MERCY
HEALTH SYSTEM

1000 MINERAL POINT AVE. • P.O. BOX 5003 • JANESVILLE, WI 53547-5003 • 608.756.6000 • MercyHealthSystem.org

Malcolm Baldrige National Quality Award
Award Recipient

RECEIVED

NOV 16 2011

HEALTH FACILITIES &
SERVICES REVIEW BOARD

November 14, 2011

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street
2nd Floor
Springfield, IL 62761

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

Dear Ms. Avery:

As you are aware, on October 7, 2011 yet another public hearing was held regarding the hospital project proposed by Mercy Crystal Lake Hospital and Medical Center, Inc. and Mercy Alliance, Inc. (collectively, **"Mercy"**) to be located in Crystal Lake, Illinois. As reflected in the Public Hearing Report dated October 19, 2011 (the **"Report"**), Mercy once again outlined the compelling case for the Project. Specifically, our application, public testimony and public comment to date have demonstrated that, if approved by the Board, the Project will:

- Provide access to a large and growing area that is underserved for physician, emergency, and hospital services.
- Greatly benefit emergency room patients if they require attention by a pediatrician, cardiologist, ear nose and throat specialist, orthopedic surgeon or other specialists because, given Mercy's integrated delivery system, such physicians may be present on-site in the clinic at the time the patient is seen in the emergency room.
- Promote high quality of care because it will extend Mercy's delivery model within Planning Area A-10.
- Provide health care services to all patients regardless of their ability to pay.
- Operate an emergency department that will provide services to all patients, including the poor, by implementing a charity care program to provide reduced fee and free services to qualifying patients and by participating in governmental payment programs, including Medicare and Medicaid.

- Promote the Board's objective of avoiding unnecessary duplication of services by (i) addressing Medical/Surgical/Pediatric bed need in Planning Area A-10, now and in the future; (ii) providing primary and secondary hospital care; (iii) addressing demonstrated physician need in McHenry County; and (iv) coordinating the continuum of care for McHenry County residents to prepare for and address the increased admissions created by various Health Reform initiatives.
- Lower the Medicaid and Self Pay (mostly charity care) exposure of other hospital providers located in McHenry County and reduce the outmigration of Medicaid and Self Pay patients from the southeast part of McHenry County to other hospitals in Lake, Cook and Kane Counties.
- Improve access for the geriatric population who are currently leaving the county for hospital services.
- Generate an estimated 385 to 600 construction related jobs within the State of Illinois and McHenry County.
- Employ an estimated 800 individuals, filling 610 full-time positions, of which approximately 450 will be new jobs (within the first year of opening the facility).
- Result in a total industry sales impact estimated to be $86.4 Million in the first year of operation to $207.5 Million five years later.
- Result in a total employment impact estimated to be from 510 FTE jobs during the ramp-up period, 650 FTE jobs in year one and 1043 jobs in year five.
- Generate tax revenue for the State of Illinois and local governments, for example we estimate that $1,372,000 to $4,396,000 in income tax will be generated for the State of Illinois (using a 3% flat rate.).

Mercy also felt, however, that it was important for the Board to hear from the future beneficiaries of this important project – the residents of Crystal Lake and McHenry County. Thus, Mercy afforded the residents of Crystal Lake and McHenry County the opportunity to be front and center to offer their compelling testimony underscoring the tremendous need for a hospital in Crystal Lake.

Mercy acknowledges that there were also individuals in attendance that opposed the Project. However, when one reads the public hearing transcript it is clear that, with very rare exception, the opposition testimony originated almost exclusively from executives or other individuals aligned with one of Mercy's competitors (collectively, the **"Competitors"**). Out of respect for the Board's and Board staff's time, the focus of this letter will not be on the many positive aspects of this Project, a few of which are outlined above. Rather, because the Competitors have put forth a lot of information regarding the Project that appears to be false and misleading, and have cast other negative aspersions on Mercy, the Project and the modification, this letter will focus on addressing certain of the major claims made by the Competitors at the public hearing.

Because the Competitors, in most instances, dragged out the same tired, old claims that Mercy has rebutted in the past, we will not attempt to address in detail each claim yet again. Instead, we will briefly address the Competitor claim and then direct the Board to the given document (attached to this letter as an exhibit) that Mercy previously submitted that addresses each claim in detail. For those keeping score at home, we have also included immediately below a handy checklist which identifies whether a given Competitor claim is false, misleading or true (yes, the Competitors did make some truthful claims, for example stating that a hospital was needed in southern McHenry County and that Mercy's efforts to modify its Project downward in size was commendable health planning).

I. COMPETITORS CLAIMS

1. **Competitor Claim – The Project will cannibalize patients from other area providers and hurt the Competitor's ability to provide safety net services.**
   True ___ False _√_ Misleading ___

2. **Competitor Claim – The Project does not address outmigration from McHenry County.**
   True ___ False _√_ Misleading ___

3. **Competitor Claim – A new hospital is needed in southern McHenry County, but the Project is not going to be located in southern McHenry County.**
   True _√_ False _√_ Misleading ___.

4. **Competitor Claim – The population of Crystal Lake is not poor or diverse.**
   True ___ False _√_ Misleading ___.

5. **Competitor Claim – Revenue will not remain in McHenry County and will, instead, be sent back to Janesville, Wisconsin.**
   True ___ False _√_ Misleading ___.

6. **Competitor Claim – The Project is not needed because area hospital providers are not operating at capacity.**
   True ___ False ___ Misleading _√_.

7. **Competitor Claim – The Project is not needed because Health Reform is designed to decrease inpatient utilization.**
   True ___ False ___ Misleading _√_.

8. **Competitor Claim – The Project will increase, not decrease, healthcare costs.**
   True ___ False _√_ Misleading ___.

9. **Competitor Claim – Mercy lacks a commitment to providing care for women.**
   True ___ False _√_ Misleading ___.

10. **Competitor Claim – The Project will have a closed medical staff that will impact a patient's freedom to choose his or her physician. Further, Physician's employed by Mercy will be forced to refer patients to Janesville for treatment of some conditions.**
    True ___ False _√_ Misleading ___.

11. **Competitor Claim – Mercy is not concerned with transparency regarding the Project and the CON application process.**
    True ___ False _√_ Misleading ___.

12. **Competitor Claim – Because the Project has a reduced bed count (and will have lower volumes) the quality of medical care will suffer.**
    True ___ False ___ Misleading _√_.

13. **Competitor Claim – Mercy does not have the financial wherewithal to complete the Project.**
    True ___ False _√_ Misleading ___.

14. **Competitor Claim – The Board's approval of the Shiloh hospital project (which was less than the 100 beds required by the Board's rules) should not serve as precedent for approving the Project.**
    True ___ False ___ Misleading _√_.

15. **Centegra does not have a monopoly in McHenry County.**
    True ___ False _√_ Misleading ___.

II. BRIEF ANALYSIS OF CLAIMS

1. **Competitor Claim – The Project will cannibalize patients from other area providers and hurt the Competitor's ability to provide safety net services.**

   True ___ False _√_ Misleading ___.

As Mercy has previously stated, and for the reasons set forth in its CON application and in its Response to the Safety Net Impact Statement attached as Exhibit A, 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.

Specifically, the Project addresses the demonstrated Medical/Surgical/Pediatric bed need in Planning Area A-10 now and in the future. The Project will be a general, acute care hospital offering community-based services to the local service area surrounding the facility. Mercy 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 an advanced level of care. Additionally, Mercy plans to add 45 new physicians in Crystal Lake, which will assist in addressing the physician need (calculated in March of 2010) in McHenry County of nearly 50 physicians. Finally, Mercy has also projected that, notwithstanding the increased admissions currently occurring as a result of the Patient Protection and Affordable Care Act of 2010 (collectively, with all related regulations, **"Health Reform"**), in years one and two of operations of the Project, admissions will be further impacted at a rate of 5% first year and 3% second year over current rates. Mercy projects that other planning/market area facilities (including the Competitors) will see a similar impact.

Additionally, the population projections supporting the Project reflect an expanding population in the service area. The payor mix of patients will represent the population as a whole, with an especially fast-growing segment of Hispanic residents. Medicare and Medicaid will comprise 43.3% of the Project's volume. The Project will *lower* the Medicaid and self pay (mostly charity care) exposure of Centegra. Since nearly 70 percent of Medicare inpatients are admitted outside of the southern one-half of McHenry County, Mercy (and the new physicians it will bring to the area) will seek to improve access for the geriatric population who are currently leaving the county for hospital services.

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 the Board's rules. 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.

Finally, Mercy notes that the Competitors that are located outside of McHenry County (Advocate Good Shepherd, Sherman Hospital and St. Alexius) are treating a significantly higher percentage of commercial (private pay) and Medicare patients from McHenry County than they are Medicaid/Charity Care. It is not the responsibility of well-insured patients from McHenry County to offset the Medicaid/Charity Care patients of Cook, Lake and Kane Counties being treated at hospitals located in these counties. If these hospitals were treating equal proportions of Medicaid/Charity Care patients from McHenry County as they were other patients, they might have a stronger argument. McHenry County hospitals, including the Project, will need the private pay and Medicare patients to support the growing safety net requirements for Medicaid/Charity Care patients from McHenry County.

2. **Competitor Claim – The Project does not address outmigration from McHenry County.**
True ___ False _√_ Misleading ___.

As stated in greater detail in the letter dated June 3, 2011 attached as Exhibit B, McHenry County has the highest outmigration in Illinois. The southern portion of McHenry County has a much higher percentage of outmigration than McHenry County as a whole (the central and northern portions of the county have minimal outmigration because there are hospitals present). The proposed project will significantly reduce the outmigration issues in McHenry County. If this is accomplished, even modestly it will keep residents in Planning Area A-10 and increase bed need demand.

The shortage of specialty physicians is one of the primary reasons that residents of McHenry County are leaving the county in order to seek medical care. McHenry County has a deficit of physicians. This is consistent with the national experience and both the Council on Graduate Medical Education and the American Medical Association recognize the current physician shortage in the U.S. will only worsen over the next several years. The operational model utilized by Mercy has been implemented effectively to recruit and retain needed physicians – thus also helping to reduce out-migration from McHenry County.

3. **Competitor Claim – A new hospital is needed in southern McHenry County, but the Project is not going to be located in southern McHenry County.**
True _√_ False _√_ Misleading ___.

The statement that a new hospital is needed in southern McHenry County is true - which is exactly why we have proposed the Project. However, in the public hearing testimony several Centegra executives, including the CEO, suggested that the Mercy Project was not going to be located in southern McHenry County. These individuals are either geographically challenged or were being disingenuously self-serving.

As we stressed during our public hearings, the development of the Project will serve to correct a mal-distribution of hospital beds within McHenry County. As represented by the chart attached as Exhibit C, if McHenry County is divided into four sub-areas, southeast, southwest, central and north, there currently exists a significant mal-distribution of beds in the county. Nearly 93% of the inpatient beds in McHenry County are located in the central sub-area, with a population of 113,196 or 32.2% of the total county population (see Exhibit C). The Project's proposed location is in the center of the six ***southeast*** McHenry County communities representing over

46% of the County's population; a dense but rapidly growing sub-area of close to 164,000 people which has no full-service emergency room, no hospital-based outpatient services, and no hospital beds. The proposed Project will address this obvious mal-distribution head-on and provide the largest portion of residents in ***southeast*** McHenry County with convenient access to much needed hospital care.

4. **Competitor Claim – The population of Crystal Lake is not poor or diverse.**
True ___ False _√_ Misleading ___.

As is set forth in greater detail in our application, public commentary and public hearing testimony, the demographic information available for McHenry County supports the need for the Project and more importantly supports the choice of location for the Project. Simply put, when completed, the Project will be located in the area in ***southern*** McHenry County (i) that is the most densely populated; (ii) which will, over the next five years, experience the largest population increase; (iii) that contains the greatest number of individuals that may need safety net services; and (iv) that contains the largest number of ethnic minorities. Over the next five years, the Crystal Lake community will experience the largest population increase.

Conversely, in Huntley, Illinois (where Centegra is proposing to build its ***much*** costlier hospital project) demand for new housing permits has plummeted. Centegra proposes to build its project in an area with a comparatively small population (26,000) and low population density, and then wait for years with the faint hope that the Huntley area will grow large enough to support Centegra's application numbers. As everyone now knows, the economic recession has slowed population growth - but especially in previously very rapidly growing areas like Huntley. In 2003 – 2005, Huntley averaged between 1,079 and 1,210 new housing permits. In 2009 new housing permits in Huntley plummeted to a dismal 75 permits. In 2010, the news wasn't much better as the number of new housing permits limped along at an anemic 107 permits. Most of Huntley's historical growth is attributable to the Dell Webb retirement community – however that community is almost completely built out (with only a few units remaining unbuilt). Due to the weak economy, slowdown in the housing market, and build-out of the Del Webb community, it is clear that the Huntley and Kane County areas will take ***much*** longer to reach the population necessary to support a new hospital than the existing population in the Crystal Lake area.

5. **Competitor Claim – Revenue will not remain in McHenry County and will, instead, be sent back to Janesville, Wisconsin.**
True ___ False _√_ Misleading ___.

Mercy Crystal Lake is a Illinois not-for-profit corporation in good standing and is recognized by the IRS as a 501(c)(3) charitable organization. As such, any excess revenues generated through operation of the proposed hospital will be reinvested into the mission of Mercy Crystal Lake and will not be transferred back across the border into Wisconsin. In fact, Mercy Alliance, the parent corporation of Mercy Crystal Lake, will be investing millions of dollars to construct and develop

the Project. So the opposite of the Competitor's premise is true, namely it's Wisconsin that is investing in Illinois.

As Mercy previously stated in its letter dated June 3, 2011, a copy of which is attached as Exhibit D, Mercy has an admirable track record of providing medical services in Illinois. If approved by the Board, the Project will generate an estimated 385 to 600 construction related jobs within the State of Illinois and McHenry County. Within the first year of opening the facility, the Project is expected to employ more then 800 individuals, filling 610 full-time positions, of which approximately 450 will be new jobs. The total industry sales impact of the Project ranges from $86.4 Million in the first year of operation to $207.5 Million five years later. The total employment impact of the proposed project ranges from 510 FTE jobs during the ramp-up period, 650 FTE jobs in year one and 1043 jobs in year five. In addition to generating jobs and income, the economic activity associated with the Project will also generate tax revenue for the State of Illinois and local governments. The clinic portion of the project will be subject to property taxes and a portion of the sales (indirect and induced) will be subject to sales taxes. Income taxes generated by the jobs increase are estimated to produce from $1,372,000 to $4,396,000 for the State of Illinois (using a 3% flat rate.).

Finally, Mercy intends to establish a community board to provide governance of the operations of the Project. As such the community board will have full responsibility to insure that the mission of Mercy Crystal Lake is upheld.

6. **Competitor Claim – The Project is not needed because area hospital providers are not operating at capacity.**
True ___ False ___ Misleading _√_.

As Mercy pointed out in its CON application, public hearing testimony, and letter dated June 3, 2011 (attached as Exhibit D), the Project will provide access to a large and growing area that is underserved for physician, emergency, and hospital services. This is demonstrated by several factors: (a) the Project will serve the largest concentration of existing population and patients; (b) the Project will address the extensive outmigration of patients from the Planning Area; (c) the Project will address the documented need for physicians in the Planning Area; (d) the Project will help to address tbe undersupply of hospital beds within the Planning Area (which is highlighted by the Board's revised bed inventory numbers and the 2009 Henry J. Kaiser Family Foundation study which states McHenry County is **174%** below the State and National averages for hospital beds); and (e) the Project will address the lack of emergency services for the density of the population served by the Project.

Finally, the 2010 McHenry County Healthy Community Analysis,[1] cited to by some of the Competitors, highlighted the rapidly expanding number of Medicaid recipients in the County. In

---

[1] 2010 McHenry County Healthy community Study, Community Analysis, Chapter 7: Income & Poverty, Page 90.

2000, there were 6,293 residents on Medicaid, or 2.4 percent of the total population. By 2009, this number grew to 25,623, or 8.0 percent of the population in less than 10 years. Most of this growth occurred in the southeast and central portions of McHenry County. In 2010, 30 percent of all Medicaid residents hospitalized from McHenry County lived in the southeast sub-area. All of these residents, many without access to good transportation, must travel outside the area for hospital care because they do not have a local hospital facility available. The Project will help address the needs of the Medicaid patients residing in the area.

7. **Competitor Claim – The Project is not needed because Health Reform is designed to decrease inpatient utilization.**
True ___ False ___ Misleading _√_.

While nobody truly knows the full impact that Health Reform will have on the U.S. health care system, with its focus on preventative care, outpatient treatment, avoidance of hospital readmissions and quality of care, many speculate that, if fully implemented, Health Reform will cause inpatient utilization at hospitals to decrease. At the public hearing, several Competitors tried to use the laudatory goals of Health Reform to support the notion that a hospital in not needed in Planning Area A-10. These Competitor's ignored the demonstrated hospital need that currently exists in the planning area, a need that, given the population growth in McHenry County, will likely only increase in the future (with or without the impact of Health Reform).

As stated above, the full impact of Health Reform is unknown at the present time. For example, decreased inpatient admissions achieved because of an increased focus on outpatient treatments and preventative care, could be offset and even eclipsed by the increased patient population that has insurance coverage of some form because of Health Reform. Mercy projects that, notwithstanding the increased admissions currently occurring as a result of Health Reform, 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 will see a similar impact. It is because, in part, of the uncertainty surrounding Health Reform and the fluctuating bed need calculations for Planning Are A-10 that Mercy decided to modify the size of the Project downward. This conservative approach will allow Mercy to meet the current demonstrated bed need in McHenry County. If additional need materializes in Planning Area A-10, Mercy is prepared to come back before the Board and propose expanding its Crystal Lake facility (or work with other area providers to come up with a less costly alternative) to meet this need.

Finally, one of the major changes to the health care system that is driven by Health Reform is the creation of accountable care organizations (**"ACOs"**). Hospital based systems throughout the U.S. are scrambling to organize hospitals, employ physicians, and eliminate duplication in order to succeed in the Health Reform environment emphasizing formation of ACOs. Mercy has been operating an "ACO-like" organization since 1991 with its health plan, employed physician

model, and expansive network of clinics and hospitals. Mercy would further develop the "future" integrated model of health care to McHenry County by 2014.

8. **Competitor Claim – The Project will increase, not decrease, healthcare costs.**
True ___ False _√_ Misleading ___.

As reflected in Mercy's application and the letter dated June 3, 2011 attached as Exhibit D, it is Mercy's belief that the Project will lower health care costs in McHenry County. First, the Applicant will keep the cost of construction down by starting the project immediately after Board approval and open its hospital facility in 2014. Delaying a project any longer (into the future) will continue to increase the overall project costs. Completing the project now will help to accomplish the Board's goal of minimizing the capital outlay.

Mercy will also minimize capital outlay by constructing a secondary care hospital, not one which offers tertiary care services (such as Level I trauma, transplants, open heart surgery, neurological surgery, etc.). It will also emphasize convenient access to outpatient and emergency services in a cost-effective manner. Mercy will establish close working relationships with its hospital neighbors who offer tertiary care services to develop seamless referral and transfer relationships. In short, the smaller hospital Project would be large enough to service the health care needs of McHenry county residents, yet would cost $85 Million less than Mercy's original project and astonishingly ***$118 Million less*** than Centegra's project.

Finally, as we emphasized in our application and public hearing testimony, as part of a fully integrated delivery system, Mercy will be positioned to deliver costs well below other hospitals in Planning Area A-10 and beyond. Over the past ten years, Mercy – a model for integrated delivery systems – has consistently been rated among the top 20 Integrated Healthcare Systems (IDSs) in the United States by SDI and *Modern Healthcare* magazine. Irrefutable evidence has been established that IDSs improve healthcare quality, patient outcomes, and reduce costs – especially for patients with complex needs. Mercy, through its vertically integrated delivery system, has learned to operate highly efficiently (and at considerably lower cost) in an environment where they are paid significantly less by Medicare than the primary hospitals serving McHenry County.

9. **Competitor Claim – Mercy lacks a commitment to providing care for women.**
True ___ False _√_ Misleading ___.

Mercy's commitment to women and their unique health care needs is unwavering, impressive and strong. And to further show Mercy's commitment, it should be noted that Mercy has been consistently recognized by Working Women Magazine as a Best Place to Work for Women and by AARP as a Best Employer for workers over the age of fifty-five (see materials attached as

Exhibit E). If approved, the Project will only serve to enhance this commitment to the women of McHenry County.

