members who were Uninsured Patients with respect to, and paid money to Advocate for, Medically Necessary Services rendered from November 19, 2000 through December 31, 2004. Settlement Class Members whose Family income at the time the Services were rendered was greater than 200 percent of the Federal Poverty Income Guidelines shall not be eligible for refunds on payments on individual bills of $500 or less, unless the Settlement Class Member made payments aggregating $1000 or more on two or more bills in a 12 month period. Any Settlement Class Member whose Family income at the time the Services were rendered was 200 percent or less of the Federal Poverty Guidelines shall be eligible for a refund on any amount paid by such Settlement Class Member. The right and procedure for obtaining a refund is described in the Notice attached hereto as Exhibit D. A copy of the Claim Form, which shall be used by the Settlement Class Member to apply for such refund, is attached hereto as Exhibit H, and shall be provided to Class Members pursuant to Section IV.C.5. Eligibility for restitution pursuant to this Section shall be based on the Family Income and Federal Poverty Guidelines at the time the Settlement Class Member received the Medically Necessary Services.

2. Advocate's aggregate obligation to pay restitution pursuant to the preceding paragraph shall not exceed three million five hundred thousand dollars ($3,500,000.00). If Settlement Class Members submit and obtain approval for restitution in an aggregate sum that is greater than $3,500,000, Advocate may prorate the amount of the refund among the qualifying Class Members. Thus, if $7,000,000 worth of claims are approved, Advocate's obligation to each qualified Class Member would not exceed 50% of the amount of his or her approved claim. Any restitution payments owing to a Named Plaintiff who has applied under this Agreement shall be paid in full and not be subject to pro-ration.

3. Claim Forms applying for restitution must be received by Advocate no later than ninety days after issuance of the Claim Form attached as Exhibit H, which shall conspicuously inform the recipients of the Notice of the deadline for submitting applications.

4. The data within Advocate's patient accounting system shall be the deciding and controlling factor in adjudicating the claims for restitution of eligible Class Members pursuant to this Settlement Agreement. If Advocate's records and data do not reflect that a particular claimant was treated at an Advocate Hospital during the eligibility period, or otherwise do not indicate that the claimant is entitled to restitution pursuant to the terms of this Settlement Agreement, then the claim shall be denied, unless the potential claimant comes forward with sufficient documentation to establish entitlement to restitution.

5. Advocate shall make a determination concerning the submitted Claim Forms within 120 days after the deadline for their submission, except that Advocate may defer the determination for any applicant whose income tax returns have been requested by Advocate from the government.

6. Advocate shall maintain records of its calculation and determination of whether restitution was payable pursuant to submitted Claim Forms. Such records shall be made available to Class Counsel for review. If Class Counsel disagree with any such determinations, they and Advocate shall attempt in good faith to resolve the determinations. If agreement is not reached following such conciliation attempts, the Class Member may appeal the denial to the Ombudsperson, who shall resolve the dispute in a manner consistent with the provisions of Section III.A.3.e above.

7. Advocate shall take reasonable steps to correct and/or expunge any adverse credit reports on any Settlement Class Members who received services during the eligible period set out in paragraph 1 above and who received a refund pursuant to this Agreement.

IV. NOTIFICATION TO SETTLEMENT CLASS MEMBERS

A. Responsibility. Advocate shall be responsible for implementing the Notice to the Settlement Class.

B. Notice Expenses. Advocate shall be responsible for, without limitation: (i) arranging for the publication and mailing of the Notice; (ii) responding to requests for the Notice; and (iii) administration of claims as set forth below. All Notice and Claims Administration Expenses shall be paid by Advocate.

C. Notice Plan Implementation.

1. Confidentiality. Advocate (and any person retained by Advocate) and Class Counsel shall sign a confidentiality agreement in a form agreed to by Class Counsel and Advocate, which shall provide that the names, addresses and other information about specific Settlement Class Members provided by either Advocate, Class Counsel or by individual Settlement Class Members shall all be treated as confidential and shall be used by Advocate or Class Counsel only as required by this Settlement Agreement and subject, if applicable, to the Health Insurance Portability and Accountability Act.

2. Publication Notice. The Publication Notice shall be published in the following newspapers: *Chicago Sun-Times* and *Daily Southtown* (in English) and *La Raza* (in Spanish). The publication Notice shall be substantially in the same form as the exemplar submitted as Exhibit D-1. The publication of the Notice will begin on a date no later than 28 days after entry of the Preliminary Approval Order and shall run in two Sunday issues of the *Sun-Times*, one Sunday issue of the *Daily Southtown* and two issues of *La Raza*.

3. Internet Notice. The parties agree that the Notice shall be posted on or linked to the Internet Website of Advocate and Class Counsel ("Internet Notice"). The Internet Notice shall be substantially in the same form as the exemplar submitted as Exhibit D. Advocate and Class Counsel shall post on or link to their respective web sites, until 180 days after Final Order, the Notice, the Preliminary Approval Order, the Settlement Agreement, and such additional information as counsel for the parties may agree upon.

4. Mailed Notice to Settlement Class Members. Advocate or its nominee shall mail the Notice by first-class postage prepaid, U.S. Mail, to the last-known addresses of Settlement Class Members as of the date of entry of the Preliminary Approval Order who were Uninsured Patients as reflected in Advocate's records. The mailed Notice shall be substantially in the same form as the exemplar submitted as Exhibit D, and shall be mailed on a schedule set forth in the Preliminary Approval Order. Advocate may exclude from such mailings Uninsured Patients who have never made any payments to Advocate, whose bills have been written off as bad debt, who have not had a judgment entered against them regarding such bills, and from whom Advocate is no longer seeking payment.

5. Claim Forms. Advocate or its nominee shall also mail by first class postage, U.S. Mail, the Claim Form to the last-known addresses as reflected in Advocate's records of those Settlement Class Members who were Uninsured Patients with respect to and paid money to Advocate for Medically Necessary Services rendered from November 19, 2000 through December 31, 2004. Such mailing shall be completed no later than fourteen days after the Effective Date.

6. Notice and Claims Requests. Advocate shall also provide a copy of the Notice and Claim Form to any Advocate Patient who requests the Notice and Claim Form.

