

ORIGINAL

11-040

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 Mercy Medical Center	HEALTH FACILITIES & SERVICES REVIEW BOARD	
Street Address:	1325 North Highland Avenue		
City and Zip Code:	Aurora, IL 60506		
County: Kane	Health Service Area VIII		

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

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Provena Mercy Medical Center		
Street Address:	1325 North Highland Avenue		
City and Zip Code:	Aurora, IL 60506		
County:	Kane	Health Service Area	VIII Health Planning Area: A-12

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
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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

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Provena Mercy Medical Center		
Street Address:	1325 North Highland Avenue		
City and Zip Code:	Aurora, IL 60506		
County:	Kane	Health Service Area	VIII Health Planning Area: A-12

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

- 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@hkllaw.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 Mercy Medical Center		
Street Address:	1325 North Highland Avenue		
City and Zip Code:	Aurora, IL 60506		
County:	Kane	Health Service Area	VIII Health Planning Area: A-12

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**.
- 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.

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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:	George Einhorn
Title:	Interim Chief Executive Officer
Company Name:	Provena Mercy Medical Center
Address:	1325 North Highland Avenue Aurora, IL 60506
Telephone Number:	630/801-2616
E-mail Address:	george.einhorn@provena.org
Fax Number:	630/859-9014

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:	1325 North Highland Avenue Aurora, IL 60506
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.

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)]

<p>Part 1110 Classification:</p> <p><input type="checkbox"/> Substantive</p> <p><input checked="" type="checkbox"/> Non-substantive</p>	<p>Part 1120 Applicability or Classification: [Check one only.]</p> <p><input type="checkbox"/> Part 1120 Not Applicable</p> <p><input type="checkbox"/> Category A Project</p> <p><input checked="" type="checkbox"/> Category B Project</p> <p><input type="checkbox"/> DHS or DVA Project</p>
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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 Mercy Medical Center, a 299-bed community hospital located in Aurora, 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 Mercy 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 Mercy 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 Mercy 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			\$335,563,000
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS			\$336,129,667
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			\$335,563,000
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS			\$336,129,667

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.

FACILITY NAME: Provena Mercy Medical Center		CITY: Aurora			
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	156	5,229	25,909	None	156
Obstetrics	16	1,239	2,699	None	16
Pediatrics	16	443	1,237	None	16
Intensive Care	16	768	3,475	None	16
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness	95	2,718	16,682	None	95
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify))					
TOTALS:	299	10,397	50,002	None	299

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

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

Yvette B. Porter
Signature of Notary

Yvette B. Porter
Signature of Notary

Seal



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 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 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

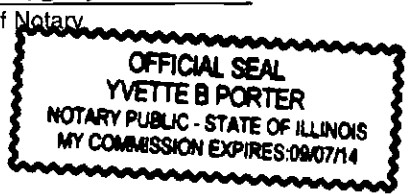
Anthony Filer
PRINTED NAME

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 Porter
Signature of Notary
Seal


*Insert EXACT legal name of the applicant

CERTIFICATION

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

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

This Application for Permit is filed on the behalf of 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

Jeanie C. Frey
SIGNATURE
Jeanie 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 PUBLIC name of the 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 Cana 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

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 22nd 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 in Commission Page 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 Mercy 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;
\$335,563,000	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
\$336,129,667	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 Mercy 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.

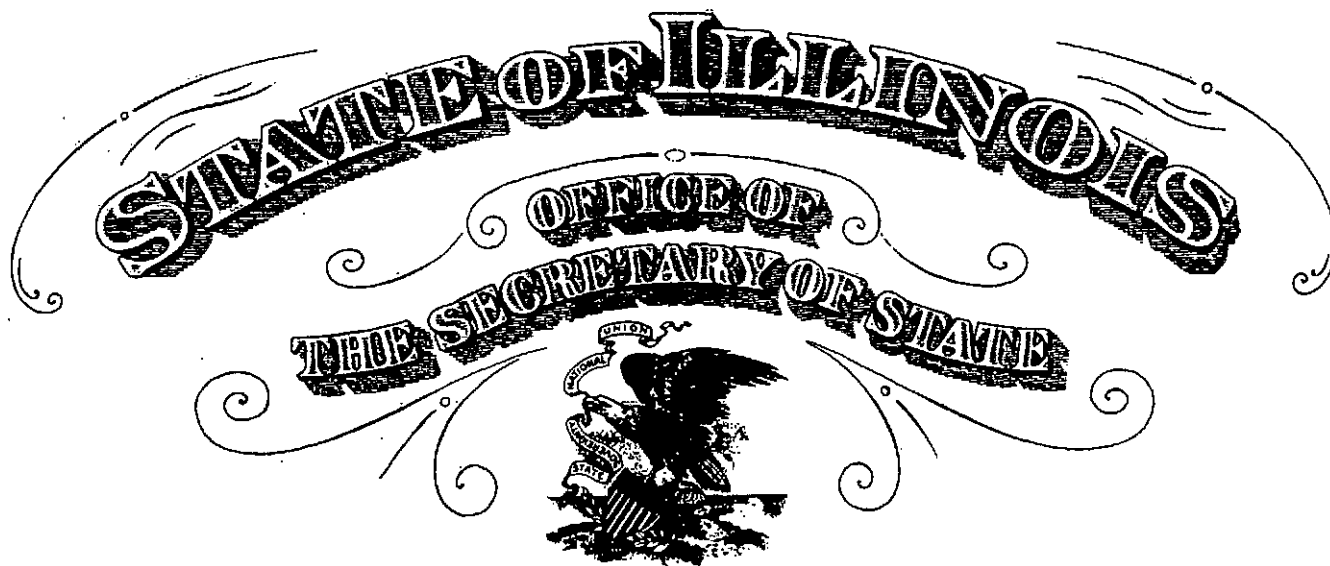
A table in the following format must be provided for all facilities as part of Attachment 44.

CHARITY CARE			
	2007	2008	2009
Net Patient Revenue	\$160,415,247	\$173,101,263	\$169,224,883
Amount of Charity Care (charges)	\$22,667,612	\$26,048,862	\$27,617,954
Cost of Charity Care	\$5,349,557	\$6,793,808	\$5,367,773

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 .*

Jesse White

Authentication #: 1104200730

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

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

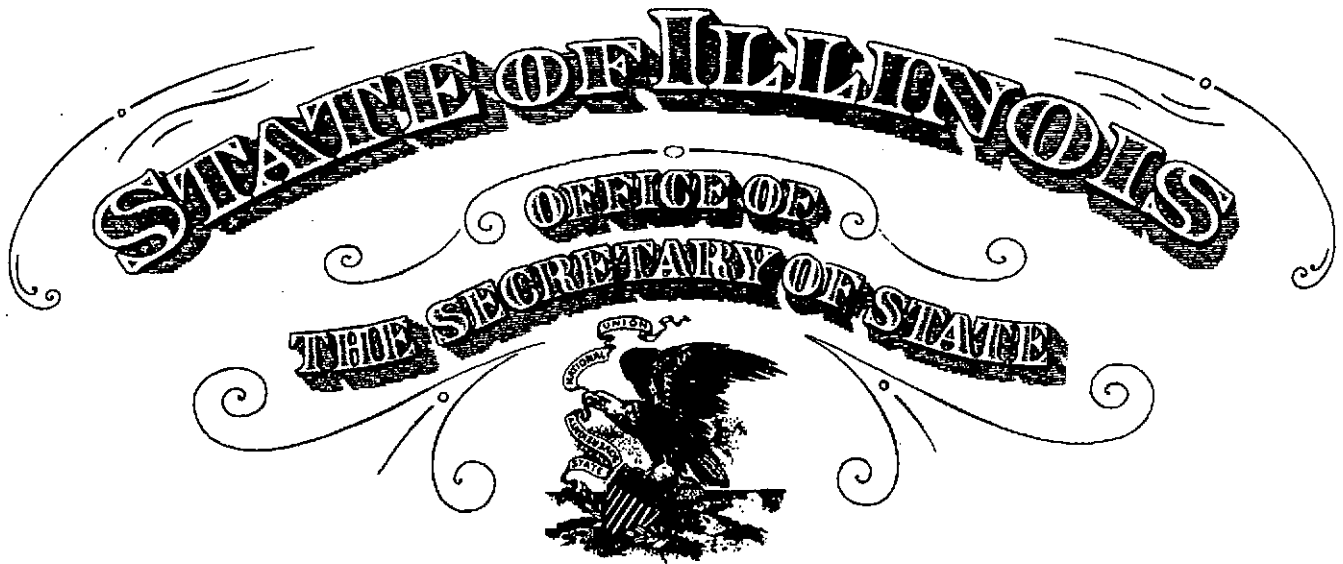
Jesse White

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.



Authentication #: 1106302140

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

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

Jesse White

SECRETARY OF STATE
ATTACHMENT I

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)

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**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

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).

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/B/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	<u>Boiler and Machinery</u> – per all terms and conditions of the policy form
\$500,000,000	<u>Certified Terrorism - TRIPRA</u>
\$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	Computer Systems – Non Physical Damage
48 hrs. waiting period and 48 hr. ded.	
Min. 100,000	Dependent Time Element Location
\$100,000	Per occurrence/location except; <ul style="list-style-type: none"> • Per location for Earthquake Shock
\$100,000	<ul style="list-style-type: none"> • Per location for Flood
\$100,000	<ul style="list-style-type: none"> • Per location for Named Storm Wind* except;
5% of Values*	(*at all affected locations, are subject to this deductible)
\$100,000 min/loc.	Service Interruption Waiting Period
24 hrs.	Terrorism – TRIPRA, and ACV portion of fire damage caused by Terrorism
Policy deductible(s) per location	
\$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 Airfite 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

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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 .*