Finally, the fact that a Centegra representative suggested that Mercy lacks commitment to the women of McHenry County is particularly disingenuous. In 2008, Centegra filed an application with the Board to approve a $58 Million renovation of its Woodstock, Illinois hospital facility. In justifying its Woodstock application and the "Woman's Pavillion" it would create, Centegra certified to the Board that "doing nothing" was not an acceptable alternative to the proposed Woodstock project. "Doing nothing" would not address the access and quality of care issues that were impacting the Woodstock facility. "Doing nothing" would not help the labor patients that were being held in the post-partum area of the Woodstock facility due to lack of available space, or help reduce the number of inductions Centegra was suspending because the units were at capacity. "Doing nothing" would not address the Woodstock facility's labor delivery recovery department operating 20% above capacity, which regularly resulted in patients being housed in recovery rooms. Finally, "doing nothing" would not help the women who Centegra argued had to leave the community and travel great distances to receive care. Yet, unfortunately for the residents of McHenry County, "doing nothing" is exactly what Centegra did in Woodstock. Less than 2 years after passionately arguing in support of the need for the Woodstock project, Centegra abandoned the project (and the women and other residents of Woodstock in the process).

10. **Competitor Claim – The Project will have a closed medical staff that will impact a patient's freedom to choose his or her physician. Further, Physician's employed by Mercy will be forced to refer patients to Janesville for treatment of some conditions.** ***True ___ False _√_ Misleading ___.***

Most physicians on staff at any hospital also have privileges at other area hospitals. For example, because the proposed hospital will not provide tertiary care, a cardiologist on staff at the proposed hospital might also have privileges at another area hospital to provide certain invasive cardiology services. This is not an uncommon occurrence. Mercy will not preclude physicians from having privileges at other hospitals. Mercy does ***not*** require physicians on its medical staff to refer patients to its hospitals. That stated, given the state of the art facilities Mercy has, the quality of staff and services it provides, we suspect that some portion of the physician population on staff will change their referral patterns and refer their patients to the proposed hospital. In all cases, however, the overriding consideration is what is in the best interest of the patient. If that dictates referral to a non-Mercy hospital, Mercy fully supports that clinical decision. Mercy plans on having an open medical staff thus allowing independent physicians to obtain practice privileges. If they meet the appropriate credentialing criteria for their areas of specialty, they will be welcomed with open arms. This has been our practice at all of our hospital facilities including Harvard and Janesville. With limited exceptions (e.g., perhaps an exclusive arrangement/closed department), Mercy will ***not*** have a closed medical staff. At all times the patient will have the freedom to choose his or her provider.

11. **Competitor Claim – Mercy is not concerned with transparency regarding the Project and the CON application process.**
True ___ False _√_ Misleading ___.

In modifying the Project, Mercy firmly believes that the modification was not a Type A modification (as defined by Board rules) that required a public hearing. Mercy disagreed with the conclusions that Board's legal counsel reached regarding the modification (as reflected in the letter attached as Exhibit F). However, at no point was Mercy's disagreement tied somehow to a desire to avoid transparency. As Mercy has stated on numerous occasions, when it is all said and done, this Project will have probably received more scrutiny than any other project considered by the Board. That is scrutiny Mercy appreciates and welcomes.

Centegra's "concern" for the public's ability to comment on Mercy's modification, however, is self-interested and disingenuous. While pushing for "transparency" in the Mercy application process, Centegra was also pushing for less transparency with respect to its own project. Centegra submitted a letter, dated June 27, 2011 (attached as Exhibit G), demanding that the Board stop allowing public participation at each Board meetings (despite the clear mandate from the Open Meetings Act calling for public participation at Board meetings, and despite the same "purposes" of the Act that Centegra would later claim (in seeking to force a public hearing for the modification) were "designed to increase public participation in the CON process and to ensure the integrity of the process"). By their own words, Centegra wants one set of standards to apply to itself, and another set to apply to everyone else.

12. **Competitor Claim – Because the Project has a reduced bed count (and will have lower volumes) the quality of medical care will suffer.**
True ___ False ___ Misleading _√_.

Health Reform is designed to have hospitals compete on the basis of comparative quality – as higher reimbursement will follow higher quality. For the scope of services proposed for Mercy's hospital, quality of area hospitals will not be affected but likely enhanced due to having a strong, high quality facility in the market. The services or procedures which can be diminished in quality through excessive competition are specialized tertiary care services like open heart surgery or neurological surgery – none of which will be provided a Mercy's facility.

Further, as Mercy has stated on numerous occasions, it is proud to have been awarded the Malcolm T. Baldrige National Quality Award in 2007. A recent report, a copy of which is attached as Exhibit H, concluded that Baldrige hospitals were significantly more likely than their peers to display faster five-year performance improvement. Additionally, the report found that

Baldrige hospitals outperformed non-Baldrige hospitals on nearly all of the individual measures of performance used in the Thompson Reuters 100 Top Hospitals survey (which include quality measures).

Finally, as stated earlier Mercy has consistently been rated among the top 20 Integrated Healthcare Systems (IDSs) in the United States by SDI and *Modern Healthcare* magazine. Irrefutable evidence has been established that IDSs improve healthcare quality, patient outcomes, and reduce costs – especially for patients with complex needs.

In short, any suggestion that that the quality of care to be provided at the proposed Project will be inferior due to the size of the hospital (when divorcing that fact from the health system operating the hospital) is baseless, self-serving and contrary to the impressive track record Mercy has established to date.

13. **Competitor Claim – Mercy does not have the financial wherewithal to complete the Project.**
True ___ False _√_ Misleading ___.

It is vital that an organization have the financial wherewithal to absorb projects the magnitude of the Project without jeopardizing the financial stability of the organization and maintain future access to capital from the municipal bond markets. For fiscal year 2009, Mercy had operating income of 3.6%, and in fiscal year 2010 operating income was 3.2%. Both years are above Moody's median range of 3.1% for A rated organizations. Mercy's financial position is strong and, despite the economic uncertainty in the hospital community, our outlook going forward from Moody's is stable.

Conversely, Centegra currently has an A minus rating from Standard & Poors, which is weaker than Mercy's A2 stable rating from Moody's Investor's Service (see Financial Analysis attached as Exhibit I). Mercy has significantly more cash reserves available for a project the magnitude of the Project than Centegra (and the Centegra project, at $233 Million, is $85 Million more than Mercy's proposed project in Crystal Lake). To fund its project, Mercy plans to use $25,144,525 of its own cash and fund the balance with $90 Million in bonds. Centegra plans to use $48 Million of its own cash and take on an additional $185 Million in debt. The Centegra project, if approved, will negatively impact Centegra's financial rating and will run the risk of decreasing Centegra's rating to below A (likely to a BBB+ rating). If that happens, Centegra will be at significant risk of not being able to fund the new hospital in Huntley and will also put itself at considerable financial risk due to overly high debt-to-equity levels.

14. **Competitor Claim – The Board's approval of the Shiloh hospital project (which was less than the 100 beds required by the Board's rules) should not serve as precedent for approving the Project.**
True ___ False ___ Misleading _√_.

Board rules provide that hospitals built within a Metropolitan Statistical Area require construction of a minimum 100 Medical/Surgical and Pediatric beds. By proposing a 70 bed hospital, the Project will not be in compliance with this one review criterion. However, Board rules also very clearly provide that ***the failure to meet one or more review criteria shall not prohibit the issuance of a permit.*** Both of the aforementioned Board rules were recently front and center at the June 28, 2010 Board meeting. At that meeting, the Board approved without issue a 94 bed hospital proposed to be constructed in Shiloh, Illinois. The Shiloh hospital contained a bed compliment of 94 beds, which (like the Project) is less than the 100 beds required by Board rules. However, unlike Planning Area A-10 which has a calculated bed need, the Shiloh planning area had a tremendous bed surplus.

At the public hearing, our Competitor, Centegra, offered inconsistent and self-serving testimony regarding what should serve as precedent for the Board by simultaneously stating that the decision in Shiloh should not serve as precedent for the Board but that the events surrounding the 2003 Mercy application somehow should (despite the fact that Board rules provide that a given Project must reviewed consistent with the Board rules that are then in place and the fact that two projects are different, the rules and review criteria for each project are markedly different, the Board staff that reviewed the two projects are different and, thankfully, the Board members that will consider and hopefully approve both projects are different). Mercy has not stated the Shiloh project should serve as "legal precedent" for the approval of the Mercy Project, and the position advanced by our Competitor that the events surrounding the 2003 application should serve as precedent in 2011 is laughable. Mercy agrees with the stated purposes of the Act that "decisions regarding proposed new health services and facilities shall be made for reasons having to do with the community health needs in the various parts of the State." Mercy does not believe that such decisions should or should not be made based on something completely unrelated to the Project that happened 8 years ago. Mercy also does not believe that the Board's approval of the Shiloh project amounts to a "direct attack" on the Board's rules or "a referendum on the reasonableness and validity of the Review Board's adopted review criteria," a position that Centegra, in attacking Mercy's modification, appears to be advancing. Rather, Mercy supports the Board's approval of the Shiloh project and believes it was appropriate. Courtney Avery, the Board's administrator, was, in fact, correct to state in the Chicago Tribune that the 100 bed rule is "stronger than a guideline, but (board members) do have the authority to approve it" (see article attached as Exhibit J).

Following the June 28th Board meeting, Mercy's leadership team determined that, in the spirit of the health planning and cost containment purposes espoused by the Illinois Health Facilities Planning Act, the most effective and efficient use of scarce health care resources was to build a smaller hospital, like the Shiloh hospital project, in Crystal Lake, Illinois. As we previously discussed, the smaller hospital proposed in the modification would be large enough to service the health care needs of McHenry county residents, yet would cost $85 Million less than Mercy's original project and astonishingly $118 Million less than Centegra's project. The smaller project is consistent with hospital construction trends in neighboring states. In looking at Illinois and

four adjacent states, including Wisconsin, Indiana, Missouri and Iowa since the Year 2000, 15 new general, medical-surgical suburban hospitals have been built during this time period (Wisconsin and Indiana have no certificate-of-need laws, while Missouri and Iowa do). They have ranged in size from 32 to 143 beds, with the overall average size being 90 beds. Nine were built with less than 100 beds while 6 were established with more than 100 beds.

Mercy is committed to responsible health planning for the residents of McHenry County. While the Shiloh project does not serve as "legal precedent" to approve the Project, it does very clearly demonstrate that the Board has the full authority to approve a project that has less than the 100 bed "stronger than a guideline" complement set forth in the Board rules. For the reasons set forth herein, Mercy respectfully requests that the Board take the same action with respect to the Mercy Project.

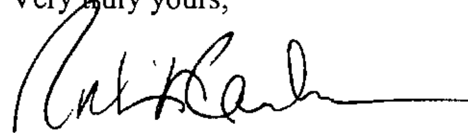
15. **Centegra does not have a monopoly in McHenry County.**
True ___ False _√_ Misleading ___.

Centegra Health System currently operates a monopoly-like ***92.5 percent*** of all hospital beds in McHenry County. If the Board does not approve the Project and instead approves Centegra's Huntley project, that percentage will increase to over 95%. Mercy representatives stressed during our public hearing, with the approval of the Project, the balance of competitive power in the County will improve significantly. Ascension Health is currently in merger discussions with Alexian Brothers (a Competitor). Advocate Healthcare (a Competitor) is currently in merger discussions with another Competitor, Sherman Hospital. Without substantially more competition (and assuming the transactions referenced above are finalized), health insurance companies covering McHenry County residents must negotiate with (i) a virtual monopoly in McHenry County: Centegra Health System; (ii) the largest health system in Illinois, Advocate Healthcare; and (iii) the largest Catholic healthcare system and top 5 largest health care system in the United States, Ascension Health. Bigger is not always better and the residents of McHenry County deserve real choice when it comes to the health care needs. Hospital competition has three benefits: greater consumer choice, better quality, and lower costs and prices. David Eisenstadt, Ph.D., Principal of MiCRA, Inc., an antitrust economist (and previously employed by the United States Department of Justice Antitrust Division), in analysis prepared for public testimony at Mercy's hearing on March 18, 2011, estimated that the entry of the Project would create expected declines in Centegra's inpatient prices to insurance companies of up to 9% depending on the geographic area. This would be favorable for health care consumers in McHenry County and adjacent counties of Lake, Cook and Kane. With the Board's approval of the Project, Mercy will contribute to the containment and reduction of charges in McHenry County over time by balancing the competitive power within McHenry County.

* * * *

As always, Mercy appreciates your consideration and attention to this matter. We look forward to seeing you in December and, as always, if you have any questions, please do not hesitate to ask.

Very truly yours,



Richard H. Gruber, Vice President
Mercy Health System Corporation

Exhibit A

MERCY
HEALTH SYSTEM

1000 MINERAL POINT AVE. • P.O. BOX 5003 • JANESVILLE, WI 53547-5003 • 608.756.6000 • MercyHealthSystem.org

National Quality Award
Award Recipient

RECEIVED

JUL 27 2011

HEALTH FACILITIES &
SERVICES REVIEW BOARD

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] nsured 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 payments [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.

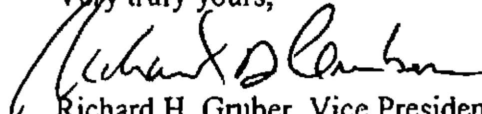
* * * *

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

TABLE OF CONTENTS

PREAMBLE and RECITALS 1

I. DEFINITIONS 2

II. REQUIRED EVENTS 6

III. SETTLEMENT TERMS 7

A. Charity Care and Uninsured Patient Discounts After the Effective Date 7

1. Charity Care 7

2. Application Form for Charity Care 9

3. Determination of Eligibility for Charity Care 11

4. Financial Counseling 13

5. Notice of Charity Care 14

6. Bills and Collection Actions 14

7. Ombudsperson 15

8. Auditor 16

9. Discounted Pricing for Uninsured Patients 17

10. Cooperation 17

11. Record Keeping 17

12. Scope of Agreement and Retention of Jurisdiction 17

B. Applications for Charity Care for Outstanding Bills for Medically Necessary Services Provided Prior to the Effective Date of Settlement 18

C. Restitution 18

IV. NOTIFICATION TO SETTLEMENT CLASS MEMBERS 19

A. Responsibility 19

B. Notice Expenses 20

C. Notice Plan Implementation 20

1. Confidentiality 20

2. Publication Notice 20

3. Internet Notice 20

4. Mailed Notice to Settlement Class Members 20

5. Claim Forms 20

6. Notice and Claims Requests 21

7. Proof of Notice 21

V. MISCELLANEOUS CLAIMS ADMINISTRATION 21

VI. OBJECTIONS AND OPT OUTS BY SETTLEMENT CLASS MEMBERS 21

VII. DISMISSAL AND RELEASE OF CLAIMS 22

VIII. EFFECT OF DISAPPROVAL, CANCELLATION OR TERMINATION 23

IX. SETTLEMENT NOT EVIDENCE AGAINST PARTIES 24

X. ATTORNEY'S FEES AND ADMINISTRATIVE EXPENSES 24

XI. MISCELLANEOUS PROVISIONS 25

A. Governing Law 25

B. Entire Agreement 25

C. Successors and Assigns 25

D. Construction 25

E. Counterparts 25

F. Mutual Representations and Warranties 25

G. Extensions 26

TABLE OF EXHIBITS

Exhibit A	Preliminary Approval Order
Exhibit B	Charity Care Policy Summary
Exhibit C	Final Approval Order
Exhibit D	Class Notice
Exhibit D-1	Publication Notice
Exhibit E	Charity Care Application
Exhibit F	Sample Denial Letter
Exhibit G	Ombudsperson Roles and Responsibilities
Exhibit H	Restitution Claim Form
Exhibit I	Named Plaintiff Account Balances Waived

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 bas 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. <u>Application Form for Charity Care</u>.

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 shall 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.

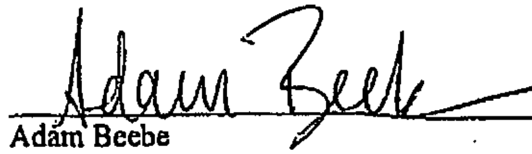
(3) Each Plaintiff represents and warrants to Advocate that he or she has not assigned or otherwise transferred to any other person or entity any claim that is a subject of this Agreement.

(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 LaValliere

____
Margaret Loncar

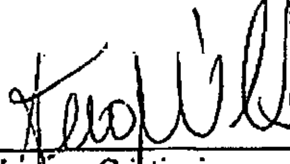
____
Ravell McDonald

____
Lillie McLinton

____
Tiffany Montgomery

Date: August 15, 2008

Adam Beebe



Vanessa Cristiani

Santos Gordils

Christopher Hauser

Tina LaValliere

Margaret Loncar

Ravell McDonald

Lillie McLinton

Tiffany Montgomery

Date: August 15, 2008

Adam Beebe

Vanessa Cristiani

Santos Gordils

Christopher Hauser

Tina LaValliere

Margaret Loncar

Ravell McDonald

Lillie McLinton

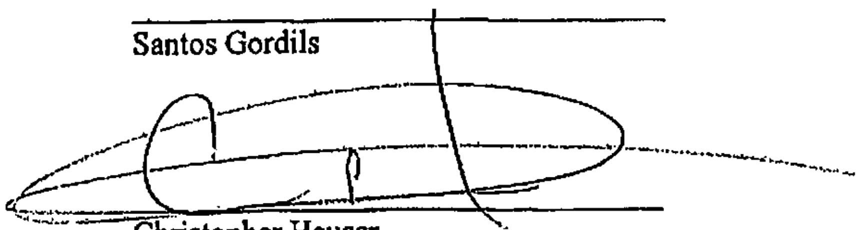
Tiffany Montgomery

Date: August 15, 2008

Adam Beebe

Vanessa Cristiani

Santos Gordils



Christopher Hauser

Tina LaValliere

Margaret Loncar

Ravell McDonald

Lillie McLinton

Tiffany Montgomery

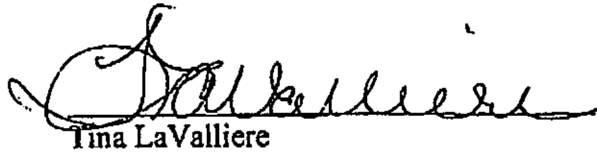
Date: August 15, 2008

Adam Beebe

Vanessa Cristiani

Santos Gordils

Christopher Hauser



Tina LaValliere

Margaret Loncar

Ravell McDonald

Lillie McLinton

Tiffany Montgomery

Date: August 15, 2008

____
Adam Beebe

____
Vanessa Cristiani

____
Santos Gordils

____
Christopher Hauser

____
Tina LaValliere

____
Margaret Loncar

____
Ravell McDonald

____
Lillie McLinton

____
Tiffany Montgomery

Date: August 15, 2008

Adam Beebe

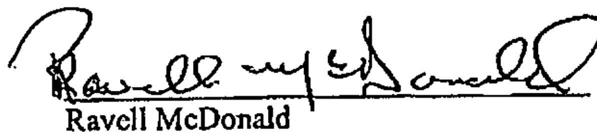
Vanessa Cristiani

Santos Gordils

Christopher Hauser

Tina LaValliere

Margaret Loncar



Ravell McDonald

Lillie McLinton

Tiffany Montgomery

Date: August 15, 2008

Adam Beebe

Vanessa Cristiani

Santos Gordils

Christopher Hauser

Tina LaValliere

Margaret Loncar

Ravell McDonald

~~Lillie Mae McClinton~~
Lillie McLinton
1033 N. Harding ave
Chicago Ill - 60651
Lillie McClinton
Tiffany Montgomery

