Constantino, Mike

From: Lawler, Daniel [daniel.lawler@klgates.com]
Sent: Wednesday, November 16, 2011 3:03 PM
To: Avery, Courtney; Constantino, Mike
Cc: Andrea R. Rozran [arozran@diversifiedhealth.net]; Streng Hadley (HStreng@centegra.com)
Subject: #10-089: Mercy Crystal Lake Hospital: Written Comment in Opposition
Attachments: Written Comment.pdf

Ms. Avery and Mr. Constantino,

Please include in the project file for #10-089, Mercy Crystal Lake Hospital and Medical Center, the attached written comment on behalf of my clients Centegra Health System, Centegra Hospital-McHenry and Centegra Hospital-Woodstock. Thank you

Dan Lawler

Daniel J. Lawler
K&L Gates LLP
70 W. Madison St., Ste. 3100
Chicago, IL 60602-4207
t. 312-807-4289
f. 312-827-8114
daniel.lawler@klgates.com
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K&L|GATES

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November 16, 2011

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

VIA EMAIL

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

Re: Project No. 10-089, Mercy Crystal Lake Hospital and Medical Center

Dear Ms. Avery:

I represent Centegra Health System, Centegra Hospital-McHenry, and Centegra Hospital-Woodstock and submit this written comment on their behalf in opposition to Project No. 10-089, Mercy Crystal Lake Hospital and Medical Center.

The modified application submitted by the Mercy applicants now makes this project virtually indistinguishable from the project proposed by the same Mercy applicants in their 2003 CON application: Project No. 03-049, Mercy Crystal Lake Hospital and Medical Center. The projects are so similar that Mercy has even taken the architectural drawings and floor plans from the 2003 project and included them in Attachment 8 of the modified application for the current project. In addition, the Mercy applicants make the identical arguments, including those relating to the claimed physician shortage and Mercy's challenge to the Review Board's minimum bed size requirement, as those that were advanced in support of the 2003 application.

Although the 2003 application was approved as a result of an admitted corrupt kickback scheme, the permit issued in that case was reversed by the Circuit Court of McHenry County on the grounds that the project did not substantially comply with the Board's criteria, and that the decision to approve the project was against the manifest weight of the evidence and was arbitrary and capricious. The Mercy applicants did not appeal the Circuit Court's judgment which was a final decision on the merits. I am including with this letter the permit application for Project No. 03-049 for submission into the project file for Project No. 10-089 to document the similarity and identity of the two projects.

As its predecessor, Mercy's modified application does not substantially comply with the Review Board's criteria, and the arguments asserted to avoid those criteria have been previously rejected by the state court. For these reasons, Project No. 10-089 should be denied.

Very truly yours,

K&L GATES LLP

Daniel J. Lawler

DJL:dp
Enclosure
cc: Mr. Michael Constantino, Supervisor, Project Review Section
Ms. Andrea Rozran, Diversified Health Resources
Ms. Hadley Streng, Centegra Health System

Copy

03-049

Illinois Health Facilities Planning Board

Application for Permit April 2000 Edition

Ray Passeri, Executive Secretary
Illinois Health Facilities Planning Board
525 W. Jefferson Street - Second Floor
Springfield, Illinois 62761

ILLINOIS HEALTH FACILITIES PLANNING BOARD

APPLICATION FOR PERMIT

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

This section must be completed for all projects.

A Facility/Project Identification

Facility Name: Mercy Crystal Lake Hospital and Medical Center
Location: East side State Rd. 31 between Three Oaks & Raymond Roads City: Crystal Lake
County: McHenry Zip: 60014 Illinois State Representative District: 64

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

Exact Legal Name: Mercy Crystal Lake Hospital and Medical Center, Inc.
Address: 2000 Lake Avenue, Woodstock IL 60098
Name of Registered Agent: Herbert Franks, Esq., Marengo, IL
Name of Chief Executive Officer: Javon R. Bea Title: President/CEO
CEO Address: Same as applicant Telephone No. (815) 337-5739

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

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

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

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

Name: Eli L. Beeding Jr Title: The Beeding Group
Address: 7488 County Road 3, Marble, CO 81623
Telephone No. 970-963-4877 E-mail Address:
Fax Number 970-704-0794

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

Name Richard H. Gruber Title: Vice President
Address: Same as B. above
Telephone No. (608) 756-6112 E-mail Address: rgruber@mhsjvl.org Fax Number (608) 756-6236

* See bottom of page 2

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

Name: Same as D. above Title ___Address
Telephone No. (____)_____E-mail Address _____
Fax Number (____)

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

Exact Legal Name of Person Who Owns Site: Mercy Health System Corporation
Address of Site Owner: 1000 Mineral Point Ave., Janesville, WI. 53547-5003
Street Address or Legal Description of Site: East side of State Route 31 between Three Oaks Road and Raymond Road

** See property legal description below.

G. Operating Entity/Licensee (complete this information for each applicable facility and insert after this page)

Exact Legal Name Same as B. Above
Address
Type of Ownership: X Non-profit Corporation For-profit Corporation Limited Liability Company Partnership Governmental Sole Proprietorship Other (specify)

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

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

** Property legal description:

The Subject Property is legally described as follows:

The North 1464.54 feet of the West 580.14 feet of the Southeast Quarter of Section 10 (exception therefrom that part taken for State Route 31 and Three Oaks Road), all in Township 43 North, Range 8 East of the Third Principal Meridian in McHenry County, Illinois.

The Parcel contains approximately 16.71 acres.

* Additional Contact Person

Dan Colby
CEO, Harvard Memorial Hospital
901 Grant Street
Harvard, IL 60033
(815)943-5431 - telephone number
(815)943-0659 - fax number
dcolby@mhsjvl.org - email address

H. Organizational Relationships

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

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

I. Status of Previous Certificate of Need Projects

Provide the project number for any of the applicant's projects that have received permits but are not yet complete (completion is defined in Part 1130.140). If all projects are complete, indicate NONE.

J. Flood Plain Requirements (refer to instructions for completion of this application)

Provide documentation regarding compliance with the Flood Plain requirements of Executive Order #4, 1979.

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

K. Historic Resources Preservation Act Requirements (refer to instructions for completion of this application)

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

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

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

1. Part 1110 Classification
(check one only)
X Substantive
Non-substantive

DHS or DVA Project

2. Part 1120 Applicability or Classification:

Part 1120 Not Applicable
Category A Project
X Category B Project

File Number 6295-370-5

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that MERCY CRYSTAL LAKE HOSPITAL AND MEDICAL CENTER, INC., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE JUNE 27, 2003, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS A DOMESTIC CORPORATION IN GOOD STANDING IN THE STATE OF ILLINOIS**********

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 1ST *day of* JULY *A.D.* 2003

Jesse White

SECRETARY OF STATE

C-260.2

ATTACHMENT IDEN _ 1

ILLINOIS
DEPARTMENT OF
NATURAL
RESOURCES

Illinois State Water Survey

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

SWS

Floodplain Information Repository
Special Flood Hazard Area Determination

Requester: Eli Beeding, Mercy Health System
Address: 1000 Mineral Point Ave., P.O. Box 5003
City, state, zip: Janesville, WI 53547-5003 Telephone: (608) 756-6014

Site for Determination:
Street address: Planned Unit Development at SE corner of IL 31 & Three Oaks Road
City, state, zip: Crystal Lake, IL
County: McHenry Sec¼: W 1/2 of SE 1/4 Section: 10 T. 43 N. R. 8 E. PM: 3rd
Site description: The North 1464.54 ft of the West 580.14 ft of the SE 1/4, T. 43 N., R. 8 E., 3rd P.M., McHenry County IL (excepting road ROW).

The property described above IS NOT located in a Special Flood Hazard Area (SFHA).
Floodway mapped: N/A Floodway on property: No
Sources used: FEMA Flood Insurance Rate Map (FIRM); annexation agreement describing property.
Community name: City of Crystal Lake, IL Community number: 170476
Panel/map number: 170732 0335 C Effective Date: January 21, 1998
Flood zone: X [unshaded] Base flood elevation, from FIRM (±0.5 ft): N/A NGVD 1929

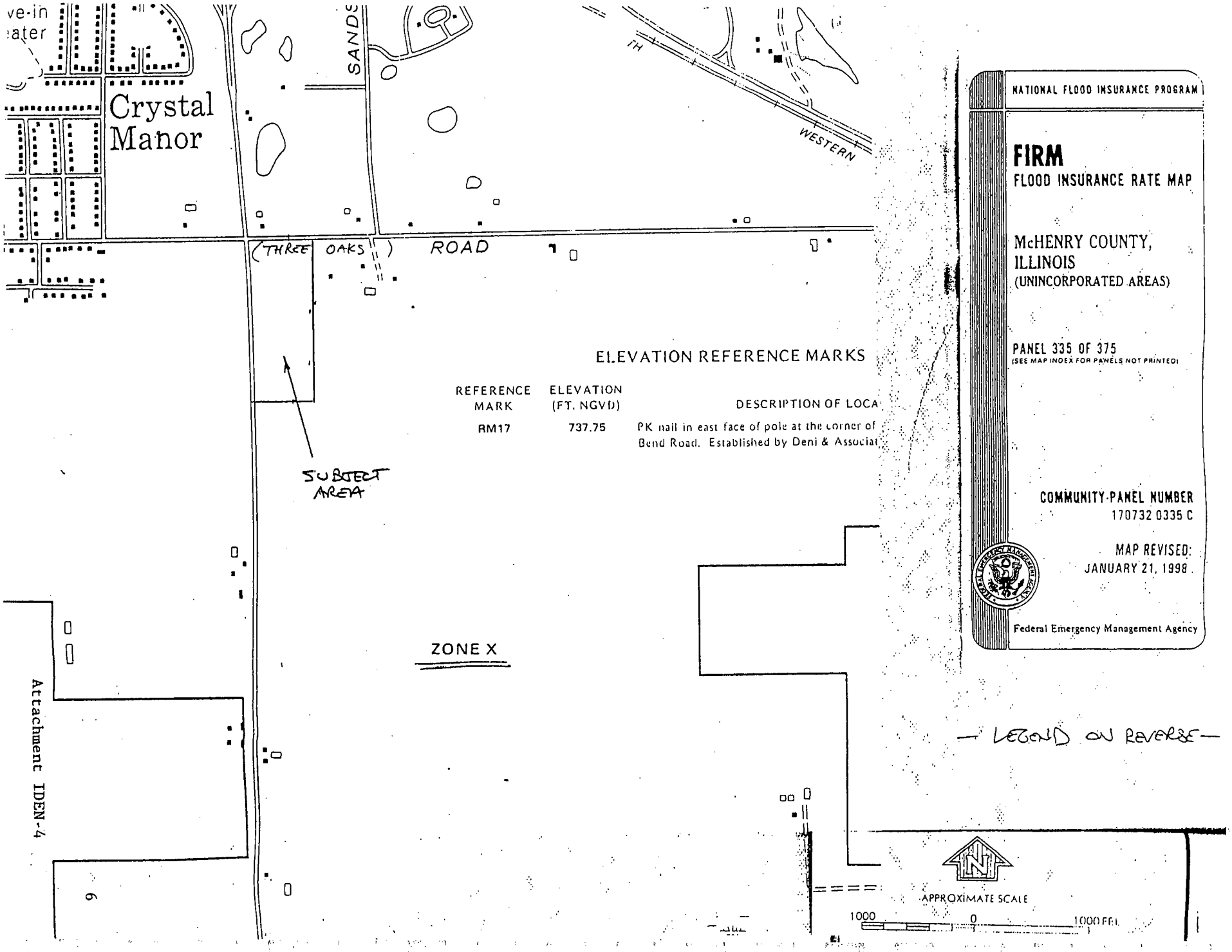
N/A a. The community does not currently participate in the National Flood Insurance Program; State and Federal grants as well as flood insurance may not be available.
N/A b. Panel not printed; no Special Flood Hazard Area on the panel.
N/A c. No maps printed; no Special Flood Hazard Area for the community.

The primary structure on the property:
N/A d. Is located in a Special Flood Hazard Area. Any activity must meet State and Federal floodplain development regulations. Federal law requires that a flood insurance policy be obtained as conditions of a federally-backed mortgage or loan that is secured by the building.
N/A e. Is located in Zone B (500-year floodplain). Flood insurance may be available at non-SFHA rates.
X f. Is not located in a Special Flood Hazard Area. Flood insurance may be available at non-floodplain rates.
N/A g. A determination of the building's exact location cannot be made on the current Federal Emergency Management Agency flood hazard map.
N/A h. Exact structure location not available or not provided for this determination.

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

Questions concerning this determination may be directed to Bill Saylor (217/333-0447) or Sally McConkey (217/333-5482) at the Illinois State Water Survey. Questions concerning requirements of Governor's Executive Order IV (1979), or State floodplain regulations, may be directed to John Lentz (847/608-3100) at the IDNR Office of Water Resources.

William Saylor, Illinois State Water Survey Title: Surface Water and Floodplain Information Date: 6/10/2003


ve-in
ater
Crystal
Manor
SANDS
TH
WESTERN
(THREE OAKS) ROAD
SUBJECT AREA
ELEVATION REFERENCE MARKS
REFERENCE MARK
ELEVATION (FT. NGVD)
DESCRIPTION OF LOCA
RM17
737.75
PK nail in east face of pole at the corner of
Bend Road. Established by Deni & Associat
ZONE X
NATIONAL FLOOD INSURANCE PROGRAM
FIRM
FLOOD INSURANCE RATE MAP
McHENRY COUNTY,
ILLINOIS
(UNINCORPORATED AREAS)
PANEL 335 OF 375
(SEE MAP INDEX FOR PANELS NOT PRINTED)
COMMUNITY-PANEL NUMBER
170732 0335 C
MAP REVISED:
JANUARY 21, 1998
Federal Emergency Management Agency
— LEGEND ON REVERSE —
APPROXIMATE SCALE
1000
0
1000 FEET
Attachment IDEN-4
6

JOY A. BEEDING, RN
ELI L. BEEDING, JR. **THE BEEDING GROUP**

Eric G. Hansen
Staff Archaeologist
Illinois Historic Preservation Agency
1 Old State Capitol Plaza
Springfield, Illinois 62701-1507

3 July 2003

Dear Mr. Hansen:

This is in reference to your letter dated 3 July, 2003 regarding IHPA LOG # 001061303.

There will be no federal or state funding involved.

We will, of course, be required to obtain several permits and licenses prior to actually building and opening our proposed hospital. However, at this time the only requirement is in regard to zoning. To that end the property has been zoned as per the attached Crystal Lake ordinance.

We are proposing to build a 70 bed hospital with a 40 physician clinic attached.

There are no standing structures within the proposed project area. Our 16 acres is vacant. The attached map shows our location.

If you have further questions, please call me.

Send your review finding to me at the address on this letterhead.

Sincerely,

/s/ Eli L. Beeding, Jr.

7488 COUNTY ROAD 3 • MARBLE, COLORADO 81623
PHONE (970) 963-4877 • FAX (970) 704-0794

Illinois Historic
Preservation Agency

Voice (217) 782-4836
1 Old State Capitol Plaza • Springfield, Illinois 62701-1507 • Teletypewriter Only (217) 524-7128

McHenry County
Crystal Lake
SEC Three Oaks Road and State Route 31
Unknown Undertaking

PLEASE REFER TO: IHPA LOG #001061303

July 3, 2003

Eli Beeding
Mercy Health System
1000 Mineral Point Avenue
P.O. Box 5003
Janesville, WI 53547-5003

Dear Mr. Beeding:

Thank you for requesting comments from our office concerning the possible effects of your project on cultural resources. Our staff has reviewed the specifications of the referenced project as submitted by your office. We cannot adequately review this proposed project until the following additional documentation has been submitted to our Agency:

1. The names of all federal and/or state permitting, funding, or licensing agencies.
2. A complete description of all elements of the proposed undertaking.
3. Current photographs, keyed to a map, of any standing structures within the project area, or a statement that there are none.

If you have any questions, please contact Ms. Frances R. Knight*, Staff Archaeologist at 217-782-9345.

Sincerely,

Anne E. Haaker

Anne E. Haaker
Deputy State Historic
Preservation Officer

AEH:FRK

*new reviewer - Eric G. Hansen, Staff Archaeologist at 217/785-4998

TOTAL P.02

IDN - 5

ORD. #5296
FILE #115

AN ORDINANCE ZONING CERTAIN PROPERTY "O-PUD" OFFICE PLANNED UNIT DEVELOPMENT DISTRICT

WHEREAS, certain territory is the subject of a certain Annexation Agreement; and

WHEREAS, said territory has been duly annexed by ordinance to the City of Crystal Lake; and

WHEREAS, by the terms of said Annexation Agreement, said territory is to be zoned "O-PUD" Office Planned Unit Development District; and

WHEREAS, it is in the best interests of the City of Crystal Lake that the property legally described hereinbelow be classified and zoned as indicated.

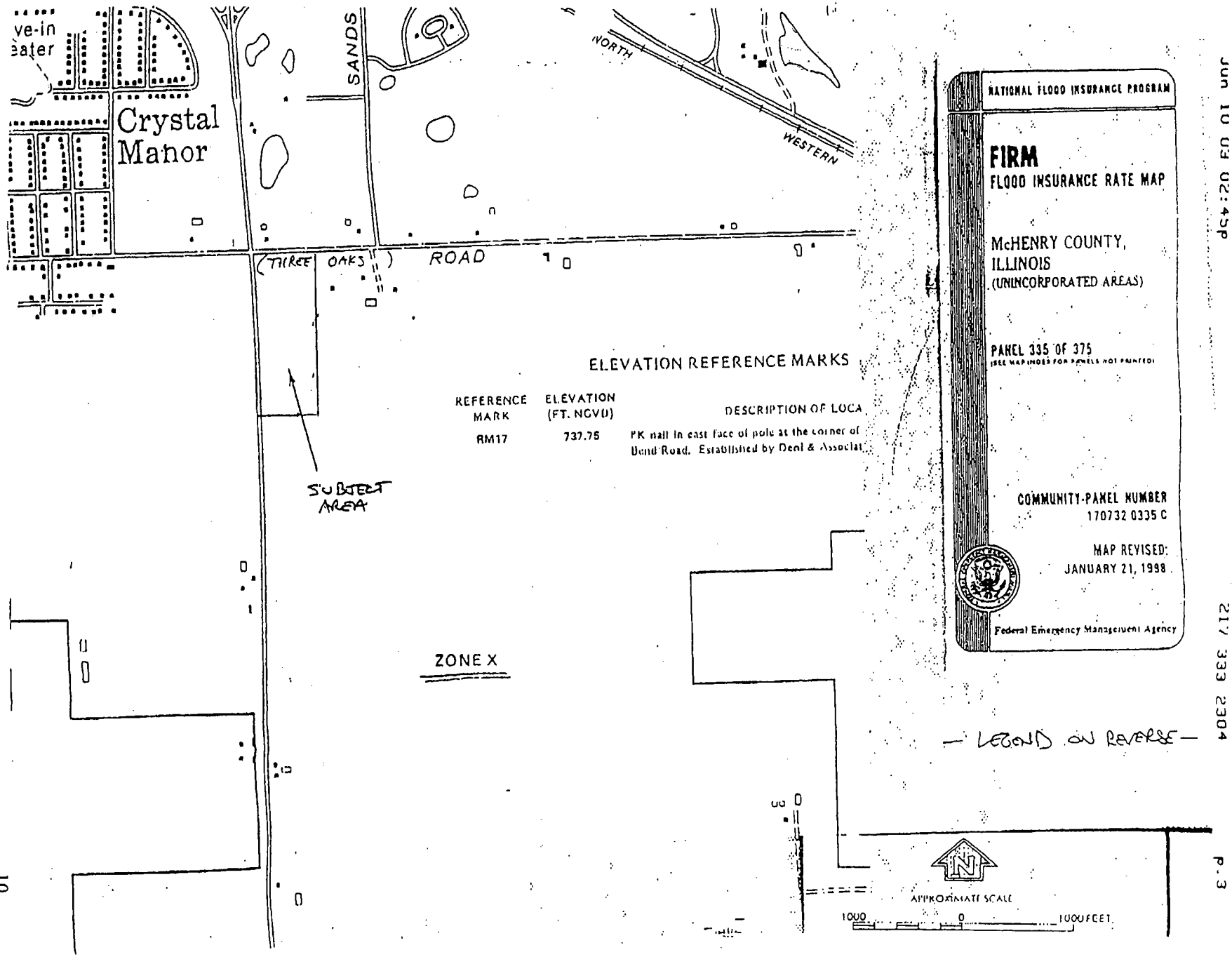
BE IT ORDAINED BY THE MAYOR AND CITY COUNCIL OF THE CITY OF CRYSTAL LAKE, McHENRY COUNTY, ILLINOIS, as follows:

SECTION I: That the following described property be and the same is hereby zoned and classified "O-PUD" Office Planned Unit Development District:

> The North 1464.54 feet of the West 580.14 feet of the Southeast Quarter of Section 10 (exception therefrom that part taken for State Route 31 and Three Oaks Road) all in Township 43 North, Range 8 East of the Third Principal Meridian in McHenry County, Illinois,

with the approval of a condition to be included in the final planned unit development for the height of the building to be constructed on the premises to

GRC-1b



ORD. #5296
FILE #115

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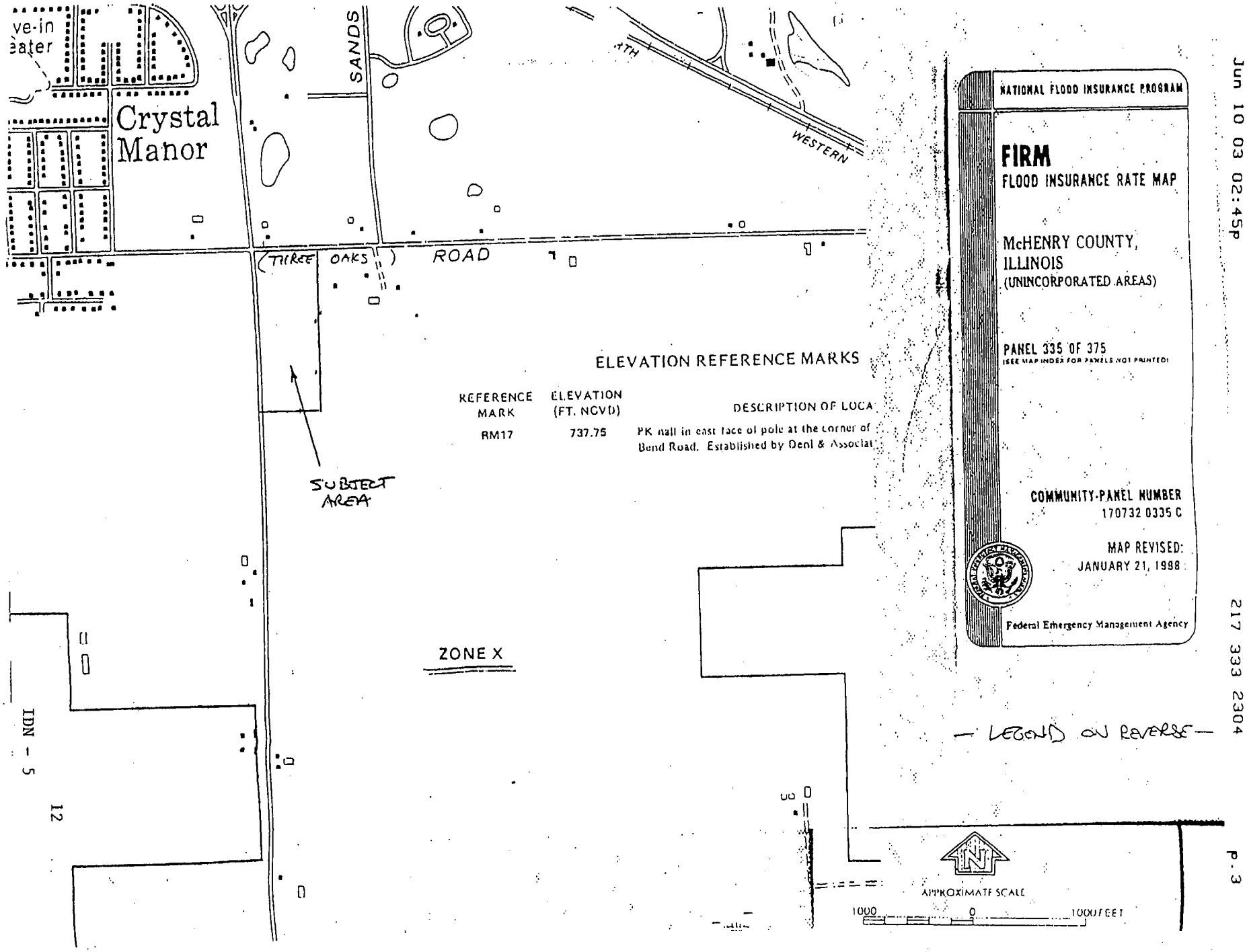
GRC-1b



M. Narrative Description

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

We propose to establish a 70-bed hospital in Crystal Lake. We are proposing to initially construct 32 of those beds and to shell the other 38 beds. All ancillary and support services will be initially constructed appropriately sized for 70 beds. The foundation of the hospital will be constructed such that expansions beyond the 70 beds can be accommodated.

A 45-physician clinic will be constructed attached to the hospital. Included will be office, treatment room and support space.

As of this writing there is no street address. The site is a 16 acre plot located on the east side State Route 31 between Three Oaks Road and Raymond Road.

The project is substantive because it is for the establishment of a facility.

The Subject Property is legally described as follows:

The North 1464.54 feet of the West 580.14 feet of the Southeast Quarter of Section 10 (exception therefrom that part taken for Stat Route 31 and Three Oaks Road), all in Township 43 North, Range 8 East of the Third Principal Meridian in McHenry County, Illinois.

The Parcel contains approximately 16.71 acres.

N. Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1190.40.b) of the component must be included in the estimated project cost. If the project contains components that are not related to the provision of health care, complete an additional table for the portions that are solely for health care and insert that table following this page (e.g. separate a nursing home's costs from the components of a retirement community; separate patient care area costs from a hospital project that includes a parking garage.

PROJECT COST AND SOURCES OF FUNDS	
Preplanning Costs	326,380
Site Survey and Soil Investigation	12,050
Site Preparation	2,340,000
Off Site Work	252,100
New Construction Contracts	47,222,358
Modernization Contracts	0
Contingencies	2,468,720
Architectural/Engineering Fees	2,911,700
Consulting and Other Fees	88,200
Movable or Other Equipment (not in construction contracts)	18,145,090
Bond Issuance Expense (project related)	1,360,000
Net Interest Expense During Construction (project related)	6,269,600
Fair Market Value of Leased Space or Equipment	0
Other Costs To Be Capitalized	0
Acquisition of Building or Other Property (excluding land)	0
ESTIMATED TOTAL PROJECT COST	81,396,198

Cash and Securities	12,036,198
Pledges	
Gifts and Bequests	
Bond Issues (project related)	69,360,000
Mortgages	
Leases (fair market value)	
Governmental Appropriations	
Grants	
Other Funds and Sources	
TOTAL FUNDS	81,396,198

O. Related Project Costs

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

   X No land acquisition is related to project; Purchase Price $_____ ; Fair Market Value $
2. Does the project involve establishment of a new facility or a new category of service? X Yes No

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

   Estimated start-up costs and operating deficit cost is $ 3,481,925 for 60 days operating expense and working capital

P. Project Status and Completion Schedules

1. Indicate the stage of the project's architectural drawings:

   None or not applicable X Schematics Preliminary Final Working

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

   25% of project costs expended May 2004 50% of project costs expended Nov. 2004
   75% of project costs expended Mar. 2005 95% of project costs expended Sept. 2005
   100% of project costs expended Dec. 2005 Midpoint of construction date Dec. 2004
   Anticipated project completion date (refer to Part 1130.140) Aug. 2006

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

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

Q. Cost/Space requirements

HOSPITAL				Amount of Proposed Total GSF That Is:			
Department/Area	Cost ($)	Existing GSF	Proposed Total GSF	New Construct.	Remodel.	As Is	Vacated
Admin./Business Office	1,018,255		3,437	3,437			
Materials Management	1,018,255		4,150	4,150			
Building Support	1,438,839		5,455	5,455			
Central Processing	1,384,537		1,260	1,260			
Dietary	2,006,995		3,780	3,780			
Pharmacy	324,661		840	840			
Building Systems HVAC	3,930,174		15,506	15,506			
Public Circulation	6,249,725		22,725	22,725			
Emergency Department	2,995,736		6,855	6,855			
Clinical Laboratory	3,107,342		2,881	2,881			
Radiology	7,391,692		9,900	9,900			
Physical & Occ. Therapy	546,021		1,474	1,474			
Respiratory Therapy	243,496		623	623			
Cardiac Rehabilitation	671,458		1,200	1,200			
Employee Facilities	295,146		1,163	1,163			
Medical Library	221,360		750	750			
Surgery	8,346,190		9,840	9,840			

Recovery	796,895		2,040	2,040			
Outpatient Surgery	2,029,131		5,182	5,182			
ICU	1,372,431		2,385	2,385			
M/S Nursing Units	11,341,000		32,412	32,412			
LDR Rooms	863,303		1,974	1,974			
OB Nursing Unit	1,770,878		4,760	4,760			
Newborn Nursery	560,778		1,513	1,513			
Housekeeping	162,331		726	726			
Laundry (Holding)	118,059		479	479			
Medical Records	1,298,644		4,373	4,373			
Snack Shop	501,749		1,147	1,147			
Yard Storage	95,922		336	336			
Human Resources	243,496		832	832			
Marketing	405,826		1,360	1,360			
Meeting Rooms	332,040		1,121	1,121			
Ambulance Garage	228,738		982	982			
Canopies	1,069,906		6,947	6,947			
Totals	64,381,009		160,408	160,408			

Attachment # INFO-7

Q. Cost/Space requirements

CLINIC				Amount of Proposed Total GSF That Is:			
Department/Area	Cost ($)	Existing GSF	Proposed Total GSF	New Construct.	Remodel.	As Is	Vacated
Building Systems	1,608,548		8,171	8,171			
Medical Records	1,542,140		7,832	7,832			
Waiting	1,254,372		6,389	6,389			
Food Court	501,749		2,550	2,550			
Public Circulation	3,438,455		17,470	17,470			
Physicians' Areas	8,669,925		44,035	44,035			
Totals	17,015,189		86,447	86,447			

Attachment # INFO-7-1

R. Facility Bed Capacity and Utilization

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

FACILITY NAME: Mercy Crystal Lake Hospital and Medical Center CITY: Crystal Lake

REPORTING PERIOD DATES: From NA to _____

Category of Service	Existing # of Beds	Number of Admissions	Patient Days	Bed Changes	Proposed # of Beds
Medical/Surgical					56
Pediatrics					
Obstetrics					10
Intensive Care					4
Neonatal ICU					
Acute Mental Illness					
Rehabilitation					
Nursing Care					
Sheltered Care					
Other (identify)					
Other (identify)					
Other (identify)					
TOTAL					70

2. For hospital projects only– if the number of beds is being decreased in any service,indicate below the affected room numbers (if additional space is required, provide the information on a separate sheet and insert following this page):

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

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

Service	# Medicare Beds	#Medicaid Beds
Nursing Care	None	None
ICF/DD Adult	None	None
Children DD	N0ne	None

S. Certification

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

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

Javon R Bea
Signature

Printed Name Javon R. Bea

Printed Title President/CEO

Notarization:
Subscribed and sworn to before me
this 27th day of July

Ralph d'Amato
Signature of Notary

Seal

Signature

Printed Name Richard H. Gruber

Printed Title Vice President

Notarization:
Subscribed and sworn to before me
this 27th day of July

Ralph d'Amato
Signature of Notary

Seal

*Insert EXACT legal name of the applicant

Application for

SECTION III. GENERAL REVIEW CRITERIA

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

A. Criterion 1110.230.a, Location

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

1. A map (8 ½" x 11") of the area showing:
   a. the location of the applicant's facility or project;
   b. the name and location of all the other facilities providing the same service within the planning area and surrounding planning areas within 30 minutes travel time of the proposed facility;
   c. the distance (in miles) and the travel time (under normal driving conditions) from the applicant's facility to each of the facilities identified in b. above;
   d. an outline of the proposed target population area.
2. For existing facilities, provide patient origin data for all admissions for the last 12 months presented by zip code. Note this information must be based upon the patient's legal residence other than a health care facility for the last 6 months immediately prior to admission. For all other projects for which referrals are required patient origin data for the referrals must be provided.
3. The ratio of beds to population (population will be based upon the latest census data by zip code) within 30 minutes travel time of the proposed project.
4. The status of the project in the zoning process. Provide letter(s) from the appropriate local officials.
5. Evidence of legal site ownership, possession, or option to purchase or lease.

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

B. Criterion 1110.230.b, Background of Applicant

Read the criterion and submit the following information:

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

Criterion 1110.230.a, Location

This review criterion requires that the "proposed project will not create a maldistribution of beds and services".

McHenry County was carved out of Cook County prior to 1838. The village of McHenry was the county seat. When Lake County was formed to the east, the village of McHenry was on the eastern border of its county. In 1842 that geographic misplacement was corrected by the legislature making Centerville (now Woodstock) the county seat of McHenry County.

The first public hospital in the county was established at Harvard in 1898. Harvard was then in the most populous part of the county. As the population grew to the south, hospitals were formed in McHenry and Woodstock. Public hospitals were established in Woodstock in 1914 and in McHenry in 1956.

The purpose of this history lesson is to demonstrate to the reader that this project will not create a maldistribution. This project will correct an existing maldistribution.

Just as the population locus moved from the Harvard area to the county seats in the first half of the 20th Century, the population center has now moved to the area in which we are proposing to build a hospital. It is the existing facilities that are maldistributed.

1. By the year 2008 (the second year after our proposed hospital opening) the only hospital within the planning area (A-10, McHenry County) that will be within 30 minutes travel time of the proposed facility will be the hospital in the city of McHenry. The travel time to that hospital, Northern Illinois Medical Center, will be 25 minutes. By the year 2013 that travel time will have increased to 30 minutes.

See the traffic study by Gewalt and Hamilton Associates, Inc., Attachment GRC-1a.

Travel times and distances between our proposed hospital site and the existing hospitals in McHenry County are as follows for CY 2008:

Harvard Memorial Hospital
Harvard, Illinois
50 minutes
38 miles

Attachment GRC-1

Northern Illinois Medical Center (NIMC)
McHenry, Illinois
25 minutes
7 miles

Memorial Medical Center
Woodstock, Illinois
31 minutes
9 miles

The zip codes that contain our target population are outlined in red on the attached map. See Attachment GRC-1b. These zip codes encompass the cities shown below.

Towns	Zip Codes
Crystal Lake	60014
Algonquin	60102
Cary	60013
Lake in the Hills (LITH)	60156

2. Patient referrals have not been used to justify this project. As is discussed elsewhere in this application, physicians in our attached clinic will be the main source of hospital patients.

3. The ratio of beds to population in Service Area A-10 within 30 minutes of the proposed project is zero/1,000.

4. The site for our proposed hospital was recently zoned as Office Planned Unit Development District. See Attachment GRC-1c. No further zoning action is required. After the CON permit is granted, the Crystal Lake City Council will be asked to grant a Special Use Permit for a hospital.

5. The Trustee's Deed for the property is Attachment GRC-1d.

Attachment GRC-1

TRAFFIC STUDY

Attachment GRC – 1a

Traffic Planning Report

GEWALT HAMILTON
ASSOCIATES, INC.

Consulting Engineers
and Surveyors

Civil, Municipal, & Traffic

850 Forest Edge Drive
Vernon Hills, Illinois 60061
tel 847 478 9700 fax 847 478 9701

To: **Rich Gruber**
Mercy Health System

From: Bonnie Flock

Date: June 27, 2003

Subject: ***Driving Time Study***
McHenry County, Illinois

PART 1. PROJECT OVERVIEW

GEWALT HAMILTON ASSOCIATES, INC. (GHA) has conducted driving time surveys in McHenry County, Illinois in light of concerns that roadway congestion in the area is and will be in the future problematic in getting hospital patients care in a timely manner. Our study findings are discussed below. *Exhibits* referenced in the text are centrally located in the Technical Addendum.

PART 2. EXISTING TRAVEL TIMES SURVEY RESULTS

Exhibit 1 illustrates the location of two existing medical facilities surveyed for travel times: Woodstock Memorial Hospital located along US 14 just west of Doty Road in the City of Woodstock and Northern Illinois Medical Center located along IL 31 just south of Bull Valley Road in the City of McHenry. *Exhibit 1* also illustrates the location of a proposed hospital site located along IL 31 just south of Three Oaks Road. Travel times were recorded from the site to the two existing medical facilities. The surveys were conducted during the weekday morning (7 AM to 9 AM), midday (11:00 AM to 1:00 PM), and evening (4 PM to 6 PM) peak periods and also during the Saturday peak period (11 AM to 1:30 PM). These times were chosen to ensure that the prevalent and non-prevalent travel patterns on the road system will be accounted for. **No unusual delays occurred during the travel runs such as foul weather (e.g. heavy snowfall or rain), road construction, or emergency vehicle activity that would adversely affect the volumes or travel patterns.**

Exhibits 2 and *3* summarize the results of the driving time surveys for travel runs made by two vehicles to and from the site and to each of the medical facilities. As shown in *Exhibit 2*, the peak travel time round trip from the site to the medical facility in Woodstock and then back to the site was recorded during the weekday evening peak period and during the Saturday midday peak period at 43 minutes. *Exhibit 3* indicated that the peak travel time to and from the site to the medical facility in McHenry was recorded during the weekday evening peak period at 28 minutes.

Point of Discussion. It is important to note that the travel times shown in *Exhibits 2* and *3* were recorded at a starting roll or in other words, the stop watch was started as the drivers were ready to travel forward. In reality, an ambulance crew will require an additional few minutes (3 to 4 minutes) to pick-up and/or drop-off the patient at the hospital thereby increasing travel times. These adjusted travel times are shown in *Exhibit 4*. *Exhibit 4* indicates that the adjusted travel times for existing conditions when considering the ambulance crew are as high as 51 minutes for the Woodstock facility and 36 minutes for the McHenry facility.

PART 2. FUTURE TRAVEL TIMES

The Northeastern Illinois Planning Commission (NIPC) and other sources were contacted regarding future growth projections and roadway congestion factors. Based on this information, the projected increases in driving times for 5, 10, and 15 year planning horizons were calculated. *Exhibit 5* illustrates the future travel times to and from the site and medical facilities...

- Future travel times are expected to reach over an hour to travel to and from either of the two medical facilities over the next 15 years. General growth in traffic volumes and congestion factors were considered in the projected travel times to and from the Woodstock facility based on the NIPC data and other sources.

- An important factor in determining future increases in travel times along IL 31 to and from the McHenry facility was considering the NIPC data and the future build-out of the Terra Cotta mixed use development. Smith Engineering Consultants, Inc. along with GHA working as the Village of Praire Grove's consultant, have been working the developer on this project. The 1,550 acre site will consist of residential, commercial, and office uses located along IL 31 approximately 1-1/2 mile south of the McHenry medical facility. Traffic volumes along IL 31 are expected to increase over 2-1/2 times than current volume levels over the next 10 years as a result of this development and other area growth. The development is planned to widen IL 31 from it's existing two-lane cross-section to a four-lane cross-section (two travel lanes in each direction); however, for only a short distance (about 2 miles). (Note that the distance between the site and the McHenry facility is 7 miles). Even with the four-lanes provided in the future, the roadway operations through the four-lane cross-section are projected to be at capacity where attainable speeds because of the high traffic loads are less than 35 miles per hour. Traveling through the remaining two-lane cross-section will yield even lower travel speeds and higher travel times.

Key Finding. Discussions with the state indicate that there are no plans at this time in the unforeseeable future to widen either IL 31 or US 14 due to the unavailable funds required for such infrastructure.