Jesse White

Authentication #: 1104200730

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

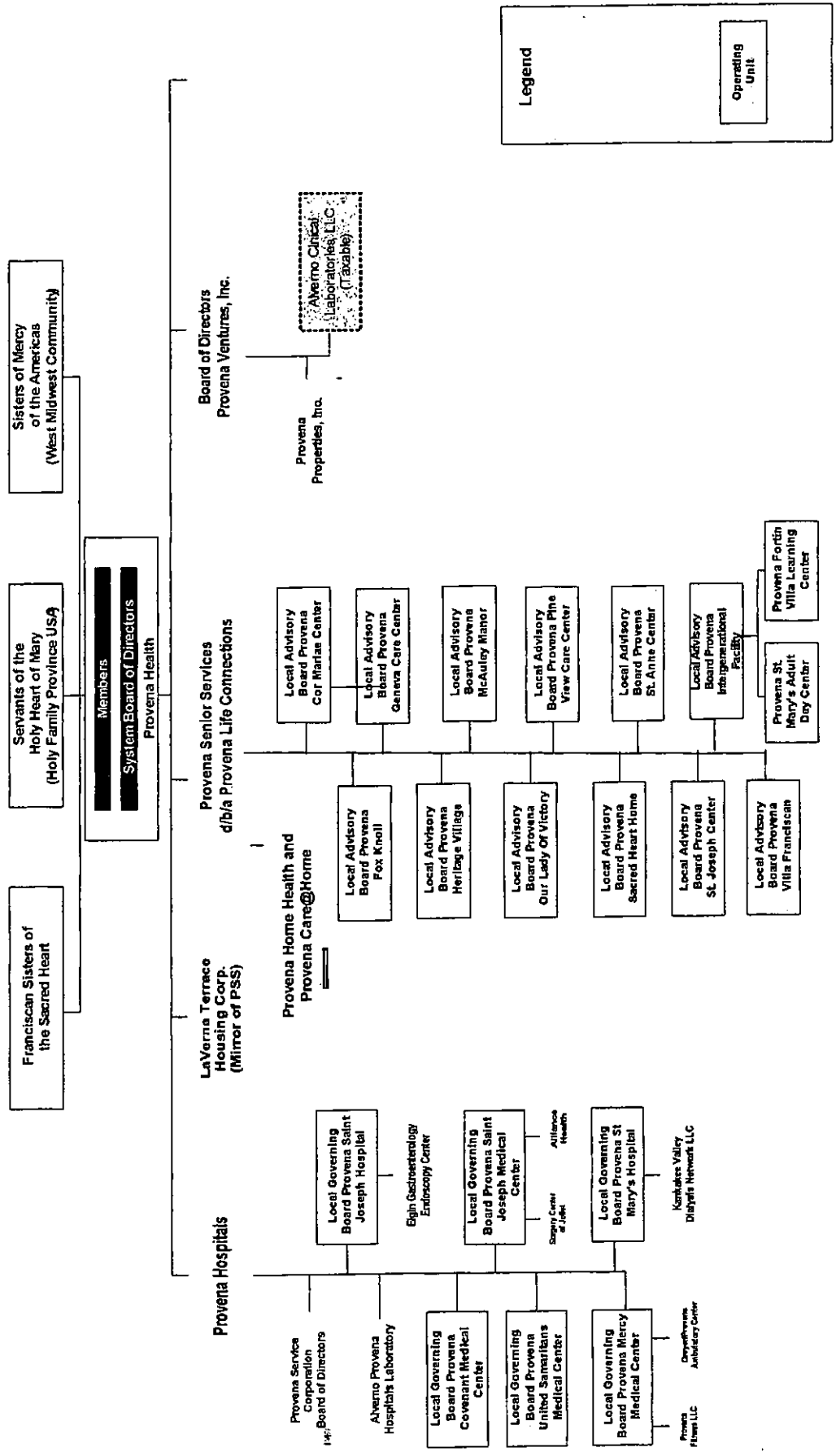
SECRETARY OF STATE

ATTACHMENT 3

CURRENT ORGANIZATIONAL CHARTS

January 2011

Provena Health
Organizational Governance Structure

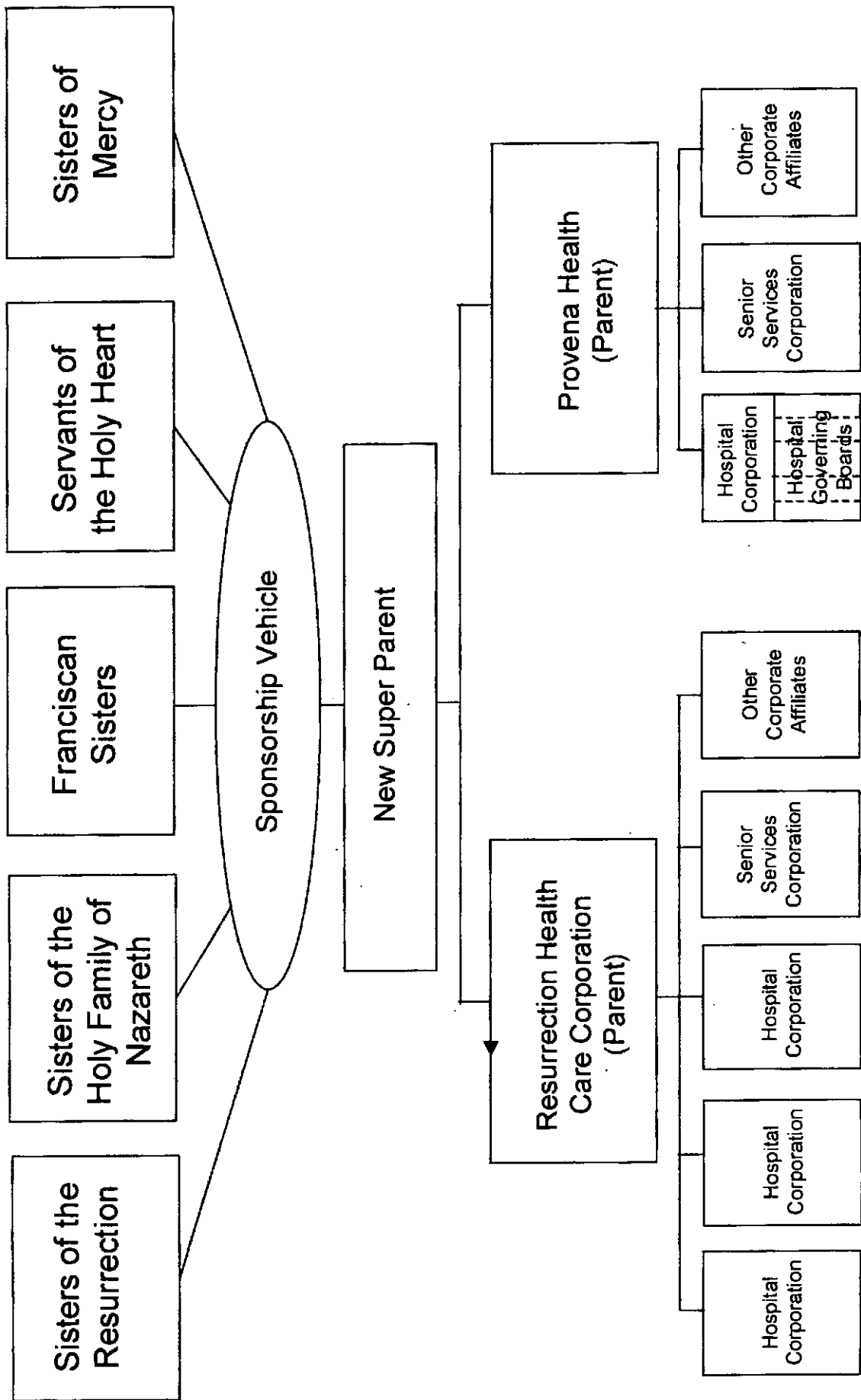


Resurrection Health Care Corporation
Legal Organizational Structure
As of October 21, 2010
Footnotes

- ^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 1110.230.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 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 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:

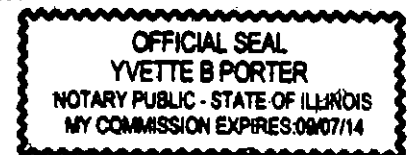
3. Neither Provena Health ("Provena") nor any wholly-affiliated corporation that owns or operates a facility subject to the IHFSRB's jurisdiction has had any adverse actions (as defined in Section 1130.140) taken against any hospital or ESRD facility during the three (3) year period prior to the filing 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 that reads "Meghan Kieffer".

Meghan Kieffer
System Senior Vice President/General Counsel



A handwritten signature in cursive script that reads "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.

DAMON T. ARNOLD, M.D.
DIRECTOR

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

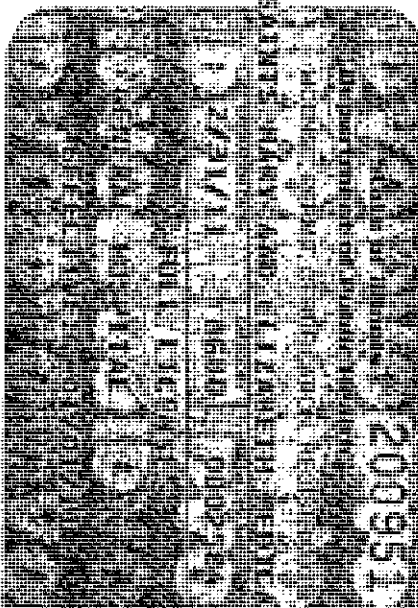
EXPIRATION DATE 12/31/11	CATEGORY B88B	IDENTIFICATION NUMBER 0002584
FULL LICENSE GENERAL HOSPITAL EFFECTIVE: 01/01/11		
BUSINESS ADDRESS		

SAINTS MARY AND ELIZABETH MEDICAL CENTER
D/B/A SAINT MARY OF NAZARETH HOSPITAL
2233 WEST DIVISION STREET
CHICAGO IL 60622

The face of this license has a colored background printed by Authority of the State of Illinois 7/97.

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 CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN
 IDENTIFICATION



11/06/10
SAINTS MARY AND ELIZABETH MEDICAL CENTER
D/B/A SAINT 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.

BANON T. ARNOLD, M.D.
DIRECTOR

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

EXPIRATION DATE	CATEGORY	LP NUMBER
12/31/11	6680	0005314

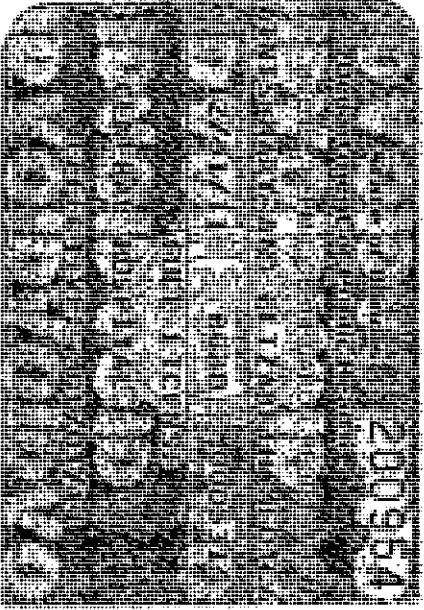
FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 10/01/11

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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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 06BD	ID NUMBER 0001974
FULL LICENSE		
GENERAL HOSPITAL		
EFFECTIVE: 01/01/11		

BUSINESS ADDRESS

RESURRECTION MEDICAL CENTER
7435 WEST TALCOTT AVENUE

CHICAGO IL 60631

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IDENTIFICATION

State of Illinois 2009495
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

EXPIRATION DATE 12/31/11	CATEGORY 06BD	ID NUMBER 0001974
FULL LICENSE		
GENERAL HOSPITAL		
EFFECTIVE: 01/01/11		

BUSINESS ADDRESS

RESURRECTION MEDICAL CENTER
7435 WEST TALCOTT AVENUE
CHICAGO IL 60631

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	I.D. NUMBER
07/02/12	B62L	0005181

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 07/03/11

06/06/11

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.

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

EXPIRATION DATE	CATEGORY	I.D. NUMBER
07/02/12	B62L	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



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.

DAMON T. ARNELDO, M.D.
DIRECTOR

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

EXPIRATION DATE 06/30/12	CATEGORY H65D	ID. NUMBER 0001008
FULL LICENSE GENERAL HOSPITAL EFFECTIVE: 07/01/11		

BUSINESS ADDRESS

HOLY FAMILY MEDICAL CENTER
100 NORTH RIVER ROAD

DES PLAINES

IL 60015 1278

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State of Illinois 2035973
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

EXPIRATION DATE 05/30/12	CATEGORY H65D	ID. NUMBER 0001008
FULL LICENSE GENERAL HOSPITAL EFFECTIVE: 07/01/11		

05/07/11

HOLY FAMILY MEDICAL CENTER
 100 NORTH RIVER ROAD

DES PLAINES IL 60016 1278

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 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. ARNDT, 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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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

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/HFAP 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 Y. ARNOLD, M.D.
DIRECTOR

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

Table with 3 columns: EXPIRATION DATE (06/30/12), CATEGORY (DEBD), I.D. NUMBER (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

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

DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

State of Illinois 2035984
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

OUR LADY OF THE RESURRECTION MEDICAL

Table with 3 columns: EXPIRATION DATE (06/30/12), CATEGORY (DEBD), I.D. NUMBER (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 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	ID NUMBER
12/31/11	BGND	0004861
FULL LICENSE GENERAL HOSPITAL EFFECTIVE: 01/01/11		

BUSINESS ADDRESS

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

URBANA

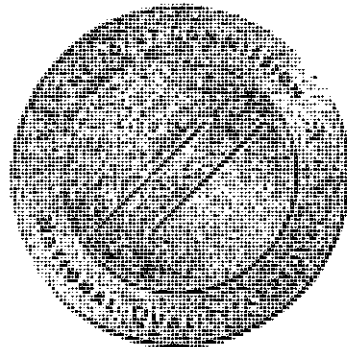
IL 61801

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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

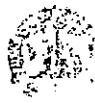
David L. Nahrwold, M.D.
Chairman of the Board

4968
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 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

EXPIRES	CATEGORY	ID NUMBER
12/31/11	RGBD	0004853
FULL LICENSE GENERAL HOSPITAL EFFECTIVE: 01/01/11		

BUSINESS ADDRESS

PROVENA HOSPITALS
D/B/A UNITED SAHARITAN MED CTR-LOGAN
812 NORTH LOGAN AVENUE

DANVILLE IL 61832

The face of this license has a colored background printed by authority of the State of Illinois - 4/07

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

EXPIRATION DATE 12/31/11	CATEGORY B6BD	LD 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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REMOVE THIS CARD TO CARRY AS AN
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State of Illinois 2009536
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION
PROVENA HOSPITALS

EXPIRATION DATE 12/31/11	CATEGORY B6BD	LD NUMBER 0004838
FULL LICENSE GENERAL HOSPITAL EFFECTIVE: 01/01/11		

BUSINESS ADDRESS

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 BGBD	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

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REMOVE THIS CARD TO CARRY AS AN
 IDENTIFICATION

State of Illinois 2009540
 Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

BUSINESS ADDRESS

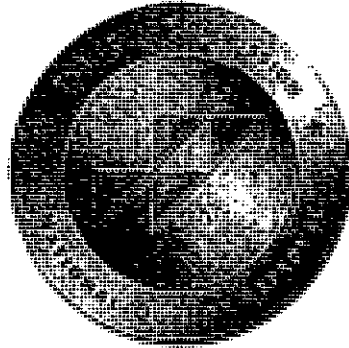
PROVENA HOSPITALS
 D/B/A SAINT JOSEPH HOSPITAL
 77 NORTH AIRLITE STREET
 ELGIN
 IL 60120

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

This person has a registration valid and approved on their certificate that complies with the provisions of the Bureau Standard Order rules and regulations and is hereby authorized to engage in the activity as indicated below.