Plaintiffs, page 1 of 3

Date: August 15, 2008

Adam Beebe

Vanessa Cristiani

Santos Gordils

Christopher Hauser

Tina LaValliere

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

Date: August 15, 2008

Curtis Moore

Thomas Pemberton

Vincent Petrozza

Nicolas Rodriquez

Terrence Rogers

Michael Sozykowny

Frank Vacha

Jeffrey Wojcik

Date: August 15, 2008

Curtis Moore

Thomas Pemberton

Vincent Petrozza

Nicolas Rodriquez

Terrence Rogers

Michael Sozykowny

Frank Vacha

Jeffrey Wojcik

Date: August 15, 2008

____
Curtis Moore

____
Thomas Pemberton

____
Vincent Petrozza

Nicolas Rodriquez

____
Terrence Rogers

____
Michael Sozykowny

____
Frank Vacha

____
Jeffrey Wojcik

Date: August 15, 2008

Curtis Moore

Thomas Pemberton

Vincent Petrozza

Nicolas Rodriquez

Terrence Rogers

Michael Sozykowny

Frank Vacha

Jeffrey Wojcik

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 Szykowny

Michael ~~Sozykowny~~ Szykowny

Frank Vacha

Jeffrey Wojcik

Date: August 15, 2008

Curtis Moore

Thomas Pemberton

Vincent Petrozza

Nicolas Rodriquez

Terrence Rogers

Michael Sozykowny

Frank Vacha

Jeffrey Wojcik

Date: August 15, 2008

Curtis Moore

Thomas Pemberton

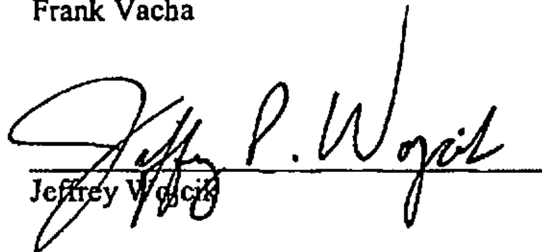
Vincent Petrozza

Nicolas Rodriquez

Terrence Rogers

Michael Sozykowny

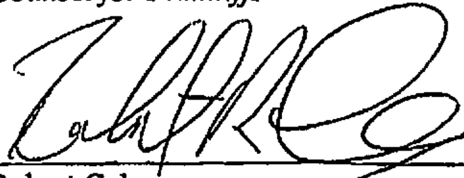
Frank Vacha



Jeffrey Wojcik

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

Defendants, page 1 of 1

Date: August 15, 2008

Advocate Health Care Network

By: ______________________
Duly Authorized Agent

Advocate Health and Hospitals Corporation

By: ______________________
Duly Authorized Agent

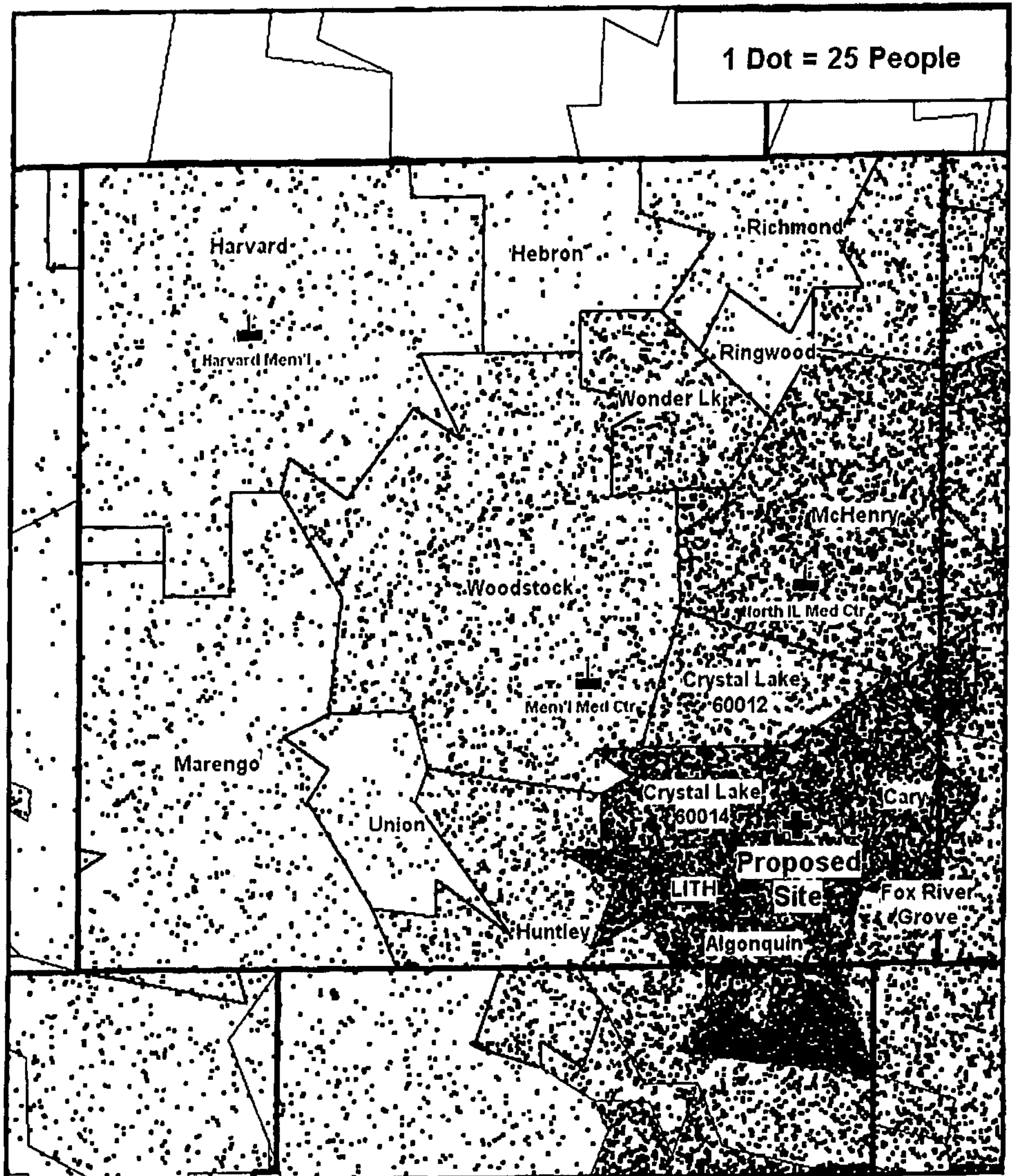
____

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

---

[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

---

[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.

---

[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

---

[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

---

[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]

---

[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

---

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

---

[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

---

[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.

---

[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] DOSE OF COMPETITION, Executive Summary at 22.

Exhibit B

MERCY
HEALTH SYSTEM

Malcolm Baldrige National Quality Award
Award Recipient

1000 MINERAL POINT AVE. • P.O. BOX 5003 • JANESVILLE, WI 53547-5003 • 608.756.6000 • MercyHealthSystem.org

June 3, 2011

Via Federal Express

RECEIVED
JUN 06 2011
HEALTH FACILITIES & SERVICES REVIEW BOARD

Mr. Dale Galassie
Chairman
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Mercy Crystal Lake Hospital and Medical Center Inc. and Mercy Alliance, Inc. ("Mercy" or the "Applicant") (Project Number 10-089) (the "Project").

Dear Chairman Galassie:

The purpose of this letter is in response to numerous public comments made in opposition to our Project both at the public hearing held on March 18, 2011 and those public comments that have been submitted thereafter.

1. Cost/Financial

Several hospital competitors have claimed that the Project will increase costs in McHenry County. As reflected in Mercy's application, it is our belief that the Project will in fact lower health care costs. First, the Applicant will keep the cost of construction down by starting the project immediately after Board approval and open its hospital facility in 2014. Due to the ongoing economic recession, hospital construction has been down substantially from 2008 through the present time. As a result, the cost of new construction is the lowest in decades. For example:

- Hospital construction costs have been flat or declining, resulting in significant savings for hospitals who are choosing to build now; this is compared to more typical cost escalation of 2-4 percent per year all the way up to 9 percent at times during the previous decade.

- Because so many hospitals and health systems have delayed construction projects due of the impact of the recession, there is a strong fear that when prices do start to rise, there will be a significant spike in escalation as pent up demand exceeds supply. As a result, there is urgency to start construction in the next 12-24 months to avoid this large, anticipated escalation in hospital construction costs.

- If the State Board waits to approve a new hospital for Planning Area A-10 a hospital project will continue to get more expensive. When Mercy proposed to build a new hospital in 2004, the total project cost was approximately $1.16 million per bed. For the

current proposed project in 2011, the cost is roughly $1.56 million per bed, a 34.5 percent increase. Delaying a project any longer (into the future) will continue to increase the overall project costs. Completing the project now will help to accomplish the State Board's goal of minimizing the capital outlay.

- While Board rules require construction of a minimum 100 Medical/Surgical and Pediatric beds within a Metropolitan Statistical Area, in considering less costly alternatives, in its application Mercy proposed reducing the size and scope of its project to consider the construction of a facility with 70 beds. This project, with an estimated total project cost of $115 million, would forego an additional capital outlay of $85 million dollars. In looking at Illinois and four adjacent states, including Wisconsin, Indiana, Missouri and Iowa since the Year 2000, 15 new general, medical-surgical suburban hospitals have been built during this time period (Wisconsin and Indiana have no certificate-of-need laws, while Missouri and Iowa do). They have ranged in size from 32 to 143 beds, with the overall average size being 90 beds. Nine were built with less than 100 beds while 6 were established with more than 100 beds.

Second, Mercy will minimize capital outlay by constructing a secondary care hospital, not one which offers tertiary care services (such as Level I trauma, transplants, open heart surgery, neurological surgery, etc.). It will also emphasize convenient access to outpatient and emergency services in a cost-effective manner. Mercy will establish close working relationships with its hospital neighbors who offer tertiary care services to develop seamless referral and transfer relationships.

Third, Mercy will contribute to the containment and reduction of charges in McHenry County over time. In McHenry County, Centegra Health System currently operates nearly 92.5 percent of all hospital beds. Mercy representatives stressed during our public hearing, that the approval of Mercy's project will balance of competitive power in the county will improve as demonstrated by the chart below. Without more substantial competition, health insurance companies must negotiate with a virtual monopoly in McHenry County: Centegra Health System. Hospital competition has three benefits: greater consumer choice, better quality, and lower costs and prices. David Eisenstadt, Ph.D., Principal of MiCRA, Inc., an antitrust economist (and previously employed by the United States Department of Justice Antitrust Division), in analysis prepared for public testimony at Mercy's hearing on March 18, 2011, estimated that the entry of Mercy Crystal Lake Hospital and Medical Center would create expected declines in Centegra Health System's inpatient prices to insurance companies of between 4 and 9 percent depending on the geographic area. This would be favorable for health care consumers in McHenry County and adjacent counties of Lake, Cook and Kane.

Comparison of Current McHenry County Bed Complement and Future Beds Depending Upon Outcomes									
				Future					
	Current			Mercy Project Approved			Centegra Project Approved		
	Centegra	Mercy	Total	Centegra	Mercy	Total	Centegra	Mercy	Total
Medical-Surgical	206	22	228	206	122	328	306	22	328
Obstetrics	33	0	33	33	20	53	53	0	53
Intensive Care	33	3	36	33	11	44	41	3	44
Acute Mental Illness	36	0	36	36	0	36	36	0	36
Total McHenry County Beds	308	25	333	308	153	461	436	25	461
Percent of McHenry County Beds	92.5%	7.5%	100.0%	66.8%	33.2%	100.0%	94.6%	5.4%	100.0%

Fourth, as we emphasized in our application and public hearing testimony, as part of a fully integrated delivery system, Mercy Crystal Lake Hospital and Medical Center will be positioned to deliver costs well below other hospitals in Planning Area A-10 and beyond. Over the past ten years, Mercy – a model for integrated delivery systems – has consistently been rated among the top 20 Integrated Healthcare Systems (IDSs) in the United States by SDI and Modern Healthcare magazine. Irrefutable evidence has been established that IDSs improve healthcare quality, patient outcomes, and reduce costs – especially for patients with complex needs. Stanford University economist Alain Enthoven, who has been studying the nation's health care system for more than 30 years, said integrated systems "are the disruptive innovation we need to turn loose on the rest of America." A 2007 study by Chicago-based Hewitt Associates found that integrated systems like Mercy and Kaiser Permanente provide 22 percent greater cost efficiency than competing systems.

To further highlight this point, the Dartmouth Atlas of Health Care publishes differences in health care spending by Hospital Referral Regions. Directly to the northwest of McHenry County is the Madison, WI HRR, where Mercy operates the largest of its three hospitals in Janesville. In 2007, Medicare paid $6,813 per enrollee for medical care. Conversely, in the Elgin HRR, which includes Centegra Hospital – McHenry, Advocate Good Shepherd Hospital, Sherman Hospital, Provena St. Joseph Hospital and St. Alexius Medical Center, Medicare paid $9,518 per enrollee, nearly 40 percent more. Medicare pays higher rates to Illinois hospitals than Wisconsin hospitals, but nowhere close to 40% more. Mercy, through its vertically integrated delivery system, has learned to operate highly efficiently (and at considerably lower cost) in an environment where they are paid 39.7 percent less by Medicare than the primary hospitals serving McHenry County.

Hospital based systems throughout the U.S. are scrambling to organize hospitals, employ physicians, and eliminate duplication in order to succeed in the health reform environment emphasizing formation of accountable care organizations (ACOs). Mercy has been operating an "ACO-like" organization since 1991 with its health plan, employed physician model, and expansive network of clinics and hospitals. Mercy would further develop the "future" integrated model of health care to McHenry County by 2014.

The population projections supporting the Mercy Project reflect an expanding population in the service area. The payor mix of patients will represent the population as a whole, with an especially fast-growing segment of Hispanic residents. Medicare and Medicaid will comprise 43.3 percent of the hospital's volume.

Payor Source	FY 2015
Medicare	29.2%
Medicaid	14.1%
Commercial	51.8%
Self-Pay	3.5%
Charity	1.4%
TOTAL	100.0%

The project will lower Medicaid and Self Pay (mostly charity care) exposure of Centegra Health System and reduce the outmigration of Medicaid and Self Pay patients from the southeast part of McHenry County to other hospitals in Lake, Cook and Kane Counties. Since nearly 70 percent of Medicare inpatients are admitted outside of the southern one-half of McHenry County, Mercy (and the new physicians it will bring to the area) will seek to improve access for the geriatric population who current leave the county for hospital services.

2. **Patient Access**

Several hospital competitors claimed that there is an overabundance of beds. As we pointed out in our application and testimony, the Mercy Project will provide access to a large and growing area that is underserved for physician, emergency, and hospital services. This is demonstrated by several factors.

- Largest concentration of existing population and patients. By geographically segmenting McHenry County into four sub-areas (as reflected in the attached chart which was previously submitted as part of Mercy's public hearing testimony), including Southeast (Crystal Lake, Cary, Fox River Grove, Algonquin and Lake in the Hills), Southwest (Huntley, Marengo and Union), Central (McHenry, Island Lake, Wonder Lake and Woodstock) and North (Harvard, Hebron, Richmond, Ringwood and Spring Grove), the patient access issues become much clearer. Based on Nielson Claritas, Inc. McHenry County population estimates for 2010 and projections for 2015, and based on COMPdata inpatient admissions for 10/1/09–9/30/10, the largest number of McHenry County residents and hospital admissions are concentrated in the Southeast sub-area of the county.

McHenry County Sub-Area	Key Sub-Area Feature	2010 Population Estimate	% of Total	2015 Population Projection	Total Admissions	% of Total
Southeast	Location of Mercy Crystal Lake Project	163,664	46.6%	177,521	13,821	39.5%
Central	Current Location of Centegra Hospitals	113,196	32.2%	122,032	12,856	36.7%
Southwest	Location of Centegra Huntley Project	40,381	11.5%	44,630	5,216	14.9%
North	Location of Mercy Harvard Hospital	34,114	9.7%	37,696	3,131	8.9%
Total		351,355	100.0%	381,879	35,024	100.0%

- Extensive outmigration of patients. From 7/1/09–6/30/10, 53% of McHenry County residents received inpatient care outside the county (and 22% at hospitals outside the defined service area). During the same period, 70% of residents from the immediate service area (Crystal Lake, Algonquin, Lake in the Hills, and Cary) received inpatient care outside the county (and 21% at hospitals outside the defined service area). Accordingly, the population growth in southern McHenry County will continue to drive the need for additional facilities.

- Physician shortages. The Applicant believes that a shortage of specialty physicians is one of the primary reasons that residents of McHenry County are leaving the county in order to seek medical care. According to physician manpower ratios from Thomson Reuters, McHenry County has a deficit of 49.9 physicians as of March 2010.[1] This includes an estimate of a 29.4 FTE shortage in the area of primary care physicians and the balance in specialty care. This is consistent with the national experience. Both the Council on Graduate Medical Education and the American Medical Association recognize a current physician shortage in the U.S. that will worsen over the next several years. The operational model utilized by the Applicant has been implemented effectively to recruit and retain needed physicians.

- Undersupply of beds. As referenced in the supplemental materials we provided with our application, a recent study by the Henry J. Kaiser Family Foundation highlights the extreme shortage of hospital beds in Planning Area A-10 based on data reported for 2009. In 2009, the State of Illinois had 2.6 Hospital Beds per 1,000 Population. The U.S. average was also 2.6 Hospital Beds per 1,000 Population.[2] McHenry County, with 333 total hospital beds in 2011 and a population of over 351,355, has slightly less than 1.0 Hospital Beds per 1,000. If McHenry County were simply at the Illinois State Average, it would have 914 hospital beds. Based on this calculation, McHenry County is 174 percent below the State and National averages for beds.

- Lack of emergency services for the density of the population. According to the same Henry J. Kaiser Family Foundation study for 2009, the State of Illinois average for Hospital Emergency Room Visits per 1,000 Population was 412. Applied to this Southeast sub-area of McHenry County, this represents an estimated 67,430 Hospital

[1] Thomson Reuters Healthcare – MarketPlanner Plus, Market Expert physician demand ratios.
[2] Henry J. Kaiser Family Foundation; www.statehealthfacts.org, 2009.

Emergency Room Visits generated from this population. Based on a 2015 population projection of 177,521, emergency room visits from this part of McHenry County will grow to 73,139. In CY2009, IDPH reported the two Centegra Hospitals treated 68,519 emergency room visits. Because of a lack of hospital emergency room services in this densely populated, growing sub-market of McHenry County, all of these residents must go out of their local area to access these services.

The Mercy Project will open as a general, acute care hospital. What will be truly unique and new to the area, however, will be the model of care. This system is based on the Mayo Clinic model, where hospital and physician offices are part of the same entity under one organizational roof. An integrated system functions differently than other health care models. The fully integrated model lowers costs and improves patient care, as patients have all the benefits of a multi-specialty clinic, as well as access to diagnostic services, emergency services, surgery suites and other hospital-based services. Such integrated services will greatly benefit emergency room patients if they require attention by a pediatrician, cardiologist, ear nose and throat specialist, orthopedic surgeon or other specialists who are present on-site in the clinic at the time the patient is seen in the emergency room.

It is also the intent of the Applicant to establish a geriatric specialty clinic as part of its overall operations at Mercy Crystal Lake Hospital and Medical Center. Mercy is committed to establishing a geriatric specialty clinic to serve this growing segment of the McHenry County population. Using the experience gained from a similar geriatric specialty clinic operated by Mercy Health System in Wisconsin, it is Mercy's intent to bring the most comprehensive geriatric services to McHenry County as is possible.

The 2010 McHenry County Healthy Community Analysis[3], cited to by competing hospitals, highlighted the rapidly expanding number of Medicaid recipients in the county. In 2000, there were 6,293 residents on Medicaid, or 2.4 percent of the total population. By 2009, this number grew to 25,623, or 8.0 percent of the population in less than 10 years. Most of this growth occurred in the southeast and central portions of McHenry County. In 2010, 30 percent of all Medicaid residents hospitalized from McHenry County live in the Southeast sub-area. All of these residents, many without access to good transportation, must travel outside the area for hospital care because they do not have a local hospital facility available.

3. Improved Quality

Several hospital competitors stated that the Project would hurt the quality of health care in the community. The Mercy Project will, in fact, promote high quality of care because it will extend Mercy's delivery model within Planning Area A-10. Mercy's commitment to patient care quality is best exemplified in its recognition by the U. S. Department of Commerce who honored Mercy with the Malcolm Baldrige National Quality Award. The award is the United States' highest Presidential honor for quality and organizational performance excellence. Mercy is

[3] 2010 McHenry County Healthy community Study, Community Analysis, Chapter 7: Income & Poverty, Page 90.

unique in receiving the honor in that all entities in the vertically integrated health system have been recognized for organizational excellence.

Mercy is committed to provide health care services to all patients regardless of their ability to pay. Mercy will meet this goal by operating an emergency department that will provide services to all patients, including the poor, by implementing a charity care program to provide reduced fee and free services to qualifying patients and by participating in governmental payment programs, including Medicare and Medicaid. Mercy will measure this goal by dollar volume of services rendered and numbers of patients served. Further, Mercy will reach out to community-based organizations in an effort to collaborate in the provision of care to the indigent. Mercy has a reputation and track record in this respect of successful collaborations. Examples of successful program collaborations in programs serving the indigent include efforts with HealthNet of Janesville, a free primary care clinic, and Mercy's physician services arrangements with Beloit Area Community Health Center, a private, not-for-profit Federally Chartered Health Center. Mercy will also develop and implement a physician recruitment plan designed to reduce the identified physician shortage by 85 percent within three years of the opening of the Mercy Crystal Lake Hospital and Medical Center. These efforts will contribute to improving the health status for the community and address health disparities due to a shortage of physicians in McHenry County and a maldistribution of hospital services in the county.

The Mercy Project will measure its quality of care against other providers in Illinois and throughout the United States. It will seek to achieve five stars for the Centers for Medicare & Medicaid Services' (CMS) Five-Star Quality Rating system by implementing its vertically integrated delivery model throughout the market area.

