

ORIGINAL

11-039

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

RECEIVED

This Section must be completed for all projects.

JUL 6 2011

Facility/Project Identification

Facility Name:	Provena United Samaritans Medical Center	HEALTH FACILITIES & SERVICES REVIEW BOARD
Street Address:	812 North Logan Street	
City and Zip Code:	Danville, IL 61832	
County:	Vermillion Health Service Area IV Health Planning Area: D-03	

Applicant /Co-Applicant Identification

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

Exact Legal Name:	Provena Hospitals
Address:	19065 Hickory Creek Drive Mokena, IL 60448
Name of Registered Agent:	Mr. Guy Wiebking
Name of Chief Executive Officer:	Mr. Guy Wiebking
CEO Address:	19065 Hickory Creek Drive Mokena, IL 60448
Telephone Number:	708/478-6300

Type of Ownership of Applicant/Co-Applicant

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

o Corporations and limited liability companies must provide an Illinois certificate of good standing.

o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

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

Primary Contact

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

Name:	Anne M. Murphy
Title:	Partner
Company Name:	Holland + Knight
Address:	131 South Dearborn Street Chicago, IL 60603
Telephone Number:	312/578-6544
E-mail Address:	Anne.Murphy@hklaw.com
Fax Number:	312/578-6666

Additional Contact

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

Name:	none
Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
Fax Number:	

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

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

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Facility/Project Identification

Facility Name:	Provena United Samaritans Medical Center		
Street Address:	812 North Logan Street		
City and Zip Code:	Danville, IL 61832		
County:	Vermillion	Health Service Area	IV Health Planning Area: D-03

Applicant /Co-Applicant Identification

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

Exact Legal Name:	Provena Health		
Address:	19065 Hickory Creek Drive Mokena, IL 60448		
Name of Registered Agent:	Mr. Guy Wiebking		
Name of Chief Executive Officer:	Mr. Guy Wiebking		
CEO Address:	19065 Hickory Creek Drive Mokena, IL 60448		
Telephone Number:	708/478-6300		

Type of Ownership of Applicant/Co-Applicant

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

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Title:	Partner
Company Name:	Holland + Knight
Address:	131 South Dearborn Street Chicago, IL 60603
Telephone Number:	312/578-6544
E-mail Address:	Anne.Murphy@hklaw.com
Fax Number:	312/578-6666

Additional Contact

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

Name:	none
Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
Fax Number:	

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

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

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Facility/Project Identification

Facility Name:	Provena United Samaritans Medical Center		
Street Address:	812 North Logan Street		
City and Zip Code:	Danville, IL 61832		
County:	Vermillion	Health Service Area	IV Health Planning Area: D-03

Applicant /Co-Applicant Identification

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

Exact Legal Name:	Resurrection Health Care Corporation
Address:	355 N. Ridge Avenue Chicago, IL 60202
Name of Registered Agent:	Ms. Sandra Bruce
Name of Chief Executive Officer:	Jeffrey Murphy
CEO Address:	355 N. Ridge Avenue Chicago, IL 60202
Telephone Number:	847/316-2352

Type of Ownership of Applicant/Co-Applicant

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

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Primary Contact

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

Name:	Anne M. Murphy
Title:	Partner
Company Name:	Holland + Knight
Address:	131 South Dearborn Street Chicago, IL 60603
Telephone Number:	312/578-6544
E-mail Address:	Anne.Murphy@hklaw.com
Fax Number:	312/578-6666

Additional Contact

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

Name:	none
Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
Fax Number:	

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

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Provena United Samaritans Medical Center		
Street Address:	812 North Logan Street		
City and Zip Code:	Danville, IL 61832		
County:	Vermillion	Health Service Area	IV Health Planning Area: D-03

Applicant /Co-Applicant Identification

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

Exact Legal Name:	Cana Lakes Health Care		
Address:	7435 West Talcott Avenue		
Name of Registered Agent:	Ms. Sandra Bruce		
Name of Chief Executive Officer:	Ms. Sandra Bruce		
CEO Address:	7435 West Talcott Avenue Chicago, IL 60631		
Telephone Number:	773/792-5555		

Type of Ownership of Applicant/Co-Applicant

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

- o Corporations and limited liability companies must provide an **Illinois certificate of good standing**.
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[Person to receive all correspondence or inquiries during the review period]

Name:	Anne M. Murphy
Title:	Partner
Company Name:	Holland + Knight
Address:	131 South Dearborn Street Chicago, IL 60603
Telephone Number:	312/578-6544
E-mail Address:	Anne.Murphy@hklaw.com
Fax Number:	312/578-6666

Additional Contact

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

Name:	none
Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
Fax Number:	

Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance-THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960

Name:	Mike Brown
Title:	Regional President & CEO
Company Name:	Provena United Samaritans Medical Center
Address:	812 North Logan Street Danville, IL 61832
Telephone Number:	217/443-5000
E-mail Address:	michael.brown@provena.org
Fax Number:	217/443-1965

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Provena Health
Address of Site Owner:	19065 Hickory Creek Drive Mokena, IL 60448
Street Address or Legal Description of Site:	812 North Logan Street Danville, IL 61832
Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.	
APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

Operating Identity/Licensee

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

Exact Legal Name:	Provena Hospitals	
Address:	19065 Hickory Creek Drive Mokena, IL 60448	
<input checked="" type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership	
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental	
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Other
<ul style="list-style-type: none">o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.o Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.		
APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.		

Organizational Relationships

Provide (for each co-applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity 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-4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.
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Flood Plain Requirements

[Refer to application instructions.]

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

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

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

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

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

DESCRIPTION OF PROJECT

1. Project Classification

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

Part 1110 Classification:

- Substantive
- Non-substantive

Part 1120 Applicability or Classification:
[Check one only.]

- Part 1120 Not Applicable
- Category A Project
- Category B Project
- DHS or DVA Project

2. Narrative Description

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

The proposed project is limited to a change of ownership of Provena United Samaritans Medical Center, a 174-bed community hospital located in Danville, Illinois. The proposed change of ownership is a result of the impending merger of the Resurrection and Provena systems through a common "super parent" corporation that will become the parent entity of Resurrection Health Care Corporation (the current Resurrection system parent) and Provena Health (the current Provena system parent).

It is the expectation of the applicants that, for a minimum of two years following the change of ownership, all programs and services currently provided by Provena United Samaritans Medical Center will continue to be provided, and consistent with IHFSRB requirements, access to the hospital's services will not be diminished. The licensee will continue to be Provena United Samaritans Medical Center.

The proposed project, consistent with Section 1110.40.a, is classified as being "non-substantive" as a result of the scope of the project being limited to a change of ownership.

Please refer to the "Project Overview" for a summary of the transaction.

**Project Costs and Sources of Funds Provena United Samaritans
Medical Center**

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

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			\$566,667
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Hospital			\$169,905,000
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS			\$170,471,667
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities			\$566,667
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Fair Market Value of Hospital			\$169,905,000
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS			\$170,471,667

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

Related Project Costs

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

Land acquisition is related to project Yes No
Purchase Price: \$ _____ not applicable
Fair Market Value: \$ _____ not applicable

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

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

Estimated start-up costs and operating deficit cost is \$ none.

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:

None or not applicable Preliminary
 Schematics Final Working

Anticipated project completion date (refer to Part 1130.140): September 30, 2011

Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):

- Purchase orders, leases or contracts pertaining to the project have been executed.
 Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies
 Project obligation will occur after permit issuance.

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

State Agency Submittals

Are the following submittals up to date as applicable:

- Cancer Registry
 APORS **please see documentation requested by State Agency staff on following pages**
 All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
 All reports regarding outstanding permits
Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Phone: 217-785-7126

FAX: 217-524-1770

From: Rose, Kevin [mailto:Edwin.Rose@provena.org]

Sent: Wednesday, February 16, 2011 12:42 PM

To: Fornoff, Jane

Subject: APORS Reporting - Provena St. Mary's Hospital and Provena Mercy Medical Center

Dear Jayne –

Thank you for working with me and staff at the local Provena ministries to assist us in improving our Adverse Pregnancy Outcome Reporting System (APORS) results. To summarize our conversation, the APORS reporting level at Provena St. Mary's Hospital is 77 and at Provena Mercy Medical Center is 75%. Given that each ministry's reporting level is only slightly below target and that each ministry is making a good faith effort to improve its reporting process such that they achieve target going forward, you will be recommending to Illinois Health Facilities and Services Review Board staff that review of any future certificate of need applications by Provena Health/Provena Hospitals be allowed to proceed, and that APORS reporting will not be a matter impacting project completeness.

Please respond back to confirm that you agree with this, and that I have accurately summarized our call. Thanks again – and I look forward to working with you and staff at the Provena ministries to ensure that we meet our targets in the future.

Sincerely,

Kevin

Kevin Rose

System Vice President, Strategic Planning & Business Development

Provena Health

19065 Hickory Creek Drive, Suite 300

From: Fornoff, Jane [mailto:Jane.Fornoff@Illinois.gov]
Sent: Thursday, February 17, 2011 1:28 PM
To: Rose, Kevin
Cc: Roate, George
Subject: RE: APORS Reporting - Provena St. Mary's Hospital and Provena Mercy Medical Center

Dear Kevin,

I am glad that you and the staff at Provena St. Mary's and Provena Mercy Medical Center are working to improve the timeliness of APORS (Adverse Pregnancy Outcome Reporting System). As I am sure you know, timely reporting is important because it helps assure that children achieve their full potential through the early case-management services provided to APORS cases.

As we discussed, since their current reporting timeliness is close to the compliance level, provided each ministry continues to make a good faith effort to improve its reporting process, I will be recommending to Illinois Health Facilities and Services Review Board staff that review of any future certificate of need applications by Provena Health/Provena Hospitals be allowed to proceed, and that APORS reporting will not be a matter impacting project completeness.

Jane

Jane Fornoff, D.Phil.

Perinatal Epidemiologist

Illinois Department of Public Health

Adverse Pregnancy Outcomes Reporting System

535 W Jefferson St, Floor 3

Springfield, IL 62761

Cost Space Requirements

not applicable

Provide in the following format, the department/area **DGSF** or the building/area **BGSF** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

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

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

Facility Bed Capacity and Utilization

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

Provena United					
FACILITY NAME: Samaritans Medical Center		CITY: Danville			
REPORTING PERIOD DATES: From: January 1, 2009 to: December 31, 2009					
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	134	4,629	22,949	None	134
Obstetrics	17	1,051	2,185	None	17
Pediatrics	9	168	423	None	9
Intensive Care	14	642	1,956	None	14
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:	174	6,490	27,513	None	174

CERTIFICATION

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

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

This Application for Permit is filed on the behalf of Provena Hospitals * 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.

Guy Wiebking
SIGNATURE

Guy Wiebking
PRINTED NAME

President and CEO
PRINTED TITLE

Anthony Filer
SIGNATURE

Anthony Filer
PRINTED NAME

Assistant Treasurer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 22nd day of March, 2011

Yvette B. Porter
Signature of Notary
Seal
OFFICIAL SEAL
YVETTE B PORTER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:09/07/14

Notarization:
Subscribed and sworn to before me
this 22nd day of March, 2011

Yvette B. Porter
Signature of Notary
Seal
OFFICIAL SEAL
YVETTE B PORTER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:09/07/14

*Insert EXACT legal name of the applicant

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- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
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This Application for Permit is filed on the behalf of Provena Health *
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.

Guy Wiebking
SIGNATURE

Guy Wiebking
PRINTED NAME


President and CEO
PRINTED TITLE

Anthony Filer
SIGNATURE

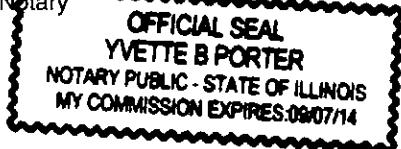
Anthony Filer
PRINTED NAME

Assistant Treasurer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 22nd day of March, 2011

Yvette B. Porter
Signature of Notary
Seal


Notarization:
Subscribed and sworn to before me
this 22nd day of March, 2011

Yvette B. Porter
Signature of Notary
Seal


*Insert EXACT legal name of the applicant

CERTIFICATION

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

This Application for Permit is filed on the behalf of Resurrection Health Care Corporation* 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.

Sandra Bruce
SIGNATURE
Sandra Bruce
PRINTED NAME
PRESIDENT AND CEO
PRINTED TITLE

Jeannie C. Frey
SIGNATURE
JEANNIE C. FREY
PRINTED NAME
SECRETARY
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 22 day of March, 2011

Notarization:
Subscribed and sworn to before me
this 22 day of March

Florita De Jesus-Ortiz
Signature of Notary

Linda M. Noyola
Signature of Notary

Seal
OFFICIAL SEAL
FLORITA DE JESUS-ORTIZ
*Insert EXACT legal name of Illinois applicant
MY COMMISSION EXPIRES: 09/29/14

Seal
OFFICIAL SEAL
LINDA M. NOYOLA
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES: 06/08/13

CERTIFICATION

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

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

This Application for Permit is filed on the behalf of Canal Lakes Health Care *
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.

Sandra Bruce
SIGNATURE
Sandra Bruce
PRINTED NAME
President
PRINTED TITLE

Jeanne C. Frey
SIGNATURE
Jeanne C. Frey
PRINTED NAME
Secretary
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 22 day of March, 2011

Notarization:
Subscribed and sworn to before me
this 22 day of March

Florita de Jesus Ortiz
Signature of Notary

Linda M. Noyola
Signature of Notary

Seal
OFFICIAL SEAL
FLORITA DE JESUS-ORTIZ
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES: 09/29/14
*Insert NOTARY Public name of the applicant

Seal
OFFICIAL SEAL
LINDA M NOYOLA
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES: 06/08/13

SECTION III – BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

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

Criterion 1110.230 – Background, Purpose of the Project, and Alternatives

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT-11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]
4. Cite the sources of the information provided as documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals as appropriate.

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

NOTE: Information regarding the "Purpose of the Project" will be included in the State Agency Report.

APPEND DOCUMENTATION AS ATTACHMENT-12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

- 1) Identify **ALL** of the alternatives to the proposed project:

Alternative options **must** include:

- A) Proposing a project of greater or lesser scope and cost;
 - B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;
 - C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and
 - D) Provide the reasons why the chosen alternative was selected.
- 2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short term (within one to three years after project completion) and long term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**
 - 3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

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

SECTION VI - MERGERS, CONSOLIDATIONS AND ACQUISITIONS/CHANGES OF OWNERSHIP

This Section is applicable to projects involving merger, consolidation or acquisition/change of ownership.

NOTE: For all projects involving a change of ownership THE TRANSACTION DOCUMENT must be submitted with the application for permit. The transaction document must be signed dated and contain the appropriate contingency language.

A. Criterion 1110.240(b), Impact Statement

Read the criterion and provide an impact statement that contains the following information:

1. Any change in the number of beds or services currently offered.
2. Who the operating entity will be.
3. The reason for the transaction.
4. Any anticipated additions or reductions in employees now and for the two years following completion of the transaction.
5. A cost-benefit analysis for the proposed transaction.

B. Criterion 1110.240(c), Access

Read the criterion and provide the following:

1. The current admission policies for the facilities involved in the proposed transaction.
2. The proposed admission policies for the facilities.
3. A letter from the CEO certifying that the admission policies of the facilities involved will not become more restrictive.

C. Criterion 1110.240(d), Health Care System

Read the criterion and address the following:

1. Explain what the impact of the proposed transaction will be on the other area providers.
2. List all of the facilities within the applicant's health care system and provide the following for each facility.
 - a. the location (town and street address);
 - b. the number of beds;
 - c. a list of services; and
 - d. the utilization figures for each of those services for the last 12 month period.
3. Provide copies of all present and proposed referral agreements for the facilities involved in this transaction.
4. Provide time and distance information for the proposed referrals within the system.
5. Explain the organization policy regarding the use of the care system providers over area providers.
6. Explain how duplication of services within the care system will be resolved.
7. Indicate what services the proposed project will make available to the community that are not now available.

APPEND DOCUMENTATION AS ATTACHMENT-19, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The following Sections **DO NOT** need to be addressed by the applicants or co-applicants responsible for funding or guaranteeing the funding of the project if the applicant has a bond rating of A- or better from Fitch's or Standard and Poor's rating agencies, or A3 or better from Moody's (the rating shall be affirmed within the latest 18 month period prior to the submittal of the application):

- Section 1120.120 Availability of Funds – Review Criteria
- Section 1120.130 Financial Viability – Review Criteria
- Section 1120.140 Economic Feasibility – Review Criteria, subsection (a)

VIII. - 1120.120 - Availability of Funds

Provena United Samaritans Medical Center

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable: Indicate the dollar amount to be provided from the following sources:

\$566,667	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: <ol style="list-style-type: none"> 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
_____	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: <ol style="list-style-type: none"> 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions.
_____	e)	Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
_____	f)	Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
\$169,905,000	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project—FMV of hospital
\$170,471,667	TOTAL FUNDS AVAILABLE	

APPEND DOCUMENTATION AS ATTACHMENT 39 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

IX.

1120.130 - Financial Viability**not applicable, funded through
Internal sources**

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

The applicant is not required to submit financial viability ratios if:

1. All of the projects capital expenditures are completely funded through internal sources
2. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
3. The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 40, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion. When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

Provide Data for Projects Classified as:	Category A or Category B (last three years)			Category B (Projected)
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.

2. Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

APPEND DOCUMENTATION AS ATTACHMENT 41, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM

X. 1120.140 - Economic Feasibility

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

A. Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

- 1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or
- 2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:
 - A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
 - B) 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.

B. Conditions of Debt Financing **not applicable, no debt financing**

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

- 1) That the selected form of debt financing for the project will be at the lowest net cost available;
- 2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;
- 3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

1. Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. \$ (A x C)	Mod. \$ (B x E)	
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

APPEND DOCUMENTATION AS ATTACHMENT 42 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM

XI. Safety Net Impact Statement not applicable, non-substantive project

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE AND DISCONTINUATION PROJECTS:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.
2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.
2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.
3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 43.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Charity (cost in dollars)	Year	Year	Year
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Medicaid (revenue)	Year	Year	Year
Inpatient			
Outpatient			
Total			

APPEND DOCUMENTATION AS ATTACHMENT 43 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XII. Charity Care Information Provena United Samaritans Medical Center

Charity Care information **MUST** be furnished for **ALL** projects.

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.
3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer. (20 ILCS 3960/3) Charity Care **must** be provided at cost.

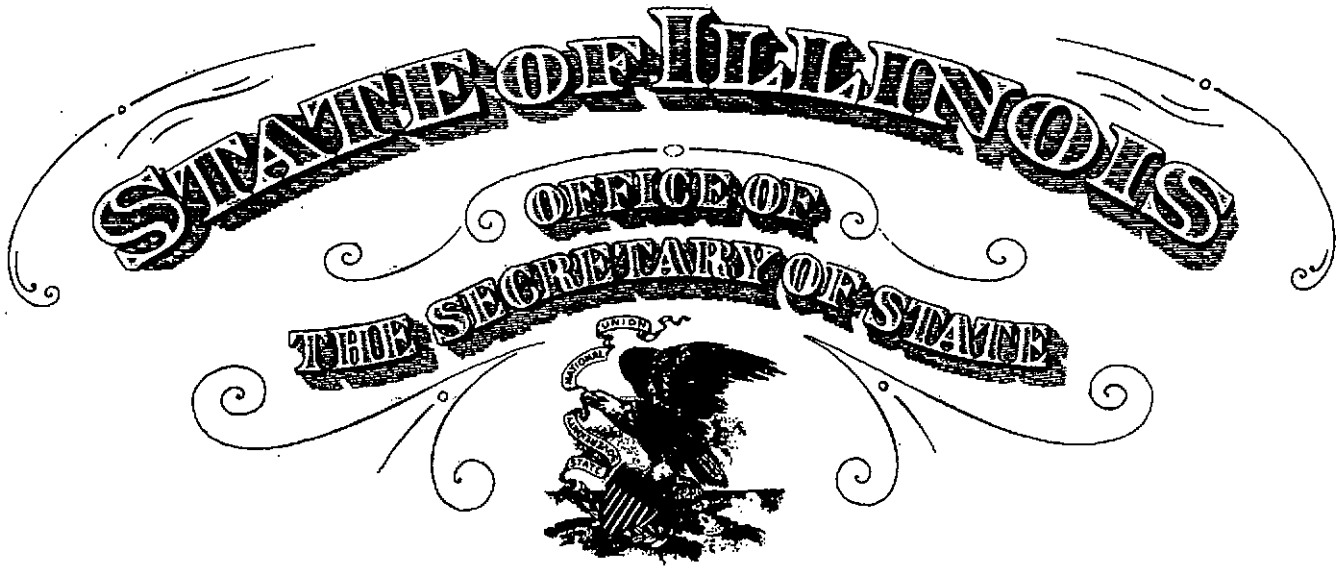
A table in the following format must be provided for all facilities as part of Attachment 44.

CHARITY CARE			
	2007	2008	2009
Net Patient Revenue	\$118,842,864	\$116,041,520	\$114,110,915
Amount of Charity Care (charges)	\$10,830,961	\$16,181,845	\$19,078,391
Cost of Charity Care	\$3,132,506	\$4,898,019	\$4,019,972

APPEND DOCUMENTATION AS ATTACHMENT-44, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Sources:

- IDPH Annual Hospital Questionnaire for Net Patient Revenue and Cost of Charity Care
- Internal Financial Statements for Amount of Charity Care (charges)



To all to whom these Presents Shall Come, Greeting:

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

PROVENA HOSPITALS, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 30, 1997, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 11TH day of FEBRUARY A.D. 2011 .



Authentication #: 1104200730

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

Jesse White

SECRETARY OF STATE
ATTACHMENT 1



To all to whom these Presents Shall Come, Greeting:

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

PROVENA HEALTH, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 10, 1985, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



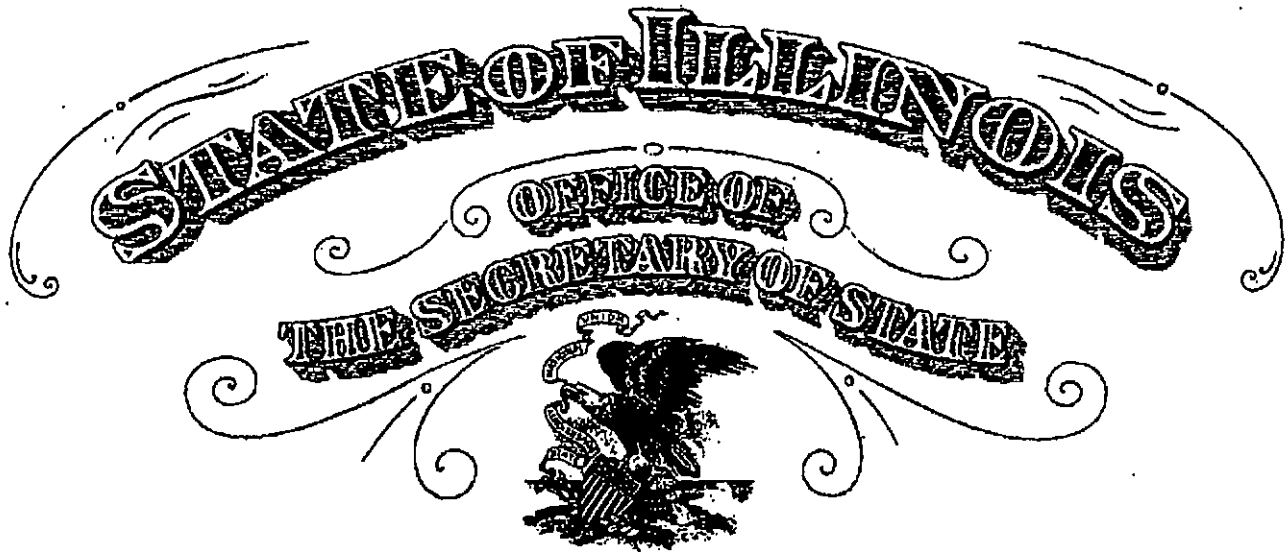
In Testimony Whereof, I hereto set
*my hand and cause to be affixed the Great Seal of
the State of Illinois, this 11TH
day of FEBRUARY A.D. 2011*

Jesse White

Authentication #: 1104200726

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

SECRETARY OF STATE
ATTACHMENT 1



To all to whom these Presents Shall Come, Greeting:

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

RESURRECTION HEALTH CARE CORPORATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 27, 1949, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 17TH day of JANUARY A.D. 2011

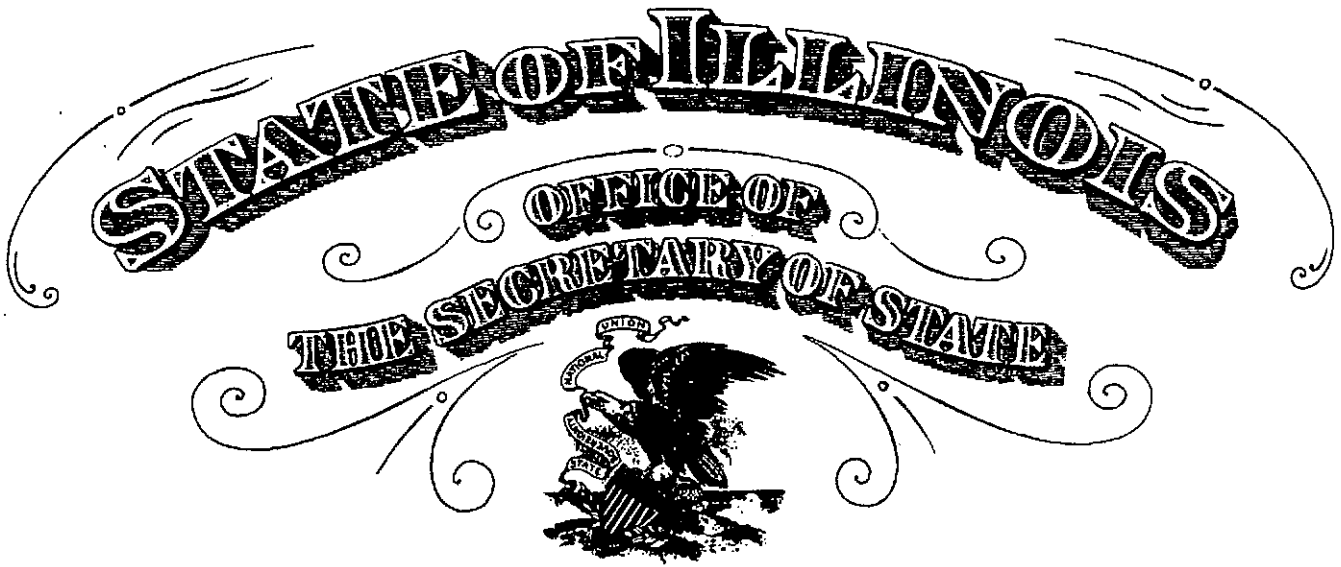
Jesse White

SECRETARY OF STATE

Authentication #: 1101700286

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

ATTACHMENT 1



To all to whom these Presents Shall Come, Greeting:

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

CANA LAKES HEALTH CARE, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JANUARY 05, 1939, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 4TH day of MARCH A.D. 2011 .



Authentication #: 1106302140
Authenticate at: <http://www.cyberdriveillinois.com>

Jesse White

SECRETARY OF STATE
ATTACHMENT 1

Evidence of Site Control-
Provena hospitals



Excess Liability

PROPERTY

First-Party insurance that indemnifies the owner or users of property for its loss, or the loss of its income-producing ability, when the loss or damage is caused by a covered peril.

INSURER: FM Global

NAMED INSURED: Provena Health and any subsidiary, and Provena Health's interest in any partnership or joint venture in which Brush Engineered Material Inc. has management control or ownership as now constituted or hereafter is acquired, as the respective interest of each may appear; all hereafter referred to as the "Insured", including legal representatives.

POLICY No.: FC999

POLICY PERIOD: June 1, 2010 – June 1, 2011 beginning and ending at 12:01 AM at the location of the property insured

**PERILS INSURED:
(LOSS OR DAMAGE INSURED)** "All Risk "of physical loss or damage including flood, earthquake, and Boiler & and Machinery Insurance as more fully stated in the policy form. (see enclosed FM Quote)

PERILS EXCLUDED:

- Indirect or Remote Loss
- Interruption of business (except as provided under BI Coverage)
- Loss of Market
- Mysterious disappearance
- Law or Ordinance (except as provided under Demolition and Increased Cost of Construction and Decontamination Costs)
- Voluntary Parting of Property
- Nuclear Reaction / Radiation
- Hostile Warlike Action
- Terrorism (except as provided under Terrorism Coverage)
- Fraudulent or Dishonest Act or Acts
- Lack of Incoming Services (except as provided by Service Interruption)
- Defective Design / Faulty Material /Faulty Workmanship
- Wear and Tear
- Settling, Cracking, Shrinking, bulging of pavements, floors, foundations...
- Changes in temperature
- Insect, animal or vermin damage
- Rain, sleet or Snow damage to Interior of buildings under construction
- Pollution
- Wind damage to Landscaping, lawns, trees, shrubs, etc. (all as more fully stated in the policy form)

Proprietary Information: Data provided on this page is proprietary between Aon and Provena. This insurance document is furnished to you as a matter of information for your convenience. It only summarizes the listed policy(ies) and is not intended to reflect all the terms and conditions or exclusions of such policy(ies). Moreover, the information contained in this document reflects coverage as of the date of this summary as shown below of the policy(ies) and does not include subsequent changes. This document is not an insurance policy and does not amend, alter or extend the coverage afforded by the listed policy(ies). The insurance afforded by the listed policy(ies) is subject to all the terms, exclusions and conditions of such policy(ies).

**PROPERTY AND INTERESTS
INSURED:**

Property: All real and personal property owned, leased, acquired by, used by, intended for use by the Insured, including but not limited to:

- Property while in Transit
- Property of Others in the Insured's Care, Custody and Control including costs to defend allegations of liability for loss or damage to such property
- Improvements and Betterments
- Personal Property of Employees and Officers
- Property of Others that the Insured has agreed to insure
- Electronic Data Processing Equipment and Media
- Fine Arts
- Newly Acquired Property
- Miscellaneous Unnamed Locations – Personal Property
(all as more fully stated in the policy form)

COVERAGES/EXTENSIONS OF COVERAGE:

- Business Interruption, including Interdependency
- Extended Period of Liability
- Extra Expense
- Expediting Expense
- Consequential/Sequential Damage
- Accounts Receivable
- Leasehold Interest
- Rental Value and Rental Income
- Royalties, Licensing Fees, Technical Fees, Commissions
- Research and Development
- Fine Arts
- Contingent Business Interruption
- Contingent Extra Expense
- Service Interruption (Off Premises Power) – Property Damage and Time Element
- Civil or Military Authority
- Ingress/Egress
- Demolition and Increased Cost of Construction – Property Damage and Time Element
- Debris removal
- Land and Water Decontamination and Clean Up Expense
- Comprehensive Boiler & Machinery Insurance
- Automatic Coverage for Newly Acquired Properties
- Valuable Papers and Records
- Electronic Data Processing Media
- Protection and Preservation of Property (Sue and Labor)
(all as more fully stated in the attached policy form)

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SPECIAL CONDITIONS:

- Brands and Labels
 - Control of Damaged Merchandise
 - Pair and Set/Consequential Reduction in Value
 - Errors and Omissions
 - Loss Adjustment Expenses/Professional Fees
- (all as more fully stated in the policy form)

PROPERTY EXCLUDED:

- Watercraft, etc.
 - Land, etc., except land improvements (not at Mines)
 - Currency, Money, etc.
 - Animals, Growing Crops, Standing Timber, etc.
 - Water, etc.
 - Export and Import shipment, etc.
 - Waterborne Shipments via the Panama Canal
 - Waterborne Shipments to and from Alaska, Hawaii, Puerto Rico, Guam and Virgin Islands
 - Underground Mines, mine shafts and any property within such mine or shaft
- (all as more fully stated in the policy form)

VALUATION:

- Building and structures at the lesser of repair or replacement cost
 - Machinery, equipment, furniture, fixtures, and improvements and betterments at replacement cost new
 - Valuable Papers and Records and EDP Media at value blank plus cost of transcription
 - Finished Stock at Selling Price
 - Stock in Process at cost of materials, labor and overhead
 - Property of others at amount stipulated in lease, or Insured's contractual or legal liability
 - Fire damage resulting from Terrorism – Actual Cast Value
- (all as more fully stated in the policy form)

POLICY LIMITS:

\$500,000,000 Policy Limit per occurrence, except;
 Included Gross Earnings
 12 Months Gross Profits
 365 Days Ordinary Payroll
 or as noted below and in the policy form

SUBLIMITS:

\$100,000,000 Accounts Receivable
 Dependent Time Element
 \$20,000,000 • Per occurrence
 \$10,000,000 • Per location
 Included • For all suppliers direct and indirect and customers

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Excluded	• California, Alaska, Hawaii, Puerto Rico, New Madrid and Pacific Northwest High Hazard Zones for Earth Movement, Terrorism
Included	Control of Damaged Merchandise
\$10,000,000	• Goods held for resale Data, Media and Software and Computer Systems – Non Physical Damage combined
Yes	• Valuation includes Research Costs
Included	Defense Costs
Included	Debris Removal
\$100,000,000	Deferred Payments/Property Sold under Conditional Sales Agreements
\$100,000,000	Earth Movement per occurrence and in the aggregate in any one policy year
Excluded	• California, Alaska, Hawaii, Puerto Rico, New Madrid and Pacific Northwest High Hazard Zones for Earth Movement, Terrorism
\$100,000,000	Errors & Omissions (PD/BI/EE)
Excluded	• California, Alaska, Hawaii, Puerto Rico, New Madrid and Pacific Northwest High Hazard Zones for Earth Movement, Terrorism
90 Days	Extended Period of Indemnity
\$100,000,000	Extra Expense and Expediting Expense Combined
\$100,000,000	Fine Arts
	• but not to exceed 10,000 limit per item for Irreplaceable Fine Arts not on a schedule of file with the company
\$100,000,000	Flood per occurrence
Included	Increased Cost of Construction & Demolition, including resultant time element at the time of loss
\$5,000,000	Ingress/Egress – the lesser of limit shown or 30 day period
Excluded	• California, Alaska, Hawaii, Puerto Rico, New Madrid and Pacific Northwest High Hazard Zones for Earth Movement, Terrorism
30 Days	Interruption by Civil Authority – the lesser or limit shown or ___ day period.
Excl. Wind	Landscaping, including Trees, Shrubs and Plants
\$10,000,000	Leasehold Interest
\$10,000,000	Miscellaneous Unnamed Locations/ Personal Property
Excluded	• California, Alaska, Hawaii, Puerto Rico, New Madrid and Pacific Northwest High Hazard Zones for Earth Movement, Terrorism
\$100,000,000	Newly Acquired Property (Automatic Coverage – 90 day reporting)

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- Excluded • California, Alaska, Hawaii, Puerto Rico, New Madrid and Pacific Northwest High Hazard Zones for Earth Movement, Terrorism
- \$10,000,000 Off Premise Storage for Property Under Construction
- Excluded • California, Alaska, Hawaii, Puerto Rico, New Madrid and Pacific Northwest High Hazard Zones for Earth Movement, Terrorism
- Included Rents
- Included Research and Development (TE)
- \$100,000 Animals (PD)
- \$25,000,000 Service Interruption- Property Damage and Time Element Combined
- \$2,500,000 • Data, Voice and Video except accidental occurrence is excluded
- Excluded • California, Alaska, Hawaii, Puerto Rico, New Madrid and Pacific Northwest High Hazard Zones for Earth Movement, Terrorism
- \$10,000,000 Soft Costs
- Included Tax Treatment of Profits
- \$10,000,000 Transit, property in the due course of (excludes ocean cargo)
- \$1,000,000 • Time Element
- \$100,000,000 Valuable Papers
- Repair or restore only • but not to exceed 10,000 limit per item for Irreplaceable Valuable Papers and Records not on a schedule of file with the company
- Included **Boiler and Machinery** – per all terms and conditions of the policy form
- \$500,000,000 **Certified Terrorism - TRIPRA**
- \$5,000,000 Terrorism
- \$1,000,000 • Miscellaneous Personal Property, Off Premises Storage for Property Under Construction, and Temporary Removal of Property
- \$1,000,000 Flood
- 12 Month Terrorism Time Element
- These limits shall not include the ACV portion of fire damage caused by Terrorism
- Or as further defined in the policy form

DEDUCTIBLES:

- Per Occurrence
- \$50,000 Property Damage
- 1 x DEQ Time element
- DEQ = Daily Equivalent
- Except as follows:

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\$100,000 min. 5% per location	Names Storm Wind (all affected locations are subject to this deductible)
\$100,000	Flood (surface water exposure) <ul style="list-style-type: none"> Provena Pineview Care Center 611 Allen Lane St. Charles, IL
\$25,000	Transit <ul style="list-style-type: none"> Property
48 hrs. waiting period and 48 hr. ded.	Data, Programs, and Software/Malicious Introduction of Machine Code
Min. \$100,000	
48 hrs. waiting period and 48 hr. ded.	Computer Systems – Non Physical Damage
Min. 100,000	
\$100,000	Dependent Time Element Location Per occurrence/location except; <ul style="list-style-type: none"> Per location for Earthquake Shock Per location for Flood Per location for Named Storm Wind* except; (*at all affected locations, are subject to this deductible)
\$100,000	
\$100,000	
\$100,000	
5% of Values*	
\$100,000 min/loc.	
24 hrs. Policy deductible(s) per location	Service Interruption Waiting Period Terrorism – TRIPRA, and ACV portion of fire damage caused by Terrorism
\$100,000	Property Damage and Time Element deductible combined applies at the following locations: <ul style="list-style-type: none"> Covenant Medical Center 130-1412 West Park (excluding 1307 and 1405 West Park) Urbana, IL Provena United Samaritans Medical Center 812 North Logan Danville, IL St. Mary's Hospital (including bridge over West Court Street) 500 West Court Street Kankakee, IL Provena St. Joseph Medical Center Madison Street, Glenwood and Springfield 333 North Madison Joliet, IL

Proprietary Information: Data provided on this page is proprietary between Aon and Provena. This insurance document is furnished to you as a matter of information for your convenience. It only summarizes the listed policy(ies) and is not intended to reflect all the terms and conditions or exclusions of such policy(ies). Moreover, the information contained in this document reflects coverage as of the date of this summary as shown below of the policy(ies) and does not include subsequent changes. This document is not an insurance policy and does not amend, alter or extend the coverage afforded by the listed policy(ies). The insurance afforded by the listed policy(ies) is subject to all the terms, exclusions and conditions of such policy(ies).

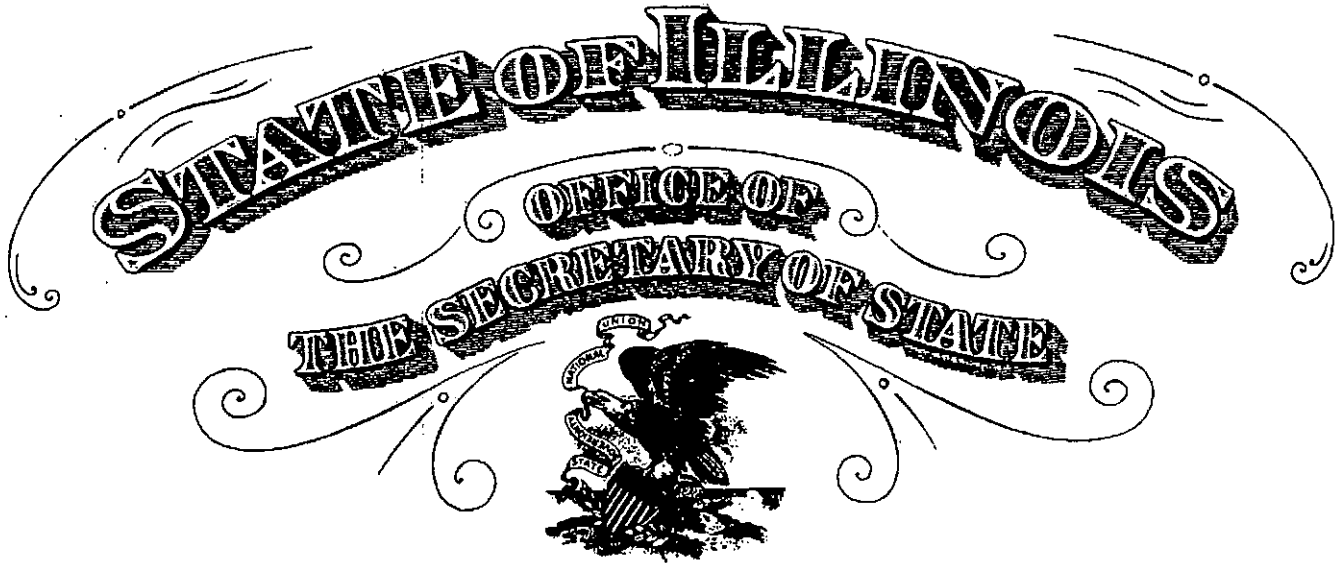
- St. Joseph Hospital
77 North Airlite Street
Elgin, IL
- Provena Mercy Center
1325 North Highland Avenue
Aurora, IL

ANNUAL PREMIUM: \$1,029,000

CLAIMS REPORTING PROCEDURES: Doug Backes
FM Global
South Northwest Highway
Park Ridge, IL 60068
Phone: 847-430 7401
Fax: 847-430-7499

Proprietary Information: Data provided on this page is proprietary between Aon and Provena.