DAVID T. ARMOUR, M.D.
 DIRECTOR

David T. Armour, M.D.
 The State of Illinois
 Department of Public Health

12/31/11	0680	0004903
FULL LICENSE		
GENERAL HOSPITAL		
EFFECTIVE: 01/01/11		

BUSINESS ADDRESS

PROVENA MERCY CENTER
 1325 NORTH HIGHLAND AVENUE
 AURORA

AURORA

IL 60506

The form on this document may be revised without notice by the Department of Public Health. 1/11

Display this part in a conspicuous place

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

2009541

State of Illinois
 Department of Public Health
 LICENSE, PERMIT, CERTIFICATION, REGISTRATION

PROVENA MERCY CENTER

12/31/11	0680	0004903
FULL LICENSE		
GENERAL HOSPITAL		
EFFECTIVE: 01/01/11		

GENERAL HOSPITAL
 EFFECTIVE: 01/01/11

11/06/10

PROVENA HOSPITALS D/B/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,

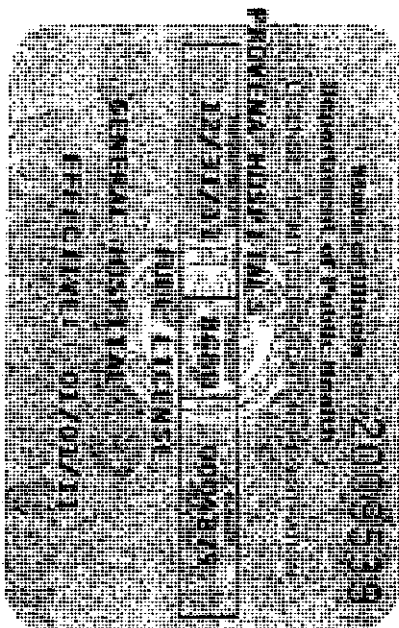
A handwritten signature in black ink that reads "Ann Scott Blouin RN, PhD".

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



← DISPLAY THIS PART IN A CONSPICUOUS PLACE

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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

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

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.

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

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

04/30/12

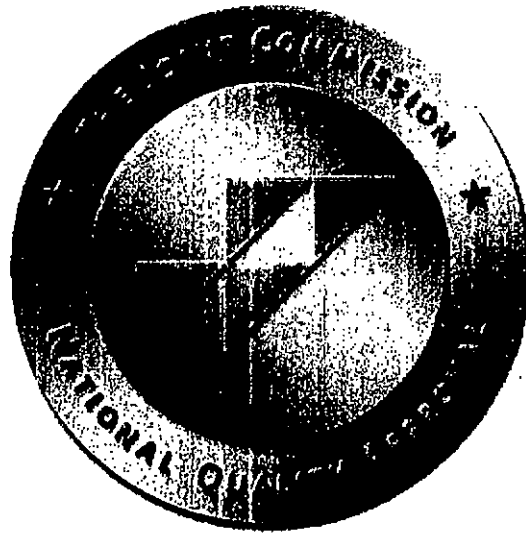
BELMONT/HARLEM SURGERY CENTER, LLC
3101 NORTH HARLEM AVENUE
CHICAGO IL 60634

FEE RECEIPT NO. 34561

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 Mercy 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 %
60506	Aurora	2,825	30.0%	30.0%
60505	Aurora	2,056	21.8%	51.8%
60542	North Aurora	659	7.0%	58.8%
60538	Montgomery	386	4.1%	62.9%
60543	Oswego	287	3.0%	66.0%
60510	Batavia	250	2.7%	68.6%
60554	Sugar Grove	217	2.3%	70.9%
60560	Yorkville	211	2.2%	73.2%
60504	Aurora	202	2.1%	75.3%
60545	Plano	178	1.9%	77.2%
60548	Sandwich	157	1.7%	78.9%
60185	West Chicago	148	1.6%	80.4%
60134	Geneva	117	1.2%	81.7%
60502	Aurora	114	1.2%	82.9%
60115	DeKalb	107	1.1%	84.0%
other ZIP Code areas contributing <1%		<u>1,506</u>	<u>16.0%</u>	100.0%
		9,420	100.0%	

As can be noted from the table above, fifteen ZIP Code areas accounted for 84% of the hospital's admissions. This analysis clearly demonstrates that Provena Mercy 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 Mercy 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 (299) or to the scope of services currently provided at Provena Mercy Medical Center.

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

- 156 medical/surgical beds
- 16 pediatrics beds
- 16 intensive care beds
- 16 obstetrics/gynecology beds
- 95 acute mental illness

Among the other clinical services currently offered and proposed to continue to be provided are: surgery (including cardiovascular 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 Mercy 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 10,400 patients, provided approximately 93,300 outpatient visits, and treated over 44,000 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 Mercy 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 over 1,000 employees (FTEs), Provena Mercy 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 Mercy 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 Mercy 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.

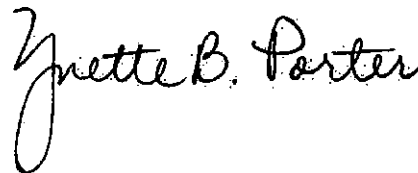
Provena and Resurrection, in consultation with the Illinois Attorney General's office, are currently revising the charity care policy to be used following the system merger. That revised policy will be provided to the State Agency upon completion.

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.

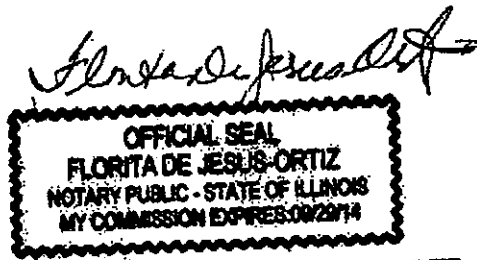
Resurrection and Provena, in consultation with the Illinois Attorney General's office, are currently revising the charity care policy to be used following the system merger. That revised policy will be provided to the State Agency upon completion.

Sincerely,

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

Sandra Bruce, FACHE
President & CEO

Notarized:



CURRENT ADMISSIONS
and
CHARITY CARE POLICIES

INSTITUTIONAL POLICY

Section: Patient Care

Policy Number: I-01-1.17

Subject: Patient Rights and Responsibilities

Page 1 of 4

**Executive Owner: Manager, Patient Admitting
Provena Mercy Medical Center**

Approval Date: 11/2010

Effective Date: 01/2007

Last Review Date: 10/2008

Revised Date: 11/2010

Supersedes:

POLICY

Provena Mercy Medical Center has defined patient's rights and responsibilities. These rights and responsibilities are in concert with values and principles inherent in the moral teachings of our mission and philosophy and all applicable federal and state laws.

PURPOSE

Provena Mercy Medical Center recognizes and respects the right of patients and affirms the patient's right to make decisions regarding his/her medical care with consideration and recognition of the psychosocial, spiritual and cultural values of the patient, including the decision to discontinue and/or withhold treatment to the extent permitted by law and by the Provena Mercy Medical Center mission and philosophy, Provena Mercy Medical Center apprises each patient of his/her rights and responsibilities and assists the patient in exercising these rights and responsibilities.

SPECIAL INSTRUCTIONS

DEFINITIONS

PROCEDURE

I. PRACTICE FOR PATIENT RIGHTS:

- A. Patients have the right to be free of any form of abuse, neglect, harassment and/or inappropriate behavior.
- B. Patients, both inpatients and outpatients will be notified of their rights at time of registration by the registrar or admitting staff. In offsite areas and Family Birth Center Patient Rights and Responsibilities brochure will be provided at point of care registration.
- C. Patients have the right to be provided care in a safe environment. **If the Hospital believes there may be a weapon, explosive device, illegal substance or alcoholic beverage in your room, belongings on your person or possessions may be searched, confiscated and disposed of as appropriate, including delivery of any item to law enforcement authorities.**
- D. Patients have the right to be visited by any persons unless the facility or physician determines that visitation would endanger the physical health or safety of a patient or visitor or would interfere with the operations of the facility.
- E. Each patient whenever possible will receive the statement of Patient Bill of Rights and Responsibilities in a language or method of communication that the patient understands.
- F. Patients will be provided interpretation for individuals who speak languages other than

- English, use alternative communication techniques or aides for those who are deaf or blind or the facility will take steps to effectively communicate with these patients.
- G. Documentation will be placed in the medical record related to the use of interpreters, alternative communication techniques or aides for deaf or blind patients.
 - H. Patients will have an opportunity to discuss the Rights and Responsibilities to ensure comprehension of the information.
 - I. Patients will be provided with information necessary to exercise their rights.
 - J. Patients will receive information regarding Centers for Medicare and Medicaid Services hotline, Illinois Department of Health, Illinois Quality Improvement Organization, Joint Commission of Hospital Accreditation and the Hospital Ethics Committee and complaint/grievance process.
 - K. Patients will be given notice of rights afforded to him/her including the right to formulate an advance directive, notice of beneficiary discharge rights, notice of non-coverage rights and the right to appeal premature discharge.
 - L. When the patient is deemed legally incompetent to make his/her own choices, a designee may be appointed to make decisions related to care.
 - M. Patient complaints, which cannot be resolved by the Department Director, will be addressed by the Patient Advocate, according to the Provena Mercy Medical Center Grievance Policy.
 - N. Patients will be provided the right to participate in the development and implementation of his/her plan of care.

II. PATIENT RESPONSIBILITIES:

- A. Treat all who provide health care services to you as well as other patients and visitors with courtesy, respect, consideration and dignity.
- B. Give accurate and complete information concerning your past illnesses, hospitalizations, medication, allergies and other pertinent information.
- C. Request further information concerning anything you do not understand.
- D. Give information regarding concerns and problems you have to a health care provider staff member.
- E. Assist in maintaining a safe environment conducive to healing.
- F. Participate in your own health care by following instructions and medical advice.
- G. Accept the consequences of refusing treatment.
- H. Assure financial obligations of the hospital bill are fulfilled.

ATTACHMENTS:

Patient Rights and Responsibilities

REFERENCES:

MANAGER, PATIENT ADMITTING

DATE

CHAIR, HOSPITAL POLICY AND PROCEDURE

DATE

PRESIDENT/CEO

DATE

Patient Rights and Responsibilities

As a healthcare patient, you have the right to:

- Considerate, respectful and safe care according to sound nursing and medical practices; the hospital's mission and scope of service; and applicable law and regulations.
- Be given reasonable information concerning your diagnosis, treatment and prognosis in terms, language, and methods of communication you can reasonably be expected to understand.
- Be given sufficient information to formulate advance directives and /or appoint a surrogate to make healthcare decisions for you to the extent permitted by law.
- Know the identity and professional status of individuals providing service.
- Know the physicians responsible for coordinating your care by name, and be an active participant in the development and evaluation of your continuous healthcare plan.
- Be given the necessary information concerning the benefits, alternatives, and risks of your treatment so that you will be able to give informed consent before treatment is initiated.
- Refuse treatment to the extent permitted by law and PMMC's Mission. Be given information concerning the consequences of refusing or not complying with treatment.
- Receive privacy and confidentiality regarding your healthcare plans, communications and records to the extent permitted by law.
- Receive an explanation of the nature and possible consequences of any research or experimental treatment before it is conducted, and to consent to or reject the treatment.
- Be given appropriate and professional healthcare services without discrimination against your race, creed, color, religion, gender, national origin, sexual orientation, disability, age, diagnosis, presence of infection, or ability to pay for services.
- Examine and receive a reasonable explanation of the total bill for services rendered.
- Be informed of any continuing health care requirements following discharge.
- Receive reasonable plans and information about resources to deal with continuing healthcare requirements following discharge.
- Be free from inappropriate use of seclusions and restraints.
- Be given information about patient rights and responsibilities and hospital policies and procedures that affect your care.
- Be given access to appropriate resources available to manage ethical conflicts in our healthcare decision-making by calling the Chaplain-On-Call or the Pastoral Care Department at extension 2615.
- Receive appropriate pain assessment and information on management of pain.
- Expect the hospital will provide or assist in the provision of interpretation (including translation) services as necessary. The hospital will address the needs of those with vision, speech, hearing, language and cognitive impairments.
- File a grievance without being threatened, restrained, or discriminated.
- Have a copy of your complete medical record available to you or your delegate within a reasonable period of time from discharge in non-emergency cases.
- Be provided care in a safe environment. Safety: If the hospital believes there may be a weapon, explosive device, illegal substance, or alcoholic beverage in your room, belongings or possessions, they may search, confiscate, and dispose of them as appropriate, including delivery of any item to law enforcement authorities.