Mercy currently employs 532 staff and doctors to support our 22 facilities including Mercy Harvard Hospital and Mercy multispecialty clinics in McHenry County and contiguous areas of Illinois. It will work off this large base of employees to fill the positions of the new hospital. Mercy uses a continuous staffing plan in order to fill new positions or replace individuals who have left employment. Through the use of newspaper advertising, trade magazines web sites, job fairs, colleges and technical training schools in Wisconsin and Illinois, Mercy partner positions are quickly and efficiently filled. Our experience in Illinois has shown that there are ample interested applicants for every job. Mercy will employ this proven process to fully staff the new facility. The staffing process will begin with the recruitment of physicians immediately upon approval of the project due to the long planning timeline necessary for physician's employment. For other staff positions, recruitment will begin one year prior to opening. All staff positions will be filled one month prior to opening so that our comprehensive training program can be completed and trial operation can begin prior to opening.

4. **Unnecessary Duplication**

Several hospital competitors claimed that the Project would duplicate services provided in the community. The Mercy Project will, in fact, promote the State Board's objective of avoiding unnecessary duplication of services by:

- Addressing 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 bed complement proposed by Mercy Crystal Lake Hospital and Medical Center.

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

- Avoiding cannibalization of patient volume. In its CON application for Centegra Hospital – Huntley, Centegra Health System indicated that the closest hospital to its new hospital in Huntley will be Centegra Hospital - Woodstock at 11 miles (and 16 minutes drive time). The next closest hospitals are Sherman Hospital (12 miles, 20 minutes), Provena St. Joseph Hospital (15 miles, 24 minutes) and Centegra Hospital – McHenry (16 miles, 25 minutes). From July 1, 2009 to June 30, 2010, Centegra Hospital – Woodstock generated 1,072 discharges from Huntley (60142), Lake in the Hills (60156), Cary (60013) and Algonquin 60102). Each of these communities is closer (by more than one-half) to Centegra Hospital – Huntley than its existing Centegra Hospital – Woodstock facility. Other than mental health services, hospital services proposed for Centegra Hospital – Huntley will be identical to those offered by Centegra Hospital – Huntley. It is likely that Centegra Health System will shift up to 1,200 discharges or more from its Woodstock hospital to a new facility in Huntley, a clear duplication of services. Consequently, Centegra Health System would face the need to downsize its Woodstock hospital in order to support volume losses to a new Huntley facility.

- Providing primary and secondary hospital care. The 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.

The Applicant has 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 will see a similar impact. In combination of these factors, the Applicant 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 the Applicant 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.

Mercy formally and informally approached Centegra Health System about a joint venture to provide a hospital and multi-specialty physicians clinic in Crystal Lake. To date, Centegra Health System has not responded favorably to any of our requests. No other healthcare provider in the proposed market area has expressed any desire to pursue a joint venture with Mercy Health System.

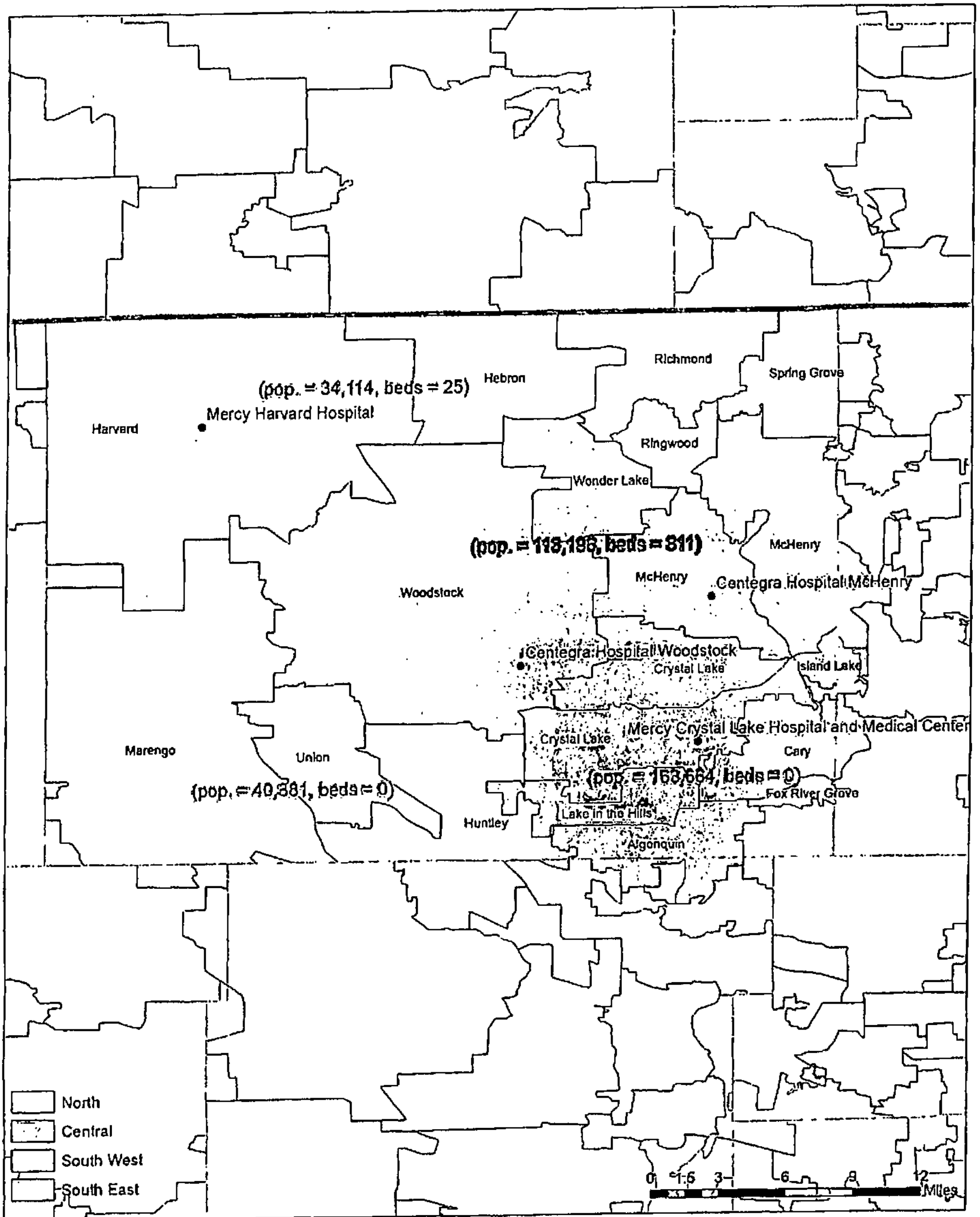
I appreciate your consideration of this matter and Mercy's proposed project.

Sincerely,

Richard Gruber, Vice President
Mercy Health System Corporation

cc: Courtney Avery, Administrator

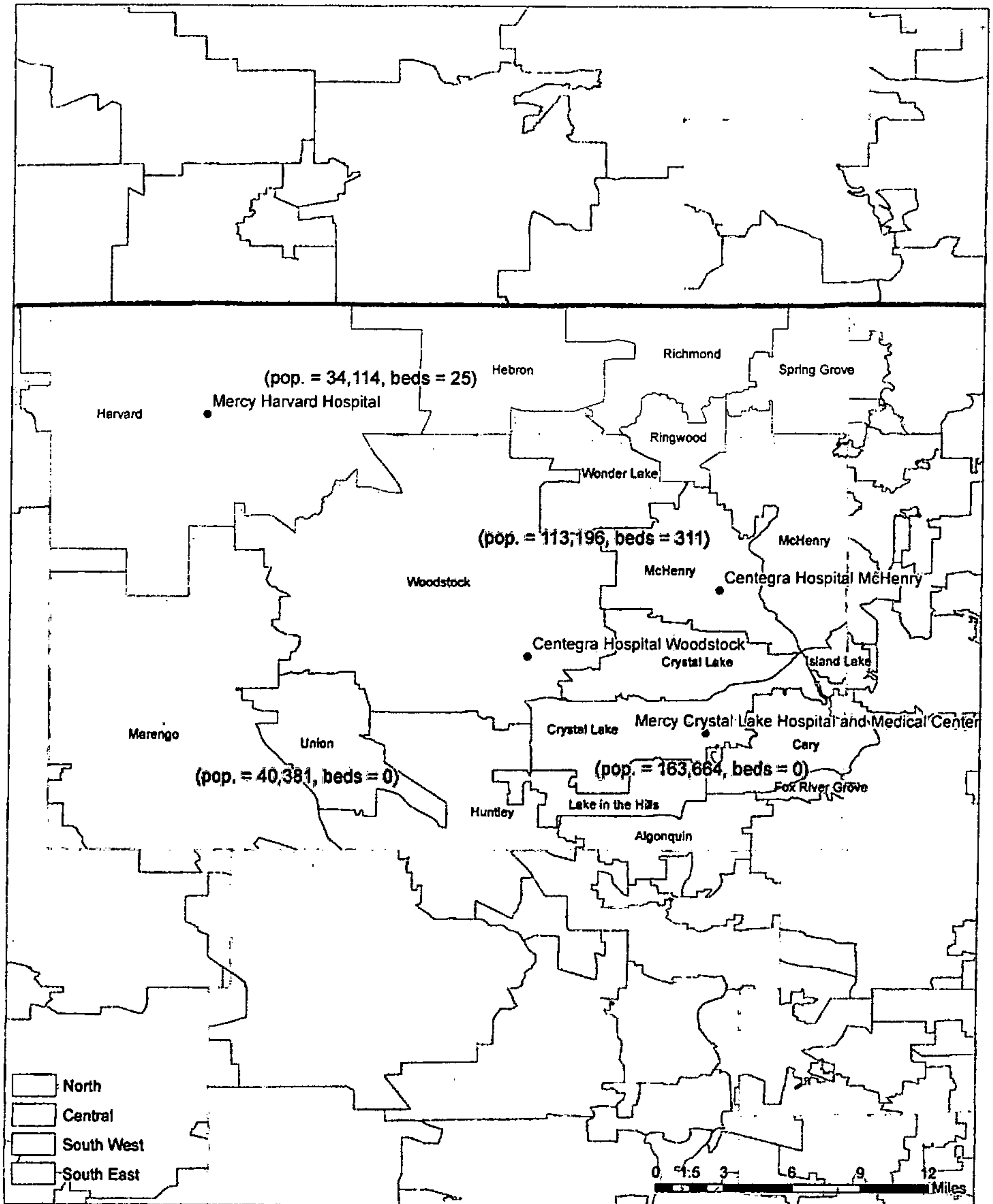
Residents and Hospital Beds in McHenry County



Sources: 2010 population figures from Claritas Nielsen, 2010 hospital bed counts from IDPH Inventory of Healthcare Facilities and Services and Need Determinations

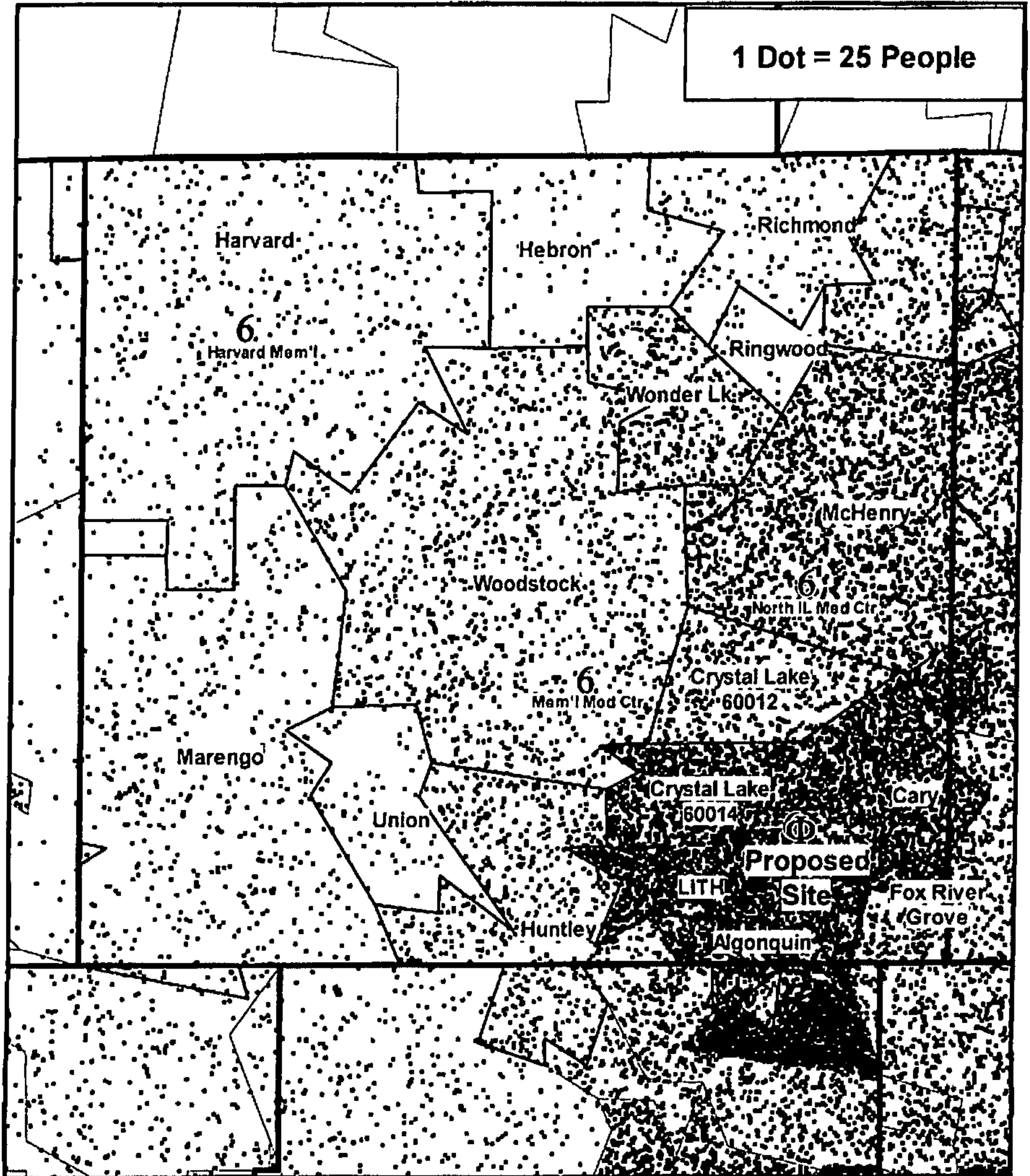
Exhibit C

Residents and Hospital Beds in McHenry County



Sources: 2010 population figures from Claritas Nielsen, 2010 hospital bed counts from IDPH Inventory of Healthcare Facilities and Services and Need Determinations

Population Density in McHenry County
2010 Population Estimate



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

Exhibit D

1000 MINERAL POINT AVE.
P.O. BOX 5003
JANESVILLE, WI 53547-5003
Tele: 608•756•6625
Fax: 608•756•6168
www.mercyhealthsystem.org

Office of the President

June 3, 2011

RECEIVED

JUN 06 2011

HEALTH FACILITIES &
SERVICES REVIEW BOARD

Mr. Dale Galassie
Chairman
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Mercy Crystal Lake Hospital and Medical Center ("Mercy") (Project Number 10-089)

Dear Chairman Galassie:

Thank you for the opportunity to provide information about Mercy's application for a Certificate of Need ("CON") to construct and operate a hospital in Crystal Lake, Illinois. The purpose of this letter is to correct the record concerning some demonstrably false statements made in opposition to our proposal at the public hearing held on March 18, 2011. We were compelled to respond to these statements because they wrongly impugned the integrity of hundreds of our partners (employees) and doctors who commit their professional lives to serving the thousands of patients Mercy treats each day at our Illinois clinics and hospital.

At the March 18, 2011 public hearing on our CON application, Centegra representatives stated that Mercy "lacks commitment to the community" and has "invested very little" in Mercy Harvard Hospital. These statements are demonstrably false and are a disservice to our hundreds of Illinois partners and doctors.

Mercy has an admirable track record of providing needed medical services in Illinois, most of them in McHenry County. Over nearly 20 years, Mercy has created 13 multi-specialty clinics in ten communities in McHenry County. We employ nearly 600 partners, including nearly 100 multi-specialty physicians. In 2003, the then-constituted Illinois Health Facilities Planning Board approved Mercy's partnership with Harvard Memorial Hospital, a financially struggling hospital serving one of the most diverse and indigent populations in McHenry County. Mercy has invested over $20 Million in Mercy Harvard Hospital upgrading its facilities and medical equipment. For example, Mercy has expanded and upgraded the facility's emergency department and operating rooms. Mercy has also added numerous new physician specialties and many new medical and surgical services. Without the commitment of Mercy and its partners, the Harvard, Illinois community would not have 24 hour emergency services, inpatient and outpatient hospital services, and a myriad of other health care services that our partners and doctors delivery daily.

Mercy has also sponsored hundreds of public health screenings and programs in McHenry County and regularly participates in other community benefit programs. Our doctors and partners routinely volunteer their time and energy at a variety of community events. Mercy and its partners touch the lives of more than 100,000 individuals each year through voluntary community involvement.

If approved, Mercy's proposed Crystal Lake facility is a logical extension of Mercy's already deep commitment to the residents of McHenry County. Equally as important, the proposed facility will positively address many barriers that currently impact that ability of McHenry County residents to access high quality, convenient and affordable health care. Mercy Health System is committed to the Crystal Lake area. The proposed hospital project meets the needs of the community in the most appropriate way by addressing the long-standing need for more acute care hospital beds and integrated health care services. There is a need for enhanced and easier access to hospital services, and data prepared by the State of Illinois confirms demand for at least 83 beds in Planning Area A-10.

Mercy has chosen to locate its hospital and medical center in the most densely populated area of McHenry County that suffers from excessive traffic congestion. The more than 163,000 residents of Crystal Lake, Lake in the Hills, Cary and Algonquin will immediately see relief because they will have easy access to a high quality integrated delivery system. Crystal Lake is also the home of the most diverse population in McHenry County and has a growing geriatric population in need of additional services. Crystal Lake also has the greatest concentration of indigent individuals in need of safety net services.

Mercy's proposed hospital project will have a profound positive impact on the economic environment in McHenry County. The project will generate an estimated 650 to 800 construction related jobs within the State of Illinois and McHenry County. Within the first year of opening the facility, Mercy Crystal Lake Hospital and Medical Center is expected to employ more then 1000 individuals, filling 840 full-time positions, of which approximately 600 will be new jobs. The total industry sales impact of Mercy Crystal Lake Hospital and Medical Center ranges from $102.78 Million in the first year of operation to $257.5 Million five years later. The total employment impact of the proposed project ranges from 729 FTE jobs during the ramp-up period, 840 FTE jobs in year one and 1330 jobs in year five.

In addition to generating jobs and income, the economic activity associated with Mercy Crystal Lake Hospital and Medical Center will also generate tax revenue for the State of Illinois and local governments. The clinic portion of the project will be subject to property taxes and a portion of the sales will be subject to sales tax. Income taxes generated by the jobs increase are estimated to produce from $1,372,000 to $4,396,000 for the State of Illinois (using a 3% flat rate.).

When one combines the anticipated benefits associated with the development of Mercy Crystal Lake Hospital and Medical Center with Mercy's historical commitment to the State of Illinois and the residents of McHenry County, any assertion that Mercy somehow "lacks commitment" or "invests very little" in the community is not only false, it is also disingenuous. Given my Illinois roots, such statements are something I take personally. By way of background, Illinois has been home to my family and me; I come from a multi-

generational Illinois family. My father and his father's side originated from Springfield, Illinois. My mother's family is from the Bloomington, Girard, and Virdin, Illinois areas. I grew up in Rockford, Illinois with my eleven brothers and sisters and attended a seminary boarding high school in Crystal Lake, Illinois and college at Northern Illinois University in DeKalb, Illinois. I have been the CEO of Mercy Health System over 21 years and have been grateful for the opportunity to improve health care for my home State of Illinois.

The proposed Mercy Crystal Lake Hospital and Medical Center is the right project, in the right location, at the right time and for the right reasons. Mercy's Crystal Lake Hospital and Medical Center will meet an immediate need for hospital beds in McHenry County, enhance access to hospital services for the greatest number of people, and most diverse population, in the area; and lower costs of health care services by creating healthy competition in an area dominated by one provider.

I appreciate your consideration of this matter and Mercy's proposed project.

Sincerely,

Javon R. Bea, President/CEO

C: Courtney Avery, Administrator

DM_US 28616466-2.066323.0026

Exhibit E

Welcome, Please Log In

2011 Best Employers

Mercy Health System

Health club discounts and scholarships are just some of the takeaways with this company

from: AARP | September 2011

Winning Years: 2011, 2009, 2008, 2007, 2006, 2005
Industry: Hospitals/Healthcare
Location: Janesville, Wisc.
Website: www.mercyhealthsystem.org

The Mercy Retiree Association offers retirees financial planning seminars and health screenings as well as other health-related programs, volunteer opportunities, social programming, mentoring opportunities and discounts on Mercy services. It is also a resource for recruitment.