PART 3. CONCLUDING REMARKS

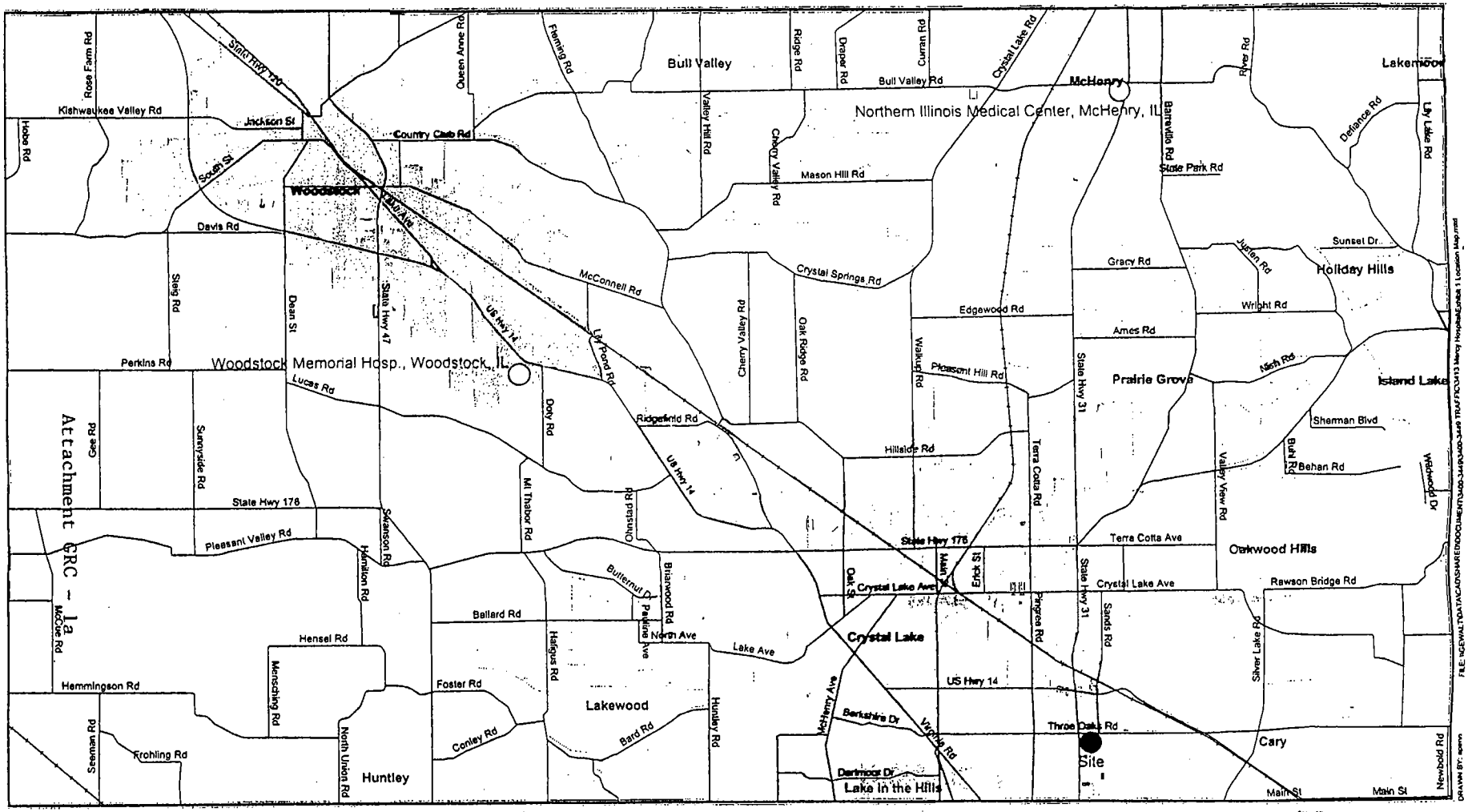
Recognizing that the McHenry County area is expected to experience general growth in population and volume demands along the various roadways and the inevitable buildout of the Terra Cotta development over the next 10 to 15 years, congestion along both US 14 and IL 31 is expected to increase thereby increasing travel times significantly. Roadway improvements for additional through lanes along these two corridors are not expected at this time with the exception of IL 31 which is planned to be widened for four lanes (two lanes in each direction); however, only for a short distance. In addition, the roadway operations through the four-lane cross-section are projected to be at capacity where attainable speeds because of the high traffic loads are extremely low, thereby increasing travel times.

PART 4. TECHNICAL ADDENDUM

The following *Exhibits* were referenced. They supply support for our findings.

Exhibit 1. Location Map
2. Mercy Drive Time Study – Proposed Site to Woodstock Memorial Hospital, Woodstock, IL
3. Mercy Drive Time Study – Proposed Site to Northern Illinois Medical Center, McHenry, IL
4. Existing Travel Times
5. Future Travel Times

Exhibit 1: Location Map



N

1 inch equals 1 mile

GEWALT HAMILTON ASSOCIATES, INC.

Consulting Engineers & Surveyors
Civil • Structural • Traffic

850 Forest Edge Drive Vernon Hills, IL 60061
Tel: 847.478.9700 Fax: 847.478.9701
www.gha-engineers.com

DATE: 6/27/2003
3413.900

Exhibit 2

Mercy Drive Time Study

Proposed Site to Woodstock Memorial Hospital, Woodstock, IL

Trip		Start Time	Stop Time	Total	Round Trip
Thursday June 12, 2003 7AM-9AM					
1	To Clinic	7:00	7:19	19 min	36 min
	From Clinic	7:19	7:36	17 min	
2	To Clinic	7:37	7:56	19 min	35 min
	From Clinic	7:56	8:12	16 min	
3	To Clinic	8:12	8:32	20 min	37 min
	From Clinic	8:33	8:50	17 min	

Peak Travel Time

Round Trip: 37 min

Thursday June 12, 2003 11AM-1PM					
4	To Clinic	11:00	11:21	21 min	42 min
	From Clinic	11:21	11:42	21 min	
5	To Clinic	11:42	12:04	22 min	41 min
	From Clinic	12:05	12:24	19 min	
6	To Clinic	12:25	12:47	22 min	42 min
	From Clinic	12:47	1:07	20 min	

Peak Travel Time

Round Trip: 42 min

Thursday June 12, 2003 4PM-6PM					
7	To Clinic	4:00	4:23	23 min	43 min
	From Clinic	4:23	4:43	20 min	
8	To Clinic	4:44	5:06	22 min	42 min
	From Clinic	5:06	5:26	20 min	
9	To Clinic	5:26	5:46	20 min	38 min
	From Clinic	5:46	6:04	18 min	

Peak Travel Time

Round Trip: 43 min

Saturday June 14, 2003 From 11AM to 1:30 PM

Trip		Start	Stop	Total	
1	To Clinic	11:00	11:22	22 min	43 min
	From Clinic	11:23	11:44	21 min	
2	To Clinic	11:45	12:06	21 min	40 min
	From Clinic	12:07	12:26	19 min	
3	To Clinic	12:28	12:49	21 min	42 min
	From Clinic	12:50	1:11	21 min	

Peak Travel Time

Round Trip: 43 min

Exhibit 3

Mercy Drive Time Study

Proposed Site to Northern Illinois Medical Center, McHenry, IL

Saturday June 7, 2003 11AM-1:30PM

Trip		Start Time	Stop Time	Total	Round Trip
1	To Hospital	11:00	11:12	12 min	23 min
	From Hospital	11:12	11:23	11 min	
2	To Hospital	11:23	11:35	12 min	24 min
	From Hospital	11:35	11:47	12 min	
3	To Hospital	11:47	11:59	12 min	25 min
	From Hospital	11:59	12:12	13 min	
4	To Hospital	12:22	12:36	14 min	27 min
	From Hospital	12:36	12:49	13 min	
5	To Hospital	12:49	1:00	11 min	24 min
	From Hospital	1:00	1:13	13 min	

Peak Travel Time

Round Trip: 27 min

Thursday June 12, 2003 7AM-9AM

1	To Hospital	7:00	7:12	12 min	24 min
	From Hospital	7:12	7:24	12 min	
2	To Hospital	7:24	7:36	12 min	24 min
	From Hospital	7:36	7:48	12 min	
3	To Hospital	7:48	7:59	11 min	22 min
	From Hospital	7:59	8:10	11 min	
4	To Hospital	8:10	8:21	11 min	25 min
	From Hospital	8:21	8:35	14 min	
5	To Hospital	8:35	8:44	9 min	21 min
	From Hospital	8:44	8:56	12 min	

Peak Travel Time

Round Trip: 25 min

Thursday June 12, 2003 11AM-1:30PM

6	To Hospital	11:00	11:11	11 min	23 min
	From Hospital	11:11	11:23	12 min	
7	To Hospital	11:23	11:34	11 min	23 min
	From Hospital	11:34	11:46	12 min	
8	To Hospital	11:46	11:58	12 min	24 min
	From Hospital	11:58	12:10	12 min	
9	To Hospital	12:10	12:22	12 min	23 min
	From Hospital	12:22	12:33	11 min	
10	To Hospital	12:33	12:44	11 min	24 min
	From Hospital	12:44	12:57	13 min	

Peak Travel Time

Round Trip: 24 min

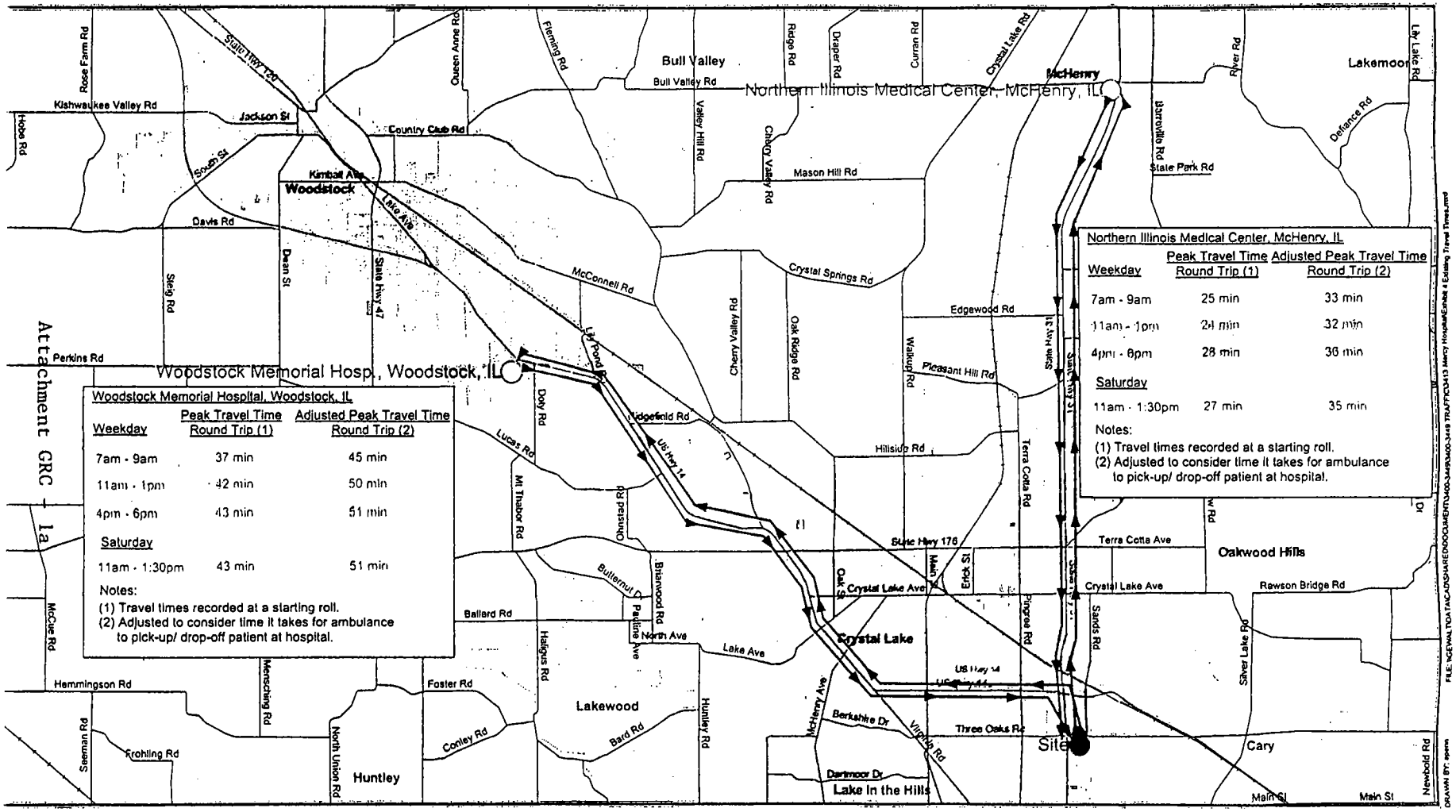
Thursday June 12, 2003 4PM-6PM

Trip		Start	Stop	Total	
11	To Hospital	4:00	4:13	13 min	26 min
	From Hospital	4:13	4:26	13 min	
12	To Hospital	4:26	4:41	15 min	28 min
	From Hospital	4:41	4:54	13 min	
13	To Hospital	4:54	5:07	13 min	25 min
	From Hospital	5:07	5:19	12 min	
14	To Hospital	5:19	5:32	13 min	25 min
	From Hospital	5:32	5:44	12 min	
15	To Hospital	5:44	5:57	13 min	25 min
	From Hospital	5:57	6:09	12 min	

Peak Travel Time

Round Trip: 28 min

Exhibit 4: Existing Travel Times



Woodstock Memorial Hospital, Woodstock, IL

Weekday	Peak Travel Time Round Trip (1)	Adjusted Peak Travel Time Round Trip (2)
7am - 9am	37 min	45 min
11am - 1pm	42 min	50 min
4pm - 6pm	43 min	51 min
Saturday		
11am - 1:30pm	43 min	51 min

Notes:
(1) Travel times recorded at a starting roll.
(2) Adjusted to consider time it takes for ambulance to pick-up/ drop-off patient at hospital.

Northern Illinois Medical Center, McHenry, IL

Weekday	Peak Travel Time Round Trip (1)	Adjusted Peak Travel Time Round Trip (2)
7am - 9am	25 min	33 min
11am - 1pm	24 min	32 min
4pm - 6pm	28 min	36 min
Saturday		
11am - 1:30pm	27 min	35 min

Notes:
(1) Travel times recorded at a starting roll.
(2) Adjusted to consider time it takes for ambulance to pick-up/ drop-off patient at hospital.

N

1 inch equals 1 mile

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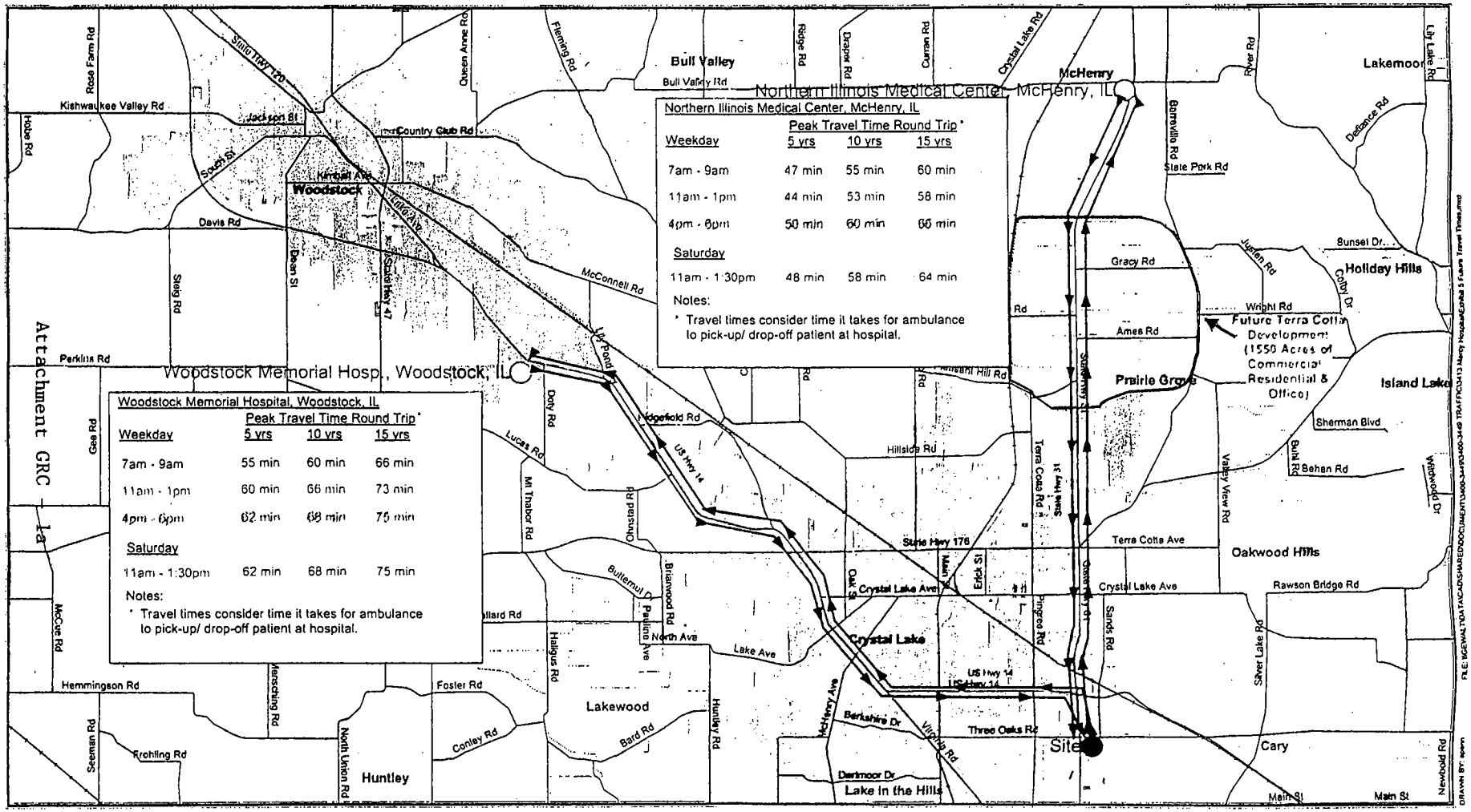
Tel: 847.478.9700 Fax: 847.478.9701
www.ghaengineers.com

DATE: 6/27/2003
3413.900

Exhibit 5: Future Travel Times



Northern Illinois Medical Center, McHenry, IL

Peak Travel Time Round Trip *

Weekday	5 yrs	10 yrs	15 yrs
7am - 9am	47 min	55 min	60 min
11am - 1pm	44 min	53 min	58 min
4pm - 6pm	50 min	60 min	66 min
Saturday			
11am - 1:30pm	48 min	58 min	64 min

Notes:

* Travel times consider time it takes for ambulance to pick-up/ drop-off patient at hospital.

Woodstock Memorial Hospital, Woodstock, IL

Peak Travel Time Round Trip *

Weekday	5 yrs	10 yrs	15 yrs
7am - 9am	55 min	60 min	66 min
11am - 1pm	60 min	66 min	73 min
4pm - 6pm	62 min	68 min	75 min
Saturday			
11am - 1:30pm	62 min	68 min	75 min

Notes:

* Travel times consider time it takes for ambulance to pick-up/ drop-off patient at hospital.

N

1 inch equals 1 mile

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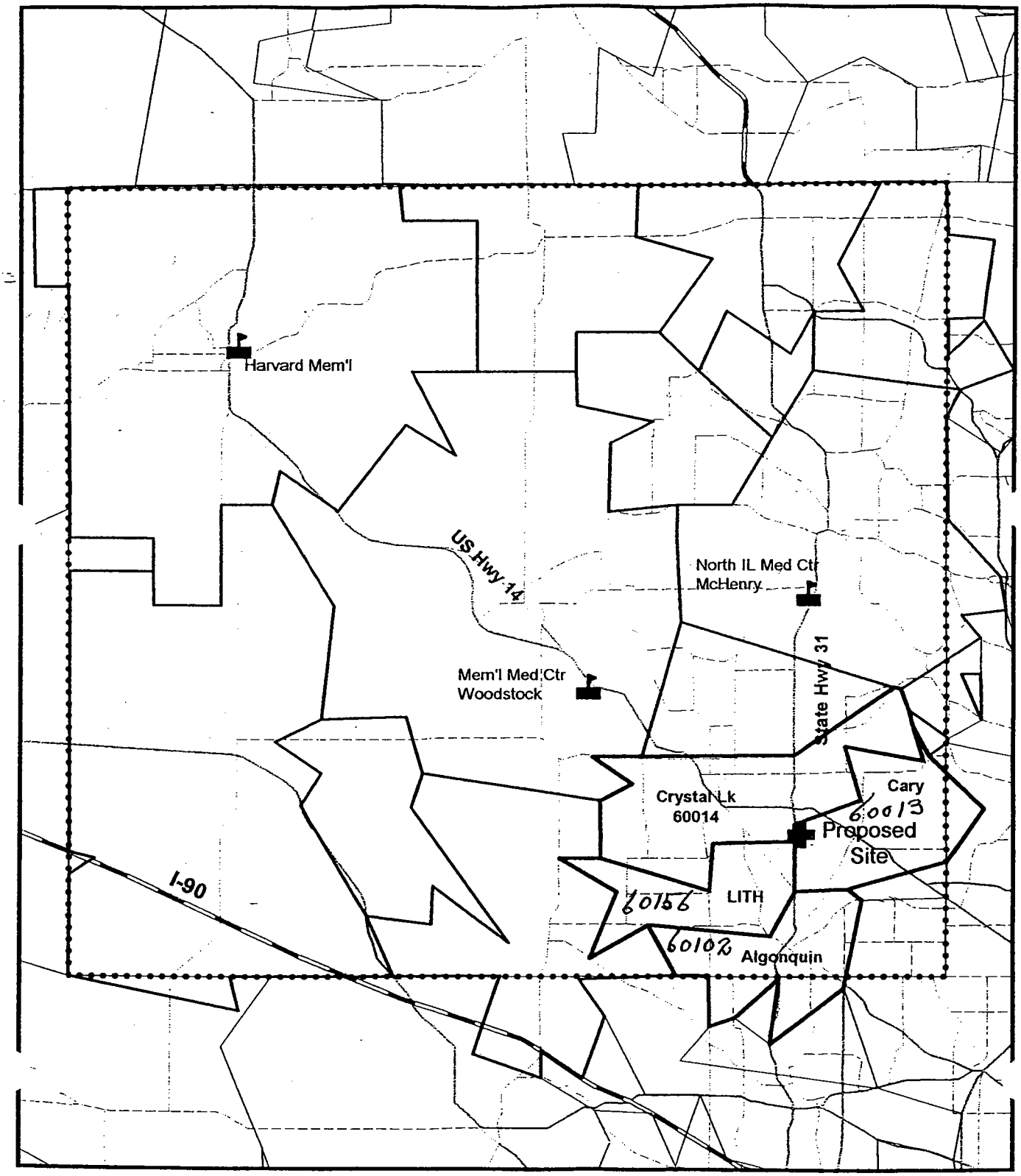
DATE: 6/27/2003
3413.900

McHenry County Hospitals



ORD. #5296
FILE #115

AN ORDINANCE ZONING CERTAIN PROPERTY "O-PUD" OFFICE PLANNED UNIT DEVELOPMENT DISTRICT

WHEREAS, certain territory is the subject of a certain Annexation Agreement; and

WHEREAS, said territory has been duly annexed by ordinance to the City of Crystal Lake; and

WHEREAS, by the terms of said Annexation Agreement, said territory is to be zoned "O-PUD" Office Planned Unit Development District; and

WHEREAS, it is in the best interests of the City of Crystal Lake that the property legally described hereinbelow be classified and zoned as indicated.

BE IT ORDAINED BY THE MAYOR AND CITY COUNCIL OF THE CITY OF CRYSTAL LAKE, McHENRY COUNTY, ILLINOIS, as follows:

SECTION I: That the following described property be and the same is hereby zoned and classified "O-PUD" Office Planned Unit Development District:

> The North 1464.54 feet of the West 580.14 feet of the Southeast Quarter of Section 10 (exception therefrom that part taken for State Route 31 and Three Oaks Road) all in Township 43 North, Range 8 East of the Third Principal Meridian in McHenry County, Illinois,

with the approval of a condition to be included in the final planned unit development for the height of the building to be constructed on the premises to

be not more than 42 feet in height in accordance with the building elevation plan dated June 16, 2000.

SECTION II: That the City Clerk be and he is hereby directed to amend the official zoning map of the City of Crystal Lake and all pertinent records of the City of Crystal Lake to show the zoning and classification of the above-described property in accordance with the provisions of this Ordinance, as provided by law.

SECTION III: That this Ordinance shall be in full force and effect from and after its passage and approval as provided by law.

AYES: 5

NAYS: 1

ABSENT: 1

PASSED this 15th day of August, 2000.

APPROVED by me this 15th day of August, 2000.

MAYOR

ATTEST:

CITY CLERK Pro Tempore

city\ordinance zoning mercy

(4)

MCHENRY COUNTY RECORDER
PHYLLIS K. WALTERS
2000R0061541
11-09-2000 10:20 AM

RECORDING FEE	18.00
PAGES	4
COUNTY STAMP FEE	1484.00
STATE STAMP FEE	2968.00

TRUSTEE'S DEED 235258 CT-T

Grantees Address: 1000 Mineral Point Avenue,
Janesville, WI 53549

This Instrument Prepared by: Mark S. Saladin
MILITELLO, ZANCK & COEN, P.C.,
40 Brink St., Crystal Lake, IL 60014

Send Future Tax Bills To: MERCY HEALTH SYSTEM CORPORATION
1000 Mineral Point Avenue, Janesville, WI 53549

STATE OF ILLINOIS
STATE & COUNTY TAX
NOV.-9.00
MC HENRY COUNTY

0000004214

REAL ESTATE TRANSFER TAX
0445200
FP351004

For Recorders Use Only

Know All Men by These Presents, THAT THE GRANTOR, HOME STATE BANK/NATIONAL ASSOCIATION, a duly organized Trust Company, organized and existing under the laws of the State of Illinois, as Trustee under the provisions of a Trust Agreement dated November 30, 1984, and known as Trust No. 3005 and having its principal business office in the City of Crystal Lake, County of McHenry and State of Illinois, for the consideration of Ten and no/100-------($10.00)---------- DOLLARS **Conveys to** MERCY HEALTH SYSTEM CORPORATION

of the City of Janesville County of Rock and State of Wisconsin ~~not in tenancy in common but in joint tenancy with right of survivorship~~ all interest in the following described premises, to-wit:

The North 1464.54 feet of the West 580.14 feet of the Southeast 1/4 of Section 10, (excepting therefrom that part taken for State Route 31 and Three Oaks Road), all in Township 43, Range 8 East of the Third Principal Meridian, in McHenry County, Illinois.

SUBJECT TO: Real estate taxes for 2000 and subsequent years; covenants, conditions, restrictions and easements of record; rights of the public, the State and the municipality to any land taken for road purposes; drainage ditches, tiles, feeders and laterals; order establishing freeway; rebate for special service area to City of Crystal Lake, Illinois; terms of Annexation Agreement with City of Crystal Lake, Illinois, dated August 15, 2000.

MAIL TO MARY PERTL
QUARLES + BRADY
411 E. WISCONSIN AVE.
MILWAUKEE, WI 53202

Attachment GRC - 1d
TC 37

00-31-9081

Subject to restrictions appearing of record

Permanent Index Number 19-10-400-010-0000

This conveyance is executed pursuant to the power and authority given to the Trustee in said Trust Agreement and every other power and authority it hereunto enabling.

In Testimony Whereof, the said Home State Bank / National Association, a duly organized Trust Company, of Crystal Lake, Illinois as Trustee as aforesaid hath hereunto caused its corporate seal to be affixed, and these presents to be signed by James J. Zambon, its SR. Vice Pres. & Tr. Off and attested by Charles J. Feck, JR., its Vice President this 30th day of October A.D. 19~~xx~~ 2000

CORPORATE SEAL

HOME STATE BANK / NATIONAL ASSOCIATION
AS TRUSTEE AS AFORESAID

By _____
Sr. Vice President & Trust Officer

Attest _____
Vice President

STATE OF ILLINOIS, }
McHENRY COUNTY } S.S.

I, the undersigned, Roma J. Udoni

a Notary Public in and for and residing in the said County in the State aforesaid, Do Hereby Certify that James J. Zambon, personally known to me to be the Sr. Vice Pres. & Trust Officer of the Home State Bank / National Association, Crystal Lake, Illinois and Charles J. Feck, Jr., personally known to me to be the Vice President of said Corporation, whose names are subscribed to the foregoing instrument, appeared before me this day in person and severally acknowledged that as such Sr. Vice Pres. & Trust Officer and Vice President they signed and delivered the said instrument of writing as Sr. Vice President & Trust Officer and Vice President of said Corporation, and caused the seal of said Corporation to be affixed thereto pursuant to authority given by the Board of Directors of said Corporation as their free and voluntary act, and as the free and voluntary act and deed of said Corporation for the uses and purposes therein set forth.

Given under my hand and notarial seal, this 30 th day of October A.D. 19~~xx~~ 2000

"OFFICIAL SEAL"
ROMA J. UDONI
Notary Public, State of Illinois
My Commission Expires 08/23/2001

_____
Notary Public

Attachment GRC - 1d 38

00031-9082

PHYLLIS K. WALTERS
McHenry County Recorder
McHenry County Government Center
Room A280
2200 North Seminary Avenue
Woodstock, IL 60098
815-334-4110
Fax 815-338-9612

MCHENRY COUNTY RECORDER
PHYLLIS K. WALTERS
2000R0061541
11-09-2000 10:20 AM

RECORDING FEE	18.00
PAGES	4
COUNTY STAMP FEE	1484.00
STATE STAMP FEE	2968.00

RECORDER'S STAMP

PLAT ACT AFFIDAVIT - METES AND BOUNDS DESCRIPTIONS

CIRCLE THE NUMBER BELOW WHICH IS APPLICABLE TO THE ATTACHED DEED

STATE OF ILLINOIS)
) SS
COUNTY OF McHENRY)

GARY L. FICHTER, being duly sworn on oath, states that he resides at 3300 Mountain Lane, Cedar City, Utah 84060

That the attached deed is not in violation of Chap. 765 ILCS par. 205/1 subsection (b) for one of the following reasons:

GLENNA R. COLLINS
NOTARY PUBLIC - STATE OF UTAH
My Commission Expires
December 28, 2002

(1.) The sale or exchange is of an entire tract of land not being a part of a larger tract of land.

2. The division or subdivision of land is into parcels or tracts of 5 acres or more in size which does not involve any new streets or easements of access.

3. The division is of lots or blocks of less than 1 acre in any recorded subdivision which does not involve any new streets or easements of access.

4. The sale or exchange of parcels of land is between owners of adjoining and contiguous land.

5. The conveyance is of parcels of land or interest therein for use as right-of-way for railroads or other public utility facilities, which does not involve any new streets or easements of access.

6. The conveyance is of land owned by a railroad or other public utility which does not involve new streets or easements of access.

7. The conveyance is of land for highway or other public purposes or grants or conveyances relating to the dedication of land for public use or instruments relating to the vacation of land impressed with public use.

8. The conveyance is made to correct descriptions in prior conveyances.

9. The sale or exchange is of parcels or tracts of land following the division into no more than two parts of a particular parcel or tract of land existing on July 17, 1959, and not involving any new streets or easements of access.

Attachment GRC - 1d

continued on reverse side

00031-9083 39 SP

10. The sale is of a single lot of less than 5 acres from a larger tract, the dimensions and configurations of said larger tract having been determined by the dimensions of configuration of said larger tract on October 1, 1973, and no sale, prior to this sale, of any lot or lots from said larger tract having taken place since October 1, 1973, and a survey of said single lot having been made by a registered land surveyor.

AFFIANT further states that ___he makes this affidavit for the purpose of inducing the County Recorder of McHenry County, Illinois to accept the attached deed for recording

Signature Gary L. Fichter

Gary L. Fichter

SUBSCRIBED AND SWORN TO
BEFORE ME THIS 27th DAY
OF Oct.
2000.

Glenna R. Collins
Notary Public

NOTARY PUBLIC
GLENNA R. COLLINS
1100 Snow Creek Dr. • PO Box 3899
Park City, Utah 84060
My Commission Expires
December 28, 2002
STATE OF UTAH

00031-9084

Criterion 1110.230.b, Background of Applicant

The applicant does not own or operate other facilities. However, the applicant is a part of Mercy Health Alliance. Other entities that are part of Mercy Health Alliance include Mercy Health System and Harvard Memorial Hospital See the following organizational chart.

All of the Mercy Health System owned or operated facilities other than Harvard Memorial Hospital are covered under the attached Joint Commission letter, dated August 21, 2002, awarding accreditation. See Attachment GRC-2b-3. The Joint Commission letter for Harvard Memorial, dated April 11, 2002, is Attachment GRC-2b-4

A listing of facilities operated by Mercy appears on page 41 a.

Attachment GRC-2

Mercy Health System Communities and Facilities 7/1/03

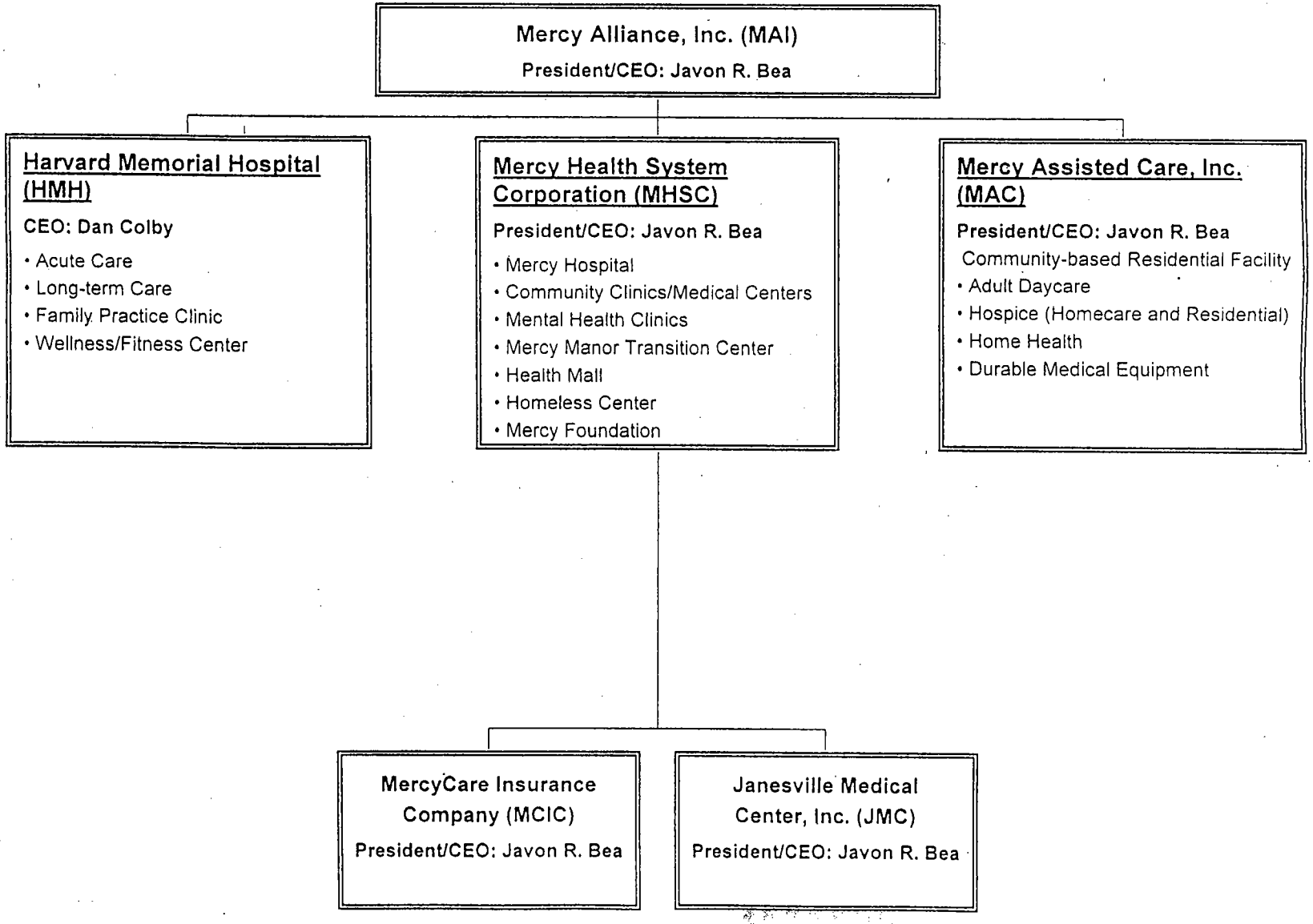
Communities

1	Algonquin	7	Delavan	12	Janesville	17	Richmond
2	Barrington	8	Edgerton	13	Lake Barrington	18	Sharon
3	Beloit	9	Evansville	14	Lake Geneva	19	Whitewater
4	Brodhead	10	Fort Atkinson	15	McHenry	20	Williams Bay
5	Cary	11	Harvard	16	Milton	21	Woodstock
6	Crystal Lake						

Facilities/Sites

1	**Algonquin Medical Center**
2	Assisted Care - Janesville
3	Assisted Care - Fort Atkinson (DME)
4	**Barrington ENT**
5	**Barrington Medical Center**
6	**Beloit Medical Center**
7	**Brodhead Medical Center**
8	Cancer Center
9	**Cary Internal Medicine Associates**
10	**Crystal Lake EAST (390 Congress Parkway; ENT Group)**
11	**Crystal Lake WEST (350 Congress Parkway)**
12	**Delavan Medical Center**
13	Dialysis Center
14	**Edgerton Medical Center**
15	**Evansville Medical Center**
16	**Harvard Family Practice Medical Center (1001 Grant Street)**
17	**Harvard Medical Center (348 S. Division)**
18	Harvard Memorial Hospital
19	Harvard Wellness Center
20	House of Mercy
21	**Lake Geneva Medical Center (relocated 3/03)**
22	**McHenry ENT**
23	Mercy Business Center (including MercyCare)
24	**Mercy Clinic East**
25	Mercy Clinic East Pharmacy
26	**Mercy Clinic South**
27	**Mercy Clinic West**
28	Mercy Clinic West Pharmacy
29	Mercy Health Mall-Assisted Care (DME)
30	**Mercy Health Mall-MHS Departments**
31	Mercy Hospital
32	Mercy Manor (relocated 2/03)
33	**Mercy Options - Janesville**
34	Mercy Options Cooperative Child Care Institute
35	**Milton Medical Center**
36	Milton Pharmacy
37	Occupational Conditioning Center & Transitional Work Program
38	**Richmond Medical Center**
39	**Sharon Medical Center**
40	**Sports Medicine and Rehabilitation Center (Janesville)**
41	**Walworth Medical Center (in Williams Bay)**
42	Walworth Pharmacy
43	Whitewater Aquatic Center (joint venture)
44	**Whitewater Medical Center**
45	**Whitewater Sports Medicine and Rehabilitation Center**
46	Woodstock Business Center
47	**Woodstock Medical Center (2000 Lake Ave)**
48	**Woodstock Medical Center North (1065 Lake Ave)**
49	Woodstock Pharmacy

MERCY ALLIANCE, INC.
CORPORATE STRUCTURE



The State of Wisconsin

DEPARTMENT OF HEALTH AND FAMILY SERVICES
DIVISION OF SUPPORTIVE LIVING

CERTIFICATE OF APPROVAL

This is to certify that **MERCY HEALTH SYSTEM CORPORATION**
doing business as **MERCY HEALTH SYSTEM CORPORATION**
at the location **1000 MINERAL POINT AVENUE**
P.O. BOX 5003
JANESVILLE, WI 53545

Type: **REGULAR**
License Number: **162**
Effective Date: **05/27/1999**

Initial Date: **01/02/1966**

is licensed to operate a General Acute Hospital in Rock County, Wisconsin.

This license is granted for a maximum capacity of **240** beds assigned to rooms as follows:

This Hospital is approved to provide service for the following bed categories:

General Beds:	180
Psychiatric Beds:	28
Alcohol Beds:	12
Rehab Beds:	20
Total Beds:	240

This License will remain in effect unless expired, suspended, revoked or voluntarily surrendered. Any and all exceptions, stipulations, or conditions to this license shall be posted next to the license certificate.