7. Proof of Notice. Advocate shall provide affidavits to the Court, with a copy to Class Counsel, attesting to the measures undertaken to provide notice and claim forms to Settlement Class Members pursuant to this Agreement.

V. MISCELLANEOUS CLAIMS ADMINISTRATION.

A. No person shall have any claim against Defendants or any of the Related Parties, the Plaintiffs, the Settlement Class, Class Counsel, or the Ombudsperson based on any eligibility determinations, distributions or payments made in accordance with this Settlement Agreement. This provision does not affect or limit in any way any right of review by the Court pursuant to Section VII.C.

B. All controversies with respect to the implementation, interpretation or enforcement of this Agreement shall be subject to the jurisdiction of the Court, provided that nothing in this Agreement shall be deemed to create a right in any individual Class Member to appeal to the Court any denial of his or her applications for Charity Care or Restitution.

VI. OBJECTIONS AND OPT OUTS BY SETTLEMENT CLASS MEMBERS

A. Any Settlement Class Member who intends to object to the fairness, reasonableness and adequacy of the Class Settlement (hereinafter "Objections") must mail a written Objection to the Court, and mail a copy to Advocate and Class Counsel at the addresses set forth below, postmarked not later than the date specified in the Court's Preliminary Approval Order. Settlement Class Members making Objections must set forth their full name, current address and telephone number. Objections must be served:

Upon Advocate at:

Edward W. Feldman
Miller Shakman & Beem LLP
180 North LaSalle, Suite 3600
Chicago, Illinois 60601

Upon Class Counsel at:

Thomas H. Geoghegan
Despres Schwartz & Geoghegan
77 West Washington, Room 711
Chicago IL 60602

Robert Cohen
Frankel & Cohen
77 West Washington, Room 1720
Chicago IL 60602

B. Objecting class members must state in writing all Objections and the reasons therefore, and a statement whether the Objector intends to appear at the Fairness Hearing(s) either with or without counsel

C. Members of the Settlement Class may elect to opt out of this Settlement Agreement, relinquishing their rights to benefits hereunder. Members of the Settlement Class who opt out of the Settlement will not release their claims under Section VII below. Class members wishing to opt out of the Settlement must send to Advocate and Class Counsel at the above addresses a letter including their name, address, and telephone number and providing a clear statement communicating that they elect to be excluded from the Settlement Class, do not wish to be a Settlement Class Member and elect to be excluded from any judgment entered pursuant to this Settlement Agreement. Any request for exclusion or opt-out must be postmarked on or before the opt-out deadline provided in the Court's Preliminary Approval Order and the Notice. The date of the postmark on the return mailing envelope shall be the exclusive means used to determine whether a request for exclusion has been timely submitted. Members of the Settlement Class who fail to submit a valid and timely request for exclusion on or before the date specified in the Preliminary Approval Order and Notice shall be bound by all terms of the Settlement Agreement and the Final Order, regardless of whether they have requested exclusion from the Settlement.

D. Any member of the Settlement Class who submits a timely request for exclusion or opt-out may not file an Objection to the Settlement and shall be deemed to have waived any rights or benefits under this Settlement Agreement.

VII. DISMISSAL AND RELEASE OF CLAIMS.

A. Advocate shall dismiss with prejudice all pending claims asserted against Class Representatives for collecting any bill for any Medically Necessary Service rendered during the Class Period for which the Class Representatives were Uninsured Patients. Advocate shall write off the unpaid balances of the Class Representatives shown in Exhibit I hereto. With respect to the Class Representatives, Advocate, or any designated agent, assignee, contractor, or purchaser of the account, shall take reasonable steps to retract any adverse information reported to any credit reporting agencies as a result of any Collection Action in a timely manner within thirty (30) days of the Effective Date of this Settlement Agreement. Nothing in this Settlement Agreement shall preclude Advocate or any of its agents, assignees or contractors from instituting legal action against Settlement Class Members, excluding the Class Representatives, for failure to pay amounts due and owing for treatment at Advocate Hospitals during the Class Period, so long as such claims and actions are consistent with the terms and conditions of this Settlement Agreement.

B. Upon the Effective Date, the Case shall be dismissed with prejudice as to Advocate pursuant to the Final Order attached hereto as Exhibit C.

C. Notwithstanding the above, the Court shall retain jurisdiction over the parties to the Settlement Agreement with respect to the construction and performance of the terms of the Settlement Agreement. In the event that any applications for relief are made, such applications will be made to the Court.

D. Upon the Effective Date: (i) the Released Claims shall be deemed, without further documentation, fully released and discharged, (ii) the Settlement Agreement shall provide the exclusive remedy for any and all Released Claims of Settlement Class Members; and (iii) the Released Parties shall not be subject to liability or expense of any kind to any Settlement Class Members, who shall be permanently barred and enjoined from initiating, asserting, or prosecuting against the Released Parties in any federal or state court or tribunal any and all Released Claims and who further covenant not to initiate, assert or prosecute such Claims.

E. Settlement Class Members are not releasing any claims for personal injuries, except for any claims for injuries incurred as a result of Advocate's billing or collection activities. Additionally, Settlement Class Members are not releasing any rights under the Health Care Services Lien Act in an adjudication under 770 ILCS 23/30.

F. The release and dismissal survive the termination or expiration of this Agreement.

VIII. EFFECT OF DISAPPROVAL, CANCELLATION OR TERMINATION

A. In the event (i) the Court does not enter the Preliminary Approval Order specified in this Settlement Agreement; (ii) the Court does not finally approve the settlement as provided in this Settlement Agreement; (iii) the Court does not enter the Final Order as provided in this Settlement Agreement; or (iv) the Settlement Agreement does not become final for any other reason, and the Parties, in their sole and unfettered discretion following reasonable efforts, do not agree in writing to modify this Settlement Agreement and the Settlement is not consummated, this Settlement Agreement shall be null and void and any order or judgment entered by the Court in furtherance of this settlement shall be vacated nunc pro tunc.