This insurance document is furnished to you as a matter of information for your convenience. It only summarizes the listed policy(ies) and is not intended to reflect all the terms and conditions or exclusions of such policy(ies). Moreover, the information contained in this document reflects coverage as of the date of this summary as shown below of the policy(ies) and does not include subsequent changes. This document is not an insurance policy and does not amend, alter or extend the coverage afforded by the listed policy(ies). The insurance afforded by the listed policy(ies) is subject to all the terms, exclusions and conditions of such policy(ies).



To all to whom these Presents Shall Come, Greeting:

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

PROVENA HOSPITALS, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 30, 1997, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 11TH day of FEBRUARY A.D. 2011 .



Authentication #: 1104200730

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

Jesse White

SECRETARY OF STATE

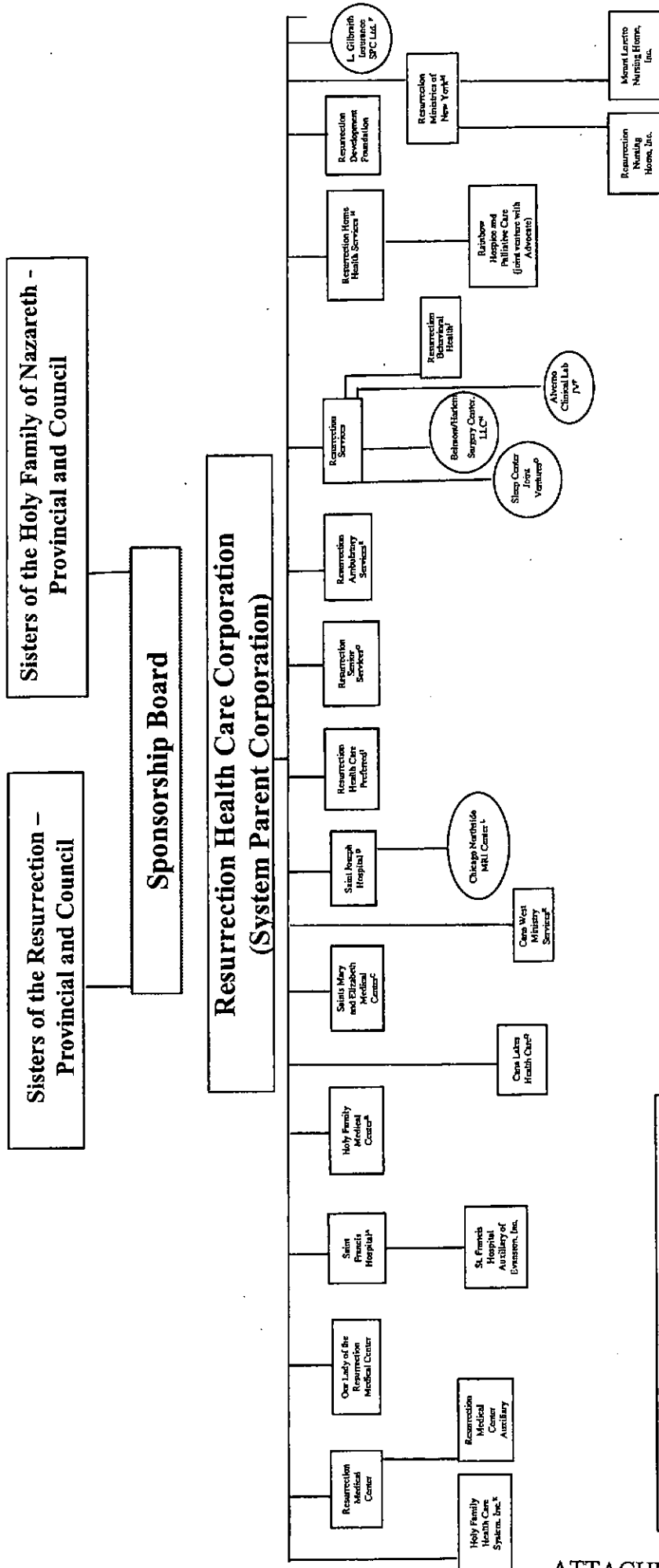
ATTACHMENT 3

CURRENT ORGANIZATIONAL CHARTS

Resurrection Health Care Corporation

Corporate Organizational and Governance Structure

October 21, 2010



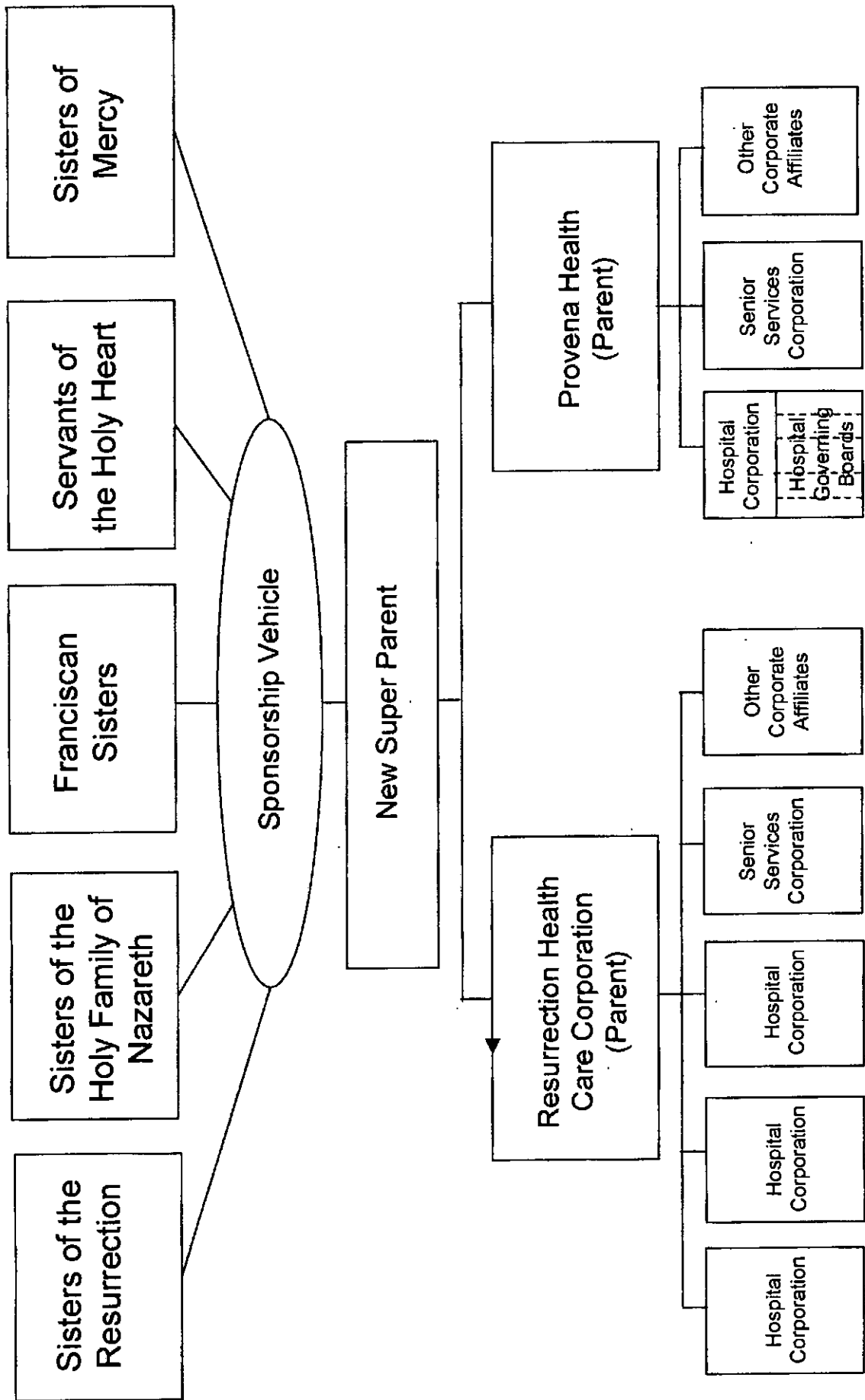
KEY:
 Boxes denote not for profit corporations.
 Circles denote for profit corporations or other entities.
 Text of footnotes A through P are on the next page.

Resurrection Health Care Corporation
Legal Organizational Structure
As of October 21, 2010
Footnotes

- ^A Formerly named Saint Francis Hospital of Evanston (name change effective November 22, 2004)
- ^B Became part of the Resurrection system effective March 1, 2001, as part of the agreement of co-sponsorship between the Sisters of the Resurrection, Immaculate Conception Province and the Sisters of the Holy Family of Nazareth, Sacred Heart Province
- ^C Created from merger of Saint Elizabeth Hospital into Saint Mary of Nazareth Hospital Center, and name change of latter (surviving) corporation, both effective 12/1/03. Saint Mary of Nazareth Hospital Center (now part of Saints Mary and Elizabeth Medical Center) became part of Resurrection system under the co-sponsorship agreement referenced in Footnote B above
- ^D Saint Joseph Hospital, *f/k/a* Cana Services Corporation, *f/k/a* Westlake Health System
- ^E Formerly known as West Suburban Health Services, this 501(c)(3) corporation had been the parent corporation of West Suburban Medical Center prior to the hospital corporation becoming part of the Resurrection Health Care system. Effective January 1, 2010, Resurrection Ambulatory Services assumed the assets and liabilities of Resurrection Services' ambulatory care services division.
- ^F A Cayman Islands corporation registered to do business as an insurance company
- ^G Corporation formerly known as Westlake Nursing and Rehabilitation Center (also *f/k/a* Leyden Community Extended Care Center, Inc.)
- ^H Resurrection Home Health Services, *f/k/a* Health Connections, Inc., is the combined operations of Extended Health Services, Inc., Community Nursing Service West, Resurrection Home Care, and St. Francis Home Health Care (the assets of all of which were transferred to Health Connections, Inc. as of July 1, 1999).
- ^I Holy Family Health Preferred is a former *d/b/a* of Saints Mary and Elizabeth Health Preferred, and Saint Joseph Health Preferred. Operates under the *d/b/a* names of Resurrection Health Preferred, Saint Francis Health Preferred, and Holy Family Health Preferred
- ^J *D/B/A* name for Proviso Family Services, *a/k/a* ProCare Centers, *a/k/a* Employee Resource Centers
- ^K Former parent of Holy Family Medical Center; non-operating 501(c)(3) "shell" available for future use
- ^L An Illinois general partnership between Saint Joseph Hospital and Advocate Northside Health System, an Illinois not for profit corporation
- ^M Resurrection Health Care is the Corporate Member of RMNY, with extensive reserve powers, including appointment/removal of all Directors and approval of amendments to the Corporation's Articles and Bylaws. The Sponsoring Member of the Corporation is the Sisters of the Resurrection New York, Inc.
- ^N Resurrection Services owns over 50% of the membership interests of Belmont/Harlem, LLC, an Illinois limited liability company, which owns and operates an ambulatory surgery center
- ^O Resurrection Services owns a majority interest in the following Illinois limited liability companies which own and operate sleep disorder diagnostic centers: RES-Health Sleep Care Center of River Forest, LLC; RES-Health Sleep Care Center of Lincoln Park, LLC; RES-Health Sleep Care Center of Evanston, LLC; RES-Health Sleep Care Center of Chicago Northwest, LLC
- ^P Joint Venture for clinical lab services for 2 other Catholic health care systems, Provena and Sisters of Saint Francis Health Services, Inc., consisting of an Indiana limited liability company of which Resurrection Services is a 1/3 member, and a tax-exempt cooperative hospital service corporation, of which all Resurrection tax-exempt system hospitals collectively have a 1/3 interest
- ^Q Formerly named Westlake Community Hospital; all the assets of this corporation were sold to VHS Westlake Hospital Inc., effective August 1, 2010
- ^R Formerly named West Suburban Medical Center; all the assets of this corporation were sold to VHS West Suburban Medical Center, Inc., effective August 1, 2010

PROPOSED ORGANIZATIONAL CHART

Super Parent Structure



IDENTIFICATION OF PROJECT COSTS

Fair Market Value of Hospital

The insured value of the hospital was used to identify the Fair Market Value, consistent with a discussion of methodology with IHFSRB staff.

Consulting and Other Fees

The transaction-related costs anticipated to be incurred by Provena Health and Resurrection Health Care Corporation (approximately \$8,500,000) was equally apportioned among the thirteen hospitals, one ASTC and one ESRD facility for which CON applications need to be filed. The transaction-related costs include, but are not limited to: the due diligence process, the preparation of transaction-related documents, the CON application development process, CON review fees, and outside legal counsel, accounting and consulting fees.

7435 West Talcott Avenue
Chicago, Illinois 60631
773.792.5555



Sandra Bruce, FACHE
President & Chief Executive Officer

March 24, 2011

Illinois Health Facilities
and Services Review Board
525 West Jefferson
Springfield, IL 62761

To Whom It May Concern:

In accordance with Review Criterion 1.10.230.b, Background of the Applicant, we are submitting this letter assuring the Illinois Health Facilities and Services Review Board (IHFSRB) that:

1. Over the past three years, there have been a total of five adverse actions involving a Resurrection hospital (each addressing Medicare Conditions of Participation). Two such actions relate to Our Lady of the Resurrection Medical Center (OLR), and three such actions relate to Saint Joseph Hospital (SJH). All five actions were initiated in 2009. Three of the five actions were fully resolved in 2009 to the satisfaction of CMS and IDPH, through plans of correction: (a) SJH was cited twice (in an initial and follow up survey) with certain deficiencies in conducting and documenting rounds on its psychiatry unit; and (b) OLR was cited with deficiencies in medical staff training and competencies in certain intubation procedures. The remaining two actions, each of which involves life safety code issues related to the age of the physical plant of OLR and SJH, are scheduled for plan of correction completion by March 31, 2011 and December 31, 2011 respectively.
2. Resurrection Health Care Corporation authorizes the State Board and State Agency access to information to verify documentation or information submitted in response to the requirements of Review Criterion 1.10.230.b or to obtain any documentation or information which the State Board or State Agency finds pertinent to this application.

If we can in any way provide assistance to your staff regarding these assurances or any other issue relative to this application, please do not hesitate to call me.

Sincerely,

A handwritten signature in cursive script that reads "Sandra Bruce".

Sandra Bruce, FACHE
President & CEO

SB/fdjo



March 23, 2011

Illinois Health Facilities
and Services Review Board
525 West Jefferson
Springfield, IL 62761

To Whom It May Concern:

In accordance with Review Criterion 1110.230.b, Background of the Applicant, we are submitting this letter assuring the Illinois Health Facilities and Services Review Board (IHFSRB) that:

3. Neither Provena Health ("Provena") nor any wholly-affiliated corporation that owns or operates a facility subject to the IHFSRB's jurisdiction has had any adverse actions (as defined in Section 1130.140) taken against any hospital or ESRD facility during the three (3) year period prior to the filing of this application, and
4. Provena Health authorizes the State Board and State Agency access to information to verify documentation or information submitted in response to the requirements of Review Criterion 1110.230.b or to obtain any documentation or information which the State Board or State Agency finds pertinent to this application.

If we can in any way provide assistance to your staff regarding these assurances or any other issue relative to this application, please do not hesitate to call me.

Sincerely,

A handwritten signature in cursive script, appearing to read "Meghan Kieffer".

Meghan Kieffer
System Senior Vice President/General Counsel



A handwritten signature in cursive script, appearing to read "Yvette B. Porter".

FACILITIES LICENSED IN ILLINOIS

	Name	Location	IDPH Licensure #
Hospitals Owned by Resurrection Health Care Corporation:			
	Saint Mary of Nazareth Hospital	Chicago	2584
	Saint Elizabeth Hospital	Chicago	5314
	Resurrection Medical Center	Chicago	1974
	Saint Joseph Hospital	Chicago	5181
	Holy Family Medical Center	Des Plaines	1008
	St. Francis Hospital of Evanston	Evanston	2402
	Our Lady of Resurrection Medical Center	Chicago	1719
Hospitals Owned by Provena Health:			
	Covenant Medical Center	Urbana	4861
	United Samaritan Medical Center	Danville	4853
	Saint Joseph Medical Center	Joliet	4838
	Saint Joseph Hospital	Elgin	4887
	Provena Mercy Center	Aurora	4903
	Saint Mary's Hospital	Kankakee	4879
Ambulatory Surgical Treatment Centers Owned by Resurrection Health Care Corporation:			
	Belmont/Harlem Surgery Center, LLC*	Chicago	7003131
End Stage Renal Disease Facilities Owned by Provena Health:			
	Manteno Dialysis Center	Manteno	n/a
Long-Term Care Facilities Owned by Provena Health:			
	Provena Villa Franciscan	Joliet	2009220
	Provena St. Anne Center	Rockford	2004899
	Provena Pine View Care Center	St. Charles	2009222
	Provena Our Lady of Victory	Bourbonnais	2013080
	Provena Geneva Care Center	Geneva	1998975
	Provena McCauley Manor	Aurora	1992916
	Provena Cor Mariae Center	Rockford	1927199
	Provena St. Joseph Center	Freeport	0041871
	Provena Heritage Village	Kankakee	0042457
Long-Term Care Facilities Owned by Resurrection Health Care Corporation:			
	Holy Family Nursing and Rehabilitation Center	Des Plaines	0048652
	Maryhaven Nursing and Rehabilitation Center	Glenview	0044768
	Resurrection Life Center	Chicago	0044354
	Resurrection Nursing and Rehabilitation Ctr.	Park Ridge	0044362
	Saint Andrew Life Center	Niles	0044776
	Saint Benedict Nursing and Rehabilitation Ctr.	Niles	0044784
	Villa Scalabrini Nursing and Rehabilitation Ctr.	Northlake	0044792
	* Resurrection Health Care Corporation has a 51% ownership interest		
	** Provena Health has a 50% ownership interest		



State of Illinois 2009511
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.

DANON T. ARNOLD, M.D.
DIRECTOR

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

EXPIRATION DATE	CATEGORY	TO NUMBER
12/31/11	B68B	0002584
FULL LICENSE GENERAL HOSPITAL EFFECTIVE: 01/01/11		

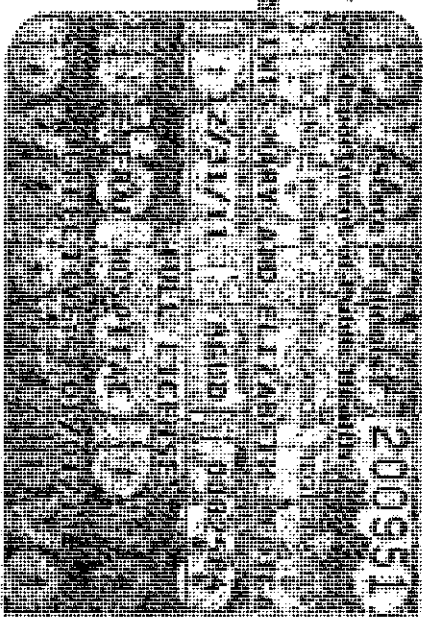
BUSINESS ADDRESS

SAINI'S MARY AND ELIZABETH MEDICAL CENTE
D/B/A SAINI MARY OF NAZARETH HOSPITAL
2233 WEST DIVISION STREET
CHICAGO IL 60622

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↑
 DISPLAY THIS PART IN A
 CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN
 IDENTIFICATION



11/06/10

SAINI'S MARY AND ELIZABETH MEDICAL
D/B/A SAINI MARY OF NAZARETH HOSPITAL
2233 WEST DIVISION STREET
CHICAGO IL 60622

FEE RECEIPT NO.



State of Illinois 2009544
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.

BANDON T. ARNOLD, M.D.
DIRECTOR

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

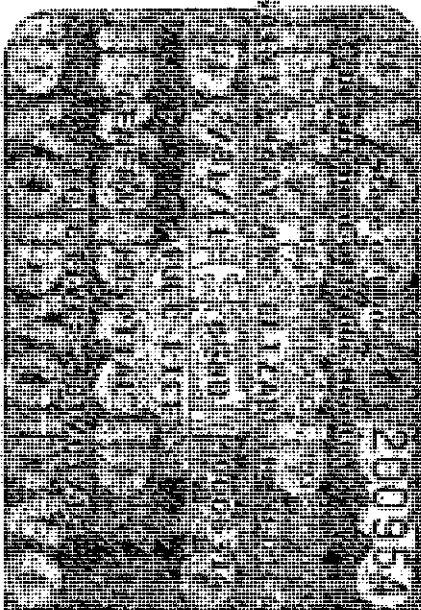
EXPIRATION DATE	CATEGORY	ID NUMBER
12/31/11	BSBD	0005314
FULL LICENSE GENERAL HOSPITAL EFFECTIVE: 01/01/11		

BUSINESS ADDRESS
SAINTS MARY AND ELIZABETH MEDICAL CENTER
D/B/A SAINT ELIZABETH HOSPITAL
1431 NORTH CLAREMONT AVENUE
CHICAGO, IL 60622

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 IDENTIFICATION



11/06/10

SAINTS MARY AND ELIZABETH MED
 D/B/A SAINT ELIZABETH HOSPITAL
 1431 NORTH CLAREMONT AVENUE
 CHICAGO IL 60622

FEE RECEIPT NO.



March 22, 2011

Margaret McDermott
Saints Mary and Elizabeth Medical Center
1431 N. Claremont
Chicago, IL 60622

Dear Ms. McDermott:

This letter is to certify that Saints Mary and Elizabeth Medical Center in Chicago, IL is currently accredited by the Healthcare Facilities Accreditation Program (HFAP) of the American Osteopathic Association (AOA).

The hospital was surveyed for re-accreditation by HFAP on November 15-17, 2010. They are currently in process and have not yet received their Accreditation Letter or Certificate.

You may use a copy of this letter with external organizations to demonstrate your accreditation status. Questions about the HFAP may be directed to my attention via phone at 312-202-8060.

Sincerely,

A handwritten signature in cursive script that reads "Troy Repuszka".

Troy Ann Repuszka, RN, BScN,
Deputy Director, HFAP



State of Illinois 2009495
 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.

DAMON T. ARNOLD, M.D.
 DIRECTOR
 Issued under the authority of
 The State of Illinois
 Department of Public Health

EXPIRATION DATE 12/31/11	CATEGORY 0680	ID NUMBER 0001974
FULL LICENSE		
GENERAL HOSPITAL		
EFFECTIVE: 01/01/11		

BUSINESS ADDRESS

RESURRECTION MEDICAL CENTER
 7435 WEST TALCOTT AVENUE

CHICAGO

IL 50631

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REMOVE THIS CARD TO CARRY AS AN
 IDENTIFICATION

State of Illinois
 Department of Public Health
 2009495

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

EXPIRATION DATE 12/31/11	CATEGORY 0680	ID NUMBER 0001974
FULL LICENSE		
GENERAL HOSPITAL		
EFFECTIVE: 01/01/11		

BUSINESS ADDRESS

RESURRECTION MEDICAL CENTER
 7435 WEST TALCOTT AVENUE
 CHICAGO IL 50631

SEE RECEIPT NO.



March 22, 2011

Sandra Bruce, CEO
Resurrection Medical Center
7435 W. Talcott
Chicago, IL 60637

Dear Ms. Bruce:

This letter is to certify that Resurrection Medical Center in Chicago, IL is currently accredited by the Healthcare Facilities Accreditation Program (HFAP) of the American Osteopathic Association (AOA).

The hospital was surveyed for re-accreditation by HFAP on November 29-December 1, 2010. They are currently in process and have not yet received their Accreditation Letter or Certificate.

You may use a copy of this letter with external organizations to demonstrate your accreditation status. Questions about the HFAP may be directed to my attention via phone at 312-202-8060.

Sincerely,

A handwritten signature in cursive script that reads "Troy Repuszka".

Troy Ann Repuszka, RN, BScN,
Deputy Director, HFAP

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION



State of Illinois 2040005

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

SAINT JOSEPH HOSPITAL

EXPIRATION DATE	CATEGORY	ID NUMBER
07/02/12	HGPE	0005181

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 07/03/11

06/26/11

SAINT JOSEPH HOSPITAL
2900 NORTH LAKE SHORE DRIVE

CHICAGO IL 60657

FEE RECEIPT NO.

State of Illinois 2040005

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.

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

DAMON P. ARNOLD, M.D.
DIRECTOR

EXPIRATION DATE	CATEGORY	ID NUMBER
07/02/12	HGPE	0005181

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 07/03/11

BUSINESS ADDRESS

SAINT JOSEPH HOSPITAL
2900 NORTH LAKE SHORE DRIVE

CHICAGO IL 60657

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February 11, 2011

Carol Schultz
Accreditation Coordinator
St. Joseph Hospital
2900 N. Lakeshore Drive
Chicago, IL 60657

Dear Ms. Schultz:

This letter is to certify that St. Joseph Hospital in Chicago, IL is currently accredited by the Healthcare Facilities Accreditation Program (HFAP) of the American Osteopathic Association (AOA).

The hospital was surveyed for re-accreditation by HFAP on October 11-13, 2010. They are currently in process and have not yet received their Accreditation Letter or Certificate.

You may use a copy of this letter with external organizations to demonstrate your accreditation status. Questions about the HFAP may be directed to my attention via phone at 312-202-8060.

Sincerely,

A handwritten signature in cursive script that reads "Troy Repuszka".

Troy Ann Repuszka, RN, BScN,
Deputy Director, HFAP

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION



State of Illinois 2035973

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

EXPIRATION DATE	CATEGORY	ID. NUMBER
06/30/12	B6EE	0001008

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 07/01/11

05/07/11

HOLY FAMILY MEDICAL CENTER
100 NORTH RIVER ROAD

DES PLAINES IL 60016 127E

FEE RECEIPT NO.

State of Illinois 2035973
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.

DANON T. ARNOLD, M.D.
DIRECTOR
Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRATION DATE	CATEGORY	ID. NUMBER
06/30/12	B6EE	0001008

FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 07/01/11

BUSINESS ADDRESS

HOLY FAMILY MEDICAL CENTER
100 NORTH RIVER ROAD

DES PLAINES IL 60016 127E

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AMERICAN OSTEOPATHIC ASSOCIATION

**BUREAU OF HEALTHCARE FACILITIES ACCREDITATION
HEALTHCARE FACILITIES ACCREDITATION PROGRAM**

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

January 7, 2011

John Baird
Chief Executive Officer
Holy Family Medical Center
100 North River Road
Des Plaines, IL 60016

Dear Mr Baird :

The American Osteopathic Association's Bureau of Healthcare Facilities Accreditation Executive Committee, at its meeting on January 4, 2011 reviewed the recertification survey report and found all Medicare conditions have been met. Your facility has been granted **Full Accreditation**, with resurvey within 3 years and AOA/HFAP **recommends continued deemed status**.

Holy Family Medical Center (All Sites as Listed)
100 North River Road
Des Plaines, IL 60016

Program: Acute Care Hospital
CCN # 140105
HFAP ID: 158128
Survey Dates: 08/23/2010 – 08/25/2010
Effective Date of Accreditation: 09/12/2010 - 09/12/2013

Condition Level Deficiencies: None
(Use crosswalk and CFR citations, if applicable):

No further action is required.

Sincerely,

George A. Reuther
Secretary

GAR/pmh

C: Laura Weber, Health Insurance Specialist, CMS
Region V, CMS

ATTACHMENT 11



State of Illinois 2009508
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.

DAMON T. ARNOLD, M.D.
DIRECTOR

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

EXPIRATION DATE 12/31/11	CATEGORY 6680	I.D. NUMBER 0002402
FULL LICENSE		
GENERAL HOSPITAL		
EFFECTIVE: 01/01/11		

BUSINESS ADDRESS

ST. FRANCIS HOSPITAL OF EVANSTON
 355 RIDGE AVENUE
 EVANSTON IL 60202

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DISPLAY THIS PART IN A
 CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN
 IDENTIFICATION

State of Illinois 2009508
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

ST. FRANCIS HOSPITAL OF EVANSTON

EXPIRATION DATE 12/31/11	CATEGORY 6680	I.D. NUMBER 0002402
FULL LICENSE		
GENERAL HOSPITAL		
EFFECTIVE: 01/01/11		

GENERAL HOSPITAL
 EFFECTIVE: 01/01/11

11/06/10
 ST. FRANCIS HOSPITAL OF EVANSTON
 355 RIDGE AVENUE
 EVANSTON IL 60202

FEE RECEIPT NO.



AMERICAN OSTEOPATHIC ASSOCIATION

BUREAU OF HEALTHCARE FACILITIES ACCREDITATION
HEALTHCARE FACILITIES ACCREDITATION PROGRAM

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

January 24, 2011

Jeffrey Murphy
Chief Executive Officer
Saint Francis Hospital
355 Ridge Avenue
Evanston, IL 60202

Dear Mr Murphy :

The American Osteopathic Association's Bureau of Healthcare Facilities Accreditation Executive Committee, at its meeting on January 18, 2011 reviewed the recertification survey report and found all Medicare conditions have been met. Your facility has been granted **Full Accreditation**, with resurvey within 3 years and AOA/HPAP **recommends continued deemed status**.

Saint Francis Hospital (All Sites as Listed)
355 Ridge Avenue
Evanston, IL 60202

Program: Acute Care Hospital
CCN # 140080
HFAP ID: 118676
Survey Dates: 10/4/2010 – 10/6/2010
Effective Date of Accreditation: 10/26/2010 - 10/26/2013

Condition Level Deficiencies: None
(Use crosswalk and CFR citations, if applicable):

No further action is required.

Sincerely,

George A. Reuther
Secretary

GAR/pmh

C: Laura Weber, Health Insurance Specialist, CMS
Region V, CMS



State of Illinois 2035984

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.

DAMON T. ARNOLD, M.D. DIRECTOR

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

EXPIRATION DATE	CATEGORY	I.D. NUMBER
06/30/12	DCBD	0001719

FULL LICENSE
 GENERAL HOSPITAL
 EFFECTIVE: 07/01/11

BUSINESS ADDRESS

OUR LADY OF THE RESURRECTION MEDICAL CTR
 5645 WEST ADDISON STREET
 CHICAGO IL 60634

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State of Illinois 2035984

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

OUR LADY OF THE RESURRECTION MEDICAL

EXPIRATION DATE	CATEGORY	I.D. NUMBER
06/30/12	DCBD	0001719

FULL LICENSE
 GENERAL HOSPITAL
 EFFECTIVE: 07/01/11

05/07/11

OUR LADY OF THE RESURRECTION MEDICAL
 5645 WEST ADDISON STREET
 CHICAGO IL 60634

FEE RECEIPT NO.



March 11, 2011

Betsy Pankau
Accreditation Coordinator
Our Lady of the Resurrection
5645 West Addison
Chicago, IL 60634

Dear Ms. Pankau:

This letter is to certify that Our Lady of the Resurrection Hospital in Chicago, IL is currently accredited by the Healthcare Facilities Accreditation Program (HFAP) of the American Osteopathic Association (AOA).

The hospital was surveyed for re-accreditation by HFAP on October 18-20, 2010. They are currently in process and have not yet received their Accreditation Letter or Certificate.

You may use a copy of this letter with external organizations to demonstrate your accreditation status. Questions about the HFAP may be directed to my attention via phone at 312-202-8060.

Sincerely,

A handwritten signature in cursive script that reads "Troy Ann Repuszka".

Troy Ann Repuszka, RN, BScN,
Deputy Director, HFAP



State of Illinois 2009538
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.

DAMON T. ARNOLD, M.D.
DIRECTOR

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

EXPIRATION DATE	CATEGORY	TX NUMBER
12/31/11	B6B0	0004861
FULL LICENSE		
GENERAL HOSPITAL		
EFFECTIVE: 01/01/11		

BUSINESS ADDRESS

**PROVENA HOSPITALS
 D/B/A COVENANT MEDICAL CENTER
 1400 WEST PARK AVENUE**

URBANA IL 61801

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Provena Covenant Medical Center

Urbana, IL

has been Accredited by



The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the
Hospital Accreditation Program

July 12, 2008

Accreditation is customarily valid for up to 39 months.

David L. Nahrwold, M.D.
Chairman of the Board

4968
Organization ID #

Mark Chassin, M.D.
President

The Joint Commission is an independent, not-for-profit, national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.





State of Illinois 2009537
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.

DANON, T. ARNOLD, M.D.
DIRECTOR

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

EXPIRATION DATE	CATEGORY	TX NUMBER
12/31/11	BGBD	0004853
FULL LICENSE		
GENERAL HOSPITAL		
EFFECTIVE: 01/01/11		

BUSINESS ADDRESS

PROENA HOSPITALS
D/B/A UNITED SAMARITAN MED CTR-LOGAN
812 NORTH EOGAN AVENUE

DANVILLE IL 61832

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Provena United Samaritans
Medical Center
Danville, IL
has been Accredited by



The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the
Hospital Accreditation Program

July 26, 2008

Accreditation is customarily valid for up to 39 months.

David L. Nahrwold

David L. Nahrwold, M.D.
Chairman of the Board

4928
Organization ID #

Mark Chassin

Mark Chassin, M.D.
President

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State of Illinois 2009536

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.

DARON T. ARNOLD, M.D.
DIRECTOR

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

Table with columns: EXPIRATION DATE (12/31/11), CATEGORY (B6BD), I.D. NUMBER (0004838), FULL LICENSE, GENERAL HOSPITAL, EFFECTIVE: 01/01/11

BUSINESS ADDRESS.

PROVENA HOSPITALS
D/B/A SAINT JOSEPH MEDICAL CENTER
333 NORTH MADISON STREET
JOLIET IL 60435

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2009536

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

PROVENA HOSPITALS

Table with columns: EXPIRATION DATE (12/31/11), CATEGORY (B6BD), I.D. NUMBER (0004838), FULL LICENSE, GENERAL HOSPITAL, EFFECTIVE: 01/01/11

EFFECTIVE: 01/01/11

11/06/10

PROVENA HOSPITALS
D/B/A SAINT JOSEPH MEDICAL CENTER
333 NORTH MADISON STREET
JOLIET IL 60435

FEE RECEIPT NO.



April 5, 2011

Jeffrey L. Brickman, M.B.A.
President and CEO
Provena Saint Joseph Medical Center
333 North Madison Street
Joliet, IL 60435

Joint Commission ID #: 7364
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of
Standards Compliance
Accreditation Activity Completed: 04/05/2011

Dear Mr. Brickman:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning January 29, 2011. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

Please visit [Quality Check®](#) on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Ann Scott Blouin, RN, Ph.D.
Executive Vice President
Accreditation and Certification Operations



State of Illinois 2009540
 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.

DAMON T. ARNOLD, M.D.
 DIRECTOR

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

EXPIRATION DATE 12/31/11	CATEGORY 86BD	ID NUMBER 0004887
FULL LICENSE		
GENERAL HOSPITAL		
EFFECTIVE: 01/01/11		

BUSINESS ADDRESS

PROVENA HOSPITALS
 D/B/A SAINT JOSEPH HOSPITAL
 77 NORTH AIRLITE STREET
 ELGIN IL 60123

The face of this license has a colored background. Printed by authority of the State of Illinois - 2467.

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REMOVE THIS CARD TO CARRY AS AN
 IDENTIFICATION

State of Illinois 2009540
 Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

DAMON T. ARNOLD, M.D.
 DIRECTOR

EXPIRATION DATE 12/31/11	CATEGORY 86BD	ID NUMBER 0004887
FULL LICENSE		
GENERAL HOSPITAL		
EFFECTIVE: 01/01/11		

BUSINESS ADDRESS

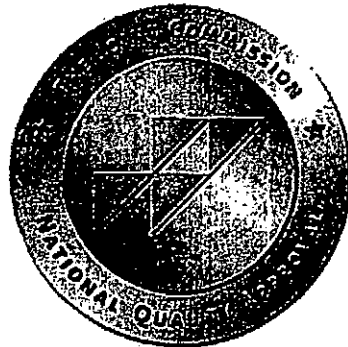
PROVENA HOSPITALS
 D/B/A SAINT JOSEPH HOSPITAL
 77 NORTH AIRLITE STREET
 ELGIN IL 60120

FEE RECEIPT NO.

Provena Saint Joseph Hospital

Elgin, IL

has been Accredited by



The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the
Hospital Accreditation Program

May 10, 2008

Accreditation is customarily valid for up to 39 months.

David L. Nahrwold

David L. Nahrwold, M.D.
Chairman of the Board

7338
Organization ID #

Mark Chassin

Mark Chassin, M.D.
President

The Joint Commission is an independent, not-for-profit, national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.





State of Illinois 2009541

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The Director of the Department of Public Health hereby certifies that the information on this license is true and correct and is hereby authorized to engage in the service of the State of Illinois.

DANON R. ARNOLD, M.D.

DIRECTOR

Board of Health
Department of Public Health

12/31/11

06800

0004903

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/11

BUSINESS ADDRESS

PROVENA MERCY CENTER

1325 NORTH HIGHLAND AVENUE

AURORA

IL 60506

This form of license is subject to the provisions of the Illinois License Act, Chapter 110, Section 1-1.1.

Display this part in a conspicuous place

REMOVE THIS CARD TO DISPLAY AS AN IDENTIFICATION

State of Illinois

2009541

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

PROVENA MERCY CENTER

12/31/11

06800

0004903

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/11

11/06/10

PROVENA HOSPITALS D/H/A MERCY CENTER FOR HEALTH CARE SERVICE 1325 NORTH HIGHLAND AVENUE AURORA IL 60506

FEE RECEIPT NO.



June 17, 2011

George Einhorn, RN
Interim CEO
Provena Mercy Medical Center
1325 North Highland Avenue
Aurora, IL 60506

Joint Commission ID #: 7240
Program: Behavioral Health Care Accreditation
Accreditation Activity: 60-day Evidence of
Standards Compliance
Accreditation Activity Completed: 06/16/2011

Dear Mr. Einhorn:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

Comprehensive Accreditation Manual for Behavioral Health Care

This accreditation cycle is effective beginning March 05, 2011. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

Please visit [Quality Check®](#) on The Joint Commission web site for updated information related to your accreditation decision.

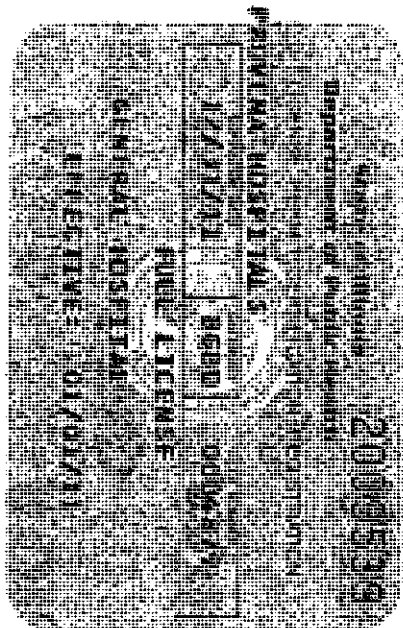
We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

A handwritten signature in black ink that reads "Ann Scott Blouin RN, Ph.D.".

Ann Scott Blouin, RN, Ph.D.
Executive Vice President
Accreditation and Certification Operations



← DISPLAY THIS PART IN A
CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN
IDENTIFICATION ←

11/06/10
 PROVENA HOSPITALS
 D/B/A SAINT MARY'S HOSPITAL
 500 WEST COURT STREET
 KANKAKEE IL 60901

FEE RECEIPT NO.



May 27, 2011

Michael Arno, MBA, MHA
President and CEO, Provena St. Mary's
Hospital.
Provena St. Mary's Hospital
500 West Court Street
Kankakee, IL 60901

Joint Commission ID #: 7367
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of
Standards Compliance
Accreditation Activity Completed: 05/27/2011

Dear Mr. Arno:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning April 02, 2011. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

Please visit [Quality Check@](#) on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Ann Scott Blouin, RN, Ph.D.
Executive Vice President
Accreditation and Certification Operations

DISPLAY THIS PART IN A CONSPICUOUS PLACE

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State of Illinois 2032822 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.