Joe Leean

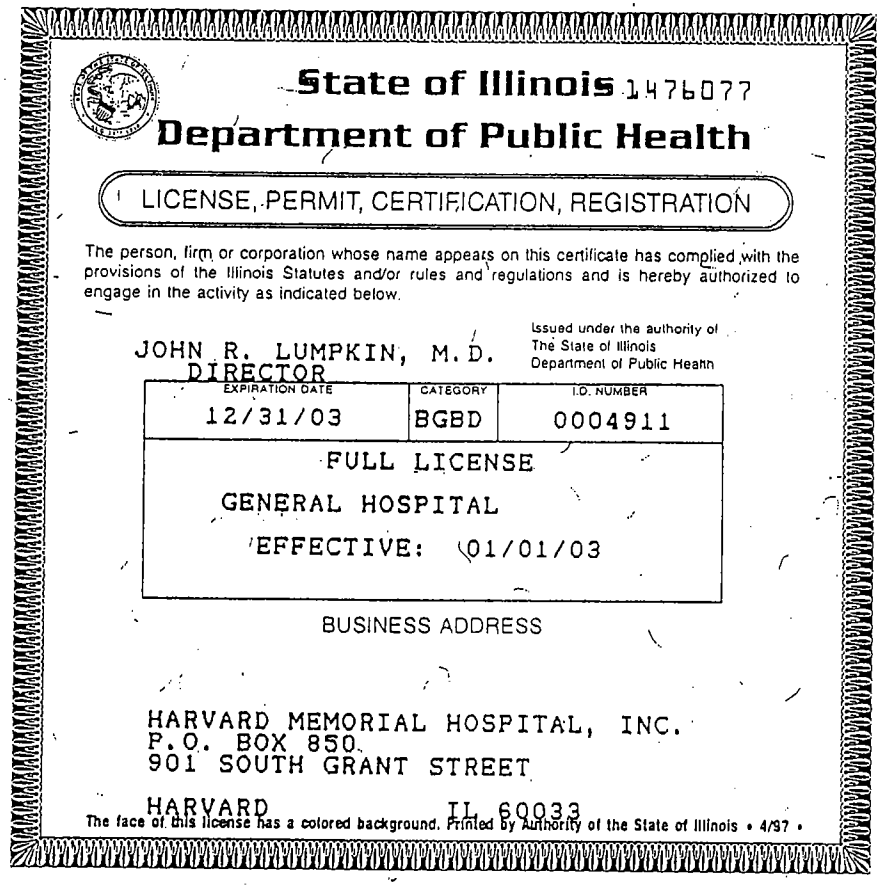
Joe Leean, Secretary DHFS

Sinikka McCabe

Sinikka McCabe, Administrator DSL

This license is not transferable or assignable
Post in a conspicuous place on premises

Attachment GRC - 2b - 1
43



State of Illinois 1476077

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

JOHN R. LUMPKIN, M.D.
DIRECTOR

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

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/03	BGBD	0004911

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/03

BUSINESS ADDRESS

HARVARD MEMORIAL HOSPITAL, INC.
P.O. BOX 850
901 SOUTH GRANT STREET
HARVARD IL 60033

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

DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

State of Illinois 1476077

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

HARVARD MEMORIAL HOSPITAL, INC.

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/03	BGBD	0004911

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/03

12/07/02

HARVARD MEMORIAL HOSPITAL, INC.
901 SOUTH GRANT STREET
HARVARD IL 60033

FEE RECEIPT NO.

Joint Commission
on Accreditation of Healthcare Organizations

Setting the Standard for Quality in Health Care

August 21, 2002

Javon R. Bea
President and CEO
Mercy Health System Corporation
PO Box 5003
Janesville, Wisconsin 53547-5003

Dear Mr. Bea:

The Joint Commission is pleased to award accreditation to your organization as result of your most recent survey, subject to the type I recommendations outlined in the attached report. This accreditation status applies to all services offered by your organization that have been surveyed by the Joint Commission. We congratulate you on your efforts to provide high quality care for those you serve.

This accreditation is effective for three years from August 10, 2002, for all services surveyed using appropriate standards from the Comprehensive Accreditation Manual for Long Term Care and the Comprehensive Accreditation Manual for Hospitals.

We direct your attention to two important Joint Commission policies. First, except as required by law, your accreditation report is confidential. You may, however, choose to make it available to the various publics you serve or others. Second, Joint Commission policy requires that you inform us of any changes in the name or ownership of your organization, or the health care services you provide either directly or through written agreement(s). Your certificate of accreditation must be returned if your organization requires a revised certificate, chooses to withdraw from accreditation, or allows the accreditation award to expire.

Congratulations on your achievement of Accreditation with Requirements for Improvement.

Sincerely,

Russell P. Massaro

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

cc: Richard L. Kochell, MD, Chief of Staff
Rowland J. McClellan, Chairman of the Board

One Renaissance Boulevard
Oakbrook Terrace, IL 60181
(630) 792-5000
http://www.jcaho.org

Joint Commission
on Accreditation of Healthcare Organizations

Setting the Standard for Quality in Health Care

April 11, 2002

Dan Colby
Chief Executive Officer
Harvard Memorial Hospital, Inc
PO Box 850
Harvard, Illinois 60033

Dear Mr. Colby:

The Joint Commission is pleased to award accreditation to your organization as result of your most recent survey, subject to the type I recommendations outlined in the attached report. This accreditation status applies to all services, including your long term care services, offered by your organization that have been surveyed by the Joint Commission. We congratulate you on your efforts to provide high quality care for those you serve.

This accreditation is effective for three years from March 30, 2002, for all services surveyed using appropriate standards from the Comprehensive Accreditation Manual for Long Term Care and the Comprehensive Accreditation Manual for Hospitals.

We direct your attention to two important Joint Commission policies. First, except as required by law, your accreditation report is confidential. You may, however, choose to make it available to the various publics you serve or others. Second, Joint Commission policy requires that you inform us of any changes in the name or ownership of your organization, or the health care services you provide either directly or through written agreement(s). Your certificate of accreditation must be returned if your organization requires a revised certificate, chooses to withdraw from accreditation, or allows the accreditation award to expire.

Congratulations on your achievement of Accreditation with Requirements for Improvement.

Sincerely,

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

cc: Mark Hayes, Chairman, Board of Directors
William A. Tortoriello, MD, FAAFP, Medical Staff President

Attachment GRC - 2b - 4

One Renaissance Boulevard
Oakbrook Terrace, IL 60181
(630) 792-5000
http://www.jcaho.org

This is to authorize the State Board and Agency access to information in order to verify any documentation or information submitted in response to the requirements of this subsection or to obtain any documentation or information that the State Board or Agency finds pertinent to this subsection.

SIGNATURE

Name Richard H. Gruber

Title Vice President

Date July 8, 2003

Attachment GRC-2b-5

Criterion 1110.230.c, Alternatives to the Proposed Project

The alternatives considered were:

1. Build a clinic in Crystal Lake and refer people requiring hospital or emergency care to the existing hospitals in Woodstock and McHenry.

2. Build a clinic in Crystal Lake and refer people requiring hospital or emergency care to our recently acquired hospital in Harvard.

3. Do nothing.

4. Build an acute care general hospital in Crystal Lake appropriate in size to the unserved population.

One need only drive in the area between our proposed site and the two closest existing hospitals and in the area to the southwest of our site to realize that the amount of traffic is, in the vernacular, "terrible".

This "terrible" traffic situation arises from two factors:

1. In the period 1990 – 2000 McHenry County was **THE** fastest growing county in Illinois. The towns of Algonquin and Lake in the Hills, located immediately to the southwest of Crystal Lake, were the fastest growing in the county.

2. McHenry County made only minor improvements in its roads during the 1990 – 2000 period. Currently the county has no plans for major improvements in road system.

Our original plan was to put a clinic in Crystal Lake. However, two major problems soon became evident. The first was that even though the people in Crystal Lake would have improved access to outpatient care, their access to inpatient care would not improve. As is documented elsewhere in this application, the travel times to existing hospitals will exceed soon 30 minutes. Secondly, our spending several million dollars to build only a clinic which would not satisfy inpatient or emergency care needs for the people in our proposed service area is not wise nor does it make any business sense.

Attachment GRC - 3

The population Density Map, Attachment GRC-3a, clearly shows the skew in population in McHenry County. What has made McHenry County such a fast growing area is the growth in the southeast corner of the county. Our proposed hospital will be centered in that fast growing corner.

The "Do Nothing" alternative certainly does not satisfy the public need. Once the population density is appreciated and the traffic problems experienced, the "Do Nothing" alternative is rejected.

What does come to mind is the need for an acute care general hospital to be centrally located in this densely populated area.

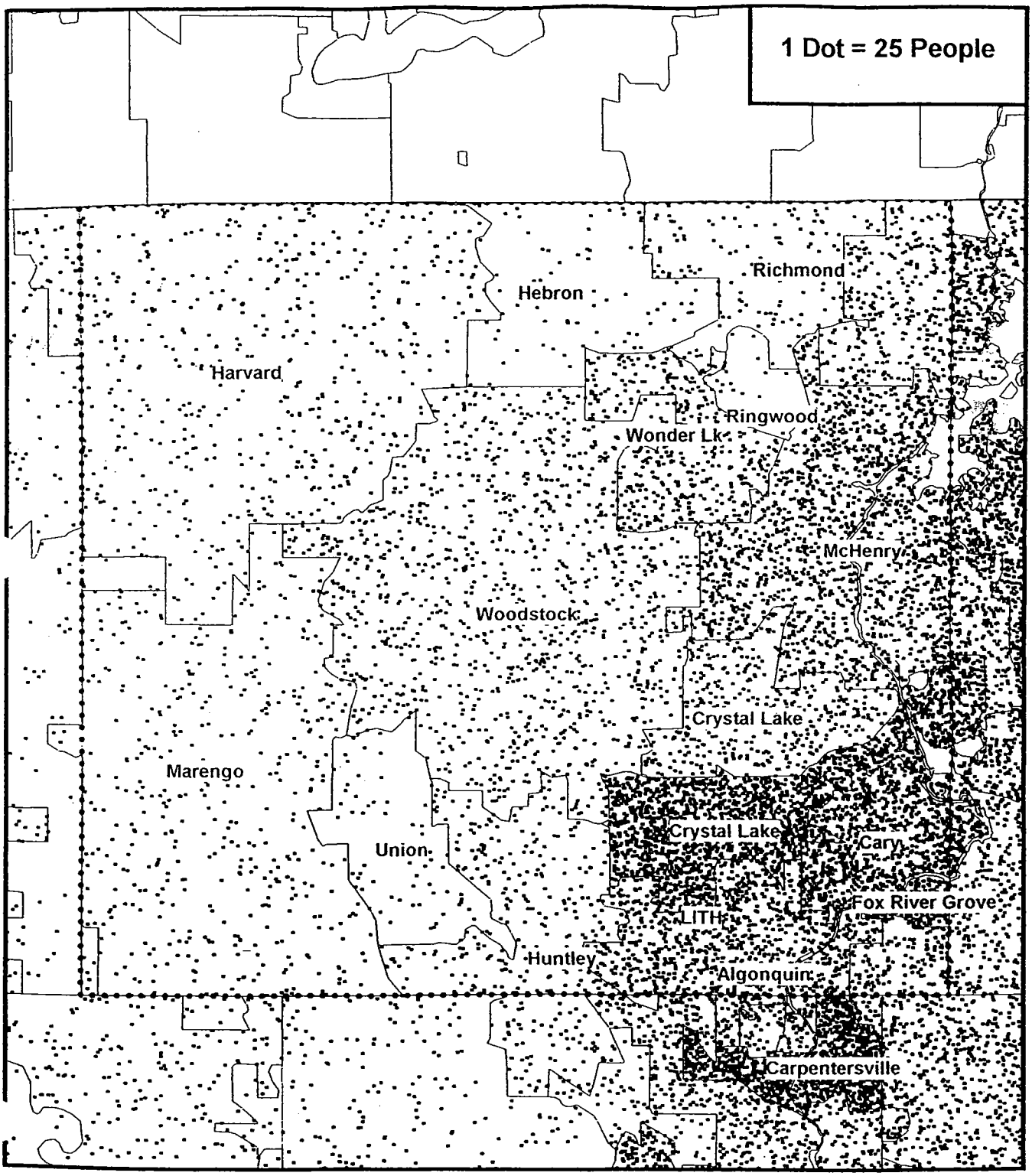
The same logic that led us to purchase this centrally located property several years ago as the site for a clinic now leads us to propose a hospital on that site.

There will be no additional cost to the people in our target area. Cost to patients at our hospital and clinic will be similar to those experienced at existing health care facilities. The benefits to the people we will serve are quick access to first class medical care as is discussed in detail elsewhere in this application. Easy access to both in and outpatient care will have obvious financial benefits for people who will otherwise lose work hours traveling to and back for hospital based services.

This proposed project is the alternative chosen because our hospital will provide care to a large number of people who are now unserved. And this proposed project is a wise move from a business perspective.

Attachment GRC-3

Population Density in McHenry County
2002 Population Estimate



Attachment GRC - 3a

Source: Solucient, Inc., Evanston, IL; Claritas, Inc., New York, NY; U.S. Census 2000

Criterion 1110.230.d, Need for the Project

NOTE: It is important that the reader understand that we have made and continue to make overtures to other hospitals in the area seeking to work cooperatively. To date these overtures have not borne fruit. See attached letter to Michael S. Eesley of Centegra Health System.

Hospital

The need methodology used for the major departments and for the nursing units is shown on this attachment and on Attachment GRC-6. The population in need was clarified by our traffic study. Use rates for the services were taken from a variety of available sources. Use rates for the identified population were then used to calculate the number of people in need of the service. Realistic estimates of the actual number of in need people who would come to our hospital were then applied. That last number of people was then used to determine workload and patient days.

All need calculations are based on the CY 2002 population estimates for the zip codes listed below. These data are estimates received via Solucient of Evanston Illinois and are estimates from Claritas, Inc. of New York, N.Y. and based on the U.S. Census 2002.

Towns	Zip Codes
Crystal Lake	60014
Algonquin	60102
Cary	60013
Lake in the Hills (LITH)	60156

These zip codes are shown on the attached map, GRC-4a.

The total estimated 2002 population of those zip codes is 99,253.

As is shown in the traffic study, Attachment GRC-1a, the travel time from our proposed site to existing hospitals soon will be equal to or greater than 30 minutes. However, as one can see on the zip code map, some of the population in these zip codes is closer to existing hospitals than they are to our proposed site. A consideration of the density of population suggests that slightly more than half of the population may reasonably be expected to come to our hospital.

Therefore, we have used 55%, 54,574, of the total zip code population as a reasonable number representing an unserved population.

Attachment GRC - 4

1. Surgery -General

NOTE: In CY 2001 those residents of our zip codes who had inpatient surgery, 74 % had their surgery done at hospitals outside of McHenry County[4].

The calculation of the number of procedure rooms needed requires the use of data from several sources because in this case we have no historical data from our to-be-built hospital.

The number of inpatient surgery cases for all of McHenry County[1] for CY 2001 was 7,750. Using those 2001 cases with the 2002 population estimate for all of McHenry County, 285,982, yields a use rate per 1,000 population of 27.10.

National data[3] for 0-99 bed hospital for the twelve month period ending 6-30-02 shows that 70.7% of total surgeries are done on an outpatient basis.

Data from Mercy Hospital in Janesville, Wisconsin (a 240 bed hospital) for 2002 shows that for all surgeries, inpatient and outpatient together, the time per case was 46 minutes.

The 70.7 outpatient percentage noted above means that the number of inpatient cases of 7,750 for McHenry County represents only 29.3% of the total done. That total equals 26,451 surgical cases.

That total number of cases and the McHenry County population yields a use rate of;

26,451 cases ÷ 285.982 thousand = 92.5 cases/1,000

Using the population of the 4 zip codes noted above the total number of cases that are expected from our identified unserved population is calculated as follows:

92.5 cases/1,000 X 54.574 = 5,048 cases

Our realistic estimate of the percentage of those cases that will come to our hospital for care is 83% for this highly physician directed function

5,048 cases X .83 = 4,190 cases

Attachment GRC - 4

The conversion of this number of cases to hours of surgery proceeds as follows:

4,190 cases X 46 minutes per case = 192,740 minutes

Thirty minutes of clean up/set up per case X 4,190 cases = 125,700 Mins.

Total minutes = 318,440

318,440 mins. ÷ 60 mins. per hour = 5,307 hours

5,307 hours ÷ 1,500 hours/procedure room* = 3.5 rooms needed

We are proposing to have 4 general procedure rooms. (We are proposing to have 10 recovery stations for these four rooms.)

*= State norm

2. Endoscopy

The outpatient surgery use rate for all of McHenry County calculates to be 65.4 cases per 1,000 population[1].

18,701 outpatient surgeries ÷ 285.92 = 65.4 cases/1,000

However, that rate seems high to apply to Endoscopy. The expectation is that on site availability of Spiral CT and Fluoroscopy will reduce the number of actual invasive endoscopies.

Thus a reduced rate per 1,000 population of 50 seems appropriate for Endoscopy.

That rate and our target population yields a total number of cases of:

50 cases/1,000 X 54.574 = 2,729 cases

We expect to capture 85% of those highly physician directed cases or:

.85 X 2,729 cases = 2,320 cases

Our hospital's experience shows that the time per endoscopy case equals 29 minutes. Including 30 minutes per case of clean up/set up for a tot al time per case of 59 minutes yields:

59 minutes/case X 2,320 cases = 136,880 total minutes

The ensuing mathematics demonstrates the need for our proposed 2 endoscopy rooms:

136,880 minutes ÷ 60 minutes per hour = 2,282 hours

2,282 hours ÷ 1,500 hours/procedure room* = 1.5 = 2 rooms

Thus we will have a total of 6 procedure rooms in our Surgery; 4 general and 2 endoscopy.

3. Delivery Suite

There were 3,929 deliveries[1] by McHenry County women in 2001.

NOTE: In CY 2001 82% of the pregnant women in our zip codes had their babies delivered in hospitals outside of McHenry County[4].

The population of women ages 14-44 was 58,052 in the year 2000[2].

The fertility rate for McHenry County is thus:

3,929 deliveries ÷ 58.052 women = 67.7 deliveries per 1,000.

Assuming that the percentage of women of childbearing age is the same in our target population as it is in all of McHenry County, our 14-44 population is:

54,574 X 20.3% = 11,079 women

The number of deliveries to be expected from our target population is then:

67.7 deliveries per 1,000 X 11.079 thousand = 750 deliveries

We are of the opinion that while pregnant women "shop around" for a hospital that they prefer, the impact of that shopping will be mitigate by our Obstetric Service emphasis as discussed in Attachment GRC-6b. Our expectation is that 80% of our target population will come to our new hospital.

750 deliveries X .80 = 600 deliveries

We are proposing to have 4 LDR's in the 1,975 gft^2 allowed by the State Norm.

3. Referrals

Referrals as such are thought not to be germane to our proposed new hospital. Our patients will be admitted by one of the physicians in our attached 45 FTE physician clinic.

Attached as GRC 4-1c are letters from our employed physicians who will staff our attached clinic certifying to the fact that they will admit the numbers of patients discussed in this application.

4. Major Medical Equipment

There is no such equipment in this project.

* = State Norm
1. Illinois Health Care Cost Containment Council (IHCCCC), CY 2001 (Illinois Discharge Data)
2. US Census 2000
3. Hospitals and Health Networks, February 2003
4. Health Care Market Analysis System (HCMAS) Market Share Report

MERCY HEALTH SYSTEM
1000 MINERAL POINT AVE.
P.O. BOX 5003
JANESVILLE, WI 53547-5003
Tele: 608•756•6623
Fax: 608•756•6168
www.mercyhealthsystem.org
Office of the President
A System for Life

June 18, 2003

Mr. Michael S. Eesley
President and CEO
Centegra Health System
527 West South Street
Woodstock, IL 60098

Dear Mike:

As you know, our two organizations have met several times to talk about potential relationships between Mercy Health System Corporation and Centegra Health System. In early 2002, Paul Laudick and I met to discuss potential options. Mr. Laudick indicated he was retiring and that you would be his successor. Subsequently, our two organizations met at the following times:

March 13, 2002

You, Paul Laudick and I had an introductory meeting.

August 6, 2002

Meeting at Mercy Walworth with Sue Ripsch, Mark Goelzer, Joe Nemeth, and Javon Bea from Mercy and Mike Eesley, Tom Dattalo, and Dr. Robert Turngren from Centegra. Meeting agenda: 1) Tour of Mercy Walworth; 2) Collaborative Opportunities for the future, i.e., joint physician organization in Illinois, current properties and potential joint efforts for Crystal Lake land and McHenry land facility; 3) Joint facility in southern McHenry County; and 4) Other Items.

November 27, 2002

Information sharing meeting to discuss the vision of Mercy Health System and Centegra Health System. Mercy participants: Javon Bea; Joe Nemeth; and Mark Goelzer. Centegra participants: Mike Eesley; Christopher Bennett; Tom Dattalo; Dr. Robert Turngren; Dr. Honeid Baxamusa; and Dr. Spiro Gerolimatos.

February 18, 2003

Mercy participants: Javon Bea; Joe Nemeth. Centegra participants: Mike Eesley; Greg Pagliuzza; Aaron Shepley; and Mark Parrington.

At our meeting in February of this year, we discussed and clarified our proposal for working together to provide health care services to residents of the communities we serve. We also emphasized our eight-year commitment to the Harvard, Illinois community, in particular to providing health care services to the poor and Medicaid population of the Harvard area. As part of that commitment, we developed a relationship with Harvard Memorial Hospital.

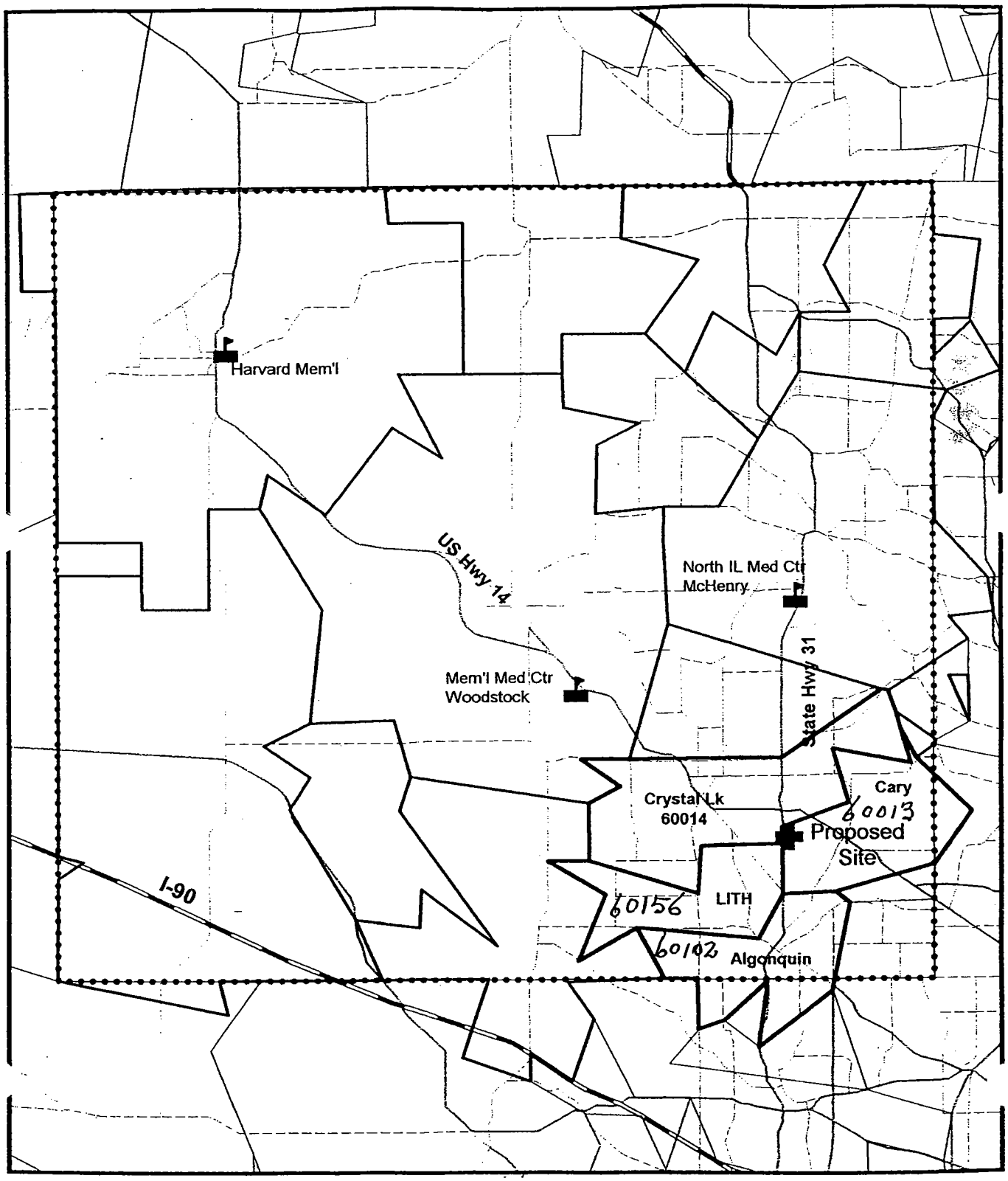
Since the time of our meeting in February of this year, we have heard nothing from Centegra regarding our proposal. We have, therefore, concluded that Centegra is not interested in pursuing a relationship with Mercy. We continue to believe that our proposal would be a benefit to the patients of our service area and to both of our organizations.

Please feel free to contact me if you have questions.

Sincerely,

Javon R. Bea
President and CEO

McHenry County Hospitals



Criterion 1110.230.d, Need for the Project

Clinic

We are proposing a clinic, attached to the hospital, for 45 FTE physicians.

The physician specialties to be located here and the number of each are shown of Attachment GRC 4 -1a.

Solucient methodology was used as the basis for estimating physician need. See Attachment GRC 4-1b. The Solucient method does not permit an analysis of an area as small as that of our target population area. Therefore, we have made judgment calls based on experience at our three clinics now located in our proposed service area to reduce the number of physicians to that thought to be needed.

When this clinic opens, we will close our two Crystal Lake clinics, Mercy East and Mercy West as well as our clinic in Cary.

The 45 FTE physicians programmed for this clinic will be the source of a large majority of our hospital admissions. These physicians will all be employees of the integrated system, specifically the applicant or an affiliate. In our system hospitalization is considered to be an extension of the patient's physician's care. We are not just hoping that patients will come to our clinic; we know that they will come.

Attachment GRC – 4 -1

CLINIC PHYSICIANS

FTE PHYSICIANS BY SPECIALTY	TOTAL
Family Practice	5
Internal Medicine	5
Pediatrics	3
OB/GYN	3
Allergy	1
Cardiology	1
Dermatology	2
ENT	1
UC	3
Gastroenterology	1
General Surgery	3
Neurology	1
Oncology	1
Ophthalmology	2
Orthopedics	3
Plastic Surgery	1
Pulmonology	1
Rheumatology	1
Rotators	6
Urology	1
TOTAL	45

Attachment GRC-4-1a

Source Notes

Physician Demand Estimates

Click here for a .pdf version of this file

Overview
Data Sources
Methodology
Applications and Caveats
Release Notes
Reference Files

Overview

Physician Demand Estimates predict the total annual demand for physician ambulatory visits and physician FTEs by ZIP Code, age group, sex, site of service, and physician specialty for every market in the United States. Twenty-eight specialties are profiled, including primary care physicians as well as various medical, surgical and pediatric specialists. Solucient used proprietary and public claims as well as Federal surveys to construct population-based visit use rates for all payers in the hospital and private office settings. These use rates are then applied to demographic projections by ZIP Code to estimate physician visits for 2002 and 2007. Physician productivity from MGMA is used to convert visit estimates into numbers of physicians demanded for 2002 and 2007.

Data Sources

- 2001 Proprietary Commercial Claims, Solucient
- 2001 Medicare Claims, CMS
- 1997-2000 National Ambulatory Medical Care Survey
- 2002 Medical Group Management Association (MGMA) Physician Compensation and Production Survey
- 2002 & 2007 Demographic Projections, Claritas, Inc.

Methodology

Visit Estimates

Solucient created physician visit estimates by first constructing ambulatory visit rates by specialty, patient age, patient sex, site of service, and county of patient residence. Visit rates are built from public and private claims streams as well as Federal surveys. Claims data are used to construct overall visit rates by age, sex, county and site of service. These overall visit rates are specific to each and every county in the United States and reflect local patterns of health care demand and access to physicians. Site of service refers to the type of setting rather than specific provider locations. The two sites available are private physician office and other. The other site includes any hospital-owned or freestanding outpatient facility.

The National Ambulatory Medical Care Survey is then used to provide physician specialty breakouts for these overall visits and to adjust the claims-based models to reflect all payers (not just Medicare and Commercial). The specialty breakouts are applied differently for each age/sex group and for each of the four census regions (Midwest, Northeast, South and West). In addition, different breakouts are constructed for urban vs. rural counties - urban counties are those belonging to a Metropolitan Statistical Area (MSA) and rural counties do not belong to an MSA.

Visits are defined as a patient's face-to-face encounter with a physician in a private office of hospital-owned setting for evaluation and management. Solucient defines such visits using the CPT-4 code definition for Evaluation and Management (E&M codes). Inpatient encounters, emergency department encounters and major surgical encounters have been excluded from the visit estimates. These excluded encounters are estimated in other Solucient demand databases.

61

Once these visit rates are completed, Solucient multiplies these rates by their appropriate populations by age and sex to yield visit volume estimates at the ZIP Code level for 2002 and 2007.

Physician FTE Estimates

Physician Full Time Equivalent (FTE) estimates are built by dividing the physician visit estimates (described above) by physician annual productivity to yield the number of physicians demanded for a given population for 2002 and 2007.

The Medical Group Management Association (MGMA) surveys physician practices across the country and publishes levels of productivity by specialty. Productivity is defined by the number of ambulatory visits a typical physician sees annually stratified by four levels of productivity: 25%, 50%, 75% and 90%. Solucient uses all four levels and calculates physician FTE demand for each productivity level. In general, Solucient recommends the 50% (or median survey response) because it best reflects the typical productivity in any given market. If physicians in a market are less or more productive than the national median, different levels of productivity can be chosen.

Solucient Physician Specialties

Physician Demand Estimates provide visit and FTE estimates for 28 distinct Solucient specialty categories. These categories represent groupings of the more detailed American Medical Association (AMA) codes - the definition of each of the Solucient specialty categories is available as a reference file at the end of this document. Visit and FTE estimates are not available for radiologists, pathologists and anesthesiologists because they are not primarily involved in direct patient care. In addition, estimates for emergency medicine visits and physicians are not included in this data but are available in other Solucient demand databases.

The Solucient Specialty Categories Are:

- Allergy/Immunology
- Cardiology
- Dermatology
- Gastroenterology
- General and Family Practice
- General Surgery
- Hematology/Oncology
- Internal Medicine
- Medical Subspecialties
- Nephrology
- Neurology
- Obstetrics and Gynecology
- Ophthalmology
- Orthopedic Surgery
- Other
- Otolaryngology
- Pediatrics
- Pediatric Cardiology
- Pediatric Neurology
- Pediatric Psychiatry
- Other Pediatric Subspecialties
- Physical Medicine and Rehabilitation
- Plastic Surgery
- Psychiatry
- Pulmonary
- Rheumatology
- Surgical Subspecialties
- Urology

Applications and Caveats

- This data represents estimates of physician visits and FTE demand and is not a perfect accounting of actual demand for physician services. While Solucient uses a vast amount of claims at a local level, these estimates may vary from actual experience.
- When choosing a productivity level for physicians, Solucient recommends using the 50% (or median survey response) because it best reflects the typical productivity in any given market. If physicians in a market are less or more productive than the national median, different levels of productivity can be chosen.
- Substitution of physician specialties may occur in some markets, depending on availability of certain specialists or unique local practice patterns. In addition, many individual physicians are board certified in multiple specialties, making it challenging to accurately measure demand for physician services for specific specialty. In such cases, Solucient

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Attachment GRC - 4 - 1b

recommends analyzing physician demand in broader categories such as primary care, medical specialties, surgical specialties and pediatric specialties. Primary care is typically defined as General and Family Practice, Internal Medicine and Pediatrics.

- Estimates for inpatient visits, emergency department visits and major surgical visits are not included. Please refer to Solucient's Emergency Department Estimates and Ambulatory Surgery Estimates for data concerning these excluded visit types.
- Estimates for radiologists, pathologists, anesthesiologists and emergency medicine are not included. To estimate staffing for these specialties, please refer to the Physician Supply Benchmark section.

Release Notes

- Release Notes for 2002 Physician Demand Estimates

Reference Files

- 2002 Solucient Physician Specialty Definitions

Physician Demand Estimates 2002/2007 Release Notes

Physician Demand Estimates methodology did not change substantially for the 2002 estimates, but use rates were updated with more recent data and the specialty breakouts in reports has changed. Details for each of the changes is listed below:

Changes in Estimates – For the 2002/2007 statistics, new use rates, productivity rates and demographics were used to calculate new estimates of both visits and FTEs. Each one is highlighted below:

- **Overall Visit Use Rates** – Newer claims were used to update the overall visit demand rates by age, sex and county. The new overall visit rates changed very little from the previous year (less than a 5% change in the rate)

- **Specialty Visit Use Rates** – Solucient uses the National Ambulatory Medical Care Survey (NAMCS) results to help distribute the visits by specialty. An additional year of NAMCS data was added to the three years of data used in last year's version increasing the number of survey respondents by 33%. Although Solucient used four years of data to minimize anomalies in the NAMCS results, this increased sample of data impacted the visit rates for specific specialties in certain regions of the country. In general, primary care (GPFP, IM, PED) physician demand visit rates changed very little from the previous year (less than 10%) due to a relatively large sample size in the survey. However, more rare medical specialties like Psychiatry, Rheumatology, Pulmonary and other medical subspecialties increased or decreased by over 20% from the previous year in certain areas of the country. These changes are due to a larger and more predictive sample of NAMCS surveys meaning that 2002 specialty rates are more accurate than last year for more rare specialties.

- **Productivity Rates** – The latest version of MGMA productivity figures (2002) shows an average increase in median physician productivity of about 7.2% over last year's numbers. However, certain specialties showed dramatic increases in the 2002 statistics (over the 2001 statistics), namely Psychiatry and Nephrology, with 31% and 55% increase in their median productivity respectively. Other specialties that showed considerable increases in median productivity were Cardiology, Neurology and Hematology/Oncology – all of which showed growth between 12% and 16% over last year. The effect of increasing productivity means that FTE demand for these physicians actually will show declines in physician need as physicians can see more patients then they did one year earlier.

- **Changes in Demographics** – The 2002/2007 Physician Demand Estimates incorporated the corresponding 2002/2007 Claritas demographics to estimate the demand for visits and ultimately FTEs. While overall population counts from 2001 to 2002 did not change very much, the age and sex composition of the population was finally updated with 2000 Census information. The change in the distribution of demographics by age and sex may have an impact upon the change

in demand for physician visits and FTEs volume between 2001 and 2002. See release notes for Demographics to understand these changes better.

Changes in Pediatric Specialty Detail – For the 2002/2007 statistics Solucient added three new pediatric subspecialties. The three new subspecialties are Pediatric Cardiology, Pediatric Psychiatry and Pediatric Neurology. A fourth specialty category was also added called Other Pediatric Subspecialty that includes all remaining pediatric subspecialties other than the three listed above. All four of these new specialty categories are equivalent to the Pediatric Subspecialty category present in last year's estimates.

Removal of Emergency Medicine Specialty – Solucient removed the Emergency Medicine/Critical Care specialty from both the visit estimates and the FTE estimates. This specialty was removed this year because emergency department visits (which make up the bulk of work for these specialists) is not included in the visit estimates. While these specialists may officially see visits in a non-emergency room setting, this volume is negligible and was removed from the estimates. For true emergency room visit demand and FTE demand, please refer to Solucient Emergency Department Estimates database.

Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson
Springfield, IL 62761

Dear Mr. Secretary: Date

This is to certify that I expect to admit (insert number of MS, OB or ICU) patients to our proposed new hospital in Crystal Lake in the year 2008.

I am looking forward to having this new facility appropriately located for the benefit of my patients.

_____
Signature

_____
Typed name

PHYSICIAN LETTERS TO FOLLOW 2004 AS PER CONVERSATION WITH MIKE C. ON 19 JUNE 2003.

Notarization
Subscribed and sworn before me
This _____ day of _____

_____
Signature of Notary

Seal

Attachment GRC-4-1c

Criterion 1110.230.e, Size of the Project

Medical/Surgical Nursing Unit

The total gft^2 for our proposed 56 Medical/Surgical beds exceeds the State Norm because of three factors.

1. All of our rooms on these units will be private rooms. The State Norm is made up of a mixture of private and semi-private rooms.

   The public expects that they will be afforded privacy for such as sleeping and for family and friends visitations. There is also the expectation that a private bathroom will be available.

   Through Emergency Preparedness planning, access to private rooms for the purpose of isolation protection related to Bioterrorism is a variable nonexistent in the past but is planned for this facility

   These days building other than private rooms is not wise from a patient satisfaction perspective.

2. Because of our building footprint a so-called "race track" corridor system is required. This configuration increases the square footage over that of the more commonly used central single corridor.

3. All of our three inpatient bed services are purposely located contiguously to each other. Thinking of what our inpatient situation might be in distant years as our service area population continues to grow has led us to size all rooms as "universal" rooms. That means that our Medical/Surgical rooms can be used for Obstetric or for ICU patients.

Other Information

The following information is offered so that compliance with State Norms can be verified.

1. Emergency Room. Based on local experience with a similar patient base, we anticipate that we will experience about 20,000 visits and a need for 10 treatment rooms.

2. Laboratory. We estimate that we will require 14 FTE.

Attachment GRC - 5

3. Radiology. We will have 8 pieces of diagnostic equipment in 8 rooms.

4. Surgery. We will have the 4 general rooms and 2 endoscopy rooms justified elsewhere in this application.

5. Recovery. We are proposing 10 recovery stations for our 4 general surgery procedure rooms.

Attachment GRC-5

Criterion 1110.230.e, Size of the Project

There is no State Norm for the size of the following departments and functions.

Clinic

The derivation of the proposed GFT^2 is shown on the following Attachment GRC - 5 – 1a.

Hospital

The derivation of the proposed GFT^2 is shown on the following Attachment GRC – 5 – 1b in the same order as the departments and functions are listed here.