B. In such a case, the Parties shall proceed in all respects as if this Settlement had not occurred, and any conditional or final order of class certification will be null and void and the Defendants shall have the right to object to certification of the Settlement Class or any other class at any future time. In the event an appeal is filed from the Court's Final Order, or any other appellate review is sought prior to the Effective Date, administration of the settlement shall be stayed pending final resolution of the appeal or other appellate review.

IX. SETTLEMENT NOT EVIDENCE AGAINST PARTIES

A. Nothing in this Agreement is or shall be construed to be an admission by any Settling Party of any act, fact, matter or proposition, and shall not be used in any manner or for any purpose in any subsequent proceeding in the Case or in any other action or proceeding. Defendants and the Related Parties deny any and all charges and wrongdoing alleged in the Case or otherwise. Whether or not the Settlement Agreement is approved, neither the Settlement Agreement, nor any document, statement, proceeding or conduct related to this Settlement Agreement, nor any reports or accounts thereof, shall in any event be disclosed or referred to for any purpose, or offered or received in evidence, in any further proceeding in the Case, or in any other civil, criminal or administrative action or proceeding against Defendants or any of the Related Parties, except for purposes of securing approval of or enforcement of this Settlement Agreement.

B. In the event the Settlement Agreement is terminated according to its terms, other than as expressly preserved by this Agreement in the event of its termination, this Agreement shall have no further force and effect with respect to any Settling Party and shall not be used in the Case or any other proceeding for any purpose. The limitations set forth in this paragraph do not apply to use and/or disclosure, by Defendants or any of the Related Parties against members of the Settlement Class or third parties for purposes of supporting a defense or counterclaim of res judicata, collateral estoppel, release, good faith settlement, judgment bar or reduction or any other theory or claim of issue preclusion or similar defense or counterclaim.

X. ATTORNEY'S FEES AND ADMINISTRATIVE EXPENSES

A. Subject to review and approval by the Court concerning reasonableness and fairness to the Settlement Class, Advocate shall pay reasonable legal fees in the sum of $543,300 and reasonable costs in the sum of $980 to the firms of Despres, Schwartz and Geoghegan and Frankel and Cohen. These legal fees and costs are not payable from any recovery to the Settlement Class Members or from any of the proceeds to which Settlement Class Members are entitled, but are payable by Advocate under section 10a of the Illinois Consumer Fraud and Deceptive Practices Act (ICFA), 815ILCS 505/10a. The parties agree that pursuant to such fee-award provision of the ICFA, Class Counsel have been compensated at a compromise average hourly rate of approximately $350, and Advocate does not dispute the hours of service represented by Class Counsel to Advocate. Plaintiffs' counsel shall be awarded the additional sum of $50,000 in full and complete satisfaction of any claim for services to be rendered by plaintiffs' counsel in monitoring or enforcing this Agreement. Class Counsel shall not be permitted to seek from Advocate or petition the Court for any additional payments for fees, costs, expenses or incentive awards, and the award shall be for all claims for attorneys' fees, costs and expenses past, present and future incurred by any attorney or law firm in connection with or related to the Case.

B. Any attorneys' fees, costs or expenses awarded by the Court to Class Counsel shall be paid by Advocate within fourteen days of the Effective Date of this Agreement.

C. Advocate's payment of Class Counsel's attorneys' fees, costs and expenses as described herein shall constitute full and complete satisfaction of any obligation by Advocate to pay any person, attorney or law firm for attorneys' fees, costs, and expenses incurred on behalf of the Plaintiffs and the Settlement Class, and shall relieve Defendants and the Related Parties from any other claims or liability to any other attorney or law firm or person for any attorneys' fees, expenses and costs to which any of them may claim to be entitled on behalf of the Plaintiffs and the Settlement Class that are in any way related to the Released Claims.

XI. MISCELLANEOUS PROVISIONS.

A. Governing Law. This Agreement is governed by and shall be construed under Illinois law.

B. Entire Agreement. This Agreement embodies the entire understanding of the Parties, and may not be modified or amended except in a written document signed by the Parties hereto. All prior correspondence, conversations, and memoranda with respect to the subject matter herein have been merged into and replaced by this Agreement.

C. Successors and Assigns. This Agreement is binding upon the parties hereto, and their respective heirs, successors and assigns.

D. Construction. No inference shall be drawn for or against any Party because of its role in the drafting of this Agreement.

E. Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original.

F. Mutual Representations and Warranties. The following representations and warranties are continuing in nature and will survive the Effective Date of this Agreement:

(1) Plaintiffs and Advocate represent and warrant to the other Parties hereto that their execution of this Agreement does not violate any covenant, agreement or other undertaking to which they, respectively, are bound.

(2) Advocate and Class Counsel represent and warrant to the other Parties hereto that they respectively are authorized to execute this Agreement.

(3) Each Plaintiff represents and warrants to Advocate that he or she has not assigned or otherwise transferred to any other person or entity any claim that is a subject of this Agreement.

(4) Each signatory hereto represents and warrants to the other parties that he or she is signing this Agreement voluntarily, of his or her own free will, has the requisite capacity to understand the contents hereof, has the right, power and authority to execute this Agreement, and has had the opportu-

nity to avail himself or herself of whatever financial and legal counsel that he or she desired, if any.

G. Extensions. The Parties reserve the right, subject to the Court's approval, to agree to or seek reasonable extensions of time needed to comply with any provisions of this Agreement.