It is your responsibility as a patient and the patient's family to:

- Treat all who provide services to you with courtesy, respect, consideration and dignity.
- Provide accurate and complete information concerning your past illness, hospitalizations, medications, allergies and other pertinent items.
- Disclose relevant information and clearly communicate wants and needs.
- Take responsibility for maximizing healthy habits to increase safety, and avoid knowingly spreading disease.
- Request further information concerning anything you do not understand.
- Communicate concerns and /or problems to an appropriate staff member or the Patient Advocate.
- Be considerate of the rights of others, and assist in the control of noise and number of visitors.
- Follow instructions and medical advice, and be an active participant in your plan of care.
- Accept the consequences of refusing treatment.
- Follow the hospital rules and regulations
- Become knowledgeable about your health plan coverage and options.
- Arrange for timely payments for services rendered.

Patient Questions/ Concerns

Our goal is to provide you with excellent care. In pursuit of that goal, your healthcare team is committed to ensuring that care, treatment and services you receive are both high quality and safe. If at any time you have concerns about your care or safety while in the hospital please contact your unit or service area's leader, or call the Patient Advocate at extension 2560. You may also contact any of the following agencies:

Office of Quality Monitoring
The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630-792-5000 (phone)
630-792-5636 (fax)
1-800-994-6610
complaint@jointcommission.org

Illinois Department of Public Health
535 West Jefferson St.
Springfield, IL 62761
1-800-252-4343

The Centers for Medicare and Medicaid Services
233 N. Michigan Ave, Suite 600
Chicago, IL 60601
1-312-886-6432 or 1-312-353-7180



PROVENA
Mercy Medical Center

1325 North Highland Avenue, Aurora, IL 60506
630-859-2222 (TEL)

WWW.PROVENA.ORG/MERCY

ATTACHMENT 19B

Responsabilidades y Derechos del Paciente

Como paciente de cuidado de salud, usted tiene derecho a:

- Un cuidado considerado, respetuoso y seguro, de acuerdo a sólidas prácticas médicas y de enfermería; a la misión del hospital y enfoque del servicio; y a las leyes y regulaciones que apliquen.
- Que se le dé información razonable respecto a su diagnóstico, tratamiento y pronosis, en términos, lenguaje y métodos de comunicación que se espere que usted pueda razonablemente comprender.
- Que se le dé suficiente información para formular directivas anticipadas y/o designe una persona para que tome las decisiones del cuidado de la salud por usted, según lo permita la ley.
- Conocer la identidad y estatus profesional de individuos proveyendo servicio.
- Saber los nombres de los médicos que sean responsables de coordinar el cuidado de su salud, y de participar activamente en el desarrollo y evaluación de su plan continuo del cuidado de su salud.
- Que se le dé la información necesaria concerniente a los beneficios, alternativas y riesgos de su tratamiento, de manera que usted pueda ofrecer autorizaciones basadas en información, antes de que el tratamiento inicie.
- Negarse a recibir tratamiento, según lo permita la ley y la Misión de PMMC. Que se le dé información concerniente a las consecuencias del negarse a recibir tratamiento, o el no cumplir con el tratamiento.
- Recibir privacidad y confidencialidad, en relación a sus planes, comunicaciones y registros del cuidado de la salud, según lo permita la ley.
- Recibir una explicación del tipo y de las posibles consecuencias de cualquier tratamiento experimental antes de que sea llevado a cabo, y de dar autorización o bien, rechazar el tratamiento.
- Que se le den servicios del cuidado de la salud apropiados y profesionales sin sufrir discriminación debido a su raza, credo, color, religión, género, nacionalidad, orientación sexual, discapacidad, edad, diagnóstico, presencia de infección, o habilidad de pagar por los servicios que necesite.
- Examinar y recibir una explicación razonable del total de la cuenta de los servicios que se le ofrecieron.

- Estar informado de cualquier requerimiento del cuidado de la salud que sea necesario seguir después de que se le ha dado de alta.
- Recibir planes e información razonables acerca de los recursos disponibles para cumplir con los requerimientos que debe seguir para el cuidado de la salud, una vez que se le ha dado de alta.
- No ser sometido al uso inapropiado de reclusión y restricciones.
- Que se le dé información acerca de los derechos y responsabilidades del paciente, y las políticas y procedimientos del hospital que afectan el cuidado que usted recibe.
- Que se le dé acceso a los recursos apropiados disponibles para manejar conflictos étnicos en nuestra toma de decisión del cuidado de la salud, llamando al Capellán que esté en guardia o al Departamento de Cuidado Pastoral a la extensión 2615.
- Recibir una evaluación apropiada de su dolor e información acerca del manejo del dolor.
- Esperar que el hospital le proporcione o ayude a ofrecerle servicios de interpretación (incluyendo traducción), según sea necesario. El hospital tomará en cuenta las necesidades de aquellos que tengan discapacidades de la vista, habla, y audición, así como también impedimentos del lenguaje y cognitivos.
- Presentar una queja sin sentirse amenazado, restringido o discriminado.
- Contar con una copia completa de su registro médico disponible a usted o a su delegado en un período razonable de tiempo a partir del momento en que se le dio de alta, en aquellos casos que no son de emergencia.
- Que se le dé cuidado en un entorno seguro. Seguridad: si el hospital considera que puede haber un arma, bomba, sustancia ilegal o bebida alcohólica en su habitación, pertenencias o posesiones, ellos pueden revisarlas, confiscarlas y disponer de ellas, según lo consideren apropiado, incluyendo la entrega de cualquier objeto a las autoridades que se encargan del cumplimiento de la ley.

Como paciente o familiar de un paciente, usted es responsable de: Tratar a todos aquellos que le proveen servicios de atención médica con cortesía, respeto, consideración y dignidad.

- Proveer información completa y acertada concerniendo sus enfermedades pasadas, hospitalizaciones, medicamentos, alergias y otra información pertinente.
- Proveer información relevante y comunicar claramente sus deseos y necesidades.
- Hacerse responsable de maximizar los hábitos saludables para aumentar su seguridad, y evitar el contagio de enfermedades que ya se sepa que el paciente tenga.
- Solicitar información adicional concerniendo cualquier cosa que usted no entienda.

- Comunicar preguntas o problemas al miembro del personal apropiado o a la persona encargada de Apoyo al Paciente.
- Ser considerado con los derechos de otras personas, y ayudar en el control del ruido y del número de visitantes.
- Seguir las instrucciones y consejos médicos, y ser un participante activo en su plan de cuidado de la salud.
- Aceptar las consecuencias al negarse a recibir tratamiento.
- Seguir las reglas y regulaciones del hospital.
- Involucrarse en el conocimiento de la cobertura y opciones de su plan de seguro médico.
- Encargarse de que se hagan a tiempo los pagos por los servicios que se ofrecieron

Preguntas / Inquietudes del paciente

Nuestra meta es proporcionarle excelente cuidado. Para alcanzar esa meta, su equipo de cuidado médico está comprometido a asegurar que la atención, tratamiento y los servicios que usted reciba sean seguros y de alta calidad. Si en cualquier momento usted tiene inquietudes sobre su cuidado o su seguridad mientras esté en el hospital, por favor contacte al líder de la unidad ó área de servicio ó llame al Representante de servicios al paciente a la extensión 2560. Usted también puede contactar a cualquiera de las siguientes agencias:

Oficina para el monitoreo de la calidad
Medicaid

Comisión Reguladora (The Joint Commission)
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630-792-5000 (teléfono)
630-792-5636 (fax)
1-800-994-6610
complaint@jointcommission.org

Departamento de Salud Pública de Illinois

535 West Jefferson St.
Springfield, IL 62761
1-800-252-4343

Los centros para servicios de Medicare y

233 N. Michigan Ave, Suite 600
Chicago, IL 60601
1-312-886-6432 or 1-312-353-7180



PROVENA
Mercy Medical Center

1325 North Highland Avenue, Aurora, IL 60506
630-859-2222 (TEL) WWW.PROVENA.ORG/MERCY

ATTACHMENT 19B

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.

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.

Section: Finance - PFS

Policy #: 5.1

Subject: Provision for Financial Assistance

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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 in dependently.

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).

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.

PROVENA HEALTH**SYSTEM POLICY****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.



Program Applying For:

- Uninsured Financial Assistance (Free/Discounted Care)
- Catastrophic Discount

Hospital Financial Assistance Program Application

NOTE: This application is for Provena Health Hospital Charges only (does not include independent physician professional charges).

Please complete both sides of this form. Return the signed form with all required documents to the address below.

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

Date of Application: _____ Date Application Mailed: _____

1. PATIENT INFORMATION - PLEASE PRINT ALL INFORMATION:

Last Name	First Name	Middle Initial
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* If the patient is a minor or full-time student, please list parent(s)/guardian(s) as applicant and co-applicant

2. APPLICANT (PATIENT/PARENT) INFORMATION:

Relationship to Patient:

- Self Spouse Parent Other

Marital Status:

- Single Married Divorced Separated

Last Name	First Name	Middle Initial	Social Security Number	Date of Birth
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Street Address	City	State	Zip	Home Phone ()
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Current Employer	Street Address	Phone	Position	Years Employed
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Total Number of Dependents: (other than self and co-applicant)	Dependent Name	Date of Birth	Relationship

3. CO-APPLICANT (SPOUSE/PARENT) INFORMATION:

Relationship to Patient

- Spouse Parent Other

Last Name	First Name	Middle Initial	Social Security Number	Date of Birth
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Street Address	City	State	Zip	Home Phone ()
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Current Employer	Street Address	Phone	Position	Years Employed
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Total Number of Dependents: (other than self and co-applicant)	Dependent Name	Date of Birth	Relationship

4. INCOME INFORMATION:

List all contributing gross income. Include 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, trusts, and veteran stipends.

Monthly Income Sources	Applicant	Co-Applicant	Combined Monthly Income
Employment Income	\$	\$	\$
Social Security	\$	\$	\$
Disability	\$	\$	\$
Unemployment	\$	\$	\$
Spousal/Child Support	\$	\$	\$
Rental Property	\$	\$	\$
Investment Income	\$	\$	\$
Other:	\$	\$	\$
Other:	\$	\$	\$
Other:	\$	\$	\$
Other:	\$	\$	\$

Total Combined Monthly Income ATTACHMENT 19B
Add all income above

UNEMPLOYMENT: If you do not have monthly income, please complete the Room and Board Statement. Available at www.provena.org/financialassistance

5. ASSETS:

Do not include the patient's primary residence; personal property exempt from judgment under Section 12-1001 of Code of Civil Procedure; or any amounts held in a pension or retirement plan. Please list assets and approximate value. Acceptable documentation includes statements from financial institutions or some other third party verifications of assets value.

Asset Name:	Approximate Value:
1.	\$
2.	\$
3.	\$

6. PROVENA HOSPITAL SERVICES:

Please indicate the Provena Hospitals that you have been seen at in the last twelve (12) months [calendar year if insured].

If additional space is needed for Account Numbers or Date of Service, please use section 7 below.	Account Number	Date(s) of Service	Patient Balances
<input type="checkbox"/> Provena Covenant Medical Center, Champaign			\$
<input type="checkbox"/> Provena Mercy Medical Center, Aurora			\$
<input type="checkbox"/> Provena Saint Joseph Hospital, Elgin			\$
<input type="checkbox"/> Provena Saint Joseph Medical Center, Joliet			\$
<input type="checkbox"/> Provena St. Mary's Hospital, Kankakee			\$
<input type="checkbox"/> Provena United Samaritans Medical Center, Danville			\$

7. ADDITIONAL INFORMATION/COMMENTS:

8. SIGNATURE:

By signing below I certify that all information is valid and complete. I will immediately notify Provena Health if my financial circumstances change.

Applicant Signature	Date	Co-applicant Signature	Date

Please submit the following information with your application:

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

If applicable, please submit the following:

- Social Security Award Letter
- Room and Board Statement (if no income) – Attachment #3
- 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

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 Mercy 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 Mercy 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 Mercy 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 Mercy Medical Center to each of the other hospitals in the Health Care System.