See Also: How the 2011 Best Employers winners were selected.

Senior Connection is a Mercy Health System program for employees age 55 and over that provides Medicare and health claims assistance, free living will and durable power of attorney for health care documents, free and affordable senior activities, trips, as well as a free prescription discount program, notary service, one-on-one counseling and referral services for elder care options.

In addition, employees with 10 or more years of service benefit from a special accelerated time off accrual system, licensure renewals are provided at no charge, and health insurance is offered at a discounted rate.

Additional Policies and Practices:

Recruiting: E-cards and direct mail campaigns target mature workers and retirees.

About Best Employers

- Best Employers for Workers Over 50. **Read**
- 2011 Best Employers for Workers Over 50 Winners. **Read**
- 2011 Judges. **Read**
- 2011 AARP Best Employers for Workers Over 50 - International. **Read**

Workplace Culture/Continued Opportunities: Employees working 20 or more hours per week are offered tuition reimbursement and certification classes while all employees are offered in-house classroom training and online training. Employees in leadership positions participate in special training sessions and institutes including the Mercy Leadership and Development Academy and the Mercy Institute for Leadership Excellence.

The Mercy Leadership Mentor Program provides new leaders with a personal mentor for at least one year.

Long-service anniversaries are celebrated with announcements, parties and awards.

Regarding programs that offer expanded educational and health benefits to employees, Mercy has: developed the Advance Practice Program, which assists employees pursuing an advanced degree by offering ongoing support and a monetary scholarship; expanded the Mercy Economic Survival Guide and Program for employees and retirees by providing additional discounts and educational resources; expanded Web-based training and webinars; provided breakout sessions during the annual benefits fair to increase one-on-one support for employees; increased monetary donation to the Stay Healthy insurance benefit; enhanced the "Healthy You" program and website which offers employees ongoing health programming and online goal tracking; expanded pension and retirement planning sessions, introduced a health savings account and provided health risk assessments.

Employees gain new experiences and develop new skills by working on team projects, by job shadowing, by working in temporary assignments in other departments and by participating in a formal job rotation program.

Mercy's Occupational Therapy Department performs workstation ergonomic evaluations and provides modifications when needed.

Benefits/Health: Employees working 20 or more hours per week receive individual and family medical and prescription drug coverage, individual and family dental insurance, individual and family long-term care insurance, as well as short-term disability. Long-term disability is offered to employees working 36 or more hours per week.

Health benefits for retirees pre-65 and 65 and over include individual and spouse medical and drug coverage, individual and spouse dental insurance, individual and spouse long-term care insurance, and the services of an employee assistance program (EAP). All of the above health benefits for retirees age 65 and over are available to new hires upon retirement.

Individual and spouse life insurance or other death benefit coverage are also offered to retirees age 65 and over. Flexible spending accounts (FSAs), and health savings accounts (HSAs) are available to assist in covering out-of-pocket health care costs.

Next: Paid time off, work from home and other benefits. >>

Benefits/Financial: Employees working 20 or more hours per week are offered a 403(b) plan with employer match and a cash-balance or other hybrid plan. Employees age 50 and over can make catch-up contributions to their 403(b) plan. Staff members and staff from the financial services firm that administers the retirement plan provide financial information and training to employees.

Short-term and long-term leaves of absence without pay and paid time off are offered to allow for caregiving. Mercy's Donated Leave Sharing Plan allows Mercy employees to donate time to other employees in need.

Full- and part-time employees are offered flu shots, health screenings, health risk appraisals, smoking cessation programs, health club discounts, physical activity and weight loss programs, stress management training and a Safety Fair.

Mercy offers on-site elder care, as well as referral services and back-up care to assist with child care,

care for grandchildren and elder care to its full- and part-time employees. In addition, Mercy provides an adaptive device benefit that offers reimbursement for adaptive care devices for employees and their dependents.

Benefits/Alternative Work Arrangements: Full-time employees working 40 hours per week can participate in job sharing while those working 20 or more hours per week are eligible for flex time, compressed work schedules, telecommuting and a formal phased retirement program.

The Work To Retire Program allows employee partners age 50 and over with five years of service the opportunity to work reduced, pool or work-at-home schedules, and allows employees age 55 and over with 15 years of service to work seasonally, for 1000 hours in a year at their discretion, while maintaining full part-time benefits.

Full-time employees are eligible to move to part-time work on a permanent or temporary basis.

Opportunities for Retirees: Mercy has 325 retirees and an individual directly responsible for retiree relations. The hospital stays connected with its retirees by communicating on a regular basis, by inviting retirees to organization events, by providing ongoing access to retirement planning workshops and education, and by formally acknowledging retirees upon retirement. Retirees are offered work opportunities including temporary work assignments, telecommuting, and full- and part-time work.

Age of Workforce: Thirty-six percent of Mercy employees are age 50 and over. The average tenure of such employees is 12.98 years.

Return to List of 2011 Best Employers Winners. >>

ADVERTISEMENT

Employee Engagement Tips Improve Employee Engagement: 10 Steps To Drive Results. Free eBook SilkRoad.com/Employee-Engagement

Web Timesheet Software Employee Time Tracking Software for companies of all sizes. Try Online! www.Replicon.com/Free_Trial

AARP Members: Make Money Own your own AARP Internet Health Care Yellow Pages for your city www.DoctorsOnDemand.tv/AARP

WORKING
MOTHER

2010 Working Mother 100 Best Companies (/node/3836/list)

Mercy Health System

Employees: 3765
Women: 83 %
Headquarters: Janesville, WI

It's a Fact!

Mercy Health System's Soup-N-Sniffles program provides full-day care for sick kids at all of its hospitals and costs just $2.50 per hour.

What We Love

From its Janesville, WI, travel clinic to its six-bed hospital in Lake Geneva, WI, this health-care system offers moms many opportunities to advance. In 2009, it built on its strong mentoring program for top executives by introducing one-on-one mentoring for new and emerging leaders; just as helpful is its eight-week Leadership Development Academy for high-potential managers, which helps them refine their people skills. Flexible schedules are used by 60% of workers, and all 64 system locations offer the option of compressed workweeks or telecommuting. Many sites have teleconferencing rooms that reduce work travel, but if moms need to make a trip, the system reimburses their child-care costs. When it's time for a break, moms can take an unpaid three-month leave with benefits or a paid sabbatical of at least two weeks, which is offered to
employees who've been with the organization ten years.

President & CEO Javon Bea

VP, HR & Organizational Development Kathy Harris

Women managers, senior managers and corporate execs 59%

Women among top earners 63%

Women on board of directors 25%

Women corporate executive hires in 2009 0%

Women participating in management or leadership training in the past year* 2%

Women participating in formalized executive succession planning last year* 3%

Women promoted last year who utilized a formal flexible work arrangement 17%

Do formal compensation policies reward managers who help women advance? No

Percentages reflect number of women participants versus company's total female workforce.

Press Releases

Mercy Health System named best employer for workers over 50

JANESVILLE, WI - The American Association for Retired Persons (AARP) recently announced that Mercy Health System, based in Janesville, Wisconsin, is one of its Best Employers for Workers Over 50. Now in its tenth year, this prestigious award was established by AARP to honor employers who demonstrate a strong commitment to a maturing workforce.

"We are honored to be recognized by AARP as a top workplace for employees over 50 for the for the flexible work options we offer our employees," says Javon R. Bea, president and CEO of Mercy Health System. "Creating a great place to work for all ages helps us do whatever it takes to keep raising the bar, to provide the best care possible for our patients."

Any U.S.-based employer with at least 50 employees is eligible to apply for the Best Employers award. Candidates are vetted to ensure that practices meet the needs of mature workers.

Key areas of consideration include: recruiting practices; opportunities for training, education and career development; workplace accommodations; alternative work options, such as flexible scheduling; job sharing and phased retirement; employee health and retirement benefits; and retiree work opportunities.

"Mercy Health System has demonstrated exemplary policies toward older workers and well deserves this honor," says Steven Carter, AARP Wisconsin Acting State director. "Their progressive policies meet the needs of mature workers and benefit their organization as well."

Mercy Health System will be profiled in the November issue of AARP The Magazine and recognized at a dinner in Chicago September 13. Mercy was ranked number one of its Top 50 Best Employers for Workers Over 50 in 2006 and has been consecutively recognized since.

For a full list of this year's Best Employers, visit aarp.org/bestemployers.

Press Releases

Mercy Health System named 100 best company by Working Mother Magazine

JANESVILLE, WI - Working Mother magazine recently announced Mercy Health System as one of its 2011 Working Mother 100 Best Companies. Demonstrating the power of change and their unwavering commitment to parents nationwide, 100 percent of this year's winning companies offer flextime hours, telecommuting, paid maternity leave and employee assistance programs.

"We are very honored to be listed among the best companies for working mothers. This award reflects the ongoing work/life benefits Mercy offers, and is also made possible by all of the dedicated working mothers at Mercy," says Javon R. Bea, president and CEO of Mercy Health System. "Working mothers continue to make valuable contributions in all areas of Mercy Health System. It's both our pleasure and responsibility to ensure that we create a supportive and flexible work environment that enable them to succeed."

Some of the comprehensive benefits for nearly 4,000 Mercy employees/partners include:

- Adoption benefits
- Childcare benefits
- Continuing education and tuition reimbursement
- Discounts
- Extensive professional development and training programs
- Job sharing/ flexibility
- Lactation accommodation
- Overnight travel childcare stipend program
- Women's Issue Task Force

"With more than 169,000 women hired last year, this year's 100 Best Companies make up an impressive group of winners who offer family-driven programs and benefits that far outpace their competitors," said Carol Evans, President, Working Mother Media. "This year's winning companies are proof that success lies in the numbers - 97 percent of companies are offering prenatal education, weight-loss, wellness, and stress-reduction programs to employees at every level."

Mercy will be recognized at Working Mother's 100 Best Companies Congress in New York City, October 18-20 and profiled in the October issue of Working Mother magazine.

Founded in 1895, Mercy Health System is a not-for-profit, vertically integrated multi-specialty health system that serves more than one million individuals through its 64 facilities in 24 southern Wisconsin and northern Illinois communities. Since 1989, Mercy Health System has grown from a stand-alone community hospital with no employed physicians and no ambulatory care centers into a comprehensive, vertically integrated health system offering an extensive network of primary and specialty care physicians, three hospitals, subspecialty centers of excellence, insurance products, long term care, retail services, and preventive health and wellness programs. Mercy employs over 400 physicians and nearly 4,000 employees, who are called partners. Mercy Health System is headquartered in Janesville, Wisconsin.

Working Mother Media: Working Mother magazine reaches 2.2 million readers and is the only national magazine for career-committed mothers; WorkingMother.com gives working mothers @home and @work advice, solutions, and ideas. This year marks the 26th anniversary of Working Mother's signature research initiative, Working Mother 100 Best Companies, and the ninth year of the Best Companies for Multicultural Women. Working Mother Media, a division of Bonnier Corporation (www.bonnier.com), includes the National Association for Female Executives (NAFE, www.nafe.com), Diversity Best

Practices (www.diversitybestpractices.com), and the Working Mother Research Institute. Working Mother Media's mission is to serve as a champion of culture change.

Exhibit F

McDermott
Will&Emery

Boston Brussels Chicago Düsseldorf Houston London Los Angeles Miami Milan Munich New York Orange County Rome San Diego Silicon Valley Washington, D.C.

Strategic alliance with MWE China Law Offices (Shanghai)

Linas J. Grikis
Attorney at Law
lgrikis@mwe.com
+1 312 984 7745

September 23, 2011

VIA U.S. MAIL AND ELECTRONIC MAIL

Frank Urso, Esq.
Illinois Health Facilities and Services Review Board
122 S. Michigan Ave.
Suite 700
Chicago, Illinois 62761

Re: Mercy Crystal Lake Hospital and Medical Center, Inc. ("**Mercy**") (Project No: 10-089) (the "**Project**")

Dear Frank:

This letter memorializes the technical assistance meeting we had at your office on September 14, 2011 regarding the Project. Also in attendance was Courtney Avery. The purpose of our meeting was to get a better understanding of the rationale Board staff used to conclude that the modification constituted a Type A modification.

I first summarized the evaluative process the Mercy team undertook in connection with the modification. I noted that as part of that process, Mercy and its leadership team listened carefully to the concerns and comments that the Board had for both the Project as well as the other pending hospital project in McHenry county. Coupled with the Board's approval at the June 28th Board meeting of the 94 bed hospital in Shiloh, Illinois (which contained a bed compliment (94 beds) that was less than the 100 beds required by Board rules), the Mercy leadership team determined that good health planning demanded, and it was in the best interest of the residents of McHenry county, to not maintain the status quo. Thus, Mercy modified the Project.

I then briefly discussed Mercy's position that the modification did not meet any of the Type A modification criterion specified in Section 1130.650 of the Board rules. I also noted that existing Board rules provide clear guidance and a simple solution to correcting mistakes and clarifying information in a given application. I noted that Board staff followed these rules when they requested that Mercy correct its application (by removing all references to cardiac catheterization) on August 11, 2011. Further, I noted that the current position advanced by Mercy's competitor, specifically that the modification constitutes a Type A modification because there was a change in the category of service (cardiac catheterization), had changed over time and sets a dangerous precedent for the Board and Board staff. I noted that just a few short

months earlier, Mercy's competitor objected to Mercy's original application because it referenced cardiac catheterization services but failed to address any of the applicable review criteria, thereby supporting the conclusion that one needs to address the applicable review criteria for a given category of service before one can actually claim to be proposing said category of service.

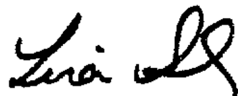
I stated that the current position advanced by Mercy's competitor potentially sets a bad precedent if followed by the Board and Board staff. Specifically, under this position if an applicant includes a reference to a category of service in its application or merely "represents" providing it to the public, but does not address any of the applicable review criteria in the application, it nonetheless constitutes "proposing" a category of service. Taking this position further, I noted that if Board staff (i) fails to catch the fleeting references to the "category of service;" (ii) deems the application complete; and (iii) fails to address how the applicant addressed the "category of service" review criteria in the State Agency Report, under this position none of that matters – the applicant nonetheless "proposed" a category of service. I then took the position to its logical conclusion and noted that if the Board later approves the application, under this position the applicant would have received approval from the Board to provide the category of service mentioned in passing. In doing so, the applicant would not have to address any of the applicable review criteria and would be able to circumvent the express intent of the Board rules.

You responded that it is within the Board's power to call a public hearing on matters before it. You noted that in the past the Board has requested multiple public hearing on other projects. You noted that, given the magnitude of the modification, the high profile of the McHenry county projects and the totality of the circumstances, the Board desired to have a public hearing on the modification. You noted that the Board would have requested an additional public hearing even if the cardiac catheterization category of service was not at issue. You stated that at this time both McHenry county hospital projects would be considered at the December Board meeting.

* * * *

I stated that while Mercy disagrees with Board staff's conclusion, Mercy nonetheless looks forward to the Public Hearing on October 7, 2011. Mercy thanks you, Board staff and the members of the Board for your assistance to date. As always, we appreciate your consideration and attention to these matters.

Cordially,



Linas J. Grikis

cc: Courtney Avery

DM_US 30178716-1.066323.0026

Grikis, Linas

From: Urso, Frank [Frank.Urso@Illinois.gov]
Sent: Monday, September 26, 2011 2:54 PM
To: Grikis, Linas
Cc: Avery, Courtney; Constantino, Mike; Morado, Juan
Subject: RE: Letter

Linas, the only comment that I have deals with the second to the last paragraph, second to the last line. You state," You noted that the Board would have requested an additional public hearing even if the cardiac catheterization category of service was not at issue." The correct statement is, "You noted that the Board could have requested an additional public hearing even if the cardiac catheterization category of service was not at issue."

Let me know if you have any questions.

Thanks, Frank

Frank W. Urso
Illinois Health Facilities and Services Review Board
General Counsel
Ethics Officer
122 S. Michigan
Chicago, Illinois 60603
frank.urso@illinois.gov
312-814-6033

CONFIDENTIALITY NOTICE: This e-mail (and attachments) contains information that belongs to the sender and may be confidential or protected by attorney-client or attorney work product privilege. The information is only for the intended recipient. If you are not the named or intended recipient, please do not disclose, copy, distribute, or use this information. If you have received this transmission in error, please promptly notify the sender of receipt of the e-mail and then destroy all copies of it. Receipt by unintended recipient does not waive attorney-client privilege or attorney work product privilege or any other exemption from disclosure. Thank you.

From: Grikis, Linas [mailto:lgrikis@mwe.com]
Sent: Friday, September 23, 2011 7:05 PM
To: Urso, Frank
Cc: Avery, Courtney
Subject: Letter

Frank - given our earlier discussions with Courtney, I am not sure whether I needed to send this to you. If so, please take a look at the attached and let me know if you have any comments or questions. Have a great weekend. - Linas

Linas Grikis
McDermott Will & Emery
227 West Monroe, Suite 4400
Chicago, Illinois 60606
312.984.7745 (Phone)
312.277.3934 (Fax)

Legal Secretary:
Nancy Wilson-Lister
312.984.2049

nlister@mwe.com

****
IRS Circular 230 Disclosure: To comply with requirements imposed by the IRS, we inform you that any U.S. federal tax advice contained herein (including any attachments), unless specifically stated otherwise, is not intended or written to be used, and cannot be used, for the purposes of (i) avoiding penalties under the Internal Revenue Code or (ii) promoting, marketing or recommending to another party any transaction or matter herein.

This message is a PRIVILEGED AND CONFIDENTIAL communication. This message and all attachments are a private communication sent by a law firm and may be confidential or protected by privilege. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or use of the information contained in or attached to this message is strictly prohibited. Please notify the sender of the delivery error by replying to this message, and then delete it from your system. Thank you.
****

Please visit http://www.mwe.com/ for more information about our Firm.

Exhibit G

K&L|GATES

RECEIVED

JUN 30 2011

HEALTH FACILITIES & SERVICES REVIEW BOARD

K&L Gates LLP
70 West Madison Street
Suite 3100
Chicago, IL 60602-4207
T 312.372.1121 www.klgates.com

June 27, 2011

Daniel J. Lawler
D 312.807.4289
F 312.827.8114
daniel.lawler@klgates.com

Via E-Mail and U.S. Mail

Frank Urso
Deputy Chief Counsel
Illinois Department of Public Health
122 South Michigan Avenue
7th Floor
Chicago, IL 60605

Re: Technical Assistance Documentation and Public Comment Issues;
Project No. 10-090, Centegra Hospital-Huntley

Dear Mr. Urso:

I represent the applicants Centegra Health System and Centegra Hospital-Huntley in Project No. 10-090, Centegra Hospital-Huntley. This letter is to provide technical assistance documentation relating to our telephone conversation on June 27, 2011 at approximately 9:45 a.m. in which your assistant, Mr. Marudao also participated. I had requested technical assistance with regard to the procedures for public comment under the Open Meetings Act at the June 28, 2011 Review Board meeting and with regard to the status of the request that was submitted by Mr. Joe Ourth, Arnstein & Lehr, to defer Review Board action on new hospital projects, including Project No. 10-090, Centegra Hospital-Huntley. You provided me with information regarding the current status of the procedures for public comment, and also advised that Mr. Ourth's request and my response to that request were received and under consideration. Thank you for providing this technical assistance.

With respect to public comment at Review Board meetings under Section 2.06(g) of the Open Meetings Act (5 ILCS 120/2.06(g)), the applicants in Project No. 10-090 share the concerns and objections raised by the Illinois Hospital Association ("IHA") in the letter of Mark Deaton, Senior Vice President and General Counsel, IHA, to Ms. Courtney Avery, Review Board Administrator, dated June 20, 2011. A copy of that letter is attached. We concur that the Review Board's current rules allowing for public comment comply with the provisions of the Open Meetings Act, and that allowing public comment prior to projects at the same meeting where the projects will be decided impairs the fairness of the proceeding and is highly prejudicial to the applicants. By way of example, at the Review Board's meeting on May 10, 2011, public speakers in opposition to a project (1) made comparisons between the applicant's proposal and the "mass extermination of the chronically sick" in Nazi Germany, (2) claimed to speak on behalf of God and threatened revolution and the judgment of God if the project were approved, and (3) made other intimidating statements directed at Board members such as "we know who you are...." (Transcript of Review Board

meeting dated May 10, 2011 at pages 21, 33, 44-45.) When statements such as these are made immediately prior to the Review Board's consideration of a project, the undue influence on Review Board members and prejudice to the applicants is patent.