LAMON T. ARNOLD, M.D.
DIRECTOR
Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRATION DATE 04/30/12	CATEGORY EGSB	ID NUMBER 7003131
FULL LICENSE		
AMEUL SURGICAL TREAT CNTR		
EFFECTIVE: 05/01/11		

BUSINESS ADDRESS

BELMONT/HARLEM SURGERY CENTER, LLC
3101 NORTH HARLEM AVENUE
CHICAGO IL 60634

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State of Illinois 2032822
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

EXPIRATION DATE 04/30/12	CATEGORY EGSB	ID NUMBER 7003131
FULL LICENSE		
AMEUL SURGICAL TREAT CNTR		
EFFECTIVE: 05/01/11		

04/30/12

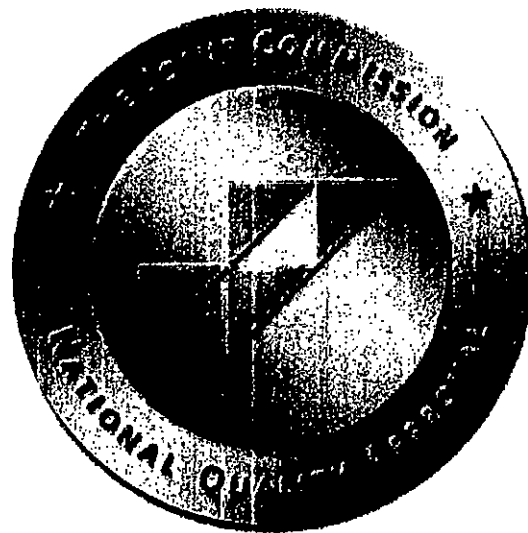
BELMONT/HARLEM SURGERY CENTER, LLC
3101 NORTH HARLEM AVENUE
CHICAGO IL 60634

FEE RECEIPT NO. 54561

elmont/Harlem Surgical Center, LLC

Chicago, IL

has been Accredited by



The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the
Ambulatory Health Care Accreditation Program

July 8, 2010

Accreditation is customarily valid for up to 39 months.

David L. Nahrwold

David L. Nahrwold, M.D.
Chairman of the Board

Organization ID #452703
Print/Reprint Date: 7/21/10

Mark Chassid

Mark Chassid, M.D.
President

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 11/14/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 99ES-63	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/15/2005
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MANTENO DIALYSIS CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 1 EAST DIVISION MANTENO, IL 60950
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

V 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 11384 A. Based on policy and procedure review, interview with hemodialysis staff members and review of patient records, Manteno Dialysis Centre located at 1 E. Division St., Manteno, IL has met the requirements at 42 CFR 405, Subpart U and is in compliance with the Conditions of Coverage for End Stage Renal Dialysis (ESRD) facilities in the State of IL, as of 11/15/05. No deficiencies were cited.</p> <p>11384</p>	V 000		
-------	--	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Josa Parkline RN</i>	TITLE CEO	(X6) DATE 11/14/05
--	---------------------	------------------------------

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

ATTACHMENT 11

PURPOSE OF PROJECT

The project addressed in this application is limited to a change of ownership as defined in the IHFSRB's rules, and does not propose any change to the services provided, including the number of beds provided at Provena United Samaritans Medical Center. The facility will continue operate as a general, acute care hospital. The hospital corporation will not change, and no change in the facility's IDPH license will be required.

The proposed change of ownership will result from the planned merger of the Provena and Resurrection systems, through the establishment of a not-for-profit, charitable "super parent" entity. This super parent will provide unified corporate oversight and system governance by serving as the corporate parent of Resurrection Health Care Corporation and Provena Health, each of which is the current parent entity of the Resurrection and Provena systems, respectively. The proposed merger—and the resultant deemed changes of ownership of the systems' facilities—will position Resurrection and Provena to strengthen access to Catholic health care, improve their long-term financial viability, enhance clinical capabilities, improve employee and medical staff satisfaction through a shared culture and integrated leadership, and position the unified system for innovation and adaptation under health care reform.

The table below identifies the hospital's inpatient origin for the 12-month period ending September 30, 2010; identifying each ZIP Code area that contributed a minimum of 1.0% of the hospital's admissions during that period.

ZIP Code	Community	Adm.	Cumulative	
			%	%
61832	Danville	3,502	55.5%	55.5%
61834	Danville	688	10.9%	66.3%
61883	Westville	339	5.4%	71.7%
61846	Georgetown	332	5.3%	77.0%
47932	Covington	180	2.9%	79.8%
61833	Tilton	174	2.8%	82.6%
61858	Oakwood	130	2.1%	84.6%
60942	Hoopeston	117	1.9%	86.5%
61924	Chrisman	102	1.6%	88.1%
61817	Catlin	94	1.5%	89.6%
61870	Ridge Farm	94	1.5%	91.1%
other ZIP Code areas contributing <1%		<u>563</u>	<u>8.9%</u>	100.0%
		6,315	100.0%	

As can be noted from the table above, eleven ZIP Code areas accounted for over 91% of the hospital's admissions. This analysis clearly demonstrates that Provena United Samaritans Medical Center provides services primarily to area residents.

The measurable goals resulting from the consolidating of the systems will be continually high patient satisfaction reports, strong utilization levels, and improved access to capital to ensure that the hospital's physical plant is well maintained and that needed equipment can be acquired. These goals will each be measurable within two years.

ALTERNATIVES

Section 1110.230(c) requests that an applicant document that the proposed project is the most effective or least costly alternative for meeting the health care needs of the population to be served.

This project is limited to a change of ownership resulting from the proposed merger of the Provena and Resurrection systems. As described elsewhere in this application, this is being implemented through the formation of a “super parent” entity that will create unified system oversight. This super parent structure will create a change in control, and under IHFSRB rules, a change of ownership of thirteen (13) hospitals, one (1) ambulatory surgical treatment center (ASTC), and one (1) end stage renal disease (ESRD) facility.

In order to best respond to Section 1110.230(c) given the nature of the project, technical assistance direction was sought from State Agency staff on February 22, 2010. Through the technical assistance process, the applicants were advised by State Agency staff that it would be appropriate to explain why this proposed system merger was the only alternative considered.

As explained in the Project Overview, Resurrection and Provena are committed to advancing the shared mission of the existing health systems in a manner that improves long-term financial viability, clinical integration and administrative efficiencies. For these two not-for-profit Catholic health systems, the merger of the systems is uniquely well-suited to meeting these mission, service delivery, and efficiency goals.

In very different circumstances, health systems might give serious consideration to an asset sale/acquisition in exchange for cash considerations, or to a corporate reorganization in which one party acquires and controls the other. Here, however, Provena and Resurrection have determined, through a process of discernment that involved both existing systems and the five (5) religious sponsors, that the systems should come together in a merger of equals transaction through a super parent structure, which will align corporate oversight, provide unified governance equally to entities currently in both systems, and avert the need for asset sale/acquisition. The System Merger Agreement has been submitted with this application.

IMPACT STATEMENT

The proposed change of ownership will have a significant positive broad-based and health care delivery impact on the communities historically served by Provena United Samaritans Medical Center. Consistent with IHFSRB rules, this impact statement covers the two-year period following the proposed change of ownership.

Reason for the Transaction

Through both discernment and due diligence processes, Provena Health (“Provena”) and its sponsoring congregations have concluded that its hospitals can better serve their patients and their communities if the Provena system were to merge with that of Resurrection Health Care Corporation (“Resurrection”). By doing so, Provena anticipates that it will be able to improve its administrative efficiencies and enhance its clinical integration efforts, consistent with its mission.

Anticipated Changes to the Number of Beds or Services Currently Offered

No changes are anticipated either to the number of beds (174) or to the scope of services currently provided at Provena United Samaritans Medical Center.

The current and proposed bed complement, consistent with Provena United Samaritans Medical Center’s 2009 IDPH Hospital Profile are:

- 134 medical/surgical beds
- 9 pediatrics beds
- 14 intensive care beds
- 17 obstetrics/gynecology beds

Among the other clinical services currently offered and proposed to continue to be provided are: surgery, nursery, clinical laboratory, pharmacy, diagnostic imaging, cardiac catheterization, GI lab, emergency department, outpatient clinics, and physical, occupational, and speech therapy.

Operating Entity

Upon the change of ownership, the operating entity/licensee will remain Provena United Samaritans Medical Center.

Additions or Reductions in Staff

No changes in clinical or non-system administrative staffing, aside from those routine changes typical of hospitals, are anticipated during the first two years following the proposed change of ownership. The applicants fully intend to offer all current hospital employees positions at compensation levels and employee benefits equivalent to their current position, compensation and benefits.

Cost/Benefit Analysis of the Transaction

1. Cost

The costs associated with the transaction are limited to those identified in Section I and discussed in ATTACHMENT 7, those being an apportionment of the transactional

costs, categorized as "Consulting and Other Fees". As required by the IHFSRB's rules, the value of the hospital is included in the project cost identified in Section I of this application document. However, that identified component of the "project cost" does not result in an expenditure by any applicant.

2. Benefit

The applicants believe that the community will benefit greatly from the change of ownership, primarily through the combined system's ability to operate more efficiently, improve clinical integration, and enhanced access to capital.

In 2009, the hospital admitted approximately 6,500 patients, provided approximately 87,400 outpatient visits, and treated nearly 38,000 patients in its emergency department.

It is the expectation of the applicants that, for a minimum of two years following the change of ownership, all programs and services currently provided by Provena United Samaritans Medical Center will continue to be provided, and consistent with IHFSRB requirements, access to the hospital's services will not be diminished. Assessments related to potential program expansion will commence shortly after the change of ownership/merger occurs.

Each of the hospitals included in the system merger will provide both charity care and services to Medicaid recipients. According to IDPH data, during 2009 the admission

of Medicaid recipients to Resurrection hospitals ranged between 8.6% and 65.2%, and for Provena hospitals ranged between 11.0% and 27.3%. The primary variable in these percentages is the geographic location of the individual hospitals. Over 20% of the patients admitted to five (5) of the thirteen (13) Resurrection and Provena hospitals in 2009 were Medicaid recipients.

Finally, with nearly 750 employees (FTEs), Provena United Samaritans Medical Center is a major area employer, and, as noted above, no changes in clinical or non-system administrative staffing, aside from those routine changes typical of hospitals, are anticipated during the first two years following the proposed change of ownership.

ACCESS

Access to the facilities addressed in the merger will not become more restrictive as a result of the merger; and letters affirming such from the Chief Executive Officers of Provena Health and Resurrection Health Care Corporation are attached.

Both Provena and Resurrection currently operate with system-wide charity care policies. Attached is the hospital's Patient and Visitor Non-Discrimination policy, and Provena's Provision of Financial Assistance policy, which applies across all of its hospitals. Provena and Resurrection intend to develop a new, consolidated charity care policy for the combined system hospitals, generally taking the best elements of each of the existing system policies. Provena and Resurrection representatives have offered to the Illinois Attorney General's office that this new charity care policy will be shared in draft form with the Attorney General's office, so that the Attorney general's office can provide input into the policy. That policy, as of the filing of this application, is being developed, and will be provided to State Agency staff when complete. Resurrection and Provena have committed to the State Agency to provide this policy to the State Agency prior to appearing before the State Board.

Provena United Samaritans Medical Center will, as is the case now, operate without any restrictive admissions policies, related to race, ethnic background, religion,

payment source, or any other factor. A copy of the hospital's policy addressing non-discrimination in its admissions practices is attached, and the policy will be retained following the system merger. The hospital will continue to admit Medicare and Medicaid recipients, as well as patients in need of charity care. In addition, no agreements with private third party payors currently in place at Provena United Samaritans Medical Center are anticipated to be discontinued as a result of the proposed change of ownership.



March 23, 2011


Illinois Health Facilities
and Services Review Board
Springfield, Illinois

To Whom It May Concern:

Please be advised that following the change of ownership of the hospitals and ESRD facility directly or indirectly owned or controlled by Provena Health, the admissions policies of those facilities will not become more restrictive.

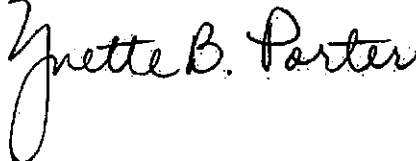
Provena and Resurrection, in consultation with the Illinois Attorney General's office, are currently revising the charity care policy to be used following the system merger. That revised policy will be provided to the State Agency upon completion.

Sincerely,


Guy Wiebking
President & CEO



Notarized:



7435 West Talcott Avenue
Chicago, Illinois 60631
773.792.5555



Sandra Bruce, FACHE
President & Chief Executive Officer

March 24, 2011

Illinois Health Facilities
and Services Review Board
Springfield, Illinois

To Whom It May Concern:

Please be advised that following the change of ownership of the hospitals and ASTC directly or indirectly owned or controlled by Resurrection Health Care Corporation, the admissions policies of those facilities will not become more restrictive.

Resurrection and Provena, in consultation with the Illinois Attorney General's office, are currently revising the charity care policy to be used following the system merger. That revised policy will be provided to the State Agency upon completion.

Sincerely,

A handwritten signature in cursive script that reads "Sandra Bruce".

Sandra Bruce, FACHE
President & CEO

Notarized:



CURRENT ADMISSIONS
and
CHARITY CARE POLICIES

Section: Administration

Policy Number: ADM -00270

Subject: Patient Nondiscrimination In Provision Of Services Page: 1 of 1

Executive Owner: President/CEO

Approval Date: 2/15/2011

Effective Date: 2/15/2011

Last Review:

Revised Date:


Supersedes: None

POLICY:

It is the policy and mission of Provena United Samaritans Medical Center to treat patients with the same respect and care regardless of that individual's:

- Race
- Color
- National origin
- Handicap
- Age
- Gender preference
- Life-style
- Religion
- Socio-economic status
- Payment Source.

In keeping with this policy clinical decisions for patient care are based solely on patient health care needs.



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ANESTHESIOLOGY (477-4794)
 CARDIOLOGY
 CHEST PHYSICIAN
 COLON RECTAL SURGERY
 DERMATOLOGY
 EYE SURGERY
 GASTROENTEROLOGY
 GYN SURGERY
 HEMATOLOGY
 HEPATOLOGY
 INFECTIOUS DISEASES
 INTERNAL MEDICINE
 NEPHROLOGY
 NEUROLOGY
 NEURO SURGERY
 OBSTETRICS/GYNECOLOGY
 ORTHOPEDICS
 PEDIATRICS
 PLASTIC SURGERY
 RADIOLOGY
 UROLOGY
 VASCULAR SURGERY

INTERNAL MEDICINE (477-4778)
 CHEST PHYSICIAN
 COLON RECTAL SURGERY
 DERMATOLOGY
 EYE SURGERY
 GASTROENTEROLOGY
 GYN SURGERY
 HEMATOLOGY
 HEPATOLOGY
 INFECTIOUS DISEASES
 INTERNAL MEDICINE
 NEPHROLOGY
 NEUROLOGY
 NEURO SURGERY
 OBSTETRICS/GYNECOLOGY
 ORTHOPEDICS
 PEDIATRICS
 PLASTIC SURGERY
 RADIOLOGY
 UROLOGY
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 NEPHROLOGY
 NEUROLOGY
 NEURO SURGERY
 OBSTETRICS/GYNECOLOGY
 ORTHOPEDICS
 PEDIATRICS
 PLASTIC SURGERY
 RADIOLOGY
 UROLOGY
 VASCULAR SURGERY

Urgent Care/Walk-In Clinic
 Hours: 8 am - 7 pm Mon-Fri, 8 am - 3 pm Sat. and Sun.
477-4707

Expanded Ambulatory Surgery Center
477-4778

**SHE'S NOT A FAILURE.
 SHE'S A FIVE
 TIME LEARNER.**

It takes most smokers several tries before they quit for good. And that's okay, because with each attempt, you learn something that brings you one step closer to success. Visit us online to see how we've helped more than a million people become ex-smokers.

AMERICAN LUNG ASSOCIATION
 We support the quitter in you.
quitterinyou.org

AMERICAN LUNG ASSOCIATION
 We support the quitter in you.
quitterinyou.org

ATTACHMENT 19B

Patient Information Guide

Building communities of healing & hope for more than a century.

PROVENA
 United Samaritans Medical Center

powerful healing.

www.provena.org/usmc | 217.443.5000

Mission, Vision, and Values

OUR MISSION

Provena Health, a Catholic health system, builds communities of healing and hope by compassionately responding to human need in the spirit of Jesus Christ.

OUR VISION

Provena Health providers are known for clinical and service excellence, and are the preferred choice based on responsiveness to community needs, quality, value, and innovation.

OUR VALUES

Building on the faith and heritage of our founding religious congregations, we commit ourselves to these values that flow from our mission and our identity as a Catholic healthcare ministry.

Respect — We affirm the individuality of each person through fairness, dignity, and compassion.

Integrity — We demonstrate the courage to speak and act honestly to build trust.

Stewardship — We use our human and economic resources responsibly, with a special concern for the poor and vulnerable.

Excellence — We achieve exceptional performance through continuous growth and development.

Patient Bill of Rights

It is your right as a patient to:

1. Be treated with courtesy, respect, consideration, and dignity by those who provide health care services to you.
2. Be given appropriate and professional quality health care services without discrimination against your race, creed, color, religion, gender, national origin, disability, or age.
3. Be given proper identification by name and title of everyone who provides health care services to you.
4. Expect that the Medical Center will make reasonable efforts to obtain an interpreter if you do not speak English.
5. Expect that the Medical Center will make reasonable attempts to obtain an interpreter if you are hearing impaired.
6. Be given access to the Medical Center's professional clinical pastoral care services to assess and meet spiritual needs regardless of religious persuasion.
7. Be given adequate and appropriate information so you will be able to give informed consent for your treatment prior to the start of any non-emergent treatment.
8. Be given adequate and appropriate information concerning your non-emergency current diagnosis, treatment, alternatives, risks and prognosis as required by your physician's legal duty to disclose, in terms of language you can reasonably be expected to understand.
9. Be given access to the Medical Center Ethics Committee and/or members when you or a legally designated surrogate decision maker encounter ethical concerns related to a medical issue and a report of the results of your inquiry. You may access the Ethics Committee by calling Extension 5125.
10. Access protective services for yourself or at the bequest of a legally designated decision maker. You may access these services by calling Extension 5125 or by asking your nurse or physician to do so.
11. Be given sufficient information to formulate advance directives and/or appoint a surrogate to make health care decisions for you to the extent permitted by law.

12. Refuse treatment to the extent permitted by law and the Medical Center's Mission and Philosophy. Be given information concerning the consequences of refusing treatment or not complying with therapy.
13. Be given information about your rights and responsibilities for receiving healthcare services. Be given information of the health care provider policies and procedures, charges for services, and your eligibility for third party reimbursement.
14. Voice grievance with and/or suggest change in healthcare services and/or staff without being threatened, restrained, or discriminated against.
15. Be advised if the Medical Center proposes that you voluntarily engage in or perform human experimentation or other research/educational projects affecting your care or treatment.
16. Receive personal and privacy information, within the law:
 - Refuse to talk with or to see anyone not officially connected with the medical center;
 - Wear appropriate personal clothing and religious or other symbolic items as long as it does not interfere with procedures or treatment;
 - Be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy;
 - Expect that any discussion or consultation involving your care will be conducted discreetly and that individuals not directly involved in your care will not be present without your permission;
 - Have your medical records read only by yourself and/or individuals directly involved in the treatment or in the monitoring of its quality, or by others with your written authorization;
 - Expect that all communications and other records pertaining to your care are to be treated as confidential.
 - Be placed in protective privacy when it is considered necessary for personal safety or that of others.
17. Receive a reasonable response to your request for services.
18. Receive evaluation, service, and/or referral as indicated by the urgency of your case.
19. Be transferred when medically permissible to another facility only after you have received complete information and explanation concerning the reasons for and alternatives to such a transfer, provided that the health service to which you will be transferred first accepted you as a patient for transfer.

20. Be given appropriate instruction or education from health care personnel as needed.
21. Be an active participant in the development and evaluation of your continuous healthcare plan.
22. Expect that the Medical Center will provide a mechanism whereby you are informed by your physician or delegate of your continuing health care requirements following discharge.
23. Have a copy of your complete medical record available to you or your delegate within a reasonable period of time from discharge in non-emergent cases.
24. The patient has the right to be free of any form of patient abuse, neglect, harassment and inappropriate behavior.

It is your responsibility as a patient to:

1. Treat all who provide health care services to you, as well as other patients and visitors, with courtesy, respect, consideration, and dignity.
2. Give accurate and complete information concerning your past illnesses, hospitalization, medications, allergies, and other pertinent information.
3. Request further information concerning anything you do not understand.
4. Give information regarding concerns and problems you have to a health care provider staff member.
5. Assist in maintaining an environment conducive to healing.
6. Participate in your own health care by following instructions and medical advice. Inform your health care provider when you are not able to keep your health care visit.
7. Cooperate and assist in making discharge plans in a responsible and timely manner.
8. Arrange for timely payment for services rendered.

SYSTEM POLICY

Section: Finance
Patient Financial Services

Policy Number: 5.1

Subject: Provision for Financial Assistance – Provena Hospitals

Page: 1 of 10

Executive Owner: System Senior VP, Chief Financial Officer

Approval Date: 05/01/06

Effective Date: 02/2011

Last Review Date: 1/17/11

Revised Date: 1/17/11

Supersedes: 8/4/10

POLICY

In order to promote the health and well-being of the community served, individuals who have no health insurance, with limited financial resources, and who are unable to access entitlement programs shall be eligible for free or discounted health care services based on established criteria for hospital charges. Eligibility criteria will be based upon the Federal Poverty guidelines, family size and medical expense. Provena Health is committed to:

- Communicating to patients so they can more fully and freely participate in providing the needed information without fear of losing basic assets and income;
- Assessing the patients' capacity to pay and reach payment arrangements that do not jeopardize the patients' health and basic living arrangements or undermine their capacity for self-sufficiency;
- Upholding and honoring patients' rights to appeal decisions and seek reconsideration, and to have a self-selected advocate to assist the patient throughout the process;
- Avoid seeking or demanding payment from or seizing exempt income or assets; and
- Providing options for payment arrangements, without requiring that the patient select higher cost options for repayment.

PURPOSE

Our Mission and Values call us to serve those in need and maintain fiscal viability. Provena Health has a long tradition of serving the poor, the needy, and all who require health care services. However, our Ministries alone cannot meet every community need. They can practice effective stewardship of resources in order to continue providing accessible and effective health care services. In keeping with effective stewardship, provision for financial assistance will be budgeted annually. Our Hospital Ministries will follow the Illinois Hospital Uninsured Patient Discount Act and the Illinois Fair Patient Billing Act.

PROVENA HEALTH**SYSTEM POLICY****Section:** Finance - PFS**Policy #:** 5.1**Subject:** Provision for Financial Assistance**Page:** 2 of 10

We also continue to play a leadership role in the community by helping to promote community-wide responses to patient needs, in partnership with government and private organizations.

This policy identifies circumstances when the ministry or related joint venture may provide care without charge or at a discount commensurate with the ability to pay, for a patient whose financial status makes it impractical or impossible to pay for medically necessary services. This policy applies only to hospital ministry charges and not independent physicians or independent company billings. The provision of free and discounted care through our Financial Assistance program is consistent, appropriate and essential to the execution of our mission, vision and values, and is consistent with our tax-exempt, charitable status.

Resources are limited and it is necessary to set limits and guidelines. These limits are not designed to turn away or discourage those in need from seeking treatment. They are in place to assure that the resources the ministry can afford to devote to its patients are focused on those who are most in need and least able to pay, rather than those who choose not to pay. Financial assessments and the review of patients' financial information are intended for the purpose of assessing need as well as gaining a holistic view of the patients' circumstances.

SPECIAL INSTRUCTIONS/ DEFINITIONS**I. Definitions**

- A. Assets:** Provena Health may use assets in the determination of the 25% maximum collectible amount in 12-month period. Assets will not be used for initial financial assistance eligibility. Patient may be excluded if patient has substantial assets (defined as a value in excess of 600% Federal Poverty Level – attachment I) Certain assets will not be considered: the uninsured patient's primary residence; personal property exempt from judgment under Section 12-1001 of the Code of Civil Procedure; or any amounts held in a pension or retirement plan. Distributions and payments from pension or retirement plans may be included as income. Acceptable documentation of assets include: statements from financial institutions or some other third party verification of an asset's value. If no other third party exists the patient shall certify as to the estimated value of the asset.
- B. Charity Care:** Health care services that were never expected to result in cash. Charity care results from providing health care services free or at a discount to individuals who do not have the ability to pay based upon income and family size compared to established federal poverty guidelines.
- C. Financial Assistance Committee:** A group of people consisting of local ministry staff and leadership that meets monthly to review requests for financial assistance. The committee will consist of the Chief Executive Officer, Chief Financial Officer, VP Mission Services, Revenue Integrity Director (or designee), Risk Manager, Director of Case/Care Management, Patient Financial Counselor/Customer Service Representative/Collection Manager and the Director of Pastoral Care or a similar mix of individuals for ministries associated with Provena Health.

PROVENA HEALTH**SYSTEM POLICY****Section:** Finance - PFS**Policy #:** 5.1**Subject:** Provision for Financial Assistance**Page:** 3 of 10

D. Family: The patient, his/her spouse (including a legal common law spouse) and his/her legal dependents according to the Internal Revenue Service rules. Therefore, if the patient claims someone as a dependent on his/her income tax return, they may be considered a dependent for purposes of the provision of financial assistance.

E. Family Income: the sum of a family's annual earnings and cash benefits from all sources before taxes, less payment made for child support. Examples include but are not limited to: Gross wages, salaries, dividends, interest, Social Security benefits, workers compensation, training stipends, regular support from family members not living in the household, government pensions, private pensions, insurance and annuity payments, income from rents, royalties, estates and trusts.

F. Uninsured patient: is a patient of a hospital and is not covered under a policy of health insurance and is not a beneficiary under a public or private health insurance, health benefit, or other health coverage program, including high deductible health insurance plans, workers' compensation, accident liability insurance, or other third party liability.

G. Illinois resident: a person who currently lives in Illinois and who intends to remain living in Illinois indefinitely. Relocation to Illinois for the sole purpose of receiving health care benefits does not satisfy the residency requirement. Acceptable verification of Illinois residency shall include any one of the following:

1. Any of the documents listed in Paragraph (J);
2. A valid state-issued identification card;
3. A recent residential utility bill;
4. A lease agreement;
5. A vehicle registration card;
6. A voter registration card;
7. Mail addressed to the uninsured patient at an Illinois address from a government or other credible source;
8. A statement from a family member of the uninsured patient who resides at the same address and presents verification of residency; or
9. A letter from a homeless shelter, transitional house or other similar facility verifying that the uninsured patient resides at the facility.

All non-IL resident applications will be reviewed by the ministry Financial Assistance Committee. (See Financial Assistance Committee definition.)

H. Income Documentation: Acceptable family income documentation shall include one (1) of the following:

1. a copy of the most recent tax return;
2. a copy of the most recent W-2 form and 1099 forms;
3. copies of the 2 most recent pay stubs;
4. written income verification from an employer if paid in cash; or
5. one other reasonable form of third party income verification deemed acceptable to the hospital.

PROVENA HEALTH**SYSTEM POLICY****Section:** Finance - PFS**Policy #:** 5.1**Subject:** Provision for Financial Assistance**Page:** 4 of 10

- I. Catastrophic Discount:** a discount provided when the patient responsibility payments specific to medical care at Provena Health Hospitals, even after payment by third-party payers, exceed 25% of the patient's family annual gross income. Any patient responsibility in excess of the 25% will be written off to charity.
- J. Medically Necessary Service:** any inpatient or outpatient hospital service, including pharmaceuticals or supplies provided by a hospital to a patient, covered under Title XVIII of the federal Social Security Act for beneficiaries with the same clinical presentation as the uninsured patient. A "medically necessary" service does not include any of the following:
1. Non-medical services such as social and vocational services.
 2. Elective cosmetic surgery, but not plastic surgery designed to correct disfigurement caused by injury, illness, or congenital defect or deformity.
 3. Services deemed not necessary by the patient's insurance provider.

II. Financial Assistance Guidelines and Eligibility Criteria (see Attachment #1)

- A. Patient must be uninsured and meet the eligibility criteria noted below or meet the definition for the Catastrophic Discount.

Eligibility Criteria	
Percentage of Poverty Guidelines	Discount Percentage
Up to 200%	100%
201 - 300%	90%
301 - 400%	80%
401 - 500%	75%
501 - 600%	Approx. 72% (calculation based on IL Hospital uninsured discount Act)

- B. All patients will be treated with respect and fairness regardless of their ability to pay.
- C. The Eligibility Criteria discount percentage will be updated annually based on the calculation set forth by the Illinois Uninsured Patient Discount Act. The Federal Poverty Guideline calculations will also be updated annually in conjunction with the published updates by the United States Department of Health and Human Services.
- D. Individuals who are deemed eligible by the State of Illinois to receive assistance under the Violent Crime Victims Compensation Act or the Sexual Assault Victims Compensation Act shall be deemed eligible for financial assistance at a level to be determined on a case-by-case basis by the Financial Assistance Committee.
- E. A financial assistance application will not need to be repeated for dates of services incurred up to six (6) months after the date of application approval. Once financial assistance eligibility has been granted, all open accounts from 12 months before the date of approval are grandfathered in as financial assistance.
- F. A patient may apply for financial assistance at any time during the revenue cycle process.

Section: Finance - PFS**Policy #:** 5.1**Subject:** Provision for Financial Assistance**Page:** 5 of 10

- G. After the financial assistance adjustment has been computed, the remaining balances will be treated in accordance with Patient Financial Services policies regarding payment arrangements. If a patient is unable to meet the payment arrangement guidelines, the Revenue Cycle Representative (or designee) may review and recommend additional financial assistance to the ministry Financial Assistance Committee.

III. Presumptive Financial Assistance Eligibility

- A. Presumptive eligibility may be determined on the basis of individual life circumstances. In these situations, a patient is deemed to be eligible for a 100 percent reduction from charges (i.e. full write-off). A patient is presumed to be eligible and therefore does not need to complete a financial assistance application if they meet one of the following criteria:
1. Participation in state funded prescription programs.
 2. Participation in Women's Infants, and Children's Programs (WIC)
 3. Food stamp eligibility
 4. Subsidized school lunch program eligibility.
 5. Eligibility for other state or local assistance program that is unfunded.
 6. Low income/subsidized housing is provided as a valid address
 7. Patient is deceased with no known estate.
 8. Patient receiving free care from a community clinic and the community clinic refers the patient to the ministry for treatment or for a procedure.
 9. Patient states that he/she is homeless. The due diligence efforts are to be documented.
 10. Patient is mentally or physically incapacitated and has no one to act on his/her behalf.
 11. Patient is currently eligible for Medicaid, but was not eligible on a prior date of service, instead of making the patient duplicate the required paperwork; the ministry will rely on the financial assistance determination process from Medicaid.
 12. Patient receives a MANG denial due to asset availability.
- B. When a patient does not complete an application and there is adequate information to support the patient's inability to pay these cases will be submitted to the ministry's Financial Assistance Committee for approval. If approved, 100% write off to financial assistance will be granted for all open accounts from 12 months before the date of approval. Assistance will not be granted for future dates of service.

Section: Finance - PFS**Policy #:** 5.1**Subject:** Provision for Financial Assistance**Page:** 6 of 10**PROCEDURE****I. Identification of Potentially Eligible Patients**

- A. Where possible, prior to the admission or pre-registration of the patient, the ministry will conduct a pre-admission/pre-registration interview with the patient, the guarantor, and/or his/her legal representative. If a pre-admission/pre-registration interview is not possible, this interview should be conducted upon admission or registration or as soon as possible thereafter. In case of an emergency admission, the ministry's evaluation of payment alternatives should not take place until the required medical screening has been provided. At the time of the initial patient interview, the following information should be gathered:
 - 1. Routine and comprehensive demographic data and employment information.
 - 2. Complete information regarding all existing third party coverage.
- B. Those patients who may qualify for financial assistance from a governmental program should be referred to the appropriate program, such as Medicaid, prior to consideration for financial assistance.
- C. Prior to an account being authorized for the filing of suit, a final review of the account will be conducted and approved by the Revenue Cycle Representative (or designee) to make sure that no application of financial assistance was ever received. Prior to a summons being filed, the Chief Financial Officer's (CFO) approval is required. Provena Health Ministries will not request nor support the use of body attachments from the court system for payment of an outstanding account; however, it is recognized that the court system may take this action independently.

II. Determination of Eligibility

- A. All patients identified as potential financial assistance recipients should be offered the opportunity to apply for financial assistance. If this evaluation is not conducted until after the patient leaves the ministry, or in the case of outpatients or emergency services, a Patient Financial Services representative will mail a financial assistance application to the patient for completion upon request. In addition, whenever possible, patient billing and collection communications will inform patients of the availability of financial assistance with appropriate contact information. When no representative of the patient is available, the ministry should take the required action to have a legal guardian/trustee appointed or to act on behalf of the patient.
- B. Patients are responsible for completing the required application forms and cooperating with the information gathering and assessment process, in order to determine eligibility for financial assistance. (See Special Instructions, III Presumptive Eligibility for exceptions).

PROVENA HEALTH**SYSTEM POLICY****Section:** Finance - PFS**Policy #:** 5.1**Subject:** Provision for Financial Assistance**Page:** 7 of 10

- C. In the evaluation of an application for financial assistance, a patient's family size, income and medical expenses will be determining factors for eligibility and discount.
- D. The Catastrophic Discount will be available to patients who have medical expenses from a Provena Health Hospital that exceed 25% of the patient's family annual gross income, even after payment by third-party payers. Any patient responsibility in excess of the 25% will be written off to charity. Services that are determined not medically necessary by a third-party payer will not be eligible for this discount.
- E. The Financial Assistance Committee will consider patient accounts on a case-by-case basis that are exceptions to the eligibility criteria. The Committee has the authority to approve/reject any ministry specific exceptions to the Provision for Financial Assistance policy based on unusual or uncommon circumstances. This includes the review of all non-IL resident applications. All decisions, whether approved or rejected, must have the rationale clearly and formally documented by the committee and maintained in the account file.

III. Notification of Eligibility Determination

- A. Clear guidelines as to the length of time required to review the application and provide a decision to the patient should be provided at the time of application. A prompt turn-around and written decision, which provides a reason(s) for denial (if appropriate) will be provided, generally within 45 days of the ministry's Financial Assistance Committee's decision after reviewing a completed application. Patients will be notified in the denial letter that they may appeal this decision and will be provided contact information to do so.
- B. If a patient disagrees with the decision, the patient may request an appeal process in writing within 45 days of the denial. The ministry's Financial Assistance Committee will review the application. Decisions reached will normally be communicated to the patient within 45 days, and reflect the Committee's final and executive review.
- C. Collection activity will be suspended during the consideration of a completed financial assistance application or an application for any other healthcare bracket (i.e., Medicare, or Medicaid, etc.). A note will be entered into the patient's account to suspend collection activity until the financial assistance process is completed. If the account has been placed with a collection agency, the agency will be notified by telephone to suspend collection efforts until a determination is made. This notification will be documented in the account notes. The patient will also be notified verbally that the collection activity will be suspended during consideration. If a financial assistance determination allows for a percent reduction but leaves the patient with a self-pay balance, payment terms will be established on the basis of disposable income.

Section: Finance - PFS**Policy #:** 5.1**Subject:** Provision for Financial Assistance**Page:** 8 of 10

- D. If a determination is made that the patient has the ability to pay all or a portion of a bill, such a determination does not prevent a reassessment of the person's ability to pay at a later date.
- E. Refunding Patient Payments – No refunds will be given for payments made prior to the financial assistance approval date.
- F. If the patient has a change in his/her financial status, the patient should promptly notify the Central Billing Office (CBO) or ministry designee. The patient may request and apply for financial assistance or a change in their payment plan terms.

IV. Patient Awareness of Policy

A. Signage

Signage will be visible in all ministries at points of registration in order to create awareness of the financial assistance program. At a minimum, signage will be posted in all patient intake areas, including, but not limited to, the emergency department, and the admission/patient registration area. All public information and/or forms regarding the provision of financial assistance will use languages that are appropriate for the ministry's service area in accordance with the state's Language Assistance Services Act. This policy will be translated to and made available in Spanish.

B. Hospital Bill

Each invoice or other summary of charges to an uninsured patient shall include with it, or on it, a prominent statement that an uninsured patient who meets certain income requirements may qualify for an uninsured discount and information regarding how an uninsured patient may apply for consideration under the hospital's financial assistance policy.

C. Policy

Every ministry, upon request, must provide any member of the public or state governmental entity a copy of its financial assistance policy. This policy will also be available on the Provena Health Website.

D. Application Form

Each ministry must make available the application used to determine a patient's eligibility for financial assistance.

Section: Finance - PFS**Policy #:** 5.1**Subject:** Provision for Financial Assistance**Page:** 9 of 10**V. Monitoring and Reporting**

1. A financial assistance log from which periodic reports can be developed shall be maintained aside from any other required financial statements.
2. Financial assistance logs will be maintained for a period of ten (10) years. At a minimum, the financial assistance logs are to include:
 - a. Account number
 - b. Date of Service
 - c. Application mailed (y / n)
 - d. Application returned and complete (y/n).
 - e. Total charges
 - f. Self-pay balances
 - g. Amount of financial assistance approved
 - h. Date financial assistance was approved/rejected
3. The financial assistance log will be printed monthly for review at the ministry Financial Assistance Committee meeting.
 - a. The financial assistance log must be signed and dated by the ministry CFO.
 - b. Financial Assistance meeting minutes must be signed by the ministry CFO.
4. The ministry's Collection Manager / Patient Financial Services Representative will approval financial assistance for amounts up to \$1,000. Amounts greater than \$1,000 but lower than \$5,000 will be approved by the ministry's Revenue Cycle Representative, those greater than \$5,000 will be approved by the ministry's CFO.
5. A record, paper or electronic, should be maintained reflecting authorization of financial assistance. These documents shall be kept for a period of ten (10) years.
6. The cost of financial assistance will be reported annually in the Community Benefit Report to the Community, IRS 990 schedule H and in compliance with the IL Community Benefit Act. Charity Care will be reported as the cost of care provided (not charges) using the documented criteria for the reporting requirement.

PROVENA HEALTH**SYSTEM POLICY****Section:** Finance - PFS**Policy #:** 5.1**Subject:** Provision for Financial Assistance**Page:** 10 of 10**ATTACHMENTS**

Eligibility Criteria for the Provena Health Financial Assistance Program – Attachment # 1

Hospital Financial Assistance Program Cover Letter and Application – Attachment # 2

Room and Board Statement – Attachment #3

REFERENCES

Section 12-1001 Code Civil Procedure

Title XVIII Federal Social Security Act

Illinois Uninsured Patient Discount Act

Illinois Fair Patient Billing Act

Violent Crime Victims Compensation Act

Sexual Crime Victims Compensation Act

Women's, Infant, Children Program (WIC)

IL Community Benefit Act

Internal Revenue Service (IRS) 990 Schedule

Ethical and Religious Directives, Part 1

Provena Health System Policy – Payment Arrangements

**ELIGIBILITY CRITERIA FOR THE
PROVENA HEALTH FINANCIAL ASSISTANCE PROGRAM**

The table below is based upon 2009 Federal Poverty Guidelines.

Family Size	2009 Federal Poverty Guidelines	200%	600%
1	\$10,830	\$21,660	\$64,980
2	\$14,570	\$29,140	\$87,420
3	\$18,310	\$36,620	\$109,860
4	\$22,050	\$44,100	\$132,300
5	\$25,790	\$51,580	\$154,740
6	\$29,530	\$59,060	\$177,180
7	\$33,270	\$66,540	\$199,620
8	\$37,010	\$74,020	\$222,060
9	\$40,750	\$81,500	\$244,500
10	\$44,490	\$88,980	\$266,940

CALCULATION PROCESS

The matrix below is to be utilized for determining the level of assistance for patients who are uninsured.

1. Patients who are uninsured **and at or below the 200% guideline** will receive a full write-off of charges.
2. For uninsured patients who **exceed the 200% guideline, but have income less than the 600% guideline**, a sliding scale will be used to determine the percent reduction of charges that will apply. The matrix for deductions is below:

DISCOUNT MATRIX	
Percentage of Poverty Guidelines	Discount Percentage
Up to 200%	100%
201 - 300%	90%
301 - 400%	80%
401 - 500%	75%
501 - 600%	Approx. 72% (calculation based on IL Hospital uninsured discount Act)



HOSPITAL FINANCIAL ASSISTANCE APPLICATION COVER LETTER

Provena Health offers a variety of financial assistance programs to meet the needs of our patients. Our programs apply only to Provena hospital charges. Please be aware you will receive a separate bill from each independent practitioner, or groups of practitioners, for care, treatment, or services provided. The Provena Health Financial Assistance Program does not apply to these charges.

In addition to the Provena Health Financial Assistance Programs, you may also be eligible for public programs such as Medicaid, Medicare or AllKids. Applying for such programs may be required prior to applying for a Provena Health Financial Assistance Program. Provena will assist patients with state funded public programs and the enrollment process.