Proximity of Provena Mercy Medical Center (1325 N, Highland Avenue Aurora) to:			Miles	Minutes
Saint Francis Hospital	355 Ridge Avenue	Evanston	48.7	80
Provena Mercy Medical Center	7435 W. Talcott Avenue	Chicago	37.9	50
Saint Mary of Nazareth Hospital and St. Elizabeth's Med. Ctr.	2233 W. Division Street	Chicago	38.8	54
Saint Joseph Hospital	2900 N. Lake Shore Drive	Chicago	44.7	65
Our Lady Resurrection Med. Ctr.	5645 West Addison St.	Chicago	41.5	59
Holy Family Medical Center	100 North River Road	Des Plaines	39.3	53
Provena United Samaritans Med. Ctr.	812 North Logan Street	Danville	159.2	191
Provena Covenant Medical Center	1400 West Park Avenue	Urbana	128	162
Provena Saint Joseph Hospital	77 North Airlite Street	Elgin	20.1	30
Provena Saint Joseph Medical Ctr.	333 North Madison Street	Joliet	26.7	48
Provena St. Mary's Hospital	500 West Court Street	Kankakee	61.8	87

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 Mercy 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 Mercy 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 Mercy Medical Center and each hospital with which PPMC maintains a referral agreement.

Referral Site	Service	Miles*	Minutes*
Advocate Lutheran General Hospital 1775 Dempster Street Park Ridge	pediatrics	38.4	50
Central DuPage Hospital 27 N. Winfield Road Winfield	neurosurgery	14	24
Loyola University Medical Center 2160 S. First Ave. Maywood	burn care	29.37	39

*MapQuest (unadjusted) March 3, 2011

Duplication of Services

As certified in this application, the applicants fully intend to retain Provena Mercy Medical Center’s clinical programmatic complement for a minimum of two years. An

initial evaluation of the clinical services provided by Provena Mercy 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 Mercy 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%
 Hawalian/ 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
<i>Dedicated Observation</i>	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:	Inpatient and Outpatient Net Revenue by Payor Source							Charity Care Expense	Total Charity Care Expense 1,869,515				
	7/1/2008 to	6/30/2009	Medicare	Medicaid	Other Public	Private Insurance	Private Pay			Totals			
Inpatient Revenue (\$)	65.7%	4.3%	0.0%	28.6%	1.4%	100.0%	127,765,641	8,348,093	0	55,727,368	2,769,114	194,610,216	1,195,049
Outpatient Revenue (\$)	26.9%	6.1%	0.0%	64.8%	2.3%	100.0%	22,972,910	5,210,335	0	55,408,824	1,926,915	85,518,984	674,466

Totals: Charity Care as % of Net Revenue
0.7%

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

Organ Transplantation

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

Laboratory Studies

Inpatient Studies 511,319
 Outpatient Studies 438,246
 Studies Performed Under Contract 88,504

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
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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	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 <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	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 Catheterization (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
<i>Dedicated Observation</i>	0					0				
Facility Utilization	271			8,473	39,293	4,480	6.2	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
	4072	1806	0	2186	282	127	
Outpatients	27.5%	20.1%	0.0%	20.3%	30.9%	1.2%	117,633
	32308	23699	0	23907	36315	1404	

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	
	52,034,979	25,140,397	0	28,361,084	3,385,602	108,922,062		1,461,036	2.0%	
Outpatient Revenue (\$)	17.6%	10.5%	0.0%	58.3%	13.6%	100.0%				
	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

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	Level 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/

	Owned		Contract		Inpatient	Outpatient	Owned		Contract		Treatments
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		Patients by Race		Patients by Ethnicity	
ADMINISTRATOR NAME:	Margaret McDermott	White	21.0%	Hispanic or Latino:	13.8%
ADMINSTRATOR PHONE	312-770-2115	Black	25.7%	Not Hispanic or Latino:	85.9%
OWNERSHIP:	Saints Mary and Elizabeth Medical Center DBA Saint	American Indian	0.1%	Unknown:	0.3%
OPERATOR:	Saints Mary and Elizabeth Medical Center DBA Saint	Asian	1.3%	IDPH Number:	2584
MANAGEMENT:	Not for Profit Corporation	Hawaiian/ Pacific	0.0%	HPA	A-02
CERTIFICATION:	None	Unknown:	52.0%	HSA	6
FACILITY DESIGNATION:	General Hospital				
ADDRESS	2233 West Divison Street	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
<i>Dedicated Observation</i>	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:	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	Private Pay		
Inpatient Revenue (\$)	64,870,370	61,419,970	36.8%	34.8%	0.0%	18.9%	9.5%	100.0%	2,662,595
Outpatient Revenue (\$)	11,265,066	22,276,179	16.6%	32.9%	0.0%	31.8%	18.7%	100.0%	1,394,629
					0	33,285,730	16,816,201	176,392,271	1,267,966
				0	21,509,882	12,633,284	67,684,411		Totals: Charity Care as % of Net Revenue
									1.1%

Birthing Data		Newborn Nursery Utilization		Organ Transplantation	
Number of Total Births:	2,014	Level 1 Patient Days	3,691	Kidney:	0
Number of Live Births:	2,004	Level 2 Patient Days	0	Heart:	0
Birthing Rooms:	0	Level 2+ Patient Days	1,409	Lung:	0
Labor Rooms:	0	Total Nursery Patientdays	5,100	Heart/Lung:	0
Delivery Rooms:	0			Pancreas:	0
Labor-Delivery-Recovery Rooms:	8			Liver:	0
Labor-Delivery-Recovery-Postpartum Rooms:	0	Laboratory Studies		Total:	0
C-Section Rooms:	2	Inpatient Studies	641,498		
CSections Performed:	544	Outpatient Studies	251,694		
		Studies Performed Under Contract	3,466		

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

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

	Owned		Contract	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

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

ADDRESS: 2900 North Lake Shore Drive **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				696	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%	
	5747	2142	22	4972	161	144	13,188
Outpatients	25.2%	15.8%	0.1%	52.9%	5.1%	1.0%	
	47383	29662	158	99559	9558	1871	188,191

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 1,487,625
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals			
Inpatient Revenue (\$)	46.8%	13.9%	0.0%	36.8%	2.5%	100.0%		Total: Charity Care as % of Net Revenue	
	64,832,024	19,290,122	0	51,002,179	3,520,673	138,644,998	652,789		
Outpatient Revenue (\$)	16.1%	3.6%	0.0%	72.0%	8.2%	100.0%			
	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

Organ Transplantation

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

Laboratory Studies

Inpatient Studies 434,758
 Outpatient Studies 111,988
 Studies Performed Under Contract 4,512

* 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:	84
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		Radiation Equipment		Therapies/ Treatments			
	Owned	Contract	Inpatient	Outpatient				
General Radiography/Fluoroscopy	17	0	12,155	22,888	Lithotripsy	0	0	0
Nuclear Medicine	4	0	611	1,114	Linear Accelerator	1	0	167
Mammography	3	0	0	8,837	Image Guided Rad Therapy	0	0	0
Ultrasound	7	0	2,986	11,466	Intensity Modulated Rad Therap	1	0	9
Diagnostic Angiography	0	0	0	0	High Dose Brachytherapy	1	0	16
Interventional Angiography	0	0	0	0	Proton Beam Therapy	0	0	0
Positron Emission Tomography (PET)	0	1	0	391	Gamma Knife	0	0	0
Computerized Axial Tomography (CAT)	1	0	3,399	9,644	Cyber knife	0	0	0
Magnetic Resonance Imaging	1	0	1,922	2,478				

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
	1726	3989	0	367	18	20	
Outpatients	21.6%	40.9%	0.1%	32.6%	3.4%	1.4%	25,461
	5505	10402	34	8304	856	360	

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	390,005	
Inpatient Revenue (\$)	23.9%	70.1%	0.0%	5.5%	0.6%	100.0%	Totals: Charity Care as % of Net Revenue	
	9,280,892	27,203,305	0	2,126,999	216,467	38,827,663		
Outpatient Revenue (\$)	16.3%	43.1%	0.0%	36.1%	4.5%	100.0%		
	3,057,316	8,058,125	0	6,755,379	838,631	18,709,451	0.7%	

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: 83,706
 Outpatient Studies: 51,107
 Studies Performed Under Contract: 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

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

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:	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 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

Radiation Equipment

Therapies/

	Owned		Contract		Inpatient	Outpatient	Owned		Contract		Therapies/ Treatments
General Radiography/Fluoroscopy	7	0	860	8,260			1	1			34
Nuclear Medicine	0	0	0	0			0	0			0
Mammography	1	0	0	3,110			0	0			0
Ultrasound	2	0	109	274			0	0			0
Diagnostic Angiography	0	0	0	0			0	0			0
Interventional Angiography	0	0	0	0			0	0			0
Positron Emission Tomography (PET)	0	0	0	0			0	0			0
Computerized Axial Tomography (CAT)	1	0	112	552			0	0			0
Magnetic Resonance Imaging	0	0	0	0			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
	5898	1458	0	1642	263	149	
Outpatients	36.6%	27.8%	0.1%	26.3%	7.5%	1.8%	106,302
	38888	29528	95	27928	7995	1868	

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 (\$)	55.8%	5.8%	0.0%	17.8%	20.6%	100.0%	922,725	1,613,276	
	45,372,692	4,707,203	0	14,436,297	16,788,176	81,304,368		Totals: Charity Care as % of Net Revenue	
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
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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		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 Catheterization (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

Diagnostic/Interventional Equipment	Owned		Contract		Examinations Inpatient	Outpatient	Radiation Equipment		Therapies/ Treatments	
	Owned	Contract	Owned	Contract			Owned	Contract		
General Radiography/Fluoroscopy	7	0	0	0	13,247	29,193	Lithotripsy	0	0	0
Nuclear Medicine	2	0	0	0	1,666	2,499	Linear Accelerator	0	0	0
Mammography	2	0	0	0	8	4,544	Image Guided Rad Therapy	0	0	0
Ultrasound	4	0	0	0	3,487	6,636	Intensity Modulated Rad Therap	0	0	0
Diagnostic Angiography	0	0	0	0	0	0	High Dose Brachytherapy	0	0	0
Interventional Angiography	0	0	0	0	0	0	Proton Beam Therapy	0	0	0
Positron Emission Tomography (PET)	0	0	0	0	0	0	Gamma Knife	0	0	0
Computerized Axial Tomography (CAT)	2	0	0	0	4,225	15,489	Cyber knife	0	0	0
Magnetic Resonance Imaging	1	1	0	0	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:	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 (\$)	31,307,091	9,452,199	0	18,919,331	3,353,949	63,032,570	184,754	186,520
Outpatient Revenue (\$)	5,291,206	1,597,515	0	3,197,553	566,851	10,653,125	1,766	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
 Inpatient Studies: 130,069
 Outpatient Studies: 43,454
 Studies Performed Under Contract: 44,795

Organ Transplantation

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

* 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 facility may not use the facility utilization prior to the Board action.