Admin./Business Office
Materials Management
Building Support
Building Systems
Public Circulation
Cardiac Rehabilitation
Employee Facilities
Medical Library
Outpatient Surgery
Housekeeping
Laundry
Medical Records
Snack Shop
Yard Storage
Human Resources
Marketing

Meeting Rooms – 2 each at 561 GFT^2 each
Ambulance Garage – space for two ambulances plus a small storage space
Canopies – To provide covered entrance on north and south sides of hospital

Attachment GRC-5-1

Mercy
Crystal Lake
Medical Center

Building Systems

	Room Name				Total NSF	Comments
1	Mechanical Room	2	@	2870	5,740	
2	Electrical Room	1	@	1700	1,700	
3	Main Communications Room	1	@	500	500	
4	Comm. Rooms (ea floor)	2	@	115	230	
	Subtotal Building Systems				8,170	

Attachment GRC-- 5 - 1a

Mercy
Crystal Lake
Medical Center

Medical Records

Room Name				Total NSF	Comments
1 Medical Records Storage	1	@	7830	7,830	5 staff x 80 SF/person = 400 SF
Subtotal Medical Records				7830	

Mercy
Crystal Lake
Medical Center

Public Circulation

	Room Name			Total NSF	Comments
1	Corridors/Stairs/Elevators	1	@ 17470	17,470	5 staff x 80 SF/person = 400 SF
	Subtotal Reception/Zone			17,470	

Attachment GRC - 5 - 1a

Mercy
Crystal Lake
Medical Center

Physician Areas

Room Name				Comments
Family Practice				
1 Exam Room	12 @	120	1,440	
2 Physician Office	4 @	120	480	
3 Nurse Station	1 @	120	120	
Internal Medicine				
4 Exam Room	12 @	120	1,440	
5 Physician Office	4 @	120	480	
6 Nurse Station	1 @	120	120	
Pediatrics				
7 Exam Room	9 @	120	1,080	
8 Physician Office	3 @	120	360	
9 Nurse Station	1 @	120	120	
Ob/Gyn				
10 Exam Room	9 @	120	1,080	
11 Physician Office	3 @	120	360	
12 Non Stress Test	1 @	140	140	
13 Nurse Station	1 @	120	120	
Allergy				
14 Exam Room	3 @	120	360	
15 Physician Office	1 @	120	120	
16 Injection Room	1 @	120	120	
17 Nurse Station	1 @	120	120	
Cardiology				
18 Exam Room	6 @	120	720	
19 Physician Office	2 @	120	240	
20 Nurse Station	1 @	120	120	
Dermatology				
21 Exam Room	5 @	120	600	
22 Physician Office	1.5 @	120	180	
23 Light Room	1 @	120	120	
24 Treatment	1 @	120	120	
25 Nurse Station	1 @	120	120	
ENT/Audiology				
26 Exam Room	3 @	120	360	
27 Physician Office	1 @	120	120	
28 Audiology Booth	2 @	120	240	
29 Treatment	1 @	140	140	
30 Nurse Station	1 @	120	120	
General Surgery				
31 Exam Room	6 @	120	720	
32 Physician Office	2 @	120	240	
33 Nurse Station	1 @	120	120	
Gastroenterology				
34 Exam Room	3 @	120	360	
35 Physician Office	1 @	120	120	
36 Nurse Station	1 @	120	120	
Neurology				
37 Exam Room	3 @	120	360	
38 Physician Office	1 @	120	120	
38 ENG	1 @	120	120	
39 Nurse Station	1 @	120	120	
Oncology				
40 Exam Room	6 @	120	720	

Attachment GRC - 5 - 1a

41 Physician Office	2	@	120	240	
42 Chemotherapy (6 chairs)	1	@	480	480	
43 Chemo Support	1	@	120	120	
44 Nurse Station	1	@	120	120	
Ophthalmology					
45 Exam Room	3	@	120	360	
46 Physician Office	1	@	120	120	
47 Lasik	1	@	140	140	
48 Visual Fields	1	@	60	60	
48 Testing	1	@	60	60	
49 Nurse Station	1	@	120	120	
Orthopedics					
50 Exam Room	6	@	120	720	
51 Physician Office	2	@	120	240	
52 Cast Room	1	@	180	180	
53 Nurse Station	1	@	120	120	
Plastic Surgery					
54 Exam Room	3	@	120	360	
55 Physician Office	1	@	120	120	
56 Nurse Station	1	@	120	120	
Pulmonology					
57 Exam Room	3	@	120	360	
58 Physician Office	1	@	120	120	
59 PFT Room	1	@	120	120	
60 Nurse Station	1	@	120	120	
Rheumatology					
61 Exam Room	3	@	120	360	
62 Physician Office	1	@	120	120	
63 Nurse Station	1	@	120	120	
Rotators					
64 Exam Room	15	@	120	1,800	
65 Physician Office	5	@	120	600	
66 Nurse Station	1	@	120	120	
Urology					
66 Exam Room	3	@	120	360	
67 Physician Office	1	@	120	120	
68 Treatment	8	@	144	1,152	
69 Nurse Station	1	@	120	120	
General Clinic					
69 Patient Toilet	16	@	80	1,280	Handicap Accessible.
70 Clean Utility	4	@	120	480	
71 Soiled Holding	4	@	120	480	
72 Equipment Storage	4	@	120	480	
73 Scale Alcove	4	@	40	160	
Business/Admin					
74 Reception/Schedule	2	@	400	800	
75 Personal Financial Counselor	4	@	120	480	
76 Conference Room	2	@	224	448	
77 Consult	2	@	126	252	
78 Records Work Room	2	@	252	504	
79 Clinic Manager	2	@	126	252	
Pharmacy/Retail					
80 Pharmacy Work	1	@	700	700	
81 Pharmacy Retail/DME	1	@	800	800	
82 Optical Retail	1	@	685	685	

Attachment GRC - 5 - 1a

Mercy
Crystal Lake
Medical Center

Subtotal Physician Areas	31,453
Physican Areas Gross Square Feet (DGSF) @ 1.40	44,034
Subtotal Clinics (NSF)	86,444

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Physician Clinics

SPACE REQUIREMENTS

Waiting

	Room Name				Total NSF	Comments
1	Waiting	2	@	3195	6,390	132 patient rooms X 2.5 = 330 seats
	Subtotal Waiting				6,390	

Mercy
Crystal Lake
Medical Center

Food Court

Room Name			Total NSF	Comments
1 Food Court	1 @	2550	2,550	
Subtotal Food Court			2,550	

Attachment GRC - 5 - 1a

Administration / Business Office

SPACE REQUIREMENTS

Administration

	Room Name				Total NSF	Required by:	Comments
1	CEO Office	1	@	144	144	Area	
2	Administrative Office	2	@	120	240	Room	
3	Secretary	2	@	80	160	Room	
4	Mailroom	1	@	120	120	Area	
5	Finance Office (Private)	1	@	120	120		
6	Finance Office (Open)	1	@	725	725		20 people x 60 SF = 1200 SF
7	Finance Conf/Work Room	1	@	225	225		10 people x 20 SF = 200 SF
8	Call Center	1	@	240	240		12 phones x 20 SF = 240 SF
9	Registration	4	@	120	480	IDPH, AIA	One per Level
Subtotal Administration					**2,454**		

Total Department Gross Square Feet (DGSF) @ 1.40	**3,436**

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Attachment GRC - 5 - 1b

Materials Management

SPACE REQUIREMENTS

Materials Management

	Room Name				Total NSF	Required by:	Comments
1	Loading Dock	1	@	180	180	IDPH,AIA	
2	Shipping and Receiving	1	@	180	180	IDPH,AIA	
3	General Storage	1	@	3170	3,170	IDPH,AIA	
4	Trash Room	1	@	120	120	IDPH,AIA	Adjacent to Loading Dock.
5	Infectious Waste	1	@	250	250	IDPH,AIA	
6	Recycling	1	@	250	250		Adjacent to Loading Dock.
Subtotal Materials Management					**4,150**		
Total Department Gross Square Feet (DGSF) @ 1.0							**4,150**

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Building Support

SPACE REQUIREMENTS

	Room Name				Total NSF	Required by:	Comments
1	Manager	1	@	100	100	none	Lower level
2	Engineer	1	@	100	100	IDPH, AIA	
3	Biomedical	1	@	.250	250	AIA	
4	Shop Area	1	@	250	250	IDPH, AIA	Lower level
5	General Storage	1	@	1500	1,500		
6	Loading Dock	1	@	1000	1,000	IDPH,AIA	
7	Shipping and Receiving	1	@	580	580	IDPH,AIA	
8	Trash Room	1	@	120	120	IDPH,AIA	Adjacent to Loading Dock.
9	Infectious Waste	1	@	100	100	IDPH,AIA	
10	Recycling	1	@	100	100		Adjacent to Loading Dock.
	Subtotal Building Support				**4,100**		
	Total Department Gross Square Feet (DGSF) @ 1.33				**5,453**		

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Attachment GRC - 5 - 1b

Building Systems

SPACE REQUIREMENTS

Building Systems

	Room Name				Total NSF	Required by:	Comments
1	Mechanical Fan Room	2	@	3000	6,000	IDPH, AIA	Basement level
2	Mechanical Boiler/Chiller	2	@	2100	4,200	IDPH, AIA	Basement level
3	Mechanical Pumps/Equip	2	@	800	1,600	IDPH, AIA	Basement level
4	Electrical Room	1	@	1700	1,700	IDPH, AIA	
5	Electrical Closet	6	@	80	480	IDPH, AIA	
6	Communication Closet	2	@	100	120	IDPH, AIA	
7	Emergency Generator	1	@	0	0	IDPH, AIA	Outdoor unit
8	Incinerator	1	@	0	0	IDPH, AIA	Outdoor unit

Subtotal Building Systems 14,100

Total Department Gross Square Feet (DGSF) @ 1.10 **15,510**

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Mercy
Crystal Lake
Medical Center

June 2, 2003

Public Areas / Circulation

SPACE REQUIREMENTS

Public Areas

	Room Name				Total NSF	Required by:	Comments
1	Public Toilets	4	@	200	800	IDPH, AIA	Male & Female on both levels
2	Public Telephones	3	@	5	15	IDPH, AIA	
3	Vending/Lounge	1	@	400	400	IDPH, AIA	
4	Community Education	1	@	200	200	IDPH	
5	Meeting Rooms	2	@	600	1,200	IDPH, AIA	Includes storage. SHELLED
6	Wheelchair Storage	1	@	110	110	IDPH, AIA	
7	Reception	1	@	180	180	IDPH, AIA	
8	Drinking Fountains	4	@	5	20	IDPH, AIA	
	Subtotal Public Areas				**2,925**		

Public Circulation

	Room Name				Total NSF	Required by:	Comments
1	Public Elevators/Lobbies	8	@	600	4,800	IDPH, AIA	Male & Female on both levels
2	Stairs	8	@	200	1,600	IDPH, AIA	
3	Public Atrium/Wait	1	@	2500	2,500	IDPH, AIA	
4	Public Corridor	1	@	10400	10,400	IDPH, AIA	
5	Entrance Vestibule	2	@	250	500	IDPH, AIA	
	Subtotal Public Circulation				**19,800**		
	Subtotal Public Areas / Circulation				**22,725**		

Total Department Gross Square Feet (DGSF) @ 1.0 **22,725**

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Attachment GRC - 5 - 1b

Cardiac Rehabilitation

SPACE REQUIREMENTS

Cardiac Rehab

	Room Name				Total NSF	Required by:	Comments
1	Patient Toilet	2	@	65	130		Combined with Shower/Changing
2	Men's Shower/Changing	1	@	65	65		
3	Women's Shower/Changing	1	@	65	65		
4	Treatment Room	1	@	108	108		
5	Gym	1	@	355	355		
6	Consult	1	@	108	108		
7	Office	1	@	108	108		
8	Handwashing	1	@	5	5		
9	Classroom	1	@	150	150		10 people x 15 SF = 150 SF
Subtotal Cardiac Rehab Zone					**1,094**		
Total Department Gross Square Feet (DGSF) @ 1.1							**1,203**

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Attachment GRC - 5 - 1b

Employee Facilities

SPACE REQUIREMENTS

Employee Facilities

	Room Name				Total NSF	Required by:	Comments
1	Employee Lounge	1	@	160	160	IDPH,AIA	Handwashing in ea. Rm.; 1 Seclusion rm
2	Employee Locker/Toilet/Sh.	2	@	255	510	IDPH,AIA	One each for men and women
3	Volunteer Area/Coats	1	@	160	160	IDPH,AIA	
	Subtotal Employee Facilities				**830**		
	Total Department Gross Square Feet (DGSF) @ 1.4						**1,162**

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Attachment GRC - 5 - 1b

Medical Library

SPACE REQUIREMENTS

	Room Name				Total NSF	Required by:	Comments
1	Medical Library	1	@	750	750	IDPH, AIA	
	Subtotal Public Areas				750		
	Total Department Gross Square Feet (DGSF) @ 1.00						**750**

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Attachment GRC - 5 - 1b

Outpatient Surgery (Prep / Phase II Recovery)

	Room Name			Total NSF	Required by:	Comments
1	Reception	1 @	250	250		
2	Prep/Phase II Recovery	15 @	125	1,875	IDPH, AIA	
3	Handwashing	4 @	5	20	IDPH, AIA	
4	Isolation	1 @	120	120	none	
5	Patient Toilet	5 @	60	300	IDPH, AIA	
6	Nurse Station	1 @	250	250	IDPH, AIA	
7	Staff Toilet	1 @	65	65	AIA	
8	Dictation	1 @	60	60	none	
9	Clean Utility	1 @	120	120	IDPH	
10	Soiled Utility	1 @	120	120	IDPH	
11	Nourishment	1 @	60	60	none	
12	Medications	1 @	60	60	IDPH	
13	Linen Alcove	1 @	20	20	none	
14	Patient Lockers	1 @	25	25	none	
	Subtotal Outpatient Surgery (Prep / Phase II Recov			**3,345**		
	Total Department Gross Square Feet (DGSF) @ 1.55					**5,185**

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SPACE REQUIREMENTS

Housekeeping

	Room Name				Total NSF	Required by:	Comments
1	Housekeeping Storage	1	@	355	355	IDPH, AIA	Cleaning supplies and equipment
2	Handwashing	1	@	5	5	IDPH, AIA	Located in Clean and Soiled Linen Storage
3	Supervisor	1	@	100	100	IDPH, AIA	Lower level
4	Janitor Closet	5	@	40	200	IDPH, AIA	Building Janitor closets located on each floor
	Subtotal Housekeeping				660		
	Total Department Gross Square Feet (DGSF) @ 1.10						726

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Attachment GRC - 5 - 1b

Laundry

SPACE REQUIREMENTS

Laundry

	Room Name				Total NSF	Required by:	Comments
1	Clean Linen Storage	1	@	210	210	IDPH, AIA	Storage for 3-days supply plus daily use
2	Soiled Linen Storage	1	@	215	215	IDPH, AIA	
3	Handwashing	2	@	5	10	IDPH, AIA	Located in Clean and Soiled Linen Storage
Subtotal Laundry					**435**		
Total Department Gross Square Feet (DGSF) @ 1.10							**479**

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Mercy
Crystal Lake
Medical Center

June 2, 2003

Medical Records

SPACE REQUIREMENTS

Medical Records

	Room Name				Total NSF	Required by:	Comments
1	Medical Records Storage	1	@	3975	3,975	IDPH, AIA	
	Subtotal Medical Records				**3,975**		
	Total Department Gross Square Feet (DGSF) @ 1.1						**4,373**

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Attachment GRC - 5 - 1b

Snack Shop

SPACE REQUIREMENTS

	Room Name				Total NSF	Required by:	Comments
1	Snack Shop/Dining	1	@	80	955	IDPH, AIA	
Subtotal Dietary					**955**		
Total Department Gross Square Feet (DGSF) @ 1.20							**1,146**

IDPH Illinios Department of Public Health (77 ILL. ADM. CODE 250 Section 250.2440 - General Hopsital Standards)

AIA AIA Guidelines for Design and Construction of Hospitals and Health Care Facilities - 2001 Edition

SPACE REQUIREMENTS

Yard Equipment Storage

	Room Name			Total NSF	Required by: Comments
1	Yard Equip. Storage	1	@ 240	240	IDPH, AIA
	Subtotal Building Support			**240**	
	Total Department Gross Square Feet (DGSF) @ 1.40				**336**

IDPH Illinios Department of Public Health (77 ILL. ADM. CODE 250 Section 250.2440 - General Hopsital Standards)

AIA AIA Guidelines for Design and Construction of Hospitals and Health Care Facilities - 2001 Edition

Attachment GRC - 5 - 1b

Human Resources

SPACE REQUIREMENTS

Human Resources

	Room Name				Total NSF	Required by:	Comments
1	HR Manager Office	1	@	120	120	Area	
2	HR Open Office	1	@	300	300	Room	
3	Secretary	1	@	80	80	Room	
4	Interview Room	1	@	120	120	Area	
5	Conference Room	1	@	140	140		Adjacent to each Reception
	Subtotal Human Resources				**760**		
	Total Department Gross Square Feet (DGSF) @ 1.10						**836**

IDPH Illinios Department of Public Health (77 ILL. ADM. CODE 250 Section 250.2440 - General Hopsital Standards)

AIA AIA Guidelines for Design and Construction of Hospitals and Health Care Facilities - 2001 Edition

Attachment GRC - 5 - 1b

Marketing

SPACE REQUIREMENTS

Marketing

	Room Name				Total NSF	Required by:	Comments
1	Mktg Manager Office	1	@	120	120	Area	
2	Administrative Office	2	@	120	240	Room	PR/Community Relations
3	Secretary	2	@	80	160	Room	
4	Workroom	1	@	200	200		
5	Mailroom/Storage	1	@	250	250	Area	
	Subtotal Marketing				**970**		
	Total Department Gross Square Feet (DGSF) @ 1.40						**1,358**

IDPH Illinios Department of Public Health (77 ILL. ADM. CODE 250 Section 250.2440 - General Hopsital Standards)

AIA AIA Guidelines for Design and Construction of Hospitals and Health Care Facilities - 2001 Edition

Criterion 1110.230.e, Size of the Project (Utilization)

Medical/Surgical Beds

Although our proposed hospital is expected to be open for business by January of 2006, we have used population estimates for CY 2002 throughout this application. We are of the opinion that this more conservative approach is wise because population projections for the year 2006 are so far removed from the last census year of 2000 as to make the numbers slightly suspect.

All need calculations are based on the CY 2002 population estimates for the zip codes listed below. These data are estimates received via Solucient of Evanston Illinois and are estimates from Claritas, Inc. of New York, N.Y. and based on the U.S. Census 2000.

Towns	Zip Codes
Crystal Lake	60014
Algonquin	60102
Cary	60013
Lake in the Hills	60156

These zip codes are shown on Attachment GRC-6a-1.

The total estimated 2002 population of those zip codes is 99,257

As the reader has seen in the attached traffic study, the travel time from our proposed site to existing hospitals soon will be equal to or greater than 30 minutes. However, as one can see on the zip code map, some of the area population in these zip codes is closer to existing hospitals than they are to our proposed site. A consideration of the density of population suggest that slightly more than half of the population may reasonably be expected to come to our hospital.

Therefore, we have used 55%, 54,574, of the total zip code population as a reasonable number representing an unserved population.

Data for McHenry County[1] for CY 2001 shows totals for Medical/Surgical Nursing Units of 8,465 admissions and 37,631 patient days.

Attachment GRC – 6a

The use rate for patient days per 1,000 for McHenry County is:

37,631 pat. days ÷ 285.982 = 131.59 days per 1,000

That use rate and the population of our target area shows that

131.59 days per 1,000 X 54.574 thousand = 7,182 days
that will be generated.

The average daily census (ADC) for those days equals:

7,182 pat. days per year ÷ 365 days per year =19.7 = 20 patients/day

We anticipate that about 70% of the available patients will come to our hospital in the first year of operation. That number of patients, 14, would give us an ADC of 12 for the year, beginning with 4 patients in the first month of operation and building to 14 by the end of the year 2007.

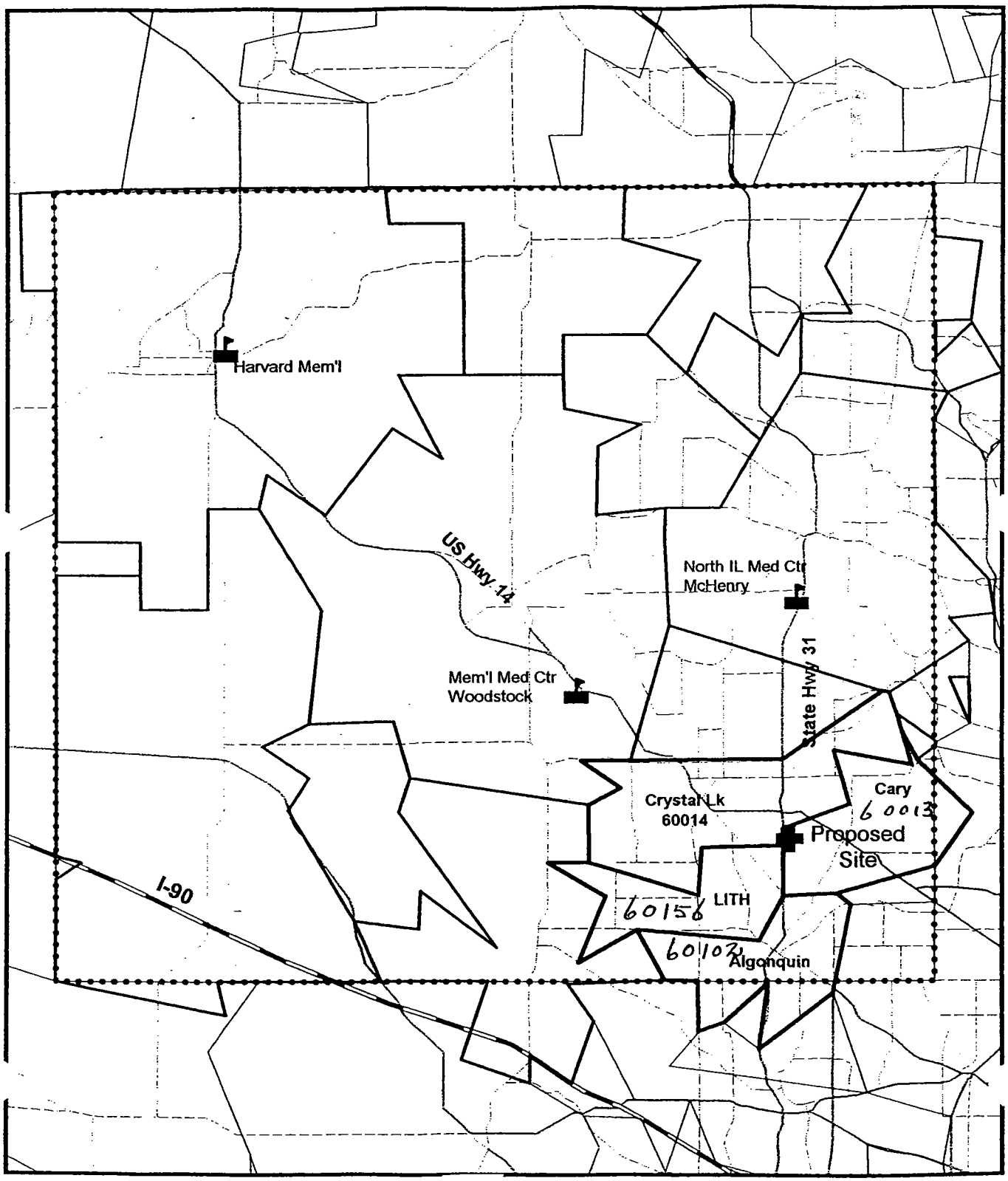
In the second year of operation we expect to receive 80% of the available patients. That percentage will give us an ADC of 16 in the second year of operation, 2008.

As is noted elsewhere in this application, our projected workload is not dependent on new physicians in the typical sense. See the Clinic discussion on Attachment GRC-4-1.

[1] IHCCCC CY 2001

Attachment GRC-6a

McHenry County Hospitals



Criterion 1110.230.e, Size of the Project (Utilization)

Obstetric Beds

Although our proposed hospital is expected to be open for business by January of 2006, we have used population estimates for CY 2002 throughout this application. We are of the opinion that this more conservative approach is wise because population projections for the year 2006 are so far removed from the last census year of 2000 as to make the numbers slightly suspect.

All need calculations are based on the CY 2002 population estimates for the zip codes listed below. These data are estimates received via Solucient of Evanston Illinois and are estimates from Claritas, Inc. of New York, N.Y. and based on the U.S. Census 2000.

Towns	Zip Codes
Crystal Lake	60014
Algonquin	60102
Cary	60013
Lake in the Hills	60013

These zip codes are shown on Attachment GRC-6a-1.

The total estimated 2002 population of those zip codes is 99,257.

As is shown in the attached traffic study, the travel time from our proposed site to existing hospitals soon will be equal to or greater than 30 minutes. However, as one can see on the zip code map, some of the area population in these zip codes is closer to existing hospitals than to our proposed site. A consideration of the density of population suggest that slightly more than half of the population may reasonably be expected to come to our hospital.

Therefore, we have used 55%, 54,574, of the total zip code population as a reasonable number representing an unserved population.

As discussed and derived on Attachment GRC-4 we expect that our target population will produce 600 deliveries. Using an average length of stay (ALOS) of 2.1 days[1], those deliveries will result in:

600 patients X 2.1 days stay per patient = 1,260 patient days

Attachment GRC – 6b

We anticipate that our Obstetrical Service will receive about 90% of the potential patients.

.90 X 1,260 patient days = 1,134 patient days

Our average daily census for post partum is then:

1,134 patient days ÷ 365 days/year = 3.1 = 4 ADC

We anticipate that this ADC will be reached quickly. Our Obstetrical Service capabilities will be widely publicized prior to the opening of the clinic and hospital. It is our plan to provide an Obstetrical Service of the highest quality. Our facilities and equipment will be state of the art. Most importantly, we will provide the widest possible range of physician specialists so that women in our area will no longer need to leave the area for care.

NOTE. The reader is reminded that there is a calculated need for 23 additional OB beds in McHenry County[1]. We are proposing to use 10 of those 23 beds in the belief that we can reverse the current out migration of patients.

We anticipate that we will build to a year's ADC in the first year of 3 patients and easily maintain an ADC of 4 for the second year of operation in 2008

As is noted elsewhere in this application, our projected workload is not dependent on new physicians in the typical sense. See the Clinic discussion on Attachment GRC-4-1.

[1] Illinois Health Facilities Planning Board Inventory, page 35.

Criterion 1110.230.e, Size of the Project (Utilization)

ICU Beds

Although our proposed hospital is expected to be open for business by January of 2006, we have used population estimates for CY 2002 throughout this application. We are of the opinion that this more conservative approach is wise because population projections for the year 2006 are so far removed from the last census year of 2000 as to make the numbers slightly suspect.

All need calculations are based on the CY 2002 population estimates for the zip codes listed below. These data are estimates received via Solucient of Evanston Illinois and are estimates from Claritas, Inc. of New York, N.Y. and based on the U.S. Census 2000.

Towns	Zip Codes
Crystal Lake	60014
Algonquin	60102
Cary	60013
Lake in the Hills	60013

These zip codes are shown on Attachment GRC-6a-1.

The total estimated 2002 population of those zip codes is 99,257.

As is shown in the attached traffic study, the travel time from our proposed site to existing hospitals soon will be equal to or greater than 30 minutes. However, as one can see on the zip code map, some of the area population in these zip codes is closer to existing hospitals than to our proposed site. A consideration of the density of population suggest that slightly more than half of the population may reasonably be expected to come to our hospital.

Therefore, we have used 55%, 54,574, of the total zip code population as a reasonable number representing an unserved population.

Attachment GRC – 6c

Using the Illinois Health Facilities Planning Board's use rate for ICU for McHenry County of 18.2 per thousand population we derive patient days as follows:

18.2 patient days per 1,000 X 54.574 = 994 patient days

We anticipate receiving 80% of those patient days:

80% X 994 patient days = 795 patient days

The ADC for those days equals:

795 days per year ÷ 365 days per year = 2.2 ADC

We anticipate that this unit will quickly reach optimum occupancy. We anticipate an ADC of 1.2 for the year, beginning with 1 patient in the first month of operation and building to 2.0 by the end of CY 2007.

In the second year of operation, 2008, we expect to reach the optimum occupancy of 60% with an ADC of 2.2 patients in our 4 beds.

As is noted elsewhere in this application, our projected workload is not dependent on new physicians in the typical sense. See the Clinic discussion on Attachment GRC-4-1.

[1] IHCCCC CY 2001

Criterion 1110.320.b, Allocation of Additional Beds

The reader is referred to the traffic study, Attachment GRC-1a.

The Density of Population Map, Attachment BEDS-1a, serves to illustrate the travel time problem in a visual way.

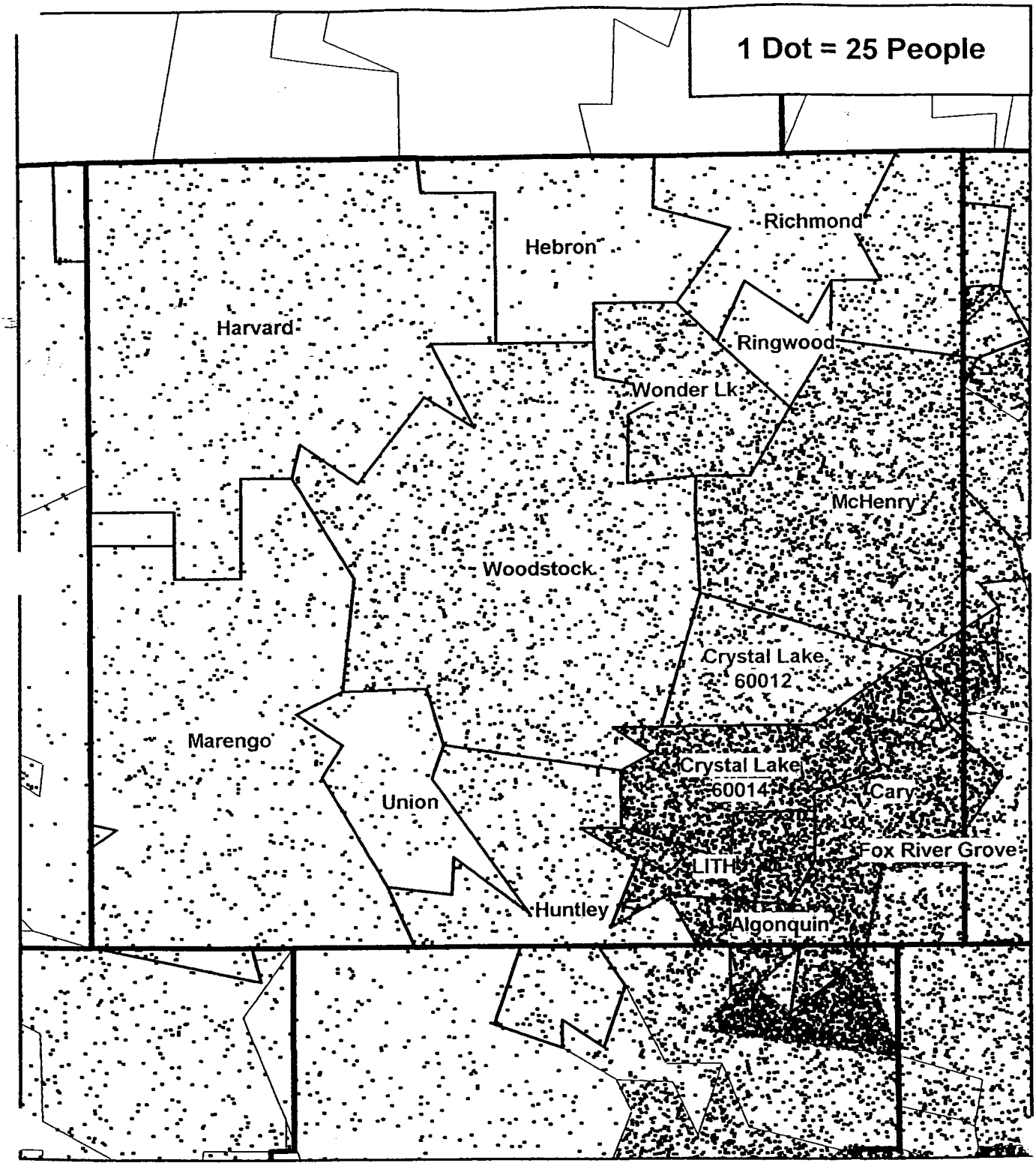
The newspaper article, Attachment BEDS-1b, gives a real world perspective to the every day problem of travel time. (Note that the photographer chose to illustrate the problem with a photograph taken at an intersection with Highway 31. Our proposed location is on Highway 31.) Perhaps most importantly, the article highlights the fact that the road system in McHenry County is not going to improve substantially in the foreseeable future.

The use of 45 minutes travel time to restrict the addition of beds seems to place an intolerable burden on those in need of inpatient care. For example, those persons making the 30-minute trip over the 7 miles to the hospital in the town of McHenry are traveling at an average speed of only 14 miles per hour. Any trip being made at an average of 14 mph will soon be seen as a burden not to be borne repeatedly. Extending that travel over a 45-minute period seems to be beyond the pale.

Thus persons who require diagnostic testing available only at hospitals and persons who are to be "regular" admissions will be faced with excessive travel times. Family and friends of those hospitalized for long stays will be tempted not to visit and thus adversely effect recovery time. Finally, those requiring emergency transportation may well find themselves in life threatening situations.

Attachment BEDS-1

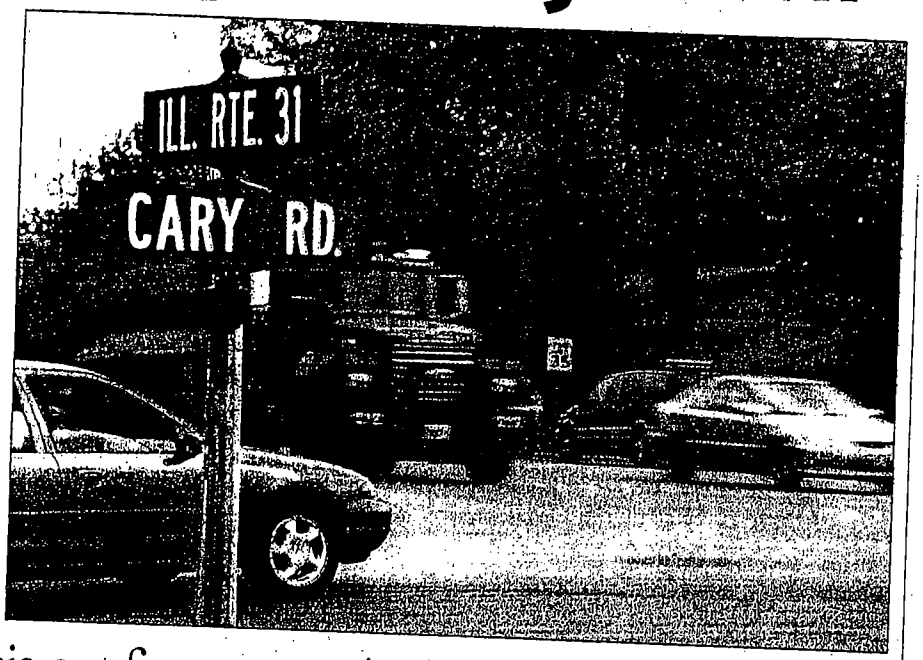
Population Density in McHenry County
2002 Population Estimate



Source: Solucient, Inc., Evanston, IL; Claritas, Inc., New York, NY; U.S. Census 2000

COUNTY TOPS NATION IN AREAS WITHOUT EXPRESSWAY ACCESS

No way out of gridlock



Motorists experience traffic congestion Friday afternoon at the intersection of Cary Road and Route 31 north of Algonquin. McHenry County is the largest county in the country without access to an expressway.

Greg Hess / The Northwest Herald

Analysis confirms motorists' nightmare

By NICK BUNKLEY
The Northwest Herald

By 3:30 p.m., traffic has slowed to a crawl past Jeffrey Schulze's law office on Route 31.

A pair of gravel trucks begin the lengthy descent into Algonquin, followed by a District 300 school bus clouded by haze in the distance.

Not even a Lake in the Hills police car is immune from the gridlock that can paralyze this and many other parts of McHenry County on a daily basis.

"People are going to keep coming here. You're going to have to deal with it," Schulze said. "A four-block trip should not take 10 or 12 minutes."

Much of the traffic that creeps by is headed for Interstate 90, a vital link to Chicago and the rest of the country that has helped bring nearly 200,000 new people to McHenry County since the tollway opened in 1958.

As a result, county residents now find that just getting to the interstate has become a battle.

McHenry County has grown into the most-populated county in the United States without access to an expressway, according to 2002 Census Bureau estimates and a road-map analysis.

Officials say the congested network of many two-lane roads and traffic lights can be discouraging to potential businesses and residents.

"Businesses, they're paying someone to sit in a truck and wait for the car in front to move," said Dan Shea, chairman of the county board's Transportation Committee. "We've never had enough money to get ahead of the curve, as they say, so we could improve roads and be in the process of improving them as traffic is building up."

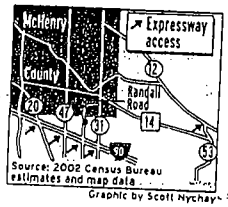
Nearly all the 208 counties larger than McHenry County are traversed by federally funded interstates, with the rest served by U.S. or state highways that have been upgraded to limited-access freeways. Most of those counties contain two or more high-speed expressways.

See ACCESS, page 2

Driving information

Most populated counties in the U.S. without expressway access

County	Population
1. McHenry	277,710
2. Anchorage, Alaska	268,983
3. Horry, S.C.	206,039
4. Sussex, Del.	163,946
5. Hawaii, Hawaii	154,794



Source: 2002 Census Bureau estimates and map data

Graphic by Scott Nychay

Access

Continued from page 1

"We are still working on the same roads that were created back in the early 1900s," said Karen Patel, president of the McHenry County Economic Development Corp. "It's critical for the region to band together to seek out federal funding for many of these grossly needed roadways. ... It's a battle that we all need to focus on together for our quality of life in McHenry County."

No access

Although a few miles of Interstate 90 cut through the southwestern corner of McHenry County, the closest exits are in Kane County near Hampshire, Huntley and Elgin.

To the east, residents still await relief promised decades ago in the form of a Route 53 extension through Lake and McHenry counties. That project, now estimated to cost nearly $1 billion, still is at least a decade away from beginning.

And at the state's northern border, the Route 12 freeway in Wisconsin narrows to a clogged, two-lane road routing vacationers through Richmond this weekend.

"The east-west roads around here are terrible," said Kent Thomas, who owns a trucking company in McHenry.

Thomas makes a daily round trip to Wheeling that, on a good day, should last an hour and 45 minutes, he said.

"Sometimes it takes as long as an hour and a half to go one way. You never know. Some days are worse than others," he said by cell phone from his truck. "It's dangerous when you have so many more cars that wouldn't have to be there if they were on expressways."

The problem is becoming worse as the population continues to grow in western areas of the county that are even farther from I-90 and other expressways.

"(Route) 47, which runs to 90, is a nightmare," said Laura Slebold, director of the Woodstock Chamber of Commerce.

"Until something's done about that, it probably does have something to do with whether people choose to live and work in Woodstock," Slebold said. "Americans are all about ease, and they don't want to spend a lot of time in the car."

Frank Schmuck, who owns a Woodstock limousine company, said mounting traffic has increased the time it takes his drivers to reach expressways on the way to O'Hare, Midway and Milwaukee airports.

"It becomes a real problem, especially scheduling turnaround times for the drivers," said Schmuck, of Service First in Transportation Inc. \"It's cut down the amount of runs they can do in a day. And I've got to have more vehicles."

Expressways can affect more than travel time and economic development in a region. Stop-and-go traffic creates far more air pollution than moving traffic, and cost of driving increases cars idle in backups.

In addition, frequent intersection on local roads lead to more accident The fatality rate on rural roads is thr times higher than on rural, interstat quality highways, according to t Federal Highway Administration.

No easy solution

As wrangling continues over e tending Route 53 into McHen County, a number of municipalities a studying downtown bypasses. Thos projects, which are in varying stage appear to be the only new roads on th horizon in the county.

The Illinois Department of Tran portation also has allocated money fc several widening projects: Route 1 Route 31 and Algonquin Road.

"I'm not saying we're keeping u with the growth, because of limite funding, but we're not ignoring th growth in McHenry County, either, said Patrick Pechnick, IDOT's enginee of program development.

Although an expressway could al motorists headed to Chicago, it woul be difficult to find a viable path tha connects the many local destinations Shea said.

"All we really have to do is improv the routes we've got now to handle traf fic a little more efficiently, and we'll b in good shape," Shea said. "I don't see clear-cut route that would save us a lo of traffic congestion."

Relatively few new expressway have been built in the decades sinc most of the 46,677-mile interstate sys tem was finished.

But residents of Hamilton, Ohio cheered the 1999 completion of an 11 mile freeway linking the city t Interstate 75 just north of Cincinnati. Planning for the highway started 3(years ago, and the project was paid fo through a $158 million bond issue.

"It's brought in a lot of new people from Interstate 75 that perhaps had never been to Hamilton before," said Kenny Craig, president of the Greater Hamilton Chamber of Commerce. "It's opened up the possibilities and opportunities for developers to look at this community."

Another community still waiting for expressway access is Horry County, S.C., where 14 million tourists visit Myrtle Beach each year. With slightly more than 200,000 permanent residents, Horry is the second-largest county in the contiguous United States without an expressway, after McHenry County.

But Horry County is likely to lose that distinction soon, when construction begins on a new Interstate there.

"We're the farthest point in South Carolina from a highway," said Stephen Greene, a spokesman for the Myrtle Beach Chamber of Commerce.

"We have serious issues with the roads coming into the area," Greene said. "It's well over 40 miles coming in. Depending on a given weekend, it can take you an hour and a half to - whatever."

SECTION VIII. REVIEW CRITERIA RELATING TO MEDICAL-SURGICAL, PEDIATRIC, OBSTETRICS, AND INTENSIVE CARE SERVICES (ACUTE)

The section is applicable to all projects proposing the addition of Medical/Surgical, Obstetric, Pediatric, or ICU beds.

A. Criterion 1110.530.a, Unit Size

Read the criterion and indicate if the existing or proposed facility is located within an MSA. X Yes No

B. Criterion 1110.530.b, Variances to Computed Bed Need

Read the criterion and, if applicable, address one of the following variances.

1. Criterion 1110.530.b.1, High Occupancy. Indicate if chosen and submit the following information:

   a. patient days and admissions for each of the last two years for the service involved;

   b. explain why it is not feasible to convert underutilized services to meet the identified demand;

   c. document that the number of beds proposed will not exceed the number needed to reduce the occupancy to the target occupancy.

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

2. Criterion 1110.530.b.2, Medically Underserved Population. Indicate if chosen and submit the following information:

   a. a map showing the location of all other area providers;

   b. a list of the travel times to other area providers;

   c. a detailed description of the admission restrictions of the other area facilities;

   d. documentation that access is restricted in the planning area;

   e. documentation that the number of beds proposed will not exceed the number needed, at the target occupancy rate, to meet the health care needs of the population identified;

   f. an explanation of how the proposed project will improve the access to care;

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

Criterion 1110.530.b.2, Medically Underserved Population

1. Attachment ACUTE-2a shows the location of the three existing hospitals in Service Area A-10, McHenry County.

2. Travel times to the other area providers are as listed below.

Harvard Memorial	Northern Illinois M.C.	Memorial M.C.
50 minutes	30 minutes	31 minutes

3. There are no known admission restrictions at the existing hospitals in the service area.

4. Access to hospitals in the planning area is restricted because of excessive travel times.

NOTE: In CY 2001 there were 124,957 McHenry County residents hospitalized. Of that number 56.8% were hospitalized outside of McHenry County[1].