The Provena Health Financial Assistance Programs include:

Program	Available to	Description	How to Apply
Uninsured Financial Assistance	Uninsured Patients	Offers free care or discounted care based on family size and income according to the Federal Poverty Guidelines	Complete the Financial Assistance Program Application
Self-Pay Discount	Uninsured Patients	Offers an automatic 20% discount	No application necessary
Catastrophic Discount	Uninsured and Insured Patients	Limits the out-of-pocket costs when medical debts specific to medical care at Provena Health Hospitals exceed 25% of the patient's family gross income	Determine if your out-of-pocket expenses exceed 25% of family gross income. If so, complete the Financial Assistance Program Application
Payment Plan Program	Uninsured and Insured Patients	Assists patients with their financial obligations by establishing payment arrangements	Contact a Financial Counselor * or the Central Billing Office at 888-740-4111 if you have already received a statement

To help us determine if you are qualified to receive financial assistance, please complete, sign and return the enclosed application along with copies of the following applicable documents:

- Federal Income Tax Return - *preferred* (or)
2 most recent paycheck stubs or other proof of income
- Driver's License or State-issued ID

If applicable, please submit the following:

- Social Security Award Letter
- Room and Board Statement (if no income) available at www.provena.org/financialassistance
- Financial Award Letter(s) for any student loans or grants
- Unemployment Compensation Benefit Award Letter

Return completed form and supporting documents to:

Provena Health
Central Billing Office
1000 Remington Blvd., Suite 110
Bolingbrook, IL 60440

We will respond to you within 45 days of receiving the completed application and supporting documents. If you have any questions or need additional assistance, please contact us at 888-740-4111 or www.Provena.org/FinancialAssistance to obtain additional information on the Provena Health Financial Assistance Programs.

HEALTH CARE SYSTEM

The proposed change of ownership will not restrict the use of other area facilities, nor will it have an impact on other area providers. For purposes of this section, health care system refers to the combined Resurrection and Provena systems.

Impact of the Proposed Transaction on Other Area Providers

Following the change of ownership, Provena United Samaritans Medical Center will continue to operate with an “open” Medical Staff model, meaning that qualified physicians both can apply for admitting privileges at the hospital, and admit patients to the hospital on a voluntary basis—the physicians will not be required to admit only to Provena United Samaritans Medical Center. In addition, the hospital’s Emergency Department will maintain its current designated level, that being “comprehensive”. As a result, ambulance and paramedic transport patterns will not be altered because of the change of ownership. Last, because the admissions policies of the hospital will not be changed to become more restrictive (please see ATTACHMENT 19B), patients will not be “deflected” from Provena United Samaritans Medical Center to other area facilities as a result of the change of ownership.

Other Facilities Within the Acquiring Co-Applicants' Health Care System

Upon the completion of the merger, twelve other hospitals will be in the new Health Care System. All of those hospitals, with the exception of Holy Family Medical Center, which operates as a Long-Term Acute Care Hospital (LTACH), operate as general acute care hospitals. The table below identifies the distance and driving time (MapQuest, unadjusted) from Provena United Samaritans Medical Center to each of the other hospitals in the Health Care System.

Proximity of Provena United Samaritans Med. Ctr (812 North Logan Street Danville) to:				
			Miles	Minutes
Saint Francis Hospital	355 Ridge Avenue	Evanston	153.7	192
Provena United Samaritans Medical Center	7435 W. Talcott Avenue	Chicago	182.2	192
Saint Mary of Nazareth Hospital and St. Elizabeth's Med. Ctr.	2233 W. Division Street	Chicago	140.6	172
Saint Joseph Hospital	2900 N. Lake Shore Drive	Chicago	174.6	186
Our Lady Resurrection Med. Ctr.	5645 West Addison St.	Chicago	178.5	191
Holy Family Medical Center	100 North River Road	Des Plaines	188.7	201
Provena Covenant Medical Center	1400 West Park Avenue	Urbana	32.6	37
Provena Mercy Medical Center	1325 N. Highland Avenue	Aurora	159.2	191
Provena Saint Joseph Hospital	77 North Airlite Street	Elgin	176.7	212
Provena Saint Joseph Medical Ctr.	333 North Madison Street	Joliet	150.9	163
Provena St. Mary's Hospital	500 West Court Street	Kankakee	86.8	109

Source: MapQuest, 02/22/2011

Consistent with a technical assistance conference held with IHFSRB Staff on February 14, 2011, historical utilization of the other facilities in the Health Care System is provided in the form of 2009 IDPH *Profiles* for those individual facilities, and those documents are attached.

Referral Agreements

Copies of Provena United Samaritans Medical Center's current referral agreements related to IDPH "categories of service" not provided directly by the hospital are attached. It is the intent of the applicants to retain all of Provena United Samaritans Medical Center's referral agreements, and each provider with which a referral agreement exists will be notified of the change of ownership. Each of the existing referral agreements will continue in their current form until those agreements are revised and/or supplemented, if and as necessary. That revision process is anticipated to take 6-12 months from the date of the change of ownership.

The table below identifies the driving time and distance between Provena United Samaritans Medical Center and each hospital with which PUSMC maintains a referral agreement.

Referral Site	Service	Miles*	Minutes*
St. John's Hospital 800 E. Carpenter Street Springfield	perinatal	119.8	123
Provena Covenant Medical Center 1400 West Park St. Urbana	general	32.6	37
University of Chicago Hospitals 5841 S. Maryland Ave. Chicago	perinatal	163.1	170

*MapQuest (unadjusted) March 3, 2011

Duplication of Services

As certified in this application, the applicants fully intend to retain Provena United Samaritans Medical Center's clinical programmatic complement for a minimum

of two years. An initial evaluation of the clinical services provided by Provena United Samaritans Medical Center would suggest that the hospital provides few, if any, clinical services not typically provided by general acute care hospitals. In addition, and as can be seen from the proximity data provided in the table above, the hospitals in the Health Care System do not have service areas that overlap.

Availability of Services to the Community

The proposed merger will, because of the strength of the newly-created system, allow for the development of important operations-based services that are not currently available. Examples of these new programs, which will benefit the community, and particularly the patient community are an electronic medical records (EMR) vehicle anticipated to be implemented system-wide, enhanced physician practice-hospital integration, more efficient equipment planning, replacement and procurement systems, and expanded material management programs; all of which will benefit the community through the resultant efficiencies in the delivery of patient care services.

In addition, Provena United Samaritans Medical Center is a primary provider of both hospital- and community-based health care programs in its community, and it is the intent of the applicants to provide a very similar community-based program complement, understanding that in the case of all hospitals, the complement of community programs is not static, and that from time-to-time programs are added or eliminated.

Ownership, Management and General Information

ADMINISTRATOR NAME: Sister Donna Marie C.R.
 ADMINSTRATOR PHONE 773-792-5153
 OWNERSHIP: Resurrection Medical Center
 OPERATOR: Resurrection Medical Center
 MANAGEMENT: Not for Profit Corporation
 CERTIFICATION: None
 FACILITY DESIGNATION: General Hospital
 ADDRESS 7435 West Talcott Avenue

Patients by Race

White 90.7%
 Black 1.7%
 American Indian 0.0%
 Asian 1.7%
 Hawaiian/ Pacific 0.3%
 Unknown: 5.5%

Patients by Ethnicity

Hispanic or Latino: 2.4%
 Not Hispanic or Latino: 92.0%
 Unknown: 5.5%
 IDPH Number: 1974
 HPA A-01
 HSA 6

CITY: Chicago

COUNTY: Suburban Cook (Chicago)

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2009	Staff Bed Occupancy Rate %
Medical/Surgical	214	225	190	11,399	53,786	2,530	4.9	154.3	72.1	68.6
0-14 Years				0	0					
15-44 Years				835	2,851					
45-64 Years				2,406	10,186					
65-74 Years				2,188	10,249					
75 Years +				5,970	30,500					
Pediatric	17	18	8	230	455	18	2.1	1.3	7.6	7.2
Intensive Care	41	30	30	2,838	8,856	0	3.1	24.3	59.2	80.9
Direct Admission				1,760	5,510					
Transfers				1,078	3,346					
Obstetric/Gynecology	23	31	31	1,053	2,466	64	2.4	6.9	30.1	22.4
Maternity				1,003	2,385					
Clean Gynecology				50	81					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Rehabilitation	65	61	59	1,370	17,925	0	13.1	49.1	75.6	80.5
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedicated Observation	0					0				
Facility Utilization	360			15,812	83,488	2,612	5.4	235.9	65.5	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	62.0%	8.6%	0.1%	26.9%	1.0%	1.4%	15,812
Outpatients	39.2%	15.0%	0.1%	42.7%	2.2%	0.8%	159,245

Financial Year Reported:

7/1/2008 to

6/30/2009

Inpatient and Outpatient Net Revenue by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals	Charity Care Expense	Total Charity Care Expense
Inpatient Revenue (\$)	65.7%	4.3%	0.0%	28.6%	1.4%	100.0%	1,195,049	1,869,515
Outpatient Revenue (\$)	26.9%	6.1%	0.0%	64.8%	2.3%	100.0%	674,466	0.7%

Totals: Charity Care as % of Net Revenue

Birthing Data

Number of Total Births: 1,038
 Number of Live Births: 1,026
 Birthing Rooms: 0
 Labor Rooms: 0
 Delivery Rooms: 0
 Labor-Delivery-Recovery Rooms: 0
 Labor-Delivery-Recovery-Postpartum Rooms: 17
 C-Section Rooms: 2
 CSections Performed: 312

Newborn Nursery Utilization

Level 1 Patient Days 1,664
 Level 2 Patient Days 1,653
 Level 2+ Patient Days 90
 Total Nursery Patientdays 3,407
 Inpatient Studies 511,319
 Outpatient Studies 438,246
 Studies Performed Under Contract 88,504

Organ Transplantation

Kidney: 0
 Heart: 0
 Lung: 0
 Heart/Lung: 0
 Pancreas: 0
 Liver: 0
 Total: 0

Laboratory Studies

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	2	2	561	101	1886	131	2017	3.4	1.3
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	9	9	1066	993	1845	1092	2937	1.7	1.1
Gastroenterology	0	0	0	0	0	0	0	0	0	0.0	0.0
Neurology	0	0	0	0	318	44	1060	93	1153	3.3	2.1
OB/Gynecology	0	0	0	0	243	625	565	526	1091	2.3	0.8
Oral/Maxillofacial	0	0	0	0	6	28	18	76	94	3.0	2.7
Ophthalmology	0	0	0	0	52	916	98	801	899	1.9	0.9
Orthopedic	0	0	0	0	855	546	1539	731	2270	1.8	1.3
Otolaryngology	0	0	0	0	90	336	164	371	535	1.8	1.1
Plastic Surgery	0	0	0	0	13	60	22	83	105	1.7	1.4
Podiatry	0	0	0	0	53	74	70	125	195	1.3	1.7
Thoracic	0	0	0	0	179	16	435	24	459	2.4	1.5
Urology	0	0	1	1	350	815	605	584	1189	1.7	0.7
Totals	0	0	12	12	3786	4554	8307	4637	12944	2.2	1.0

SURGICAL RECOVERY STATIONS Stage 1 Recovery Stations 12 Stage 2 Recovery Stations 20

Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	5	5	1579	3774	970	2519	3489	0.6	0.7
Laser Eye Procedures	0	2	0	2	0	16	0	10	10	0.0	0.6
Pain Management	0	0	4	4	191	6576	143	4932	5075	0.7	0.8
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0
	Multipurpose Non-Dedicated Rooms										
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+Nondedicated labs):	4
Cath Labs used for Angiography procedures	0
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	1

Emergency/Trauma Care

Certified Trauma Center by EMS	<input type="checkbox"/>
Level of Trauma Service	Level 1 Level 2
	--- ---
Operating Rooms Dedicated for Trauma Care	0
Number of Trauma Visits:	0
Patients Admitted from Trauma	0
Emergency Service Type:	Comprehensive
Number of Emergency Room Stations	21
Persons Treated by Emergency Services:	38,300
Patients Admitted from Emergency:	9,625
Total ED Visits (Emergency+Trauma):	38,300

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	3,366
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	1,987
Interventional Catheterizations (0-14):	0
Interventional Catheterizations (15+)	813
EP Catheterizations (15+)	566

Cardiac Surgery Data

Total Cardiac Surgery Cases:	215
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	215
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	147

Outpatient Service Data

Total Outpatient Visits	159,245
Outpatient Visits at the Hospital/ Campus:	159,245
Outpatient Visits Offsite/off campus	0

Diagnostic/Interventional Equipment

	Examinations				Radiation Equipment			Therapies/ Treatments
	Owned	Contract	Inpatient	Outpatient	Owned	Contract		
General Radiography/Fluoroscopy	9	0	33,176	30,020	Lithotripsy	0	0	0
Nuclear Medicine	5	0	3,504	5,520	Linear Accelerator	1	0	4,907
Mammography	2	0	19	19,164	Image Guided Rad Therapy	1	0	5108
Ultrasound	9	0	6,240	11,421	Intensity Modulated Rad Therap	0	0	0
Diagnostic Angiography	0	0	0	0	High Dose Brachytherapy	1	0	73
Interventional Angiography	0	0	0	0	Proton Beam Therapy	0	0	0
Positron Emission Tomography (PET)	1	0	8	724	Gamma Knife	0	0	0
Computerized Axial Tomography (CAT)	3	0	12,006	18,683	Cyber knife	0	0	0
Magnetic Resonance Imaging	2	0	2,390	5,544				

Ownership, Management and General Information

ADMINISTRATOR NAME: Jeff Murphy
ADMINSTRATOR PHONE: 847-316-2353
OWNERSHIP: Saint Francis Hospital
OPERATOR: Saint Francis Hospital
MANAGEMENT: Not for Profit Corporation
CERTIFICATION: None
FACILITY DESIGNATION: General Hospital
ADDRESS: 355 Ridge Avenue

Patients by Race

White 48.2%
 Black 23.5%
 American Indian 0.3%
 Asian 4.0%
 Hawaiian/ Pacific 0.0%
 Unknown: 24.1%

Patients by Ethnicity

Hispanic or Latino: 7.4%
 Not Hispanic or Latino: 75.9%
 Unknown: 16.7%
 IDPH Number: 2402
 HPA A-08
 HSA 7

CITY: Evanston

COUNTY: Suburban Cook County

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2009	Staff Bed Occupancy Rate %
Medical/Surgical	206	157	135	5,662	28,734	4,032	5.8	89.8	43.6	57.2
0-14 Years				0	0					
15-44 Years				889	3,318					
45-64 Years				1,741	8,300					
65-74 Years				1,151	6,190					
75 Years +				1,881	10,926					
Pediatric	12	12	6	283	636	211	3.0	2.3	19.3	19.3
Intensive Care	35	35	32	2,280	7,775	85	3.4	21.5	61.5	61.5
Direct Admission				1,678	5,840					
Transfers				602	1,935					
Obstetric/Gynecology	18	12	12	850	2,148	152	2.7	6.3	35.0	52.5
Maternity				714	1,862					
Clean Gynecology				136	286					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedicated Observation	0					0				
Facility Utilization	271			8,473	39,293	4,480	5.2	119.9	44.3	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	48.1%	21.3%	0.0%	25.8%	3.3%	1.5%	8,473
Outpatients	27.5%	20.1%	0.0%	20.3%	30.9%	1.2%	117,633

Financial Year Reported:	7/1/2008 to 6/30/2009		Inpatient and Outpatient Net Revenue by Payor Source					Charity Care Expense	Total Charity Care Expense 3,344,304
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals			
Inpatient Revenue (\$)	47.8%	23.1%	0.0%	26.0%	3.1%	100.0%	1,883,268	Totals: Charity Care as % of Net Revenue 2.0%	
	52,034,979	25,140,397	0	28,361,084	3,385,602	108,922,062			
Outpatient Revenue (\$)	17.6%	10.5%	0.0%	58.3%	13.6%	100.0%	1,461,036		
	10,022,592	5,962,992	0	33,167,642	7,755,578	56,908,804			

Birthing Data

Number of Total Births: 721
 Number of Live Births: 710
 Birthing Rooms: 0
 Labor Rooms: 0
 Delivery Rooms: 0
 Labor-Delivery-Recovery Rooms: 0
 Labor-Delivery-Recovery-Postpartum Rooms: 18
 C-Section Rooms: 2
 CSections Performed: 175

Newborn Nursery Utilization

Level 1 Patient Days 1,729
 Level 2 Patient Days 660
 Level 2+ Patient Days 24
 Total Nursery Patientdays 2,413

Organ Transplantation

Kidney: 0
 Heart: 0
 Lung: 0
 Heart/Lung: 0
 Pancreas: 0
 Liver: 0
 Total: 0

Laboratory Studies

Inpatient Studies 402,225
 Outpatient Studies 229,844
 Studies Performed Under Contract 7,672

* Note: On 4/22/2009, Board approved the voluntary reduction of 104 beds within Medical Surgical, Pediatric, Ob-Gyn and ICU categories of service. The total bed count for the facility is 271 beds.

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	2	2	168	12	604	19	623	3.6	1.6
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	2	2	1096	801	2218	990	3208	2.0	1.2
Gastroenterology	0	0	2	2	0	0	0	0	0	0.0	0.0
Neurology	0	0	1	1	78	8	244	13	257	3.1	1.6
OB/Gynecology	0	0	1	1	188	277	514	342	856	2.7	1.2
Oral/Maxillofacial	0	0	0	0	0	0	0	0	0	0.0	0.0
Ophthalmology	0	0	2	2	22	744	24	584	608	1.1	0.8
Orthopedic	0	0	2	2	565	706	1379	1001	2380	2.4	1.4
Otolaryngology	0	0	0	0	58	161	90	219	309	1.6	1.4
Plastic Surgery	0	0	1	1	23	54	82	94	176	3.6	1.7
Podiatry	0	0	0	0	9	92	12	121	133	1.3	1.3
Thoracic	0	0	0	0	0	0	0	0	0	0.0	0.0
Urology	0	0	2	2	141	147	223	129	352	1.6	0.9
Totals	0	0	15	15	2348	3002	5390	3512	8902	2.3	1.2

SURGICAL RECOVERY STATIONS	Stage 1 Recovery Stations	11	Stage 2 Recovery Stations	28
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Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	3	3	808	1830	616	1427	2043	0.8	0.8
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	1	1	21	542	20	351	371	1.0	0.6
Cystoscopy	0	0	2	2	113	132	130	113	243	1.2	0.9
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+Nondedicated labs):	2
Cath Labs used for Angiography procedures	0
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Emergency/Trauma Care

Certified Trauma Center by EMS	<input checked="" type="checkbox"/>
Level of Trauma Service	Level 1 Adult
Operating Rooms Dedicated for Trauma Care	2
Number of Trauma Visits:	851
Patients Admitted from Trauma	491
Emergency Service Type:	Comprehensive
Number of Emergency Room Stations	20
Persons Treated by Emergency Services:	34,500
Patients Admitted from Emergency:	5,956
Total ED Visits (Emergency+Trauma):	35,351

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	836
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	524
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	312
EP Catheterizations (15+)	0

Cardiac Surgery Data

Total Cardiac Surgery Cases:	75
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	75
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	63

Outpatient Service Data

Total Outpatient Visits	117,633
Outpatient Visits at the Hospital/ Campus:	106,748
Outpatient Visits Offsite/off campus	10,885

Diagnostic/Interventional Equipment

	Examinations				Radiation Equipment			Therapies/ Treatments
	Owned	Contract	Inpatient	Outpatient	Owned	Contract		
General Radiography/Fluoroscopy	4	0	13,559	29,471	Lithotripsy	0	0	0
Nuclear Medicine	2	0	1,028	2,280	Linear Accelerator	1	0	119
Mammography	3	0	0	10,623	Image Guided Rad Therapy	0	0	0
Ultrasound	4	0	1,473	4,435	Intensity Modulated Rad Therap	1	0	74
Diagnostic Angiography	0	0	0	0	High Dose Brachytherapy	0	0	0
Interventional Angiography	0	0	0	0	Proton Beam Therapy	0	0	0
Positron Emission Tomography (PET)	0	1	0	128	Gamma Knife	0	0	0
Computerized Axial Tomography (CAT)	2	0	2,988	18,677	Cyber knife	0	0	0
Magnetic Resonance Imaging	1	0	897	2,119				

Ownership, Management and General Information

ADMINISTRATOR NAME: Margaret McDermott
 ADMINSTRATOR PHONE: 312-770-2115
 OWNERSHIP: Saints Mary and Elizabeth Medical Center DBA Saint
 OPERATOR: Saints Mary and Elizabeth Medical Center DBA Saint
 MANAGEMENT: Not for Profit Corporation
 CERTIFICATION: None
 FACILITY DESIGNATION: General Hospital
 ADDRESS: 2233 West Divison Street

Patients by Race

White 21.0%
 Black 25.7%
 American Indian 0.1%
 Asian 1.3%
 Hawaiian/ Pacific 0.0%
 Unknown: 52.0%

Patients by Ethnicity

Hispanic or Latino: 13.8%
 Not Hispanic or Latino: 85.9%
 Unknown: 0.3%
 IDPH Number: 2584
 HPA A-02
 HSA 6

CITY: Chicago

COUNTY: Suburban Cook (Chicago)

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2009	Staff Bed Occupancy Rate %
Medical/Surgical	186	186	152	10,373	48,081	3,623	5.0	141.7	76.2	76.2
0-14 Years				10	20					
15-44 Years				2,528	8,045					
45-64 Years				3,883	17,282					
65-74 Years				1,831	9,616					
75 Years +				2,121	13,118					
Pediatric	14	14	14	925	2,092	535	2.8	7.2	51.4	51.4
Intensive Care	32	32	30	2,010	7,979	5	4.0	21.9	68.4	68.4
Direct Admission				1,204	4,536					
Transfers				806	3,443					
Obstetric/Gynecology	20	20	20	2,199	5,113	235	2.4	14.7	73.3	73.3
Maternity				2,193	5,103					
Clean Gynecology				6	10					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	120	120	120	3,968	34,495	0	8.7	94.5	78.8	78.8
Rehabilitation	15	15	15	325	3,847	0	11.8	10.5	70.3	70.3
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedicated Observation	0					0				
Facility Utilization	387			18,994	101,607	4,398	5.6	290.4	75.0	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	34.1%	42.9%	0.0%	18.8%	2.1%	2.1%	18,994
	6478	8142	8	3562	402	402	
Outpatients	20.6%	42.5%	0.1%	30.7%	3.3%	2.8%	160,335
	33067	68076	170	49228	5270	4524	

Financial Year Reported:	7/1/2008 to 6/30/2009		Inpatient and Outpatient Net Revenue by Payor Source					Charity Care Expense	Total Charity Care Expense 2,662,596
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals			
Inpatient Revenue (\$)	36.8%	34.8%	0.0%	18.9%	9.5%	100.0%	1,394,629	Totals: Charity Care as % of Net Revenue	
	64,870,370	61,419,970	0	33,285,730	16,816,201	176,392,271			
Outpatient Revenue (\$)	16.6%	32.9%	0.0%	31.8%	18.7%	100.0%	1,267,966	1.1%	
	11,265,066	22,276,179	0	21,509,882	12,633,284	67,684,411			

Birthing Data

Number of Total Births: 2,014
 Number of Live Births: 2,004
 Birthing Rooms: 0
 Labor Rooms: 0
 Delivery Rooms: 0
 Labor-Delivery-Recovery Rooms: 8
 Labor-Delivery-Recovery-Postpartum Rooms: 0
 C-Section Rooms: 2
 CSections Performed: 544

Newborn Nursery Utilization

Level 1 Patient Days 3,691
 Level 2 Patient Days 0
 Level 2+ Patient Days 1,409
 Total Nursery Patientdays 5,100

Laboratory Studies

Inpatient Studies 641,498
 Outpatient Studies 251,694
 Studies Performed Under Contract 3,466

Orqan Transplantation

Kidney: 0
 Heart: 0
 Lung: 0
 Heart/Lung: 0
 Pancreas: 0
 Liver: 0
 Total: 0

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	1	1	843	87	2000	135	2135	2.4	1.6
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	6	6	963	704	1561	767	2328	1.6	1.1
Gastroenterology	0	0	0	0	5	15	7	9	16	1.4	0.6
Neurology	0	0	0	0	156	3	589	7	596	3.8	2.3
OB/Gynecology	0	0	0	0	519	499	744	403	1147	1.4	0.8
Oral/Maxillofacial	0	0	0	0	9	9	9	18	27	1.0	2.0
Ophthalmology	0	0	0	0	2	149	4	229	233	2.0	1.5
Orthopedic	0	0	0	0	325	162	637	217	854	2.0	1.3
Otolaryngology	0	0	0	0	70	99	66	109	175	0.9	1.1
Plastic Surgery	0	0	0	0	20	9	44	19	63	2.2	2.1
Podiatry	0	0	0	0	103	125	93	171	264	0.9	1.4
Thoracic	0	0	0	0	173	26	297	17	314	1.7	0.7
Urology	0	0	1	1	324	298	447	300	747	1.4	1.0
Totals	0	0	8	8	3512	2185	6498	2401	8899	1.9	1.1

SURGICAL RECOVERY STATIONS	Stage 1 Recovery Stations	9	Stage 2 Recovery Stations	19
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Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	3	3	1767	3958	628	1534	2162	0.4	0.4
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	0	0	0	0	0	0	0	0.0	0.0
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+Nondedicated labs):	2
Cath Labs used for Angiography procedures	0
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Emergency/Trauma Care

Certified Trauma Center by EMS	<input type="checkbox"/>
Level of Trauma Service	Level 1 Level 2
Operating Rooms Dedicated for Trauma Care	0
Number of Trauma Visits:	0
Patients Admitted from Trauma	0
Emergency Service Type:	Comprehensive
Number of Emergency Room Stations	31
Persons Treated by Emergency Services:	57,393
Patients Admitted from Emergency:	11,665
Total ED Visits (Emergency+Trauma):	57,393

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	1,438
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	852
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	268
EP Catheterizations (15+)	318

Cardiac Surgery Data

Total Cardiac Surgery Cases:	75
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	75
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	61

Outpatient Service Data

Total Outpatient Visits	160,335
Outpatient Visits at the Hospital/ Campus:	160,335
Outpatient Visits Offsite/off campus	0

Diagnostic/Interventional Equipment

	Examinations			
	Owned	Contract	Inpatient	Outpatient
General Radiography/Fluoroscopy	8	0	15,828	37,232
Nuclear Medicine	3	0	1,871	2,905
Mammography	1	0	23	4,690
Ultrasound	4	0	3,416	16,042
Diagnostic Angiography	0	0	0	0
Interventional Angiography	0	0	0	0
Positron Emission Tomography (PET)	0	0	0	0
Computerized Axial Tomography (CAT)	2	0	4,168	18,333
Magnetic Resonance Imaging	1	0	1,315	2,749

Radiation Equipment

	Radiation Equipment		Therapies/ Treatments
	Owned	Contract	
Lithotripsy	1	1	6
Linear Accelerator	1	0	124
Image Guided Rad Therapy	0	0	0
Intensity Modulated Rad Therap	0	0	0
High Dose Brachytherapy	0	0	0
Proton Beam Therapy	0	0	0
Gamma Knife	0	0	0
Cyber knife	0	0	0

Ownership, Management and General Information

ADMINISTRATOR NAME: Roberta Luskin-Hawk
ADMINSTRATOR PHONE: 773-665-3972
OWNERSHIP: Saint Joseph Hospital
OPERATOR: Saint Joseph Hospital
MANAGEMENT: Not for Profit Corporation
CERTIFICATION: None
FACILITY DESIGNATION: General Hospital
ADDRESS: 2900 North Lake Shore Drive

Patients by Race

White 68.6%
 Black 18.6%
 American Indian 0.1%
 Asian 3.9%
 Hawaiian/ Pacific 0.5%
 Unknown: 8.2%

Patients by Ethnicity

Hispanic or Latino: 7.6%
 Not Hispanic or Latino: 84.2%
 Unknown: 8.2%
 IDPH Number: 2493
 HPA A-01
 HSA 6

CITY: Chicago

COUNTY: Suburban Cook (Chicago)

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2009	Staff Bed Occupancy Rate %
Medical/Surgical	219	186	186	7,862	36,064	2,485	4.9	105.6	48.2	56.8
0-14 Years				1	6					
15-44 Years				1,901	9,333					
45-64 Years				2,550	11,595					
65-74 Years				1,060	4,252					
75 Years +				2,350	10,878					
Pediatric	11	7	7	293	754	137	3.0	2.4	22.2	34.9
Intensive Care	23	21	21	1,587	6,734	65	4.3	18.6	81.0	88.7
Direct Admission				698	3,753					
Transfers				891	2,981					
Obstetric/Gynecology	23	23	23	1,925	4,453	103	2.4	12.5	54.3	54.3
Maternity				1,903	4,406					
Clean Gynecology				22	47					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	26	26	26	652	5,996	0	9.2	16.4	63.2	63.2
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	35	34	34	1,312	9,266	1	7.1	25.4	72.5	74.7
Rehabilitation	23	23	17	448	4,367	0	9.7	12.0	52.0	52.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
<i>Dedicated Observation</i>	0					0				
Facility Utilization	360			13,188	67,634	2,791	5.3	192.9	53.6	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	43.6%	16.2%	0.2%	37.7%	1.2%	1.1%	13,188
Outpatients	25.2%	15.8%	0.1%	52.9%	5.1%	1.0%	188,191

Financial Year Reported:	Inpatient and Outpatient Net Revenue by Payor Source						Charity Care Expense	Total Charity Care Expense
	7/1/2008 to	6/30/2009	Medicare	Medicaid	Other Public	Private Insurance		
Inpatient Revenue (\$)	64,832,024	19,290,122	0	51,002,179	3,520,673	138,644,998	652,789	1,487,625
Outpatient Revenue (\$)	8,703,376	1,963,278	0	38,807,662	4,430,471	53,904,787	834,836	0.8%

Birthing Data

Number of Total Births: 1,837
 Number of Live Births: 1,833
 Birthing Rooms: 0
 Labor Rooms: 0
 Delivery Rooms: 0
 Labor-Delivery-Recovery Rooms: 1
 Labor-Delivery-Recovery-Postpartum Rooms: 17
 C-Section Rooms: 2
 CSections Performed: 557

Newborn Nursery Utilization

Level 1 Patient Days: 2,892
 Level 2 Patient Days: 199
 Level 2+ Patient Days: 2,812
 Total Nursery Patientdays: 5,903
Laboratory Studies
 Inpatient Studies: 434,758
 Outpatient Studies: 111,988
 Studies Performed Under Contract: 4,512

Organ Transplantation

Kidney: 0
 Heart: 0
 Lung: 0
 Heart/Lung: 0
 Pancreas: 0
 Liver: 0
 Total: 0

* Note: On 4/22/2009, Board approved the voluntary reduction of 42 beds within M/S, Ped and ICU categories of service. The total bed count for the facility is 360 beds. IMRT procedures are done on one of the Linear Accelerators.

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	1	1	265	136	765	254	1019	2.9	1.9
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	10	10	603	718	1656	1357	3013	2.7	1.9
Gastroenterology	0	0	0	0	22	1	25	1	26	1.1	1.0
Neurology	0	0	0	0	74	21	276	55	331	3.7	2.6
OB/Gynecology	0	0	0	0	280	450	856	729	1585	3.1	1.6
Oral/Maxillofacial	0	0	0	0	4	1	6	1	7	1.5	1.0
Ophthalmology	0	0	0	0	2	987	5	1241	1246	2.5	1.3
Orthopedic	0	0	0	0	362	837	920	1487	2407	2.5	1.8
Otolaryngology	0	0	0	0	66	776	92	998	1090	1.4	1.3
Plastic Surgery	0	0	0	0	39	331	267	1095	1362	6.8	3.3
Podiatry	0	0	0	0	30	241	51	445	496	1.7	1.8
Thoracic	0	0	0	0	40	11	135	20	155	3.4	1.8
Urology	0	0	1	1	133	339	212	473	685	1.6	1.4
Totals	0	0	12	12	1920	4849	5266	8156	13422	2.7	1.7

SURGICAL RECOVERY STATIONS	Stage 1 Recovery Stations	12	Stage 2 Recovery Stations	9
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Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	4	4	736	3738	879	4219	5098	1.2	1.1
Laser Eye Procedures	0	0	1	1	1	133	3	177	180	3.0	1.3
Pain Management	0	0	1	1	225	954	263	534	797	1.2	0.6
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+Nondedicated labs):	2
Cath Labs used for Angiography procedures	1
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Emergency/Trauma Care

Certified Trauma Center by EMS	<input type="checkbox"/>
Level of Trauma Service	Level 1 <input type="checkbox"/> Level 2 <input type="checkbox"/>
Operating Rooms Dedicated for Trauma Care	0
Number of Trauma Visits:	0
Patients Admitted from Trauma	0
Emergency Service Type:	Comprehensive
Number of Emergency Room Stations	14
Persons Treated by Emergency Services:	20,131
Patients Admitted from Emergency:	5,311
Total ED Visits (Emergency+Trauma):	20,131

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	882
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	582
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	285
EP Catheterizations (15+)	15

Cardiac Surgery Data

Total Cardiac Surgery Cases:	64
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	64
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	53

Outpatient Service Data

Total Outpatient Visits	188,191
Outpatient Visits at the Hospital/ Campus:	160,748
Outpatient Visits Offsite/off campus	27,443

Diagnostic/Interventional Equipment

	Examinations			
	Owned	Contract	Inpatient	Outpatient
General Radiography/Fluoroscopy	17	0	12,155	22,888
Nuclear Medicine	4	0	611	1,114
Mammography	3	0	0	8,837
Ultrasound	7	0	2,986	11,466
Diagnostic Angiography	0	0	0	0
Interventional Angiography	0	0	0	0
Positron Emission Tomography (PET)	0	1	0	391
Computerized Axial Tomography (CAT)	1	0	3,399	9,644
Magnetic Resonance Imaging	1	0	1,922	2,478

Radiation Equipment

	Radiation Equipment		Therapies/ Treatments
	Owned	Contract	
Lithotripsy	0	0	0
Linear Accelerator	1	0	167
Image Guided Rad Therapy	0	0	0
Intensity Modulated Rad Therap	1	0	9
High Dose Brachytherapy	1	0	16
Proton Beam Therapy	0	0	0
Gamma Knife	0	0	0
Cyber knife	0	0	0

Ownership, Management and General Information

ADMINISTRATOR NAME: Margaret McDermott
 ADMINSTRATOR PHONE: 312-770-2115
 OWNERSHIP: Saints Mary and Elizabeth Medical Center DBA St El
 OPERATOR: Saints Mary and Elizabeth Medical Center DBA St El
 MANAGEMENT: Not for Profit Corporation
 CERTIFICATION: None
 FACILITY DESIGNATION: General Hospital
 ADDRESS: 1431 North Claremont

Patients by Race

White 19.3%
 Black 59.8%
 American Indian 0.0%
 Asian 0.4%
 Hawaiian/ Pacific 0.0%
 Unknown: 20.5%

Patients by Ethnicity

Hispanic or Latino: 4.0%
 Not Hispanic or Latino: 75.6%
 Unknown: 20.5%
 IDPH Number: 2360
 HPA A-02
 HSA 6

CITY: Chicago

COUNTY: Suburban Cook (Chicago)

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2009	Staff Bed Occupancy Rate %
Medical/Surgical	40	40	40	3,414	9,323	0	2.7	25.5	63.9	63.9
0-14 Years				0	0					
15-44 Years				1,479	3,898					
45-64 Years				1,866	5,225					
65-74 Years				67	194					
75 Years +				2	6					
Pediatric	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Intensive Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Direct Admission				0	0					
Transfers				0	0					
Obstetric/Gynecology	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Maternity				0	0					
Clean Gynecology				0	0					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	28	26	22	525	6,849	0	13.0	18.8	67.0	72.2
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	40	70	70	2,181	18,452	0	8.5	50.6	126.4	72.2
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedicated Observation	0					0				
Facility Utilization	108			6,120	34,624	0	5.7	94.9	87.8	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	28.2%	65.2%	0.0%	6.0%	0.3%	0.3%	6,120
Outpatients	21.6%	40.9%	0.1%	32.6%	3.4%	1.4%	25,461

Financial Year Reported:

	7/1/2008 to	6/30/2009	Inpatient and Outpatient Net Revenue by Payor Source					Charity Care Expense	Total Charity Care Expense
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals			
Inpatient Revenue (\$)	23.9%	70.1%	0.0%	5.5%	0.6%	100.0%	322,570	390,005	
Outpatient Revenue (\$)	16.3%	43.1%	0.0%	36.1%	4.5%	100.0%	67,435	Totals: Charity Care as % of Net Revenue	
	9,280,892	27,203,305	0	2,126,999	216,467	38,827,663		0.7%	
	3,057,316	8,058,125	0	6,755,379	838,631	18,709,451			

Birthing Data

Number of Total Births: 0
 Number of Live Births: 0
 Birthing Rooms: 0
 Labor Rooms: 0
 Delivery Rooms: 0
 Labor-Delivery-Recovery Rooms: 0
 Labor-Delivery-Recovery-Postpartum Rooms: 0
 C-Section Rooms: 0
 CSectons Performed: 0

Newborn Nursery Utilization

Level 1 Patient Days: 0
 Level 2 Patient Days: 0
 Level 2+ Patient Days: 0
 Total Nursery Patientdays: 0
Laboratory Studies
 Inpatient Studies: 83,706
 Outpatient Studies: 51,107
 Studies Performed Under Contract: 0

Organ Transplantation

Kidney: 0
 Heart: 0
 Lung: 0
 Heart/Lung: 0
 Pancreas: 0
 Liver: 0
 Total: 0

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	0	0	0	1	0	1	1	0.0	1.0
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	4	4	0	385	0	411	411	0.0	1.1
Gastroenterology	0	0	0	0	0	0	0	0	0	0.0	0.0
Neurology	0	0	0	0	0	0	0	0	0	0.0	0.0
OB/Gynecology	0	0	0	0	0	21	0	17	17	0.0	0.8
Oral/Maxillofacial	0	0	0	0	0	9	0	8	8	0.0	0.9
Ophthalmology	0	0	0	0	0	536	0	462	462	0.0	0.9
Orthopedic	0	0	0	0	0	274	0	372	372	0.0	1.4
Otolaryngology	0	0	0	0	0	94	0	102	102	0.0	1.1
Plastic Surgery	0	0	0	0	0	2	0	2	2	0.0	1.0
Podiatry	0	0	0	0	0	59	0	76	76	0.0	1.3
Thoracic	0	0	0	0	0	2	0	1	1	0.0	0.5
Urology	0	0	1	1	0	283	0	214	214	0.0	0.8
Totals	0	0	5	5	0	1666	0	1666	1666	0.0	1.0

SURGICAL RECOVERY STATIONS	Stage 1 Recovery Stations	8	Stage 2 Recovery Stations	18
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Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	2	2	0	12	0	3	3	0.0	0.3
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	0	0	0	0	0	0	0	0.0	0.0
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+Nondedicated labs):	0
Cath Labs used for Angiography procedures	0
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Emergency/Trauma Care

Certified Trauma Center by EMS	<input type="checkbox"/>	
Level of Trauma Service	Level 1	Level 2
Operating Rooms Dedicated for Trauma Care	0	
Number of Trauma Visits:	0	
Patients Admitted from Trauma	0	
Emergency Service Type:	Comprehensive	
Number of Emergency Room Stations	8	
Persons Treated by Emergency Services:	4,286	
Patients Admitted from Emergency:	341	
Total ED Visits (Emergency+Trauma):	4,286	

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	0
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	0
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	0
EP Catheterizations (15+)	0

Cardiac Surgery Data

Total Cardiac Surgery Cases:	0
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	0
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	0

Outpatient Service Data

Total Outpatient Visits	25,461
Outpatient Visits at the Hospital/ Campus:	25,461
Outpatient Visits Offsite/off campus	0

Diagnostic/Interventional Equipment

	Examinations			
	Owned	Contract	Inpatient	Outpatient
General Radiography/Fluoroscopy	7	0	860	8,260
Nuclear Medicine	0	0	0	0
Mammography	1	0	0	3,110
Ultrasound	2	0	109	274
Diagnostic Angiography	0	0	0	0
Interventional Angiography	0	0	0	0
Positron Emission Tomography (PET)	0	0	0	0
Computerized Axial Tomography (CAT)	1	0	112	552
Magnetic Resonance Imaging	0	0	0	0

Radiation Equipment

	Radiation Equipment		Therapies/ Treatments
	Owned	Contract	
Lithotripsy	1	1	34
Linear Accelerator	0	0	0
Image Guided Rad Therapy	0	0	0
Intensity Modulated Rad Therap	0	0	0
High Dose Brachytherapy	0	0	0
Proton Beam Therapy	0	0	0
Gamma Knife	0	0	0
Cyber knife	0	0	0

Ownership, Management and General Information

ADMINISTRATOR NAME: Ivette Estrada
 ADMINSTRATOR PHONE: 773-282-3003
 OWNERSHIP: Our Lady of the Resurrection Medical Center
 OPERATOR: Our Lady of the Resurrection Medical Center
 MANAGEMENT: Not for Profit Corporation
 CERTIFICATION: None
 FACILITY DESIGNATION: General Hospital
 ADDRESS: 5645 West Addison Street

Patients by Race

White 76.2%
 Black 7.8%
 American Indian 0.1%
 Asian 1.8%
 Hawaiian/ Pacific 0.2%
 Unknown: 13.9%