Date: August 15, 2008

Adam Beebe

Vanessa Cristiani

Santos Gordils

Christopher Hauser

Tina LaVallicre

Margaret Loncar

Ravell McDonald

Lillie McLinton

Tiffany Montgomery

Date: August 15, 2008

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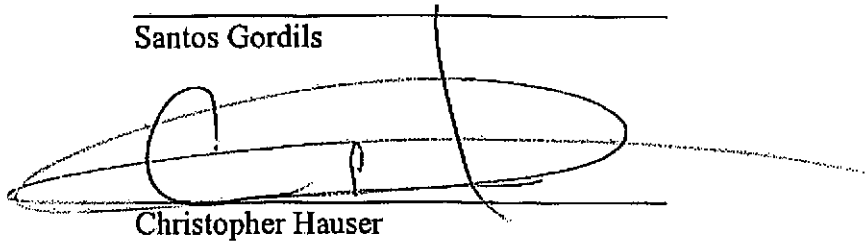

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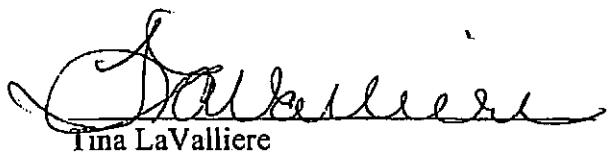

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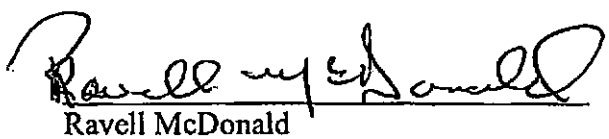

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Ravell McDonald

Lillie McLinton
1033 N. Harding ave
Chicago Ill - 60651

Tiffany Montgomery

Date: August 15, 2008

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Margaret Loncar

Ravell McDonald

Lillie McLinton

Tiffany Montgomery

Date: August 15, 2008

Curtis P. Moore
Curtis Moore

Thomas Pemberton

Vincent Petrozza

Nicolas Rodriquez

Terrence Rogers

Michael Sozykowny

Frank Vacha

Jeffrey Wojcik

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Date: August 15, 2008

Curtis Moore

Thomas Pemberton

Vincent Petrozza

Nicolas Rodriquez

Terrence Rogers

Change of Address →

Old: 4048 Dean Dr.
Oak Lawn, Il. 60453

New: 8124 44th St.
Lyons, Il. 60534

Michael ~~Sozykowny~~ Szykowny

Frank Vacha

Jeffrey Wojcik

Date: August 15, 2008

Curtis Moore

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Date: August 15, 2008

Thomas H. Geoghegan
Despres Schwartz & Geoghegan
77 West Washington, Room 711
Chicago IL 60602
Counsel for Plaintiffs

Robert Cohen
Frankel & Cohen
77 West Washington, Room 1720
Chicago IL 60602
Counsel for Plaintiffs

Date: August 15, 2008

Advocate Health Care Network

By: _____
Duly Authorized Agent

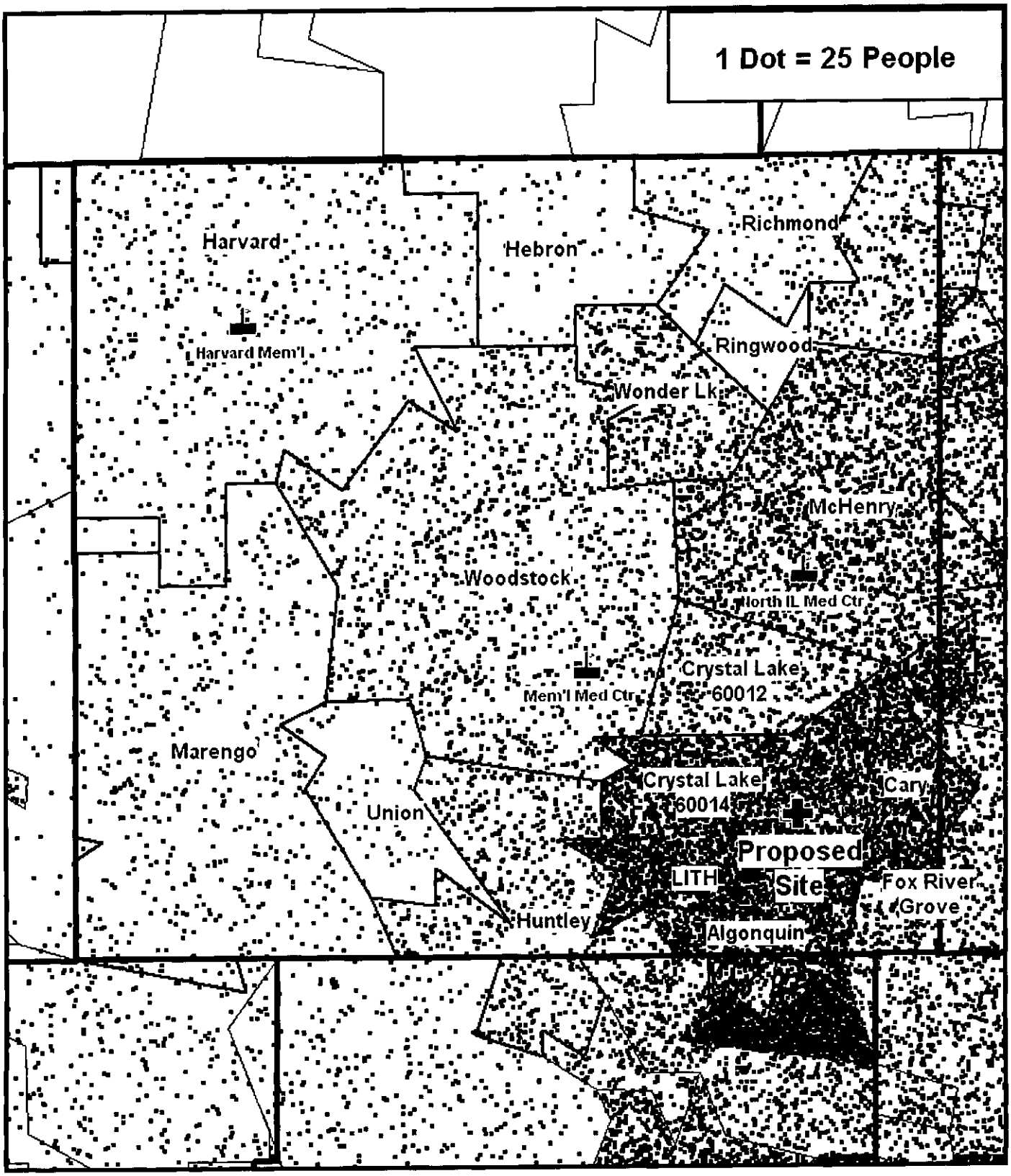
Advocate Health and Hospitals Corporation