The reader should also be aware that our Harvard Clinic provided care to a large number of Medicaid patients amounting to 42.1% of total revenue[2]. This demonstrates our commitment to the provision of care to all persons.

The reader is referred to the traffic study, Attachment GRC-1a.

The Density of Population Map, Attachment BEDS-1a, serves to illustrate the travel time problem in a visual way.

The newspaper article, Attachment BEDS-1b, gives a real world perspective to the every day problem of travel time. (Note that the photographer chose to illustrate the problem with a photograph taken at an intersection with Highway 31. Our proposed location is on Highway 31.) Perhaps most importantly, the article highlights the fact that the road system in McHenry County is not going to improve substantially in the foreseeable future.

Attachment ACUTE - 2

The use of 45 minutes travel time to restrict the addition of beds seems to place an intolerable burden on those in need of inpatient care. For example, those persons making the 31-minute trip over the 7 miles to the hospital in the town of McHenry are traveling at an average speed of only 14 miles per hour. Any trip being made at an average of 14 mph will soon be seen as a burden not to be borne repeatedly. Extending that travel over a 45-minute period seems to be beyond the pale.

Thus persons who require diagnostic testing available only at hospitals and persons who are to be "regular" admissions will be faced with excessive travel times. Family and friends of those hospitalized for long stays will be tempted not to visit and thus adversely effect recovery time. Finally, those requiring emergency transportation may well find themselves in life threatening situations.

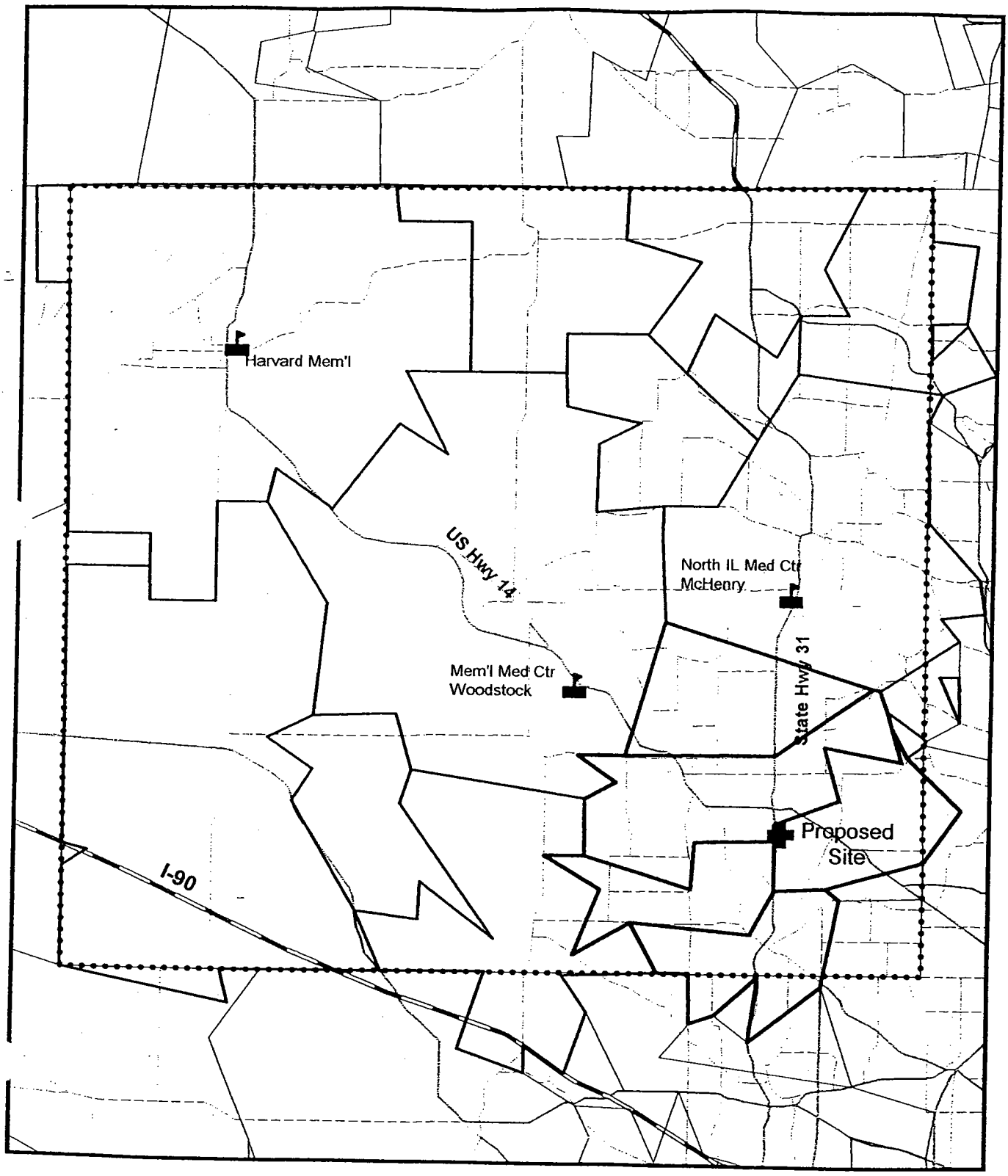
5. Documentation that the number of beds proposed will not exceed the number needed has been provided in Attachments GRC-6a, GRC-6b and GRC-6c.

6. Access to care will be improved by locating this proposed hospital and attached clinic in the center of what is obviously an unserved population. Please see the discussion on Alternatives, Attachment GRC-3.

1. IHCCCC Data for 2001
2. Internal Data

Attachment ACUTE-2

McHenry County Hospitals



Attachment ACUTE – 2a

SECTION XXIX. REVIEW CRITERIA RELATING TO FINANCIAL FEASIBILITY (FIN)

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

Does the applicant (or the entity that is responsible for financing the project or is responsible for assuming the applicant's debt obligations in case of default) have a bond rating of "A" or better? Yes X No .

If yes is indicated, submit proof of the bond rating of "A" or better (that is less than two years old) from Fitch's, Moody's or Standard and Poor's rating agencies and go to Section XXX. If no is indicated, submit the most recent three years' audited financial statements including the following:

1. **Balance sheet**
2. **Income statement**
3. **Change in fund balance**
4. **Change in financial position**

APPEND THE REQUIRED DOCUMENTS AS ATTACHMENT FINANCIALS AND PLACE AFTER ALL OTHER APPLICATION ATTACHMENTS INCLUDING THE REMAINING ATTACHMENTS FOR THIS SECTION AND FOR SECTION XXX.

A. Criterion 1120.210.a, Financial Viability

1. Viability Ratiors

If proof of an "A" or better bond rating has not been provided, read the criterion and complete the following table providing the viability ratios for the most recent three years for which audited financial statements are available. Category B projects must also provide the viability ratios for the first full fiscal year after project completion or for the first full fiscal year when the project achieves or exceeds target utilization (per Part 1100), whichever is later.

Provide Data for Projects Classified as:	Category A or Category B (last three years)			Category B
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each. Insert the worksheets after this page.

2. Variance

Compare the viability ratios provided to the Part 1120 Appendix A review standards. If any of the standards for the applicant or for any co-applicant are not met, provide documentation that a person or organization will assume the legal responsibility to meet the debt obligations should the applicant default. The person or organization must demonstrate compliance with the ratios in Appendix A when proof of a bond rating of "A" or better has not been provided.

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

Moody's Investors Service

99 Church Street
New York, New York 10007

Lisa Martin
Vice President/Senior Credit Officer
Public Finance Group
Tel: 212.553.1423

June 30, 2003

Mr. Joseph Nemeth
Vice President & Chief Financial Officer
Mercy Health System
1000 Mineral Point Avenue
P.O. Box 5003
Janesville, WI 53547

Dear Mr. Nemeth,

This is to confirm the financial strength of the "Obligated Group" consisting of Mercy Health System Corporation, Mercy Alliance, Inc.--formerly known as Southern Wisconsin Health System, Inc.--and Mercy Assisted Care, Inc. was used to determine your current bond rating. You have informed us that the obligated group will include Mercy Crystal Lake Hospital and Medical Center, Inc. The Obligated Group's most recent borrowing received a rating from Moody's of A2 under the Wisconsin Health and Educational Facilities Authority Revenue Bonds, Series 1999 (Mercy Health System Corporation).

Please let me know if you have any questions.

Sincerely,

Lisa A. Martin

SECTION XXX. REVIEW CRITERIA RELATING TO ECONOMIC FEASIBILITY (ECON)

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

A. Criterion 1120.310.a, Reasonableness of Financing Arrangements

Is the project classified as a Category B project? Yes X No ○. If no is indicated this criterion is not applicable. If yes is indicated, has proof of a bond rating of "A" or better been provided? Yes X No ○. If yes is indicated this criterion is not applicable, go to item B. If no is indicated, read the criterion and address the following:

Are all available cash and equivalents being used for project funding prior to borrowing? ○ Yes ○ No

If no is checked, provide a notarized statement signed by two authorized representatives of the applicant entity (in the case of a corporation, one must be a member of the board of directors) that attests to the following:

1. a portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order that the current ratio does not fall below 2.0 times; or

2. borrowing is less costly than the liquidation of existing investments and the existing investments being retained may be converted to cash or used to retire debt within a 60 day period.

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

B. Criterion 1120.310.b, Conditions of Debt Financing

Read the criterion and provide a notarized statement signed by two authorized representatives of the applicant entity (in the case of a corporation, one must be a member of the board of directors) that attests to the following as applicable:

D. Criterion 1120.310.d, Projected Operating Costs

Read the criterion and provide in the space below the facility's projected direct annual operating costs (in current dollars per equivalent patient day or unit of service, as applicable) for the first full fiscal year of operation after project completion or for the first full fiscal year when the project achieves or exceeds target utilization pursuant to 77 Ill. Adm. Code 1100, whichever is later. If the project involves a new category of service, also provide the annual operating costs for the service. Direct cost are the fully allocated costs of salaries, benefits, and supplies. Indicate the year for which the projected operating costs are provided. CY 2008

M/S Nursing Unit: $ 1,581,304 (sal.+ben.+sup.)
÷ 5,746 pat days = $ 275/pat day

Post Partum: $ 361,594 (s+b+s)
÷ 1,260 pat. day = $ 287/pat. day

ICU: $ 512,529 (s+b+s)
÷ 795 pat. days = $ 645/pat. day

Hospital: $ 21,946, 463 (sal.+ben.+sup.)
÷ 15,001 eq. pat. days = $ 1,463/pat.day

Clinic: $ 27,261,150 (s+b+s)
÷ 92,725 = $ 294/visit

E. Criterion 1120.310.e, Total Effect of the Project on Capital Costs

Is the project classified as a category B project? Yes X No ___. If no is indicated, go to item F. If yes is indicated, provide in the space below the facility's total projected annual capital costs as defined in Part 1120.130.f (in current dollars per equivalent patient day) for the first full fiscal year of operation after project completion or for the first full fiscal year when the project achieves or exceeds target utilization pursuant to 77 Ill. Adm. Code 1100, whichever is later. Indicate the year for which the projected capital costs are provided. CY 2008

Hospital

$ 6,308,640 (dep.+amort.+int.) for

hospital part of project ÷ 15,001 eq. pat. day =

$ 421/ eq. pat. day

Clinic

$ 1,779,360 (d+a+i) for

clinic part of project ÷ 92,725 visits =

$ 19.19 visit

F. Criterion 1120.310.f, Non-patient Related Services

Is the project classified as a category B project and involve non-patient related services? Yes No X. If no is indicated, this criterion is not applicable. If yes is indicated, read the criterion and document that the project will be self-supporting and not result in increased charges to patients/residents or that increased charges are justified based upon such factors as, but not limited to, a cost benefit or other analysis that demonstrates the project will improve the applicant's financial viability.

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

Read the criterion and provide a notarized statement signed by two authorized representatives of the applicant entity (in the case of a corporation, one must be a member of the board of directors) that attests to the following as applicable:

1. The selected form of debt financing the project will be at the lowest net cost available.

2. There is no leasing associated with this project.

Javon R Bea
Signature

Javon R. Bea
Printed Name

President/CEO
Printed Title

Notarization:
Subscribed and sworn to before me
this 9th day of July

Signature of Notary

Joseph Nemeth
Signature

Joseph Nemeth
Printed Name

Vice President/CFO
Printed Title

Notarization:
Subscribed and sworn to before me
this 9th day of July

Signature of Notary

Attachment ECON-2

HOSPITAL

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (List below)	A B Cost/Sq. Foot		C D Gross Sq. Feet		E F Gross Sq. Feet		G Const. $	H Mod. $	Total Costs
	New	Mod.	New	Circ*	Mod.	Circ*	(AXC)	(BXE)	(G + H)
Admin./Bus. Office	190		3,437	20			653,030		653,030
Materials Manage.	157		4,150	20			651,550		651,550
Building Support	169		5,455	17			921,895		921,895
Central Processing	344		1,260	20			433,440		433,440
Dietary	340		3,780	22			1,285,200		1,285,200
Pharmacy	247		840	10			207,480		207,480
Bldg. HVAC	133		15,506	17			2,062,298		2,062,298
Public Circulation	176		22,725	100			3,999,600		3,999,600
Emergency Dept.	280		6,855	20			1,919,400		1,919,400
Clinical Laboratory	280		2,881	20			806,680		806,680
Radiology	313		9,900	20			3,098,700		3,098,700
Physical & Occ. Therapy	238		1,474	20			350,812		350,812

Respiratory Ther.	249		623	15			155,127		155,127
Cardiac Rehab.	359		1,200	15			430,800		430,800
Employee Facilities	163		1,163	25			189,569		189,569
Medical Library	190		750	10			142,500		142,500
Surgery	423		9,840	20			4,162,320		4,162,320
Recovery	251		2,040	20			512,040		512,040
Outpatient Surgery – Prep & Recovery	251		5,182	20			1,300,682		1,300,682
ICU	369		2,385	20			880,065		880,065
M/S Nurse. Units	224		32,412	20			7,260,288		7,260,288
LDR Rooms	280		1,974	20			552,720		552,720
OB Nursing Unit	238		4,760	20			1,132,880		1,132,880
Newborn Nursery	238		1,513	20			360,094		360,094
Housekeeping	145		726	5			105,270		105,270
Laundry (Holding)	157		479	5			75,203		75,203
Medical Records	190		4,373	20			830,870		830,870
Snack Shop	280		1,147	20			321,160		321,160
Yard Storage	190		336	15			63,840		63,840
Human Resources	190		832	15			158,080		158,080
Marketing	190		1,360	20			258,400		258,400
Meeting Rooms	190		1,121	30			212,990		212,990

Ambulance Garage	150		982	15			147,300		147,300
Canopies	99		6,947	100			687,753		687,753
Contingency							1,876,227		1,876,227
Totals			160,408				38,206,263		38,206,263

*Include the percentage (%) of space for circulation

Attachment ECON-3

CLINIC

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (List below)	A Cost/Sq. Foot	B	C Gross Sq. Feet	D	E Gross Sq. Feet	F	G Const. $	H Mod. $	Total Costs
	New	Mod.	New	Circ*	Mod.	Circ*	(AXC)	(BXE)	(G + H)
Building Systems	126		8,171	20			1,029,546		1,029,546
Medical Records	126		7,832	20			986,832		986,832
Public Circulation	126		17,470	20			2,201,220		2,201,220
Physicians' Areas	126		44,035	20			5,548,410		5,548,410
Waiting	126		6,389	20			805,014		805,014
Food Court	126		2,550	20			321,300		321,300
Contingency							592,493		592,493
Totals			86,447				$ 11,484,815		$ 11,484,815

*Include the percentage (%) of space for circulation

Attachment ECON 3-1

Items and Costs

Preplanning

See Attachments ECON – 4-1 for yearly breakdown of costs.

Site Survey & Soil Investigation

Phase I Environmental Hazards.....$ 1,800
Site Investigation.....$ 4,225
Soil Borings.....$ 6,025

Site Preparation

See Attachment ECON – 4 – 2 for a breakdown of costs.

Consulting and Other Fees

CON Consultant.....$ 70,000
Traffic Study.....$ 3,200
Building Permits.....$ 15,000

Attachment ECON-4

Mercy Health System
CONSTRUCTION IN PROGRESS
FY2000
1650-9775

Month	Description	Amount	Life
6	Architech Fees Crystal Lake	989.66	
5	CIP Labor	308.25	20
5	CIP Labor	288.19	20
10	Geotechnical engineering	6,025.00	
12	Crystal Lake Predesign	4,345.65	
12	Crystal Lake Predesign	1,368.71	
12	Crystal Lake Predesign	4,388.58	
12	Crystal Lake Predesign	16,034.01	
12	Crystal Lake Predesign	17,627.89	
12	Crystal Lake Predesign	20,849.98	
12	Crystal Lake Predesign	16,173.52	
12	Crystal Lake	3,446.90	
5	Surveying for New Crystal Lake Clinic	1,000.00	20
5	Real Estate Appraisers	1,500.00	20
5	Legal Fees	544.00	20
5	CIP Labor	330.59	20
6	Surveying Fees	1,500.00	
6	Architech Fees Crystal Lake	2,307.07	
6	Architech Fees Crystal Lake	30.94	
6	Architech Fees Crystal Lake	8,059.45	
7	Algonquin Prop Purch	767.00	
7	Travel Exp	136.50	

Vendor	Invoice #	Inv Date	Acct #	
HG & A	57435	9/14/99	9700	
Gary Bauman			9775	NEW Crystal Lake
Gary Bauman		11/23/99	9775	NEW Crystal Lake
KTE	3686	3/31/00	9775	Crystal Lake
Hammel Green & Abrahamson	58824	12/15/99	9775	Crystal Lake
Hammel Green & Abrahamson	59371	1/19/00	9775	Crystal Lake
Hammel Green & Abrahamson	59959	2/16/00	9775	Crystal Lake
Hammel Green & Abrahamson	60540	3/15/00	9775	Crystal Lake
Hammel Green & Abrahamson	60744	4/19/00	9775	Crystal Lake
Hammel Green & Abrahamson	61476	5/16/00	9775	Crystal Lake
Hammel Green & Abrahamson	61946	6/14/00	9775	Crystal Lake
Waggoner Law Firm	2201099	6/8/00	9775	Crystal Lake
Charles A. Mionske	377640	11/17/99	9775	NEW Crystal Lake
Harrison & Assoc	96106-02	11/8/99	9775	NEW Crystal Lake
Waggoner Law Firm	2201099	11/29/99	9775	NEW Crystal Lake
Gary Bauman		11/23/99	9775	NEW Crystal Lake
Charles Mionske	377668	12/7/99	9775	Crystal Lake
HG & A	55227	5/7/99	9775	Crystal Lake
HG & A	56205	7/9/99	9775	Crystal Lake
HG & A	58145	11/8/99	9775	Crystal Lake
Quarles & Brady		12/1/99	9775	Crystal Lake
Chris Ness		1/28/00	9775	Crystal Lake

Mercy Health System
CONSTRUCTION IN PROGRESS
FY2001
1650-9775

Month	Description	Amount	Life	Vendor	Invoice #	Inv Date	Acct #	
2	Meeting with Arch	206.60	10	Steve McMullen		08/02/00	9775	Crystal Lake
3	Architect Fees	123.74	20	Hammel Green & Abraham	55709	06/02/99	9775	Crystal Lake
3	Architect Fees	18,953.43	20	Hammel Green & Abraham	63218	08/17/00	9775	Crystal Lake
4		260.00	40				9775	Crystal Lake
6	Architect Fees	7,688.23	40	Hammel Green & Abrahams	65644	12/14/00	9775	Crystal Lake
9	Signs	2,982.00	10	Sign-a-Rama	8050	02/28/01	9775	Crystal Lake
11	Architect Fees	2,389.10	20	HGA	67579	04/06/01	9775	
11	Architect Fees	201.63	20	HGA	68591	05/15/01	9775	
12	architect Fees	11,551.52	20	Hammel Green & Abraham	69184	06/12/01	9775	Crystal Lake
3	Architect Fees	1,667.81	20	Hammel Green & Abraham	63892	09/14/00	9775	Crystal Lake
4	Legal Fees	4,988.75	40	Waggoner Law Firm		09/08/00	9775	Crystal Lake
4	Legal Fees	235.00	40	Quarles & Brady	39561	09/01/00	9775	Crystal Lake
4	Legal Fees	211.00	40	Quarles & Brady	39587	09/01/00	9775	Crystal Lake
4	Architect Fees	29,090.22	40	Hammel Green & Abraham	63006	07/25/00	9775	Crystal Lake
4	Permits	250.00	40	Village of Williams Bay	377962	10/19/00	9775	Crystal Lake
4	Legal Fees	288.00	40	Waggoner Law Firm	2201099	10/09/00	9775	Crystal Lake
5	Crystal Lake Predesign	163.35	40	Hammel Green & Abraha	64315	10/12/00	9775	Crystal Lake
5	Crystal Lake Predesign	412.54	40	Waggoner Law Firm	2201099	11/08/00	9775	Crystal Lake
5	Crystal Lake Predesign	35.47	40	Steve McMullen		11/28/00	9775	Crystal Lake
7	Architect Fees	1,986.79	40	Hammel Green & Abrahams	66293	01/18/01	9775	Crystal Lake
	Crystal Lake Predesign	1,000.00	40	CIP Labor $			9775	Crystal Lake

Attachment ECON - 4 - 1
120

Mercy Health System
Fixed Asset Purchases
FY2002
1650-9775

Month	Description	Amount	Life	Vendor	Invoice #	Inv Date	Acct #	
1	Architect Fees	910.24	40	Hammel, Green & Abrahamson	69662	07/17/01	9775	Crystal Lake
2	Architect Fees	71.13	20	Hammel Green & Abrahamson	70254	08/15/01	9775	Crystal Lake
3	Legal Services	1,514.00		Waggoner law	2201099	09/07/01	9775	Crystal Lake
3	Architech Fees	1,513.08		HGA	70705	09/12/01	9775	Crystal Lake
4	Architect Fees	1,799.69	20	Hammel, Green & Abrahamson	71467	10/15/01	9775	Crystal Lake
4	Legal Fees - sale of property	1,810.08	Land	Waggoner Law Firm		10/12/01	9775	Crystal Lake
5	Legal Fees	2,599.38	10	Waggoner Law Firm	2201099	11/08/01	9775	Crystal Lake
5	Architect Fees	6,498.83	10	HGA	71677	11/14/01	9775	Crystal Lake
6	Crystal Lake Annexation	1,284.01	20	Waggoner Law Firm		12/12/01	9775	Crystal Lake
7	CIP-CRYSTAL LAKE CLINIC	848.85		Hammel Green & Abrahamson	73221	01/16/02	9775	CIP-CRYSTAL LAKE CLINIC
7	CIP-CRYSTAL LAKE CLINIC	(1,284.01)		Waggoner Law Firm		12/12/01	9775	CIP-CRYSTAL LAKE CLINIC
10	CIP-CRYSTAL LAKE CLINIC	367.05		Hammel, Green, and Abrahamson	74583	04/17/02	9775	CIP-CRYSTAL LAKE CLINIC

Attachment ECON - 4 - 1
121

Mercy Health System
Fixed Asset Purchases
FY2003
1650-9775

Month	Description	Amount	Life	Vendor	Invoice #	Inv Date	Acct #
4	Mercy Clinic Lake Clinic Expansion-PD to SD	4,811.72		Hammel, Green,and Abrahamson, Inc.	77766	10/16/02	9775
8	Mercy Clinic Lake Clinic Expansion-PD to SD	10,611.11		Hammel, Green,and Abrahamson, Inc.	79708	02/12/03	9775
9	Mercy Clinic Lake Clinic Expansion-PD to SD	98,766.62		Hammel, Green,and Abrahamson, Inc.	80562	03/12/03	9775
11							9775

Attachment ECON - 4 - 1
122

Mercy Crystal Lake Hospital (Basement - 3rd) Revised Estimate

Hammel, Green and Abrahamson Inc
701 Washington Avenue North
Minneapolis, MN 55401-1180
Phone: 612-758-4000 Fax: 612-758-4199

HGA
Architecture | Engineering | Planning

Project : Mercy Crystal Lake, Crystal Lake, IL
Estimate File : Mercy Crystal Lake SD Estimate est
Estimator : JT/MM
Primary Project Qty : 267,496 SF

Report Includes Taxes & Insurance.

3:10:11PM
6/2/03

HGA Comm # : 1195-115-00

Description	Quantity	Unit $	Total $	$ / SF
+++ SITEWORK +++				
EXCAVATION, GRADING & BACKFILL				
CUT & FILL DIRECT ON SITE - SCRAPERS - LARGE JOB (Move approx. 2'-0" over entire site)	51,627.00 CUYD	2.55	131,817	0.49
RETENTION POND (Allowance)	1.00 LS	50,000.00	50,000	0.19
Total EXCAVATION, GRADING & BACKFILL			$181,816.53	$0.68
SITE DRAINAGE & UTILITIES				
SITE UTILITIES (Incl. Elec service, Not incl. P-lot storm)	1.00 LS	400,000.00	400,000	1.50
Total SITE DRAINAGE & UTILITIES			$400,000.00	$1.50
ROADS & WALKS				
BITUMINOUS PAVING 6" BASE / 3"ASPHALT (Cars)	28,216.00 SQYD	12.00	338,592	1.27
BITUMINOUS PAVING 8" BASE / 4"ASPHALT (Trucks)	7,980.00 SQYD	15.00	119,700	0.45
PAVEMENT STRIPPING	653.00 EACH	35.00	22,855	0.09
PAVEMENT MARKINGS	148.00 EACH	65.00	9,620	0.04
B6X24 CONC. CURB & GUTTER	12,156.00 LNFT	15.00	182,340	0.68
5" CONCRETE SIDEWALKS	9,065.00 SQFT	4.50	40,793	0.15
SPECIAL CONCRETE SIDEWALKS @ NORTH PARKING LOT ENTRANCE	15,193.00 SQFT	8.00	121,544	0.45
6" CONCRETE PAVING	5,097.00 SQFT	5.50	28,034	0.10
Total ROADS & WALKS			$863,477.00	$3.23
SITE IMPROVEMENTS				
SITE IRRIGATION (1/2 of sod quantity)	60,606.00 SQFT	0.75	45,456	0.17
7' HIGH CHAIN LINK FENCE @ LOADING DOCK	145.00 LNFT	28.00	4,060	0.02
EXTERIOR SIGNAGE (Allowance)	1.00 LS	200,000.00	200,000	0.75
KEYSTONE RETAINING WALLS	10,589.00 SQFT	17.00	180,013	0.67
Total SITE IMPROVEMENTS			$429,529.00	$1.61
LANDSCAPING				
LANDSCAPING (Allowance)	1.00 LS	150,000.00	150,000	0.56
SOD (Allowance)	13,468.00 SQYD	3.50	47,138	0.18
SEED (Allowance)	7,656.00 SQYD	0.50	3,828	0.01
POROUS PAVEMENT @ FIRE LANE WEST SIDE	7,178.00 SQFT	1.00	7,178	0.03
Total LANDSCAPING			$208,144.00	$0.78
SF CONCRETE				
CONCRETE RETAINING WALL @ LOADING DOCK	256.00 SQFT	20.00	5,120	0.02
6'X6'X2' PAD FOOTINGS @ CANOPIES	8.00 EACH	524.03	4,192	0.02
STRIP FOOTINGS @ LOADING DOCK RETAINING WALL (CY)	18.96 CUYD	290.63	5,510	0.02
6" CONCRETE STOOPS	100.00 SQFT	9.16	916	0.00
8" MECHANICAL PAD	1,044.00 SQFT	8.00	8,352	0.03
Total SF CONCRETE			$24,090.91	$0.09
STONE				
ARISTCRAFT STONE MASONRY WALL OUTSIDE CAFETERIA (Incl. precast cap& foundations)	750.00 SQFT	100.00	75,000	0.28
ARISTCRAFT STONE MASONRY TOWER STRUCTURE OUTSIDE CAFETERIA (Incl. steel struct.	1.00 EACH	20,000.00	20,000	0.07
Total STONE			$95,000.00	$0.36
MISCELLANEOUS & ORNAMENTAL METAL				
6" PIPE BOLLARD	12.00 EACH	200.00	2,400	0.01
STEEL STAIRS	14.00 RISE	246.12	3,446	0.01
Total MISCELLANEOUS & ORNAMENTAL METAL			$5,845.68	$0.02
PAINTING & WALL COVERING				
PAINT STAIRS	1.00 EACH	355.00	355	0.00
Total PAINTING & WALL COVERING			$355.00	$0.00
EQUIPMENT				
PARKING CONTROL (Allowance)	1.00 EACH	25,000.00	25,000	0.09
Total EQUIPMENT			$25,000.00	$0.09
SPECIAL CONSTRUCTION				
HELI-PAD (Allowance)	1.00 LSUM	100,000.00	100,000	0.37
PRE-ENGINEERED METAL STRUCTURE (Yard Equipment)	330.00 SQFT	20.00	6,600	0.02
Total SPECIAL CONSTRUCTION			$106,600.00	$0.40
Total +++ SITEWORK +++			$2,339,858.12	$8.75

Attachment ECON - 4 - 2

ILLINOIS HEALTH FACILITIES PLANNING BOARD

SUPPLEMENTAL DOCUMENTATION IN SUPPORT OF APPLICATION FOR PERMIT

Applicant

Mercy Crystal Lake Hospital and Medical Center, Inc.
Project #03-049

Brief Summary of Project

As set forth in the State Agency Report ("SAR"), the proposed project ("Project") is:

> [T]o establish a 70-bed hospital which will contain 56 medical/surgical ("med/surg"), 10 obstetric ("OB") and four intensive care ("ICU") beds. The applicants will also construct a clinic connected to the hospital to house physician offices. The hospital will contain 160,408 gross square feet ("GSF") and the clinic will contain 86,447 GSF. The total estimated project cost is $81,396,198.

I. Bed Related Review Criteria

A. Establishment of Additional Hospitals – Criterion 1110.320(a)

As set forth in the SAR, the criterion sets forth a minimum of 100 beds for the establishment of new hospitals located within a Metropolitan Statistical Area ("MSA"). This review criterion originally required that hospitals be constructed with a minimum of 250 med/surg beds, which was reduced to the current level in the early 1980s.

The reduction in the criterion over time recognizes that changes in the delivery of health care have resulted in smaller facilities being able to treat the same patient volume. Specifically, the following environmental factors have resulted in the fact that the same number of patients can be served adequately by smaller facilities with fewer beds:

- Dramatically declining average lengths of stay ("ALOS")
- Private rooms versus semi-private rooms
- Increased financial viability of smaller hospitals

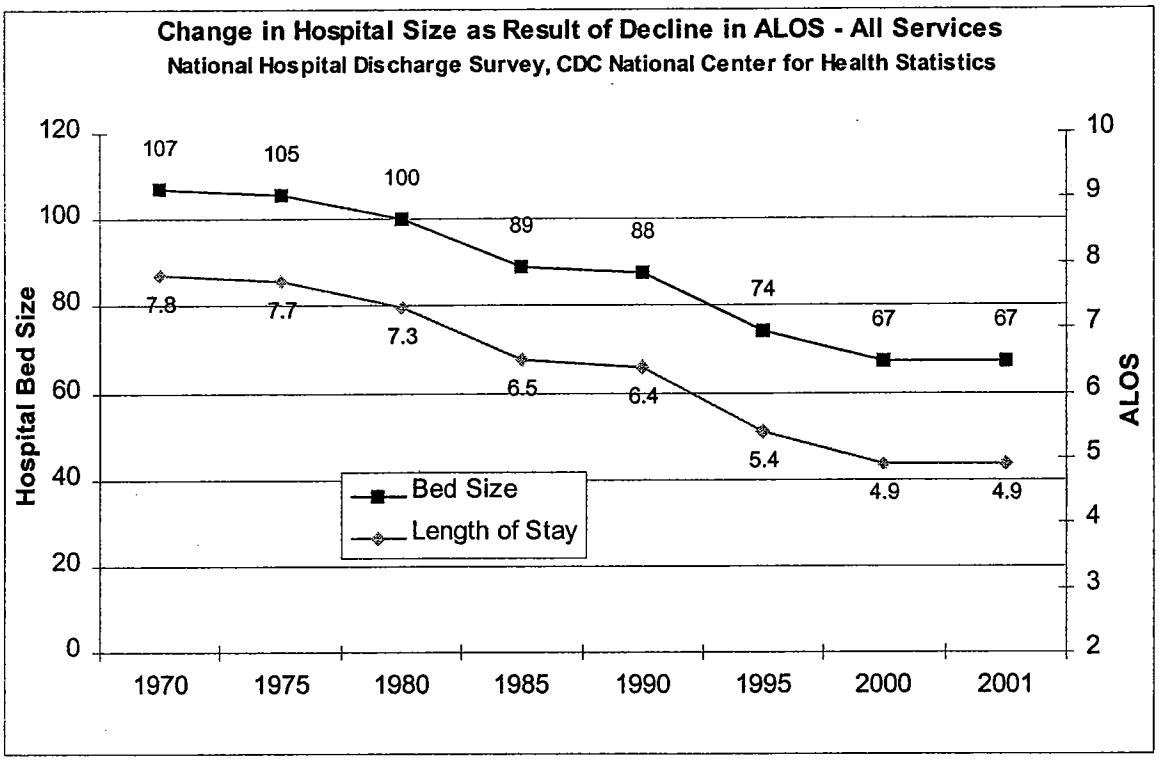
1. Declining ALOS

ALOS for hospital inpatients have declined dramatically over the past 20 years due primarily to:

- The advancement of technology and increase in outpatient procedures
- Medicare's implementation of prospective reimbursement system based upon diagnosis related groups or DRGs in October 1983
- Pressures of managed care reimbursement

As a result, a 67-bed hospital constructed in 2001 could adequately treat the same number of patients as a 100-bed hospital constructed in 1980. The following graph, using data from the

National Hospital Discharge Survey, conducted by the Center for Disease Control's ("CDC") National Center for Health Statistics demonstrates this point:



As the chart indicates, due solely to the decline in ALOS, fewer beds were required to treat the same patient volume in 2001 than were required in 1980. Specifically, the chart shows that at 80% occupancy (the State target for med/surg units with 1-100 beds), only 67 beds were needed in 2001 to treat the same patient volume that required 100 beds in 1980. The supporting data for the chart are attached under **Tab 1**.

Given these clear trends in utilization, the Project is being submitted with a total of 70 beds – which roughly corresponds to the ratio of beds (0.67:1) derived from the CDC data when compared to the State's review criterion developed in the early 1980s and continued projected decline in ALOS through the opening of this facility in 2006.

2. Private v. Semi-private Rooms

As set forth in the articles attached under **Tab 2**, the industry standard has evolved from constructing hospitals with a mix of private and semi-private rooms to constructing hospitals with exclusively private rooms. We also note that the most recently completed new hospital in the State of Illinois – Northwestern Memorial Hospital – involved exclusively private rooms.

With semi-private rooms, additional beds were required that often went unused. Specifically:

- Patients with infectious diseases cannot be placed in semi-private rooms with other patients due to safety considerations – as the severity of illness for inpatients has increased over the last 20 years, this concern has become even greater

- As a matter of practice and patient preference, men and women cannot share semi-private rooms

Accordingly, additional beds were needed because it was known that not all semi-private rooms would be fully occupied. With exclusively private rooms, however, all beds may be utilized. For this reason, the Project has been proposed with all private rooms.

Any cost concern for patients who will receive private rooms instead of semi-private rooms is unfounded. The Illinois Health Care Cost Containment Council's *Illinois Hospital Price Survey Report: 2000* indicates that the average Chicago charge master price for a private med/surg room was $835 while the price for a semi-private med/surg room was $826 or only 1% lower (a copy of the report is attached under **Tab 3**).

3. Increased Financial Viability of Smaller Hospitals

The current review criterion was promulgated in part based upon the determination that 100 beds was the minimum number of beds necessary to achieve a "critical mass" such that a new hospital could survive and prosper operationally and economically. Notwithstanding this, the vast majority of new hospitals constructed since 1981 have fewer than 100 beds. Specifically, the applicant commissioned a study from the American Hospital Association ("AHA") of new hospitals (*i.e.,* non-replacement hospitals) built since 1981. As set forth in the AHA's letter attached under **Tab 4**, 76% of the new hospitals built since 1981 have fewer than 100 beds. Accordingly, the Project is consistent with the modern trend to build smaller hospitals of under 100 beds.

Finally, the applicant has included under **Tab 5** financial projections for the Project. The projections are based on the utilization figures set forth in Section III(B) of this document. As these projections show, even at 70 beds, the Project has a positive contribution margin of over $5 million in the second year of operation.

B. Allocation of Additional Beds – Criterion 1110.320(b)

1. ICU

The SAR indicated that the Project met the utilization requirement with respect to ICU beds, as all six facilities identified within 45 minutes travel time are experiencing high utilization for ICU beds.

2. OB

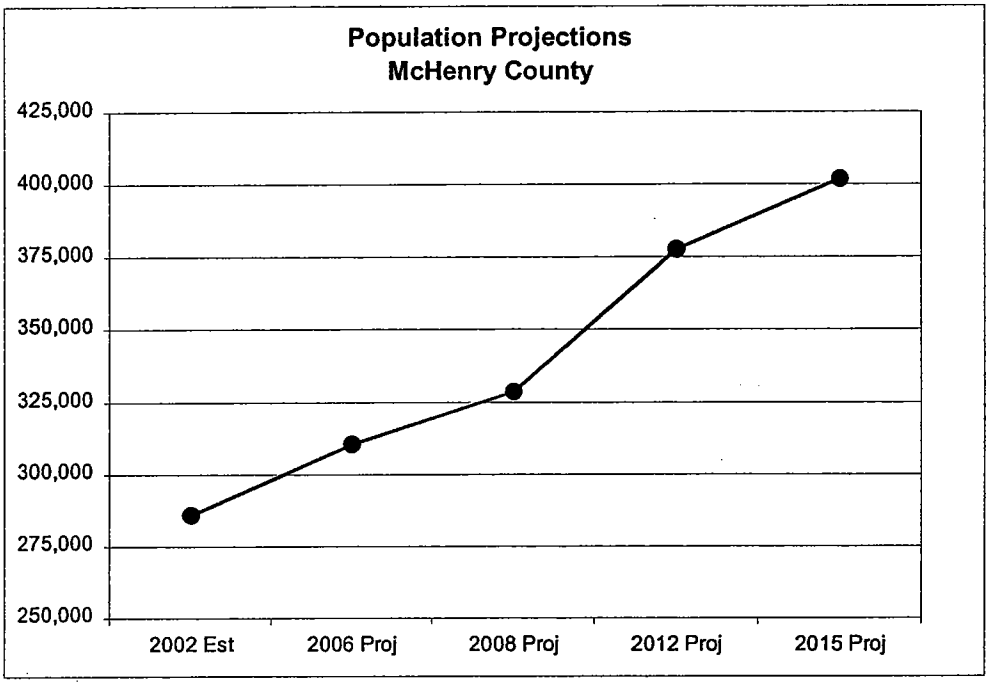
Notwithstanding the levels of utilization by the six facilities identified in the SAR, we note that the Inventory of Health Care Facilities and Services and Need Determinations (November 15, 2003) shows a need for 23 additional OB beds in the A-10 planning area. Accordingly, there is documented need for the ten OB beds contained within the Project. The successful completion of the Project will help alleviate this need.

3. Med/surg

As the SAR indicated, one of the three facilities located in the A-10 planning area currently exceeds the State's target utilization for med/surg beds. As a general matter, it is common for hospitals in Illinois to fall below the med/surg target utilization. Notwithstanding this, many of the other facilities cited in the SAR are close to the utilization target using 2001 data (St. Alexis

Medical Center – 80.4%, Northern Illinois Medical Center – 73.6% and Good Shepherd Hospital – 73.4%).

In addition, the population of McHenry County continues to grow rapidly. As the following chart indicates, the population of McHenry County is projected to grow by almost an additional 150,000 residents over the next 11 years (the chart was prepared using data from Solucient, Inc. and the applicant's planning department).