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
<i>Gastrointestinal</i>	0	0	3	3	13	103	12	89	101	0.9	0.9
<i>Laser Eye Procedures</i>	0	0	1	1	0	145	0	37	37	0.0	0.3
<i>Pain Management</i>	0	0	0	0	0	0	0	0	0	0.0	0.0
<i>Cystoscopy</i>	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

Emergency/Trauma Care

Certified Trauma Center by EMS
 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 Catheterization Utilization

Total Cardiac Cath Procedures: 0
 Diagnostic Catheterizations (0-14) 0
 Diagnostic Catheterizations (15+) 0
 Interventional Catheterizations (0-14): 0
 Interventional Catheterizations (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 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	
<i>General Radiography/Fluoroscopy</i>	8	0	6,055	4,191	<i>Lithotripsy</i> 0 0 0
<i>Nuclear Medicine</i>	2	0	50	410	<i>Linear Accelerator</i> 0 0 0
<i>Mammography</i>	3	0	0	4,250	<i>Image Guided Rad Therapy</i> 0 0 0
<i>Ultrasound</i>	5	0	769	2,692	<i>Intensity Modulated Rad Therap</i> 0 0 0
<i>Diagnostic Angiography</i>	0	0	0	0	<i>High Dose Brachytherapy</i> 0 0 0
<i>Interventional Angiography</i>	0	0	0	0	<i>Proton Beam Therapy</i> 0 0 0
<i>Positron Emission Tomography (PET)</i>	0	0	0	0	<i>Gamma Knife</i> 0 0 0
<i>Computerized Axial Tomography (CAT)</i>	1	0	1,554	1,125	<i>Cyber knife</i> 0 0 0
<i>Magnetic Resonance Imaging</i>	1	0	0	722	

<u>Ownership, Management and General Information</u>		<u>Patients by Race</u>		<u>Patients by Ethnicity</u>	
ADMINISTRATOR NAME:	Mike Brown	White	80.1%	Hispanic or Latino:	2.1%
ADMINSTRATOR PHONE	217-443-5201	Black	16.9%	Not Hispanic or Latino:	97.3%
OWNERSHIP:	Provena Health	American Indian	0.1%	Unknown:	0.5%
OPERATOR:	Provena Health	Asian	0.2%	IDPH Number:	4853
MANAGEMENT:	Church-Related	Hawaiian/ Pacific	0.0%	HPA	D-03
CERTIFICATION:	None	Unknown:	2.7%	HSA	4
FACILITY DESIGNATION:	General Hospital				
ADDRESS	812 North Logan Street	CITY:	Danville	COUNTY:	Vermilion County

<u>Facility Utilization Data by Category of Service</u>										
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)

<u>Inpatients and Outpatients Served by Payer Source</u>							
	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	

<u>Financial Year Reported:</u>	1/1/2009 to 12/31/2009		<u>Inpatient and Outpatient Net Revenue by Payer Source</u>					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		Totals: Charity Care as % of Net Revenue	
Outpatient Revenue (\$)	14.4%	11.7%	1.5%	59.1%	13.3%	100.0%	2,953,903	3.5%	
	10,036,415	8,123,116	1,056,472	41,059,236	9,246,308	69,521,547			

<u>Birthing Data</u>		<u>Newborn Nursery Utilization</u>		<u>Organ Transplantation</u>	
Number of Total Births:	787	Level 1 Patient Days	1,217	Kidney:	0
Number of Live Births:	787	Level 2 Patient Days	33	Heart:	0
Birthing Rooms:	0	Level 2+ Patient Days	0	Lung:	0
Labor Rooms:	0	Total Nursery Patientdays	1,250	Heart/Lung:	0
Delivery Rooms:	0			Pancreas:	0
Labor-Delivery-Recovery Rooms:	5			Liver:	0
Labor-Delivery-Recovery-Postpartum Rooms:	0	<u>Laboratory Studies</u>		Total:	0
C-Section Rooms:	1	Inpatient Studies	476,188		
CSections Performed:	245	Outpatient Studies	538,649		
		Studies Performed Under Contract	69,358		

* 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 Act has not been finalized and 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

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:	58
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 Level 2
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/ Treatments
	Owned	Contract	Inpatient	Outpatient	Owned	Contract		
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
Medicated 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: 956
 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 a facility is 210 beds. Actual Cost of Services Provided to Charity Care Inpatients and Outpatients was calculated using the 2009 Medicare SPD Code 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 of 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	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	2.6	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

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	522	3444	434	2870	3304	0.8	0.8
<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	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
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 Catheterization (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				Radiation Equipment			Therapies/ Treatments
	Owned	Contract	Inpatient	Outpatient	Owned	Contract		
<i>General Radiography/Fluoroscopy</i>	14	0	12,224	20,241	<i>Lithotripsy</i>	0	1	140
<i>Nuclear Medicine</i>	3	0	372	2,846	<i>Linear Accelerator</i>	1	0	3,100
<i>Mammography</i>	1	0	0	2,379	<i>Image Guided Rad Therapy</i>	0	0	0
<i>Ultrasound</i>	4	0	2,260	4,607	<i>Intensity Modulated Rad Therap</i>	0	0	0
<i>Diagnostic Angiography</i>	1	0	1,087	429	<i>High Dose Brachytherapy</i>	0	0	0
<i>Interventional Angiography</i>	0	0	0	0	<i>Proton Beam Therapy</i>	0	0	0
<i>Positron Emission Tomography (PET)</i>	0	1	0	82	<i>Gamma Knife</i>	0	0	0
<i>Computerized Axial Tomography (CAT)</i>	2	0	3,751	9,384	<i>Cyber knife</i>	0	0	0
<i>Magnetic Resonance Imaging</i>	1	0	891	1,879				

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

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

CITY: Aurora **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	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%	0.6%	30.2%	3.2%	2.1%	
	3809	2838	55	3140	335	220	10,397
Outpatients	15.9%	30.9%	0.6%	32.2%	17.8%	2.6%	
	14809	28825	557	29986	16615	2462	93,254

Financial Year Reported:	11/1/2009 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 (\$)	39.1%	33.6%	0.4%	24.9%	1.9%	100.0%		5,367,773	
	30,667,645	26,391,096	350,575	19,532,576	1,501,912	78,443,804	2,638,341		
Outpatient Revenue (\$)	17.1%	23.7%	0.4%	54.8%	4.1%	100.0%			
	15,493,796	21,553,255	323,234	49,733,701	3,677,093	90,781,079	2,729,432	3.2%	

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 reporting.

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
Gastrointestinal	0	0	2	2	801	1305	865	1310	2175	1.1	1.0
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	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	Level 2
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 Catheterization (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

	Radiation Equipment		Therapies/ Treatments
	Owned	Contract	
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

ADMINISTRATOR NAME: Stephen O. Scogna
ADMINISTRATOR PHONE: 847-695-3200 x5474
OWNERSHIP: Provena Hospitals d/b/a Provena Saint Joseph Hospi
OPERATOR: Provena Hospitals d/b/a Provena Saint Joseph Hospi
MANAGEMENT: Church-Related
CERTIFICATION: None
FACILITY DESIGNATION: General Hospital
ADDRESS: 77 North Airlite Street

Patients by Race

White 81.5%
 Black 5.6%
 American Indian 0.0%
 Asian 1.5%
 Hawaiian/ Pacific 0.0%
 Unknown: 11.5%

Patients by Ethnicity

Hispanic or Latino: 9.8%
 Not Hispanic or Latino: 89.3%
 Unknown: 0.8%
 IDPH Number: 4887
 HPA A-11
 HSA 8

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
	4679	975	63	2711	210	208	
Outpatients	25.7%	17.9%	0.4%	42.7%	11.5%	1.7%	94,884
	24364	17017	422	40545	10954	1582	

Financial Year Reported:

1/1/2009 to 12/31/2009

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 (\$)	52.0%	17.7%	0.3%	28.1%	1.9%	100.0%	1,675,691	3,749,548
	39,020,448	13,249,904	210,860	21,061,538	1,439,586	74,982,336		
Outpatient Revenue (\$)	22.5%	14.4%	0.4%	60.1%	2.6%	100.0%	2,073,857	2.3%
	20,044,749	12,794,644	327,225	53,398,003	2,348,798	88,913,419		

Birthing Data

Number of Total Births: 222
 Number of Live Births: 222
 Birthing Rooms: 0
 Labor Rooms: 0
 Delivery Rooms: 0
 Labor-Delivery-Recovery Rooms: 7
 Labor-Delivery-Recovery-Postpartum Rooms: 0
 C-Section Rooms: 1
 CSections Performed: 47

Newborn Nursery Utilization

Level 1 Patient Days: 368
 Level 2 Patient Days: 239
 Level 2+ Patient Days: 63
 Total Nursery Patientdays: 670
 Inpatient Studies: 238,112
 Outpatient Studies: 152,236
 Studies Performed Under Contract: 80,753

Organ Transplantation

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

* 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 ist 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 and the 2008 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	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
Gastrointestinal	0	0	0	0	0	0	0	0	0	0.0	0.0
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
	<u>Multipurpose Non-Dedicated Rooms</u>										
	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			Therapies/ Treatments
	Owned	Contract	Inpatient	Outpatient	Owned	Contract		
General Radiography/Fluoroscopy	5	0	14,504	22,969	Lithotripsy	0	0	0
Nuclear Medicine	3	0	1,491	3,217	Linear Accelerator	2	0	4,854
Mammography	3	0	0	6,823	Image Guided Rad Therapy	0	0	0
Ultrasound	5	0	3,507	9,429	Intensity Modulated Rad Therap	1	0	1120
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	182	Gamma Knife	0	0	0
Computerized Axial Tomography (CAT)	2	0	6,194	16,786	Cyber knife	0	0	0
Magnetic Resonance Imaging	1	0	1,449	2,538				

Ownership, Management and General Information		Patients by Race		Patients by Ethnicity	
ADMINISTRATOR NAME:	Jeffrey L. Brickman	White	77.3%	Hispanic or Latino:	8.2%
ADMINSTRATOR PHONE	815-725-7133	Black	12.7%	Not Hispanic or Latino:	91.5%
OWNERSHIP:	Provena Health	American Indian	0.0%	Unknown:	0.3%
OPERATOR:	Provena Hospitals d/b/a Provena St. Joseph Medical	Asian	0.8%	IDPH Number:	4838
MANAGEMENT:	Not for Profit Corporation	Hawaiian/ Pacific	0.0%	HPA	A-13
CERTIFICATION:	None	Unknown:	9.2%	HSA	9
FACILITY DESIGNATION:	General Hospital				
ADDRESS	333 North Madison Street	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
Dedicated Observation	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 Payer 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
	10793	3154	212	8099	751	466	
Outpatients	27.4%	16.9%	0.8%	48.5%	5.2%	1.3%	232,432
	63576	39251	1779	112829	12070	2927	

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 (\$)	50.0%	11.1%	0.0%	25.3%	13.6%	100.0%	3,377,931	7,284,458	
	101,834,552	22,548,805	0	51,620,573	27,643,931	203,647,861			
Outpatient Revenue (\$)	22.3%	6.0%	0.0%	51.9%	19.7%	100.0%	3,906,527	1.8%	
	46,700,399	12,443,368	0	108,545,931	41,267,927	208,957,625			

Birthing Data		Newborn Nursery Utilization		Organ Transplantation	
Number of Total Births:	2,016	Level 1 Patient Days	3,719	Kidney:	0
Number of Live Births:	2,011	Level 2 Patient Days	0	Heart:	0
Birthing Rooms:	0	Level 2+ Patient Days	1,943	Lung:	0
Labor Rooms:	0	Total Nursery Patientdays	5,662	Heart/Lung:	0
Delivery Rooms:	0			Pancreas:	0
Labor-Delivery-Recovery Rooms:	0			Liver:	0
Labor-Delivery-Recovery-Postpartum Rooms:	33	Laboratory Studies		Total:	0
C-Section Rooms:	2	Inpatient Studies	766,465		
CSections Performed:	745	Outpatient Studies	603,298		
		Studies Performed Under Contract	31,054		

* 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	

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	606,576
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				

Ownership, Management and General Information

ADMINISTRATOR NAME: Michael Arno
ADMINISTRATOR 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
<i>Dedicated Observation</i>	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
	3474	1343	94	2171	320	143	
Outpatients	26.9%	15.1%	1.4%	40.9%	14.1%	1.5%	103,475
	27886	15592	1481	42310	14624	1582	

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 2,657,530
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals			
Inpatient Revenue (\$)	52.5%	14.5%	0.2%	29.7%	3.1%	100.0%	1,856,922	Totals: Charity Care as % of Net Revenue	
	32,691,073	9,028,207	105,333	18,527,435	1,932,268	62,284,316			
Outpatient Revenue (\$)	19.1%	8.9%	0.2%	65.9%	5.9%	100.0%	800,608	1.9%	
	15,172,947	7,045,738	132,298	52,276,990	4,708,645	79,336,618			

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 190.