By: _____
Duly Authorized Agent

_____
Edward W. Feldman
Miller Shakman & Beem LLP
180 North La Salle Street, Suite 3600
Chicago, IL 60601
Counsel for Defendants

EXHIBIT B
Population Map

Population Density in McHenry County
2010 Population Estimate



Source: Nielsen Claritas, Inc., New York, NY; U.S. Census 2000

EXHIBIT C
FTC/DOC Joint Statement

Joint Statement of the Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission Before the Illinois Task Force on Health Planning Reform

September 15, 2008[1]

The Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission appreciate the opportunity to share our views on the impact of Certificate-of-Need ("CON") laws on health care markets.[2]

The Antitrust Division and the FTC (together, the Agencies) have investigated and litigated antitrust cases in markets across the country involving hospitals, physicians, ambulatory surgery centers, stand-alone radiology programs, medical equipment, pharmaceuticals, and other health care goods and services. In addition to this enforcement, we have conducted hearings and undertaken research on various issues in health care competition. For example, in 2003, we conducted 27 days of hearings on competition and policy concerns in the health care industry, hearing from approximately 250 panelists, eliciting 62 written submissions, and generating almost 6,000 pages of transcripts.[3] As a result of that effort, the Agencies jointly published an extensive report in July 2004 entitled, *Improving Health Care: A Dose of Competition*.[4] We regularly issue informal advisory letters on the application of the antitrust laws to health care markets, and periodically issue reports and general guidance to the health care community. Through this work, we have developed a substantial understanding of the competitive forces that drive innovation, costs, and prices in health care.

The Agencies' experience and expertise has taught us that Certificate-of-Need laws impede the efficient performance of health care markets. By their very nature, CON laws

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[1] This statement draws from testimony delivered on behalf of the Antitrust Division to the General Assembly and Senate of the State of Georgia on February 23, 2007; to the Committee on Health of the Alaska House of Representatives on January 31, 2008; and to the Florida Senate Committee on Health and Human Services Appropriations on March 25, 2008. It also draws from testimony delivered on behalf of the Federal Trade Commission to the Committee on Health of the Alaska House of Representatives on February 15, 2008 and to the Florida State Senate on April 2, 2008.

[2] This statement responds to an invitation from Illinois State Senator Susan Garrett, co-chair of the Illinois Task Force on Health Planning Reform, dated June 30, 2008.

[3] This extensive hearing record is largely available at http://www.ftc.gov/bc/healthcare/research/healthcarehearing.htm.

[4] FEDERAL TRADE COMMISSION AND THE DEPARTMENT OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (July 2004), *available at* http://www.usdoj.gov/atr/public/health_care/204694.htm (hereinafter A DOSE OF COMPETITION).

create barriers to entry and expansion to the detriment of health care competition and consumers. They undercut consumer choice, stifle innovation, and weaken markets' ability to contain health care costs. Together, we support the repeal of such laws, as well as steps that reduce their scope.

We have also examined historical and current arguments for CON laws, and conclude that such arguments provide inadequate economic justification for depriving health care consumers of the benefits of competition. To the extent that CONs are used to further non-economic goals, they impose substantial costs, and such goals can likely be more efficiently achieved through other mechanisms. We hope you will carefully consider the substantial costs that CON laws may impose on consumers as you consider eliminating or otherwise amending Illinois's CON requirements.

I. Scope of Remarks

Although we do not intend to focus on specific aspects of the CON program in Illinois, we are generally familiar with the issues before you and recognize them as issues that CON laws present in other states and markets. Also, please note that it is not the intent of the Agencies to "favor any particular procompetitive organization or structure of health care delivery over other forms that consumers may desire. Rather, [our] goal is to ensure a competitive marketplace in which consumers will have the benefit of high quality, cost-effective health care and a wide range of choices . . ."[5] Our mission is to preserve and promote consumer access to the benefits of competition, rather than any particular marketplace rival or group of rivals.

II. Importance of Competition and the Harm Caused by Regulatory Barriers to Entry

A. The Benefits of Competition in Health Care

Our concerns about the harm from CON laws are informed by one fundamental principle: market forces tend to improve the quality and lower the costs of health care goods and services. They drive innovation and ultimately lead to the delivery of better health care. In contrast, over-restrictive government intervention can undermine market forces to the detriment of health care consumers and may facilitate anticompetitive private behavior.

In our antitrust investigations we often hear the argument that health care is "different" and that competition principles do not apply to the provision of health care services. However, the proposition that competition cannot work in health care is not

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[5] U.S. Department of Justice and Federal Trade Commission, Statements of Antitrust Enforcement Policy in Health Care, August 1996, Introduction, at 3, *available at* http://www.usdoj.gov/atr/public/guidelines/1791.htm.

supported by the evidence or the law. Similar arguments made by engineers and lawyers – that competition fundamentally does not work and, in fact is harmful to public policy goals – have been rejected by the courts, and private restraints on competition have long been condemned.[6] Beginning with the seminal 1943 decision in *American Medical Association v. United States*, the Supreme Court has come to recognize the importance of competition and the application of antitrust principles to health care.[7] The Antitrust Division and the Federal Trade Commission have worked diligently to make sure that barriers to that competition do not arise.

During our extensive health care hearings in 2003, we obtained substantial evidence about the role of competition in our health care delivery system and reached the conclusion that vigorous competition among health care providers "promotes the delivery of high-quality, cost-effective health care."[8] Specifically, competition results in lower prices and broader access to health care and health insurance, while non-price competition can promote higher quality.[9]

Competition has also brought consumers important innovations in health care delivery. For example, health plan demand for lower costs and "'patient demand for a non-institutional, friendly, convenient setting for their surgical care'" drove the growth of Ambulatory Surgery Centers.[10] Ambulatory Surgery Centers offered patients more convenient locations, shorter wait times, and lower coinsurance than hospital departments.[11] Technological innovations, such as endoscopic surgery and advanced anesthetic agents, were a central factor in this success.[12] Many traditional acute care hospitals have responded to these market innovations by improving the quality, variety, and value of their own surgical services, often developing on- or off-site ambulatory surgery centers of their own.