Section 2.06(g) of the Open Meetings Act requires public comment to be "under the rules established and recorded by the public body." (5 ILCS 120/2.06(g).) Public comment on projects pending before the Review Board at the Board meeting at which the project is considered is not in accordance with the established rules of the Review Board and, in fact, violates the Board's existing regulations regarding *ex parte* information. Section 1130.635 of the Review Board's rules specifically limit public comment.to that which is "submitted in accordance with the public comment and public hearing provisions of this Part...." (77 Ill. Adm. Code 1130.635(c).) Part 1130 does not allow public comment at Review Board meetings. Moreover, public comment that is not made in accordance with the promulgated rules of the Review Board is *ex parte* information under Section 1130.635(d).

Finally, we believe that allowing public comment at the Review Board meeting is inconsistent with the legislative intent expressed in the Illinois Health Facilities Planning Act (20 ILCS 3960/1 et seq.) and Public Act 96-0031. Section 6(c-5) of the Planning Act allows members of the public to submit written responses to State Agency Reports. Prior to June 30, 2009, the Planning Act allowed these responses to be submitted at least two business days before the meeting of the State Board. However, Public Act 96-0031 amended Section 6(c-5) to require written responses "at least 10 days before the meeting of the State Board." Other written materials could thereafter be submitted only at the Review Board's discretion. Oral public comment at the Review Board meeting on pending projects conflicts with Section 6(c-5) specifically limits public comment to written comments on the State Agency Report submitted 10 days before the State Board meeting, and other additional *written* material submitted at the Review Board's discretion, oral public comment at Review Board meetings on pending projects is inconsistent with Section 6(c-5).

For these reasons, we do not believe that public comment at Review Board meetings on projects to be acted upon by the Review Board on that day complies with the provisions of the Planning Act or the Review Board's promulgated regulations. If public comment is to be allowed, we agree with the IHA's position, expressed in Mr. Deaton's attached email to Ms. Avery dated June 24, 2011 that, in order to mitigate the prejudice to the applicants and the potential of tainting the decision-making process with last minute unsubstantiated information, public comment should be placed at the end of the agenda.

Thank you for your consideration of these issues.

Very truly yours,

K&L GATES LLP

Daniel J. Lawler
One of the Attorneys for Centegra Health System and Centegra Hospital-Huntley, the Applicants in Project 10-090

DJL:dp
Enclosures

cc: Ms. Courtney Avery, Administrator

IHA Illinois Hospital Association

OFFICERS
CHAIR
Gary Kaatz
Rockford
CHAIR-ELECT
Alan Channing
Chicago
IMMEDIATE PAST CHAIR
Patrick Magoon
Chicago
IMMEDIATE PAST PAST CHAIR
Harry Wolin
Havana
TREASURER
Connie Schroeder
Pittsfield
SECRETARY
James Leonard, M.D.
Urbana
PRESIDENT
Maryjane Wurth
Naperville

TRUSTEES
Jeffrey Brickman
Joliet
Sandra Bruce
Chicago
David Crane
Hinsdale
Edgar Curtis
Springfield
Randall Dauby
McLeansboro
Steven Drucker
Chicago
Michael Easley
Crystal Lake
Mark Frey
Arlington Heights
Dean Harrison
Chicago
William Huff
DuQuoin
Brian Lemon
Berwyn
Barbara Martin
Waukegan
Michael McManus
Centreville
Nancy Newby
Nashville
Keith Page
Maryville
Michael Perry, M.D.
Freeport
Kevin Poorten
DeKalb
William Santulli
Oak Brook
Rob Schmitt
Gibson City
Joanne Smith, M.D.
Chicago
Keith Steffen
Peoria
Paul Whelton, M.D.
Maywood

June 20, 2011

Courtney Avery
Administrator
Illinois Health Facilities and Services Review Board
122 S. Michigan Ave. 7th Floor
Chicago, IL 60603

Dear Ms. Avery:

The Illinois Hospital Association respectfully urges the Health Facilities and Services Review Board to discontinue the practice of permitting public comments related to projects at the meeting where the board intends to vote on the projects. This new procedure was just adopted at the last board meeting – without the benefit of the rule-making process.

IHA strongly supports full public participation in the certificate of need process. The existing regulations already provide for that full and complete participation. Creating this additional opportunity for comment immediately prior to a decision will do nothing but taint the process, create substantial delays in approving time-sensitive transactions, and prejudice applicants. And it adds nothing to the public's ability to participate.

The Illinois Open Meetings Act provides that "any person shall be permitted an opportunity to address public officials under the rules established and recorded by the public body." 5 ILCS 120/2.06(g). This provision does two things. It honors the right of the public to participate in the governmental process. But just as importantly, it protects another right of the public – the right to fair and balanced decisions by public officials – by requiring public bodies to adopt rules governing public participation. Those two elements – participation guided by rules – go to the heart of democracy. The people are not served by a free-for-all.

The first requirement of Section 2.06(g) – the opportunity for public comment – is clearly satisfied by the board's existing regulations. They allow an incredible degree of public comment and participation in the certificate of need process – both in writing and in person. See: 77 Ill.Adm.Code 1130.910 – 1130.995 "Public Hearing and Comment Procedures." The openness and reasonableness of the process is demonstrated by the large volume of written comments and the large amount of oral testimony provided by members of the public.

The second requirement of Section 2.06(g) – reasonable ground rules – must also be honored. Allowing public comment on projects at the same meeting where they will be decided imposes a tremendous and unfair burden on both the board and applicants

without adding one iota to the public's ability to participate. It could well taint the board's decision-making and deprive applicants of due process.

Certificate of need applications can be incredibly complex and incredibly contentious. Millions of dollars can be at stake. All of that requires a process that allows the staff and the board to make as rational a decision as possible after carefully weighing all of the information presented -- by applicants, opponents, and the public. The existing regulations do that very well.

Permitting last-minute comment allows the introduction of unreliable, unsubstantiated, inflammatory, and prejudicial information – either intentionally or unintentionally – immediately prior to a vote. Hours of thoughtful review and analysis by applicants, board staff, and board members can be undone without any recourse. Such a chaotic process serves no one – least of all the public, which deserves the best thinking and decision-making possible from its government officials. This is exactly why the board's exiting rules require a twenty-day hiatus in comments prior to action on an application.

For these reasons, the Illinois Hospital Association urges the Health Facilities and Services Review Board to abide by its existing regulations regarding public participation in the certificate of need process and not to allow additional public comment on projects at the hearing where they will be acted upon. The existing regulations satisfy the Open Meetings Act and serve the best interest of the public in a fair and thoughtful process.

Sincerely,

Mark D. Deaton
Senior Vice President & General Counsel

cc Dale Galassie, Chair, Illinois Health Facilities and Services Review Board
Frank Urso, Illinois Health Facilities and Services Review Board
Dave Carvalho, Illinois Department of Public Health
Lynn Patton, Office of the Attorney General
Paul Gaynor, Office of the Attorney General

> From: Deaton, Mark
> Sent: Friday, June 24, 2011 12:26 PM
> To: 'Courtney.Avery@illinois.gov'
> Cc: 'Gaynor, Paul J.'; 'lpatton@atg.state.il.us'; 'Carvalho, David'; 'Frank.Urso@illinois.gov'; Guild, Ann; 'spratt@atg.state.il.us'
> Subject: Follow Up to IHA Letter
> Importance: High
>
> Dear Ms. Avery -
>
> I am writing to suggest a simple, temporary solution to the issues raised in IHA's June 20 letter (copy attached). At next week's board meeting, I suggest placing the public comment period as the final item on the board's agenda - or at least following all action items.
>
> The Open Meeting Act's requirement of "an opportunity to address public officials" does not require any particular placement on an agenda. Placing the public comment period at the end of the agenda mitigates the very real potential of tainting the decision-making process with last-minute unsubstantiated information. As my letter indicates, this threatens the deliberative process of the board and exposes the board's decisions to challenge.
>
> While this may not be the best long-term solution, it does not appear that we will be able to resolve the question prior to Tuesday's meeting. I believe that placing the comment period at the end of the agenda complies with the Open Meetings Act, protects the legitimacy of the board's deliberations, and allows the interested parties additional time to discuss a more permanent procedure.
>
> Thank you again for the time and attention you are devoting to this issue. Please let me know if you have any questions or need additional information.
>
> Mark D. Deaton
> Senior Vice President & General Counsel
> Illinois Hospital Association
> 1151 East Warrenville Road
> P.O. Box 3015
> Naperville, Illinois 60566
>
> 630-276-5466 Telephone & Fax
> mdeaton@ihastaff.org<mailto:mdeaton@ihastaff.org>
>
> cc David Carvalho, Illinois Department of Public Health
> Frank Urso, Illinois Department of Public Health
> Lynn Patton, Office of the Attorney General
> Paul Gaynor, Office of the Attorney General
> Sarah Pratt, Office of the Attorney General
> Ann Guild, Illinois Hospital Association
>
>
>
> From: Deaton, Mark
> Sent: Monday, June 20, 2011 4:40 PM
> To: 'Courtney.Avery@illinois.gov'
> Cc: Gaynor, Paul J.; 'lpatton@atg.state.il.us'; 'Carvalho, David'; 'Frank.Urso@illinois.gov'; Wurth, Maryjane; Peters, Howard; Guild, Ann

> Subject: Letter From IHA to Health Facilities and Services Review Board
>
> Dear Ms. Avery -
>
> Please find attached a letter from the Illinois Hospital Association regarding the issue of public comments on projects before the Health Facilities & Services Review Board. I have also sent a copy by regular mail, but wanted to share IHA's view as soon as possible given that there is a board meeting scheduled for next week.
>
> Thank you very much.
>
> Mark D. Deaton
> Senior Vice President & General Counsel
> Illinois Hospital Association
> 1151 East Warrenville Road
> P.O. Box 3015
> Naperville, Illinois 60566
>
> 630-276-5466 Telephone & Fax
> mdeaton@ihastaff.org<mailto:mdeaton@ihastaff.org>
>
> cc David Carvalho, Illinois Department of Public Health
> Frank Urso, Illinois Department of Public Health
> Lynn Patton, Office of the Attorney General
> Paul Gaynor, Office of the Attorney General
> Maryjane Wurth, Illinois Hospital Association
> Howard Peters, Illinois Hospital Association
> Ann Guild, Illinois Hospital Association
>
> <IHA Letter to HFSRB June 20 2011.pdf>

This transmission may contain information that is privileged, confidential, or exempt from disclosure under applicable law. If you are not the intended recipient, consider yourself notified that any disclosure, copying, distribution, use, or reliance on this transmission is STRICTLY PROHIBITED. Please destroy this transmission in any format and notify the sender, if you received this transmission in error. Thank you.

Exhibit H

RESEARCH PAPER

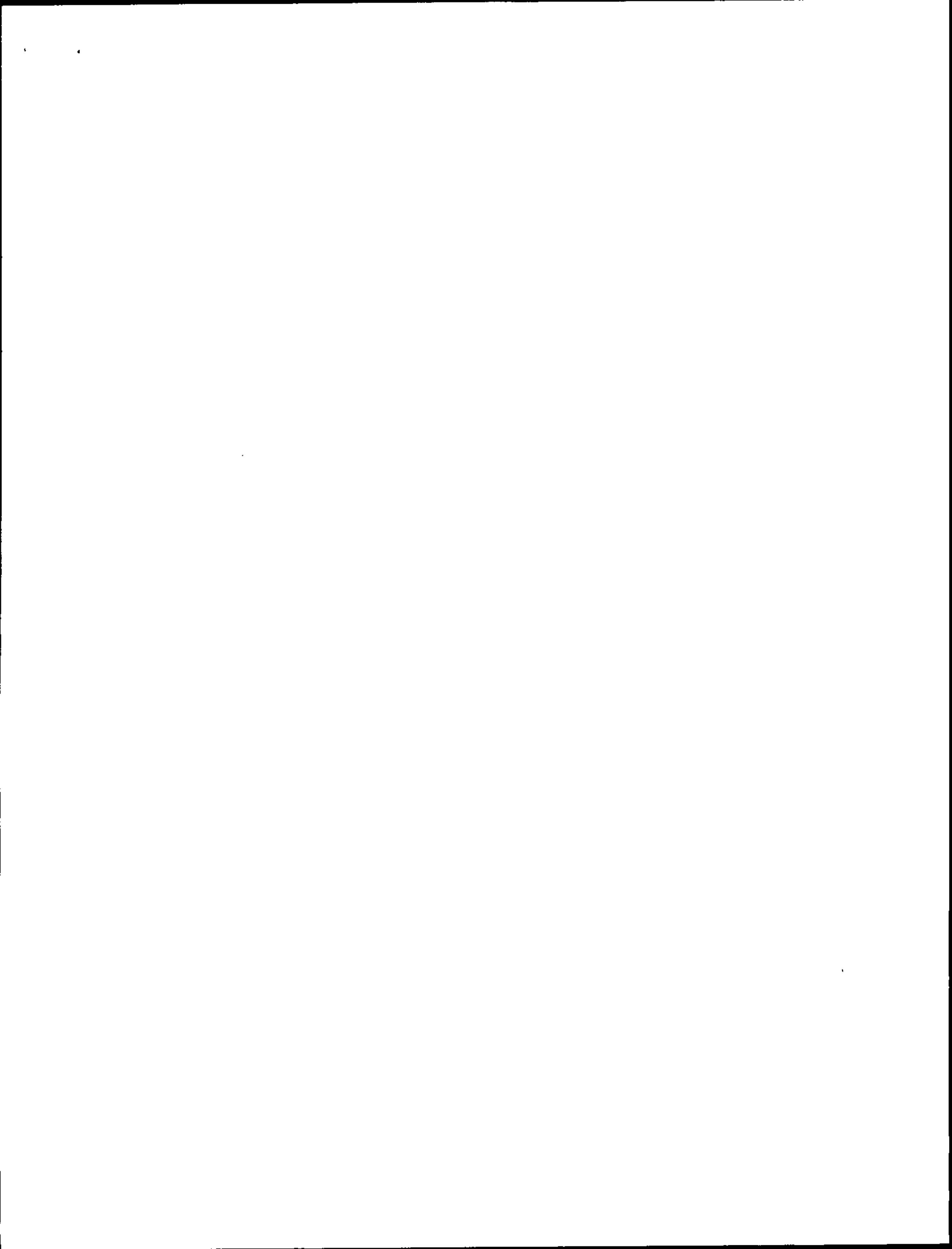
COMPARISON OF ... APPLICANTS AND ... PEER HOSPITALS ON ... BALANCED SCORECARD

DAVID A. FOSTER, PHD, MPH
CENTER FOR HEALTHCARE ANALYTICS

JEAN CHENOWETH, SENIOR VICE PRESIDENT
CENTER FOR HEALTHCARE IMPROVEMENT AND
100 TOP HOSPITALS℠ PROGRAMS

OCTOBER 2011

THOMSON REUTERS



EXECUTIVE SUMMARY

The Malcolm T. Baldrige National Quality Award process has long been recognized as an extraordinary means for for-profit, not-for-profit, and healthcare organizations to improve organizational performance and competitiveness globally. Historically, it has not been possible to establish a causal relationship between use of the Baldrige process and the success of healthcare organizations because of the many factors that contribute to organizational performance.

The Baldrige Board of Governors identified the *Thomson Reuters 100 Top Hospitals*® national study as a statistical approach for assessing similar aspects of organizational improvement and performance in hospitals and health systems. This research investigates the relationship between healthcare organizations that have achieved recognition through the Malcolm Baldrige National Quality Award process[1] and highest performance (top 3 percent of all hospitals) on the *100 Top Hospitals* National Balanced Scorecard.

The results of this study demonstrate a number of strong associations between the performance of Baldrige hospitals (award winners and applicants receiving site visits) and *100 Top Hospitals* award winners. The analyses show:

- There is substantial agreement between the results of the Baldrige process and the data-based *100 Top Hospitals* award: Hospitals that have been Baldrige award recipients are significantly more likely than their peers to win a *100 Top Hospitals* national award.
- Baldrige hospitals were significantly more likely than their peers to display faster five-year performance improvement.
- Baldrige hospitals, as a group, were about 83 percent more likely than non-Baldrige hospitals to be awarded a *100 Top Hospitals* national award for excellence in balanced organization-wide performance.
- Baldrige hospitals outperformed non-Baldrige hospitals on nearly all of the individual measures of performance used in the *100 Top Hospitals* composite score.

The results demonstrate that hospitals using the Baldrige process exhibit significantly higher rates of improvement in balanced organizational performance than non-Baldrige hospitals. And hospitals using the Baldrige process are significantly more likely than peers to become *100 Top Hospitals* award winners, thereby achieving performance equal to or better than the top 3 percent. Although the Baldrige process and the *100 Top Hospitals* statistical measurements are quite different, the results of this study suggest that the methods are complementary and identify similarly high-achieving organizations.

INTRODUCTION

The Baldrige Program was established by the United States Congress in 1987 for the purpose of improving the competitiveness and performance of U.S. organizations. In 2001, the Award, originally open only to for-profit businesses, was expanded to include organizations in the education and healthcare sectors.

Assessing the impact the program has on the performance of the not-for-profit and government organizations is challenging because of the absence of normative data and comparisons. The Baldrige program recognizes that many factors contribute to the performance of complex organizations and that demonstrating causal relationships between the use of the Baldrige approach and any particular organization's success, or lack thereof, would be difficult. More recently, efforts to demonstrate such impact have turned to assessing whether organizations that have demonstrated a certain level of maturity in their use of the Baldrige approach outperform their industry as a whole on key metrics, when such metrics are available.

The healthcare sector is of particular interest to Baldrige program stakeholders. Since 2005, healthcare organizations have represented more than 50 percent of the applicants for the Baldrige Award as healthcare spending approaches 20 percent of the nation's gross domestic product. In viewing organizational performance, the Baldrige criteria take a balanced approach requiring the evaluation of results across five categories: product and process (healthcare) outcomes, customer-focused outcomes, workforce-focused outcomes, leadership and governance outcomes, and financial and market outcomes. To assess the success of the program in the healthcare sector, the program made an effort to identify a data set that would closely match this view.

The *100 Top Hospitals* program was selected because it uses independent public data to measure the overall organizational performance of hospitals and health systems to identify those organizations that set the national benchmarks for delivering balanced excellence (quality, efficiency, financial stability, and patient satisfaction) and high value to the communities served. The program is based on a national balanced scorecard[2] and reflects the impact of leadership on achievement of organizational mission and goals.

To continue the Baldrige commitment to protecting the privacy of individual applications, and to focus on effective users of the Baldrige approach, it was decided to study all hospitals identified by the Baldrige Panel of Judges as potential role model organizations. This included all Baldrige Award winners and all organizations that received site visits in the past five years. The applications of award recipients are in the public domain. Permission to review the applications was received from those reaching the site visit stage, from 2002-2010, without public identification. This group was then compared to the *100 Top Hospitals* data sets in an attempt to assess the value created by organizations employing the Baldrige approach.

The *100 Top Hospitals* study is annual, quantitative research that identifies the hospitals with the best facility-wide performance.[3] For 18 years, the *100 Top Hospitals* research has helped hospital leaders gain an objective comparison of their performance to similar hospitals and develop a balanced plan to reach for excellence. At the heart of this research is the *100 Top Hospitals* National Balanced Scorecard, a set of actionable measures that evaluates performance excellence in clinical care, patient perception of care, operational efficiency, and financial stability.

The *100 Top Hospitals* study was selected as a basis for comparison because the study's measurement areas match well with the Baldrige performance categories. This table shows how the two organizations' performance metrics align:

BALDRIGE OUTCOMES	100 TOP HOSPITALS PERFORMANCE CATEGORIES
Leadership and governance	Composite score
Product and process	Patient outcomes: mortality, complications, patient safety, core measures
Customer focus	HCAHPS score
Financial and market	Profitability, expenses, length of stay

Both methods show a correlation between strong governance and high performance on a balanced scorecard, a concept that is backed up by research, including that of Dr. Lawrence Prybil.[4]

Baldrige provided a list of 38 hospitals to be included in this study. This list includes nine Baldrige award applicants with site visits since 2007 (site-visit hospitals that gave permission for release of identities) and 29 hospitals that won a Baldrige award between 2002–2010. This group of 38 is referred to collectively as "Baldrige hospitals" throughout this document. Those who won a Baldrige award are called "Baldrige winners." All other hospitals in the study are assumed to have no Baldrige activity (neither a site visit nor an award) and are referred to as non-Baldrige hospitals, or peers.

Baldrige winners are selected by evaluating results across five categories: product and process (health care) outcomes, customer-focused outcomes, workforce-focused outcomes, leadership and governance outcomes, and financial and market outcomes. They are also evaluated against six process categories.

We used *100 Top Hospitals* databases to identify hospitals that have received a *100 Top Hospitals* award for current organization-wide performance (*100 Top Hospitals* national award winners) or the highest five-year rate of performance improvement (*100 Top Hospitals*: Performance Improvement Leaders[5] award).