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

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 Level 2 ---
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:	658
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

3330 MARIA LINDEN DRIVE
 ROCKFORD, IL. 61114
 Reference Numbers Facility ID 6005771
 Health Service Area 001 Planning Service Area 201

Administrator
 Teresa Wester-Peters

Contact Person and Telephone
 Sandra Fuller
 815-877-7416

Registered Agent Information
 Date Completed 4/29/2010
 Teresa Wester-Peters
 3330 Maria Linden Drive
 Rockford, IL 61114

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	0
Endocrine/Metabolic	0
Blood Disorders	0
*Nervous System Non Alzheimer	0
Alzheimer Disease	0
Mental Illness	0
Developmental Disability	0
Circulatory System	28
Respiratory System	23
Digestive System	10
Genitourinary System Disorders	14
Skin Disorders	4
Musculo-skeletal Disorders	14
Injuries and Poisonings	10
Other Medical Conditions	12
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	
Nursing Care	73	73	69	73	69	4	73	16	113	484
Skilled Under 22	0	0	0	0	0	0	0	0	484	475
Intermediate DD	0	0	0	0	0	0	0	0	122	122
Sheltered Care	61	61	53	61	53	8	0	0	0	0
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 Set Up
	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	Medicaid	Other Public	Insurance	Private Pay	Charity Care	TOTALS
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		198
Intermediate DD	0	0	0	0	0	0		0		81
Sheltered Care	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	Medicare	Medicaid	Other		Private Pay	Charity Care	TOTALS
			Public	Insurance			
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 KANKAKEE, IL. 60901		Aggressive/Anti-Social	1	DIAGNOSIS	
Reference Numbers Facility ID 6004246		Chronic Alcoholism	1	Neoplasms	0
Health Service Area 009 Planning Service Area 091		Developmentally Disabled	0	Endocrine/Metabolic	0
Administrator		Drug Addiction	1	Blood Disorders	0
Carol McIntyre		Medicaid Recipient	1	*Nervous System Non Alzheimer	0
Contact Person and Telephone		Medicare Recipient	0	Alzheimer Disease	19
CAROL D MCINTYRE		Mental Illness	1	Mental Illness	0
815-939-4506		Non-Ambulatory	0	Developmental Disability	1
Registered Agent Information		Non-Mobile	0	Circulatory System	31
Date Completed 4/9/2010		Public Aid Recipient	0	Respiratory System	10
		Under 65 Years Old	0	Digestive System	5
		Unable to Self-Medicare	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

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	Residents on 1/1/2009	
Nursing Care	51	51	51	51	42	9	51	0	72	
Skilled Under 22	0	0	0	0	0	0		0	225	Total Admissions 2009
Intermediate DD	0	0	0	0	0	0		0	223	Total Discharges 2009
Sheltered Care	79	36	36	36	32	47			74	Residents on 12/31/2009
TOTAL BEDS	130	87	87	87	74	56	51	0	0	Identified Offenders

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	
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	Other				Private	Charity	TOTALS
	Medicare	Medicaid	Public Insurance	Pay	Care		
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		ADMISSION RESTRICTIONS		RESIDENTS BY PRIMARY DIAGNOSIS	
400 W. SULLIVAN ROAD		Aggressive/Anti-Social	0	DIAGNOSIS	
AURORA, IL. 60506		Chronic Alcoholism	0	Neoplasms	3
Reference Numbers	Facility ID 6005912	Developmentally Disabled	0	Endocrine/Metabolic	0
Health Service Area 008	Planning Service Area 089	Drug Addiction	0	Blood Disorders	0
Administrator		Medicaid Recipient	0	*Nervous System Non Alzheimer	5
Jennifer Roach		Medicare Recipient	0	Alzheimer Disease	3
Contact Person and Telephone		Mental Illness	1	Mental Illness	1
Bill Erue		Non-Ambulatory	0	Developmental Disability	0
630-859-3700		Non-Mobile	0	Circulatory System	17
Registered Agent Information	Date Completed	Public Aid Recipient	0	Respiratory System	3
Megan Kieffer	5/7/2010	Under 65 Years Old	0	Digestive System	6
19065 Hickory Creek Drive Suite 300		Unable to Self-Medicare	0	Genitourinary System Disorders	0
Mokena, IL 60448		Ventilator Dependent	1	Skin Disorders	1
FACILITY OWNERSHIP		Infectious Disease w/ Isolation	0	Musculo-skeletal Disorders	15
NON-PROF CORPORATION		Other Restrictions	0	Injuries and Poisonings	4
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	63
				Total Residents Diagnosed as Mentally Ill	1

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	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		0	Identified Offenders	0
TOTAL BEDS	87	87	74	87	63	24	87	9		

LEVEL OF CARE	FACILITY UTILIZATION - 2009										Licensed Beds Occ. Pct.	Peak Beds Set Up Occ. Pct.
	BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE											
	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL			
Nursing Care	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.	Pat. days	Pat. days	Pat. days	Pat. days	Pat. days	Pat. days		
Skilled Under 22	10591	33.4%	1312	39.9%	0	695	10073	192	22863	72.0%	72.0%	
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%	
Sheltered Care			0	0.0%	0	0	0	0	0	0.0%	0.0%	
TOTALS	10591	33.4%	1312	39.9%	0	695	10073	192	22863	72.0%	72.0%	

AGE GROUPS	RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009										
	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	Other		Private Insurance	Charity Care	TOTALS		
	Medicare	Medicaid Public					
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-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	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 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	107	107	107	94	13	55	90	95	205
Skilled Under 22	0	0	0	0	0	0		0		206
Intermediate DD	0	0	0	0	0	0		0		94
Sheltered Care	0	0	0	0	0	0				0
TOTAL BEDS	107	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	Licensed Beds Occ. Pct.	Peak Beds Set Up Occ. Pct.
	Pat. days	Occ. Pct.	Pat. days	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		Private Pay	Charity Care	TOTALS
			Public	Insurance			
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	SkUnd22	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	SkUnd22	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-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	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

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	120	110	110	110	103	17	120	80	88	270
Skilled Under 22	0	0	0	0	0	0		0		255
Intermediate DD	0	0	0	0	0	0		0		103
Sheltered Care	0	0	0	0	0	0				0
TOTAL BEDS	120	110	110	110	103	17	120	80		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	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
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

4405 HIGHCREST ROAD
 ROCKFORD, IL. 61107
 Reference Numbers Facility ID 6008817
 Health Service Area 001 Planning Service Area 201

Administrator
 Janelle Chadwick

Contact Person and Telephone
 JANELLE CHADWICK
 815-229-1999

Registered Agent Information
 Meghan Kieffer
 19608 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	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	4
Endocrine/Metabolic	4
Blood Disorders	0
*Nervous System Non Alzheimer	7
Alzheimer Disease	0
Mental Illness	0
Developmental Disability	0
Circulatory System	33
Respiratory System	8
Digestive System	5
Genitourinary System Disorders	13
Skin Disorders	4
Musculo-skeletal Disorders	26
Injuries and Poisonings	34
Other Medical Conditions	5
Non-Medical Conditions	0
TOTALS	143

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	Total Admissions 2009
Nursing Care	179	179	163	179	143	36	119	60	153	724
Skilled Under 22	0	0	0	0	0	0		0		
Intermediate DD	0	0	0	0	0	0		0		734
Sheltered Care	0	0	0	0	0	0				143
TOTAL BEDS	179	179	163	179	143	36	119	60	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	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	Other				Private Pay	Charity Care	TOTALS
	Medicare	Medicaid	Public Insurance	Insurance			
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	194	102
									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

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	0
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	1

Note: Reported restrictions denoted by '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
Total Residents Diagnosed as Mentally Ill 102	

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	176	176	173	176	158	18	176	82	Total Admissions 2009	517
Skilled Under 22	0	0	0	0	0	0		0	Total Discharges 2009	525
Intermediate DD	0	0	0	0	0	0		0	Residents on 12/31/2009	158
Sheltered Care	0	0	0	0	0	0			Identified Offenders	0
TOTAL BEDS	176	176	173	176	158	18	176	82		

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	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%

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	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	Medicare		Other		Private	Charity	TOTALS
	Medicare	Medicaid	Public	Insurance	Pay	Care	
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

LIFE CARE FACILITY

Date Completed
5/6/2010

No

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	Residents on 1/1/2009	96
Skilled Under 22	0	0	0	0	0	0	0	0	Total Admissions 2009	150
Intermediate DD	0	0	0	0	0	0	0	0	Total Discharges 2009	150
Sheltered Care	0	0	0	0	0	0	0	0	Residents on 12/31/2009	96
TOTAL BEDS	99	99	99	99	96	3	99	99	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	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	Medicare	Medicaid	Other Public	Insurance	Private Pay	Charity Care	TOTALS
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		ADMISSION RESTRICTIONS		RESIDENTS BY PRIMARY DIAGNOSIS	
7370 WEST TALCOTT CHICAGO, IL. 60631		Aggressive/Anti-Social	0	DIAGNOSIS	
Reference Numbers Facility ID 6014575		Chronic Alcoholism	0	Neoplasms	4
Health Service Area 006 Planning Service Area 601		Developmentally Disabled	1	Endocrine/Metabolic	10
Administrator		Drug Addiction	1	Blood Disorders	0
Nancy Razo		Medicaid Recipient	0	*Nervous System Non Alzheimer	14
Contact Person and Telephone		Medicare Recipient	0	Alzheimer Disease	9
BRENDA DAVIS		Mental Illness	1	Mental Illness	16
847-813-3712		Non-Ambulatory	0	Developmental Disability	0
Registered Agent Information		Non-Mobile	0	Circulatory System	22
Sandra Bruce		Public Aid Recipient	0	Respiratory System	10
7435 West Talcott		Under 65 Years Old	0	Digestive System	4
Chicago, IL 60631		Unable to Self-Medicare	0	Genitourinary System Disorders	3
FACILITY OWNERSHIP		Ventilator Dependent	1	Skin Disorders	4
NON-PROF CORPORATION		Infectious Disease w/ Isolation	0	Musculo-skeletal Disorders	23
CONTINUING CARE COMMUNITY		Other Restrictions	0	Injuries and Poisonings	0
LIFE CARE FACILITY		No Restrictions	0	Other Medical Conditions	42
		<i>Note: Reported restrictions denoted by '1'</i>		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 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	161
Nursing Care	147	147	146	147	146	1	112	112	Total Admissions 2009	264
Skilled Under 22	0	0	0	0	0	0		0	Total Discharges 2009	264
Intermediate DD	0	0	0	0	0	0		0	Residents on 12/31/2009	161
Sheltered Care	15	15	15	15	15	0			Identified Offenders	0
TOTAL BEDS	162	162	161	162	161	1	112	112		

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	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		Private	Charity	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		ADMISSION RESTRICTIONS		RESIDENTS BY PRIMARY DIAGNOSIS	
1001 NORTH GREENWOOD AVENUE		Aggressive/Anti-Social	1	DIAGNOSIS	
PARK RIDGE, IL. 60068		Chronic Alcoholism	1	Neoplasms	31
Reference Numbers	Facility ID 6007892	Developmentally Disabled	1	Endocrine/Metabolic	0
Health Service Area 007	Planning Service Area 702	Drug Addiction	1	Blood Disorders	0
Administrator		Medicaid Recipient	0	*Nervous System Non Alzheimer	58
James Farlee		Medicare Recipient	0	Alzheimer Disease	26
Contact Person and Telephone		Mental Illness	1	Mental Illness	0
BRENDA DAVIS		Non-Ambulatory	0	Developmental Disability	0
847-813-3712		Non-Mobile	0	Circulatory System	69
Registered Agent Information	Date Completed	Public Aid Recipient	0	Respiratory System	41
Sandra Bruce	5/6/2010	Under 65 Years Old	0	Digestive System	0
7435 West Talcott		Unable to Self-Medicare	0	Genitourinary System Disorders	12
Chicago, IL 60631		Ventilator Dependent	1	Skin Disorders	0
FACILITY OWNERSHIP		Infectious Disease w/ Isolation	0	Musculo-skeletal Disorders	25
NON-PROF CORPORATION		Other Restrictions	0	Injuries and Poisonings	0
CONTINUING CARE COMMUNITY	No	No Restrictions	0	Other Medical Conditions	0
LIFE CARE FACILITY	No	<i>Note: Reported restrictions denoted by '1'</i>		Non-Medical Conditions	0
				TOTALS	262
				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	298	285	262	262	262	36	298	298	243	603
Skilled Under 22	0	0	0	0	0	0		0	584	262
Intermediate DD	0	0	0	0	0	0		0		
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	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	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		Private	Charity	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-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	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	115	157
Skilled Under 22	0	0	0	0	0	0		0		152
Intermediate DD	0	0	0	0	0	0		0		115
Sheltered Care	0	0	0	0	0	0				0
TOTAL BEDS	135	135	122	135	115	20	135	135		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	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		Private Pay	Charity Care	TOTALS
			Public	Insurance			
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-Medicate	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 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	251	231	170	231	160	91	149	247	153	580
Skilled Under 22	0	0	0	0	0	0		0		573
Intermediate DD	0	0	0	0	0	0		0		160
Sheltered Care	0	0	0	0	0	0				0
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 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	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	Medicare	Medicaid	Other Public	Insurance	Private Pay	Charity Care	TOTALS
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 NSQ & 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
 Sandra Bruce
 7435 West Talcott
 Chicago, IL 60631

FACILITY OWNERSHIP
 NON-PROF CORPORATION

CONTINUING CARE COMMUNITY No
 LIFE CARE FACILITY No

Date Completed
 5/6/2010

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-Medicate	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	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	414
Intermediate DD	0	0	0	0	0	0		0	420
Sheltered Care	7	0	0	0	0	7			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	Medicaid	Other Public	Insurance	Private Pay	Charity Care	TOTALS
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.