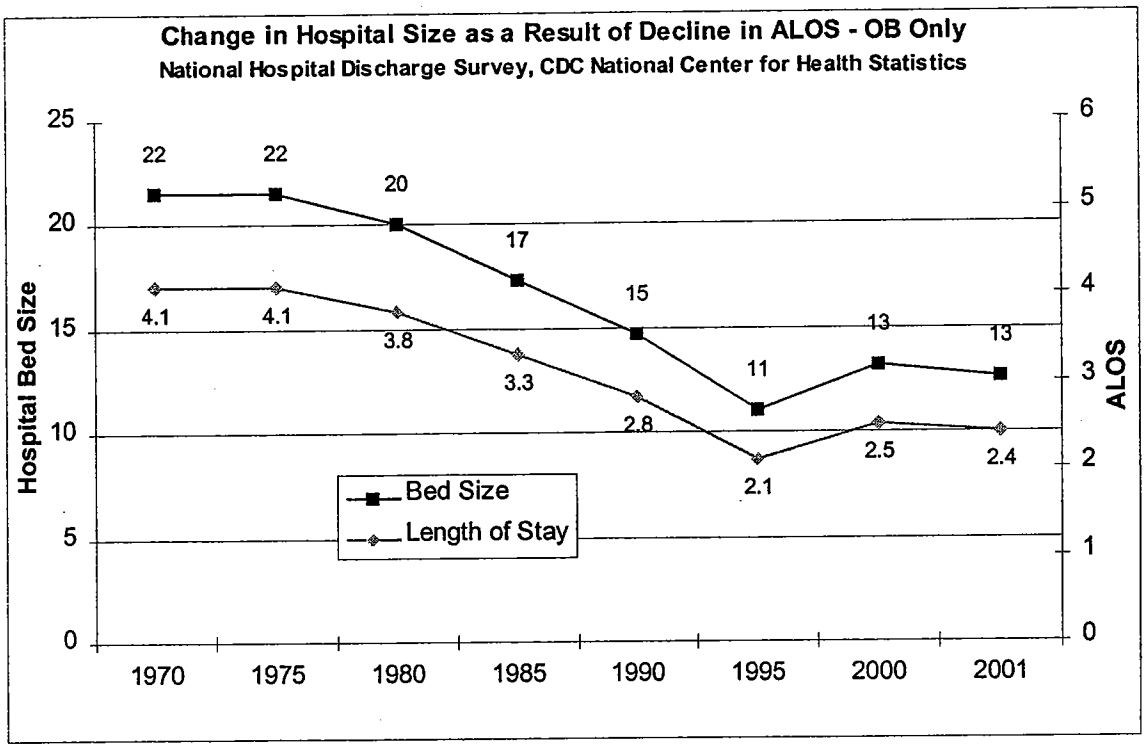
Given this growth rate, the county's residents' need for additional med/surg bed capacity should increase dramatically over the next 10 years, exceeding current capacity.

II. Review Criteria Relating to Med/Surg, OB and ICU

A. Unit Size – Criterion 1110.530(a)

This criterion sets forth the minimum number of beds for various categories of service, including OB and ICU. As set forth in the SAR, the review criterion calls for a 4-bed ICU unit within an MSA. The SAR indicates that the Project meets this criterion. Therefore, the only issue relates to the bed sizes for the med/surg and OB units.

The review criterion calls for a 20-bed OB unit within an MSA, while the Project proposes a 10-bed OB unit. As set forth above, hospital ALOS have declined dramatically over the past 20 years. This trend applies equally with respect to OB procedures. The following graph, again prepared using data from the *National Hospital Discharge Survey*, conducted by the CDC, demonstrates this point:



As the chart indicates, due solely to the decline in ALOS, fewer beds were required to treat the same OB patient volumes in 2001 than were required in 1980. Moreover, the chart shows that at 75% occupancy (the State target for OB units with 1-25 beds), only 13 beds were needed to treat the same patient volume in 2001 that required 20 beds in 1980. The supporting data for the chart are attached under **Tab 6**. Given these clear trends in utilization, the Project is being submitted with 10 OB beds – which roughly corresponds to the ratio of beds (0.65:1) when compared to the current review criterion.

B. Variances to Bed Need – Criterion 1110.530(b)

The criterion states that the applicant may document a medically underserved variance by "an assessment of area population characteristics which would indicate an access problem."

As set forth under **Tab 7**, data provided by Solucient, Inc. indicate that McHenry County currently is experiencing a shortage of 110 physicians. This is consistent with the national experience which is reported in the HealthLeaders article attached under **Tab 7**. The article states that both the Council on Graduate Medical Education and the American Medical Association recognize a current physician shortage in the US that will worsen over the next fifteen years. The operational model utilized by the applicant has been implemented effectively to recruit and retain needed physicians.

The applicant believes that this is one of the primary reasons that residents of McHenry County are leaving the county in order to seek medical care. Without an adequate physician supply, residents of the county will seek care from physicians in other locations. These physicians, in turn, will utilize inpatient facilities in areas closer to their offices (*i.e.,* outside of McHenry County). Accordingly, the applicant believes that the access problem stems from an undersupply of physicians in the community.

The applicant intends to address this access problem through the recruitment and employment of 45 physicians in McHenry County at the Crystal Lake location. This is the rationale for the medical office building adjoining the hospital facility in the Project.

The applicant believes that its model of employed physician partners will not only address the McHenry County access problem, but also will provide sufficient utilization of the proposed hospital. Specifically, the Mercy Crystal Lake Hospital and Medical Center will be part of a fully-integrated health care delivery system. This system is based on the Mayo Clinic model, where hospital and doctors offices are part of the same entity under one roof. An integrated system functions differently than other health care practice models. The fully-integrated model improves patient care, as patients will have all the benefits of a multi-specialty clinic, as well as the needed access to diagnostic services, an emergency room, surgery suites and other hospital-based services. This will greatly benefit the emergency room patients if they require attention by a pediatrician, cardiologist, ear nose and throat specialist, orthopedic surgeon or some other specialist who is present on-site in the clinic space at the time the patient is seen in the emergency room. The reality of medicine is that physicians direct hospital admissions. The logical extension of the 45-physician multi-specialty clinic operation, OB services, and the proposed emergency department is the availability of hospital beds. In addition to the physicians located at the Mercy Crystal Lake Medical Center, the patients will have access to over 250 physicians in the Mercy Alliance system, as well as to other specialists who provide certain tertiary care services at other hospitals such as Sherman, Northwestern or Loyola.

Mercy Alliance, through its affiliates, employs a broad base of physicians, podiatrists, allied health professionals, and nurses. Nevertheless, the medical staff at Mercy Crystal Lake will be an open staff so that it is not necessary for a doctor, a dentist, or a podiatrist to be employed at our hospital or clinic in order to obtain privileges at Mercy Crystal Lake Hospital. Thus, patients will be able to see their family doctor, be referred to a medical or surgical specialist, have all necessary diagnostic tests performed and, if necessary, outpatient or inpatient surgery and hospitalization with follow-up post-hospitalization rehabilitation care all at the same site, by the same organization with common patient records.

III. General Review Criteria

A. Location – Criterion 1110.230(a)

Pursuant to this criterion, the applicant first is to document that the primary purpose of the proposed project is to provide care to residents of the planning area in which the Project will be physically located. As set forth above, the purpose of the Project is specifically to address the undersupply of physicians in McHenry County. The applicant's model is designed to bring the needed physician resources to the community and to provide a facility sufficient to address the care needed by the residents who will now remain in the community to seek care (as opposed to out-migrating to other communities). As the physicians who will support this facility by virtue of their referrals are not currently located within the community, the typical referral letters cannot be provided.

Also pursuant to this criterion, the applicant is to demonstrate that the location selected for a proposed project will not create a maldistribution of beds and services. The criterion states that maldistribution is typified by the lack of a sufficient population concentration in an area to support the proposed project. Said in the positive, the applicant must demonstrate that the population concentration in the area is in fact sufficient to support the proposed project.

As noted in the original application and again in Section I(B)(3) above, the population of McHenry County is growing rapidly. Facilities located in the county are at or near the State's target utilization rates. Moreover, data indicates that the county currently has an undersupply of 110 physicians. As a result, it follows that residents are seeking care outside of the community. Accordingly, the population growth in McHenry County will continue to drive the need for additional facilities. The applicant's model for care, its intention to recruit 45 physicians to the Crystal Lake facility in McHenry County to address the physician undersupply and its construction of the Project will support the community's growing need for care.

B. Need for the Project – Criterion 1110.230(d)

This criterion requires that the applicant document that it will serve a population group in need of the services proposed and that insufficient service exists to meet the need. This is demonstrated by providing some of the following documentation:

- Area Studies (which evaluate population trends and service use factors)
- Calculation of Need Based on Models of Estimating Need for the Service
- Identification of Individuals Likely to Use the Project

With respect to area studies, as set forth in the original application and again above, McHenry County's population is growing at an unprecedented rate. Moreover, the data set forth above indicate that the county is in need of an additional 110 physicians to serve its current population. It is the applicant's intent to address this need for physicians and to provide an inpatient facility to treat what will be the resulting need for hospital services. Accordingly, the population growth and service use factors indicate that the county can support the Project, particularly because of the applicant's meeting the need for physicians.

With respect to need, the information discussed in Section II(B) above demonstrates the need for physicians in McHenry County. If this need is addressed, the need for the facility will exist as the physicians will reduce the out-migration of services from McHenry County.

With respect to individuals who will use the project, attached under **Tab 8** is a spreadsheet setting forth the calculated utilization of the facility by the 45 physicians at the Crystal Lake site, from other employed physicians of the applicant, and through the emergency department. Calculations are based on the applicant's historical experience at its hospital facility in Janesville, Wisconsin, where the same integrated health delivery model is employed. The data show that, based upon the projected number of patients days generated by the 45 physicians, the 70-bed facility will operate at an overall occupancy of 77% soon after beginning operation. The data also show that the projected occupancy for the med/surg, OB and ICU categories of service will be as follows:

Category of Service	Inpatient Days	Available Beds	Avg. Daily Census	Occupancy
Med/surg	16,356	56	44.8	80.0%
OB	2,211	10	6.1	60.6%
ICU	1,143	4	3.1	78.3%
Total	19,710	70	54.0	77.1%

C. Size of the Project – Criterion 1110.230(e)

As set forth in the SAR: "If the applicants' projected patient volume is accepted, then most of the areas proposed are appropriately sized. The only exceptions are for the med/surg and surgical recovery areas." With respect to the med/surg area, there are three explanations for why the size exceeds what the State may be accustomed to seeing:

- All rooms are private rooms (consistent with the trend identified in Section I(A)(2) above).
- All of the rooms are universally sized and, thus, larger which creates efficiencies if med/surg rooms are to be utilized at a later time for OB or ICU.
- The building utilizes a race track corridor system instead of the traditional long corridor system, creating staffing efficiencies. Specifically, patient support activities are enhanced as staff are located closer to patient rooms than under a traditional long corridor system.

While increasing the gross square footage required, all three of these features create additional efficiencies within the facility.

With respect to the recovery space, which represents only 2% of the total hospital gross square footage, the project exceeds that State standard by only 240 gross square feet.

Finally, the applicant has recalculated the anticipated occupancy rates (the underlying detail is set forth under **Tab 8**). As the revised calculations set forth above show, overall occupancy is projected to be 77%, med/surg occupancy is projected to be 80%, OB occupancy is projected to be 60.6% and ICU occupancy is projected to be 78.3%.

IV. Economic Feasibility – Reasonableness of Project Cost – Criterion 1120.310(c)

The SAR indicated that the Project was in compliance with all applicable economic feasibility criteria except for the architectural and engineering fees for the Project. In addition, the SAR raised a question as to whether the total construction costs could be understated due to shelled space.

A. Architectural and Engineering Fees

The SAR indicated that the Project was in compliance with all applicable economic feasibility criteria except that the architectural and engineering fees for the Project exceeded the State

standard by $29,617. The figure originally included in the application was based upon a larger project. The Project was reduced prior to submission of the application, but the architectural and engineering fees were not reduced. Accordingly, the architectural and engineering fees have been reduced to $2,882,000. This figure is below the State standard. As a result of this change, the Project is in conformance with all standards for economic feasibility.

B. New Construction

The SAR questioned whether additional construction expenditures would take place in the future due to 38 shelled med/surg beds. The SAR also questioned whether the total construction costs of the Project are understated due to the shelled space.

The total project costs of $81,396,198 disclosed in the application and described in the SAR represent the total costs for building out, equipping and operationalizing all 70 beds disclosed in the application. Thus, notwithstanding any issue of when the 38 shelled med/surg beds would be made operational, the cost of doing so is already included within the application and total project costs.

The applicant wishes to make clear that all 56 med/surg beds disclosed in the application will be constructed within the costs and timeframe set forth in the application.

The only change to the overall Project cost is a reduction of $29,700 due to the reduction of the architectural and engineering fees. Thus, the total Project cost is $81,366,498.

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Tab 4	American Hospital Association – Hospital Construction Size Data – 1981-2002
Tab 5	Financial Projections for the Project
Tab 6	*National Hospital Discharge Survey*, Center for Disease Control's National Center for Health Statistics – ALOS Data for OB Services 1970-2001
Tab 7	Solucient, Inc. Physician Manpower Study for McHenry Count 2002 & *The Physician Shortage is Official: Now What?*, HealthLeaders (Jan. 14, 2004)
Tab 8	Calculated Utilization and Occupancy of Total Beds and Each Category of Service for the Project

Tab 1
Trend in Hospital Use and ALOS and Resulting Bed Size - All Services
Source: U.S. Department of Health and Human Services, Center for Disease Control

Historical Data	1970	1975	1980	1985	1990	1995	2000	2001
Number of Discharges (Thousands)	29,127	34,043	37,832	35,056	30,788	30,722	31,706	32,653
Rate of discharges per 1000 pop	144.3	159	168	148	122	116	114	115
Number of days of care in thousands	226,445	262,389	274,508	226,217	197,422	164,627	155,857	160,000
Rate of days of care per 1000 population	1,122	1,227	1,217	958	784	620	560	565
Average length of stay	7.8	7.7	7.3	6.5	6.4	5.4	4.9	4.9
Mercy Health System Average LOS			5.04	4.87	5.00	5.03	4.31	4
Population								

Equivalent Bed Analysis	1970	1975	1980	1985	1990	1995	2000	2001
Bed Size at 80% Occupancy	107	105	100	89	88	74	67	67
Average Daily Census	99.9	98.6	93.5	83.2	82.0	69.1	62.7	62.7
Average Length of Stay	7.8	7.7	7.3	6.5	6.4	5.4	4.9	4.9
Total Patient Days	36457	35990	34120	30381	29914	25240	22903	22903
Discharges	4674	4674	4674	4674	4674	4674	4674	4674

The Business Journal of Milwaukee - November 11, 2002
http://milwaukee.bizjournals.com/milwaukee/stories/2002/11/11/focus2.html

The Business Journal
SERVING GREATER MILWAUKEE

IN DEPTH: HEALTH CARE

Private hospital rooms the new norm

Patients demand them; HMOs question costs

Becca Mader

Consumer demand for privacy, as well as the potential for greater operational efficiency, is tearing down the curtain in many Milwaukee-area hospital rooms.

Semiprivate rooms are becoming the exception rather than the norm. New construction projects are focusing exclusively on private rooms, and existing hospitals use semiprivate rooms for single occupancy when volume is low, without charging a higher rate.

Consumers have become more vocal over the past 10 years with their health care demands, especially for privacy and confidentiality, says Mark Knight, president of Knight Consulting Group in Milwaukee.

"Health care consumers are expecting and demanding private rooms when they have a hospital stay," says Jeff Squire, communications director at Aurora Health Care, Milwaukee. "Health care providers are responding to that consumer demand more than anything else."

But consumer demand comes at a price that is unavoidable, says Bill Felsing, chief executive office of United Healthcare, Milwaukee.

"We as consumers do expect more and more," Felsing asserts. "We have seen health care costs rise because of individual expectations. This is no different."

There may be improved efficiencies from remodeling or construction, but "unless that ostensible efficiency translates into a downward change in what providers are charging for those services, employers and employees won't get the benefit of that," says Joe Kachelski, spokesman for Wisconsin Association of Health Plans in Madison.

'Strong argument'

Hospital administrators see it differently.

Ed Olson, president and chief executive officer of Waukesha Memorial Hospital, says it's in hospitals' best interest to have patients in private rooms.

Patients are sicker than they were 15 to 20 years ago, requiring "more intensive-care-type services, more equipment, more staff attention — and that all requires more privacy and the ability to work more closely with patients," he says.

Private rooms also provide for a better healing environment, as patients are able to get more rest and recover more quickly.

They also help with infection control and provide for "a more efficient layout and a safer environment to conduct business," says Jonathan Flyte, vice president of facilities development for Covenant Healthcare System Inc., Milwaukee.

Olson says for the same number of beds, the hospital can achieve a 15 percent improvement in room usage with private rooms compared to semiprivate.

Patient revenue is not sacrificed, he adds, because the hospital isn't turning any patients away in order to keep exclusively private rooms. Waukesha Memorial has 300 beds, half of which are semiprivate.

When volume is high, the hospital simply doesn't have the luxury of using semiprivate rooms as private ones, he explains. Both Covenant and Waukesha Memorial once charged different rates for private and semiprivate, but Covenant stopped that within the last six months and Waukesha Memorial stopped several years ago.

It's unfair to charge a private room rate for a patient who didn't request one but was nonetheless placed alone in a semiprivate room, they say.

"There's a strong argument to be made (about private rooms)," Knight says. "It means you can run a more cost-efficient operation."

Administrators say the ultimate cost savings from improved efficiencies will offset any upfront construction or remodeling costs.

George Quinn, vice president of finance for the Madison-based Wisconsin Hospital Association, notes that hospitals are better able to meet patients' demand for privacy with new facilities.

Several new projects — St. Joseph Community Hospital in West Bend, Waukesha Memorial Hospital, and the South Tower at St. Joseph Regional Medical Center and its Wisconsin Heart Hospital— will have strictly private rooms.

"I don't think there are many that have not gone that route," Knight says. "I don't see anything to change the trend."

Though private rooms aren't the sole reason for new construction, they are one of the benefits, Squire says. At St. Luke's Medical Center, a new heart tower is being constructed to meet demand for heart care services. But the additional space will allow St. Luke's to convert its semiprivate rooms to private ones. Currently, 344 out of 711 beds are semiprivate.

Seven of Aurora's 12 hospitals have exclusively private rooms.

Creating more private rooms within existing facilities is less feasible because hospitals are experiencing increasing volume, making it hard to justify the extra space per patient, Quinn says.

St. Francis Hospital has seen extremely high occupancy rates and needs its semiprivate rooms to meet that demand, says Flyte. When patient volume is low, it accommodates patient requests for privacy by placing a single patient in a double room.

Less flexibility, more moving

To be sure, semiprivate rooms have some advantages. They can help a hospital handle increased occupancy during peak seasons. They also entail less square footage per patient. A typical private room might range from 240 square feet to 270 square feet, Olson says, while a semiprivate with two patients might be about 300 square feet.

But semiprivate rooms don't offer the same flexibility as private rooms, administrators say. Gender and infectious disease issues limit which patients can be put together in one room. And it becomes a juggling act if two roommates are not compatible.

When a private room opens up, most patients want to make the move from semiprivate anyway, says Candace Czarnecki, vice president for hospital operations and nurse executive for the Ozaukee campus of Columbia St. Mary's Hospital.

Before moving to the Ozaukee campus location in Mequon in 1994, staff members at Columbia St. Mary's Port Washington campus found they were handling a lot of transfers, mostly at patients' requests. That translates into additional paperwork and coordination for staff, Czarnecki says.

The Ozaukee campus has no semiprivate rooms. Columbia St. Mary's Milwaukee campus has 152 private rooms and 30 semiprivate rooms. Out of 311 beds at the Columbia St. Mary's Columbia campus, about half are semiprivate. Whenever possible, however, they are used as private rooms.

Rooms at a planned new Columbia St. Mary's Hospital will be designed with the interest of the patient in mind, Czarnecki says.

"Our patients and family and staff love private rooms," Czarnecki says. "I can't imagine the public being comfortable with going back to semiprivate rooms."

HDR

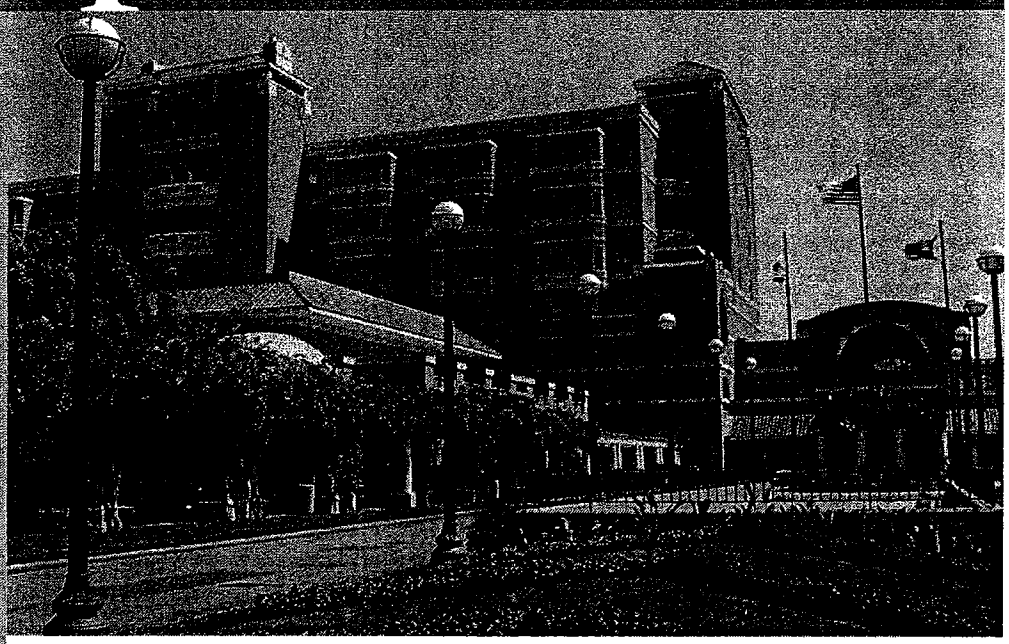
pulse

Trends and Ideas in Healthcare Solutions

inside

Bigger Hospitals & Patient Rooms
What's Driving Today's Hospital Expansion

How We Got Here
A Historical Look at the Changing Face of Healthcare Environments



Right: In 1998, Huntington Memorial Hospital, Pasadena, California, added a 125,000-square-foot tower atop its existing building to accommodate future changes in technology and patient care. An additional tower, now under state plan review, will be completed in 2006.

Healthcare's Operative Word: Bigger

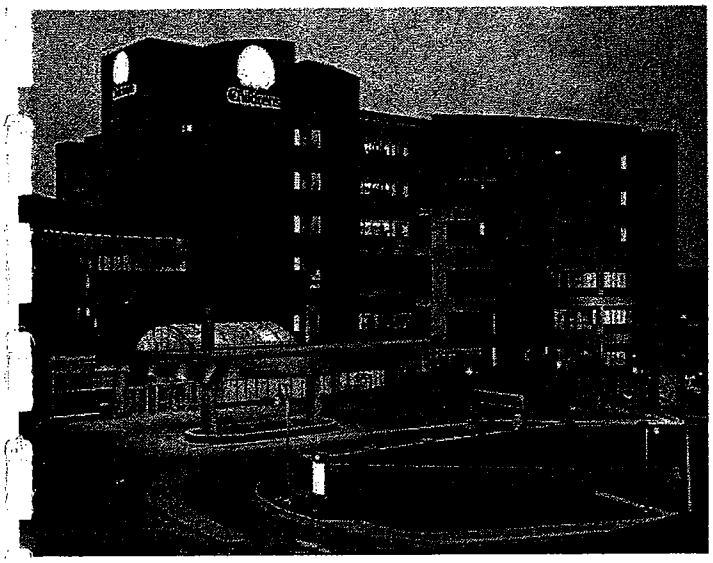
Hospitals Growing by the Decade

As the nation's 76 million baby-boomers awaken each morning to new aches and pains, the healthcare industry is scrambling to revitalize existing healthcare facilities with large, complex renovations and additions– or building shiny, new, state-of-the-art hospitals.

Whether these projects are renovations/additions or completely new hospitals, they are getting bigger and bigger. The two main contributors to this trend? An aging population and the demand for more sophisticated medical services.

Other factors:

- Old infrastructure
- Dramatically evolving technology with specific requirements
- Rising demand for inpatient beds
- New design requirements for patient rooms
- Continuing growth of ambulatory care services
- Healthcare systems adapting to new delivery models



HDR designed the new 118-bed, 275,000-square-foot Children's Hospital in Omaha, Nebraska, which was built across the street from its previous location, to allow for future growth and to incorporate new hospital trends and technology.

In February 2002, the Sheppard Pratt Health System commissioned HDR to provide full A/E services for a replacement inpatient psychiatric hospital and significant renovations to existing facilities. The new hospital is scheduled for completion in 2005. (Rendering: Ernest Burden, III.)

Utilization Takes a U-Turn

Where hospital occupancy has languished for several years, there's a new spotlight on the increased demand for all kinds of medical services, both now and indefinitely into the future.

According to the American Hospital Association, the licensed bed count increased slightly in 2001 for the first time in 17 years. That growth came in tandem with a decrease in the actual number of hospitals, keeping alive a three-decade trend.

But now, with an aging population, aging infrastructure and evolving healthcare delivery models, existing hospitals are faced with renovating, adding capacity or building new – and bigger – hospitals. Many opt for the first two choices, but a surprising number are going with new construction, according to Jim Pine, HDR national director of healthcare.

Generally speaking, hospital additions and renovations are dollar-for-dollar cheaper than new hospital space, Pine said. But he points out that there's a limit to what can be done when retrofitting older facilities.

The fact is that demand for inpatient beds is growing again. Today's hospital executives are faced with deciding whether to spend the money for a new hospital, add on, or eliminate some services in their existing facilities because of space constraints. And competition often dictates a full line-up of services.

Where We've Been

What has caused the space boom in today's hospitals? A walk through the past few decades helps tell the story.

The 1960s – Many of today's hospitals were new 20, 30 or even 40 years ago. The late sixties through the late seventies brought the "golden age of hospital construction," according to Paul Brye, HDR senior consultant.

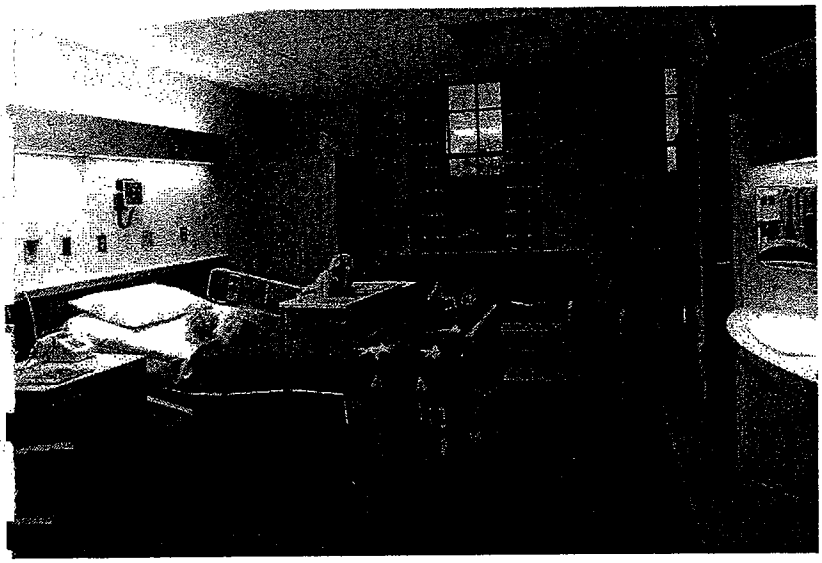
Demand for inpatient care was expanding everywhere in the country. Written into law in 1965, the Medicare and Medicaid programs became a direct federal and state funding pipeline into every hospital in the country, Brye said. This made many previously unpaid medical services reimbursable.

There was little regulation. Even capital costs were reimbursed. "You spent a dollar and you got a dollar," Brye said. Hospitals' profit and loss statements and balance sheets began to look brighter. And patients who might have foregone medical procedures before were now having them done, always as inpatients.

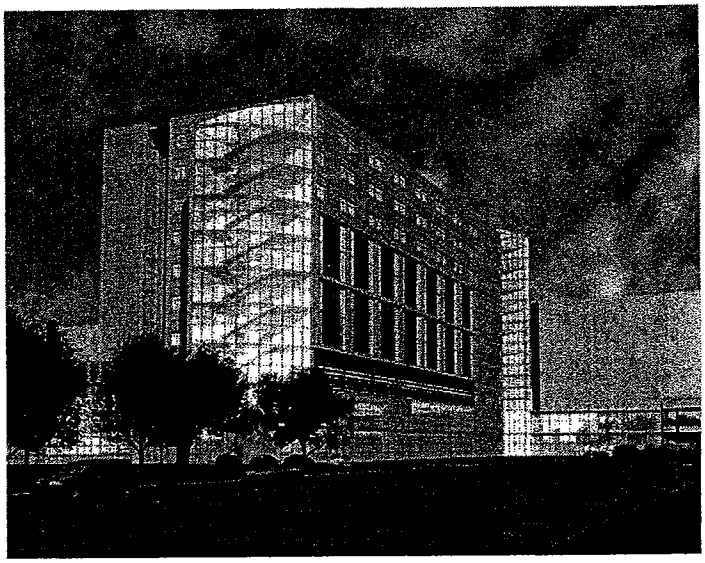
Outpatient surgeries or tests did not exist. The average hospital stay was 10 days, Brye said. A simple biopsy could mean a three-day stay. If you had a heart attack, you could plan on at least 21 days.

In the 1960s, there were no requirements - or needs - for technologically advanced equipment. Emergency rooms were much smaller and less complex, and so were operating rooms.

The typical hospital design in the '60s had 700 square feet per bed.



Larger, private patient rooms, like this pediatric room at Mayo Eugenio Litta Children's Hospital in Rochester, Minnesota, allow easier caregiver access to equipment, room for advanced roll-in testing and treatment equipment, and family space.



The Saint Alphonsus Regional Medical Center's strategic master plan for its Boise, Idaho, campus includes this new state-of-the-art medical center. HDR is working with the client on a six-year, multi-phased implementation plan valued at $121.6 million.

The 1970s – This decade brought the beginnings of government intervention into medical care through required utilization reviews of hospital admissions and lengths of stay. The National Health Planning Act of 1975 was intended, in part, to control the proliferation of inpatient beds. In addition, design guidelines for such areas as the intensive care unit were becoming more technically oriented.

Then technology took off and the CT scanner was the hot item on everyone's wish list. It was the first successful marriage of computer technology to a medical instrument, Brye said - and it was very expensive, adding more to medical costs in general. Also making their debut in the '70s were ambulatory surgery and cancer treatment centers where a patient could see his oncologist and get radiation therapy all under one roof. Neonatology took on much greater importance as did other specialties.

The '70s saw the emergence of mostly semi-private patient rooms and hospitals with all private rooms. A combination of expanding inpatient capacity, new construction and a rapid influx of technology drove healthcare costs up dramatically.

The 1980s – In the '80s, technology came into full bloom. Ambulatory surgery expanded on a grand scale. Instruments and equipment became smaller, making outpatient surgery easier. A new all-inclusive design for hospital maternity rooms created an environment for all aspects of birthing.

Cancer patients could receive care at their community hospital, instead of traveling miles to a specialty cancer center in a distant state. Hospital emergency departments expanded and became more sophisticated to answer increasing demand in volume and types of services.

The 1983 advent of Diagnostic Related Group reimbursements lowered financial incentives for hospitals to rely so heavily on inpatient care. Patients were sent home much sooner. This created a major push toward outpatient care, along with new technologies that allowed such services as orthopedic arthroscopic surgery and eye surgery to be done on a completely outpatient basis. The same held true for magnetic resonance and ultrasound imaging, nuclear medicine and cardiology procedures.

The 1990s – In the 1990s, there was major growth in healthcare systems, along with major strides in both information and clinical technology. Healthcare systems were catching up in their IT capabilities and learning how to leverage IT to advance actual clinical practices, instead of just adding equipment. Information technology was now influencing space programming and architectural design to a much greater degree. And a larger movement began to replace the aging hospitals of the "golden era," Brye said.

Private rooms were now the norm, especially in for-profit hospitals wanting to achieve a hotel-like atmosphere, Brye said. He added that HDR, the country's number 2 designer of healthcare facilities, has almost exclusively programmed private rooms in the past 10 years.

(continued on back)

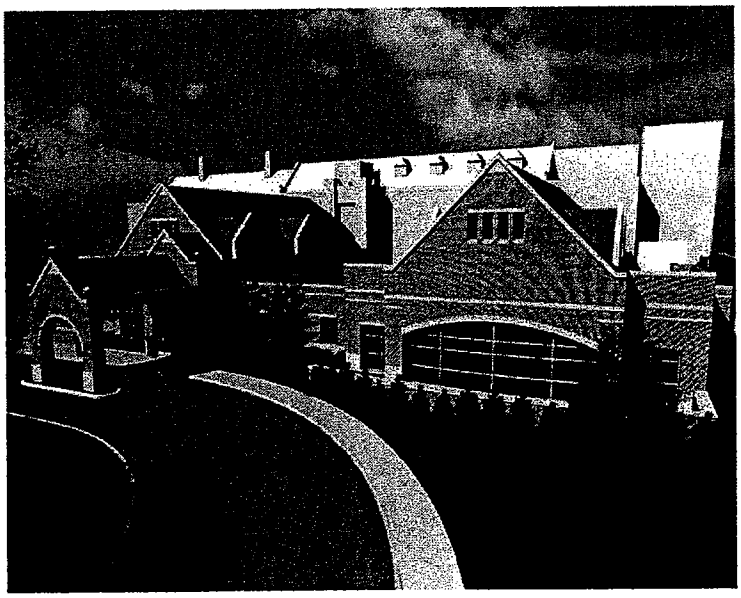
The 2000s – Today's inpatient hospital rooms are considerably larger and more family-focused. Studies have shown that family involvement in patient care improves recovery time, while reducing the cost of treatment. Today's choosier consumer wants ample space for family, including sleepover facilities, bathroom amenities and areas for such things as computers.

Patient rooms must also accommodate more bedside equipment for treatment and testing. In addition, clinical staff spaces for such things as supplies, hand washing facilities and computers are making their way into patient rooms, which are now checking in at 320 to 370 square feet.

The 20' x 20' operating room of the '70s is being replaced by suites ranging from 650 to 700 square feet today. Space for more surgical equipment is being incorporated, as well as staging for robotics. Emergency rooms continue to grow and are the "dominant port of entry into acute healthcare," Brye said.

All these factors add up to bigger, more complex hospital projects - from 2,500 to 2,800 square feet per bed today – about four times the per bed square footage of the '70s.

And healthcare construction is more robust than ever before.



HDR worked with the oncology staff in residence at Ball Memorial Hospital, Muncie, Indiana, to program and design a remodel and expansion of its cancer center. Construction on this patient-focused regional referral center was completed in September 2002.

HDR pulse

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Hospitals scramble to meet demand for private rooms

The Boston Globe

By Liz Kowalczyk, Globe Staff, 9/7/2003

Growing numbers of hospital patients, seeking peace, privacy, and quiet, are demanding a limited resource -- private rooms -- prompting hospitals to convert offices, doctors' sleeping quarters, and even entire buildings into single rooms.

Along with a trend toward sicker patients who need isolation for medical reasons or to prevent the spread of infection, hospital administrators said, patients are complaining about roommates. Some refuse to turn down the television, some family members talk into the wee hours, and some simply need so much medical care that nurses and doctors are at their bedside around the clock, making it hard for others to rest. Other patients say, and increasingly administrators agree, that privacy and calm will help them heal faster.

This was the reason Karen Hartford, 43, requested a private room at Brigham and Women's Hospital for a hysterectomy last year. "I wouldn't call you up if I didn't know you from a hole in the wall and say, `Let's go to Europe and have a good time.' Why would I want to be in a room with a stranger when I'm at my worst?" Hartford said. "When you're in the hospital, it's time to focus on you and your well-being. That would have been a deal-breaker for me. I probably would have canceled my surgery if I couldn't get a private room."

Boston hospitals rarely have more than 50 percent of their nonintensive care beds in private rooms, and at some hospitals like Massachusetts General Hospital, only 20 percent of the beds for adult surgery and medical patients are in singles. Since transplant patients, dying patients, and those with infectious diseases get first priority, this means patients who want more privacy often must wait to see if a room opens up during their stay.

As a result, the waiting list for private rooms at the Brigham grows to 15 to 20 patients on a very busy day, even though the hospital has a relatively large number of singles: 180 rooms with one bed plus 105 private childbirth rooms. Including intensive care units, the Brigham has a total of 719 beds.

The hospital began to expand the number of single beds by turning an old rehabilitation unit into the Shapiro Pavilion, a hotel-like private floor with its own dedicated chef, 14 private rooms, wood paneling, sweeping views of Jamaica Pond and the Northeastern University football field, and high tea for families at 4 p.m. Above each bed, nature photographs slide down to hide blood pressure monitors, oxygen, and suction equipment.

Not everyone, however, can afford the Shapiro Pavilion, which costs patients $250 to $800 out-of-pocket a night depending on room size. So the hospital last year converted offices to 10 single rooms, and will turn an on-call sleeping floor for residents into another 10 private rooms next spring. These rooms don't have a restaurant menu or 16th-floor views, but the hospital is trying to mimic the privacy of the luxury Shapiro floor at a more affordable price. Patients pay a surcharge of $137 for a private room -- over and above what their insurance pays -- because the hospital cannot earn as much revenue as if it used the space for double rooms, hospital executives said.

Mount Auburn Hospital in Cambridge, which has 56 beds in four-person rooms, Cape Cod Hospital, and Beth Israel Deaconess Medical Center are expanding their number of private rooms, while Tufts-New England Medical Center and Mass. General are not, primarily because they don't have the space. Faulkner Hospital in Boston and Lahey Clinic in Burlington have almost all singles. In Los Angeles, UCLA Medical Center is building a new hospital of just private rooms.

"If you think about it, there is no other place you would go and be expected to check in overnight with someone you don't know," said Jeanette Ives Erickson, senior vice president and chief nurse at Mass. General, who would like to have more single rooms if the hospital could find the space.

Though Massachusetts officials said they are not worried, other state regulators fear the move to single rooms is creating a two-tier system of hospital rooms, where the wealthy reside on separate floors with private rooms and the poor are placed in older doubles, one hospital executive said. Several years ago, New York State public health officials denied a request by New York Weill Cornell Medical Center to build more than 50 percent private rooms in its new hospital, said Susan Mascitelli, vice president for patient services. In the older hospital, about one in seven rooms were private. In New York City, surcharges for a private room range from $300 to $500, and Mascitelli said "they wanted a single class of care for everyone." State officials said they did not recall the reasons for the denial.

Before World War II, most hospitals were organized in 30-bed wards, in which nurses more easily could keep an eye on large numbers of patients. As Americans grew more concerned about privacy and patients rights, however, hospitals began to build four- and two-bed rooms. Now, the number of antibiotic-resistant bacterial infections among patients is growing, and preliminary studies suggest that immune systems of patients living in low-stress environments are stronger, said Gary Burk, a principal at Ratcliff, a California architecture firm that designs hospitals. Hospitals undertaking construction projects now, he said, build almost all single rooms.

Some older people who have no family, however, want a roommate for company. And the semiprivate room system is reinforced by insurers, which usually pay only for semiprivate rooms.

Assumptions about the financial advantage of double rooms, however, is changing.

Dr. Michael Karpf, director of UCLA Medical Center, which is building a $700 million, 525-bed hospital because the existing facility was damaged during the 1994 Northridge earthquake, said single rooms are more efficient. All the beds can be used, whereas hospitals sometimes cannot use both beds in a double room because a patient requires isolation, or they cannot pair a man and a woman. "We have 10 to 12 beds that can't be filled at all times," he said.

While UCLA negotiated higher rates with insurers to cover the cost of private rooms, many hospitals on the East Coast charge extra.

Jeanette Clough, president of Mount Auburn Hospital, said when patients stayed in the hospital an average of seven to eight days, an extra daily charge of $100 seemed exorbitant.

Now that the average length of stay at the hospital has dropped to 3.5 days over the last decade, however, many patients are willing to pay the surcharge for privacy.

Bill Emswiler, 44, of Walpole, would have gladly paid extra when he had surgery to remove what turned out to be a noncancerous stomach tumor at Mass. General two years ago.

His first two roommates were in and out quickly. The third, however, was paraplegic and needed 24-hour care from his family, who talked in the room late into the night. Emswiler asked for a private room -- or at least a quieter one -- but nurses said the floor was full.