Thomson Reuters identifies *100 Top Hospitals* award winners using public data and a balanced scorecard with a focus on four domains — quality, efficiency, finance, and consumer assessment of care. The study accounts for differences in size and teaching status and uses only publicly available data. We compared Baldrige hospitals to hospitals included in *100 Top Hospitals* studies with data from years 2002–2009. The *100 Top Hospitals* studies generally include approximately 3,000 hospitals. Among these in-study hospitals, there were a mixture of Baldrige and non-Baldrige hospitals. See the appendix for more information about the *100 Top Hospitals* study methodology.

Analysis

To determine associations between the Baldrige and *100 Top Hospitals* designations of hospital performance and improvement, we:

- Measured the association between Baldrige hospitals and the overall, organization-level score (composite) on the *100 Top Hospitals* performance metric, for data years 2002–2009.
- Measured the association between Baldrige hospitals and individual metrics comprising the *100 Top Hospitals* composite performance measures, for data years 2005–2009:
  - Risk-adjusted mortality index (in-hospital)
  - Risk-adjusted complications index
  - Risk-adjusted patient safety index
  - Core measures mean percent
  - Severity-adjusted average length of stay
  - Case mix- and wage-adjusted inpatient expense per discharge
  - Adjusted operating profit margin
- Assessed whether Baldrige award winners are more or less likely to demonstrate faster rates of improvement than peers on the *100 Top Hospitals* organization-level composite score and/or the individual performance measures listed above.
- Evaluated whether Baldrige award winners are more or less likely to be *100 Top Hospitals* winners than non-Baldrige award winners, for data years 2002–2009.

In the initial analyses, we used descriptive statistics to characterize counts, proportions, and averages. The comparative analyses required adjustment for the *100 Top Hospitals* comparison group (small, medium, and large community; teaching, and major teaching hospitals — see appendix for details) because all *100 Top Hospitals* rankings and identification of winners are comparison-group specific.

We used regression models in the analytical comparisons to evaluate the likelihood that Baldrige hospitals would also be hospitals that received recognition as a national *100 Top Hospitals* award winner or as having significant five-year improvement rates.

Though this study aims to uncover associations between the Baldrige and *100 Top Hospitals* designations of hospital performance and improvement, it is not possible to identify causal relationships. In particular, the timing of any associations between Baldrige hospitals and *100 Top Hospitals* performance is uncertain. To evaluate this issue, we established lag periods in either direction to characterize the strength of any discovered associations in terms of temporal relationships between Baldrige and *100 Top Hospitals* awards.

The unit of analysis for this investigation was the hospital year. These analyses treated each hospital with one year of data as a unit of analysis. When that hospital had a new year of data, it would then represent a new unit of analysis. Note that in any given year of *100 Top Hospitals* data, the number of Baldrige hospitals that match with the *100 Top Hospitals* in-study hospitals may vary due to standard exclusions that are implemented when producing the *100 Top Hospitals* study databases.

We compared the evaluation between Baldrige activity and *100 Top Hospitals* performance across 13 time lags, which are defined as the number of years between the Baldrige activity for any given hospital and that hospital's performance on *100 Top Hospitals*. The 13 lag periods range from -6 years, in which the *100 Top Hospitals* evaluations occurred six years before the Baldrige activity, to +6 years, in which the *100 Top Hospitals* award would or would not have been received six years after the Baldrige activity.

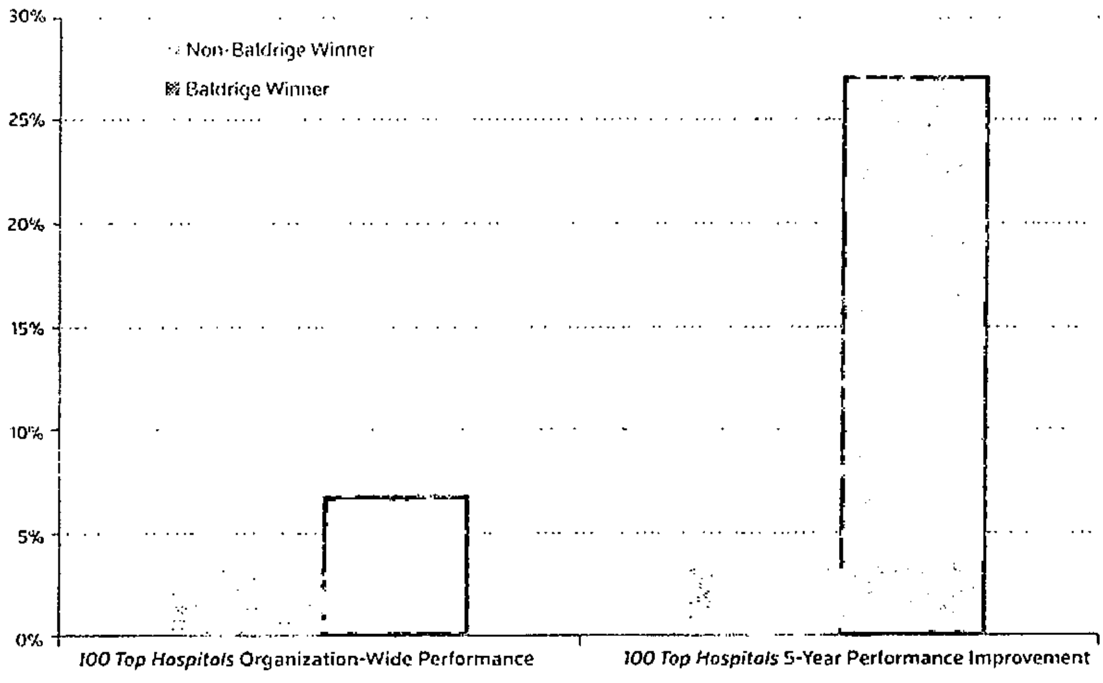
In general, we made the comparisons between Baldrige and *100 Top Hospitals* by matching the Baldrige winners and site-visit hospitals, or, for some analyses, just Baldrige winners, with all in-study hospitals included in a given *100 Top Hospitals* study. This allowed us to evaluate the proportion of hospitals, either Baldrige or non-Baldrige, that were awarded *100 Top Hospitals* status. To adjust for hospital comparison group, these comparisons were implemented through the application of either linear or logistic regression models in which a hospital comparison group was entered as a categorical adjustment variable. The analysis of lag-periods was, as were other analyses, adjusted for a hospital comparison group, but additionally included adjustment for year of data.

RESULTS

Baldrige Award Recipients More Likely to be *100 Top Hospitals* Award Winners

When evaluating what proportion of Baldrige winners (excluding site-visit hospitals as defined above) won a *100 Top Hospitals* award with data from 2002–2009, we found the following (Figure 1):

- Baldrige hospitals were more than twice as likely as their peers to win a *100 Top Hospitals* national award. A full 7 percent of Baldrige winner hospitals also won a *100 Top Hospitals* award, while only about 3 percent of their non-Baldrige peers won.
- Baldrige hospitals were more likely than their peers to display top five-year performance improvement. More than 27 percent of Baldrige winner hospitals also won a *100 Top Hospitals*: Performance Improvement Leaders (PIL) award, while only 3 percent of their non-Baldrige peers won the award. This association was not seen in previous years of the PIL study. This result was based on the most recent *100 Top Hospitals* longitudinal study of performance improvement, which used data years 2005–2009. Earlier *100 Top Hospitals* longitudinal, or performance improvement, studies did not show a statistically significant difference between Baldrige winners and non-Baldrige winner hospitals.
- These differences are statistically (and substantively) significant.
- These statistics were developed using the regression model to adjust for hospital size and teaching status (*100 Top Hospitals* comparison groups — see appendix for details).



*Organization-wide performance includes data years 2002–2009. Five-year improvement includes data years 2005–2009.

Associations Between Baldrige and *100 Top Hospitals* Awards: Detailed Results

We performed a lag-time analysis to evaluate whether there was a temporal relationship between achievement in Baldrige and the *100 Top Hospitals* study. In other words, we wanted to find whether the data suggested that winning Baldrige most often preceded winning *100 Top Hospitals* status, if there was no apparent temporal relationship between Baldrige and *100 Top Hospitals* success, or if it most often happened that winning *100 Top Hospitals* status preceded winning the Baldrige award. To do this, we compared the proportion of hospitals that did receive a *100 Top Hospitals* award among the Baldrige hospitals (winners and site visit hospitals) within given lag periods.

Over the 13 lag periods, Baldrige hospitals showed an overall proportion of winners of *100 Top Hospitals* awards of 6.14 percent, whereas the non-Baldrige hospitals were *100 Top Hospitals* winners at a rate of 3.35 percent. Therefore, the Baldrige hospitals, as a group, were about 83 percent more likely than non-Baldrige activity hospitals to be awarded the *100 Top Hospitals* national (organization-wide performance) award.

In 10 of the 13 lag periods examined, the Baldrige activity hospitals showed a higher proportion of *100 Top Hospitals* winners than did the non-Baldrige hospitals. Only the +3 year lag was statistically significant ($p = 0.007$, odds ratio 5.999, 95 percent confidence interval 1.627–22.120), showing that Baldrige activity hospitals were about six times as likely as non-Baldrige activity hospitals to be *100 Top Hospitals* winners. The overall pattern is clear — the Baldrige activity hospitals had consistently higher rates of success in the *100 Top Hospitals* national study. These findings are shown in Figure 2 and Table 1 (see next page).

FIGURE 2: PERCENT OF HOSPITALS IDENTIFIED AS *100 TOP HOSPITALS* WINNERS, BY TIME LAG

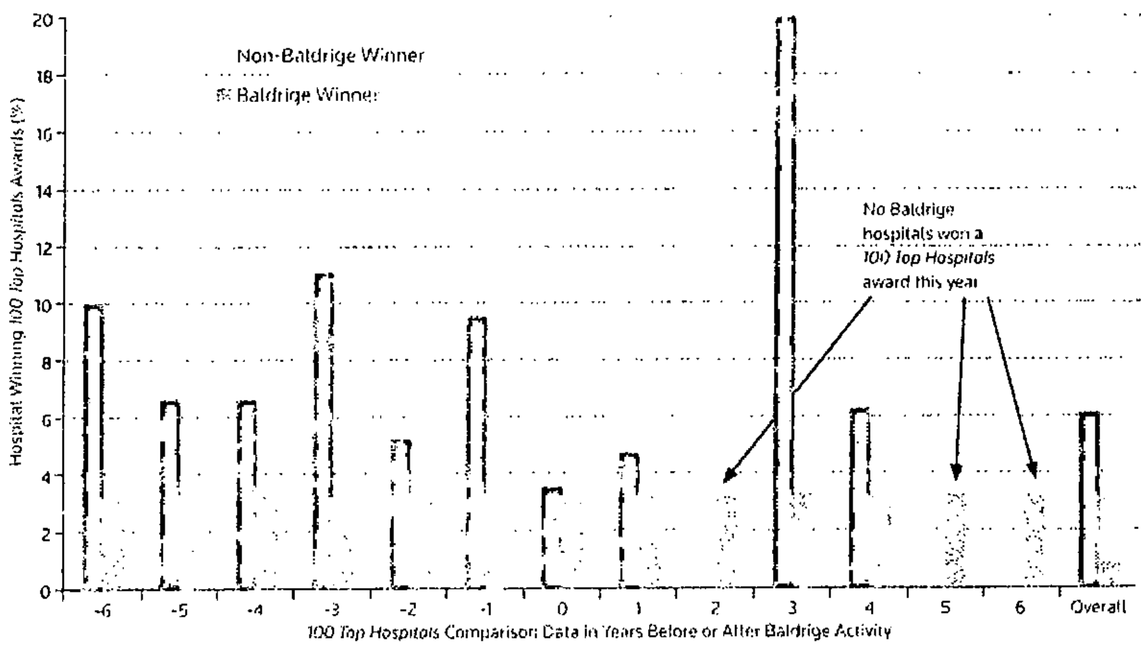


TABLE 1: STATISTICS FOR BALDRIGE AND NON-BALDRIGE HOSPITALS IDENTIFIED AS *100 TOP HOSPITALS* WINNERS

LAG (YEARS BEFORE OR AFTER BALDRIGE ACTIVITY)	BALDRIGE HOSPITALS INCLUDED IN *100 TOP HOSPITALS* STUDY DATABASE	NUMBER OF BALDRIGE HOSPITALS THAT WERE *100 TOP HOSPITALS* WINNERS	*100 TOP HOSPITALS* NATIONAL AWARD WINNERS (%): BALDRIGE HOSPITALS	*100 TOP HOSPITALS* NATIONAL AWARD WINNERS (%): NON-BALDRIGE HOSPITALS	DIFFERENCE BETWEEN BALDRIGE AND NON-BALDRIGE HOSPITALS (%)	P-VALUE
-6	10	1	10.00	3.35	2.412	0.410
-5	15	1	6.67	3.35	1.621	0.644
-4	15	1	6.67	3.35	1.493	0.702
-3	18	2	11.11	3.34	2.560	0.216
-2	19	1	5.26	3.35	1.152	0.891
-1	21	2	9.52	3.34	2.241	0.284
0	28	1	3.57	3.35	0.873	0.895
1	21	1	4.76	3.35	1.225	0.844
2	21	0	0.00	3.35	N/A*	0.967
3	15	3	20.00	3.34	5.999	0.007
4	16	1	6.25	3.35	1.355	0.771
5	15	0	0.00	3.35	N/A*	0.958
6	14	0	0.00	3.35	N/A*	0.960
Overall	228	14	6.14	3.35	--	--

*No Baldrige hospitals won a *100 Top Hospitals* national award this year.

The next phase of the analysis focused on measure-specific results. We made these comparisons at lag year +3 because the analysis of lag times indicated that this time difference showed the largest difference between Baldrige and non-Baldrige hospitals in terms of winning the *100 Top Hospitals* award.

To compare the two groups, we placed hospitals in percentiles of performance, then averaged the percentile for each group. With the exception of expense per adjusted discharge, the Baldrige hospitals outperformed non-Baldrige hospitals on all of the *100 Top Hospitals* measures used in these study years, although only the Core Measures results were statistically significant. We analyzed both adjusted and non-adjusted data (adjusted for hospital comparison group). Table 2 shows the results.

[illegible]

100 TOP HOSPITALS PERFORMANCE MEASURE	[illegible]		P-VALUE	BALDRIGE VERSUS NON-BALDRIGE	
	BALDRIGE	NON-BALDRIGE		DIFFERENCE	BALDRIGE HOSPITALS PERFORMED ...
Risk-Adjusted Mortality Index	56.820	50.010	0.311	7.57%	Better
Risk-Adjusted Complications Index	51.540	50.020	0.861	1.30%	Better
Patient Safety Index	58.230	50.010	0.274	8.17%	Better
Core Measures Score*	88.810	86.320	0.016	4.90 percentage points	Better
Severity-Adjusted Average Length of Stay†	59.280	50.010	0.109	11.69%	Better
Case Mix- and Wage-Adjusted Inpatient Expense*	$6,015	$5,920	0.530	$346	Worse
Adjusted Operating Profit Margin*	4.787%	3.186%	0.798	2.03 percentage points	Better

* Original units reported in CMS data (i.e., not percentile data) because these measures are not normalized by hospital comparison group (bed size and teaching status)
† For this measure, lower is better
§ Adjusted for hospital comparison group.

LIMITATIONS

Thomson Reuters relies on the accuracy of Medicare administrative claims data and does not attempt to infer or correct values found therein. Hospitals missing data required to calculate *100 Top Hospitals* performance measures are excluded from the study, as are:

- Specialty hospitals
- Federally owned hospitals
- Non-U.S. hospitals
- Hospitals with fewer than 25 acute-care beds
- Hospitals with fewer than 100 Medicare patient discharges in the year of study
- Hospitals with Medicare average lengths of stay longer than 25 days in the year of study
- Hospitals with no reported Medicare patient deaths in the year of study
- Hospitals for which a current Medicare Cost Report was not available
- Hospitals with a current Medicare Cost Report not based on a 12-month reporting period

The statistical analyses used here do not take into account the "nesting" or lack of independence within results for a given hospital involving multiple ascertainment of the same hospital over time. In other words, when a hospital contributes multiple hospital years of information based on multiple years of the study — while each of those years is in fact representative of a different sample of patients — technically, the hospital results for multiple years of ascertainment would be more highly correlated across those multiple years than they would be for the results across multiple hospitals. Even so, this limitation would

tend to impact estimates of the variance rather than estimates of the differences in performance between Baldrige and non-Baldrige hospitals.

It should also be noted that in the *100 Top Hospitals* database, hospitals that file cost reports jointly with other hospitals under one provider number are analyzed as one organization. Baldrige applicants, on the other hand, can define the number of hospitals included in their application. For this research, we used the application definition.

Another limitation of this investigation is that administrative data are being used. While it is very common practice in the industry to use administrative data, it is acknowledged that such data does not contain the kind of clinically detailed information that would be ideal for risk adjustment. Therefore, any reports of associations here are not meant to imply a causal connection. In other words, we can study correlations or associations here, but cannot make conclusions related to actual cause-and-effect type of relationships.

CONCLUSIONS

Despite difficulties related to sparse data spread over many years, the results of this investigation clearly show that Baldrige hospitals (those that won the Baldrige Award or had site visits related to the award), performed better than similar hospitals (by bed size and teaching status) that were not Baldrige hospitals. Specifically, when we examined the three-year lag between the Baldrige activity and subsequently winning the *100 Top Hospitals* national award, we found the Baldrige-activity hospitals to be almost six times as likely to become *100 Top Hospitals* winners as non-Baldrige hospitals. The difference was statistically significant.

In examining the measure-specific differences between Baldrige and non-Baldrige hospitals, it is noteworthy that every measure used in the *100 Top Hospitals* study except — expense per adjusted discharge — showed better performance by the Baldrige hospitals than for the non-Baldrige hospitals, although only Core Measures showed a statistically significant difference. In other words, while only one measure difference was statistically significant, almost all measures showed the same pattern of better performance by the Baldrige activity hospitals.

Finally, in examining the longitudinal performance using the *100 Top Hospitals* Performance Improvement Leadership study for data years 2005–2009, we again see a statistically significantly higher rate of *100 Top Hospitals* awards for improvement over time among the Baldrige activity hospitals compared with non-Baldrige hospitals.

Despite severe limitations in sample size, the results of this investigation clearly reveal that hospitals with Baldrige activity outperform similar hospitals without Baldrige activity.

The *100 Top Hospitals* is a quantitative study that identifies 100 hospitals with the highest achievement on a balanced scorecard based on Norton and Kaplan's[5] concept with a focus on four domains — quality, efficiency, finance, and consumer assessment of care. The study accounts for differences in size and teaching status and uses only publicly available data. The *100 Top Hospitals* studies provide numerous examples of performance excellence, as evidenced in a number of published studies.[6-8] The four main steps we take in selecting the *100 Top Hospitals* are:

1. Building the database of hospitals, including special selection and exclusion criteria. The study focuses on short-term, acute-care, non-federal U.S. hospitals that treat a broad spectrum of patients. The data come from public sources including the Medicare Provider Analysis and Review (MedPAR) dataset, the Centers for Medicare and Medicaid Services (CMS) Hospital Compare dataset, and the Medicare Cost Report. The 2011 study included 2,914 hospitals.

2. Classifying hospitals into comparison groups according to bed size and teaching status. (The number of hospitals included in the 2011 study is in parentheses):

   - Major teaching hospitals (175)
   - Teaching hospitals (435)
   - Large community hospitals (338)
   - Medium community hospitals (1,042)
   - Small community hospitals (924)

3. Scoring hospitals on 10 performance measures:

   - Risk-adjusted mortality index (in-hospital)
   - Risk-adjusted complications index
   - Risk-adjusted patient safety index
   - Core measures mean percent
   - 30-day, risk-adjusted mortality rate for acute myocardial infarction (AMI), heart failure, and pneumonia*
   - 30-day, risk-adjusted readmission rate for AMI, heart failure, and pneumonia*
   - Severity-adjusted average length of stay
   - Case mix- and wage-adjusted inpatient expense per discharge
   - Profitability (adjusted operating profit margin)
   - Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) score (patient rating of overall hospital performance)*

*Not included in the Baldrige/*100 Top Hospitals* analysis because results were not available for all data years.

4. Determining the *100 Top Hospitals* award winners by ranking hospitals relative to their comparison group. Within the five hospital comparison groups, we ranked hospitals on the basis of their performance on each of the 10 measures relative to other hospitals in their group. We then summed each hospital's performance-measure rankings and re-ranked, overall, to arrive at a final rank for the hospital. The hospitals with the best final rank in each comparison group were selected as the winners. All measures except the 30-day mortality rate and 30-day readmission rate received a weight of one in the final ranking process. For the 30-day mortality and readmission rate measures, we give the rates for each of the conditions (AMI, heart failure, and pneumonia) a weight of 1/6 in the final *100 Top Hospitals* ranking process for winner selection.