Patients by Ethnicity

Hispanic or Latino: 9.8%
 Not Hispanic or Latino: 76.3%
 Unknown: 13.9%
 IDPH Number: 1719
 HPA: A-01
 HSA: 6

CITY: Chicago

COUNTY: Suburban Cook (Chicago)

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2009	Staff Bed Occupancy Rate %
Medical/Surgical	213	193	124	6,884	33,414	2,597	5.2	98.7	46.3	51.1
0-14 Years				27	57					
15-44 Years				884	3,152					
45-64 Years				1,978	9,385					
65-74 Years				1,255	6,409					
75 Years +				2,740	14,411					
Pediatric	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Intensive Care	20	20	20	1,600	6,393	36	4.0	17.6	88.1	88.1
Direct Admission				1,154	4,605					
Transfers				446	1,788					
Obstetric/Gynecology	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Maternity				0	0					
Clean Gynecology				0	0					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	66	56	49	1,372	13,966	0	10.2	38.3	58.0	68.3
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
<i>Dedicated Observation</i>	0					0				
Facility Utilization	299			9,410	53,773	2,633	6.0	154.5	51.7	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	62.7%	15.5%	0.0%	17.4%	2.8%	1.6%	9,410
Outpatients	36.6%	27.8%	0.1%	26.3%	7.5%	1.8%	106,302

Financial Year Reported:	Inpatient and Outpatient Net Revenue by Payor Source						Charity Care Expense	Total Charity Care Expense
	7/1/2008 to	6/30/2009	Medicare	Medicaid	Other Public	Private Insurance		
Inpatient Revenue (\$)	55.8%	5.8%	0.0%	17.8%	20.6%	100.0%	922,725	1,613,275
	45,372,692	4,707,203	0	14,436,297	16,788,176	81,304,368		
Outpatient Revenue (\$)	19.2%	13.3%	0.0%	31.7%	35.7%	100.0%	690,550	1.2%
	10,380,455	7,196,801	0	17,126,806	19,287,337	53,991,399		

Birthing Data

Number of Total Births: 1
 Number of Live Births: 1
 Birthing Rooms: 0
 Labor Rooms: 0
 Delivery Rooms: 0
 Labor-Delivery-Recovery Rooms: 0
 Labor-Delivery-Recovery-Postpartum Rooms: 0
 C-Section Rooms: 0
 CSections Performed: 0

Newborn Nursery Utilization

Level 1 Patient Days: 0
 Level 2 Patient Days: 0
 Level 2+ Patient Days: 0
 Total Nursery Patientdays: 0

Organ Transplantation

Kidney: 0
 Heart: 0
 Lung: 0
 Heart/Lung: 0
 Pancreas: 0
 Liver: 0
 Total: 0

Laboratory Studies

Inpatient Studies: 396,802
 Outpatient Studies: 297,369
 Studies Performed Under Contract: 10,827

* Note: According to Board action on 4/22/09, Board reduced 164 M/S beds overall voluntarily. New CON count for the facility is 299 beds

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	0	0	0	0	0	0	0	0.0	0.0
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	8	8	880	426	1399	424	1823	1.6	1.0
Gastroenterology	0	0	0	0	3	1	3	1	4	1.0	1.0
Neurology	0	0	0	0	162	12	492	19	511	3.0	1.6
OB/Gynecology	0	0	0	0	122	169	175	156	331	1.4	0.9
Oral/Maxillofacial	0	0	0	0	0	0	0	0	0	0.0	0.0
Ophthalmology	0	0	0	0	5	612	4	353	357	0.8	0.6
Orthopedic	0	0	0	0	364	360	603	442	1045	1.7	1.2
Otolaryngology	0	0	0	0	41	56	61	70	131	1.5	1.3
Plastic Surgery	0	0	0	0	8	23	21	30	51	2.6	1.3
Podiatry	0	0	0	0	0	0	0	0	0	0.0	0.0
Thoracic	0	0	0	0	28	0	83	0	83	3.0	0.0
Urology	0	0	1	1	170	169	267	196	463	1.6	1.2
Totals	0	0	9	9	1783	1828	3108	1691	4799	1.7	0.9

SURGICAL RECOVERY STATIONS Stage 1 Recovery Stations 8 Stage 2 Recovery Stations 19

Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	1	1	0	2	1148	1403	1200	1501	2701	1.0	1.1
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	1	0	1	0	1225	0	18375	18375	0.0	15.0
Cystoscopy	0	0	1	1	141	169	191	196	387	1.4	1.2
Multipurpose Non-Dedicated Rooms											
Minor/Local Procedur	0	1	0	1	0	89	0	59	59	0.0	0.7
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+Nondedicated labs):	1
Cath Labs used for Angiography procedures	1
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Emergency/Trauma Care

Certified Trauma Center by EMS	<input type="checkbox"/>
Level of Trauma Service	Level 1 Level 2
Operating Rooms Dedicated for Trauma Care	0
Number of Trauma Visits:	0
Patients Admitted from Trauma	0
Emergency Service Type:	Comprehensive
Number of Emergency Room Stations	18
Persons Treated by Emergency Services:	37,917
Patients Admitted from Emergency:	6,634
Total ED Visits (Emergency+Trauma):	37,917

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	625
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	479
Interventional Catheterizations (0-14):	0
Interventional Catheterizations (15+)	146
EP Catheterizations (15+)	0

Cardiac Surgery Data

Total Cardiac Surgery Cases:	0
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	0
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	0

Outpatient Service Data

Total Outpatient Visits	106,302
Outpatient Visits at the Hospital/ Campus:	106,302
Outpatient Visits Offsite/off campus	0

Diagnostic/Interventional Equipment

	Examinations		Radiation Equipment		Therapies/ Treatments			
	Owned	Contract	Inpatient	Outpatient				
General Radiography/Fluoroscopy	7	0	13,247	29,193	Lithotripsy	0	0	0
Nuclear Medicine	2	0	1,666	2,499	Linear Accelerator	0	0	0
Mammography	2	0	8	4,544	Image Guided Rad Therapy	0	0	0
Ultrasound	4	0	3,487	6,636	Intensity Modulated Rad Therap	0	0	0
Diagnostic Angiography	0	0	0	0	High Dose Brachytherapy	0	0	0
Interventional Angiography	0	0	0	0	Proton Beam Therapy	0	0	0
Positron Emission Tomography (PET)	0	0	0	0	Gamma Knife	0	0	0
Computerized Axial Tomography (CAT)	2	0	4,225	15,489	Cyber knife	0	0	0
Magnetic Resonance Imaging	1	1	922	1,555				

Ownership, Management and General Information

ADMINISTRATOR NAME: John Baird
 ADMINSTRATOR PHONE: 847-813-3161
 OWNERSHIP: Holy Family Medical Center
 OPERATOR: Holy Family Medical Center
 MANAGEMENT: Not for Profit Corporation
 CERTIFICATION: Long Term Acute Care Hospital (LTACH)
 FACILITY DESIGNATION: General Hospital
 ADDRESS: 100 North River Road

Patients by Race

White 71.2%
 Black 5.0%
 American Indian 0.0%
 Asian 2.5%
 Hawaiian/ Pacific 0.3%
 Unknown: 21.0%

Patients by Ethnicity

Hispanic or Latino: 1.3%
 Not Hispanic or Latino: 79.0%
 Unknown: 19.7%
 IDPH Number: 1008
 HPA A-07
 HSA 7

CITY: Des Plaines

COUNTY: Suburban Cook County

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2009	Staff Bed Occupancy Rate %
Medical/Surgical	59	110	100	1,524	32,196	0	21.1	88.2	####	80.2
0-14 Years				0	0					
15-44 Years				507	3,009					
45-64 Years				546	9,236					
65-74 Years				179	7,529					
75 Years +				292	12,422					
Pediatric	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Intensive Care	0	8	6	160	1,937	0	12.1	5.3	0.0	66.3
Direct Admission				37	448					
Transfers				123	1,489					
Obstetric/Gynecology	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Maternity				0	0					
Clean Gynecology				0	0					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	129	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedicated Observation	0					0				
Facility Utilization	188			1,561	34,133	0	21.9	93.5	49.7	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	33.6%	14.0%	0.0%	48.9%	1.2%	2.3%	1,561
Outpatients	32.0%	24.6%	0.0%	38.5%	4.2%	0.6%	22,405

Financial Year Reported:	7/1/2008 to	6/30/2009	Inpatient and Outpatient Net Revenue by Payor Source					Charity Care Expense	Total Charity Care Expense
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals			
Inpatient Revenue (\$)	49.7%	15.0%	0.0%	30.0%	5.3%	100.0%	184,754	186,520	
Outpatient Revenue (\$)	49.7%	15.0%	0.0%	30.0%	5.3%	100.0%	1,766	Totals: Charity Care as % of Net Revenue 0.3%	

Birthing Data

Number of Total Births: 0
 Number of Live Births: 0
 Birthing Rooms: 0
 Labor Rooms: 0
 Delivery Rooms: 0
 Labor-Delivery-Recovery Rooms: 0
 Labor-Delivery-Recovery-Postpartum Rooms: 0
 C-Section Rooms: 0
 CSections Performed: 0

Newborn Nursery Utilization

Level 1 Patient Days 0
 Level 2 Patient Days 0
 Level 2+ Patient Days 0
 Total Nursery Patientdays 0

Organ Transplantation

Kidney: 0
 Heart: 0
 Lung: 0
 Heart/Lung: 0
 Pancreas: 0
 Liver: 0
 Total: 0

Laboratory Studies

Inpatient Studies 130,069
 Outpatient Studies 43,454
 Studies Performed Under Contract 44,795

* Note: On 4/22/09, Board approved the reclassification of the beds under new category of service called Long Term Acute Care (LTAC) per PART 1100 rule. Facility opted to keep 59 beds in M/S and rest of the M/S beds clubbed with ICU were categorized as LTAC beds =129 beds. According to Board action on 4/22/09, Board reduced 50 LTAC beds voluntarily. New CON count for the facility is 188 beds (M/S=59, LTAC = 129). A full public hearing was held on 4/22/09.

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	0	0	3	6	3	8	11	1.0	1.3
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	1	1	66	74	87	60	147	1.3	0.8
Gastroenterology	0	0	0	0	82	77	52	75	127	0.6	1.0
Neurology	0	0	0	0	0	0	0	0	0	0.0	0.0
OB/Gynecology	0	0	0	0	1	35	1	24	25	1.0	0.7
Oral/Maxillofacial	0	0	0	0	0	2	0	1	1	0.0	0.5
Ophthalmology	0	0	1	1	0	794	0	573	573	0.0	0.7
Orthopedic	0	0	0	0	0	18	0	31	31	0.0	1.7
Otolaryngology	0	0	0	0	0	19	0	21	21	0.0	1.1
Plastic Surgery	0	0	0	0	0	186	0	460	460	0.0	2.5
Podiatry	0	0	0	0	0	223	0	497	497	0.0	2.2
Thoracic	0	0	0	0	3	0	3	0	3	1.0	0.0
Urology	0	0	0	0	12	13	10	11	21	0.8	0.8
Totals	0	0	2	2	167	1447	156	1761	1917	0.9	1.2

SURGICAL RECOVERY STATIONS

Stage 1 Recovery Stations

13

Stage 2 Recovery Stations

21

Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	3	3	13	103	12	89	101	0.9	0.9
Laser Eye Procedures	0	0	1	1	0	145	0	37	37	0.0	0.3
Pain Management	0	0	0	0	0	0	0	0	0	0.0	0.0
Cystoscopy	0	0	1	1	7	0	9	0	9	1.3	0.0
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+Nondedicated labs):	0
Cath Labs used for Angiography procedures	0
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	0
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	0
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	0
EP Catheterizations (15+)	0

Emergency/Trauma Care

Certified Trauma Center by EMS	<input type="checkbox"/>
Level of Trauma Service	Level 1 ---
	Level 2 ---
Operating Rooms Dedicated for Trauma Care	0
Number of Trauma Visits:	0
Patients Admitted from Trauma	0
Emergency Service Type:	Stand-By
Number of Emergency Room Stations	0
Persons Treated by Emergency Services:	0
Patients Admitted from Emergency:	0
Total ED Visits (Emergency+Trauma):	0

Cardiac Surgery Data

Total Cardiac Surgery Cases:	0
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	0
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	0

Outpatient Service Data

Total Outpatient Visits	22,405
Outpatient Visits at the Hospital/ Campus:	22,405
Outpatient Visits Offsite/off campus	0

Diagnostic/Interventional Equipment	Examinations				Radiation Equipment			Therapies/ Treatments
	Owned	Contract	Inpatient	Outpatient	Owned	Contract		
General Radiography/Fluoroscopy	8	0	6,055	4,191	Lithotripsy	0	0	0
Nuclear Medicine	2	0	50	410	Linear Accelerator	0	0	0
Mammography	3	0	0	4,250	Image Guided Rad Therapy	0	0	0
Ultrasound	5	0	769	2,692	Intensity Modulated Rad Therap	0	0	0
Diagnostic Angiography	0	0	0	0	High Dose Brachytherapy	0	0	0
Interventional Angiography	0	0	0	0	Proton Beam Therapy	0	0	0
Positron Emission Tomography (PET)	0	0	0	0	Gamma Knife	0	0	0
Computerized Axial Tomography (CAT)	1	0	1,554	1,125	Cyber knife	0	0	0
Magnetic Resonance Imaging	1	0	0	722				

Ownership, Management and General Information

ADMINISTRATOR NAME: Mike Brown
ADMINISTRATOR PHONE: 217-443-5201
OWNERSHIP: Provena Health
OPERATOR: Provena Health
MANAGEMENT: Church-Related
CERTIFICATION: None
FACILITY DESIGNATION: General Hospital
ADDRESS: 812 North Logan Street

Patients by Race

White 80.1%
 Black 16.9%
 American Indian 0.1%
 Asian 0.2%
 Hawaiian/ Pacific 0.0%
 Unknown: 2.7%

Patients by Ethnicity

Hispanic or Latino: 2.1%
 Not Hispanic or Latino: 97.3%
 Unknown: 0.5%
 IDPH Number: 4853
 HPA D-03
 HSA 4

CITY: Danville

COUNTY: Vermillion County

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2009	Staff Bed Occupancy Rate %
Medical/Surgical	134	82	76	4,629	19,701	3,248	5.0	62.9	46.9	76.7
0-14 Years				0	0					
15-44 Years				708	2,035					
45-64 Years				1,318	5,251					
65-74 Years				830	3,906					
75 Years +				1,773	8,509					
Pediatric	9	8	8	168	329	94	2.5	1.2	12.9	14.5
Intensive Care	14	12	12	996	1,910	46	2.0	5.4	38.3	44.7
Direct Admission				642	1,231					
Transfers				354	679					
Obstetric/Gynecology	17	15	15	1,051	2,065	120	2.1	6.0	35.2	39.9
Maternity				916	1,738					
Clean Gynecology				135	327					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
<i>Dedicated Observation</i>	0					0				
Facility Utilization	174			6,490	24,005	3,508	4.2	75.4	43.3	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	49.7%	24.2%	0.4%	22.1%	1.1%	2.6%	6,490
	3224	1570	24	1434	71	167	
Outpatients	19.3%	31.7%	0.9%	35.1%	8.4%	4.5%	87,354
	16876	27695	795	30690	7345	3953	

Financial Year Reported:	1/1/2009 to 12/31/2009		Inpatient and Outpatient Net Revenue by Payor Source					Charity Care Expense	Total Charity Care Expense
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals			
Inpatient Revenue (\$)	37.6%	20.5%	0.3%	36.8%	4.8%	100.0%	1,066,068	4,019,971	
	16,776,873	9,156,068	128,018	16,398,885	2,129,524	44,589,368			
Outpatient Revenue (\$)	14.4%	11.7%	1.5%	59.1%	13.3%	100.0%	2,953,903	Totals: Charity Care as % of Net Revenue	
	10,036,415	8,123,116	1,056,472	41,059,236	9,246,308	69,521,547	2,953,903	3.5%	

Birthing Data

Number of Total Births: 787
 Number of Live Births: 787
 Birthing Rooms: 0
 Labor Rooms: 0
 Delivery Rooms: 0
 Labor-Delivery-Recovery Rooms: 5
 Labor-Delivery-Recovery-Postpartum Rooms: 0
 C-Section Rooms: 1
 CSections Performed: 245

Newborn Nursery Utilization

Level 1 Patient Days: 1,217
 Level 2 Patient Days: 33
 Level 2+ Patient Days: 0
 Total Nursery Patientdays: 1,250
Laboratory Studies
 Inpatient Studies: 476,188
 Outpatient Studies: 538,649
 Studies Performed Under Contract: 69,358

Organ Transplantation

Kidney: 0
 Heart: 0
 Lung: 0
 Heart/Lung: 0
 Pancreas: 0
 Liver: 0
 Total: 0

* Note: According to Board action on 4/22/09, Board reduced 36 beds (M/S= 24, Ped=9, OB=2, ICU=1) overall voluntarily. New CON count for the facility is 174 beds. Regarding Actual Cost of Services Provided to Charity Care Inpatients and Outpatients, Provena calculated using the 2009 IRS 990 Schedule H instructions to determine the cost to charge ratio. This methodology was used because the 2009 Medicare Cost Report was not available from the AHQ was due.

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	0	0	63	13	171	13	184	2.7	1.0
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	4	4	872	789	1817	875	2692	2.1	1.1
Gastroenterology	0	0	2	2	138	108	150	73	223	1.1	0.7
Neurology	0	0	0	0	0	0	0	0	0	0.0	0.0
OB/Gynecology	0	0	0	0	293	339	641	386	1027	2.2	1.1
Oral/Maxillofacial	0	0	0	0	0	0	0	0	0	0.0	0.0
Ophthalmology	0	0	0	0	0	0	0	0	0	0.0	0.0
Orthopedic	0	0	0	0	169	65	476	104	580	2.8	1.6
Otolaryngology	0	0	0	0	9	318	20	448	468	2.2	1.4
Plastic Surgery	0	0	0	0	1	1	1	1	2	1.0	1.0
Podiatry	0	0	0	0	1	17	1	25	26	1.0	1.5
Thoracic	0	0	0	0	0	0	0	0	0	0.0	0.0
Urology	0	0	0	0	25	6	42	6	48	1.7	1.0
Totals	0	0	6	6	1571	1656	3319	1931	5250	2.1	1.2

SURGICAL RECOVERY STATIONS	Stage 1 Recovery Stations	0	Stage 2 Recovery Stations	0
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Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	2	2	363	1151	277	865	1142	0.8	0.8
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	0	0	0	0	0	0	0	0.0	0.0
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+Nondedicated labs):	1
Cath Labs used for Angiography procedures	0
Dedicated Diagnostic Catheterization Labs	1
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	56
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	56
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	0
EP Catheterizations (15+)	0

Emergency/Trauma Care

Certified Trauma Center by EMS	<input type="checkbox"/>
Level of Trauma Service	Level 1 ---
Operating Rooms Dedicated for Trauma Care	0
Number of Trauma Visits:	0
Patients Admitted from Trauma	0
Emergency Service Type:	Basic
Number of Emergency Room Stations	29
Persons Treated by Emergency Services:	37,712
Patients Admitted from Emergency:	4,225
Total ED Visits (Emergency+Trauma):	37,712

Cardiac Surgery Data

Total Cardiac Surgery Cases:	0
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	0
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	0

Outpatient Service Data

Total Outpatient Visits	217,114
Outpatient Visits at the Hospital/ Campus:	217,114
Outpatient Visits Offsite/off campus	0

Diagnostic/Interventional Equipment

Examinations

Radiation Equipment

Therapies/

	Owned		Contract		Inpatient	Outpatient	Owned		Contract		Therapies/ Treatments
General Radiography/Fluoroscopy	6	0	8,830	23,841			Lithotripsy	0	0	0	
Nuclear Medicine	2	0	402	1,803			Linear Accelerator	1	0	11,445	
Mammography	1	0	0	3,925			Image Guided Rad Therapy	0	0	0	
Ultrasound	2	0	922	6,877			Intensity Modulated Rad Therap	0	0	0	
Diagnostic Angiography	0	0	0	0			High Dose Brachytherapy	0	0	0	
Interventional Angiography	0	0	0	0			Proton Beam Therapy	0	0	0	
Positron Emission Tomography (PET)	0	1	0	132			Gamma Knife	0	0	0	
Computerized Axial Tomography (CAT)	2	0	3,222	11,462			Cyber knife	0	0	0	
Magnetic Resonance Imaging	2	0	454	3,565							

Ownership, Management and General Information

ADMINISTRATOR NAME: David A. Bertauski
 ADMINSTRATOR PHONE: 217-337-2141
 OWNERSHIP: Provena Covenant Medical Center
 OPERATOR: Provena Covenant Medical Center
 MANAGEMENT: Church-Related
 CERTIFICATION: None
 FACILITY DESIGNATION: General Hospital
 ADDRESS: 1400 West Park Avenue

Patients by Race

White 82.4%
 Black 14.0%
 American Indian 0.1%
 Asian 1.2%
 Hawaiian/ Pacific 0.0%
 Unknown: 2.3%

Patients by Ethnicity

Hispanic or Latino: 1.1%
 Not Hispanic or Latino: 97.7%
 Unknown: 1.2%
 IDPH Number: 4861
 HPA D-01
 HSA 4

CITY: Urbana COUNTY: Champaign County

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2009	Staff Bed Occupancy Rate %
Medical/Surgical	110	95	83	5,325	18,950	3,012	4.1	60.2	54.7	63.3
0-14 Years				0	0					
15-44 Years				653	1,806					
45-64 Years				1,724	6,148					
65-74 Years				1,027	3,703					
75 Years +				1,921	7,293					
Pediatric	6	4	3	74	140	0	1.9	0.4	6.4	9.6
Intensive Care	15	14	14	1,397	3,594	34	2.6	9.9	66.3	71.0
Direct Admission				659	1,695					
Transfers				738	1,899					
Obstetric/Gynecology	24	22	22	1,249	2,839	74	2.3	8.0	33.3	36.3
Maternity				988	2,223					
Clean Gynecology				261	616					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Wing Beds				0	0		0.0	0.0		
Acute Mental Illness	30	25	21	923	4,246	0	4.6	11.6	38.8	46.5
Rehabilitation	25	21	19	396	4,362	0	11.0	12.0	47.8	56.9
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Educated Observation	0					0				
Facility Utilization	210			8,626	34,131	3,120	4.3	102.1	48.6	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payer Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	45.8%	16.6%	1.9%	30.2%	2.8%	2.8%	
	3951	1429	164	2602	238	242	8,626
Outpatients	16.6%	45.8%	1.9%	30.4%	4.0%	1.3%	
	39058	107961	4488	71721	9524	3089	235,841

Financial Year Reported:	1/1/2009 to 12/31/2009		Inpatient and Outpatient Net Revenue by Payer Source					Charity Care Expense	Total Charity Care Expense
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals			
Inpatient Revenue (\$)	43.0%	15.2%	0.4%	38.5%	3.0%	100.0%		4,601,304	
	36,829,206	13,070,156	320,129	32,988,965	2,538,299	85,746,755	1,846,049		
Outpatient Revenue (\$)	11.9%	4.9%	2.6%	66.1%	14.4%	100.0%			
	9,423,391	3,928,867	2,085,649	52,568,920	11,481,099	79,487,926	2,755,255	2.8%	

Birthing Data

Number of Total Births: 961
 Number of Live Births: 958
 Birthing Rooms: 0
 Labor Rooms: 0
 Delivery Rooms: 0
 Labor-Delivery-Recovery Rooms: 9
 Labor-Delivery-Recovery-Postpartum Rooms: 0
 C-Section Rooms: 2
 Sections Performed: 276

Newborn Nursery Utilization

Level 1 Patient Days: 1,592
 Level 2 Patient Days: 0
 Level 2+ Patient Days: 798
 Total Nursery Patientdays: 2,390
Laboratory Studies
 Inpatient Studies: 225,927
 Outpatient Studies: 271,900
 Studies Performed Under Contract: 58,884

Organ Transplantation

Kidney: 0
 Heart: 0
 Lung: 0
 Heart/Lung: 0
 Pancreas: 0
 Liver: 0
 Total: 0

Note: According to Board action on 4/22/09, Board reduced 44 beds (M/S= 18, Ped=12, AMI=10, ICU=3, Rehab=1) overall voluntarily. New CON count for the facility is 210 beds. Actual Cost of Services Provided to Charity Care Inpatients and Outpatients was calculated using the 2009 MS-990 Schedule H instructions to determine the cost to charge ratio. This methodology was used by Provena because the 2009 Medicare Cost Report was not available at time the AHQ was due.

ATTACHMENT 10

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	0	0	178	473	495	614	1109	2.8	1.3
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	12	12	451	1199	1256	1557	2813	2.8	1.3
Gastroenterology	0	0	0	0	0	0	0	0	0	0.0	0.0
Neurology	0	0	0	0	20	54	56	70	126	2.8	1.3
OB/Gynecology	0	0	0	0	189	502	527	652	1179	2.8	1.3
Oral/Maxillofacial	0	0	0	0	11	30	31	38	69	2.8	1.3
Ophthalmology	0	0	0	0	194	514	540	666	1206	2.8	1.3
Orthopedic	0	0	0	0	413	1102	1153	1431	2584	2.8	1.3
Otolaryngology	0	0	0	0	276	734	767	953	1720	2.8	1.3
Plastic Surgery	0	0	0	0	3	7	9	10	19	3.0	1.4
Podiatry	0	0	0	0	129	342	360	443	803	2.8	1.3
Thoracic	0	0	0	0	17	46	47	59	106	2.8	1.3
Urology	0	0	0	0	237	630	660	818	1478	2.8	1.3
Totals	0	0	12	12	2118	5633	5901	7311	13212	2.8	1.3

SURGICAL RECOVERY STATIONS	Stage 1 Recovery Stations	15	Stage 2 Recovery Stations	0
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Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	2	2	522	3444	434	2870	3304	0.8	0.8
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	0	0	0	0	0	0	0	0.0	0.0
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+Nondedicated labs):	3
Cath Labs used for Angiography procedures	3
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Emergency/Trauma Care

Certified Trauma Center by EMS	<input type="checkbox"/>
Level of Trauma Service	Level 1 Level 2
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Operating Rooms Dedicated for Trauma Care	0
Number of Trauma Visits:	0
Patients Admitted from Trauma	0
Emergency Service Type:	Comprehensive
Number of Emergency Room Stations	22
Persons Treated by Emergency Services:	35,126
Patients Admitted from Emergency:	4,218
Total ED Visits (Emergency+Trauma):	35,126

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	1,931
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	1,341
Interventional Catheterizations (0-14):	0
Interventional Catheterizations (15+)	563
EP Catheterizations (15+)	27

Cardiac Surgery Data

Total Cardiac Surgery Cases:	123
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	123
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	109

Outpatient Service Data

Total Outpatient Visits	235,841
Outpatient Visits at the Hospital/ Campus:	235,841
Outpatient Visits Offsite/off campus	0

Diagnostic/Interventional Equipment

	Examinations			
	Owned	Contract	Inpatient	Outpatient
General Radiography/Fluoroscopy	14	0	12,224	20,241
Nuclear Medicine	3	0	372	2,846
Mammography	1	0	0	2,379
Ultrasound	4	0	2,260	4,607
Diagnostic Angiography	1	0	1,087	429
Interventional Angiography	0	0	0	0
Positron Emission Tomography (PET)	0	1	0	82
Computerized Axial Tomography (CAT)	2	0	3,751	9,384
Magnetic Resonance Imaging	1	0	891	1,879

Radiation Equipment

	Radiation Equipment		Therapies/ Treatments
	Owned	Contract	
Lithotripsy	0	1	140
Linear Accelerator	1	0	3,100
Image Guided Rad Therapy	0	0	0
Intensity Modulated Rad Therap	0	0	0
High Dose Brachytherapy	0	0	0
Proton Beam Therapy	0	0	0
Gamma Knife	0	0	0
Cyber knife	0	0	0

Ownership, Management and General Information

ADMINISTRATOR NAME: James D. Witt
ADMINSTRATOR PHONE 630-801-2616
OWNERSHIP: Provena Hospitals d/b/a Provena Mercy Medical Cent
OPERATOR: Provena Hospitals d/b/a Provena Mercy Medical Cent
MANAGEMENT: Church-Related
CERTIFICATION: None
FACILITY DESIGNATION: General Hospital
ADDRESS 1325 North Highland Avenue **CITY:** Aurora **COUNTY:** Kane County

Patients by Race

White 62.8%
 Black 11.6%
 American Indian 0.0%
 Asian 0.6%
 Hawaiian/ Pacific 0.0%
 Unknown: 25.0%

Patients by Ethnicity

Hispanic or Latino: 22.7%
 Not Hispanic or Latino: 75.0%
 Unknown: 2.3%
 IDPH Number: 4903
 HPA A-12
 HSA 8

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admlssions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2009	Staff Bed Occupancy Rate %
Medical/Surgical	156	122	87	5,229	22,430	3,479	5.0	71.0	45.5	58.2
0-14 Years				0	0					
15-44 Years				972	3,368					
45-64 Years				1,634	7,079					
65-74 Years				900	4,051					
75 Years +				1,723	7,932					
Pediatric	16	16	11	443	867	370	2.8	3.4	21.2	21.2
Intensive Care	16	16	16	1,097	3,425	50	3.2	9.5	59.5	59.5
Direct Admission				768	2,286					
Transfers				329	1,139					
Obstetric/Gynecology	16	16	15	1,239	2,620	79	2.2	7.4	46.2	46.2
Maternity				1,145	2,419					
Clean Gynecology				94	201					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	95	72	64	2,718	16,682	0	6.1	45.7	48.1	63.5
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
<i>Dedicated Observation</i>	0					0				
Facility Utilization	299			10,397	46,024	3,978	4.8	137.0	45.8	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	36.6%	27.3%	0.5%	30.2%	3.2%	2.1%	10,397
Outpatients	15.9%	30.9%	0.6%	32.2%	17.8%	2.6%	93,254

Financial Year Reported:	Inpatient and Outpatient Net Revenue by Payor Source							Charity Care Expense	Total Charity Care Expense 5,367,773
	1/1/2009 to	12/31/2009	Medicare	Medicaid	Other Public	Private Insurance	Private Pay		
Inpatient Revenue (\$)	39.1%	33.6%	0.4%	24.9%	1.9%	100.0%	30,667,645	2,638,341	Totals: Charity Care as % of Net Revenue 3.2%
Outpatient Revenue (\$)	17.1%	23.7%	0.4%	54.8%	4.1%	100.0%	15,493,796	2,729,432	

Birthing Data

Number of Total Births: 1,124
 Number of Live Births: 1,121
 Birthing Rooms: 0
 Labor Rooms: 0
 Delivery Rooms: 0
 Labor-Delivery-Recovery Rooms: 0
 Labor-Delivery-Recovery-Postpartum Rooms: 16
 C-Section Rooms: 2
 CSections Performed: 377

Newborn Nursery Utilization

Level 1 Patient Days 1,746
 Level 2 Patient Days 989
 Level 2+ Patient Days 0
 Total Nursery Patientdays 2,735
Laboratory Studies
 Inpatient Studies 238,354
 Outpatient Studies 122,789
 Studies Performed Under Contract 28,893

Organ Transplantation

Kidney: 0
 Heart: 0
 Lung: 0
 Heart/Lung: 0
 Pancreas: 0
 Liver: 0
 Total: 0

* Note: According to Board action on 4/22/09, Board reduced 16 beds (Ped=12, AMI=4) overall voluntarily. New CON count for the facility is 299 beds. Actual Cost of Services Provided to Charity Care Inpatients and Outpatients was calculated using the 2009 IRS 990 Schedule H instructions to determine the cost to charge ratio. This methodology was used because the 2009 Medicare Cost Report was not available at time of audit.

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	2	0	0	2	377	74	1537	124	1661	4.1	1.7
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	10	10	668	678	1337	989	2326	2.0	1.5
Gastroenterology	0	0	0	0	0	0	0	0	0	0.0	0.0
Neurology	0	0	0	0	54	33	230	78	308	4.3	2.4
OB/Gynecology	0	0	0	0	138	210	308	240	548	2.2	1.1
Oral/Maxillofacial	0	0	0	0	3	2	9	4	13	3.0	2.0
Ophthalmology	0	0	0	0	1	15	3	15	18	3.0	1.0
Orthopedic	0	0	0	0	539	390	1320	699	2019	2.4	1.8
Otolaryngology	0	0	0	0	75	75	115	88	203	1.5	1.2
Plastic Surgery	0	0	0	0	11	5	32	7	39	2.9	1.4
Podiatry	0	0	0	0	29	32	38	54	92	1.3	1.7
Thoracic	0	0	0	0	0	0	0	0	0	0.0	0.0
Urology	0	0	0	0	84	117	194	157	351	2.3	1.3
Totals	2	0	10	12	1979	1631	5123	2455	7578	2.6	1.5

SURGICAL RECOVERY STATIONS	Stage 1 Recovery Stations	12	Stage 2 Recovery Stations	19
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Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
<i>Gastrointestinal</i>	0	0	2	2	801	1305	865	1310	2175	1.1	1.0
<i>Laser Eye Procedures</i>	0	0	0	0	0	0	0	0	0	0.0	0.0
<i>Pain Management</i>	0	0	0	0	0	0	0	0	0	0.0	0.0
<i>Cystoscopy</i>	0	0	0	0	0	0	0	0	0	0.0	0.0
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+Nondedicated labs):	3
Cath Labs used for Angiography procedures	1
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Emergency/Trauma Care

Certified Trauma Center by EMS	<input checked="" type="checkbox"/>
Level of Trauma Service	Level 1 Adult
Operating Rooms Dedicated for Trauma Care	0
Number of Trauma Visits:	658
Patients Admitted from Trauma	334
Emergency Service Type:	Comprehensive
Number of Emergency Room Stations	26
Persons Treated by Emergency Services:	43,713
Patients Admitted from Emergency:	4,485
Total ED Visits (Emergency+Trauma):	44,371

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	1,701
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	983
Interventional Catheterizations (0-14):	0
Interventional Catheterizations (15+)	531
EP Catheterizations (15+)	187

Cardiac Surgery Data

Total Cardiac Surgery Cases:	185
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	185
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	185

Outpatient Service Data

Total Outpatient Visits	196,631
Outpatient Visits at the Hospital/ Campus:	196,631
Outpatient Visits Offsite/off campus	0

Diagnostic/Interventional Equipment

	Examinations			
	Owned	Contract	Inpatient	Outpatient
General Radiography/Fluoroscopy	4	0	12,923	26,254
Nuclear Medicine	2	0	1,035	3,306
Mammography	2	0	0	3,497
Ultrasound	3	0	2,531	9,994
Diagnostic Angiography	0	0	0	0
Interventional Angiography	0	0	0	0
Positron Emission Tomography (PET)	0	0	0	0
Computerized Axial Tomography (CAT)	3	0	4,665	13,917
Magnetic Resonance Imaging	2	0	658	2,465

Radiation Equipment

	Owned	Contract	Therapies/ Treatments
Lithotripsy	0	1	20
Linear Accelerator	0	0	0
Image Guided Rad Therapy	0	0	0
Intensity Modulated Rad Therap	0	0	0
High Dose Brachytherapy	0	0	0
Proton Beam Therapy	0	0	0
Gamma Knife	0	0	0
Cyber knife	0	0	0

Ownership, Management and General Information		Patients by Race		Patients by Ethnicity	
ADMINISTRATOR NAME:	Stephen O. Scogna	White	81.5%	Hispanic or Latino:	9.8%
ADMINISTRATOR PHONE	847-695-3200 x5474	Black	5.6%	Not Hispanic or Latino:	89.3%
OWNERSHIP:	Provena Hospitals d/b/a Provena Saint Joseph Hospi	American Indian	0.0%	Unknown:	0.8%
OPERATOR:	Provena Hospitals d/b/a Provena Saint Joseph Hospi	Asian	1.5%	IDPH Number:	4887
MANAGEMENT:	Church-Related	Hawaiian/ Pacific	0.0%	HPA	A-11
CERTIFICATION:	None	Unknown:	11.5%	HSA	8
FACILITY DESIGNATION:	General Hospital				
ADDRESS	77 North Airlite Street	CITY:	Elgin	COUNTY:	Kane County

Facility Utilization Data by Category of Service										
Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2009	Staff Bed Occupancy Rate %
Medical/Surgical	99	99	99	5,890	27,862	3,810	5.4	86.8	87.6	87.6
0-14 Years				34	75					
15-44 Years				941	3,341					
45-64 Years				1,774	7,903					
65-74 Years				1,098	5,495					
75 Years +				2,043	11,048					
Pediatric	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Intensive Care	15	15	15	1,123	4,210	0	3.7	11.5	76.9	76.9
Direct Admission				637	2,493					
Transfers				486	1,717					
Obstetric/Gynecology	0	15	6	232	508	66	2.5	1.6	0.0	10.5
Maternity				215	468					
Clean Gynecology				17	40					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	30	30	25	1,185	6,055	0	5.1	16.6	55.3	55.3
Rehabilitation	34	34	34	902	9,691	0	10.7	26.6	78.1	78.1
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedicated Observation	0					0				
Facility Utilization	178			8,846	48,326	3,876	5.9	143.0	80.3	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source							
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	52.9%	11.0%	0.7%	30.6%	2.4%	2.4%	8,846
Outpatients	25.7%	17.9%	0.4%	42.7%	11.5%	1.7%	94,884
	4679	975	63	2711	210	208	
	24364	17017	422	40545	10954	1582	

Financial Year Reported:	Inpatient and Outpatient Net Revenue by Payor Source						Charity Care Expense	Total Charity Care Expense 3,749,548
	1/1/2009 to	12/31/2009	Medicare	Medicaid	Other Public	Private Insurance		
Inpatient Revenue (\$)	39,020,448	13,249,904	210,860	21,081,538	1,439,586	74,982,336	1,675,691	
Outpatient Revenue (\$)	20,044,749	12,794,644	327,225	53,398,003	2,348,798	88,913,419	2,073,857	Totals: Charity Care as % of Net Revenue 2.3%

Birthing Data		Newborn Nursery Utilization		Organ Transplantation	
Number of Total Births:	222	Level 1 Patient Days	368	Kidney:	0
Number of Live Births:	222	Level 2 Patient Days	239	Heart:	0
Birthing Rooms:	0	Level 2+ Patient Days	63	Lung:	0
Labor Rooms:	0	Total Nursery Patientdays	670	Heart/Lung:	0
Delivery Rooms:	0			Pancreas:	0
Labor-Delivery-Recovery Rooms:	7			Liver:	0
Labor-Delivery-Recovery-Postpartum Rooms:	0			Total:	0
C-Section Rooms:	1				
CSections Performed:	47				

* Note: According to project #09-033, approved on 10/13/09, facility discontinued 15 bed OB category of service. The data shown is prior to its discontinuation. Actual Cost of Services Provided to Charity Care Inpatients and Outpatients was calculated using the 2009 IRS 990 Schedule H instructions to determine the cost to charge ratio. This methodology was used because the 2009 Medicare Cost Report was not available until 2010.