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[6] *See, e.g., F.T.C. v. Superior Court Trial Lawyers Ass'n*, 493 U.S. 411 (1990); *National Society of Professional Engineers v. U.S.*, 435 U.S. 679 (1978).

[7] 317 U.S. 519, 528, 536 (1943) (holding that a group of physicians and a medical association were not exempted by the Clayton Act and the Norris-LaGuardia Acts from the operation of the Sherman Act, although declining to reach the question whether a physician's practice of his or her profession constitutes "trade" under the meaning of Section 3 of the Sherman Act).

[8] A DOSE OF COMPETITION, Executive Summary, at 4.

[9] *Id.*; *see also id.*, Ch. 3, §VIII.

[10] Id., Ch. 3 at 25.

[11] MEDICARE PAYMENT ADVISORY COMMISSION, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY § 2F, at 140 (2003), *available at* http://www.medpac.gov/publications/congressional_reports/Mar03_Entire_report.pdf.

[12] A DOSE OF COMPETITION, Ch. 3 at 24.

This type of competitive success story has occurred often in health care in the areas of pharmaceuticals, urgent care centers, limited service or "retail" clinics, and the development of elective surgeries such as LASIK, to name just a few. Without private or governmental impediments to their performance, we can expect health care markets to continue to deliver such benefits.

B. CON Laws Create Barriers to Beneficial Competition

CON laws are a regulatory barrier to entry, which, by their nature, are an impediment to health care competition. Accordingly, in *A Dose of Competition*, we urged states to rethink their CON laws.[13]

1. Original Cost-Control Reasons For CON Laws No Longer Apply

We made that recommendation in part because the original reason for the adoption of CON laws is no longer valid. Many CON programs trace their origin to a repealed federal mandate, the National Health Planning and Resources Development Act of 1974, which offered incentives for states to implement CON programs. At that time, the federal government and private insurance reimbursed health care charges predominantly on a "cost-plus" basis, which provided incentives for over-investment. There was concern that, because patients are usually not price-sensitive, providers engaged in a "medical arms race" by unnecessarily expanding their services to offer the perceived highest-quality services, allegedly driving up health care costs.[14] The hope was that CON laws would provide a counterweight against that skewed incentive.

Thus, it is important to note that:

- CON laws were not adopted as a means of cross-subsidizing care;
- CON laws were not adopted to have centralized planning of health care markets as an end in itself;
- CON laws were not adopted to supplant or augment state-law licensing regulations designed to protect the health and safety of the population from poor-quality health care.

Since the 1970s, the reimbursement methodologies that may in theory have justified CON laws initially have significantly changed. The federal government, as well as private third-party payors, no longer reimburse on a cost-plus basis. In 1986, Congress repealed the

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[13] A DOSE OF COMPETITION, Executive Summary at 22.

[14] *See* A DOSE OF COMPETITION, Ch. 8 at 1-2.

National Health Planning and Resources Development Act of 1974. And health plans and other purchasers now routinely bargain with health care providers over prices. Essentially, government regulations have changed in a way that eliminates the original justification for CON programs.[15]

CON laws also appear to have generally failed in their intended purpose of containing costs. Numerous studies have examined the effects of CON laws on health care costs,[16] and the best empirical evidence shows that "on balance . . . CON has no effect or actually increases both hospital spending per capita and total spending per capita."[17] A recent study conducted by the Lewin Group for the state of Illinois confirms this finding, concluding that "the evidence on cost containment is weak," and that using "the CON process to reduce overall expenditures is unrealistic."[18]

2. CON Laws Impose Additional Costs and May Facilitate Anti-Competitive Behavior

Not only have CON laws been generally unsuccessful at reducing health care costs, but they also impose additional costs of their own. First, like any barrier to entry, CON laws interfere with the entry of firms that could otherwise provide higher-quality services than

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[15] A DOSE OF COMPETITION, Ch. 8 at 1-6.

[16] A DOSE OF COMPETITION, Ch. 8 at 1-6; CHRISTOPHER J. CONOVER & FRANK A. SLOAN, EVALUATION OF CERTIFICATE OF NEED IN MICHIGAN, CENTER FOR HEALTH POLICY, LAW AND MANAGEMENT, TERRY SANFORD INSTITUTE OF PUBLIC POLICY, DUKE UNIVERSITY, A REPORT TO THE MICHIGAN DEPT. OF COMMUNITY HEALTH, 30 (May 2003); David S. Salkever, *Regulation of Prices and Investment in Hospital in the United States*, in 1B Handbook of Health Economics, 1489-90 (A.J. Culyer & J.P. Newhouse eds., 2000) ("there is little evidence that [1970's era] investment controls reduced the rate of cost growth."); Washington State Joint Legislative Audit and Review Committee (JLARC), Effects of Certificate of Need and Its Possible Repeal, *I* (Jan. 8, 1999) ("CON has not controlled overall health care spending or hospital costs."); DANIEL SHERMAN, FEDERAL TRADE COMMISSION, THE EFFECT OF STATE CERTIFICATE-OF-NEED LAWS ON HOSPITAL COSTS: AN ECONOMIC POLICY ANALYSIS, iv, 58-60 (1988) (concluding, after empirical study of CON programs' effects on hospital costs using 1983-84 data on 3,708 hospitals, that strong CON programs do not lead to lower costs but may actually increase costs); MONICA NOETHER, FEDERAL TRADE COMMISSION, COMPETITION AMONG HOSPITALS 82 (1987) (empirical study concluding that CON regulation led to higher prices and expenditures); KEITH B. ANDERSON & DAVID I. KASS, FEDERAL TRADE COMMISSION, CERTIFICATE OF NEED REGULATION OF ENTRY INTO HOME HEALTH CARE: A MULTI-PRODUCT COST FUNCTION ANALYSIS (1986) (economic study finding that CON regulation led to higher costs, and that CON regulation did little to further economies of scale).

[17] *See* CONOVER & SLOAN, REPORT TO MICHIGAN, *supra* note 15, at 30.