"It was pretty hard to sleep, both because of my own pain and the commotion going on," said Emswiler, who was bothered enough to complain to the patient advocate after he went home. "I wasn't the most pleasant person by the end of the week."

Liz Kowalczyk can be reached at kowalczyk@globe.com.

Mills-Peninsula Health Services
A Sutter Health Affiliate

Single hospital rooms not only are nicer — they're safer for patients

When Mills-Peninsula designed its new $400-million hospital with almost all single rooms, it wasn't just for good customer service.

"Most new hospitals today are designed with all single rooms because they are safer and also help hold down cost by allowing us to operate more efficiently," Mills-Peninsula CEO Bob Merwin said.

"We know that single rooms are safer," he said. "When there's only one person in a room, there is no risk of infection from patient to patient.

"Single rooms also help us serve our patients more efficiently. We don't have to worry about who's already in the room when we place a new person," Merwin said. "That covers not only infectious disease issues, but also compatibility. For example, there are no problems of gender or severity of illness when each person has his or her own room. It's also quieter and more restful, which helps healing."

"Most important, there is no additional cost to Medicare patients for single rooms," according to Diana Gray, program manager for the independent Health Insurance Counseling and Advocacy Program (HICAP).

HICAP helps more than 3.9 million Medicare beneficiaries statewide to understand and navigate the program's many complex rules, regulations and policies.

"If two hospitals are next door to each other and one has all single rooms and the other has all semi-private rooms, the payment to the hospital from Medicare would be exactly the same for the exact same procedure," Gray explained. "Medicare bases its payments on the procedure performed, not the type of room.

"Medicare also does not charge any additional copay for a single room in a hospital that provides only single rooms," she said.

"Medicare's patient guidebook says that, in general, Medicare will only cover the cost of a private room if it is deemed medically necessary," Gray said. "However, the same regulation clearly states that a private room will be considered medically necessary if it is the only kind of room available.

"Specifically, The Medicare rule says: 'if the patient is admitted to a hospital that has only private rooms and no semiprivate or ward accommodations, medical necessity will be deemed to exist for the accommodations furnished.

Beneficiaries may not be subjected to an extra charge for a private room in an all-private room hospital.'"

As far as Mills-Peninsula is concerned, serving seniors is central to our mission, Merwin said. "More than half of our patients are Medicare beneficiaries. We are not going to charge differently than we do today just because we are able to offer nicer, safer rooms. We will always be ready to provide care for the older adults in our community."

For more information about Medicare coverage, call HICAP at 1 800 434 0222.

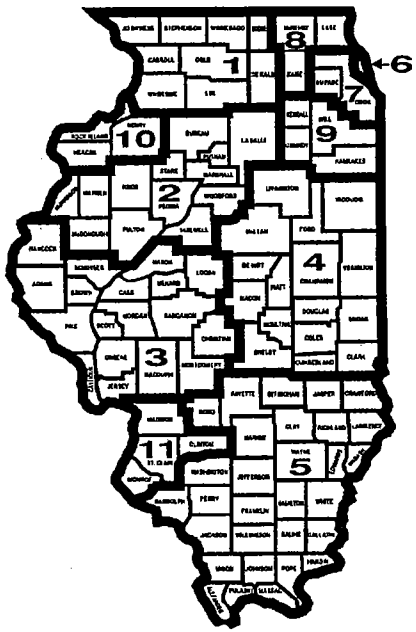
Illinois Hospital Price Survey Report: *2000*

Provided by:

IHCCC Illinois Health Care
Cost Containment Council

Inside:

- *Facility Type*
- *Bed Counts*
- *Room Prices*
- *Prices for Diagnostic Services*
- *Average Charges for Inpatient Procedures*
- *Average Charges for Outpatient Procedures*



George H. Ryan, Governor
Lenell Gwin-Beaty, Executive Director

Greetings:

The Illinois Health Care Cost Containment Council (IHCCCC), created in 1984 by the Illinois General Assembly, is a state agency mandated to collect and disseminate information about the costs of hospital care in our state. Funded partly by the taxpayers and by users of the Council=s information, IHCCCC represents consumers, businesses, insurance companies, hospitals and physicians.

By law, Illinois' hospitals are required to post prices for selected inpatient and outpatient services. The Council collects this information through an annual survey of hospital prices. The *Hospital Price Survey Report: 2000* summarizes the results from this survey. We hope you will find this information useful, and we encourage you to contact the Council with any suggestions on how we can make our information more useful.

Address and telephone number:

Illinois Health Care Cost Containment Council
Lenell Gwin-Beaty, Executive Director

4500 South Sixth Street Road, Suite 215
Springfield, Illinois 62703
(217) 786 - 7001

160 North LaSalle Street, Suite S-200
Chicago, Illinois 60601
(312) 793 - 1440

Web Page Address - *http://www.state.il.us/agency/hcccc/*

Toll-free *Health Care Hotline – 1/866-847-3246*

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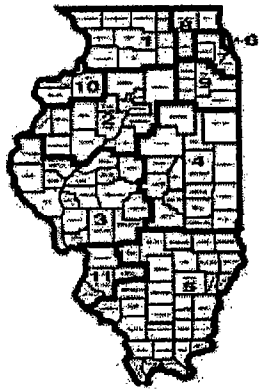
Introduction

The ***Illinois Hospital Price Survey Report: 2000*** includes price survey information on Illinois' 214 acute care hospitals providing services in calendar year 2000. This survey lists each hospital according to its Health Service Area listed below:

- *City of Chicago* *Health Service Area 6*

- *Suburban Chicago* *Health Service Area 7*
  Suburban Cook & DuPage counties
  Health Service Area 8
  Kane, Lake & McHenry counties.
  Health Service Area 9
  Grundy, Kankakee, Kendall & Will counties.



- *Northwest Illinois* *Health Service Area 1*
  Boone, Carroll, DeKalb, JoDaviess, Lee, Ogle, Stephenson, Whiteside& Winnebago counties.
  Health Service Area 10
  Henry, Mercer & Rock Island counties.

- *Central Illinois* *Health Service Area 2*
  Bureau, Fulton, Henderson, Knox, LaSalle, Marshall, McDonough, Peoria, Putnam, Stark, Tazewell, Warren & Woodford counties.
  Health Service Area 3
  Adams, Brown, Calhoun, Cass, Christian, Greene, Hancock, Jersey, Logan, Macoupin, Mason, Menard, Montgomery, Morgan, Pike, Sangamon, Schuyler & Scott counties.
  Health Service Area 4
  Champaign, Clark, Coles, Cumberland, DeWitt, Douglas, Edgar, Ford, Iroquois, Livingston, Macon, McLean, Moultrie, Piatt, Shelby & Vermilion counties.

- *Southern Illinois Health Service Area 5*
  Alexander, Bond, Clay, Crawford, Edwards, Effingham, Fayette, Gallatin, Hamilton, Hardin, Jackson, Jasper, Jefferson, Johnson, Lawrence, Marion, Massac, Perry, Pope, Pulaski, Randolph, Richland, Saline, Union, Wabash, Washington, Wayne, White & Williamson counties.
  Health Service Area 11
  Clinton, Madison, Monroe & St. Clair counties.

Explanation of Terms in 2000 Price Survey Report

The report examines, by hospital, information in five key areas -- Facility Type, Bed Counts, Room Types, Diagnostic Services, Inpatient Procedures, and Outpatient Procedures. Prices appear for Room Types (Table B) and Diagnostic Services (Table C) categories, while average charges appear for Inpatient Procedures (Table D) and Outpatient Procedures (Table E). Each table lists hospital specific information.

Some facilities may not offer all procedures, while some services are not priced them separately. In these instances, the following codes will appear – ***n/a for service not available, n/p for procedure not performed, and n/s for procedures not priced separately.***

GENERAL TERMS

International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). ICD-9-CM is a system designed to index hospital discharge records by disease and for data storage and retrieval. It is also used to classify morbidity and mortality information for statistical purposes.

Current Procedural Terminology, Fourth Edition (CPT-4). CPT-4 is a systematic way to code procedures and services performed by physicians. Each procedure or code is identified with a 5-digit code; the CPT codes simplify the report and may include physician charges.

Uniform Billing-1992 for Illinois Manual Revenue Code. A code that identifies a specific accommodation, ancillary service or billing calculation, primarily for bed and room prices at a hospital.

Health Service Area (HSA). An HSA is one of 11 areas of the state designated by the federal government for health planning purposes.

Prices (as found in Room Type, Table B, and Diagnostic Services, Table C). The hospital master price as reported for this procedure as of December 31, 2000.

Average Charges (as found in Inpatient Procedures, Table D, and Outpatient Procedures, Table E). The average dollar amount charged in a specific CPT-4 or ICD-9 service or procedure during a hospital stay. Actual payments are likely to be less than charges.

TABLE A - Facility Type & Bed Counts

(Turn to pages 10-17)

Facility Type - In Table A, Facility Type describes the services provided at each facility. The facility types are self-designated by each hospital and are as follows:

1.) General - Short Term
2.) General - Long Term
3.) Tuberculosis
4.) Psychiatric
5.) Chronic Disease (not Rehabilitation)
6.) Rehabilitation
7.) Childrens Hospital
8.) General Hospital with Specialty Caseload

Bed Counts by Type - This part of Table A lists the number of beds by type at each facility. The bed types are as follows:

Burn Unit - includes care for burn victims in a designated unit.
Intensive Care Unit - includes coronary care, combined intensive coronary care unit, other intensive care, pulmonary care unit and pediatric intensive care.
Medical/Surgical - includes orthopedics, ophthalmology, trauma, neurology, gynecology, intermediate intensive and special care (in which nurse does not have direct vision over all patients), cardio-thoracic-vascular, ENT, tuberculosis, inpatient renal dialysis, dental (assigned to M/S), urology and research. *Does not include combined obstetrics/gynecology.*
Neonatal (*Level III*) Premature - includes neonatal ICU.
Obstetrics - includes obstetrics and combined obstetrics/gynecology.
Pediatric - includes pediatrics with and without nurses' station and pediatric unit nurses station.
Psychiatric - does not include substance abuse beds.
Rehabilitation - does not include long-term care beds
Substance Abuse - does not include psychiatric beds
Skilled Nursing - includes frequent medical supervision (skilled care, continuous skilled nursing observations, restorative nursing and other services) for patients who need care and treatment during the post-acute illness phase or recurrence of long-term illness symptoms.
Hospice - includes any hospitalization for respite care based on a physician diagnosis of a terminal illness.
Intermediate Care Facility (ICF) - includes basic nursing care and other restorative services under periodic medical direction for patients who have long-term illnesses or disabilities and have stabilized in condition.

Please note that the *Total Column is the number of staffed beds reported, not the sum of bed types at each hospital.*

TABLE B - Room Types

(Turn to pages 18-25)

Private Room (*Med/Surg, Revenue Code 111*) - Hospital charge master price ($) as of December 31, 2000 for one day in a 1-bed medical/surgical room.

Private Room (*Pediatric, Revenue Code 113*) - Hospital charge master price ($) as of December 31, 2000 for one day in a 1-bed pediatrics room.

Private Room (*Psych, Revenue Code 114*) - Hospital charge master price ($) as of December 31, 2000 for one day in a 1-bed psychiatric room.

Private Room (*Rehab, Revenue Code 118*) - Hospital charge master price ($) as of December 31, 2000 for one day in a 1-bed rehabilitation room.

Semi-Private Room (*Med/Surg, Revenue Code 121*) - Hospital charge master price ($) as of December 31, 2000 for one day in a 2-bed medical surgical room.

Semi-Private Room (*Pediatric, Revenue Code 123*) - Hospital charge master price ($) as of December 31, 2000 for one day in a 2-bed pediatric room.

Semi-Private Room (*Psych, Revenue Code 124*) - Hospital charge master price ($) as of December 31, 2000 for one day in a 2-bed psychiatric room.

Semi-Private Room (*Rehab, Revenue Code 128*) - Hospital charge master price ($) as of December 31, 2000 for one day in a 2-bed psychiatric room.

Room with 3+ Beds (*Med/Surg, Revenue Code 131*) - Hospital charge master price ($) as of December 31, 2000 for one day in a medical/surgical room with 3 or more beds.

Room with 3+ Beds (*Pediatric, Revenue Code 133*) - Hospital charge master price ($) as of December 31, 2000 for one day in a pediatric room with 3 or more beds.

Room with 3+ Beds (*Psych, Revenue Code 134*) - Hospital charge master price ($) as of December 31, 2000 for one day in a psychiatric room with 3 or more beds.

Room with 3+ Beds (*Rehab, Revenue Code 138*) - Hospital charge master price ($) as of December 31, 2000 for one day in a rehabilitation room with 3 or more beds.

Intensive Care Unit (*Special Med, Revenue Code 201*) - Hospital charge master price ($) as of December 31, 2000 for one day in a special medical intensive care unit bed.

Intensive Care Unit (*Surg, Revenue Code 202*) - Hospital charge master price ($) as of December 31, 2000 for one day in a surgical intensive care unit bed.

Intensive Care Unit (*Psych, Revenue Code 204*) - Hospital charge master price ($) as of December 31, 2000 for one day in a psychiatric intensive care unit bed.

Emergency Room (*Revenue Code 450*) - Hospital charge master price ($) as of December 31, 2000 for minimum emergency room services.

TABLE C - Diagnostic Services

(Turn to pages 26-33)

Mammography (*Screening Bilateral Mammogram, CPT-4 76092*) - Hospital charge master price ($) as of December 31, 2000 for a mammography (screening bilateral mammogram).

X-ray (*Head/Skull, CPT-4 70260*) - Hospital charge master price ($) as of December 31, 2000 for an x-ray of the head/skull.

CAT Scan (*Brain without Contrast, CPT-4 70450*) - Hospital charge master price ($) as of December 31, 2000 for CAT scan of the brain *WITHOUT* contrast.

CAT Scan (*Brain with Contrast, CPT-4 70460*) - Hospital charge master price ($) as of December 31, 2000 for CAT scan of the brain *WITH* contrast.

MRI of the Brain (*without Contrast, CPT-4 70551*) - Hospital charge master price ($) as of December 31, 2000 for a magnetic resonance imaging (MRI) of the brain and brain stem *WITHOUT* contrast materials.

Upper G.I. Series (*CPT-4 74240*) - Hospital charge master price ($) as of December 31, 2000 for an upper G.I. series (x-ray of stomach and small intestine).

Chest X-Ray (*Frontal/Lateral, CPT-4 71020*) - Hospital charge master price ($) as of December 31, 2000 for a frontal and lateral x-ray of the chest.

HIV (*HIV-1 & HIV-2*) Single Assay *(CPT-4 86703)* - Hospital charge master price ($) as of December 31, 2000 for an HIV single assay (detection of HIV antibodies).

HIV Confirmatory Test (*Western Blot, CPT-4 86689*) - Hospital charge master price ($) as of December 31, 2000 for an HIV confirmatory test (Western Blot).

Electrocardiogram (*CPT-4 93005*) - Hospital charge master price ($) as of December 31, 2000 for an electrocardiogram with at least 12 leads (tracing only).

Complete Blood Count *(CPT-4 85025)* - Hospital charge master price ($) as of December 31, 2000 for a blood count that includes red blood cell count, white blood cell count and white blood cell differential.

Urinalysis ***(CPT-4 81003)*** – Hospital charge master price ($) as of December 31, 2000, for an analysis of a urine sample without microscopy.

Blood Chemistry ***(CPT-4 80049)*** - Hospital charge master price ($) as of December 31, 2000 for a routine blood analysis.

Blood Typing Only ***(CPT-4 86900)*** - Hospital charge master price ($) as of December 31, 2000 for an analysis of a blood sample to determine blood type only.

Rh Factor Only ***(CPT-4 86901)*** - Hospital charge master price ($) as of December 31, 2000 for an analysis of a blood sample to determine Rh factor only.

TABLE D - Inpatient Procedures

(Turn to pages 34-41)

Open Appendectomy ***(ICD-9 47.09)*** - Average charge ($) during calendar year 2000 for an inpatient open appendectomy (removal of appendix).

Open Cholecystectomy ***(ICD-9 51.22)*** - Average charge ($) during calendar year 2000 for an inpatient open cholecystectomy (removal of gall bladder).

Knee Replacement ***(ICD-9 81.54)*** - Average charge ($) during calendar year 2000 for an inpatient knee replacement.

Total Hip Replacement ***(ICD-9 81.51)*** - Average charge ($) during calendar year 2000 for an inpatient total hip replacement.

Heart Transplant ***(ICD-9 37.5)*** - Average charge ($) during calendar year 2000 for an inpatient heart transplant.

Kidney Transplant ***(ICD-9 55.69)*** - Average charge ($) during calendar year 2000 for an inpatient kidney transplant.

Modified Radical Mastectomy ***(ICD-9 85.43)*** - Average charge ($) during calendar year 2000 for an inpatient modified radical mastectomy (complete removal of breast).

TABLE E - Outpatient Procedures

(Turn to pages 42-49)

Tonsillectomy with Adenoidectomy ***(CPT-4 42820 & 42821, ICD-9 28.3)*** - Average charge ($) during calendar year 2000 for an outpatient tonsillectomy with Adenoidectomy (removal of tonsils and adenoids).

Extracapsular Removal of Cataract with Insertion of Lens ***(CPT-4 66984, ICD-9 13.59)*** - Average charge ($) during calendar year 2000 for an outpatient extracapsular cataract removal with insertion of lens prosthesis.

Incisional Breast Biopsy ***(CPT-4 19101, ICD-9 85.12)*** - Average charge ($) during calendar year 2000 for an outpatient incisional breast biopsy.

Excision of Breast Lesion ***(CPT-4 19120 & 19125, ICD-9 85.21)***- Average charge ($) during calendar year 2000 for an outpatient excision of a breast lesion.

Cystourethroscopy ***(CPT-4 52000, ICD-9 57.32)*** - Average charge ($) during calendar year 2000 for an outpatient cystourethroscopy (diagnostic examination of urinary bladder).

D & C ***(Non-Obstetrical, CPT-4 58120, ICD-9 69.09)*** - Average charge ($) during calendar year 2000 for an outpatient dilation and curettage (expansion of cervical canal of uterus to scrape lining of the uterine wall for diagnostic and/or therapeutic purposes).

Upper Gastrointestinal Endoscopy ***(CPT-4 43235, ICD-9 45.13)*** - Average charge ($) during calendar year 2000 for an outpatient upper gastrointestinal endoscopy (observing stomach and/or small intestine cavity with use of endoscopes).

Excision of Skin Lesion (*CPT-4 11400 through CPT-4 11646, ICD-9 86.3)* - Average charge ($) during calendar year 2000 for an outpatient excision of skin lesion (removal of benign lesions of skin or subcutaneous tissues).

Arthroscopy (*Knee, CPT-4 29870, ICD-9 80.26*) - Average charge ($) during calendar year 2000 for an outpatient arthroscopy of the knee (diagnostic viewing of the interior of the knee joint with an arthroscope).

Carpal Tunnel Release (*CPT-4 64721, ICD-9 04.43)* - Average charge ($) during calendar year 2000 for an outpatient carpal tunnel release (decompression or freeing of the median nerve in the wrist from scar tissue).

Hernia Repair (*Inguinal, CPT-4 49505 through CPT-4 49525, ICD-9 53.00*) - Average charge ($) during calendar year 2000 for an outpatient inguinal hernia repair (repair of protrusion of hernial sac containing the intestines).

Colonoscopy (*CPT-4 45378, ICD-9 45.23)* - Average charge ($) during calendar year 2000 for an outpatient colonoscopy (examination of entire colon with use of a colonoscope).

Sigmoidoscopy (*CPT-4 45330, ICD-9 45.24)* - Average charge ($) during calendar year 2000 for an outpatient sigmoidoscopy (examination of sigmoid colon, or lower portion of colon with use of a sigmoidoscope).

Tympanostomy (*CPT-4 69433 & 69436, ICD-9 20.01)* - Average charge ($) during calendar year 2000 for an outpatient tympanostomy (insertion of ventilation tubes into middle ear).

Needle Biopsy of Prostate (*CPT-4 55700, ICD-9 60.11)* - Average charge ($) during calendar year 2000 for an outpatient needle or punch biopsy of prostate.

Becoming an Effective Consumer of Health Care

There are several other steps you can take to become an effective consumer of health care. Listed below are eight things to consider which will assist you in this process:

- ***Take advantage of telephone nursing services*** provided by health care providers, insurance companies, health maintenance organizations (HMO), etc. Such services allow the consumer to speak to a nurse and ask questions about appropriate medical care, find a physician or obtain health information.

- ***Prepare ahead of time for doctor's appointments.*** Write out a list of questions and concerns and bring it to the appointment. If unclear about anything, ask the doctor for further explanation.

- ***Before services/treatments are done, ask questions*** about the care, the costs and alternate treatment options available.

- ***Always review your insurance policy and benefits package*** to decide what steps need to be followed to insure proper coverage. Also, ask about the percentage of the cost that will have to be absorbed by you. Not all health plans offer complete, coverage of care or payments. For instance, it may be necessary to call your insurer before entering the hospital to maximize your benefits.

- ***When the health care bill arrives, check it carefully*** and contact the provider's billing department if an error is suspected. This review should be done whether the claim is submitted to the insurance company or not.

- ***Obtain educational materials*** from your doctor and/or hospital. Ask your doctors for educational materials, take a trip to the library, search the Internet or contact the national or local association related to the disease or procedure to obtain more information.

- ***Join an organized patient group.*** Ask the doctor or area hospital about support groups. Such a group can provide you with more information and support. Other resources you can use to find this information are the telephone directory, the newspaper, the Internet or a local bulletin board.

- ***Before you receive treatment,*** there are specific questions you should ask your doctor and surgeon. Free consumer pamphlets regarding this subject are available:

  - **Call the Agency for Health Care Research and Quality (AHRQ) publication** clearinghouse and ask for document number 95-0027 *Questions to Ask Your Doctor Before Treatment.* Call (800) 358-9295 or visit the web at www.ahrq.gov.

  - **Call or write to the American College of Surgeons** and ask for the series of pamphlets titled *When You Need an Operation.* This information is also available on the web ***www.facs.org***.

    ACS
    Office of Public Information
    633 N. St. Clair Street
    Chicago, IL 60611-3211
    (312) 202-5000

Why Hospital Reimbursements Vary

What is paid to the hospital may vary depending upon a variety of factors. Listed in this section are some common reasons why hospital reimbursements vary.

Type of Payer

Reimbursements received by providers vary depending upon who pays:

Patients with insurance coverage. Patients with insurance pay discounted, capitated or customary and usual fees negotiated by their insurance company, HMO or PPO. Many policies only provide partial coverage.

Patients covered by government programs. Medicaid and sometimes Medicare reimburse hospitals at preestablished rates for services rendered.

Patients who are under insured or lack insurance and do not qualify for Medicaid. The unpaid portion of a bill is absorbed by the hospital and paid, in part, through rates charged to those who have coverage.

Cross Subsidization

Charges may vary among hospitals because of cross subsidization, which is used to help fund care for government-assisted patients, the under insured and uninsured. Cross subsidization, or cost shifting, means that charges to patients may reflect an amount to help pay for part of the uncompensated care provided by the hospital to the indigent population. The amount that needs to be subsidized will vary from hospital to hospital, depending on the number of indigent patients that particular hospital serves.

Other Hospital Level Factors

Technology. Not only is medical technology very expensive, but also employing highly trained personnel to administer "state of the art" technology is also costly. Thus, the level of technology in which a hospital invests will affect charges.

Types of services offered. Hospitals often offer different levels of care and may specialize in one or more types of services. For instance, a hospital may specialize in heart procedures, respiratory disorders or psychiatric care, and may show higher average charges than other hospitals for these services because of the expense involved in treating severe cases.

Research and teaching hospitals. Although many benefits are returned to the community, providing research and medical training is costly and can influence a hospitals charges.

Business costs. Hospitals must pay for new equipment, construction, maintenance/renovations and malpractice insurance. Increased costs associated with these activities may be reflected in patient charges.

Pricing practices. Some facilities charge a flat fee, which includes one charge for all services or a given procedure. Others charge according to actual time, services, consultation and supplies required for the individual patient.

Miscellaneous Factors

Patient severity of illness. Two people admitted to the hospital for the same condition may require different levels of care due to various factors, such as complications, comorbidities and other related difficulties.

Length of hospital stay. Longer hospital stays are likely to result in higher charges.

Physician practice/treatment patterns. The kinds of diagnostic tests ordered, treatments preferred, etc., vary somewhat from physician to physician and explain, in part, the difference in charges among patients.

Geographic area. Labor and other costs vary by geographic area within the state (urban vs. rural) and may influence charges.

Table B
Charge Master Prices($) for Select Rooms at Illinois Hospitals
2000

Hospital Name	City	Private Room Med/ Surge	Private Room Ped-iatric	Private Room Psych	Private Room Rehab	Semi-Private Room Med Surge	Semi-Private Room Ped-iatric	Semi-Private Room Psych	Semi-Private Room Rehab	Room With 3+ Beds Med/ Surg	Room With 3+ Beds Ped-iatric	Room With 3+ Beds Psych	Room With 3+ Beds Rehab	Intensive Care Room Spec/Med	Intensive Care Room Surg	Intensive Care Room Psych	ER
Illinois Average		**$615**	**$640**	**$828**	**$739**	**$589**	**$617**	**$802**	**$711**	**$621**	**$725**	**$730**	**$657**	**$1,298**	**$1,311**	**$1,328**	**$83**
Chicago Illinois Average		**$835**	**$841**	**$915**	**$822**	**$826**	**$847**	**$890**	**$827**	**$960**	**$921**	**$872**	**$670**	**$1,694**	**$1,743**	**$1,806**	**$117**
Health Service Area 6 Average		**$835**	**$841**	**$915**	**$822**	**$826**	**$847**	**$890**	**$827**	**$960**	**$921**	**$872**	**$670**	**$1,694**	**$1,743**	**$1,806**	**$117**
Advocate Illinois Masonic	Chicago	1,169	n/a	1,427	n/a	1,106	1,106	1,296	n/a	n/a	n/a	n/a	n/a	3,007	3,007	n/a	88
Advocate Ravenswood Hospital	Chicago	897	897	897	897	851	851	851	851	n/a	n/a	n/a	n/a	1,760	1,760	n/a	140
Bethany Hospital	Chicago	824	n/a	n/a	n/a	824	n/a	766	n/a	n/a	n/a	n/a	n/a	1,691	1,691	n/a	70
Chicago Lakeshore Hospital	Chicago	n/a	n/a	1,323	n/a	n/a	n/a	1,323	n/a	n/a	n/a	1,323	n/a	n/a	n/a	n/a	n/a
Children's Memorial Hospital	Chicago	n/s	969	n/s	n/s	n/s	893	875	n/s	n/s	893	n/s	n/s	n/s	n/s	n/s	80
Cook County Hospital	Chicago	n/s	n/s	n/s	n/s	1,800	1,800	n/a	n/a	1,800	1,800	n/a	n/a	2,500	2,500	n/a	200
Edgewater Medical Center	Chicago	809	n/a	n/a	n/a	767	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1,596	n/a	n/a	51
Grant Hospital	Chicago	1,057	n/a	1,057	1,057	854	n/a	854	854	n/a	n/a	n/a	n/a	2,009	2,009	n/a	114
Hartgrove Hospital	Chicago	n/a	n/a	n/a	n/a	n/a	n/a	1,015	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Holy Cross Hospital	Chicago	1,050	n/s	n/a	n/s	1,008	1,008	n/a	1,090	n/a	n/a	n/a	n/a	2,029	2,029	n/a	60
Jackson Park Hosp. & Med. Ctr.	Chicago	790	n/a	1,010	n/a	n/s	n/s	n/s	n/a	n/s	n/s	n/s	n/a	1,584	n/s	n/s	170
LaRabida Children's Hospital	Chicago	n/a	n/a	n/a	n/a	n/a	600	n/a	n/a	n/a	600	n/a	n/a	850	n/a	n/a	150
Loretto Hospital	Chicago	429	379	448	350	379	379	448	350	n/a	n/a	n/a	n/a	n/a	n/a	n/a	307
Louis A. Weiss Memorial Hosp.	Chicago	945	n/a	n/a	n/a	886	n/a	n/a	772	n/a	n/a	n/a	n/a	n/a	1,896	n/a	123
Mercy Hospital & Medical Ctr.	Chicago	999	999	n/a	n/a	942	942	1,080	1,146	n/a	n/a	n/a	n/a	n/a	n/a	n/a	217
Methodist Hospital of Chicago	Chicago	693	n/a	693	n/a	661	n/a	661	n/a	629	n/a	629	n/a	1,319	1,319	n/a	134
Michael Reese Medical Center	Chicago	977	977	905	821	905	905	905	905	n/s	n/s	n/s	821	2,073	n/s	n/s	73
Mt. Sinai Hospital Medical Ctr	Chicago	995	995	995	n/a	960	960	960	n/a	n/a	n/a	n/a	n/a	1,948	1,948	1,948	286
Northwestern Memorial Hospital	Chicago	995	n/a	995	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	2,280	2,280	2,280	122
Norwegian-American Hospital	Chicago	625	625	n/a	n/a	563	563	n/a	n/a	n/a	n/a	n/a	n/a	1,219	1,219	n/a	125
Our Lady of the Resurrection	Chicago	440	n/a	n/a	n/a	430	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1,800	1,800	n/a	81
Provident Hospital	Chicago	690	690	n/a	n/a	630	630	n/a	n/a	n/a	n/a	n/a	n/a	1,200	1,200	n/a	225
Rehabilitation Institute	Chicago	n/a	n/a	n/a	n/a	n/a	n/a	n/a	715	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Resurrection Medical Center	Chicago	850	800	n/a	910	800	800	n/a	910	n/s	n/s	n/s	n/s	1,815	1,815	n/s	113
Roseland Community Hospital	Chicago	581	581	n/a	n/a	488	488	n/a	n/a	n/a	n/a	n/a	n/a	1,331	1,331	n/a	37
Rush-Presby.-St. Lukes Med Ctr	Chicago	1,125	1,125	n/a	1,125	1,116	1,116	1,206	1,116	n/a	n/a	n/a	n/a	2,003	2,003	n/a	169
Sacred Heart Hospital	Chicago	660	n/a	n/a	n/a	660	n/a	n/a	n/a	660	n/a	n/a	n/a	1,300	1,300	n/a	114

Table B
Charge Master Prices($) for Select Rooms at Illinois Hospitals
2000

Hospital Name	City	Private Room Med/ Surge	Private Room Ped- iatric	Private Room Psych	Private Room Rehab	Semi- Private Room Med Surge	Semi- Private Room Ped- iatric	Semi- Private Room Psych	Semi- Private Room Rehab	Room With 3+ Beds Med/ Surg	Room With 3+ Beds Ped- iatric	Room With 3+ Beds Psych	Room With 3+ Beds Rehab	Intensive Care Room Spec/Med	Intensive Care Room Surg	Intensive Care Room Psych	ER
Schwab Rehabilitation Hosp.	Chicago	n/a	n/a	n/a	619	n/a	n/a	n/a	595	n/a	n/a	n/a	576	n/a	n/a	n/a	n/a
South Shore Hospital	Chicago	690	n/a	n/a	690	650	n/a	n/a	650	n/a	650	n/a	620	1,450	n/a	n/a	85
St. Anthony Hospital	Chicago	775	775	775	n/a	750	750	725	n/a	n/a	n/a	n/a	n/a	1,615	1,615	n/a	80
St. Bernard Hospital	Chicago	720	720	720	n/a	690	690	690	n/a	n/a	n/a	n/a	n/a	1,305	1,305	1,305	110
St. Elizabeth's Hospital	Chicago	675	675	440	n/a	655	655	425	n/a	n/a	n/a	n/a	n/a	1,250	1,250	n/a	50
St. Joseph HLTH CTR Hospital	Chicago	980	980	980	865	910	910	910	810	n/a	n/a	n/a	n/a	2,080	2,080	2,080	48
St. Mary of Nazareth Hosp. Ctr	Chicago	840	840	840	840	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1,850	n/s	n/s	48
Swedish Covenant Hospital	Chicago	985	985	985	985	985	985	985	985	n/a	n/a	n/a	n/a	2,270	2,270	n/a	116
Thorek Hospital & Medical Ctr.	Chicago	610	n/a	n/a	n/a	580	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1,245	1,245	n/a	98
Trinity Hospital	Chicago	662	n/a	n/a	n/a	641	610	n/a	n/a	n/a	n/a	n/a	n/a	1,219	1,219	n/a	55
Univ of Chicago Hospitals	Chicago	1,260	1,260	1,280	n/a	1,190	1,190	1,295	n/a	n/a	n/a	n/a	n/a	2,250	2,250	n/a	143
University of Illinois	Chicago	710	710	710	710	665	665	665	665	665	665	665	665	1,420	1,420	1,420	91
Vencor Hospital Chicago Cntral	Chicago	1,050	n/a	n/a	n/a	1,050	n/a	n/a	n/a	1,050	n/a	n/a	n/a	1,325	n/a	n/a	n/a
Vencor Hospital North Chicago	Chicago	n/s	n/s	n/s	n/s	1,050	n/a	770	n/a	n/a	n/a	n/a	n/a	1,325	1,325	n/a	68
Suburban Chicago Average		**$765**	**$778**	**$1,010**	**$827**	**$737**	**$731**	**$940**	**$758**	**$773**	**$782**	**$1,082**	**$1,200**	**$1,650**	**$1,633**	**$1,169**	**$86**
Health Service Area 7 Average		**$823**	**$836**	**$1,073**	**$939**	**$798**	**$802**	**$999**	**$810**	**$773**	**$782**	**$1,082**	**$1,200**	**$1,706**	**$1,684**	**$1,169**	**$99**
Alexian Bros. Behavioral Hlth	Hoffman Ests	n/a	n/a	n/a	n/a	n/a	n/a	1,095	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Alexian Bros. Medical Center	Elk Grove Vill.	755	755	n/a	n/a	690	690	n/a	775	n/a	n/a	n/a	n/a	1,365	1,365	n/a	97
BHC Streamwood Hospital Inc	Streamwood	n/a	n/a	n/a	n/a	n/a	n/a	795	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Central DuPage Hospital	Winfield	795	970	1,405	n/a	780	935	1,308	n/a	n/a	n/a	n/a	n/a	1,730	1,730	n/a	113
Christ Hospital	Oak Lawn	775	775	n/s	n/s	725	775	775	725	675	n/a	n/a	n/a	1,550	1,550	1,150	100
Edward Hospital	Naperville	803	803	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1,591	1,216	n/a	137
Elmhurst Memorial Hospital	Elmhurst	504	504	504	n/a	487	487	487	n/a	487	n/a	n/a	n/a	871	871	n/a	81
Evanston Hospital	Evanston	762	827	1,084	900	757	822	1,084	900	n/a	822	n/a	n/a	1,900	1,900	1,178	77
Foster G. McGaw Hospital	Maywood	875	875	n/a	715	875	875	n/a	715	n/a	n/a	n/a	n/a	2,050	2,050	n/a	77
Glenbrook Hospital	Glenview	762	827	n/a	n/a	757	822	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	77
GlenOaks Medical Center	Glendale Hts.	840	840	1,113	n/a	790	790	1,055	n/a	n/a	n/a	n/a	n/a	2,330	2,330	1,113	71
Good Samaritan Hospital	Downers Gr.	751	751	1,035	n/a	683	683	1,035	n/a	n/a	n/a	n/a	n/a	1,628	1,628	n/a	78
Gottlieb Memorial Hospital	Melrose Park	1,022	1,022	n/a	n/a	992	938	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	51
Hinsdale Hospital	Hinsdale	835	875	1,000	1,000	775	815	1,000	940	n/a	815	n/a	n/a	1,815	1,815	n/a	120

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2000

Hospital Name	City	Private Room Med/ Surge	Private Room Ped-iatric	Private Room Psych	Private Room Rehab	Semi-Private Room Med Surge	Semi-Private Room Ped-iatric	Semi-Private Room Psych	Semi-Private Room Rehab	Room With 3+ Beds Med/ Surg	Room With 3+ Beds Ped-iatric	Room With 3+ Beds Psych	Room With 3+ Beds Rehab	Intensive Care Room Spec/Med	Intensive Care Room Surg	Intensive Care Room Psych	ER
Ingalls Memorial Hospital	Harvey	730	730	n/a	n/a	685	685	989	740	n/a	n/a	n/a	n/a	1,520	1,520	n/a	n/a
La Grange Memorial Hospital	La Grange	n/a	n/a	n/a	n/a	776	814	n/a	n/a	n/a	n/a	n/a	n/a	1,815	1,815	n/a	71
Linden Oaks Hospital	Naperville	n/a	n/a	1,081	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Little Company of Mary Hosp.	Evergreen Pk	943	943	1,029	n/a	943	943	1,029	723	n/a	943	n/a	n/a	1,743	1,743	n/a	163
Lutheran General Hospital	Park Ridge	795	n/s	n/s	n/s	695	755	805	795	n/a	n/a	n/a	n/a	1,790	1,790	n/a	97
MacNeal Hospital	Berwyn	n/s	1,300	n/s	n/s	1,100	1,250	965	655	n/a	n/a	n/a	n/a	2,400	2,400	1,215	80
Marianjoy Rehabilitation Hosp.	Wheaton	n/a	n/a	n/a	n/a	n/a	n/a	n/a	558	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Northwest Community Hospital	Arlington Hts.	740	770	1,050	n/a	630	770	975	n/a	630	770	975	n/a	1,140	1,710	n/a	47
Oak Forest Hospital	Oak Forest	1,070	n/a	n/a	1,200	1,070	n/a	n/a	1,200	1,070	n/a	n/a	1,200	2,300	n/a	n/a	135
Oak Park Hospital	Oak Park	682	n/a	n/a	720	682	n/a	n/a	720	n/a	n/a	n/a	n/a	n/a	1,371	n/a	55
Palos Community Hospital	Palos Heights	725	660	n/a	n/a	700	635	800	n/a	n/a	625	n/a	n/a	1,500	1,500	n/a	110
Riveredge Hospital	Forest Park	n/a	n/a	1,315	n/a	n/a	n/a	1,315	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Rm Health Providers Ltd Psp	Hinsdale	1,100	n/a	n/a	n/a	1,100	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Rush North Shore Medical Ctr.	Skokie	775	n/s	1,200	n/a	725	n/s	1,200	n/a	n/a	n/a	n/a	n/a	1,600	1,600	n/s	104
South Suburban Hospital	Hazel Crest	790	n/a	n/a	n/a	750	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1,590	1,590	n/a	93
St. Alexius Medical Center	Hoffman Ests	755	755	n/a	n/a	700	700	n/a	n/a	n/a	n/a	n/a	n/a	1,445	1,445	n/a	72
St. Francis Hospital	Evanston	805	805	1,011	n/a	775	775	1,011	n/a	775	775	n/a	n/a	1,800	1,800	n/a	144
St. Francis Hospital&Hlth Ctr	Blue Island	767	834	n/a	n/a	706	749	n/a	n/a	n/a	n/a	n/a	n/a	1,805	1,551	n/a	209
St. James Hospital & Hlth Ctr.	Chicago Hts.	725	725	n/a	n/a	725	725	n/a	n/a	725	725	n/a	n/a	1,540	n/a	n/a	93
St. James Hospital&Health CTR	Olympia Fields	953	912	1,129	1,129	909	909	1,084	1,084	n/a	n/a	n/a	n/a	2,125	n/a	n/a	87
The Rock Creek Center	Lemont	n/a	n/a	1,190	n/a	n/a	n/a	1,190	n/a	n/a	n/a	1,190	n/a	n/a	n/a	1,190	n/a
Vencor Hospital Northlake	Northlake	1,050	n/a	n/a	n/a	1,050	n/a	n/a	n/a	1,050	n/a	n/a	n/a	1,325	n/a	n/a	40
West Suburban Hospital	Oak Park	984	984	n/a	n/a	927	927	n/a	n/a	n/a	n/a	n/a	n/a	2,017	2,017	n/a	148
Westlake Hospital	Melrose Park	896	n/a	956	914	896	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1,800	1,800	n/a	109
Health Service Area 8 Average		**$682**	**$677**	**$904**	**$685**	**$631**	**$629**	**$886**	**$618**	**$0**	**$0**	**$0**	**$0**	**$1,512**	**$1,544**	**$0**	**$71**
Condell Medical Center	Libertyville	636	636	n/a	n/a	592	592	828	n/a	n/a	n/a	n/a	n/a	n/a	1,433	n/a	33
Copley Memorial Hospital	Aurora	822	822	n/a	822	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1,719	1,719	n/a	46
Delnor Comm. Hospital-Geneva	Geneva	700	700	n/a	n/a	700	700	n/a	n/a	n/a	n/a	n/a	n/a	1,700	1,700	n/a	61
Good Shepherd Hospital	Barrington	666	666	962	n/a	600	600	896	n/a	n/a	n/a	n/a	n/a	1,244	n/a	n/a	79
Harvard Memorial Hospital Inc.	Harvard	930	n/a	n/a	n/a	795	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1,941	1,941	n/a	84
Highland Park Hospital	Highland Park	762	827	1,084	n/a	757	822	1,804	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	77