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	0	0	207	32	830	74	904	4.0	2.3
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	10	10	1040	981	1919	1261	3180	1.8	1.3
Gastroenterology	0	0	0	0	713	1170	741	1169	1910	1.0	1.0
Neurology	0	0	0	0	98	10	312	19	331	3.2	1.9
OB/Gynecology	0	0	0	0	63	103	141	115	256	2.2	1.1
Oral/Maxillofacial	0	0	0	0	4	0	4	0	4	1.0	0.0
Ophthalmology	0	0	0	0	3	279	4	287	291	1.3	1.0
Orthopedic	0	0	0	0	565	588	1472	1001	2473	2.6	1.7
Otolaryngology	0	0	0	0	77	200	118	377	495	1.5	1.9
Plastic Surgery	0	0	0	0	19	41	73	84	157	3.8	2.0
Podiatry	0	0	0	0	4	31	9	49	58	2.3	1.6
Thoracic	0	0	0	0	0	0	0	0	0	0.0	0.0
Urology	0	0	0	0	189	502	278	510	788	1.5	1.0
Totals	0	0	10	10	2982	3937	5901	4946	10847	2.0	1.3

SURGICAL RECOVERY STATIONS	Stage 1 Recovery Stations	11	Stage 2 Recovery Stations	22
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Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
<i>Gastrointestinal</i>	0	0	0	0	0	0	0	0	0	0.0	0.0
<i>Laser Eye Procedures</i>	0	0	0	0	0	0	0	0	0	0.0	0.0
<i>Pain Management</i>	0	0	0	0	0	0	0	0	0	0.0	0.0
<i>Cystoscopy</i>	0	0	0	0	0	0	0	0	0	0.0	0.0
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+Nondedicated labs):	4
Cath Labs used for Angiography procedures	2
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Emergency/Trauma Care

Certified Trauma Center by EMS	<input checked="" type="checkbox"/>
Level of Trauma Service	Level 1 Adult
Operating Rooms Dedicated for Trauma Care	1
Number of Trauma Visits:	564
Patients Admitted from Trauma	424
Emergency Service Type:	Comprehensive
Number of Emergency Room Stations	20
Persons Treated by Emergency Services:	32,913
Patients Admitted from Emergency:	4,257
Total ED Visits (Emergency+Trauma):	33,477

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	1,373
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	732
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	481
EP Catheterizations (15+)	160

Cardiac Surgery Data

Total Cardiac Surgery Cases:	64
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	64
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	64

Outpatient Service Data

Total Outpatient Visits	204,613
Outpatient Visits at the Hospital/ Campus:	172,261
Outpatient Visits Offsite/off campus	32,352

Diagnostic/Interventional Equipment

Examinations

Radiation Equipment

	Owned		Contract		Inpatient	Outpatient	Owned		Contract		Therapies/ Treatments
<i>General Radiography/Fluoroscopy</i>	5	0	14,504	22,969				0	0		0
<i>Nuclear Medicine</i>	3	0	1,491	3,217				2	0		4,854
<i>Mammography</i>	3	0	0	6,823				0	0		0
<i>Ultrasound</i>	5	0	3,507	9,429				1	0		1120
<i>Diagnostic Angiography</i>	0	0	0	0				0	0		0
<i>Interventional Angiography</i>	0	0	0	0				0	0		0
<i>Positron Emission Tomography (PET)</i>	0	1	0	182				0	0		0
<i>Computerized Axial Tomography (CAT)</i>	2	0	6,194	16,786				0	0		0
<i>Magnetic Resonance Imaging</i>	1	0	1,449	2,538				0	0		0

Ownership, Management and General Information

ADMINISTRATOR NAME: Jeffrey L. Brickman
 ADMINSTRATOR PHONE: 815-725-7133
 OWNERSHIP: Provena Health
 OPERATOR: Provena Hospitals d/b/a Provena St. Joseph Medical
 MANAGEMENT: Not for Profit Corporation
 CERTIFICATION: None
 FACILITY DESIGNATION: General Hospital
 ADDRESS: 333 North Madison Street

Patients by Race

White 77.3%
 Black 12.7%
 American Indian 0.0%
 Asian 0.8%
 Hawaiian/ Pacific 0.0%
 Unknown: 9.2%

Patients by Ethnicity

Hispanic or Latino: 8.2%
 Not Hispanic or Latino: 91.5%
 Unknown: 0.3%
 IDPH Number: 4838
 HPA: A-13
 HSA: 9

CITY: Joliet

COUNTY: Will County

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2009	Staff Bed Occupancy Rate %
Medical/Surgical	319	282	271	15,783	67,402	9,063	4.8	209.5	65.7	74.3
0-14 Years				40	94					
15-44 Years				3,366	11,237					
45-64 Years				4,893	19,502					
65-74 Years				2,680	13,171					
75 Years +				4,804	23,398					
Pediatric	13	13	13	525	1,415	692	4.0	5.8	44.4	44.4
Intensive Care	52	52	51	4,413	11,848	22	2.7	32.5	62.5	62.5
Direct Admission				2,801	8,350					
Transfers				1,612	3,498					
Obstetric/Gynecology	33	33	33	2,406	6,039	275	2.6	17.3	52.4	52.4
Maternity				2,182	5,500					
Clean Gynecology				224	539					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	31	31	31	1,390	9,613	0	6.9	26.3	85.0	85.0
Rehabilitation	32	32	30	570	6,544	0	11.5	17.9	56.0	56.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
<i>Dedicated Observation</i>	0					0				
Facility Utilization	480			23,475	102,861	10,052	4.8	309.4	64.4	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	46.0%	13.4%	0.9%	34.5%	3.2%	2.0%	23,475
Outpatients	27.4%	16.9%	0.8%	48.5%	5.2%	1.3%	232,432

Financial Year Reported:	1/1/2009 to 12/31/2009		Inpatient and Outpatient Net Revenue by Payor Source					Charity Care Expense	Total Charity Care Expense 7,284,458
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals			
Inpatient Revenue (\$)	50.0%	11.1%	0.0%	25.3%	13.6%	100.0%	101,834,552	3,377,931	
Outpatient Revenue (\$)	22.3%	6.0%	0.0%	51.9%	19.7%	100.0%	46,700,399	3,906,527	
								Totals: Charity Care as % of Net Revenue	
								1.8%	

Birthing Data

Number of Total Births: 2,016
 Number of Live Births: 2,011
 Birthing Rooms: 0
 Labor Rooms: 0
 Delivery Rooms: 0
 Labor-Delivery-Recovery Rooms: 0
 Labor-Delivery-Recovery-Postpartum Rooms: 33
 C-Section Rooms: 2
 CSections Performed: 745

Newborn Nursery Utilization

Level 1 Patient Days: 3,719
 Level 2 Patient Days: 0
 Level 2+ Patient Days: 1,943
 Total Nursery Patientdays: 5,662
Laboratory Studies
 Inpatient Studies: 766,465
 Outpatient Studies: 603,298
 Studies Performed Under Contract: 31,054

Organ Transplantation

Kidney: 0
 Heart: 0
 Lung: 0
 Heart/Lung: 0
 Pancreas: 0
 Liver: 0
 Total: 0

* Note: The 2 Linear Accelerators are capable of performing IGRT, IMRT and Brachytherapy treatments. Actual Cost of Services Provided to Charity Care Inpatients and Outpatients was calculated using the 2009 IRS 990 Schedule H instructions to determine the cost to charge ratio. This methodology was used because the 2009 Medicare Cost Report was not available at time the AHQ was due

Surgical Specialty	Surgery and Operating Room Utilization										
	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	2	2	237	0	1377	0	1377	5.8	0.0
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	8	8	1383	1564	2553	1989	4542	1.8	1.3
Gastroenterology	0	0	0	0	1962	3416	1405	2393	3798	0.7	0.7
Neurology	0	0	0	0	373	49	1548	124	1672	4.2	2.5
OB/Gynecology	0	0	0	0	346	686	775	763	1538	2.2	1.1
Oral/Maxillofacial	0	0	0	0	2	25	5	62	67	2.5	2.5
Ophthalmology	0	0	0	0	6	386	11	363	374	1.8	0.9
Orthopedic	0	0	0	0	900	854	1974	1294	3268	2.2	1.5
Otolaryngology	0	0	0	0	143	436	201	541	742	1.4	1.2
Plastic Surgery	0	0	0	0	16	101	29	195	224	1.8	1.9
Podiatry	0	0	0	0	19	118	30	246	276	1.6	2.1
Thoracic	0	0	0	0	421	197	1266	323	1589	3.0	1.6
Urology	0	0	0	0	213	232	743	1309	2052	3.5	5.6
Totals	0	0	10	10	6021	8064	11917	9602	21519	2.0	1.2

SURGICAL RECOVERY STATIONS	Stage 1 Recovery Stations	10	Stage 2 Recovery Stations	0
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Procedure Type	Dedicated and Non-Dedicated Procedure Room Utilization										
	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	3	3	1962	3416	1405	2393	3798	0.7	0.7
Laser Eye Procedures	0	0	1	1	0	56	0	21	21	0.0	0.4
Pain Management	0	0	1	1	57	170	66	202	268	1.2	1.2
Cystoscopy	0	0	1	1	184	350	251	385	636	1.4	1.1
Multipurpose Non-Dedicated Rooms											
	0	0	1	1	0	2	0	1	1	0.0	0.5
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs	
Total Cath Labs (Dedicated+Nondedicated labs):	4
Cath Labs used for Angiography procedures	0
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	1

Cardiac Catheterization Utilization	
Total Cardiac Cath Procedures:	2,714
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	1,329
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	995
EP Catheterizations (15+)	390

Emergency/Trauma Care	
Certified Trauma Center by EMS	<input checked="" type="checkbox"/>
Level of Trauma Service	Level 1 Adult Level 2 ---
Operating Rooms Dedicated for Trauma Care	1
Number of Trauma Visits:	904
Patients Admitted from Trauma	866
Emergency Service Type:	Comprehensive
Number of Emergency Room Stations	43
Persons Treated by Emergency Services:	69,565
Patients Admitted from Emergency:	12,450
Total ED Visits (Emergency+Trauma):	70,469

Cardiac Surgery Data	
Total Cardiac Surgery Cases:	855
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	855
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	284

Outpatient Service Data	
Total Outpatient Visits	506,676
Outpatient Visits at the Hospital/ Campus:	464,506
Outpatient Visits Offsite/off campus	42,070

Diagnostic/Interventional Equipment	Examinations				Radiation Equipment			Therapies/ Treatments
	Owned	Contract	Inpatient	Outpatient	Owned	Contract		
General Radiography/Fluoroscopy	29	0	26,372	71,389	Lithotripsy	0	1	27
Nuclear Medicine	4	0	3,667	10,206	Linear Accelerator	2	0	70
Mammography	2	0	0	13,856	Image Guided Rad Therapy	2	0	40
Ultrasound	8	0	5,143	19,181	Intensity Modulated Rad Therap	2	0	36
Diagnostic Angiography	0	0	0	0	High Dose Brachytherapy	2	0	19
Interventional Angiography	0	0	0	0	Proton Beam Therapy	0	0	0
Positron Emission Tomography (PET)	0	1	0	0	Gamma Knife	0	0	0
Computerized Axial Tomography (CAT)	7	0	8,981	29,106	Cyber knife	0	0	0
Magnetic Resonance Imaging	4	0	4,170	8,779				

ATTACHMENT 19C

Ownership, Management and General Information

ADMINISTRATOR NAME: Michael Arno
 ADMINSTRATOR PHONE: (815) 937-2401
 OWNERSHIP: Provena Hospitals
 OPERATOR: Provena Hospitals d/b/a Provena St.Marys Hospital
 MANAGEMENT: Church-Related
 CERTIFICATION: None
 FACILITY DESIGNATION: General Hospital
 ADDRESS: 500 West Court Street

Patients by Race

White 78.3%
 Black 20.7%
 American Indian 0.0%
 Asian 0.2%
 Hawaiian/ Pacific 0.0%
 Unknown: 0.7%

Patients by Ethnicity

Hispanic or Latino: 3.1%
 Not Hispanic or Latino: 96.6%
 Unknown: 0.3%
 IDPH Number: 4879
 HPA A-14
 HSA 9

CITY: Kankakee

COUNTY: Kankakee County

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2009	Staff Bed Occupancy Rate %
Medical/Surgical	105	83	77	4,471	19,084	952	4.5	54.9	52.3	66.1
0-14 Years				5	19					
15-44 Years				817	2,600					
45-64 Years				1,789	6,969					
65-74 Years				694	3,272					
75 Years +				1,166	6,224					
Pediatric	14	13	10	542	1,711	445	4.0	5.9	42.2	45.4
Intensive Care	26	25	25	2,051	5,860	75	2.9	16.3	62.5	65.0
Direct Admission				1,417	3,233					
Transfers				634	2,627					
Obstetric/Gynecology	12	13	8	466	1,042	52	2.3	3.0	25.0	23.1
Maternity				420	936					
Clean Gynecology				46	106					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	25	21	21	649	3,488	3	5.4	9.6	38.3	45.5
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedicated Observation	0					0				
Facility Utilization	182			7,545	31,185	1,527	4.3	89.6	49.2	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	46.0%	17.8%	1.2%	28.8%	4.2%	1.9%	7,545
Outpatients	26.9%	15.1%	1.4%	40.9%	14.1%	1.5%	103,475

Financial Year Reported:	Inpatient and Outpatient Net Revenue by Payor Source						Charity Care Expense	Total Charity Care Expense
	1/1/2009 to	12/31/2009	Medicare	Medicaid	Other Public	Private Insurance		
Inpatient Revenue (\$)	32,691,073	9,028,207	105,333	18,527,435	1,932,268	62,284,316	1,856,922	2,657,530
Outpatient Revenue (\$)	15,172,947	7,045,738	132,298	52,276,990	4,708,645	79,336,618	800,608	Totals: Charity Care as % of Net Revenue

Birthing Data

Number of Total Births: 424
 Number of Live Births: 420
 Birthing Rooms: 0
 Labor Rooms: 0
 Delivery Rooms: 0
 Labor-Delivery-Recovery Rooms: 1
 Labor-Delivery-Recovery-Postpartum Rooms: 4
 C-Section Rooms: 1
 CSections Performed: 116

Newborn Nursery Utilization

Level 1 Patient Days: 781
 Level 2 Patient Days: 242
 Level 2+ Patient Days: 20
 Total Nursery Patientdays: 1,043

Organ Transplantation

Kidney: 0
 Heart: 0
 Lung: 0
 Heart/Lung: 0
 Pancreas: 0
 Liver: 0
 Total: 0

Laboratory Studies

Inpatient Studies: 167,326
 Outpatient Studies: 204,947
 Studies Performed Under Contract: 0

* Note: According to Board action on 4/22/09, Board reduced 4 ICU beds overall voluntarily. New CON count for the facility is 182 beds. Actual Cost of Services Provided to Charity Care Inpatients and Outpatients (Part II, Question 3 on page 14) was calculated using the 2009 IRS 990 Schedule H instructions to determine the cost to charge ratio. This methodology was used because the 2009 Medicare Cost Report was not available for the 2009 period.

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	0	0	0	0	0	0	0	0.0	0.0
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	7	7	450	640	839	989	1828	1.9	1.5
Gastroenterology	0	0	0	0	166	69	201	83	284	1.2	1.2
Neurology	0	0	0	0	51	747	121	909	1030	2.4	1.2
OB/Gynecology	0	0	0	0	197	248	391	416	807	2.0	1.7
Oral/Maxillofacial	0	0	0	0	12	9	24	17	41	2.0	1.9
Ophthalmology	0	0	0	0	3	385	8	422	430	2.7	1.1
Orthopedic	0	0	0	0	394	607	1047	1223	2270	2.7	2.0
Otolaryngology	0	0	0	0	10	285	15	360	375	1.5	1.3
Plastic Surgery	0	0	0	0	1	33	4	66	70	4.0	2.0
Podiatry	0	0	0	0	11	76	18	154	172	1.6	2.0
Thoracic	0	0	0	0	24	14	60	17	77	2.5	1.2
Urology	0	0	1	1	197	659	301	872	1173	1.5	1.3
Totals	0	0	8	8	1516	3772	3029	5528	8557	2.0	1.5

SURGICAL RECOVERY STATIONS	Stage 1 Recovery Stations	0	Stage 2 Recovery Stations	0
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Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	5	5	360	1289	382	1565	1947	1.1	1.2
Laser Eye Procedures	0	0	1	1	0	22	0	17	17	0.0	0.8
Pain Management	0	0	0	0	0	0	0	0	0	0.0	0.0
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0

Multipurpose Non-Dedicated Rooms

0	0	0	0	0	0	0	0	0	0	0.0	0.0
0	0	0	0	0	0	0	0	0	0	0.0	0.0
0	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+Nondedicated labs):	2
Cath Labs used for Angiography procedures	2
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Emergency/Trauma Care

Certified Trauma Center by EMS	<input checked="" type="checkbox"/>
Level of Trauma Service	Level 1 Adult
Operating Rooms Dedicated for Trauma Care	1
Number of Trauma Visits:	291
Patients Admitted from Trauma	223
Emergency Service Type:	Comprehensive
Number of Emergency Room Stations	22
Persons Treated by Emergency Services:	31,174
Patients Admitted from Emergency:	5,913
Total ED Visits (Emergency+Trauma):	31,465

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	858
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	522
Interventional Catheterizations (0-14):	0
Interventional Catheterizations (15+)	113
EP Catheterizations (15+)	23

Cardiac Surgery Data

Total Cardiac Surgery Cases:	0
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	0
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	0

Outpatient Service Data

Total Outpatient Visits	218,663
Outpatient Visits at the Hospital/ Campus:	187,202
Outpatient Visits Offsite/off campus	31,461

Diagnostic/Interventional Equipment

	Examinations		Radiation Equipment		Therapies/ Treatments
	Owned	Contract	Inpatient	Outpatient	
General Radiography/Fluoroscopy	7	0	7,780	30,258	Lithotripsy 0 1 156
Nuclear Medicine	2	0	1,405	1,861	Linear Accelerator 0 0 0
Mammography	4	0	0	4,584	Image Guided Rad Therapy 0 0 0
Ultrasound	4	0	2,102	6,361	Intensity Modulated Rad Therap 0 0 0
Diagnostic Angiography	0	0	0	0	High Dose Brachytherapy 0 0 0
Interventional Angiography	0	0	0	0	Proton Beam Therapy 0 0 0
Positron Emission Tomography (PET)	0	1	0	0	Gamma Knife 0 0 0
Computerized Axial Tomography (CAT)	2	0	2,494	15,811	Cyber knife 0 0 0
Magnetic Resonance Imaging	2	0	609	255	

NUMBER OF PATIENTS BY AGE GROUP

AGE	MALE	FEMALE	TOTAL
0-14	15	12	27
15-44	159	185	344
45-64	308	322	630
65-74	266	388	654
75+ Yea	192	420	612
TOTAL	940	1,327	2,267

NUMBER OF PATIENTS BY PRIMARY PAYMENT SOURCE

PAYMENT SOURCE	MALE	FEMALE	TOTAL
Medicaid	25	26	51
Medicare	414	851	1,265
Other Public Insurance	0	0	0
Private Pay	10	16	26
Charity Care	3	1	4
TOTAL	940	1,327	2,267

NET REVENUE BY PAYOR SOURCE for Fiscal Year

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense	Charity Care Expense as % of Total Net Revenue
18.7%	0.5%	0.0%	58.6%	22.2%	100.0%		0%
870,580	21,951	0	2,730,613	1,035,739	4,658,883	16,139	

OPERATING ROOM UTILIZATION FOR THE REPORTING YEAR

SURGERY AREA	TOTAL SURGERIES	SURGERY PREP and CLEAN-UP		TOTAL SURGERY (HOURS)	AVERAGE CASE TIME (HOURS)
		SURGERY TIME (HOURS)	CLEAN-UP TIME (HOURS)		
Cardiovascular	0	0.00	0.00	0.00	0.00
Dermatology	0	0.00	0.00	0.00	0.00
Gastroenterology	266	133.00	88.00	221.00	0.83
General	16	12.00	7.00	19.00	1.19
Laser Eye	0	0.00	0.00	0.00	0.00
Neurological	0	0.00	0.00	0.00	0.00
OB/Gynecology	0	0.00	0.00	0.00	0.00
Ophthalmology	1304	652.00	325.00	977.00	0.75
Oral/Maxillofacial	0	0.00	0.00	0.00	0.00
Orthopedic	287	287.00	119.00	406.00	1.41
Otolaryngology	37	22.00	12.00	34.00	0.92
Pain Management	148	74.00	24.00	98.00	0.66
Plastic	0	0.00	0.00	0.00	0.00
Podiatry	164	164.00	68.00	232.00	1.41
Thoracic	0	0.00	0.00	0.00	0.00
Urology	45	30.00	22.00	52.00	1.16
TOTAL	2267	1,374.00	665.00	2039.00	0.90

PROCEDURE ROOM UTILIZATION FOR THE REPORTING YEAR

SURGERY AREA	PROCEDURE ROOMS	TOTAL SURGERIES	SURGERY PREP and CLEAN-UP		TOTAL SURGERY (HOURS)	AVERAGE CASE TIME (HOURS)
			SURGERY TIME (HOURS)	CLEAN-UP TIME (HOURS)		
Cardiac Catheteriza	0	0	0	0	0	0.00
Gastro-Intestinal	0	0	0	0	0	0.00
Laser Eye	0	0	0	0	0	0.00
Pain Management	0	0	0	0	0	0.00
TOTALS	0	0	0	0	0	0.00

Reference Numbers	Facility Id	7003131	Number of Operating Rooms	4	
Health Service Area	006	Planning Service Area	030	Procedure Rooms	0
BELMONT/HARLEM SURGERY CENTER, LLC			Exam Rooms	0	
3101 NORTH HARLEM AVENUE			Number of Recovery Stations Stage 1	5	
CHICAGO, IL 60634			Number of Recovery Stations Stage 2	8	

Administrator	Date
FAITH MCHALE	Completed
	4/26/2010

Registered Agent
NANCY ARMATAS

Property Owner
RESURRECTION SERVICES

Legal Owner

Type of Ownership
Limited Liability Company (RA required)

HOSPITAL TRANSFER RELATIONSHIPS

HOSPITAL NAME	NUMBER OF PATIENTS
RESURRECTION MEDICAL CENTER, CHICAGO	2
OUR LADY OF RESURRECTION, CHICAGO	0
	0
	0
	0

STAFFING PATTERNS

PERSONNEL	FULL-TIME EQUIVALENTS
Administrator	0.00
Physicians	0.00
Nurse Anesthetists	0.00
Dir. of Nurses	1.00
Reg. Nurses	2.00
Certified Aides	1.00
Other Hlth. Profs.	2.00
Other Non-Hlth. Profs	3.00
TOTAL	9.00

DAYS AND HOURS OF OPERATION

Monday	10
Tuesday	10
Wednesday	10
Thursday	10
Friday	10
Saturday	0
Sunday	0

FACILITY NOTES

HISTORICAL UTILIZATION OF
MANTENO DIALYSIS CENTER

Provena Health maintains a 50% ownership interest in Manteno Dialysis Center, 15-station ESRD facility located in Manteno, Illinois. According to data provided by The Renal Network, Manteno Dialysis Center operated at 41.11% of capacity during the reporting quarter ending September 30, 2009.

PROVENA COR MARIAE CENTER		ADMISSION RESTRICTIONS		RESIDENTS BY PRIMARY DIAGNOSIS		
3330 MARIA LINDEN DRIVE		Aggressive/Anti-Social	0	DIAGNOSIS		
ROCKFORD, IL. 61114		Chronic Alcoholism	0	Neoplasms	0	
Reference Numbers	Facility ID 6005771	Developmentally Disabled	0	Endocrine/Metabolic	0	
Health Service Area 001	Planning Service Area 201	Drug Addiction	0	Blood Disorders	0	
Administrator		Medicaid Recipient	0	*Nervous System Non Alzheimer	0	
Teresa Wester-Peters		Medicare Recipient	0	Alzheimer Disease	0	
Contact Person and Telephone		Mental Illness	0	Mental Illness	0	
Sandra Fuller		Non-Ambulatory	0	Developmental Disability	0	
815-877-7416		Non-Mobile	0	Circulatory System	28	
Registered Agent Information	Date Completed	Public Aid Recipient	0	Respiratory System	23	
Teresa Wester-Peters	4/29/2010	Under 65 Years Old	0	Digestive System	10	
3330 Maria Linden Drive		Unable to Self-Medicate	0	Genitourinary System Disorders	14	
Rockford, IL 61114		Ventilator Dependent	1	Skin Disorders	4	
FACILITY OWNERSHIP		Infectious Disease w/ Isolation	0	Musculo-skeletal Disorders	14	
NON-PROF CORPORATION		Other Restrictions	0	Injuries and Poisonings	10	
CONTINUING CARE COMMUNITY	No	No Restrictions	0	Other Medical Conditions	12	
LIFE CARE FACILITY	No	<i>Note: Reported restrictions denoted by 'I'</i>			Non-Medical Conditions	7
					TOTALS	122
					Total Residents Diagnosed as Mentally Ill	14

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

ADMISSIONS AND DISCHARGES - 2009

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	ADMISSIONS AND DISCHARGES - 2009	
									Residents on 1/1/2009	Identified Offenders
Nursing Care	73	73	69	73	69	4	73	16	113	113
Skilled Under 22	0	0	0	0	0	0	0	0	484	484
Intermediate DD	0	0	0	0	0	0	0	0	475	475
Sheltered Care	61	61	53	61	53	8	0	0	122	122
TOTAL BEDS	134	134	122	134	122	12	73	16		

FACILITY UTILIZATION - 2009

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL	Licensed Beds	Peak Beds
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.							
Nursing Care	10344	38.8%	4319	74.0%	0	0	8821	167	23651	88.8%	88.8%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	1570	17775	0	19345	86.9%	86.9%
TOTALS	10344	38.8%	4319	74.0%	0	1570	26596	167	42996	87.9%	87.9%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009

AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	0	0	0	0	0	0	0	0	0	0	0
60 to 64	1	1	0	0	0	0	0	1	1	2	3
65 to 74	2	2	0	0	0	0	2	3	4	5	9
75 to 84	3	12	0	0	0	0	5	8	8	20	28
85+	10	38	0	0	0	0	10	24	20	62	82
TOTALS	16	53	0	0	0	0	17	36	33	89	122

PROVENA COR MARIAE CENTER

3330 MARIA LINDEN DRIVE

ROCKFORD, IL. 61114

Reference Numbers Facility ID 6005771

Health Service Area 001 Planning Service Area 201

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare		Other		Private	Charity	TOTALS
	Medicare	Medicaid	Public	Insurance	Pay	Care	
Nursing Care	36	12	3	3	15	0	69
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD		0	0	0	0	0	0
Sheltered Care			0	0	53	0	53
TOTALS	36	12	3	3	68	0	122

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	343	207
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	144	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	1	1
Amer. Indian	0	0	0	0	0
Black	4	0	0	0	4
Hawaiian/Pac. Isl.	0	0	0	0	0
White	65	0	0	52	117
Race Unknown	0	0	0	0	0
Total	69	0	0	53	122

ETHNICITY	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Hispanic	0	0	0	1	1
Non-Hispanic	69	0	0	52	121
Ethnicity Unknown	0	0	0	0	0
Total	69	0	0	53	122

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	2.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	9.54
LPN's	13.78
Certified Aides	41.78
Other Health Staff	0.00
Non-Health Staff	58.70
Totals	126.80

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
36.0%	5.9%	0.0%	5.5%	52.6%	100.0%		0.3%
3,213,321	522,027	0	494,247	4,684,406	8,914,001	25,072	

*Charity Expense does not include expenses which may be considered a community benefit.

PROVENA GENEVA CARE CENTER

1101 EAST STATE STREET
 GENEVA, IL. 60134
 Reference Numbers Facility ID 6003503
 Health Service Area 008 Planning Service Area 089

Administrator
 Dawn Renee Furman

Contact Person and Telephone

DAWN. R. FURMAN
 630-232-7544

Registered Agent Information

Date
 Completed
 5/12/2010

FACILITY OWNERSHIP

NON-PROF CORPORATION

CONTINUING CARE COMMUNITY

No

LIFE CARE FACILITY

No

ADMISSION RESTRICTIONS

Aggressive/Anti-Social 0
 Chronic Alcoholism 1
 Developmentally Disabled 1
 Drug Addiction 1
 Medicaid Recipient 0
 Medicare Recipient 0
 Mental Illness 0
 Non-Ambulatory 0
 Non-Mobile 0
 Public Aid Recipient 0
 Under 65 Years Old 0
 Unable to Self-Medicate 0
 Ventilator Dependent 1
 Infectious Disease w/ Isolation 0
 Other Restrictions 0
 No Restrictions 0

Note: Reported restrictions denoted by '1'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS
 Neoplasms 0
 Endocrine/Metabolic 1
 Blood Disorders 0
 *Nervous System Non Alzheimer 5
 Alzheimer Disease 24
 Mental Illness 11
 Developmental Disability 1
 Circulatory System 10
 Respiratory System 10
 Digestive System 3
 Genitourinary System Disorders 1
 Skin Disorders 0
 Musculo-skeletal Disorders 2
 Injuries and Poisonings 1
 Other Medical Conditions 12
 Non-Medical Conditions 0

TOTALS 81

Total Residents Diagnosed as Mentally Ill 15

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

ADMISSIONS AND DISCHARGES - 2009

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	ADMISSIONS AND DISCHARGES - 2009	
									Residents on 1/1/2009	
Nursing Care	107	106	106	106	81	26	63	69	89	190
Skilled Under 22	0	0	0	0	0	0	0	0		198
Intermediate DD	0	0	0	0	0	0	0	0		81
Sheltered Care	0	0	0	0	0	0	0	0		0
TOTAL BEDS	107	106	106	106	81	26	63	69	Identified Offenders	0

FACILITY UTILIZATION - 2009

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL	Licensed Beds Occ. Pct.	Peak Beds Set Up Occ. Pct.
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.							
Nursing Care	6481	28.2%	19671	78.1%	0	311	5973	0	32436	83.1%	83.8%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	0	0	0	0.0%	0.0%
TOTALS	6481	28.2%	19671	78.1%	0	311	5973	0	32436	83.1%	83.8%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009

AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	1	0	0	0	0	0	0	0	1	0	1
60 to 64	1	0	0	0	0	0	0	0	1	0	1
65 to 74	4	4	0	0	0	0	0	0	4	4	8
75 to 84	6	19	0	0	0	0	0	0	6	19	25
85+	6	40	0	0	0	0	0	0	6	40	46
TOTALS	18	63	0	0	0	0	0	0	18	63	81

PROVENA GENEVA CARE CENTER

1101 EAST STATE STREET
GENEVA, IL. 60134

Reference Numbers Facility ID 6003503

Health Service Area 008 Planning Service Area 089

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Other					Charity Care	TOTALS
	Medicare	Medicaid	Public	Insurance	Private Pay		
Nursing Care	15	47	0	1	18	0	81
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD		0	0	0	0	0	0
Sheltered Care			0	0	0	0	0
TOTALS	15	47	0	1	18	0	81

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	274	224
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	0	0	0	0	0
Hawaiian/Pac. Isl.	0	0	0	0	0
White	81	0	0	0	81
Race Unknown	0	0	0	0	0
Total	81	0	0	0	81

ETHNICITY	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Hispanic	0	0	0	0	0
Non-Hispanic	81	0	0	0	81
Ethnicity Unknown	0	0	0	0	0
Total	81	0	0	0	81

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.50
Director of Nursing	1.00
Registered Nurses	7.50
LPN's	12.00
Certified Aides	41.00
Other Health Staff	7.00
Non-Health Staff	24.00
Totals	94.00

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
32.7%	38.5%	0.0%	1.5%	27.2%	100.0%		0.0%
2,055,000	2,417,269	0	95,656	1,709,374	6,277,299	0	

*Charity Expense does not include expenses which may be considered a community benefit.

PROVENA HERITAGE VILLAGE		ADMISSION RESTRICTIONS		RESIDENTS BY PRIMARY DIAGNOSIS		
901 NORTH ENTRANCE		Aggressive/Anti-Social	1	DIAGNOSIS		
KANKAKEE, IL. 60901		Chronic Alcoholism	1	Neoplasms	0	
Reference Numbers	Facility ID 6004246	Developmentally Disabled	0	Endocrine/Metabolic	0	
Health Service Area 009	Planning Service Area 091	Drug Addiction	1	Blood Disorders	0	
Administrator		Medicaid Recipient	1	*Nervous System Non Alzheimer	0	
Carol McIntyre		Medicare Recipient	0	Alzheimer Disease	19	
Contact Person and Telephone		Mental Illness	1	Mental Illness	0	
CAROL D MCINTYRE		Non-Ambulatory	0	Developmental Disability	1	
815-939-4506		Non-Mobile	0	Circulatory System	31	
Registered Agent Information	Date Completed 4/9/2010	Public Aid Recipient	0	Respiratory System	10	
		Under 65 Years Old	0	Digestive System	5	
		Unable to Self-Medicate	0	Genitourinary System Disorders	0	
		Ventilator Dependent	1	Skin Disorders	0	
		Infectious Disease w/ Isolation	0	Musculo-skeletal Disorders	0	
		Other Restrictions	0	Injuries and Poisonings	0	
		No Restrictions	0	Other Medical Conditions	8	
FACILITY OWNERSHIP		<i>Note: Reported restrictions denoted by '1'</i>			Non-Medical Conditions	0
NON-PROF CORPORATION					TOTALS	74
CONTINUING CARE COMMUNITY	No					
LIFE CARE FACILITY	No				Total Residents Diagnosed as Mentally Ill	0

LEVEL OF CARE	LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS								ADMISSIONS AND DISCHARGES - 2009	
	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	Residents on 1/1/2009	
Nursing Care	51	51	51	51	42	9	51	0	Total Admissions 2009	225
Skilled Under 22	0	0	0	0	0	0		0	Total Discharges 2009	223
Intermediate DD	0	0	0	0	0	0		0	Residents on 12/31/2009	74
Sheltered Care	79	36	36	36	32	47			Identified Offenders	0
TOTAL BEDS	130	87	87	87	74	56	51	0		

FACILITY UTILIZATION - 2009											
BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE											
LEVEL OF CARE	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL	Licensed Beds	Peak Beds Set Up
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.	Pat. days	Pat. days	Pat. days	Pat. days	Pat. days	Occ. Pct.	Occ. Pct.
Nursing Care	8657	46.5%	0	0.0%	0	547	9197	0	18401	98.9%	98.9%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	5840	365	6205	21.5%	47.2%
TOTALS	8657	46.5%	0	0.0%	0	547	15037	365	24606	51.9%	77.5%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009												
AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	TOTAL	
Under 18	0	0	0	0	0	0	0	0	0	0	0	
18 to 44	0	0	0	0	0	0	0	0	0	0	0	
45 to 59	1	0	0	0	0	0	0	0	1	0	1	
60 to 64	0	0	0	0	0	0	0	0	0	0	0	
65 to 74	0	4	0	0	0	0	0	0	0	4	4	
75 to 84	5	10	0	0	0	0	0	4	5	14	19	
85+	3	19	0	0	0	0	4	24	7	43	50	
TOTALS	9	33	0	0	0	0	4	28	13	61	74	

PROVENA HERITAGE VILLAGE

901 NORTH ENTRANCE

KANKAKEE, IL. 60901

Reference Numbers Facility ID 6004246

Health Service Area 009 Planning Service Area 091

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other		Private Pay	Charity Care	TOTALS
			Public	Insurance			
Nursing Care	24	0	0	10	8	0	42
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD		0	0	0	0	0	0
Sheltered Care			0	0	31	1	32
TOTALS	24	0	0	10	39	1	74

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	206	177
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	113	102

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	1	0	0	0	1
Hawaiian/Pac. Isl.	0	0	0	0	0
White	41	0	0	32	73
Race Unknown	0	0	0	0	0
Total	42	0	0	32	74

ETHNICITY	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Hispanic	0	0	0	0	0
Non-Hispanic	42	0	0	32	74
Ethnicity Unknown	0	0	0	0	0
Total	42	0	0	32	74

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	7.00
LPN's	11.00
Certified Aides	41.00
Other Health Staff	4.00
Non-Health Staff	48.00
Totals	113.00

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
47.3%	0.0%	0.0%	3.7%	49.0%	100.0%		0.2%
2,600,153	0	0	200,575	2,691,589	5,492,317	9,000	

*Charity Expense does not include expenses which may be considered a community benefit.

PROVENA MCAULEY MANOR

400 W. SULLIVAN ROAD
 AURORA, IL. 60506
 Reference Numbers Facility ID 6005912
 Health Service Area 008 Planning Service Area 089

Administrator
 Jennifer Roach

Contact Person and Telephone
 Bill Erue
 630-859-3700

Registered Agent Information
 Megan Kieffer
 19065 Hickory Creek Drive Suite 300
 Mokena, IL 60448

FACILITY OWNERSHIP
 NON-PROF CORPORATION

CONTINUING CARE COMMUNITY No
LIFE CARE FACILITY No

ADMISSION RESTRICTIONS

Aggressive/Anti-Social	0
Chronic Alcoholism	0
Developmentally Disabled	0
Drug Addiction	0
Medicaid Recipient	0
Medicare Recipient	0
Mental Illness	1
Non-Ambulatory	0
Non-Mobile	0
Public Aid Recipient	0
Under 65 Years Old	0
Unable to Self-Medicare	0
Ventilator Dependent	1
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	0

Note: Reported restrictions denoted by '1'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	
Neoplasms	3
Endocrine/Metabolic	0
Blood Disorders	0
*Nervous System Non Alzheimer	5
Alzheimer Disease	3
Mental Illness	1
Developmental Disability	0
Circulatory System	17
Respiratory System	3
Digestive System	6
Genitourinary System Disorders	0
Skin Disorders	1
Musculo-skeletal Disorders	15
Injuries and Poisonings	4
Other Medical Conditions	5
Non-Medical Conditions	0
TOTALS	63
Total Residents Diagnosed as Mentally Ill	1

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

ADMISSIONS AND DISCHARGES - 2009

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	ADMISSIONS AND DISCHARGES - 2009	
									Residents on 1/1/2009	
Nursing Care	87	87	74	87	63	24	87	9	Total Admissions 2009	517
Skilled Under 22	0	0	0	0	0	0		0	Total Discharges 2009	516
Intermediate DD	0	0	0	0	0	0		0	Residents on 12/31/2009	63
Sheltered Care	0	0	0	0	0	0			Identified Offenders	0
TOTAL BEDS	87	87	74	87	63	24	87	9		

FACILITY UTILIZATION - 2009

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL	Licensed Beds Occ. Pct.	Peak Beds Set Up Occ. Pct.
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.							
Nursing Care	10591	33.4%	1312	39.9%	0	695	10073	192	22863	72.0%	72.0%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	0	0	0	0.0%	0.0%
TOTALS	10591	33.4%	1312	39.9%	0	695	10073	192	22863	72.0%	72.0%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009

AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	1	0	0	0	0	0	0	0	1	0	1
45 to 59	0	1	0	0	0	0	0	0	0	1	1
60 to 64	2	0	0	0	0	0	0	0	2	0	2
65 to 74	5	1	0	0	0	0	0	0	5	1	6
75 to 84	5	10	0	0	0	0	0	0	5	10	15
85+	6	32	0	0	0	0	0	0	6	32	38
TOTALS	19	44	0	0	0	0	0	0	19	44	63

PROVENA MCAULEY MANOR

400 W. SULLIVAN ROAD

AURORA, IL. 60506

Reference Numbers Facility ID 6005912

Health Service Area 008 Planning Service Area 089

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare		Other		Private	Charity	TOTALS
	Medicare	Medicaid	Public	Insurance	Pay	Care	
Nursing Care	24	4	0	4	31	0	63
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD		0	0	0	0	0	0
Sheltered Care			0	0	0	0	0
TOTALS	24	4	0	4	31	0	63

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	228	207
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	1	0	0	0	1
Hawaiian/Pac. Isl.	0	0	0	0	0
White	60	0	0	0	60
Race Unknown	2	0	0	0	2
Total	63	0	0	0	63

ETHNICITY	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Hispanic	2	0	0	0	2
Non-Hispanic	61	0	0	0	61
Ethnicity Unknown	0	0	0	0	0
Total	63	0	0	0	63

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	7.00
LPN's	3.00
Certified Aides	22.00
Other Health Staff	6.00
Non-Health Staff	32.00
Totals	72.00

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
48.8%	2.4%	0.0%	3.0%	45.8%	100.0%		0.1%
3,259,177	161,944	0	201,199	3,056,364	6,678,684	7,530	

*Charity Expense does not include expenses which may be considered a community benefit.

PROVENA OUR LADY OF VICTORY

20 BRIARCLIFF LANE
BOURBONNAIS, IL. 60914
Reference Numbers Facility ID 6007009
Health Service Area 009 Planning Service Area 091

Administrator
Robin Gifford

Contact Person and Telephone
ROBIN GIFFORD
815-937-2022

Registered Agent Information
Date Completed 5/6/2010

FACILITY OWNERSHIP
NON-PROF CORPORATION
CONTINUING CARE COMMUNITY No
LIFE CARE FACILITY No

ADMISSION RESTRICTIONS

Aggressive/Anti-Social	0
Chronic Alcoholism	0
Developmentally Disabled	0
Drug Addiction	0
Medicaid Recipient	0
Medicare Recipient	0
Mental Illness	0
Non-Ambulatory	0
Non-Mobile	0
Public Aid Recipient	0
Under 65 Years Old	0
Unable to Self-Medicate	0
Ventilator Dependent	1
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	0

Note: Reported restrictions denoted by '1'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	
Neoplasms	2
Endocrine/Metabolic	5
Blood Disorders	2
*Nervous System Non Alzheimer	5
Alzheimer Disease	1
Mental Illness	1
Developmental Disability	0
Circulatory System	25
Respiratory System	17
Digestive System	2
Genitourinary System Disorders	8
Skin Disorders	2
Musculo-skeletal Disorders	9
Injuries and Poisonings	5
Other Medical Conditions	10
Non-Medical Conditions	0
TOTALS	94
Total Residents Diagnosed as Mentally Ill	1

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

ADMISSIONS AND DISCHARGES - 2009

LEVEL OF CARE	LICENSED BEDS	PEAK	PEAK	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	ADMISSIONS AND DISCHARGES - 2009	
		BEDS SET-UP	BEDS USED					Residents on 1/1/2009	
Nursing Care	107	107	107	94	13	55	90	95	205
Skilled Under 22	0	0	0	0	0		0		206
Intermediate DD	0	0	0	0	0		0		94
Sheltered Care	0	0	0	0	0				0
TOTAL BEDS	107	107	107	94	13	55	90		Identified Offenders 0

FACILITY UTILIZATION - 2009

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL Pat. days	Licensed Beds	Peak Beds Set Up
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.	Pat. days	Pat. days	Pat. days	Pat. days		Occ. Pct.	Occ. Pct.
Nursing Care	7906	39.4%	23104	70.3%	0	480	2785	0	34275	87.8%	87.8%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	0	0	0	0.0%	0.0%
TOTALS	7906	39.4%	23104	70.3%	0	480	2785	0	34275	87.8%	87.8%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009

AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	1	0	0	0	0	0	0	0	1	1
45 to 59	0	0	0	0	0	0	0	0	0	0	0
60 to 64	2	2	0	0	0	0	0	0	2	2	4
65 to 74	4	10	0	0	0	0	0	0	4	10	14
75 to 84	10	20	0	0	0	0	0	0	10	20	30
85+	4	41	0	0	0	0	0	0	4	41	45
TOTALS	20	74	0	0	0	0	0	0	20	74	94

PROVENA OUR LADY OF VICTORY

20 BRIARCLIFF LANE

BOURBONNAIS, IL. 60914

Reference Numbers Facility ID 6007009

Health Service Area 009 Planning Service Area 091

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	21	64	0	0	9	0	94
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD		0	0	0	0	0	0
Sheltered Care			0	0	0	0	0
TOTALS	21	64	0	0	9	0	94

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	177	173
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkiUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	8	0	0	0	8
Hawaiian/Pac. Isl.	0	0	0	0	0
White	86	0	0	0	86
Race Unknown	0	0	0	0	0
Total	94	0	0	0	94

ETHNICITY	Nursing	SkiUnd22	ICF/DD	Shelter	Totals
Hispanic	0	0	0	0	0
Non-Hispanic	94	0	0	0	94
Ethnicity Unknown	0	0	0	0	0
Total	94	0	0	0	94

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	10.00
LPN's	16.00
Certified Aides	27.00
Other Health Staff	0.00
Non-Health Staff	37.00
Totals	92.00

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
38.1%	46.8%	0.0%	2.6%	12.5%	100.0%		0.0%
2,380,646	2,919,597	0	162,995	777,678	6,240,916	0	

*Charity Expense does not include expenses which may be considered a community benefit.