[18] The Lewin Group, *An Evaluation of Illinois' Certificate of Need Program*, prepared for the Illinois Commission on Government Forecasting and Accountability (February 15, 2007), at 31 (hereinafter Lewin Group).

those offered by incumbents.[19] This may tend to depress consumer choice between different types of treatment options or settings,[20] and it may reduce the pressure on incumbents to improve their own offerings.[21]

Second, CON laws can be subject to various types of abuse, creating additional barriers to entry, as well as opportunities for anticompetitive behavior by private parties. In some instances, existing competitors have exploited the CON process to thwart or delay new competition to protect their own supra-competitive revenues. Such behavior, commonly called "rent seeking," is a well-recognized consequence of certain regulatory interventions in the market.[22] For example, incumbent providers may use the hearing and appeals process to cause substantial delays in the development of new health care services and facilities. Such delays can lead both the incumbent providers and potential competitors to divert substantial funds from investments in such facilities and services to legal, consulting, and lobbying expenditures; and such expenditures, in turn, have the potential to raise costs, delay, or – in some instances – prevent the establishment of new facilities and programs.[23]

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[19] A DOSE OF COMPETITION, Ch. 8 at 4 (citing *Hosp. Corp. of Am.*, 106 F.T.C. 361, 495 (1985) (Opinion of the Commission) (stating that "CON laws pose a very substantial obstacle to both new entry and expansion of bed capacity in the Chattanooga market" and that "the very purpose of the CON laws is to restrict entry")).

[20] With regard to hospital markets, *see, e.g.*, UNITED STATES DEPT. OF HEALTH AND HUMAN SERVICES, FINAL REPORT TO THE CONGRESS AND STRATEGIC IMPLEMENTING PLAN REQUIRED UNDER SECTION 5006 OF THE DEFICIT REDUCTION ACT OF 2005 (2006), *available at* http://www.cms.hhs.gov/PhysicianSelfReferral/06a_DRA_Reports.asp (reporting at specialty hospitals a "quality of care at least as good as, and in some cases better than, care provided at local competitor hospitals" for cardiac care, as well as "very high" patient satisfaction in cardiac hospitals and orthopedic specialty hospitals) (citations omitted). In addition, specialty hospitals appear to offer shorter lengths of stay, per procedure, than peer hospitals. *See also* MEDICARE PAYMENT ADVISORY COMMISSION, REPORT TO THE CONGRESS: PHYSICIAN-OWNED SPECIALTY HOSPITALS, vii (Mar. 2005), *available at* http://www.medpac.gov/documents/Mar05_SpecHospitals.pdf (hereinafter MEDPAC).

[21] *See, e.g.*, MEDPAC, *supra* note 19, at 10 (observing both administrative improvements – "Some community hospital administrators admit that competition with specialty hospitals has had some positive effects on community hospitals' operations" – and other qualitative improvements – "We heard several examples of constructive improvements sparked by the entrance of a specialty hospital into a market, including extending service hours, improving operating room scheduling, standardizing the supplies in the operating room, and upgrading equipment.").

[22] Paul Joskow and Nancy Rose, *The Effects of Economic Regulation*, *in* 2 HANDBOOK OF INDUSTRIAL ORGANIZATION (Schmalensee and Willig, eds., 1989).

[23] *See, e.g., Armstrong Surgical Ctr., Inc. v. Armstrong County Mem'l Hosp.*, 185 F.3d 154, 158 (3rd Cir. 1999) (an ambulatory surgery center alleged that a competing hospital had conspired with nineteen of its physicians to make factual misrepresentations as well as boycott threats to the state board, allegedly causing the board to deny the center its CON); *St. Joseph's Hosp., Inc. v. Hosp. Corp. of America*, 795 F.2d 948 (11th Cir. 1986) (a new hospital applying for a CON alleged that an existing competitor submitted false information to the CON board; that the board relied on that information in denying the CON; and that the

Moreover, much of this conduct, even if exclusionary and anticompetitive, may be shielded from federal antitrust scrutiny, because it involves protected petitioning of the state government.[24] During our hearings, we gathered evidence of the widespread recognition that existing competitors use the CON process "to forestall competitors from entering an incumbent's market."[25]

In addition, incumbent providers have sometimes entered into anticompetitive agreements that were facilitated by the CON process, if outside the CON laws themselves. For example:

- In 2006, the Antitrust Division alleged that a hospital in Charleston, West Virginia used the threat of objection during the CON process, and the potential ensuing delay and cost, to induce another hospital seeking a CON for an open heart surgery program not to apply for it at a location that would have well served Charleston consumers.[26] The hospital eventually entered into a consent decree with the Antitrust Division (without a trial on the merits) which prohibited the hospital from taking actions that would restrict other health care facilities from developing cardiac surgery services.[27]

- In another case from West Virginia, the Antitrust Division alleged that two closely competing hospitals agreed to allocate certain health care services among themselves.[28] The informal urging of state CON officials led the hospitals to agree that just one of the hospitals would seek approval for an open heart surgery program, while the other would seek approval to provide cancer treatment services.[29] These hospitals also entered into a consent

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defendants also acted in bad faith to obstruct, delay, and prevent the hospital from obtaining a hearing and later a review of the adverse decision).

[24] *Eastern Rail. Pres. Conf. v. Noerr Motor Frgt., Inc.*, 365 U.S. 127 (1961).

[25] A DOSE OF COMPETITION, Executive Summary at 22.

[26] *U.S. v. Charleston Area Med. Ctr., Inc.*, Civil Action 2:06 -0091 (S.D.W.Va. 2006), *available at* http://www.usdoj.gov/atr/cases/f214400/214477.htm.

[27] Justice Department Requires West Virginia Medical Center to End Illegal Agreement (Feb. 6, 2006), *available at* http://home.atrnet.gov/subdocs/214463.htm.

[28] *U.S. v. Bluefield Regional Medical Center, Inc.*, 2005-2 Trade Cases ¶ 74,916 (S.D. W.Va. 2005).