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Lake Forest Hospital	Lake Forest	710	710	n/a	n/a	710	710	n/a	n/a	n/a	n/a	n/a	n/a	1520	1520	n/a	49
Memorial Medical Center	Woodstock	567	567	851	n/a	513	513	662	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	40
Midwestern Regional Med. Ctr.	Zion	650	n/a	n/a	n/a	606	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1409	n/a	n/a	107
Northern Illinois Medical Ctr.	McHenry	567	567	851	581	513	513	662	581	n/a	n/a	n/a	n/a	n/a	n/a	n/a	40
Provena Mercy Cntr For Hlth Cr	Aurora	635	635	n/a	n/a	624	624	800	n/a	n/a	n/a	n/a	n/a	1338	1338	n/a	94
Provena St Therese Medical Ctr	Waukegan	630	630	n/s	654	590	590	830	654	n/a	n/a	n/a	n/a	n/s	1326	n/s	80
Provena St. Joseph Hospital	Elgin	626	626	772	686	559	559	730	621	n/a	n/a	n/a	n/a	1329	n/a	n/a	58
Sherman Hospital Association	Elgin	740	740	n/a	n/a	740	740	n/a	n/a	n/a	n/a	n/a	n/a	1700	1700	n/a	39
Victory Memorial Hospital	Waukegan	598	n/s	n/a	n/a	542	591	762	n/a	n/a	n/a	n/a	n/a	1224	1224	n/a	183
Health Service Area 9 Average		**$657**	**$738**	**$590**	**$716**	**$637**	**$637**	**$703**	**$675**	**$0**	**$0**	**$0**	**$0**	**$1,589**	**$1,540**	**$0**	**$52**
Morris Hospital	Morris	710	895	n/a	n/a	685	685	n/a	n/a	n/a	n/a	n/a	n/a	1710	1710	n/a	46
Provena St. Joseph Med Center	Joliet	729	729	n/a	817	692	692	867	817	n/a	n/a	n/a	n/a	1718	1718	n/a	42
Provena St. Mary's Hospital	Kankakee	640	n/a	590	n/a	625	625	n/a	n/a	n/a	n/a	n/a	n/a	1460	1460	n/a	70
Riverside Medical Center	Kankakee	620	n/a	n/a	n/a	609	609	563	609	n/a	n/a	n/a	n/a	1470	1470	n/a	55
Silver Cross Hospital	Joliet	590	590	n/a	615	575	575	680	600	n/a	n/a	n/a	n/a	n/s	1345	n/a	50
Central Illinois Average		**482**	**479**	**625**	**564**	**456**	**457**	**569**	**508**	**427**	**390**	**560**	**390**	**939**	**1009**	**1050**	**67**
Health Service Area 2 Average		**$485**	**$477**	**$556**	**$514**	**$466**	**$465**	**$457**	**$464**	**$465**	**$390**	**$390**	**$390**	**$921**	**$987**	**$938**	**$63**
Community Hospital of Ottawa	Ottawa	508	508	494	685	488	488	494	685	n/a	n/a	n/a	n/a	938	938	938	53
Community Medical Cntr West IL	Monmouth	475	n/a	n/a	n/a	475	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	70
Eureka Hospital	Eureka	575	n/a	n/a	n/a	540	n/a	n/a	n/a	540	n/a	n/a	n/a	925	925	n/a	74
Galesburg Cottage Hospital	Galesburg	556	556	758	608	497	497	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	70
Graham Hospital Association	Canton	520	n/a	n/a	n/a	490	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1,075	1,075	n/a	60
Hopedale Hospital	Hopedale	331	n/a	n/a	n/a	303	n/a	n/a	n/a	n/a	n/a	n/a	n/a	562	562	n/a	52
Illinois Valley Community Hosp	Peru	473	n/a	473	n/a	455	n/a	455	n/a	n/a	n/a	n/a	n/a	967	967	n/a	60
McDonough District Hospital	Macomb	500	n/a	n/a	n/a	465	465	n/a	n/a	465	n/a	n/a	n/a	n/s	n/s	n/a	70
Mendota Community Hospital	Mendota	495	495	n/a	n/a	475	475	n/a	n/a	n/a	n/a	n/a	n/a	990	990	n/a	63
Methodist Medical Center	Peoria	376	n/a	n/a	334	376	376	462	308	n/a	n/a	n/a	n/a	1,492	1,492	n/a	79
Pekin Hospital	Pekin	530	510	500	n/a	500	490	475	n/a	n/a	n/a	n/a	n/a	1,315	1,315	n/a	22

Table B
Charge Master Prices($) for Select Rooms at Illinois Hospitals
2000

Hospital Name	City	Private Room Med/ Surge	Private Room Ped- iatric	Private Room Psych	Private Room Rehab	Semi- Private Room Med Surge	Semi- Private Room Ped- iatric	Semi- Private Room Psych	Semi- Private Room Rehab	Room With 3+ Beds Med/ Surg	Room With 3+ Beds Ped- iatric	Room With 3+ Beds Psych	Room With 3+ Beds Rehab	Intensive Care Room Spec/Med	Intensive Care Room Surg	Intensive Care Room Psych	ER
Perry Memorial Hospital	Princeton	585	n/a	n/a	n/a	555	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1,650	n/a	75
Proctor Hospital	Peoria	363	363	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	363	363	n/a	73
St. Francis Medical Center	Peoria	430	430	n/a	430	400	400	400	400	390	390	390	390	400	400	n/a	54
St. Margaret's Hospital	Spring Valley	510	510	n/a	n/a	495	495	n/a	n/a	n/a	n/a	n/a	n/a	925	925	n/a	84
St. Mary's Hospital	Streator	587	n/a	n/a	n/a	547	567	n/a	n/a	n/a	n/a	n/a	n/a	1,241	1,241	n/a	80
St. Mary's Medical Center	Galesburg	445	445	n/a	n/a	402	402	n/a	n/a	n/a	n/a	n/a	n/a	787	n/a	n/a	33
Health Service Area 3 Average		**467**	**465**	**609**	**0**	**439**	**437**	**557**	**470**	**399**	**0**	**0**	**0**	**967**	**991**	**0**	**72**
Abraham Lincoln Memorial Hosp.	Lincoln	491	491	n/a	n/a	464	464	n/a	n/a	n/a	n/a	n/a	n/a	589	589	n/a	225
Blessing Hospital	Quincy	405	405	n/a	n/a	360	360	n/a	360	n/a	n/a	n/a	n/a	360	360	n/a	61
Blessing Hospital at 14th St.	Quincy	n/a	n/a	n/a	n/a	n/a	n/a	630	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Carlinville Area Hospital	Carlinville	376	n/a	n/a	n/a	366	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	72
Community Memorial Hospital	Staunton	430	n/s	n/a	n/a	415	n/s	n/a	n/a	n/a	n/a	n/a	n/a	560	560	n/a	25
Doctors Hospital	Springfield	565	n/a	587	n/a	540	n/a	500	n/a	540	n/a	n/a	n/a	n/a	850	n/a	115
Hillsboro Area Hospital	Hillsboro	364	364	n/a	n/a	338	338	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	73
Illini Community Hospital	Pittsfield	506	n/s	n/a	n/a	473	n/s	n/a	n/a	n/a	n/a	n/a	n/a	1,507	1,507	n/a	70
Jersey Community Hospital	Jerseyville	319	319	n/a	n/a	289	289	n/a	n/a	n/a	n/a	n/a	n/a	700	700	n/a	53
Mason District Hospital	Havana	462	n/a	n/a	n/a	440	n/a	n/a	n/a	n/a	n/a	n/a	n/a	700	700	n/a	79
Memorial Hospital	Carthage	510	n/s	n/a	n/a	480	n/s	n/a	n/a	n/a	n/a	n/a	n/a	1,150	1,150	n/a	66
Memorial Medical Center	Springfield	580	580	580	n/a	542	542	542	580	n/a	n/a	n/a	n/a	1,610	1,610	n/a	98
Pana Community Hospital	Pana	335	n/s	n/a	n/a	310	n/s	n/a	n/a	258	n/s	n/a	n/a	721	n/s	n/a	70
Passavant Area Hosp.	Jacksonville	639	639	n/a	n/a	593	593	n/a	n/a	n/a	n/a	n/a	n/a	1,600	1,600	n/a	28
Sarah Culbertson Memorial Hosp	Rushville	475	413	n/a	n/a	445	413	n/a	n/a	n/a	n/a	n/a	n/a	607	607	n/a	54
St. Francis Hospital	Litchfield	485	n/a	n/a	n/a	445	n/a	n/a	n/a	n/a	n/a	n/a	n/a	935	935	n/a	31
St. John's Hospital	Springfield	610	610	660	n/a	585	585	n/a	n/a	n/a	n/a	n/a	n/a	1,718	1,718	n/a	82
St. Vincent Memorial Hospital	Taylorville	494	n/s	n/a	n/a	462	n/s	n/a	n/a	n/a	n/a	n/a	n/a	794	n/s	n/a	82
Thomas H. Boyd Memorial Hosp.	Carrollton	365	365	n/a	n/a	357	357	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	25
Health Service Area 4 Average		**497**	**493**	**690**	**631**	**465**	**465**	**670**	**578**	**372**	**0**	**730**	**0**	**929**	**1,062**	**1,107**	**65**
BroMenn Regional Medical Ctr.	Normal	685	685	825	650	650	650	795	615	n/a	n/a	n/a	n/a	1,480	1,480	1,610	74
Carle Foundation Hospital	Urbana	600	n/a	n/a	600	506	506	n/a	506	n/a	n/a	n/a	n/a	658	658	n/a	80

Table B
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2000

Hospital Name	City	Private Room Med/ Surge	Private Room Ped-iatric	Private Room Psych	Private Room Rehab	Semi-Private Room Med Surge	Semi-Private Room Ped-iatric	Semi-Private Room Psych	Semi-Private Room Rehab	Room With 3+ Beds Med/ Surg	Room With 3+ Beds Ped-iatric	Room With 3+ Beds Psych	Room With 3+ Beds Rehab	Intensive Care Room Spec/Med	Intensive Care Room Surg	Intensive Care Room Psych	ER
Decatur Memorial Hospital	Decatur	349	349	n/a	n/a	312	312	n/a	n/a	n/a	n/a	n/a	n/a	990	990	n/a	55
Dr. John Warner Hospital	Clinton	395	395	n/a	n/a	365	365	n/a	n/a	n/a	n/a	n/a	n/a	520	n/a	n/a	56
Gibson Community Hospital	Gibson City	n/a	n/a	n/a	n/a	480	n/a	n/a	n/a	n/a	n/a	n/a	n/a	850	n/a	n/a	74
Hoopeston Com Mem Hosp & NH	Hoopeston	n/a	n/a	n/a	n/a	450	450	n/a	n/a	n/a	n/a	n/a	n/a	200	n/a	n/a	96
Iroquois Memorial Hospital	Watseka	560	n/a	n/a	n/a	550	n/a	n/a	n/a	n/a	n/a	n/a	n/a	899	n/a	n/a	65
John & Mary E. Kirby Hospital	Monticello	450	n/a	n/a	n/a	450	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	77
Paris Community Hospital	Paris	493	493	n/a	n/a	468	468	n/a	n/a	n/a	n/a	n/a	n/a	878	878	n/a	24
Provena Covenant Medical Cntr	Urbana	615	615	n/a	645	585	585	640	615	n/a	n/a	n/a	n/a	1,233	1,233	n/a	83
Provena United Samaritan Logan	Danville	567	567	n/a	n/a	545	545	n/a	n/a	n/a	n/a	n/a	n/a	1,128	1,128	n/a	55
Provena United Samaritan Sager	Danville	n/a	n/a	760	n/a	n/a	n/a	716	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sarah Bush Lincoln Hlth. Ctr.	Mattoon	535	535	535	n/a	535	535	535	n/a	n/a	n/a	n/a	n/a	875	875	n/a	93
Shelby Memorial Hospital	Shelbyville	426	n/a	n/a	n/a	372	n/a	n/a	n/a	372	n/a	n/a	n/a	852	n/a	n/a	57
St. James Hospital	Pontiac	450	450	n/a	n/a	410	410	n/a	n/a	n/a	n/a	n/a	n/a	1,110	1,110	n/a	93
St. Joseph's Hosp. Med. Ctr.	Bloomington	426	426	n/a	n/a	387	387	n/a	n/a	n/a	n/a	n/a	n/a	1,013	1,013	n/a	45
St. Mary's Hospital	Decatur	415	415	604	n/a	378	378	604	n/a	n/a	n/a	n/a	n/a	1,255	1,255	604	28
The Pavilion Foundation	Champaign	n/a	n/a	730	n/a	n/a	n/a	730	n/a	n/a	n/a	730	n/a	n/a	n/a	n/a	n/a
Northwest Illinois Average		**$528**	**$546**	**$674**	**$550**	**$500**	**$529**	**$747**	**$547**	**$0**	**$685**	**$0**	**$0**	**$1,088**	**$1,150**	**$0**	**$58**
Health Service Area 1 Average		**$548**	**$563**	**$748**	**$550**	**$525**	**$563**	**$850**	**$525**	**$0**	**$685**	**$0**	**$0**	**$1,118**	**$1,143**	**$0**	**$52**
CGH Medical Center	Sterling	396	409	n/a	n/a	368	409	n/a	n/a	n/a	n/a	n/a	n/a	907	907	n/a	50
Freeport Memorial Hospital	Freeport	410	410	n/a	n/a	385	410	n/a	n/a	n/a	n/a	n/a	n/a	810	810	n/a	36
Galena Stauss Hospital	Galena	490	n/a	n/a	n/a	470	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	54
Kath Shaw Bethea Hosp	Dixon	439	439	651	n/a	422	439	n/a	n/a	n/a	n/a	n/a	n/a	935	935	n/a	50
Kindred Hospital/Sycamore	Sycamore	662	n/a	n/a	n/a	662	n/a	n/a	n/a	n/a	n/a	n/a	n/a	893	n/a	n/a	56
Kishwaukee Community Hospital	De Kalb	720	720	n/a	n/a	670	670	955	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	44
Morrison Community Hospital	Morrison	463	n/a	n/a	n/a	447	n/a	n/a	n/a	n/a	n/a	n/a	n/a	533	533	n/a	69
Northwest Suburban Community	Belvidere	498	n/a	n/a	n/a	455	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	43
Rochelle Community Hospital	Rochelle	504	n/s	n/s	n/s	499	n/s	n/s	n/s	n/s	n/s	n/s	n/s	771	771	n/s	48
Rockford Memorial Hospital	Rockford	550	525	735	550	525	525	735	525	n/a	n/a	n/a	n/a	1,650	1,650	n/a	55
St. Anthony Hospital Med. Ctr.	Rockford	679	679	n/a	n/a	679	723	n/a	n/a	n/a	n/a	n/a	n/a	1,969	1,969	n/a	57

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Valley West Community Hospital	Sandwich	690	n/a	n/a	n/a	630	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1296	1296	n/a	70
Health Service Area 10 Average		**$463**	**$483**	**$450**	**$0**	**$433**	**$450**	**$440**	**$570**	**$0**	**$0**	**$0**	**$0**	**$1,012**	**$1,165**	**$0**	**$74**
Hammond-Henry District Hosp.	Geneseo	400	n/a	n/a	n/a	375	n/a	n/a	n/a	n/a	n/a	n/a	n/a	950	950	n/a	70
Illini Hospital	Silvis	400	400	n/a	n/a	400	400	n/a	n/a	n/a	n/a	n/a	n/a	1300	1300	n/a	65
Kewanee Hospital	Kewanee	567	567	n/a	n/a	567	567	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1423	n/a	61
Mercer County Hospital	Aledo	486	n/a	n/a	n/a	440	n/a	n/a	n/a	n/a	n/a	n/a	n/a	809	n/a	n/a	79
Trinity Medical Center-West	Rock Island	n/a	n/a	450	n/a	385	385	440	570	n/a	n/a	n/a	n/a	990	990	n/a	98
Southern Illinois Average		**449**	**450**	**493**	**559**	**420**	**421**	**497**	**545**	**395**	**393**	**466**	**329**	**890**	**894**	**1077**	**80**
Health Service Area 5 Average		**$441**	**$440**	**$499**	**$634**	**$409**	**$414**	**$520**	**$624**	**$392**	**$367**	**$464**	**$329**	**$798**	**$820**	**$846**	**$80**
Clay County Hospital	Flora	387	387	n/a	n/a	372	372	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	39
Cornerstone Healthcare of Ill.	Carmi	320	320	n/a	n/a	300	300	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	27
Crawford Memorial Hospital	Robinson	437	n/a	n/a	n/a	415	n/a	n/a	n/a	329	n/a	n/a	n/a	n/s	804	n/a	170
Crossroads Community Hospital	Mount Vernon	480	480	n/a	n/a	450	450	n/a	n/a	n/a	n/a	n/a	n/a	860	860	n/a	75
Edward A. Utlaut Memorial Hosp	Greenville	430	n/a	n/a	n/a	380	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	55
Fairfield Memorial Hospital	Fairfield	435	435	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	730	730	n/a	37
Fayette County Hospital	Vandalia	359	n/a	n/a	n/a	329	n/a	n/a	n/a	n/a	n/a	n/a	n/a	741	741	n/a	90
Ferrell Hospital Inc.	Eldorado	495	n/a	n/a	n/a	470	n/a	n/a	n/a	470	n/a	n/a	n/a	n/a	n/a	n/a	93
Good Samaritan Reg Health Cntr	Mount Vernon	401	401	n/a	329	383	383	n/a	329	383	383	n/a	329	846	846	n/a	104
Hamilton Memorial Hospital	Mcleansboro	445	n/a	n/a	n/a	425	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	85
Hardin County General Hospital	Rosiclare	n/a	n/a	n/a	n/a	319	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	57
Harrisburg Medical Center	Harrisburg	386	n/s	n/a	n/a	373	n/s	591	n/a	n/a	n/a	n/a	n/a	n/a	783	n/a	28
Herrin Hospital	Herrin	468	468	n/a	939	444	n/a	n/a	919	n/a	n/a	n/a	n/a	919	n/a	n/a	88
Lawrence County Memorial Hosp.	Lawrenceville	417	n/a	n/a	n/a	406	n/a	529	n/a	395	n/a	n/a	n/a	651	651	n/a	107
Marion Memorial Hospital	Marion	517	517	n/a	n/a	478	478	n/a	n/a	n/a	n/a	n/a	n/a	1,029	1,029	n/a	72
Marshall Browning Hospital	Duquoin	396	396	n/a	n/a	357	357	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	67
Massac Memorial Hospital	Metropolis	410	n/a	n/a	n/a	380	n/a	n/a	n/a	n/a	n/a	n/a	n/a	920	920	n/a	72
Memorial Hospital	Carbondale	476	n/a	n/a	n/a	455	455	n/a	n/a	n/a	n/a	n/a	n/a	n/a	956	n/a	92

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Pinckneyville Community Hosp.	Pinckneyville	370	n/a	n/a	n/a	348	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	59
Richland Memorial Hospital	Olney	513	513	598	n/a	489	489	578	n/a	n/a	n/a	578	n/a	n/a	830	n/a	66
Salem Township Hospital	Salem	445	n/a	n/a	n/a	425	n/a	n/a	n/a	425	n/a	n/a	n/a	795	795	n/a	91
Sparta Community Hospital	Sparta	480	480	n/s	n/s	475	475	n/s	n/s	n/s	n/s	n/s	n/s	885	885	n/s	69
St. Anthony's Memorial Hosp.	Effingham	475	475	n/a	n/a	415	415	n/a	n/a	n/a	n/a	n/a	n/a	703	703	n/a	52
St. Joseph Memorial Hospital	Murphysboro	490	n/a	n/a	n/a	471	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	782	n/a	88
St. Mary's Hospital	Centralia	401	401	401	n/a	383	383	383	n/a	351	351	351	n/a	846	846	846	41
The Franklin Hospital	Benton	395	n/a	n/a	n/a	379	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	88
U. M. W. A. Union Hospital	West Frankfort	543	n/a	n/a	n/a	414	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	88
Union Co Hosp Dis	Anna	521	n/s	n/a	n/a	488	n/s	n/a	n/a	n/a	n/a	n/a	n/a	n/s	893	n/a	64
Unity St Clement Health Serv	Red Bud	391	n/a	n/a	n/a	367	n/a	n/a	n/a	n/a	n/a	n/a	n/a	416	n/a	n/a	211
Wabash General Hospital	Mount Carmel	540	n/a	n/a	n/a	503	n/a	n/a	n/a	n/a	n/a	n/a	n/a	924	n/a	n/a	135
Washington County Hospital	Nashville	447	447	n/a	n/a	416	416	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	105
Health Service Area 11 Average		**$474**	**$469**	**$491**	**$485**	**$455**	**$431**	**$479**	**$466**	**$415**	**$445**	**$470**	**$0**	**$1,028**	**$1,042**	**$1,192**	**$77**
Alton Memorial Hospital	Alton	572	572	n/a	n/a	540	540	n/a	n/a	n/a	n/a	n/a	n/a	1,439	1,439	n/a	114
Anderson Hospital	Maryville	450	n/a	n/a	n/a	425	n/a	n/a	n/a	n/a	n/a	n/a	n/a	995	995	n/a	100
Memorial Hospital	Belleville	447	n/a	487	n/a	435	450	475	n/a	415	445	470	n/a	1,050	1,050	n/a	75
St. Anthony's Health Center	Alton	358	358	427	411	352	352	420	404	n/a	n/a	n/a	n/a	1,085	1,085	1,085	58
St. Elizabeth Medical Center	Granite City	555	555	730	n/a	515	515	730	n/a	n/a	n/a	n/a	n/a	1,300	1,300	1,300	58
St. Elizabeth's Hospital	Belleville	532	532	572	559	509	509	533	528	n/a	n/a	n/a	n/a	979	979	n/a	96
St. Joseph's Hospital	Breese	439	439	n/a	n/a	418	418	n/a	n/a	n/a	n/a	n/a	n/a	867	867	n/a	77
St. Joseph's Hospital	Highland	420	405	n/a	n/a	405	405	n/a	n/a	n/a	n/a	n/a	n/a	900	n/a	n/a	60
St. Mary's Hospital	East St. Louis	550	n/a	240	n/a	550	295	240	n/a	n/a	n/a	n/a	n/a	695	695	n/a	40
Touchette Regional Hospital	Centreville	423	423	n/a	n/a	402	402	n/a	n/a	n/a	n/a	n/a	n/a	972	972	n/a	100

American Hospital Association

MEMORANDUM

One North Franklin
Chicago, IL 60606

(312) 422-2050 Phone
(312) 422-4700 Fax
www.aha.org

To: Susan Yesnick
Gardner Carton & Douglas LLP

From: Sara Beazley

Subject: Hospital Construction, 1981-present
Final Data

Date: January 9, 2004

Time period

The data below represent new hospital facilities that opened between 1981 through 2000, with an additional six facilities from a 2002 listing.

Definitions

As we discussed at the onset of the project, "new" hospitals include facilities that came into physical being as hospitals during the specified time period. New hospitals do not include replacement facilities (hospitals built to replace an already existing hospital) or renovations (alterations that may or may not include new construction to an already existing facility).

Summary of data

Total projects identified:	429
Total projects for which bed counts are available:	394
Total projects for hospitals with less than 100 beds:	298

American Hospital Association

MEMORANDUM

Sources of data

AHA Annual Survey Database documentation booklets for survey years 1981-1987, 1996-1999.

AHA Guide to the Health Care Field. Annual directory of hospitals that provides bed counts.

Hospital Closure. 1999, 2000 editions. Washington, DC: Office of the Inspector General, HHS. These are the only two editions that included a list of opened/reopened hospitals.

Health Care Construction Reports. Monthly newsletter published by American Hospital Publishing, Inc. from 1987 to 1997, summarizing health facility construction projects.

Hospital Construction Reports. Predecessor publication to *Health Care Construction Reports.* Issues from 1981 to 1986 were checked.

"Hospitals that opened/closed in 2002." *Modern Healthcare.* http://www.modernhealth.com

MemberSeek. Internal database used by AHA to track hospitals.

Cautions

The data uncovered by this research should be used with caution and only as estimates. AHA does not literally track the construction of new hospitals; rather, it tracks the opening, life, and closing of hospitals through its national hospital registry.

Two underlying assumptions of the research performed for this project were:

1) a hospital did not exist before the date noted in the MemberSeek database;

2) given the highly specialized construction that is usually required for a hospital building, the appearance of a hospital in the MemberSeek database represents a newly constructed facility.

Verification of this latter assumption was made on a continuous basis by looking for facilities (old hospitals that may have closed and were sitting vacant, other health facilities that may have been converted into hospitals) that may have occupied the same address as the hospital for a time period preceding the date of the hospital's database record.

A final quality check was made by comparing the list of new hospitals with a directory of hospitals in existence in 1980 – any hospitals from the "new" list that appeared in the 1980 listing were eliminated.

The master list of hospitals that accompanies this summary was created as a working list of projects as they were identified using the various sources available. The date beside each hospital may be the date of the survey year when the hospital first appeared, the date from MemSeek when the hospital was added, or the date of the newsletter when the construction project was first announced. This date is not intended to indicate the actual year the hospital started receiving patients.

C:\TEMP\yesnick1.doc

Tab 5

Mercy Crystal Lake and Medical Center, Inc
Financial Projections for the Project

	Year 1 2006-2007 Hospital	Year 2 2007-2008 Hospital
Revenue:		
Hospital	$81,962,481	$135,518,904
Clinic		
Total Revenue	$81,962,481	$135,518,904
Deductions	$43,910,874	$75,299,060
Net Revenue	$38,051,607	$60,219,844
Expenses:		
Salary Expense	$16,073,739	$20,303,534
MD Salary Expense	$3,782,903	$4,781,891
Other Direct Expense	$15,898,840	$23,722,194
Depreciation and Interest	$6,317,600	$6,317,600
Total Expenses	$42,073,082	$55,125,219
Contribution Margin	($4,021,475)	$5,094,625

Tab 6
Trend in Hospital Use and ALOS and Resulting Bed Size - OB Services
Source: U.S. Department of Health and Human Services, Center for Disease Control

Historical Data	1970	1975	1980	1985	1990	1995	2000	2001
Number of Discharges (Thousands)	29,127	34,043	37,832	35,056	30,788	30,722	31,706	32,653
Rate of discharges per 1000 pop	144.3	159	168	148	122	116	114	115
Number of days of care in thousands	226,445	262,389	274,508	226,217	197,422	164,627	155,857	160,000
Rate of days of care per 1000 population	1,122	1,227	1,217	958	784	620	560	565
Average length of stay	7.8	7.7	7.3	6.5	6.4	5.4	4.9	4.9
Mercy Health System Average LOS			5.04	4.87	5.00	5.03	4.31	4
Population								

Equivalent Bed Analysis	1970	1975	1980	1985	1990	1995	2000	2001
Bed Size at 75% Occupancy	22	22	20	17	15	11	13	13
Average Daily Census	11.2	11.2	10.4	9.0	7.6	5.7	6.8	6.5
Average Length of Stay	4.1	4.1	3.8	3.3	2.8	2.1	2.5	2.4
Total Patient Days	4,081	4,081	3,783	3,285	2,787	2,090	2,489	2,389
Discharges	995	995	995	995	995	995	995	995

Tab 7
Physician Demand by Cluster & Specialty
McHenry County, Illinois - 2002 Estimate

Surplus/(Deficit):

Specialty	Cl 21 Woodstk	Cl 22 McHen+	Cl 23 Crystal Lake	Cl 24 Algonq/Cary	Cl 25 Huntley	Cl 26 Marengo+	Cl 27 Harvard+	Cl 28 Richmond+	McHenry County
Allergy/Immunology	-0.5	-1.0	0.9	-1.1	-0.2	-0.2	-0.3	-0.2	-2.5
Cardiology	0.6	0.3	0.4	-2.2	-0.5	-0.7	-0.7	-0.5	-3.4
Dermatology	0.1	-1.9	0.1	-1.8	-0.3	-0.4	-0.5	-0.4	-5.1
Gastroenterology	-0.6	-0.2	-1.2	-1.1	-0.2	-0.3	-0.3	-0.3	-4.1
General & Family Practice	1.6	-10.2	-10.1	-3.6	-1.7	-3.9	0.5	-0.4	-27.8
General Surgery	0.1	1.3	-2.6	-2.3	-0.7	-0.8	0.0	-0.7	-5.7
Hematology/Oncology	0.5	-1.0	-1.0	-0.8	-0.2	-0.3	-0.3	-0.2	-3.3
Internal Medicine	3.8	1.6	10.0	-3.2	-1.8	-0.4	-0.8	-2.0	7.1
Medical Subspecialties	-0.1	-2.3	-2.1	-2.1	-0.4	-0.5	-0.6	-0.5	-8.5
Nephrology	-0.1	-0.2	-0.2	-0.2	-0.1	-0.1	-0.1	-0.1	-1.0
Neurology	-0.3	0.3	2.4	-0.6	-0.1	-0.1	-0.2	-0.1	1.3
Obstetrics and Gynecology	3.5	-1.4	-0.2	-5.3	-0.1	-1.6	-1.9	-1.4	-8.3
Ophthalmology	-1.2	1.7	-1.2	-0.9	-0.4	-0.6	-0.6	-0.4	-3.7
Orthopedic Surgery	-0.7	0.5	3.6	-3.3	0.4	-0.8	0.1	-0.6	-0.9
Other	-0.5	0.0	-1.0	-1.0	-0.2	0.8	-0.3	-0.2	-2.3
Other Pediatric Subspecialti	-0.3	-0.7	0.2	-0.8	-0.1	-0.2	-0.2	-0.2	-2.3
Otolaryngology	1.8	-1.4	-0.4	-0.3	-0.4	-0.5	0.4	-0.5	-1.2
Pediatric Cardiology	0.0	-0.1	-0.1	-0.1	0.0	0.0	0.0	0.0	-0.3
Pediatric Neurology	-0.1	-0.1	-0.2	-0.2	0.0	0.0	0.0	0.0	-0.5
Pediatric Psychiatry	-0.3	2.4	2.4	0.3	-0.1	-0.1	-0.2	-0.1	4.4
Pediatrics	6.5	-4.8	-1.8	-7.2	0.7	-2.1	-2.6	-1.0	-12.3
Physical Medicine and Rehab.	-0.6	-0.3	-1.3	-1.2	-0.2	-0.3	-0.3	-0.2	-4.3
Plastic Surgery	-0.8	-1.6	-0.5	-1.5	-0.3	-0.3	-0.4	-0.3	-5.7
Psychiatry	-2.0	-1.1	2.9	-3.9	-0.6	-1.0	-1.1	-0.8	-7.6
Pulmonary	-0.2	-0.4	-0.4	-0.3	-0.1	-0.1	-0.1	-0.1	-1.8
Rheumatology	0.6	-0.7	-0.7	-0.6	-0.1	-0.2	-0.2	-0.1	-1.8
Surgical Subspecialties	-1.2	-1.4	1.8	-2.0	-0.4	-0.5	-0.6	-0.4	-4.8
Urology	0.1	-0.9	0.2	-1.6	-0.3	-0.5	-0.5	-0.4	-3.8
TOTAL	9.4	-23.6	0.0	-48.8	-8.1	-15.5	-11.5	-12.0	-110.1

Source: Solucient, Inc., Evanston, IL

HealthLeaders EXTRA!

The Physician Shortage is Official: Now What?

By Jennifer Moody, for HealthLeaders News, Jan. 12, 2004

SUMMARY (full story below)

For years, few healthcare experts were willing to admit there was a physician shortage, says HealthLeaders member Jennifer Moody. But now that even the AMA is admitting there is not a physician surplus, the time is now to take steps to fix the problem.

FULL STORY

When you have the flu, you don't have to read in the newspapers that there's a bug going around. But for the flu to be considered an epidemic, you do need experts to confirm the fact, and their opinions must be duly noted in the medical and general press. At that point, the powers that be may be ready to take notice and address the problem.

The same principle applies to physician supply. In recent years, many hospital administrators have experienced problems when it comes to finding physicians. Despite the headaches caused by physician recruitment, however, few healthcare experts were willing to admit that there is a net shortage of doctors in the U.S. In fact, since 1980, most academics and other informed observers have contended that

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we have a significant oversupply of physicians. That changed in October 2003, when the Council on Graduate Medical Education (COGME) reversed its longstanding position on physician supply. COGME is a panel of healthcare experts charged with periodically reporting to Congress on the state of physician manpower in the U.S.. For years, COGME has projected a surplus of physicians. In 1994, for example, it predicted that there would be over 130,000 too many physicias in the U.S. by the year 2000.

These projections came under increasing scrutiny from hospital and administrators and physician recruiters, particularly Merritt, Hawkins & Associates, which published annual surveys showing an increase in demand for physicians and a corresponding increase in the financial incentives used to recruit them. Then, in February, 2002, Health Affairs published a report authored by Richard Cooper, M.D., of the Medical College of Wisconsin, projecting a deficit of 200,000 physicians by the year 2020.

For several years, Dr. Cooper, to his credit, was one of the sole voices in the healthcare field challenging the surplus theory. His report was like a boulder tossed into a pond, and ended the placidity of many of those who believed we had a comfortable surplus of doctors. About eight months later, COGME endorsed a study projecting that the U.S. will be short up to 96,000 physicians by the year 2020.

The final piece fell into place in December, when an AMA advisory council advised the AMA to abandon its longstanding position that there is a physician surplus. Even the AMA, which has vested interest in keeping physician supply moderate, has conceded that the surplus theory no longer holds water - not when so many of its own members are overworked and are finding it difficult to attract new physicians to their practices. Coincidentally, the AMA advisory council made its recommendation the same month that the Association of American Medical Colleges reported that for the first time ever the majority of people applying to medical school are women. As AMA statistics show, female physicians work about 18 percent fewer hours, so the increased presence of women in the medical field will have a profound effect on physician supply, and indeed already has.

While there is still some support for the surplus position, with COGME and the AMA reversing their previous stance, the shortage viewpoint now prevails. As they say in the self-help culture, admitting the problem is the first step. Now that we have, it's time to act. Here are a few steps health leaders should consider:

1. **Help put an end to budget cuts.**

   Recently, the Wisconsin legislature virtually eliminated state funding for graduate medical education. GME funding on the federal level has been the target of cuts for several years. On both the state and federal level, GME cuts have been justified by the proposition that we have too many physicians. Since that argument is now questionable, the AHA and the various state hospital associations need to be urged to fight hard to increase GME funding. The new Medicare bill provides some help, but more funds will be needed.

2. **Push for changes in medical education**

   The number of medical schools in the U.S. has remained constant for 20 years, and Dr. Cooper reports that most schools have little or no capacy for expansion. One vexing challenges is a shortage of teachers, but funding is the real key. Money needs to be found for new medical schools, but that will be difficult without widespread public support.

   As access to physcians diminishes and wait times increase, public support will grow. In addition, health leaders must influence medical education policy. A belief still exists in some quarters that 50 percent of physicians should be trained in primary care, when, in fact, an aging population and advancing technology is driving the need for specialists.

3. **Keep access to foreign physicians open.**

   In the last several years, access to foreign trained physicians has been diminished. Since the late 1990's, foreign-trained physicians have had to pass the Clinical Skills Assessment Test. This test is expensive from the viewpoint of most foreign physicians, who must travel to Philadelphia to take it.

   The number of foreign physicians applying to the annual resident match has decreased considerably since this requirement went into effect. The events of 9/11 also have inhibited access to foreign physicians, as some government agengies have stopped sponsoring them for visas, citing security concerns.

   Foreign physicians are not a long-term answer, but many health facilities would be at a total loss without them. The Clinical Skills Assessment Test should be rethought and facilities in healthcare shortage areas should be able to employ foreign physicians on work visas.

4. **Prepare for the long haul**

   Even if the resolve and money were there to increase physician supply today, the impact of doing so wouldn't be felt for 10 years. It takes a long time to train a physician, so don't wait for a solution to present itself.

   Instead, take a close look at your medical staff and try to project current and future needs three to five years out. Have a plan for replacing doctors likely to leave your community or retire, and know what types of physicians your service area is likely to need. Having a realistic picture on physician need is the first in addressing the supply challenge.

5. **Focus on retention**

   New physicians will be increasingly hard to come by, so it is important to hold on to those you have. Interview or survey staff physicians to determine what they like about your facility and what they would like to see enhanced. Doctors want the basics - access to the OR, quick turnaournds on tests, good equipment, a competent staff - more than they want governance in

the hospital or even shared financial opportunity. Find out what your doctors need and give it to them, if you can.

6. **Out-recruit the other guys**

   The fact is that unless you are lucky enough to find a resident, the physicians you recruit will be pulled from someone else's medical staff and will contribute to someone else's shortage. That's just the rules of the game. Health leaders must do what it takes to create both the incentives and the practice styles that are most attractive to physicians - all while remaining within federal physician recruiting guidelines.

The next 10 years or so are likely to present ongoing challenges in physician supply and recruitment. There's no immediate fix, but through perserverance and commitment, health leaders can at least alleviate some of the difficulties.

Jennifer Moody is vice president of AmeriMed Consulting (www.amerimedconsulting.com) a national health care consulting firm based in Irving, Texas. She can be reached at **jmoody@amerimedconsulting.com** .

SEND TO FRIEND | **POST OPINION**

1 Opinion

Physician Shortage **by William on January 12, 2004 at 11:35AM**

I believe this presents an increased opportunity for Nurse Practitioners to assist in reducing the shortage of primary healthcare providers.

Reply

EDITORIAL GUIDELINES

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A Proposal for Health System Redesign: Part 3
By Brad Stephan, for HealthLeaders News, July 31, 2003
Steer Clear of Physician Recruiting Violations

Tab 8

PHYSICIAN VOLUMES BY SPECIALTY AND PHYSICIAN
MERCY CRYSTAL LAKE HOSPITAL

SPECIALTY	Crystal Lake Clinic	PER MD - MHS HISTORY IP Disch	IP Days	ALOS	Projected Patient Days
CARDIOLOGY	1	25.5	64.5	2.5	65
FAMILY PRACTICE	5	75.7	247.7	3.3	1,238
GASTROENTEROLOGY	1	35.3	12.3	0.3	12
INTERNAL MEDICINE	5	87.3	458.7	5.3	2,293
NEUROLOGY	1	9.0	37.0	4.1	37
OB/GYN	6	174.2	368.5	2.1	2,211
ONCOLOGY	1	74.5	257.0	3.4	257
ORTHOPEDICS	3	140.3	454.0	3.2	1,362
OTOLARYNGOLOGY	1	51.5	34.0	0.7	34
PEDIATRICS	3	29.3	64.0	2.2	192
PULMONOLOGY	1	153.0	764.0	5.0	764
SURGERY, GENERAL	3	97.3	402.8	4.1	1,208
SURGERY, PLASTIC	2	22.0	36.0	1.6	72
UROLOGY	1	49.0	133.0	2.7	133
ROTATORS	2	72.06	207.25	2.9	415
OPHTHALMOLOGY	2	0.0	0.0	0.0	0
DERMATOLOGY	2	0.0	0.0	0.0	0
RHEUMATOLOGY	1	0.0	0.0	0.0	0
ALLERGY	1	0.0	0.0	0.0	0
IMMEDIATE CARE	3	0.0	0.0	0.0	0
TOTAL AT THIS SITE	45	1,323.65	4,269.33	3.23	10293
			Average Per Day		**28**
Other Mercy MDS					
AlgonquinClinic (PCP)	10				3532
			Average Per Day		**10**
Specialty Referral from	For some of the following services				
Woodstock Clinic	Ortho				
Harvard Clinic	Cardiology				
McHenry Clinic	General Surgery				
Richmond Clinic	Neuro Surgery				
Lake Barrington Clinic	ENT		**Average Per Day**		**8**
Emergency Admits and Non Mercy MD's					**8**
			Total projection		**54**

Service Type	IP Days	Available Beds	Avg Daily Census	Pct of Occupancy
MED-SURG	16,356	56	44.8	80.0%
ICU	1,143	4	3.1	78.3%
OB	2,211	10	6.1	60.6%
TOTAL	19,710	70	54.0	77.1%