PROVENA PINE VIEW CARE CENTER

611 ALLEN LANE
ST. CHARLES, IL. 60174
Reference Numbers Facility ID 6007439
Health Service Area 008 Planning Service Area 089

Administrator
MELISSA ADAMS

Contact Person and Telephone
HOLLY ORLAND
630-377-2211

Registered Agent Information
Date Completed 5/7/2010

FACILITY OWNERSHIP
NON-PROF CORPORATION

CONTINUING CARE COMMUNITY No
LIFE CARE FACILITY No

ADMISSION RESTRICTIONS

Aggressive/Anti-Social	0
Chronic Alcoholism	0
Developmentally Disabled	0
Drug Addiction	1
Medicaid Recipient	0
Medicare Recipient	0
Mental Illness	1
Non-Ambulatory	0
Non-Mobile	0
Public Aid Recipient	0
Under 65 Years Old	0
Unable to Self-Medicate	0
Ventilator Dependent	1
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	0

Note: Reported restrictions denoted by '1'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	
Neoplasms	4
Endocrine/Metabolic	0
Blood Disorders	0
*Nervous System Non Alzheimer	5
Alzheimer Disease	1
Mental Illness	3
Developmental Disability	0
Circulatory System	12
Respiratory System	11
Digestive System	3
Genitourinary System Disorders	5
Skin Disorders	4
Musculo-skeletal Disorders	11
Injuries and Poisonings	4
Other Medical Conditions	36
Non-Medical Conditions	4
TOTALS	103
Total Residents Diagnosed as Mentally Ill	24

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED
Skilled Under 22	0	0	0	0	0	0		0
Intermediate DD	0	0	0	0	0	0		0
Sheltered Care	0	0	0	0	0	0		0
TOTAL BEDS	120	110	110	110	103	17	120	60

ADMISSIONS AND DISCHARGES - 2009

Residents on 1/1/2009	88
Total Admissions 2009	270
Total Discharges 2009	255
Residents on 12/31/2009	103
Identified Offenders	0

FACILITY UTILIZATION - 2009

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL	Licensed Beds Occ. Pct.	Peak Beds Set Up Occ. Pct.
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.							
Nursing Care	8895	20.3%	17874	81.6%	0	607	7533	0	34909	79.7%	86.9%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	0	0	0	0.0%	0.0%
TOTALS	8895	20.3%	17874	81.6%	0	607	7533	0	34909	79.7%	86.9%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009

AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	1	1	0	0	0	0	0	0	1	1	2
60 to 64	3	2	0	0	0	0	0	0	3	2	5
65 to 74	2	5	0	0	0	0	0	0	2	5	7
75 to 84	8	13	0	0	0	0	0	0	8	13	21
85+	12	56	0	0	0	0	0	0	12	56	68
TOTALS	26	77	0	0	0	0	0	0	26	77	103

PROVENA PINE VIEW CARE CENTER

611 ALLEN LANE
ST. CHARLES, IL. 60174

Reference Numbers Facility ID 6007439

Health Service Area 008 Planning Service Area 089

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Other				Private Pay	Charity Care	TOTALS
	Medicare	Medicaid	Public	Insurance			
Nursing Care	25	50	0	1	27	0	103
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD		0	0	0	0	0	0
Sheltered Care			0	0	0	0	0
TOTALS	25	50	0	1	27	0	103

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	327	227
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	0	0	0	0	0
Hawaiian/Pac. Isl.	0	0	0	0	0
White	103	0	0	0	103
Race Unknown	0	0	0	0	0
Total	103	0	0	0	103

ETHNICITY	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Hispanic	0	0	0	0	0
Non-Hispanic	103	0	0	0	103
Ethnicity Unknown	0	0	0	0	0
Total	103	0	0	0	103

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	20.00
LPN's	5.00
Certified Aides	38.00
Other Health Staff	0.00
Non-Health Staff	41.00
Totals	106.00

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
38.1%	30.5%	0.0%	2.6%	28.8%	100.0%		0.0%
2,855,512	2,289,829	0	193,073	2,163,888	7,502,302	0	

*Charity Expense does not include expenses which may be considered a community benefit.

PROVENA ST. ANN CENTER			ADMISSION RESTRICTIONS		RESIDENTS BY PRIMARY DIAGNOSIS		
4405 HIGHCREST ROAD			Aggressive/Anti-Social	1	DIAGNOSIS		
ROCKFORD, IL. 61107			Chronic Alcoholism	1	Neoplasms	4	
Reference Numbers	Facility ID	6008817	Developmentally Disabled	1	Endocrine/Metabolic	4	
Health Service Area	001	Planning Service Area	201	Drug Addiction	Blood Disorders	0	
Administrator			Medicaid Recipient	0	*Nervous System Non Alzheimer	7	
Janelle Chadwick			Medicare Recipient	0	Alzheimer Disease	0	
Contact Person and Telephone			Mental Illness	1	Mental Illness	0	
JANELLE CHADWICK			Non-Ambulatory	0	Developmental Disability	0	
815-229-1999	Date		Non-Mobile	0	Circulatory System	33	
Registered Agent Information	Completed		Public Aid Recipient	0	Respiratory System	8	
Meghan Kieffer	4/28/2010		Under 65 Years Old	0	Digestive System	5	
19608 Hickory Creek Drive Suite 300			Unable to Self-Medicare	0	Genitourinary System Disorders	13	
Mokena, IL 60448			Ventilator Dependent	1	Skin Disorders	4	
FACILITY OWNERSHIP			Infectious Disease w/ Isolation	0	Musculo-skeletal Disorders	26	
NON-PROF CORPORATION			Other Restrictions	0	Injuries and Poisonings	34	
CONTINUING CARE COMMUNITY	No		No Restrictions	0	Other Medical Conditions	5	
LIFE CARE FACILITY	No		<i>Note: Reported restrictions denoted by 'I'</i>			Non-Medical Conditions	0
					TOTALS	143	
					Total Residents Diagnosed as Mentally Ill	0	

LEVEL OF CARE	LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS						ADMISSIONS AND DISCHARGES - 2009		Residents on 1/1/2009	153
	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED		
Nursing Care	179	179	163	179	143	36	119	60	Total Discharges 2009	734
Skilled Under 22	0	0	0	0	0	0		0	Residents on 12/31/2009	143
Intermediate DD	0	0	0	0	0	0		0	Identified Offenders	0
Sheltered Care	0	0	0	0	0	0		0		
TOTAL BEDS	179	179	163	179	143	36	119	60		

FACILITY UTILIZATION - 2009											
BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE											
LEVEL OF CARE	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL	Licensed Beds	Peak Beds Set Up
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.	Pat. days	Pat. days	Pat. days	Pat. days	Pat. days	Occ. Pct.	Occ. Pct.
Nursing Care	15823	36.4%	19188	87.6%	0	3254	16973	0	55238	84.5%	84.5%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	0	0	0	0.0%	0.0%
TOTALS	15823	36.4%	19188	87.6%	0	3254	16973	0	55238	84.5%	84.5%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009												
AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female		
Under 18	0	0	0	0	0	0	0	0	0	0	0	
18 to 44	0	0	0	0	0	0	0	0	0	0	0	
45 to 59	1	1	0	0	0	0	0	0	1	1	2	
60 to 64	0	2	0	0	0	0	0	0	0	2	2	
65 to 74	5	8	0	0	0	0	0	0	5	8	13	
75 to 84	8	27	0	0	0	0	0	0	8	27	35	
85+	23	68	0	0	0	0	0	0	23	68	91	
TOTALS	37	106	0	0	0	0	0	0	37	106	143	

PROVENA ST. ANN CENTER

4405 HIGHCREST ROAD

ROCKFORD, IL. 61107

Reference Numbers Facility ID 6008817

Health Service Area 001 Planning Service Area 201

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare		Other		Private	Charity	TOTALS
	Medicare	Medicaid	Public	Insurance	Pay	Care	
Nursing Care	44	52	0	8	39	0	143
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD		0	0	0	0	0	0
Sheltered Care			0	0	0	0	0
TOTALS	44	52	0	8	39	0	143

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	231	195
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	7	0	0	0	7
Hawaiian/Pac. Isl.	0	0	0	0	0
White	136	0	0	0	136
Race Unknown	0	0	0	0	0
Total	143	0	0	0	143

ETHNICITY	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Hispanic	1	0	0	0	1
Non-Hispanic	142	0	0	0	142
Ethnicity Unknown	0	0	0	0	0
Total	143	0	0	0	143

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	21.00
LPN's	35.00
Certified Aides	100.00
Other Health Staff	5.00
Non-Health Staff	54.00
Totals	217.00

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
39.0%	18.5%	0.0%	8.5%	34.0%	100.0%		0.0%
4,961,570	2,358,343	0	1,081,399	4,329,706	12,731,018	0	

*Charity Expense does not include expenses which may be considered a community benefit.

PROVENA ST. JOSEPH CENTER

659 EAST JEFFERSON STREET
 FREEPORT, IL. 61032

Reference Numbers Facility ID 6008973
 Health Service Area 001 Planning Service Area 177

Administrator
 Michelle Lindeman

Contact Person and Telephone
 Michelle Lindeman
 815-232-6181

Registered Agent Information
 Date Completed 5/4/2010

FACILITY OWNERSHIP
 NON-PROF CORPORATION
 CONTINUING CARE COMMUNITY No
 LIFE CARE FACILITY No

ADMISSION RESTRICTIONS

Aggressive/Anti-Social	0
Chronic Alcoholism	0
Developmentally Disabled	0
Drug Addiction	0
Medicaid Recipient	0
Medicare Recipient	0
Mental Illness	1
Non-Ambulatory	0
Non-Mobile	0
Public Aid Recipient	0
Under 65 Years Old	0
Unable to Self-Medicare	0
Ventilator Dependent	1
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	0

Note: Reported restrictions denoted by '1'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	
Neoplasms	2
Endocrine/Metabolic	5
Blood Disorders	1
*Nervous System Non Alzheimer	11
Alzheimer Disease	3
Mental Illness	6
Developmental Disability	2
Circulatory System	41
Respiratory System	5
Digestive System	7
Genitourinary System Disorders	3
Skin Disorders	0
Musculo-skeletal Disorders	9
Injuries and Poisonings	2
Other Medical Conditions	5
Non-Medical Conditions	0
TOTALS	102
Total Residents Diagnosed as Mentally Ill 9	

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

ADMISSIONS AND DISCHARGES - 2009

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	ADMISSIONS AND DISCHARGES - 2009	
									Residents on 1/1/2009	Total Admissions 2009
Nursing Care	120	111	111	108	102	18	120	94	103	193
Skilled Under 22	0	0	0	0	0	0		0		
Intermediate DD	0	0	0	0	0	0		0		
Sheltered Care	0	0	0	0	0	0		0		
TOTAL BEDS	120	111	111	108	102	18	120	94	102	194
									Identified Offenders	0

FACILITY UTILIZATION - 2009

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL	Licensed Beds Occ. Pct.	Peak Beds Set Up Occ. Pct.
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.							
Nursing Care	4263	9.7%	23066	67.2%	0	1291	10535	0	39155	89.4%	96.6%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	0	0	0	0.0%	0.0%
TOTALS	4263	9.7%	23066	67.2%	0	1291	10535	0	39155	89.4%	96.6%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009

AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	0	0	0	0	0	0	0	0	0	0	0
60 to 64	0	0	0	0	0	0	0	0	0	0	0
65 to 74	1	8	0	0	0	0	0	0	1	8	9
75 to 84	9	23	0	0	0	0	0	0	9	23	32
85+	9	52	0	0	0	0	0	0	9	52	61
TOTALS	19	83	0	0	0	0	0	0	19	83	102

PROVENA ST. JOSEPH CENTER

659 EAST JEFFERSON STREET

FREEPORT, IL. 61032

Reference Numbers Facility ID 6008973

Health Service Area 001 Planning Service Area 177

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare		Other		Private	Charity	TOTALS
	Medicare	Medicaid	Public	Insurance	Pay	Care	
Nursing Care	12	59	0	2	29	0	102
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD		0	0	0	0	0	0
Sheltered Care			0	0	0	0	0
TOTALS	12	59	0	2	29	0	102

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	195	163
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	3	0	0	0	3
Hawaiian/Pac. Isl.	0	0	0	0	0
White	98	0	0	0	98
Race Unknown	1	0	0	0	1
Total	102	0	0	0	102

ETHNICITY	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Hispanic	0	0	0	0	0
Non-Hispanic	101	0	0	0	101
Ethnicity Unknown	1	0	0	0	1
Total	102	0	0	0	102

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	8.00
LPN's	15.00
Certified Aides	44.00
Other Health Staff	6.00
Non-Health Staff	47.00
Totals	122.00

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
18.4%	40.8%	0.0%	6.3%	34.5%	100.0%		0.1%
1,196,547	2,652,594	0	411,964	2,245,919	6,507,024	4,872	

*Charity Expense does not include expenses which may be considered a community benefit.

PROVENA VILLA FRANCISCAN
 210 NORTH SPRINGFIELD AVENUE
 JOLIET, IL. 60435
 Reference Numbers Facility ID 6012678
 Health Service Area 009 Planning Service Area 197

Administrator
 Ann Dodge

Contact Person and Telephone
 ANN DODGE
 815-725-3400

Registered Agent Information

Date Completed
 4/28/2010

ADMISSION RESTRICTIONS	
Aggressive/Anti-Social	0
Chronic Alcoholism	0
Developmentally Disabled	0
Drug Addiction	0
Medicaid Recipient	0
Medicare Recipient	0
Mental Illness	0
Non-Ambulatory	0
Non-Mobile	0
Public Aid Recipient	0
Under 65 Years Old	0
Unable to Self-Medicare	0
Ventilator Dependent	0
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	1

RESIDENTS BY PRIMARY DIAGNOSIS	
DIAGNOSIS	
Neoplasms	0
Endocrine/Metabolic	2
Blood Disorders	1
*Nervous System Non Alzheimer	2
Alzheimer Disease	0
Mental Illness	3
Developmental Disability	0
Circulatory System	4
Respiratory System	5
Digestive System	2
Genitourinary System Disorders	9
Skin Disorders	2
Musculo-skeletal Disorders	90
Injuries and Poisonings	2
Other Medical Conditions	36
Non-Medical Conditions	0
TOTALS	158

FACILITY OWNERSHIP
 NON-PROF CORPORATION
CONTINUING CARE COMMUNITY No
LIFE CARE FACILITY No

Note: Reported restrictions denoted by '1'

Total Residents Diagnosed as Mentally Ill 102

LEVEL OF CARE	LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS							ADMISSIONS AND DISCHARGES - 2009		
	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	Residents on 1/1/2009	
Nursing Care	176	176	173	176	158	18	176	82	166	517
Skilled Under 22	0	0	0	0	0	0		0		525
Intermediate DD	0	0	0	0	0	0		0		158
Sheltered Care	0	0	0	0	0	0				0
TOTAL BEDS	176	176	173	176	158	18	176	82		

LEVEL OF CARE	FACILITY UTILIZATION - 2009									Licensed Beds Occ. Pct.	Peak Beds Set Up Occ. Pct.
	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL		
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.	Pat. days	Pat. days	Pat. days	Pat. days	Pat. days		
Nursing Care	24894	38.8%	16739	55.9%	0	989	16317	0	58939	91.7%	91.7%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	0	0	0	0.0%	0.0%
TOTALS	24894	38.8%	16739	55.9%	0	989	16317	0	58939	91.7%	91.7%

AGE GROUPS	RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009										GRAND TOTAL
	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	3	0	0	0	0	0	0	0	3	0	3
60 to 64	2	0	0	0	0	0	0	0	2	0	2
65 to 74	7	8	0	0	0	0	0	0	7	8	15
75 to 84	25	38	0	0	0	0	0	0	25	38	63
85+	9	66	0	0	0	0	0	0	9	66	75
TOTALS	46	112	0	0	0	0	0	0	46	112	158

PROVENA VILLA FRANCISCAN
210 NORTH SPRINGFIELD AVENUE
JOLIET, IL. 60435

Reference Numbers Facility ID 6012678
Health Service Area 009 Planning Service Area 197

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Other				Private Pay	Charity Care	TOTALS
	Medicare	Medicaid	Public Insurance				
Nursing Care	77	43	0	1	37	0	158
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD		0	0	0	0	0	0
Sheltered Care			0	0	0	0	0
TOTALS	77	43	0	1	37	0	158

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	280	250
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	9	0	0	0	9
Hawaiian/Pac. Isl.	0	0	0	0	0
White	149	0	0	0	149
Race Unknown	0	0	0	0	0
Total	158	0	0	0	158

ETHNICITY	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Hispanic	7	0	0	0	7
Non-Hispanic	151	0	0	0	151
Ethnicity Unknown	0	0	0	0	0
Total	158	0	0	0	158

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	2.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	23.42
LPN's	14.40
Certified Aides	65.80
Other Health Staff	14.00
Non-Health Staff	137.38
Totals	258.00

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
51.8%	15.4%	0.0%	0.9%	31.9%	100.0%		0.0%
7,277,014	2,169,644	0	119,626	4,478,378	14,044,662	0	

*Charity Expense does not include expenses which may be considered a community benefit.

ST. BENEDICT NURSING & REHAB

6930 WEST TOUHY AVENUE

NILES, IL. 60714

Reference Numbers Facility ID 6008874

Health Service Area 007 Planning Service Area 702

Administrator

Peter Goschy

Contact Person and Telephone

BRENDA DAVIS

847-813-3712

Registered Agent Information

Sandra Bruce

7435 West Talcott

Chicago, IL 60631

FACILITY OWNERSHIP

NON-PROF CORPORATION

CONTINUING CARE COMMUNITY

No

LIFE CARE FACILITY

No

ADMISSION RESTRICTIONS

Aggressive/Anti-Social	1
Chronic Alcoholism	1
Developmentally Disabled	1
Drug Addiction	1
Medicaid Recipient	0
Medicare Recipient	0
Mental Illness	1
Non-Ambulatory	0
Non-Mobile	0
Public Aid Recipient	0
Under 65 Years Old	0
Unable to Self-Medicare	0
Ventilator Dependent	1
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	0

Note: Reported restrictions denoted by '1'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	
Neoplasms	3
Endocrine/Metabolic	5
Blood Disorders	0
*Nervous System Non Alzheimer	8
Alzheimer Disease	0
Mental Illness	0
Developmental Disability	0
Circulatory System	26
Respiratory System	28
Digestive System	10
Genitourinary System Disorders	4
Skin Disorders	0
Musculo-skeletal Disorders	0
Injuries and Poisonings	0
Other Medical Conditions	12
Non-Medical Conditions	0
TOTALS	96

Total Residents Diagnosed as Mentally Ill 0

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

ADMISSIONS AND DISCHARGES - 2009

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	ADMISSIONS AND DISCHARGES - 2009	
									Residents on 1/1/2009	
Nursing Care	99	99	99	99	96	3	99	99	Total Admissions 2009	150
Skilled Under 22	0	0	0	0	0	0		0	Total Discharges 2009	150
Intermediate DD	0	0	0	0	0	0		0	Residents on 12/31/2009	96
Sheltered Care	0	0	0	0	0	0			Identified Offenders	0
TOTAL BEDS	99	99	99	99	96	3	99	99		

FACILITY UTILIZATION - 2009

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL Pat. days	Licensed Beds	Peak Beds Set Up
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.	Pat. days	Pat. days	Pat. days	Pat. days		Occ. Pct.	Occ. Pct.
Nursing Care	7889	21.8%	5350	14.8%	0	0	21399	0	34638	95.9%	95.9%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	0	0	0	0.0%	0.0%
TOTALS	7889	21.8%	5350	14.8%	0	0	21399	0	34638	95.9%	95.9%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009

AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	0	0	0	0	0	0	0	0	0	0	0
60 to 64	0	0	0	0	0	0	0	0	0	0	0
65 to 74	2	1	0	0	0	0	0	0	2	1	3
75 to 84	9	18	0	0	0	0	0	0	9	18	27
85+	10	56	0	0	0	0	0	0	10	56	66
TOTALS	21	75	0	0	0	0	0	0	21	75	96

ST. BENEDICT NURSING & REHAB

6930 WEST TOUHY AVENUE

NILES, IL. 60714

Reference Numbers Facility ID 6008874

Health Service Area 007 Planning Service Area 702

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Other				Private	Charity	TOTALS
	Medicare	Medicaid	Public	Insurance	Pay	Care	
Nursing Care	22	16	0	0	58	0	96
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD		0	0	0	0	0	0
Sheltered Care			0	0	0	0	0
TOTALS	22	16	0	0	58	0	96

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	261	233
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	0	0	0	0	0
Hawaiian/Pac. Isl.	0	0	0	0	0
White	96	0	0	0	96
Race Unknown	0	0	0	0	0
Total	96	0	0	0	96

ETHNICITY	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Hispanic	0	0	0	0	0
Non-Hispanic	96	0	0	0	96
Ethnicity Unknown	0	0	0	0	0
Total	96	0	0	0	96

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	8.68
LPN's	5.52
Certified Aides	40.61
Other Health Staff	43.00
Non-Health Staff	11.00
Totals	110.81

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
39.8%	7.4%	0.0%	0.0%	52.7%	100.0%		0.0%
3,792,372	707,936	0	0	5,021,073	9,521,381	0	

*Charity Expense does not include expenses which may be considered a community benefit.

RESURRECTION LIFE CENTER

7370 WEST TALCOTT
 CHICAGO, IL. 60631
 Reference Numbers Facility ID 6014575
 Health Service Area 006 Planning Service Area 601

Administrator
 Nancy Razo

Contact Person and Telephone
 BRENDA DAVIS
 847-813-3712

Registered Agent Information
 Sandra Bruce
 7435 West Talcott
 Chicago, IL 60631

FACILITY OWNERSHIP
 NON-PROF CORPORATION

CONTINUING CARE COMMUNITY No
LIFE CARE FACILITY No

ADMISSION RESTRICTIONS

Aggressive/Anti-Social	0
Chronic Alcoholism	0
Developmentally Disabled	1
Drug Addiction	1
Medicaid Recipient	0
Medicare Recipient	0
Mental Illness	1
Non-Ambulatory	0
Non-Mobile	0
Public Aid Recipient	0
Under 65 Years Old	0
Unable to Self-Medicate	0
Ventilator Dependent	1
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	0

Note: Reported restrictions denoted by '1'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	
Neoplasms	4
Endocrine/Metabolic	10
Blood Disorders	0
*Nervous System Non Alzheimer	14
Alzheimer Disease	9
Mental Illness	16
Developmental Disability	0
Circulatory System	22
Respiratory System	10
Digestive System	4
Genitourinary System Disorders	3
Skin Disorders	4
Musculo-skeletal Disorders	23
Injuries and Poisonings	0
Other Medical Conditions	42
Non-Medical Conditions	0
TOTALS	161
Total Residents Diagnosed as Mentally Ill	
	16

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

ADMISSIONS AND DISCHARGES - 2009

LEVEL OF CARE	LICENSED BEDS	PEAK	PEAK	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	ADMISSIONS AND DISCHARGES - 2009	
		BEDS SET-UP	BEDS USED					Residents on 1/1/2009	Total Admissions 2009
Nursing Care	147	147	146	147	146	1	112	112	161
Skilled Under 22	0	0	0	0	0	0	0	0	264
Intermediate DD	0	0	0	0	0	0	0	0	264
Sheltered Care	15	15	15	15	15	0	0	0	161
TOTAL BEDS	162	162	161	162	161	1	112	112	Identified Offenders 0

FACILITY UTILIZATION - 2009

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL Pat. days	Licensed Beds	Peak Beds Set Up
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.	Pat. days	Pat. days	Pat. days	Pat. days		Occ. Pct.	Occ. Pct.
Nursing Care	8445	20.7%	24529	60.0%	0	0	19603	0	52577	98.0%	98.0%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	5475	0	5475	100.0%	100.0%
TOTALS	8445	20.7%	24529	60.0%	0	0	25078	0	58052	98.2%	98.2%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009

AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	0	0	0	0	0	0	0	0	0	0	0
60 to 64	0	0	0	0	0	0	0	0	0	0	0
65 to 74	1	0	0	0	0	0	2	0	3	0	3
75 to 84	4	31	0	0	0	0	1	3	5	34	39
85+	16	94	0	0	0	0	0	9	16	103	119
TOTALS	21	125	0	0	0	0	3	12	24	137	161

RESURRECTION LIFE CENTER

7370 WEST TALCOTT

CHICAGO, IL. 60631

Reference Numbers Facility ID 6014575

Health Service Area 006 Planning Service Area 601

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare		Other Public Insurance		Private Pay	Charity Care	TOTALS
	Medicare	Medicaid	Public	Insurance	Pay	Care	
Nursing Care	20	79	0	0	47	0	146
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD		0	0	0	0	0	0
Sheltered Care			0	0	15	0	15
TOTALS	20	79	0	0	62	0	161

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	261	0
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	166	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	2	0	0	0	2
Hawaiian/Pac. Isl.	0	0	0	0	0
White	144	0	0	15	159
Race Unknown	0	0	0	0	0
Total	146	0	0	15	161

ETHNICITY	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Hispanic	1	0	0	0	1
Non-Hispanic	145	0	0	15	160
Ethnicity Unknown	0	0	0	0	0
Total	146	0	0	15	161

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	21.02
LPN's	7.00
Certified Aides	51.71
Other Health Staff	11.77
Non-Health Staff	30.40
Totals	123.90

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
29.0%	22.2%	0.0%	0.0%	48.8%	100.0%		0.0%
3,599,478	2,752,857	0	0	6,046,287	12,398,622	0	

*Charity Expense does not include expenses which may be considered a community benefit.

FACILITY NOTES

Bed Change 7/15/2009 Added 10 nursing care beds and discontinued 10 sheltered care beds. Facility now has 147 nursing care and 15 sheltered care beds.

RESURRECTION NSG & REHAB CTR

1001 NORTH GREENWOOD AVENUE
PARK RIDGE, IL. 60068

Reference Numbers Facility ID 6007892
Health Service Area 007 Planning Service Area 702

Administrator
James Farlee

Contact Person and Telephone
BRENDA DAVIS
847-813-3712

Registered Agent Information
Sandra Bruce
7435 West Talcott
Chicago, IL 60631

FACILITY OWNERSHIP
NON-PROF CORPORATION

CONTINUING CARE COMMUNITY No
LIFE CARE FACILITY No

ADMISSION RESTRICTIONS

Aggressive/Anti-Social	1
Chronic Alcoholism	1
Developmentally Disabled	1
Drug Addiction	1
Medicaid Recipient	0
Medicare Recipient	0
Mental Illness	1
Non-Ambulatory	0
Non-Mobile	0
Public Aid Recipient	0
Under 65 Years Old	0
Unable to Self-Medicate	0
Ventilator Dependent	1
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	0

Note: Reported restrictions denoted by '1'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	
Neoplasms	31
Endocrine/Metabolic	0
Blood Disorders	0
*Nervous System Non Alzheimer	58
Alzheimer Disease	26
Mental Illness	0
Developmental Disability	0
Circulatory System	69
Respiratory System	41
Digestive System	0
Genitourinary System Disorders	12
Skin Disorders	0
Musculo-skeletal Disorders	25
Injuries and Poisonings	0
Other Medical Conditions	0
Non-Medical Conditions	0
TOTALS	262
Total Residents Diagnosed as Mentally Ill 0	

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

ADMISSIONS AND DISCHARGES - 2009

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	ADMISSIONS AND DISCHARGES - 2009	
									Residents on 1/1/2009	
Nursing Care	298	285	262	262	262	36	298	298	Total Admissions 2009	603
Skilled Under 22	0	0	0	0	0	0		0	Total Discharges 2009	584
Intermediate DD	0	0	0	0	0	0		0	Residents on 12/31/2009	262
Sheltered Care	0	0	0	0	0	0			Identified Offenders	1
TOTAL BEDS	298	285	262	262	262	36	298	298		

FACILITY UTILIZATION - 2009

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL	Licensed Beds Occ. Pct.	Peak Beds Set Up Occ. Pct.
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.							
Nursing Care	20742	19.1%	41546	38.2%	0	2026	21347	1068	86729	79.7%	83.4%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	0	0	0	0.0%	0.0%
TOTALS	20742	19.1%	41546	38.2%	0	2026	21347	1068	86729	79.7%	83.4%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009

AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	5	3	0	0	0	0	0	0	5	3	8
60 to 64	5	9	0	0	0	0	0	0	5	9	14
65 to 74	16	21	0	0	0	0	0	0	16	21	37
75 to 84	20	49	0	0	0	0	0	0	20	49	69
85+	22	112	0	0	0	0	0	0	22	112	134
TOTALS	68	194	0	0	0	0	0	0	68	194	262

RESURRECTION NSG & REHAB CTR

1001 NORTH GREENWOOD AVENUE

PARK RIDGE, IL. 60068

Reference Numbers Facility ID 6007892

Health Service Area 007 Planning Service Area 702

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare		Other Public Insurance		Private Pay	Charity Care	TOTALS
	Medicare	Medicaid	Public	Insurance	Pay	Care	
Nursing Care	52	136	0	8	62	4	262
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD		0	0	0	0	0	0
Sheltered Care			0	0	0	0	0
TOTALS	52	136	0	8	62	4	262

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	261	220
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Asian	4	0	0	0	4
Amer. Indian	0	0	0	0	0
Black	4	0	0	0	4
Hawaiian/Pac. Isl.	0	0	0	0	0
White	254	0	0	0	254
Race Unknown	0	0	0	0	0
Total	262	0	0	0	262

ETHNICITY	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Hispanic	2	0	0	0	2
Non-Hispanic	260	0	0	0	260
Ethnicity Unknown	0	0	0	0	0
Total	262	0	0	0	262

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	59.50
LPN's	3.00
Certified Aides	92.00
Other Health Staff	10.00
Non-Health Staff	89.00
Totals	255.50

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
48.2%	25.9%	0.0%	0.0%	25.9%	100.0%		0.1%
9,977,713	5,363,092	0	0	5,373,527	20,714,332	26,938	

*Charity Expense does not include expenses which may be considered a community benefit.

MARYHAVEN NSG. & REHAB. CTR.

1700 EAST LAKE AVENUE
 GLENVIEW, IL. 60025
 Reference Numbers Facility ID 6005854
 Health Service Area 007 Planning Service Area 702

Administrator
 Sara Szumski

Contact Person and Telephone
 BRENDA DAVIS
 847-813-3712

Registered Agent Information
 Sandra Bruce
 7435 West Talcott
 Chicago, IL 60631

FACILITY OWNERSHIP
 NON-PROF CORPORATION

CONTINUING CARE COMMUNITY No
LIFE CARE FACILITY No

ADMISSION RESTRICTIONS

Aggressive/Anti-Social	0
Chronic Alcoholism	0
Developmentally Disabled	1
Drug Addiction	1
Medicaid Recipient	0
Medicare Recipient	0
Mental Illness	0
Non-Ambulatory	0
Non-Mobile	0
Public Aid Recipient	0
Under 65 Years Old	0
Unable to Self-Medicate	0
Ventilator Dependent	1
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	0

Note: Reported restrictions denoted by '1'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	
Neoplasms	3
Endocrine/Metabolic	4
Blood Disorders	0
*Nervous System Non Alzheimer	5
Alzheimer Disease	38
Mental Illness	0
Developmental Disability	1
Circulatory System	22
Respiratory System	3
Digestive System	1
Genitourinary System Disorders	1
Skin Disorders	0
Musculo-skeletal Disorders	33
Injuries and Poisonings	0
Other Medical Conditions	4
Non-Medical Conditions	0
TOTALS	115
Total Residents Diagnosed as Mentally Ill	
	6

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

ADMISSIONS AND DISCHARGES - 2009

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	ADMISSIONS AND DISCHARGES - 2009	
									Residents on 1/1/2009	Total Admissions 2009
Nursing Care	135	135	122	135	115	20	135	135	Total Discharges 2009	152
Skilled Under 22	0	0	0	0	0	0		0	Residents on 12/31/2009	115
Intermediate DD	0	0	0	0	0	0		0	Identified Offenders	0
Sheltered Care	0	0	0	0	0	0				
TOTAL BEDS	135	135	122	135	115	20	135	135		

FACILITY UTILIZATION - 2009

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL	Licensed Beds Occ. Pct.	Peak Beds Set Up Occ. Pct.
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.							
Nursing Care	5974	12.1%	21182	43.0%	0	0	15550	0	42706	86.7%	86.7%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	0	0	0	0.0%	0.0%
TOTALS	5974	12.1%	21182	43.0%	0	0	15550	0	42706	86.7%	86.7%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009

AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	0	2	0	0	0	0	0	0	0	2	2
60 to 64	1	3	0	0	0	0	0	0	1	3	4
65 to 74	3	3	0	0	0	0	0	0	3	3	6
75 to 84	8	20	0	0	0	0	0	0	8	20	28
85+	15	60	0	0	0	0	0	0	15	60	75
TOTALS	27	88	0	0	0	0	0	0	27	88	115

MARYHAVEN NSG. & REHAB. CTR.

1700 EAST LAKE AVENUE

GLENVIEW, IL. 60025

Reference Numbers Facility ID 6005854

Health Service Area 007 Planning Service Area 702

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare		Medicaid		Other Public	Private Insurance	Charity Care	TOTALS
	Medicare	Medicaid	Public	Insurance	Pay	Care		
Nursing Care	9	45	0	1	60	0	115	
Skilled Under 22	0	0	0	0	0	0	0	
ICF/DD		0	0	0	0	0	0	
Sheltered Care			0	0	0	0	0	
TOTALS	9	45	0	1	60	0	115	

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	224	201
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	1	0	0	0	1
Hawaiian/Pac. Isl.	0	0	0	0	0
White	114	0	0	0	114
Race Unknown	0	0	0	0	0
Total	115	0	0	0	115

ETHNICITY	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Hispanic	0	0	0	0	0
Non-Hispanic	115	0	0	0	115
Ethnicity Unknown	0	0	0	0	0
Total	115	0	0	0	115

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	17.21
LPN's	5.11
Certified Aides	38.34
Other Health Staff	3.73
Non-Health Staff	39.86
Totals	106.25

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
33.8%	29.7%	0.0%	0.0%	36.5%	100.0%		0.0%
3,019,283	2,645,099	0	0	3,256,278	8,920,660	0	

*Charity Expense does not include expenses which may be considered a community benefit.

HOLY FAMILY NURSING & REHABILITA CENTER

2380 DEMPSTER STREET
 DES PLAINES, IL. 60016
 Reference Numbers Facility ID 6004543
 Health Service Area 007 Planning Service Area 702

Administrator
 Tony Madl

Contact Person and Telephone
 BRENDA DAVIS
 847-813-3712

Registered Agent Information
 Sandra Bruce
 7435 West Talcott Avenue
 Chicago, IL 60631

FACILITY OWNERSHIP
 NON-PROF CORPORATION

CONTINUING CARE COMMUNITY No
LIFE CARE FACILITY No

ADMISSION RESTRICTIONS

Aggressive/Anti-Social	1
Chronic Alcoholism	0
Developmentally Disabled	0
Drug Addiction	1
Medicaid Recipient	0
Medicare Recipient	0
Mental Illness	1
Non-Ambulatory	0
Non-Mobile	0
Public Aid Recipient	0
Under 65 Years Old	0
Unable to Self-Medicare	0
Ventilator Dependent	0
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	0

Note: Reported restrictions denoted by '1'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	
Neoplasms	0
Endocrine/Metabolic	11
Blood Disorders	4
*Nervous System Non Alzheimer	17
Alzheimer Disease	3
Mental Illness	10
Developmental Disability	0
Circulatory System	26
Respiratory System	24
Digestive System	1
Genitourinary System Disorders	5
Skin Disorders	8
Musculo-skeletal Disorders	14
Injuries and Poisonings	13
Other Medical Conditions	24
Non-Medical Conditions	0
TOTALS	160

Total Residents Diagnosed as Mentally Ill 10

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

ADMISSIONS AND DISCHARGES - 2009

LEVEL OF CARE	LICENSED BEDS	PEAK	PEAK	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	ADMISSIONS AND DISCHARGES - 2009	
		BEDS SET-UP	BEDS USED					Residents on 1/1/2009	
Nursing Care	251	231	170	231	160	91	149	247	153
Skilled Under 22	0	0	0	0	0	0	0	0	580
Intermediate DD	0	0	0	0	0	0	0	0	573
Sheltered Care	0	0	0	0	0	0	0	0	160
TOTAL BEDS	251	231	170	231	160	91	149	247	Identified Offenders 0

FACILITY UTILIZATION - 2009

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare		Medicaid		Other Public	Private	Private	Charity	TOTAL	Licensed	Peak Beds
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.		Insurance	Pay	Care		Pat. days	Beds
Nursing Care	8617	15.8%	34052	37.8%	0	0	10734	1382	54785	59.8%	65.0%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	0	0	0	0.0%	0.0%
TOTALS	8617	15.8%	34052	37.8%	0	0	10734	1382	54785	59.8%	65.0%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009

AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	2	2	0	0	0	0	0	0	2	2	4
45 to 59	9	8	0	0	0	0	0	0	9	8	17
60 to 64	5	7	0	0	0	0	0	0	5	7	12
65 to 74	9	13	0	0	0	0	0	0	9	13	22
75 to 84	5	31	0	0	0	0	0	0	5	31	36
85+	7	62	0	0	0	0	0	0	7	62	69
TOTALS	37	123	0	0	0	0	0	0	37	123	160

HOLY FAMILY NURSING & REHABILITA CENTER

2380 DEMPSTER STREET
DES PLAINES, IL. 60016

Reference Numbers Facility ID 6004543
Health Service Area 007 Planning Service Area 702

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Other			Private Insurance	Charity Care	TOTALS	
	Medicare	Medicaid	Public				
Nursing Care	27	99	0	6	22	6	160
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD		0	0	0	0	0	0
Sheltered Care			0	0	0	0	0
TOTALS	27	99	0	6	22	6	160

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	261	220
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Asian	5	0	0	0	5
Amer. Indian	0	0	0	0	0
Black	5	0	0	0	5
Hawaiian/Pac. Isl.	0	0	0	0	0
White	150	0	0	0	150
Race Unknown	0	0	0	0	0
Total	160	0	0	0	160

ETHNICITY	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Hispanic	11	0	0	0	11
Non-Hispanic	149	0	0	0	149
Ethnicity Unknown	0	0	0	0	0
Total	160	0	0	0	160

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	28.40
LPN's	3.20
Certified Aides	51.02
Other Health Staff	14.60
Non-Health Staff	48.50
Totals	147.72

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
34.7%	41.4%	0.0%	0.0%	23.9%	100.0%		1.7%
3,796,733	4,533,430	0	0	2,623,018	10,953,181	181,416	

*Charity Expense does not include expenses which may be considered a community benefit.