[29] *See id.* at 2-3 (referring to the prohibited conduct).

decree with the Antitrust Division (without a trial on the merits) that prohibited the hospitals from enforcing the agreement between them.[30]

- In Vermont, two home health agencies entered into anticompetitive territorial market allocations, facilitated by the state regulatory program, to give each other exclusive geographic markets.[31] Without the state's CON laws, competitive entry into these markets normally might have disciplined such cartel behavior. The Antitrust Division found that as a result, Vermont consumers were paying higher prices than were consumers in states where home health agencies competed against each other.[32]

Finally, the CON process itself may sometimes be susceptible to corruption. For example, as the task force is probably aware, in 2004, a member of the Illinois Health Facilities Planning Board was convicted for using his position on the Board to secure the approval of a CON application for Mercy Hospital. In exchange for his help, the Board member agreed to accept a kickback from the owner of the construction company that had been hired to work on the new hospital.[33]

3. Protecting Revenues of Incumbents Does Not Justify CON Laws

Incumbent hospitals often argue that they should be protected against additional competition so that they can continue to cross-subsidize care provided to uninsured or under-insured patients. Under this rationale, CON laws should impede the entry of new health care providers that consumers might enjoy (such as independent ambulatory surgery centers, free-standing radiology or radiation-therapy providers, and single- or multi-specialty physician-owned hospitals) for the express purpose of preserving the market power of incumbent providers. The providers argue that without CON laws, they would be deprived of revenue that otherwise could be put to charitable use.[34]

We fully appreciate the laudatory public-policy goal of providing sufficient funding for the provision of important health care services – at community hospitals and elsewhere

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[30] *Id.*

[31] Department of Justice Statement on the Closing of the Vermont Home Health Investigation (Nov. 23, 2005), *available at* http://www.usdoj.gov/atr/public/press_releases/2005/213248.htm.

[32] *Id.*

[33] Plea Agreement at 20-23, *U.S. v. Levine* (D. Ill. 2005) (No. 05-691).

[34] There is an ironic element to this argument: What started as laws intended to control costs have become laws intended to inflate costs. Proponents of CON laws now would use these barriers to entry to stifle competition, protect incumbent market power, frustrate consumer choice, and keep prices and profits high.

– to those who cannot afford them, and for whom government payments are either unavailable or too low to cover the cost of care. But at the same time, we want to be clear that the imposition of regulatory barriers to entry as an indirect means of funding indigent care may impose significant costs on all health care consumers – consumers who might otherwise benefit from additional competition in health care markets.

First, as noted above, CON laws stifle new competition that might otherwise encourage community hospitals to improve their performance. For example, in studying the effects of new single-specialty hospitals, the Medicare Payment Advisory Committee (MedPAC) found that certain community hospitals responded to competition by improving efficiency, adjusting their pricing, and expanding profitable lines of business.[35] In addition to administrative and operational efficiencies, the MedPAC Report identified several examples of improvements sparked by the entrance of a specialty hospital into a market, including extended service hours, improved operating room scheduling, standardized supplies in the operating room, and upgraded equipment.[36]

Second, we note that general CON requirements such as those imposed under Illinois law sweep very broadly, instead of targeting specific, documented social needs (such as indigent care). Although the Agencies do not suggest to Illinois policy makers any particular mechanism for funding indigent care, we note that solutions more narrowly tailored to the state's recognized policy goals may be substantially less costly to Illinois consumers than the current CON regime, and that the Lewin Group report commissioned by the state identifies various alternatives that may be more efficient in advancing such goals.[37]

Third, it is possible that CON laws do not actually advance the goal of maintaining indigent care at general community hospitals. Recently the federal government studied just this issue in connection with the emergence of single-specialty hospitals around the country. That study found that, for several reasons, specialty hospitals did not undercut the financial

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[35] *See, e.g.*, MEDPAC, *supra* note 19, at 10 ("Some community hospital administrators admit that competition with specialty hospitals has had some positive effects on community hospitals' operations"). Other studies have found that the presence of for-profit competitors leads to increased efficiency at nonprofit hospitals. Kessler, D. and McClellan M., "The Effects of Hospital Ownership on Medical Productivity," RAND Journal of Economics 33 (3), 488-506 (2002).

[36] MEDPAC, *supra* note 19, at 10; *see also* Greenwald, L. et al., "Specialty Versus Community Hospitals: Referrals, Quality, and Community Benefits," *Health Affairs* 25, no. 1 (2006): 116-117; Stensland J. and Winter A., "Do Physician-Owned Cardiac Hospitals Increase Utilization?" *Health Affairs* 25, no. 1 (2006): 128 (some community hospitals have responded to the presence of specialty hospitals by recruiting physicians and adding new cardiac catheterization labs).

[37] *See* Lewin Group, at 29 (discussing various financing options for charity care in Illinois).

viability of rival community hospitals.[38] One substantial reason for this was that specialty hospitals generally locate in areas that have above-average population growth. Thus, they are competing for a new and growing patient population, not just siphoning off the existing customer base of the community hospitals. This is consistent with the Lewin Group study showing that safety-net hospitals in non-CON states actually had higher profit margins than safety-net hospitals in CON states.[39]

III. Conclusion

The Agencies believe that CON laws impose substantial costs on consumers and health care markets and that their costs as well as their purported benefits ought to be considered with care. CON laws were adopted in most states under particular market and regulatory conditions substantially different from those that predominate today. They were intended to help contain health care spending, but the best available research does not support the conclusion that CON laws reduce such expenditures. As the Agencies have said, "[O]n balance, CON programs are not successful in containing health care costs, and . . . they pose serious anticompetitive risks that usually outweigh their purported economic benefits."[40] CON laws tend to create barriers to entry for health care providers who may otherwise contribute to competition and provide consumers with important choices in the market, but they do not, on balance, tend to suppress health care spending. Moreover, CON laws may be especially subject to abuse by incumbent providers, who can seek to exploit a state's CON process to forestall the entry of competitors in their markets. For these reasons, the Agencies encourage the task force to seriously consider whether Illinois's CON law does more harm than good.

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[38] MEDPAC, *supra* note 19, at 23-24; *see also* MedPAC, REPORT TO THE CONGRESS: PHYSICIAN-OWNED SPECIALTY HOSPITALS REVISITED, at 21-25 (August 2006), *available at* http://www.medpac.gov/documents/Aug06_specialtyhospital_mandated_report.pdf.

[39] Lewin Group, at 28.

[40] A DOSE OF COMPETITION, Executive Summary at 22.