For a detailed methodology of the *100 Top Hospitals* study, you may download the study abstract at *www.100tophospitals.com/top-national-hospitals/.*

1. NIST. Baldrige Performance Excellence Program. Baldrige by Sector: Healthcare. *http://www.nist.gov/baldrige/enter/health_care.cfm*.
2. Kaplan RS, Norton DP. The Balanced Scorecard: Measures that Drive Performance. Harvard Bus Rev, Jan–Feb 1992.
3. Thomson Reuters. *100 Top Hospitals*: Study Overview and Research Findings, 18th Edition. Ann Arbor, MI: March 2011. Available for download at *www.100tophospitals.com/top-national-hospitals*.
4. Prybil L, Levey S, Peterson R, Heinrich D, Brezinski P, Zamba G, Amendola A, Price J, Roach W. Governance in High-Performing Community Health Systems. A Report on Trustee and CEO Views. Chicago, IL: Grant Thornton, LLC. 2009.
5. Thomson Reuters. *100 Top Hospitals*: Performance Improvement Leaders, 5th edition study abstract. Ann Arbor, MI: August, 2008.
6. Griffith JR, Alexander JA, Foster DA. Is Anybody Managing the Store? National Trends in Hospital Performance. Healthc Manag. 2006 Nov-Dec; 51(6):392-405; discussion 405-6.
7. McDonagh KJ. Hospital Governing Boards: A Study of Their Effectiveness in Relation to Organizational Performance. Healthc Manag. 2006 Nov–Dec; 51(6).
8. Chenoweth J, Safavi K. Leadership Strategies for Reaching Top Performance Faster. J Healthc Tech. January 2007. HCT Project Volume 4.
9. Chenoweth J, Foster DA, Waibel BC. Best Practices in Board Oversight of Quality. The Governance Institute. June 2006.
10. Bass K, Foster DA, Chenoweth J. Study Results — Proving Measurable Leadership and Engagement Impact on Quality, CMS Invitational Conference on Leadership and Quality. Sept 28, 2006.
11. Health Research & Educational Trust and Prybil, L. Governance in High-Performing Organizations: A Comparative Study of Governing Boards in Not-For-Profit Hospitals. Chicago: HRET in Partnership with AHA. 2005.
12. Cejka Search and Solucient, LLC. 2005 Hospital CEO Leadership Survey.
13. Griffith JR, Alexander JA, Jelinek RC. Measuring Comparative Hospital Performance. Healthc Manag. 2002 Jan-Feb; 47(1).
14. Griffith JR, Knutzen SR, Alexander JA. Structural versus Outcomes Measures in Hospitals: A Comparison of Joint Commission and Medicare Outcomes Scores in Hospitals. Qual Manag Health Care. 2002; 10(2): 29-38.
15. Lee DW, Foster DA. The association between hospital outcomes and diagnostic imaging: early findings. J Am Coll Radiol. 2009 Nov; 6(11):780-5.
16. Bonis PA, Pickens GT, Rind DM, Foster DA. Association of a clinical knowledge support system with improved patient safety reduced complications and shorter length of stay among Medicare beneficiaries in acute care hospitals in the United States. Int J Med Inform. 2008 Nov;77(11):745-53. Epub 2008 Jun 19.
17. Kroch E, Vaughn T, Koepke M, Roman S, Foster DA, Sinha S, Levey S. Hospital Boards and Quality Dashboards. J Patient Safety. 2(1):10-19, March 2006.
18. Foster DA. Top Cardiovascular Care Means Greater Clinical and Financial Value. Ann Arbor, MI: Center for Healthcare Improvement, Thomson Reuters. November 2009.
19. Foster DA. HCAHPS 2008: Comparison Results for *100 Top Hospitals*® Winners versus Non-Winners. Ann Arbor, MI: Thomson Reuters Center for Healthcare Improvement. August 2008.
20. Foster DA. Risk-Adjusted Mortality Index Methodology. Ann Arbor, MI: Center for Healthcare Improvement, Thomson Reuters. July 2008.
21. Foster DA. Trends in Patient Safety Adverse Outcomes and *100 Top Hospitals* Performance, 2000–2005. Ann Arbor, MI: Center for Healthcare Improvement, Thomson Reuters. March 2008.
22. Shook J, Young J. Inpatient and Outpatient Growth by Service Line: 2006 Thomson Reuters *100 Top Hospitals*®: Performance Improvement Leaders versus Peer Hospitals. Ann Arbor, MI: Center for Healthcare Improvement, Thomson Reuters. August 2007.

ABOUT THOMSON REUTERS

Thomson Reuters is the world's leading source of intelligent information for businesses and professionals. We combine industry expertise with innovative technology to deliver critical information to leading decision makers in the financial, legal, tax and accounting, healthcare and science and media markets, powered by the world's most trusted news organization. With headquarters in New York and major operations in London and Eagan, Minnesota, Thomson Reuters employs 55,000 people and operates in over 100 countries.

Thomson Reuters
777 E. Eisenhower Parkway
Ann Arbor, MI 48108 USA
Phone +1 800 366 7526

thomsonreuters.com

©2011 Thomson Reuters.
All rights reserved.

H PRO MDS 1110 10427 MC

THOMSON REUTERS

Exhibit I

Ziegler

200 S. Wacker Dr.
Suite #2000
Chicago, IL 60606

Direct line: 312-596-1596

www.ziegler.com

RECEIVED

JUN 03 2011

HEALTH FACILITIES &
SERVICES REVIEW BOARD

June 1, 2010

Ms. Courtney Avery
Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson St., Second Floor
Springfield, IL 62761

Dear Ms. Avery:

Ziegler Capital Markets writes in support of the Certificate of Need Application filed on December 29, 2010 by Mercy Alliance, Inc. ("Mercy") for the construction of a new hospital facility and multi-specialty physician clinic to be located in Crystal Lake (Project No. 10-089) (the "Project"). We have reviewed the proposed Project as described in the CON application and amendments and assessed potential implications of the Project to Mercy's financial position and service area.

We support Mercy's CON primarily due to: strong historical financial operations which mitigate the risks inherent with the construction of a new hospital and increasing competition in the market which will positively affect healthcare consumers in the form of lower healthcare costs.

Mercy Alliance, Inc.

Mercy is an integrated healthcare delivery system which provides a comprehensive range of services to residents in southern Wisconsin, McHenry County, Illinois and communities in northern Illinois. Mercy operates three hospitals, including Mercy Harvard, a 25 bed critical access provider, located in Harvard, Illinois. In addition, Mercy operates a 45-bed skilled nursing facility and a specialty clinic at the Mercy Harvard campus. Mercy has invested over $20 million recently in Mercy Harvard for the renovation and remodeling of the facility including larger, state of the art surgical suites, expanded laboratory, restructuring the emergency department, an enlarged conference and community center, additional parking areas and working capital.

Mercy also utilizes extensive clinic operations to serve the needs of residents in each of its service areas. Currently, Mercy operates 38 community-based clinics ranging from single-physician practices to large, multi-specialty centers with outpatient surgery, urgent care services and diagnostics. Mercy currently operates 18 community-based clinics in northern Illinois.

A key factor that differentiates Mercy from other health systems is its physician partnership model. This model involves forming virtual partnerships with employed physicians. These partnerships allow Mercy to achieve full system integration, a key strategy linked to the mission, vision, values and Mercy's culture of excellence. Mercy employs approximately 320 physicians located in community-based clinic practices and in hospital-based practices. Of those physicians, approximately 230 physicians are located in community-based clinics.

Mercy has been a leading provider of healthcare services in its market and has been recognized nationally for its achievements in quality patient care and workplace environment. In 2007 Mercy received the Malcolm Baldrige National Quality Award from President George W. Bush, the nation's highest Presidential honor for quality and organizational excellence. In 2009 Mercy was ranked number 20 in the top 100 Integrated Healthcare Network by SDI and Modern Healthcare. From 2006-2009, Mercy was named to Working Mother magazine's 100 Best Companies for working mothers.

Financial Operations

Over the last five years Mercy has generated strong operating performance. Net patient revenues have grown 10.3% over the past five years, primarily due to new programs, increased utilization from existing services and clinical sites, good patient satisfaction scores and strong quality measures. In FY08 Mercy's operating profitability softened to $14 million or a 2.84% operating margin which is still consistent with Moody's 'A' category medians. In response, Mercy's management team implemented several performance improvement initiatives including aggressive expense management, elimination of underperforming programs and alignment of FTE's to operations. In FY09 and FY10, operating performance strengthened despite continued economic weakness and Mercy's operating income grew to $17 million or 3.59% and $15 million or 3.16%, respectively. Operating cash flow has also been significant and consistent as the organization has produced operating cash flow aggregating to approximately $119 million since FY08. Mercy's metrics compare favorably to rating agency medians for "A" rated hospital credits as depicted in the chart below. Ziegler strongly believes that the ability to produce strong and consistent operating performance, as Mercy has clearly done over the last four fiscal years, is the single most important factor in determining if a large capital project such as a new hospital is affordable to an organization.

Mercy Alliance, Inc.

Key Financial Ratio Comparison vs S&P Medians

	Mercy Alliance, Inc.				Moody's Hospital Medians			
	2007	2008	2009	2010	A2	A3	Baa1	Baa2
Net Patient Revenue	$453,113	$488,712	$526,353	$465,689	$440,454	$354,489	$355,504	$255,208
Operating Margin	3.54%	2.84%	3.28%	3.16%	3.10%	2.60%	1.60%	1.50%
Excess Margin	6.77%	3.97%	0.70%	4.40%	5.10%	4.60%	3.80%	3.00%
Operating Cash Flow Margin	8.62%	7.65%	8.01%	8.54%	9.70%	9.90%	8.10%	8.40%

Mercy has a modest but improving balance sheet. Unrestricted cash has increased to $158.5 million at FYE 10 from $135.5 million at FYE 08. This resulted in increasing days cash on hand by nearly 26 days to 133.7 days in FY10. Mercy's current total debt is approximately $181 million. Debt to capitalization is moderate at 44.6% while debt to cash flow is manageable at 4.33 times. Capital spending has been significant reflecting continued expansion of the organization's outpatient service platform and enhancements to inpatient facilities. Mercy has invested $139 million over the last five years in its physical plants. This substantial capital investment was funded from operating cash flow along with prudent use of leverage. This investment has achieved its intended effect: increased utilization of services offered by Mercy in addition to providing healthcare access to patients through its comprehensive physician partnership model.

New hospital projects carry substantial short-term and long-term risks which can materially affect the outcome of a project and are more appropriate for providers with stronger profitability and liquidity. These risks include: managing construction costs and timetable, meeting revenue and expense assumptions, efficiently transitioning patients to the new facility, and operating a new facility under an entirely different cost structure. On a historical pro forma basis, the inclusion of additional interest and depreciation expense would still result in Mercy being

able to achieve better than breakeven operating performance. Pro forma operating income would be $1.3 million generating an operating margin of 0.27%, while EBIDA would be attractive at 9.71%. While we recognize that the increase in indebtedness will put near term rating pressure on Mercy due primarily to weakened balance sheet metrics, the strength of operations will afford Mercy the ability to present a cohesive credit story to the capital markets without a first step of improving its operations, which the organization has clearly demonstrated an ability to do after FY 2008. Further, as investors and agencies put more weighting on revenue diversity, risk dispersion, and scale, the Project creates the opportunity to achieve a higher rating longer term.

Service Area Impact

Healthcare service in McHenry County, Illinois is dominated by one provider, Centegra Health System ("Centegra"). Centegra currently operates two facilities in the County which serves the vast majority of the County and surrounding communities in adjacent counties. Centegra has a dominant market position with nearly 50% market share in its primary service area. While higher acuity patients matriculate to other providers near the Chicago metro market, there is limited competition to Centegra for the services that the organization provides. Centegra has also submitted a Certificate of Need application, Project No. 10-090, for the construction of a third hospital in McHenry County, which will be located in Huntley. Their planned $233 million project, if approved, will further expand their market dominance and grant their organization significantly more leverage with commercial and managed care payers active in the market. Ziegler believes that Centegra, which would have a pro forma balance sheet more consistent with a non-investment grade provider, would need to significantly improve their much more modest operating performance (compared to Mercy) in order to offset the increased depreciation and interest expense and access the capital markets to fund the majority of the project as planned. This is problematic as Centegra's operating income has been declining since 2007. In their most recent fiscal year, Centegra produced operating income of $3.2 million or a margin of less than 1.0%. With the addition of the incremental interest and depreciation expense associated with a new hospital, Centegra's operating income on a pro forma basis would turn significantly negative and well below rating agency investment grade medians. In preparation to access the capital markets at a reasonable cost, Centegra will be pressured to leverage its dominant market position to significantly increase insured reimbursement rates, pushing consumer healthcare costs to McHenry county residents materially higher in order to increase its income from operations to an acceptable level.

Competition typically benefits the consumer and increases the economic benefit to the service area. Health care is no different. The greater choice consumers have of physicians and services will lead to higher quality and lower costs as providers actively compete for patients. McHenry County is currently underserved in physicians and number of hospital beds. Allowing for the leading provider of healthcare services to gain even greater market share will not lead to increased quality at lower prices. Consumers of healthcare will not benefit if Centegra becomes larger. Mercy is a recognized leader in quality and is a proven financial operator in a very difficult environment characterized by continuing reimbursement challenges. Ziegler strongly believes the Project is affordable, consistent with Mercy's mission, vision, and values, and serves the best interests of the community.

Respectfully,

Ziegler Investment Banking
Healthcare Finance

Ziegler

EXHIBIT A

May 31, 2011

Financial Consultant Report Prepared For Mercy Alliance, Inc.

As it relates to the Certificate of Need Application filed by Centegra Health System (Project No. 10-090) on December 29, 2010

ZIEGLER HEALTHCARE FINANCE/INVESTMENT BANKING

I. Executive Summary

Ziegler Capital Markets has been engaged by Mercy Health Alliance (MHA) in connection with its appeal to the Certificate of Need (CON) application filed on December 29, 2010 by Centegra Hospital - Huntley and (the "Hospital") and Centegra Health System (CHS) for construction of a new hospital facility (Project No. 10-090) (the "Project"). Ziegler Capital Markets has reviewed the proposed Project as described in the CON application and assessed potential implications of the Project to CHS's financial position.

The key issues discussed in the following report and the main observations are as follows:

- **New hospital projects carry substantial short-term and long-term risks, which can materially affect the outcome of a project, and are more appropriate for providers with stronger profitability and liquidity than CHS.** Standard & Poor's (S&P) published a study on replacement hospitals titled: *U.S. Not-for-Profit Replacement Hospitals Offer Great Opportunity, But Risks Abound* discussing the risk associated with constructing a replacement hospital which is significantly similar to that of building a new hospital. In their study, the hospitals and health systems that undertook a replacement hospital project faced several key challenges associated with a constructing a new facility. The hospitals rated by S&P demonstrated strong financial performance prior to the replacement hospital project. At the time of financing, average operating margin for these hospitals was 6.9%, and the average days cash on hand was 260 days.

- **CHS will nearly double its long term debt burden likely resulting in a multi-notch downgrade of its S&P rating and a substantial increase in current and future capital costs.** The proposed $183M of new debt represents significant additional leverage for CHS. At the end of FY10, CHS's debt-to-capitalization ratio was 52%, above the A- median of 45%. Factoring in the proposed new debt, CHS will increase its leverage to a pro forma FYE 2010 debt-to-capitalization ratio of 68% which is more consistent with a non-investment grade rated provider. In fact, all but one of Centegra's seven key financial ratios on a pro forma basis will be below the respective investment grade medians.

- **Additional operating expense associated with the Project further pressures CHS's financial position.** The incremental interest and depreciation expense associated with the Project after its completion are estimated at $16.8M, assuming fixed rate debt issuance at current market rates with an overall level aggregate debt service. This amount represents approximately 4.2% of CHS's FY10 operating expense. CHS pro forma projected loss in profitability of $13.6M adversely impacts the organization's financial position and exacerbates concerns associated with a materially weaker pro forma balance sheet.

- **The physician strategy to support the project further pressures the organization's financial position.** CHS has embarked upon a strategy to increase the number of employed physicians through Centegra Primary Care, LLC (CPC) to create a larger presence in its market with particular focus in Huntley. This strategy has led to significant increase in loses at CPC which were $13.7M in FY10 and $14.8M in FY09 up from FY08 loss of $8.1M with moderate increase in utilization.

- **The approval of the CHS CON application will grant the organization a dominant market position and likely lead to higher costs for healthcare consumers.** Given a materially weaker pro forma balance sheet and a substantial increase in depreciation and interest expense associated with the Project, CHS will be pressured to leverage its dominant share and increase insured reimbursement rates pushing consumer healthcare costs materially higher.

- **Given a market characterized by higher interest rates, extremely wide credit spreads, and a dearth of viable credit enhancement, borrowing costs for CHS will increase significantly constraining the organization's ability to fund capital.** A rating downgrade and weakening balance sheet that is associated with the Project will impair CHS's ability to fund future capital improvements that are necessary to optimize the quality of care for healthcare consumers.

EXHIBIT B

EISENSTADT TESTIMONY
EXPECTED CENTEGRA PRICE DECLINE GIVEN
MERCY-CRYSTAL LAKE'S EXPECTED SHARE

GEOGRAPHIC AREA	EXPECTED CENTEGRA PRICE DECLINE
CENTEGRA-WOODSTOCK PSA	9 PERCENT
CENTEGRA-WOODSTOCK PSA+SSA	6 PERCENT
CENTEGRA-MCHENRY PSA	8 PERCENT
CENTEGRA-MCHENRY PSA+SSA	4 PERCENT

Exhibit J

Advertisement:

TRIB local Crystal Lake

Public hearing scheduled for modified Mercy hospital plan

By Lawerence Synett TribLocal reporter Aug. 29 at 11:24 a.m.

Village of Cary administrator Cameron Davis speaks during a March 18 public hearing in Crystal Lake. The public hearing was held for Mercy Health System, who wants to open a new hospital in Crystal Lake. A second public hearing for a modified Mercy plan is scheduled for Oct. 7. (Shaun Sartin/Chicago Tribune)

A modified plan for a new hospital in Crystal Lake that was shot down by a state regulatory panel in June will be subject to a public hearing.

The Illinois Health Facilities and Services Review Board has tentatively scheduled an Oct. 7 public hearing for Mercy Health System's proposed 70-bed hospital at the corner of Three Oaks Road and Route 31.

The open meeting came at the request of Centegra Health System, which is in the midst of its own appeal process for a new hospital at the corner of Haligus and Reed roads in Huntley.

Mercy officials believed the modified plan, which scales back the number of beds from 128 to

70, did not warrant a public hearing.

"Our interpretation of state guidelines were different than what review board staff determined," Mercy Vice President Rich Gruber said. "I think this is just another example of opponents using every tool they have at their disposal to ensure that the process is dragged out."

The modifications would cut the original $200 million cost of the project by $85 million and decrease the building size by 90,000 square feet. It would feature 46 medical/surgical, 20 obstetric and four intensive care unit beds.

The state board requires a minimum of 100 beds, but members have the ability to negotiate the number of beds based on the needs of the community, according to Courtney Avery, review board administrator.

"It's stronger than a guideline, but (board members) do have the authority to approve it," she said. "We don't see a lot of modifications like this, but in fairness, we don't get a lot of hospital applications like this."

Centegra officials requested the public hearing because the project is substantially different than the original.

"Whether Centegra or someone else called for this, the public has a right to know about this project," said Mike Eesley, chief executive officer at Centegra. "We don't want to ruin our public image, but if we don't look out for the betterment of the community, who will?"

The state board denied the separate applications from Centegra and Mercy amid concerns they would leave too many empty beds at existing medical facilities nearby. Opponents from nearby hospitals have argued either plan would saturate the area and dilute services available to patients.

"With this next public hearing, it will have the greatest public scrutiny of any project ever considered by the review board," Gruber said. "I welcome that scrutiny."

A state board approved Mercy's application for a 70-bed hospital at the same site in 2004. The successful bid was later nixed after board members became the target of a corruption probe. Mercy officials were never accused of any wrongdoings, and the board was later revamped.

The new proposal is too similar to the one marred in corruption more than seven years ago, said Susan Milford, Centegra senior vice president of strategic marketing.

"It's nearly identical," she said. "It isn't about serving the community, it's about improving their margin."

The smaller project would have less of an adverse impact on competitors, Gruber said.

"That is a positive," he said. "This is the right-size project for the population we want to serve."

There are no modifications to a $233 million Centegra proposal for a 128-bed hospital on the site of its current health and fitness centers.

The state board will discuss both appeals in November.

The time and location of the public hearing has yet to be determined.

www.twitter.com/lsynett