VILLA SCALABRINI NSG & REHAB

480 NORTH WOLF ROAD
NORTHLAKE, IL. 60164
Reference Numbers Facility ID 6009591
Health Service Area 007 Planning Service Area 704

Administrator
Jim Kouzious

Contact Person and Telephone
BRENDA DAVIS
847-813-3712

Registered Agent Information Date Completed 5/6/2010
Sandra Bruce
7435 West Talcott
Chicago, IL 60631

FACILITY OWNERSHIP
NON-PROF CORPORATION

CONTINUING CARE COMMUNITY No
LIFE CARE FACILITY No

ADMISSION RESTRICTIONS

Aggressive/Anti-Social	0
Chronic Alcoholism	1
Developmentally Disabled	1
Drug Addiction	1
Medicaid Recipient	0
Medicare Recipient	0
Mental Illness	1
Non-Ambulatory	0
Non-Mobile	0
Public Aid Recipient	0
Under 65 Years Old	0
Unable to Self-Medicare	0
Ventilator Dependent	0
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	0

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	
Neoplasms	6
Endocrine/Metabolic	26
Blood Disorders	10
*Nervous System Non Alzheimer	28
Alzheimer Disease	28
Mental Illness	0
Developmental Disability	3
Circulatory System	43
Respiratory System	18
Digestive System	5
Genitourinary System Disorders	7
Skin Disorders	2
Musculo-skeletal Disorders	48
Injuries and Poisonings	0
Other Medical Conditions	0
Non-Medical Conditions	0
TOTALS	224

Total Residents Diagnosed as Mentally ill 14

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

ADMISSIONS AND DISCHARGES - 2009

LEVEL OF CARE	LICENSED BEDS	PEAK	PEAK	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	ADMISSIONS AND DISCHARGES - 2009	
		BEDS SET-UP	BEDS USED					Residents on 1/1/2009	
Nursing Care	246	253	230	253	224	22	171	202	230
Skilled Under 22	0	0	0	0	0	0	0	0	414
Intermediate DD	0	0	0	0	0	0	0	0	420
Sheltered Care	7	0	0	0	0	7	0	0	224
TOTAL BEDS	253	253	230	253	224	29	171	202	Identified Offenders 0

FACILITY UTILIZATION - 2009

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare		Medicaid		Other Public	Private	Private	Charity	TOTAL	Licensed	Peak Beds
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.		Insurance	Pay	Care		Pat. days	Beds
Nursing Care	17447	28.0%	45709	62.0%	0	1267	18792	433	83648	93.2%	90.6%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	0	0	0	0.0%	0.0%
TOTALS	17447	28.0%	45709	62.0%	0	1267	18792	433	83648	90.6%	90.6%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009

AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	1	1	0	0	0	0	0	0	1	1	2
45 to 59	4	2	0	0	0	0	0	0	4	2	6
60 to 64	2	0	0	0	0	0	0	0	2	0	2
65 to 74	5	13	0	0	0	0	0	0	5	13	18
75 to 84	14	50	0	0	0	0	0	0	14	50	64
85+	25	107	0	0	0	0	0	0	25	107	132
TOTALS	51	173	0	0	0	0	0	0	51	173	224

VILLA SCALABRINI NSG & REHAB

480 NORTH WOLF ROAD

NORTHLAKE, IL. 60164

Reference Numbers Facility ID 6009591

Health Service Area 007 Planning Service Area 704

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare		Other		Private	Charity	TOTALS
	Medicare	Medicaid	Public	Insurance	Pay	Care	
Nursing Care	44	126	0	6	47	1	224
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD		0	0	0	0	0	0
Sheltered Care			0	0	0	0	0
TOTALS	44	126	0	6	47	1	224

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	252	212
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	18	0	0	0	18
Hawaiian/Pac. Isl.	0	0	0	0	0
White	197	0	0	0	197
Race Unknown	9	0	0	0	9
Total	224	0	0	0	224

ETHNICITY	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Hispanic	16	0	0	0	16
Non-Hispanic	208	0	0	0	208
Ethnicity Unknown	0	0	0	0	0
Total	224	0	0	0	224

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	34.61
LPN's	7.05
Certified Aides	75.20
Other Health Staff	13.30
Non-Health Staff	64.89
Totals	197.05

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
41.3%	31.6%	0.0%	0.0%	27.2%	100.0%		0.5%
7,596,699	5,807,508	0	0	4,996,309	18,400,516	89,396	

*Charity Expense does not include expenses which may be considered a community benefit.

**SOUTH CENTRAL ILLINOIS PERINATAL NETWORK
LETTER OF AGREEMENT
between
SAINT JOHN'S HOSPITAL
and
PROVENA UNITED SAMARITANS MEDICAL CENTER**

This Affiliation Agreement ("AGREEMENT") entered into as of the 17th day of November, 2007, by and between St. John Hospital., an Illinois not-for-profit corporation, located and doing business in Springfield, Illinois, hereinafter referred to as ADMINISTRATIVE PERINATAL CENTER, and Provena Hospitals, an Illinois not for profit d/b/a Provena United Samaritans Medical Center doing business in Danville, Illinois hereinafter referred to as LEVEL II CENTER.

RECITALS

- A. Member institutions of the South Central Illinois Perinatal Network ("SCIPN") region ("REGION") believe that the goals of the perinatal services of the member institutions are to make optimal preconception, maternal-fetal, neonatal, infant and family care available to the families in the REGION through a regional network.
- B. St. John's Hospital a Level III Perinatal Institution, which has been designated by the State of Illinois as an ADMINISTRATIVE PERINATAL CENTER pursuant to the Illinois Department of Public Health Rules and Regulations, desires to provide perinatal service to LEVEL II CENTER.
- C. LEVEL II CENTER desires to receive perinatal services from ADMINISTRATIVE PERINATAL CENTER.

NOW THEREFORE, in consideration of the mutual promises and covenants contained herein, ADMINISTRATIVE PERINATAL CENTER and LEVEL II CENTER hereby agree to the following terms and conditions:

I. PREREQUISITES

This agreement conforms to the Illinois Compiled Statutes, Developmental Disability Prevention Act (410 IL CS 250), Abused and Neglected Child Reporting Act (325 IL CS 5 et seq.), Hospital Licensing Act (210 IL CS 45) and Code of Civil Procedure (735 IL CS 5/8 - 2101).

**TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER I: MATERNAL AND CHILD HEALTH**

**Part 640
Regionalized perinatal Care**

Provena United Samaritans Medical Center will function as a Level II Perinatal Service Unit per Subpart O of the Maternity and Newborn Services Regulations, State of Illinois and the Regionalized perinatal Health Care Code of Illinois.

The Perinatal Program will be administered by St. John's Hospital ADMINISTRATIVE PERINATAL CENTER through the Chairpersons of Obstetrics/Gynecology and Pediatrics and the Level II Center.

II. COMMUNICATION SERVICES

2.1 The Director of Maternal/Fetal Medicine of the ADMINISTRATIVE PERINATAL CENTER shall oversee:

- a. The maintenance of 24-hour ADMINISTRATIVE PERINATAL CENTER obstetric hotlines for consultation/referral and transfer/transport of obstetric patients.**

St. John's Hospital: 1-888-544-8464

- b. The prompt sending of patient management and outcome information from the ADMINISTRATIVE PERINATAL CENTER primary physician, who cared for the patient, to the referring CENTER and physician**
- c. A board certified or active candidate obstetrician shall be present and available in-house 24 hours a day at the ADMINISTRATIVE PERINATAL CENTER.**
- d. Maternal – Fetal Medicine consultation will be available 24 hours a day at the ADMINISTRATIVE PERINATAL CENTER.**

The Director of Neonatology of the ADMINISTRATIVE PERINATAL CENTER shall oversee:

- a. The maintenance of 24-hour ADMINISTRATIVE PERINATAL CENTER neonatal hotlines for consultation/referral and transfer/transport of neonatal patients.

St. John's Hospital: 1-888-544-6464

- b. The prompt sending of patient management and outcome information from the ADMINISTRATIVE PERINATAL CENTER Neonatologists who cared for the patient to the referring physician.

While the ADMINISTRATIVE PERINATAL CENTER primary physician will endeavor to keep the referring physician from the referring CENTER informed concerning the continuing progress of transferred/transported patients, the referring physician may call the ADMINISTRATIVE PERINATAL CENTER and/or LEVEL III CENTER to check on interim developments.

III. REFERRALS

3.1 The ADMINISTRATIVE PERINATAL CENTER or Level III Center will accept all medically eligible obstetrical/neonatal patients. When beds are unavailable it will be the responsibility of the ADMINISTRATIVE PERINATAL CENTER or Level III Center to locate and make arrangement for the transfer of patients to a hospital designated by the State of Illinois as a Level III Perinatal Unit. Inter Hospital transport will follow the guidelines set forth in the "Guidelines for Perinatal Care by AGOG and AAP".

3.2 MATERNAL REFERRALS

- a. The LEVEL II CENTER shall have a policy requiring general obstetricians to obtain consultations from or transfer care to the appropriate sub-specialists as outlined in the standards for Level II.
- b. Physicians will consult and/or transfer to the ADMINISTRATIVE PERINATAL CENTER or Level III Center obstetrical patients who require the services of the ADMINISTRATIVE PERINATAL CENTER, including

but not limited to, patients outlined in Paragraph a and in Appendix A.

- c. LEVEL II CENTER will have responsibility, through a peer review process, for assuring Maternal-Fetal Medicine consultations are obtained appropriately, as stipulated in the perinatal rules and regulations, for hospitalized maternal/fetal patients.
- d. Requests for transport of high-risk mothers may be initiated by any physician or his designee at the LEVEL II Center. The Director of Maternal/Fetal medicine or his designee, after consultation with the referring physician at the LEVEL II Center will decide whether to have patient remain at the LEVEL II Center, or be transferred immediately. Additionally, the best possible transport mechanisms from available alternative sand the staff needed for transport will be determined jointly.
- e. The following information shall accompany the patient being transferred:

Admission form	Laboratory Values
Admission History/Physical	Prenatal Records
Physician Progress notes	Medical History
Nurses Notes	Discharge Summary
Outpatient Testing Dates-Summary	

- d. Twenty-four hour hotlines for immediate consultation, referral, and transport of Maternal-Fetal patients:

NETWORK LEVEL III CENTERS

Carle Foundation Hospital: 1-800-451-4330

St. John's Hospital: 1-888-544-6464

3.3 NEONATAL REFERRALS

- a. Physicians will consult and/or transfer to the ADMINISTRATIVE PERINATAL CENTER or Level III Center neonatal patients who require the services of the ADMINISTRATIVE PERINATAL CENTER or Level III Center including but not limited to, patients, outlined in

the perinatal rules and regulations (See Appendix B for patients to be included for consultation or transfer).

- b. Decisions regarding transport personnel and mode of transport will be made jointly with the physician caring for the patient at the LEVEL II CENTER and the Neonatologists on call at the ADMINISTRATIVE PERINATAL CENTER or the LEVEL III CENTER.
- c. Twenty-four hour neonatal hotlines for immediate consultation, referral, and transport of neonatal patients are available at both network LEVEL III CENTERS

Carle Foundation Hospital 1-800-451-4330

St. John's Hospital 1-888-544-6464

- d. Information to accompany the patient at the time of transfer should include the following.

Admission form	Admission
History/Physical	Nurses Notes
Physician's Progress Notes	Transfer Summary
Laboratory Values	

IV. EDUCATIONAL SERVICES

4.1 The ADMINISTRATIVE PERINATAL CENTER agrees that a professional outreach education program is essential to the goal of improved pregnancy outcomes. The ADMINISTRATIVE PERINATAL CENTER will collaborate with the LEVEL II CENTER and other LEVEL III CENTERS to meet the regional outreach education needs.

4.2 In an effort to enhance present educational objectives, the LEVEL II CENTER and the ADMINISTRATIVE PERINATAL CENTER will collaborate on the content of outreach education programs emphasizing improved accessibility of the educational programs throughout the Region.

V. FOLLOW-UP AND REPORTING SERVICES

5.1 The ADMINISTRATIVE PERINATAL CENTER and LEVEL II CENTER shall work together to institute an enhancement for the current Illinois Department of Public Health Perinatal Report of Activities. Monthly statistics will be reported to the

ADMINISTRATIVE PERINATAL CENTER by all institutions in the Region by the 15th day following the closing month.

5.2 The **LEVEL II CENTER** shall designate a person to coordinate the community nursing follow-up referral process as required by the Illinois Department of Public Health rules with the designated local agency.

VI. JOINT MORTALITY AND MORBIDITY CONFERENCES

6.1 The **ADMINISTRATIVE PERINATAL CENTER** and **LEVEL III CENTER** in which patients are primarily referred, will conduct three times per year reviews of perinatal activities with the **LEVEL II CENTER**.

Mortality and Morbidity conferences for **LEVEL II CENTER** will be provided tri-annually. The **ADMINISTRATIVE PERINATAL CENTER STAFF** along with the **LEVEL III Co-Director's** and their delegated staff will be responsible to attend these Mortality and Morbidity Conferences. Other attendees for the **LEVEL II CENTER** may include other physician specialists, hospital administration, clinical and patient care leadership, and quality staff.

The content of the conference must include but not be limited to still births, neonatal deaths, maternal deaths, maternal/neonatal transports, exception log entries, and handicapping conditions.

Case abstracts will be prepared by the **ADMINISTRATIVE PERINATAL CENTER**. The complete medical records of the cases for review, from all institutions in the Region, will be forwarded to the **ADMINISTRATIVE PERINATAL CENTER** three weeks prior to the scheduled conference to facilitate the abstract prior to the conference.

Data from the Morbidity and Mortality Conferences are collected and utilized as a framework for Network Continuous Quality Improvement Activities

Except as otherwise required herein, the parties agree that this information is privileged and confidential quality assurance information privileged pursuant to the Illinois Medical Studies Act and is not subject to disclosure or release.

VII. SOUTH CENTRAL ILLINOIS PERINATAL CENTER COMMITTEE'S

7.1 **LEVEL II CENTER** will participate in the South Central Illinois Perinatal Network Regional Perinatal Management Group, "an organization of representatives of perinatal services, providers

and service related agencies and organizations within a regional perinatal network that is responsible for the planning, development, evaluation and operation of the network and the establishment of regional priorities and policies for system support activities and staff.

7.2 LEVEL II CENTER will participate in the South Central Illinois Perinatal Network Regional Quality Council, a standing sub-committee of Regional Perinatal Management Group that is responsible for monitoring quality of care and implementing the recommendations of quality of care with in the perinatal care system.

VIII. IDENTIFICATION OF CHILDREN WITH HANDICAPPING CONDITIONS

The primary care physician will be responsible for the identification of high risk obstetrical patients, fetuses and newborns with an actual or potential handicaps or developmental disabilities. This includes determination of the need for referral for more intensive or specialized care than that is locally available.

The primary care physician will seek counseling and referral services as soon as practicable following the identification of a handicapping condition.

IX. TERM AND TERMINATION

9.1 Term. The promises and obligations herein contained shall commence as of November 19, 2007 for an initial term of one (1) year periods therefrom and shall be automatically renewed under like terms for one (1) year periods thereafter, unless either party gives to the other party written notice of intent not to renew this AGREEMENT at least ninety (90) days prior to the expiration of its initial term or the then-existing renewal period subject, however, to termination under Section 9.2.

9.2 Termination. This AGREEMENT may be sooner terminated on the first to occur of the following:

- a. Written agreement by both parties to terminate this AGREEMENT.
- b. Written direction by the Illinois Department of Public Health or Human Services to terminate this AGREEMENT.
- c. In the event either party of this AGREEMENT shall, with or without cause, at anytime give to the other at least sixty (60)

days advance written notice and upon approval by the Illinois Department of Public Health or Human Services to terminate, this AGREEMENT, shall terminate on the future date specified in such notice.

- d. In the event of the material breach of any of the terms or conditions of this AGREEMENT by either party and the failure of the breaching party to correct such breach within (10) business days after written notice of such breach by either party, such other party may terminate the AGREEMENT within sixty (60) days by delivering to the breaching party written notice of termination and the effective date thereof.
- e. If either party is prevented from performing its obligations under this AGREEMENT by strikes or other labor disputes, official or unofficial; fire, war, flood; or any other reason beyond the party's reasonable control, each party's rights and obligations hereunder shall cease without further notice.

X. MISCELLANEOUS

10.1 Assignments. This AGREEMENT and all rights and benefits hereunder are personal to LEVEL II CENTER and ADMINISTRATIVE PERINATAL CENTER STAFF and neither this AGREEMENT nor any right or interest of LEVEL II CENTER or ADMINISTRATIVE PERINATAL CENTER STAFF herein, or arising hereunder, shall be voluntarily or involuntarily sold, transferred, or assigned without written consent by the other party, and any attempt at assignment is void. However, ADMINISTRATIVE PERINATAL CENTER STAFF shall have the right to assign this AGREEMENT to affiliate or Subsidiary Corporation. Addendum to this AGREEMENT may be made should a change in network structure occur that impacts LEVEL II CENTER.

10.2 Independent Contractor. It is expressly acknowledged by the parties that they are independent contractors and that nothing in this AGREEMENT is intended nor shall be construed to create an employer/employee relationship or a joint venture relationship between the parties.

10.3 Changes or Modifications. No change or modification of this AGREEMENT shall be valid unless the same shall be in

writing signed by ADMINISTRATIVE PERINATAL CENTER STAFF and the LEVEL II CENTER. No waiver of any provision of the AGREEMENT shall be valid unless in writing and signed by the person or party against whom charged.

10.4 Entire Agreement. This AGREEMENT constitutes the entire AGREEMENT between the parties and contains all of the agreements between the parties with respect to the subject administrative and professional services at PRACTICE and at LEVEL II CENTER, LEVEL II CENTER AND ADMINISTRATIVE PERINATAL CENTER STAFF shall be entitled to no benefits other than those specified here. LEVEL II Center and ADMINISTRATIVE PERINATAL CENTER STAFF acknowledge that in entering into and executing the AGREEMENT, they have relied solely upon the representations and agreements contained in the AGREEMENT. This AGREEMENT supersedes any and all other agreements either written or oral, between the parties with respect to the subject matter herein.

10.5 Notices. Notices required herein shall be considered effective when delivered in person or sent by United States Certified Mail postage prepaid, return receipt requested and addressed to:

ST. JOHN'S HOSPITAL
Administrator
St. John's Hospital
800 East Carpenter
Springfield, IL 62769

LEVEL II CENTER
CEO
Provena United Samaritans Medical Center
812 Logan Ave.
Danville, IL 61832

With Copy: Provena Health
19065 Hickory Creek Drive
Suite 300
Mokena, Illinois 60448
Attn: General Counsel

10.6 Governing Law. This AGREEMENT has been executed and delivered in, and shall be interpreted, construed, and enforced pursuant to and in accordance with the laws of Illinois.

10.7 Severability. The invalidity or unenforceability of any particular provision of this AGREEMENT shall not effect the other provisions hereof, and

this AGREEMENT shall be construed in all respects as if such invalid or unenforceable provision were omitted.

10.8 Waiver of Breach. The waiver by either party or breach or violation any provision of the AGREEMENT shall not operate as, or be construed to e, a waiver of any subsequent breach of the same or other provision hereof.

10.9 Headings. The section titles and other headings contained in this Agreement are for reference only and shall not affect in any way the meaning or interpretation of this AGREEMENT.

10.10 Indemnification

A. LEVEL II CENTER agrees to indemnify and hold harmless ADMINISTRATIVE PERINATAL CENTER from and against any and all liabilities, losses, damages, claims or causes of action, including any expenses connected therewith (including reasonable attorney's fees), which directly or indirectly arise out of the negligent or willful acts or omissions of LEVEL II CENTER or its employees, agents or representatives pursuant to this Agreement.

B. ADMINISTRATIVE PERINATAL CENTER agrees to indemnify and hold harmless LEVEL II CENTER from and against any and all liabilities, losses, damages, claims or caused of action, including any expenses connected therewith (including reasonable attorney's fees), which directly or indirectly arise out of the negligent or willful acts or omissions of ADMINISTRATIVE PERINATAL CENTER or its employees, agents, or representatives pursuant to the Agreement.

10.11 Compliance.

ADMINISTRATIVE PERINATAL CENTER acknowledges and shall uphold LEVEL II CENTER commitment to compliance with all federal and state laws and regulations. Each party certifies to the other that it has not been excluded from participation in Medicare, Medicaid, or any other federal or state funded health care program. Both parties agree to maintain the confidentiality of all patient information encountered under the terms of this Agreement (including, but not limited to, medical records, electronic, data, radiology films, laboratory blocks and slides and billing information) in accordance with applicable state and federal laws, including the Health Insurance Portability and Accountability Act of

1996 ("HIPAA") and the Standards of Privacy of Individually Identifiable Health Information promulgated by the federal Department of Health and Human Services pursuant to its authority under HIPAA.

IN WITNESS WHEREOF, The parties hereto have executed
the AGREEMENT in multiple originals on the last date written
below.

St. John's Hospital:

Provena United Samaritans Medical Center:

Richard Cook
President and CEO

Paul Bortol
President and CEO

12/5/07
Date

11/29/07
Date

Andie Harvey III
Director Maternal-Fetal Medicine

[Signature]
Director Obstetrics

12/5/07
Date

11-19-07
Date

Michael Sherman MD FRC
Director Neonatology

B. Pomales MD
Director Pediatrics

11-29-07
Date

11-19-07
Date

APPENDIX A Level II Center

Maternal:

For the following maternal conditions, consultation with a maternal-fetal medicine sub specialist with subsequent management and delivery at the appropriate facility as determined by mutual collaboration is recommended.

- A) Current obstetric history suggestive of potential difficulties such as:
- intrauterine growth restriction
 - prior neonatal death
 - two or more previous preterm deliveries less than 34 weeks
 - a single previous preterm delivery less than 30 weeks
 - birth of a neonate with serious complications resulting in a handicapping condition
 - recurrent spontaneous abortion or fetal demise
 - family history of genetic disease
- B) Active chronic medical problems with known increase in perinatal mortality, such as:
- cardiovascular disease Class I and Class II
 - autoimmune disease, reactive airway disease requiring treatment with systemic corticosteroids
 - seizure disorder
 - controlled hyperthyroidism on replacement therapy
 - hypertension controlled on a single medication
 - idiopathic thrombocytopenia purpura
 - thromboembolic disease
 - malignant disease (especially when active)
 - renal disease with functional impairment
 - human immunodeficiency viral infection (consultation may be with maternal-fetal medicine or infectious disease sub specialist);
- C) Selected obstetric complications that present prior to 34 weeks gestation, such as:
- suspected intrauterine growth restriction
 - polyhydramnios
 - oligohydramnios
 - pre-eclampsia/pregnancy-induced hypertension
 - congenital viral disease
 - maternal surgical conditions
 - suspected fetal abnormality or anomaly

- isoimmunization with antibody titers greater than 1:8
 - antiphospholipid syndrome
- D) Abnormalities of the reproductive tract known to be associated with an increase in preterm delivery, such as:
- uterine anomalies
 - diethyl-stilbesterol exposure
- E) Insulin dependent diabetes Class A2 and B or greater (White's Criteria).

Subsequent patient management and site of delivery shall be determined by mutual collaboration between the patient's physician and the maternal-fetal medicine sub-specialist.

For the following maternal conditions, referral to a maternal-fetal medicine sub specialist for evaluation shall occur. Subsequent patient management and site of delivery shall be determined by mutual collaboration between the patient's physician and the maternal-fetal medicine sub specialist

- A) Selected chronic medical conditions with a known increase in perinatal mortality, such as:
- cardiovascular disease with functional impairment (Class III or greater)
 - respiratory failure requiring mechanical ventilation
 - acute coagulopathy
 - intractable seizures
 - coma
 - Sepsis
 - solid organ transplantation
 - active autoimmune disease requiring corticosteroid treatment
 - unstable reactive airway disease
 - renal disease requiring dialysis or with a serum creatinine concentration greater than 1.5 mg%
 - active hyperthyroidism
 - hypertension that is unstable or requires more than one medication to control
 - severe hemoglobinopathy;
- B) Selected obstetric complications that present prior to 32 weeks gestation, such as:
- multiple gestation with more than two fetuses
 - twin gestation complicated by demise

- discordancy or maldevelopment of one fetus or by fetal-fetal transfusion
 - premature labor unresponsive to first-line tocolytics
 - premature rupture of membranes
 - medical and obstetrical complications of pregnancy possibly requiring induction of labor or non-emergent caesarean section for maternal or fetal indications, such as severe pre-eclampsia;
- C) Isoimmunization with possible need for intrauterine transfusion;
- D) Insulin-dependent diabetes mellitus Classes C, D, R, F, or H (White's Criteria)
- E) Congenital anomaly or abnormality requiring an invasive suspected fetal procedure, neonatal surgery or postnatal medical intervention to preserve life, such as:
- fetal hydrops
 - pleural effusion
 - ascites
 - persistent fetal arrhythmia
 - major organ system malformation-malfunction
 - genetic condition.

Subsequent patient management and site of delivery shall be determined by mutual collaboration between the patient's physician and the maternal-fetal medicine sub-specialist.

**APPENDIX B
LEVEL II**

NEONATAL:

Neonatal Conditions Recommended for Consultation with Neonatology

- Premature birth with gestation less than 32 weeks
- Infants with a birth weight less than 1500 grams
- Infants with 10 minute Apgar scores of 5 or less;
- Stable infants identified as having handicapping conditions or developmental disabilities that threaten subsequent development.

Neonatal Conditions for which Transfer Shall Occur after discussion with the Perinatal Center:

- Premature birth that is less than 30 weeks gestation;
- Birthweight less than or equal to 1250 grams;
- Infants requiring mechanical ventilation beyond the initial stabilization period of 6 hours;
- Infants who require a sustained inhaled oxygen concentration in excess of 50% in order to maintain a transcutaneous or arterial oxygen saturation greater than or equal to 92%
- Infants with significant congenital heart disease associated with cyanosis, congestive heart failure, or impaired peripheral blood flow;
- Infants with major congenital malformations requiring immediate comprehensive evaluation or neonatal surgery;
- Infants requiring neonatal surgery with general anesthesia;
- Infants with sepsis, unresponsive to therapy, associated with persistent shock or other organ system failure;
- Infants with uncontrolled seizures;
- Infants with stupor, coma, hypoxic ischemic encephalopathy Stage II or greater;
- Infants requiring double-volume exchange transfusion;

- **Infants with metabolic derangement persisting after initial correction therapy;**
- **Infants identified as having handicapping conditions that threaten life for which transfer can improve outcome**

HOSPITAL TRANSFER AGREEMENT

THIS HOSPITAL TRANSFER AGREEMENT ("Agreement") is made this 15th day of June, 2006 (the "Effective Date") by and between Provena United Samaritans Medical Center, a health care service provider, an Illinois not-for-profit corporation (the "Transferring Facility"), and Provena Health d/b/a/ Provena Covenant Medical Center, an Illinois not-for-profit corporation ("Receiving Hospital"). (Transferring Facility and Receiving Hospital may each be referred to herein as a "Party" and collectively as the "Parties").

RECITALS

WHEREAS, Transferring Facility provides health care services to the community; and

WHEREAS, patients of Transferring Facility ("Patients") may require transfer to a Hospital for acute-inpatient or other emergency health care services; and

WHEREAS, Receiving Hospital owns and operates a licensed and Medicare certified acute care Hospital in reasonable proximity to Transferring Facility, which has a twenty-four (24) hour emergency room and provides emergency health care services; and

WHEREAS, the Parties desire to enter into this Agreement in order to specify the rights and duties of each of the Parties and to specify the procedure for ensuring the timely transfer of patients to Receiving Hospital.

NOW, THEREFORE, to facilitate the timely transfer of patients to Receiving Hospital, the Parties hereto agree as follows:

ARTICLE I

TRANSFER OF PATIENTS

In the event that any Patient needs acute inpatient or emergency care and has either requested to be taken to Receiving Hospital, or is unable to communicate a preference for Hospital services at a different Hospital, and a timely transfer to Receiving Hospital would best serve the immediate medical needs of Patient, a designated staff member of Transferring Facility shall contact the admitting office or emergency department of Receiving Hospital (the "Emergency Department") to facilitate admission. Receiving Hospital shall receive Patient in accordance with applicable federal and state laws and regulations, the standards of the Joint Commission on the Accreditation of Healthcare Organizations ("JCAHO") and any other applicable accrediting bodies, and reasonable policies and procedures of Receiving Hospital's responsibility for Patient care shall begin when Patient arrives upon Receiving Hospital's property.

ARTICLE II

RESPONSIBILITIES OF TRANSFERRING FACILITY

Transferring Facility shall be responsible for performing or ensuring the performance of the following:

- (a) Arranging for ambulance service to Receiving Hospital;
- (b) Designating a person who has authority to represent Transferring Facility and coordinate the transfer of Patients to Receiving Hospital;
- (c) Notifying Receiving Hospital's designated representative prior to transfer to alert him or her of the impending arrival of Patient and provide information on Patient to the extent allowed pursuant to Article IV;
- (d) Notifying Receiving Hospital of the estimated time of arrival of the Patient;
- (e) Recognizing and complying with the requirements of any federal and state law and regulations or local ordinances that apply to the care and transfer of individuals to Receiving Hospitals for emergency care.

ARTICLE III

RESPONSIBILITIES OF RECEIVING HOSPITAL

Receiving Hospital shall be responsible for performing or ensuring performance of the following:

- (a) Designating a person who has authority to represent and coordinate the transfer and receipt of Patients into the Emergency Department; and
- (b) Timely admission of Patient to Receiving Hospital when transfer of patient is medically appropriate as determined by Receiving Hospital attending physician subject to Hospital capacity and patient census issues; and
- (c) Recognizing and complying with the requirements of any federal and state law and regulations or local ordinances that apply to patients who present at emergency departments.

ARTICLE IV

PATIENT INFORMATION

In order to meet the needs of Patients with respect to timely access to emergency care, Transferring Facility shall provide information on Patients to Receiving Hospital, to the extent approved in advance or authorized by law and to the extent Transferring Facility has such information available. Such information may include: Patient Name, Social Security Number, Date of Birth, insurance coverage and/or Medicare beneficiary information (if applicable),

known allergies or medical conditions, treating physician, contact person in case of emergency and any other relevant information Patient has provided Transferring Facility in advance, to be given in connection with seeking emergency care. Transferring Facility shall maintain the confidentiality of medical/insurance information provided by Patient and received from Patient, in connection with Patient's provision of such information, Patient's authorization to disclose such information to Emergency Department personnel, all in accordance with applicable state and federal rules and regulations governing the confidentiality of patient information.

ARTICLE V

NON EXCLUSIVITY

This Agreement shall in no way give Receiving Hospital an exclusive right of transfer of Patients of Transferring Facility. Transferring Facility may enter into similar agreements with other Receiving Hospitals, and Patients will continue to have complete autonomy with respect to choice of Receiving Hospital service providers, as further described in Article 6.

ARTICLE VI

FREEDOM OF CHOICE

In entering into this Agreement, Transferring Facility in no way is acting to endorse or promote the services of Receiving Hospital. Rather, Transferring Facility intends to coordinate the timely transfer of Patients for emergency care. Patients are in no way restricted in their choice of emergency care providers.

ARTICLE VII

BILLING AND COLLECTIONS

Receiving Hospital shall be responsible for the billing and collection of all charges for professional services rendered at Receiving Hospital. Transferring Facility shall in no way share in the revenue generated by professional services delivered to Patients at Receiving Hospital.

ARTICLE VIII

INDEPENDENT RELATIONSHIP

Section 8.1 In performing services pursuant to this Agreement, Receiving Hospital and all employees, agents or representatives of Receiving Hospital are, at all times, acting and performing as independent contractors and nothing in this Agreement is intended and nothing shall be construed to create an employer/employee, principal/agent, partnership or joint venture relationship. Transferring Facility shall neither have nor exercise any direction or control over the methods, techniques or procedures by which Receiving Hospital or its employees, agents or representatives perform their professional responsibilities and functions. The sole interest of Transferring Facility is to coordinate the timely transfer of Patients to Receiving Hospital for emergency care.

Section 8.2 Receiving Hospital shall be solely responsible for the payment of

compensation and benefits to its personnel and for compliance with any and all payments of all taxes, social security, unemployment compensation and worker's compensation.

Section 8.3 Notwithstanding the terms of this Agreement, in no event shall Receiving Hospital or any Receiving Hospital personnel be responsible for the acts or omissions of non-Receiving Hospital personnel.

ARTICLE IX

INSURANCE

Both Parties shall maintain, at no cost to the other Party Facility, professional liability insurance in an amount customary for its business practices. Receiving Hospital shall provide evidence of the coverage required herein to Transferring Facility on an annual basis.

ARTICLE X

INDEMNIFICATION

Each Party shall indemnify, defend and hold harmless the other Party from and against any and all liability, loss, claim, lawsuit, injury, cost, damage or expense whatsoever (including reasonable attorneys' fees and court costs), imposed by a third party and arising out of, incident to or in any manner occasioned by the performance or nonperformance of any duty or responsibility under this Agreement by such indemnifying Party, or any of its employees, agents, contractors or subcontractors.

ARTICLE XI

TERM AND TERMINATION

Section 11.1 Term. The term of this Agreement shall commence on the Effective Date and shall continue in effect for one (1) year (the "Initial Term") and SHALL RENEW ON AN ANNUAL BASIS ("RENEWAL TERM") ABSENT WRITTEN NOTICE BY EITHER PARTY OF NON-RENEWAL TO THE OTHER PARTY THIRTY (30) CALENDAR DAYS PRIOR TO THE EXPIRATION OF THE INITIAL TERM OR ANY SUBSEQUENT RENEWAL TERM OF THIS AGREEMENT.

Section 11.2 Events of Termination. Notwithstanding the foregoing, this Agreement may be terminated upon the occurrence of any one (1) of the following events:

(a) Either Party may terminate this Agreement at any time upon sixty (60) days prior written notice to the other Party.

(b) If either Party shall apply for or consent to the appointment of a receiver, trustee or liquidator of itself or of all or a substantial part of its assets, file a voluntary petition in bankruptcy, or admit in writing its inability to pay its debts as they become due, make a general assignment for the benefit of creditors, file a petition or an answer seeking reorganization or arrangement with creditors or take advantage of any insolvency law, or if an order, judgment, or decree shall be entered by a court of competent

jurisdiction or an application of a creditor, adjudicating such Party to be bankrupt or insolvent, or approving a petition seeking reorganization of such Party or appointing a receiver, trustee or liquidator of such Party or of all or a substantial part of its assets, and such order, judgment, or decree shall continue in effect and unstayed for a period of thirty (30) consecutive calendar days, then the other Party may terminate this Agreement upon ten (10) business days' prior written notice to such Party.

Section 11.3 Immediate Termination. Notwithstanding anything to the contrary herein, this Agreement will be terminated immediately upon the following events: (a) the suspension or revocation of the license, certificate or other legal credential authorizing Receiving Hospital to provide emergency care services; (b) termination of Receiving Hospital's participation in or exclusion from any federal or state health care program for any reason; (c) the cancellation or termination of Receiving Hospital's professional liability insurance required under this Agreement without replacement coverage having been obtained.

ARTICLE XII

MISCELLANEOUS PROVISIONS

Section 12.1 Entire Agreement. This Agreement constitutes the entire understanding between the Parties with respect to the subject matter hereof. This Agreement supersedes any and all other prior agreements either written or oral, between the Parties with respect to the subject matter hereof.

Section 12.2 Counterparts. This Agreement may be executed in two or more counterparts, each of which shall be deemed an original, but all such counterparts together shall constitute one and the same instrument.

Section 12.3 Waiver. Any waiver of any terms and conditions hereof must be in writing, and signed by the Parties. A waiver of any of the terms and conditions hereof shall not be construed as a waiver of any other terms and conditions hereof.

Section 12.4 Severability. The provisions of this Agreement shall be deemed severable, and, if any portion shall be held invalid, illegal or unenforceable for any reason, the remainder of this Agreement shall be effective and binding upon the Parties.

Section 12.5 Headings. All headings herein are inserted only for convenience and ease of reference and are not to be considered in the construction or interpretation of any provision of this Agreement.

Section 12.6 Assignment. This Agreement, being intended to secure the services of Receiving Hospital, shall not be assigned, delegated or subcontracted by Receiving Hospital without prior written consent of Transferring Facility.

Section 12.7 Governing Law. This Agreement shall be construed under the laws of the state of Illinois, without giving affect to choice of law provisions.

Section 12.8 Notices. Any notice herein required or permitted to be given shall be in writing and shall be deemed to be duly given on the date of service if served personally on the

other Party, or on the fourth (4th) day after mailing, if mailed to the other Party by certified mail, return receipt requested, postage pre-paid, and addressed to the Parties as follows:

To Transferring Facility:

Mike Brown, CNE/COO
Provena United Samaritans Medical
Center
812 North Logan Avenue
Danville, Illinois 61832

To Receiving Hospital:

Patricia Schulte, CNE/COO
Provena Covenant Medical Center
1400 West Park Street
Urbana, Illinois 61801

or such other place or places as either Party may designate by written notice to the other.

Section 12.9 Amendment. This Agreement may be amended upon mutual, written agreement of the Parties.

Section 12.10 Regulatory Compliance. The Parties agree that nothing contained in this Agreement shall require Transferring Facility to refer patients to Receiving Hospital for emergency care services or to purchase goods and services. Notwithstanding any unanticipated effect of any provision of this Agreement, neither Party will knowingly and intentionally conduct its behavior in such a manner as to violate the prohibition against fraud and abuse in connection with the Medicare and Medicaid programs.

Section 12.11 Access to Books and Records. If applicable, upon written request of the Secretary of Health and Human Services or the Comptroller General of the United States, or any of their duly authorized representatives, Receiving Hospital shall make available to the Secretary or to the Comptroller General those contracts, books, documents and records necessary to verify the nature and extent of the costs of providing its services under this Agreement. Such inspection shall be available for up to four (4) years after the rendering of such service. This Section is included pursuant to and is governed by the requirements of Public Law 96-499 and Regulations promulgated thereunder. The Parties agree that any attorney-client, accountant-client or other legal privileges shall not be deemed waived by virtue of this Agreement.

IN WITNESS THEREOF, the Parties have cause this Agreement to be executed by their duly authorized officers hereto setting their hands as of the date first written above.

TRANSFERRING FACILITY

Provena United Samaritans Medical Center, an Illinois not for profit corporation

By: Michael L. Brown
Mike Brown

Its: CNE/COO

RECEIVING HOSPITAL

Provena Covenant Medical Center, an Illinois not for profit corporation

By: Patricia A. Schulte
Patricia Schulte

Its: CNE/COO

Audited Financial Statements as evidence of the availability of funds are provided in the Certificate of Need application addressing the change of ownership of Resurrection Medical Center



March 22, 2011

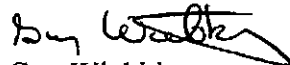
Illinois Health Facilities
and Services Review Board
Springfield, Illinois

RE: FUNDING OF PROJECT

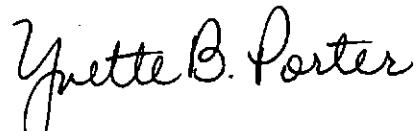
To Whom It May Concern:

I hereby attest that all of the real costs associated with the changes of ownership of the facilities directly or indirectly owned and/or controlled by either Resurrection Health Care Corporation or Provena Health will be funded in total with cash or equivalents.

Sincerely,


Guy Wiebking
President and CEO

Notarized:





ATTACHMENT 42A

7435 West Talcott Avenue
Chicago, Illinois 60631
773.792.5555



Sandra Bruce, FACHE
President & Chief Executive Officer

March 22, 2011

Illinois Health Facilities
and Services Review Board
Springfield, Illinois

RE: FUNDING OF PROJECT

To Whom It May Concern:

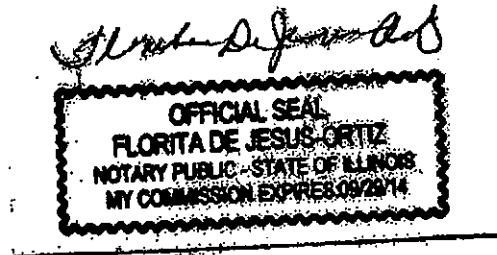
I hereby attest that all of the real costs associated with the changes of ownership of the facilities directly or indirectly owned and/or controlled by Resurrection Health Care Corporation will be funded in total with cash or equivalents.

Sincerely,

A handwritten signature in cursive script that reads "Sandra Bruce".

Sandra Bruce, FACHE
President & Chief Executive Officer

Notarized:



OPERATING and CAPITAL COSTS
per ADJUSTED PATIENT DAY

Provena United Samaritans Medical Center
2012 Projection

ADJUSTED PATIENT DAYS:

\$	<u>73,394,000</u>	
\$	2,411	30,444

OPERATING COSTS

salaries & benefits	\$	52,600,000
supplies	\$	<u>9,318,000</u>
TOTAL	\$	61,918,000

Operating cost/adjusted patient day:	\$	2,033.83
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CAPITAL COSTS

depreciation, amortization and interest	\$	6,669,000
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Capital cost/adjusted patient day:	\$	219.06
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