PATIENT TRANSFER AGREEMENT
BETWEEN
PROVENA MERCY MEDICAL CENTER
AND
LOYOLA UNIVERSITY MEDICAL CENTER

THIS AGREEMENT is made and is effective as of this 1st day of October, 2010 by and between Loyola University Medical Center, an Illinois not-for-profit corporation located in Maywood, Illinois ("Receiving Hospital") and Provena Mercy Medical Center, an Illinois not-for-profit corporation located in Aurora, Illinois ("Transferring Facility").

WHEREAS, both parties hereto desire to assure continuity of care and treatment appropriate to the needs of medically unstable pediatric and adult patients requiring medically specialized burn or trauma care and treatment; and

WHEREAS, both parties will cooperate to achieve this purpose; and

NOW THEREFORE, Receiving Hospital and Transferring Facility hereby covenant and agree as follows:

When Transferring Facility has determined that a pediatric or adult patient is medically unstable, and requires medically specialized burn or trauma care and treatment unavailable at Transferring Facility or any hospital facility within the Provena Health System, and when a physician of Receiving Hospital accepts the transfer of such Transferring Facility's patient requiring such care and treatment, then Receiving Hospital agrees to admit such a patient as promptly as possible provided transfer and admission requirements are met and adequate staff, equipment, bed space and capacity to provide medically specialized care and treatment for such a patient are available at Receiving Hospital.

The parties hereto agree that the referring physician of Transferring Facility, in consultation with the receiving physician at Receiving Hospital, should determine the method of transport and the appropriate personnel, if any, to accompany a patient during any transfer to Receiving Hospital. Transferring Facility agrees that it will send with each patient at the time of transfer, any transfer form(s) and medical records necessary to ensure continuity of care following transfer.

Transferring Facility understands and agrees, upon Receiving Hospital's request, to accept for return transfer and prompt admission to Transferring Facility, any patient that has been medically stabilized and that has been transferred to Receiving Hospital pursuant to this agreement.

The parties hereto acknowledge that they are each "Covered Entities," as that term is defined by the Health Insurance Portability and Accountability Act ("HIPAA"), and each party agrees to comply with all applicable requirements of the HIPAA Privacy and

Security Rules and the Standards for Privacy and Security of Individually Identifiable Health Information, 45 C.F.R. Part 160, 162 and 164, Subparts A and E.

The parties hereto agree to comply with applicable federal and state laws and regulations, and the standards of the Joint Commission on the Accreditation of Healthcare Organizations.

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

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

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

The parties hereto agree that charges for care and services performed in connection with this Agreement shall be collected by the party rendering such care and services directly from the patient, third party payor or other sources normally billed by the institution and neither party shall have any liability to the other party for such charges.

Each party acknowledges the non-exclusive nature of this Agreement. It is the parties' intention that the relationship between Receiving Hospital and Transferring Facility be that of independent contractors. The governing body of each shall have exclusive control of policies, management, assets and affairs of its respective institution. Each party will maintain such insurance as will fully protect it from any and all claims of any nature for damage to property or from personal injury including death, made by anyone which may arise from operations carried on by either party under this Agreement.

The term of this Agreement shall begin on the 1st day of October, 2010 and continue through September 30, 2011 ("Initial Term") and **SHALL AUTOMATICALLY RENEW ON AN ANNUAL BASIS (RENEWAL TERM) ABSENT WRITTEN NOTICE OF NON-RENEWAL BY EITHER PARTY THIRTY (30) DAYS PRIOR TO THE EXPIRATION OF THE INITIAL TERM OR ANY RENEWAL TERM.** Either party hereto may terminate this Agreement without cause upon providing ninety (90) days advance written notice.

This Agreement shall automatically terminate without regard to notice upon the date that either party to this Agreement: a) ceases to have a valid provider agreement with the Secretary of the Department of Health and Human Services; or b) fails to renew, has suspended or revoked its license or registration issued by the State to operate as an acute care Hospital.

All notices which either party is required to give to the other under or in conjunction with this Agreement shall be in writing, and shall be given by addressing the same to such other party at the address indicated below, and by depositing the same so addressed, certified mail, postage prepaid, in the United States mail, or by delivering the same personally to such other party. Any notice mailed or telegraphed shall be deemed to have been given two (2) United States Post Office delivery days following the date of mailing or on the date of delivery to the telegraph company.

Any notice provided to Receiving Hospital shall be directed to:

Patricia Cassidy
Senior Vice President
Loyola University Medical Center
2160 South First Avenue
Maywood, Illinois 60153

With copies to:

Senior Vice President and General Counsel
Office of the General Counsel
Loyola University Medical Center
2160 South First Avenue
Maywood, Illinois 60153

Any notice provided to Transferring Facility shall be directed to:

James D. Witt
President and CEO
Provena Mercy Medical Center
1325 N. Highland Ave
Aurora, IL 60506

With copies to:

Adam Johnson, RN, BSN, TNS
Trauma Coordinator
Provena Mercy Medical Center
1325 N. Highland Ave
Aurora, IL 60506

Neither party to this Agreement may assign any of the rights or obligation under this Agreement without the express written consent of the other party. Any attempt to assign this Agreement without consent shall be void.

Neither Party is under any obligation to refer or transfer patients to the other Party and neither Party will receive any payment for any patient referred or transferred to the other Party. A Party may refer or transfer patients to any facility based on the professional judgment of the treating physician and the individual needs and wishes of the patient.

The Parties acknowledge and agree that, in performing their respective obligations under this Agreement, each is acting as an independent contractor. Transferring Facility and Receiving Hospital are not and shall not be considered joint venturers or partners, and nothing herein shall be construed to authorize either Party to act as general agent for the other. Neither Party, by virtue of this Agreement, assumes any liability for any debts or obligations of either a financial or legal nature incurred by the other Party.

This Agreement shall be interpreted and governed by the substantive and procedural laws of the State of Illinois. The parties hereto both consent to the jurisdiction of Illinois courts to resolve any dispute arising from this Agreement.

This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all such counterparts together shall constitute one and the same instrument.

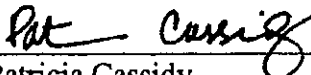
IN WITNESS WHEREOF, we the undersigned, duly authorized representatives have executed and delivered this Agreement without reservation and having read the Terms contained herein.

**FOR LOYOLA UNIVERSITY
MEDICAL CENTER:**

**FOR PROVENA MERCY
MEDICAL CENTER:**

Signature:

Signature:



Patricia Cassidy

James D. Witt

Title:
Sr. Vice President

Title:
President & Chief Executive Officer

HOSPITAL TRANSFER AGREEMENT

THIS TRANSFER AGREEMENT (this "Agreement") is entered into as of the 24th day of April 2009, by and between Central Dupage Hospital, an Illinois non-profit corporation ("Receiving Facility") and Provena Hospitals, d/b/a/ Provena Mercy Medical Center, an Illinois non-profit corporation ("Transferring Facility") (each a "Party" and collectively "Parties").

WHEREAS, Transferring Facility operates a general acute care hospital;

WHEREAS, Receiving Facility operates a general acute hospital with a range of specialized services (the "Specialized Services" including services identified in Exhibit A);

WHEREAS, Transferring Facility identifies from time to time patients who are need of the Specialized Services which are not available at Transferring Facility; and

WHEREAS, Receiving Facility and Transferring Facility desire, through this Agreement, to facilitate the timely and medically appropriate transfer of patients requiring Specialized Services;

NOW, THEREFORE, for and in consideration of the terms, conditions, covenants, agreements and obligations contained herein, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, it is hereby mutually agreed by the Parties as follows:

ARTICLE I.

Patient Transfer Arrangement

1.1. Acceptance of Patients. Upon recommendation of an attending physician at Transferring Facility and subject to the limitations set forth in this Agreement, Receiving Facility agrees to receive and admit if appropriate a transferred patient requiring Specialized Services. The obligation of Receiving Facility to accept the patient shall be subject to customary admission requirements and Receiving Facility's capacity to treat the patient at the time of the transfer. The Parties agree to adopt a mutually agreeable transfer protocol (the "Transfer Protocol"), which shall detail the specific process for notifying a party of a proposed transfer, required provider communications, communication of acceptance or rejection decision, and transport for patients requiring Specialized Services. Transferring Facility and Receiving Facility agree that the general transfer procedures and the Transfer Protocol shall be made known to the relevant patient care personnel of each Party. Transferring Facility shall be responsible for notifying the patient and/or appropriate patient representative of any applicable transfer procedure related to this Agreement.

1.2. Appropriate Transfer. Except as modified by the Transfer Protocol, Transferring Facility's shall arrange for appropriate and safe transportation of patients requiring Specialized Services. The Transferring Facility shall ensure that the transfer is an "appropriate transfer" under the Emergency Medical Treatment and Active Labor Act, as it may be amended, and that such transfer is carried out in accordance with all applicable laws. The Transferring Facility agrees to transfer the personal effects and information relating to the patient and to remain responsible for the same until signed for by a representative of the party to whom the same are transferred.

1.3. Standards. Each Party shall maintain all legally required certifications and licenses from all applicable governmental and accrediting bodies, and shall maintain full eligibility for participation in Medicare and Medicaid. Specifically without limitation, each Party shall maintain full accreditation by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO").

1.4. Billing and Collections. All bills incurred with respect to services performed by either Party for patients received from the other shall be collected by the Party rendering such services directly from the patient, third party insurance coverage (including Medicare or Medicaid), or other sources normally billed by the Party, and neither Party shall have any liability to the other for such charges. The Parties expect that the patient shall be solely responsible for the cost of his transport to the Facility.

1.5. Medical Information and Records. Subject to applicable confidentiality requirements, the Parties shall exchange all information which may be necessary or useful in the care and treatment of patients requiring Specialized Services and as may be necessary for each Party's healthcare operations. The Transferring Facility shall send a copy of all applicable patient medical records that are available at the time of a patient transfer to the Receiving Facility, and shall supplement such information as may be necessary and appropriate. In addition, Transferring Facility shall use its best efforts to makes its medical providers available to Receiving Facility medical providers for relevant questions and discussions relating to Transferring Facility's care and treatment of a transferred patient.

1.6. Non-Exclusive. This Agreement shall be non-exclusive. Either Party shall be free to enter into any other similar arrangement at any time and nothing in this Agreement shall be construed as limiting the right of either Party to affiliate or contract with any other hospital, nursing home, home health agency, school or other entity on either a limited or general basis while this Agreement is in effect. Neither Party shall use the other Party's name or marks in any promotional or advertising material without first obtaining the written consent of the other Party.

1.7. General Compliance. At all times, both Parties shall comply with all federal, state and local laws, rules and regulations now in effect or later adopted relating to their respective obligations hereunder and that may be otherwise applicable to the Parties including, but not limited to, laws, rules and regulations regarding confidentiality, disclosure and retention of patient records, such as the regulations promulgated under the Health Insurance Portability and Accountability Act of 1996. To the best of each Party's respective knowledge, neither Transferring Facility or Receiving Facility, nor any employee, officer, director or agent thereof, is an "excluded person" under the Medicare rules and regulations

ARTICLE II.

Term and Termination

2.1. Term. This Agreement shall be effective as of the day and year first written above and shall remain in effect until terminated as provided herein.

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

(a) Termination by Mutual Consent. The Parties may terminate this Agreement at any time by mutual written consent, and such termination shall be effective upon the date stated in the consent.

(b) Termination Without Cause. Either Party may terminate this Agreement, for any reason whatsoever, upon thirty (30) days' prior written notice.

(c) Termination for Cause. Each Party shall have the right to immediately terminate this Agreement for cause upon the happening of any of the following:

(i) Upon a Party's reasonable determination that the continuation of this Agreement would endanger patients, or the Party's employees or staff;

(ii) Violation by the other Party of any material provision of this Agreement;

(iii) Proposed exclusion of either Party from participation in the Medicare or Medicaid programs or conviction of either Party of a felony; or

(iv) Either Party's loss or suspension of any certification, license, accreditation (including JCAHO accreditation), or other approval necessary to render patient care services.

ARTICLE III.

Certification and Insurance

3.1. Insurance. Each Party shall maintain during the term of this Agreement, at its sole cost and expense, general liability and professional liability insurance in such amounts as are reasonable and customary in the industry to guard against those risks which are customarily insured against in connection with the operation of their respective businesses. Each Party agrees to provide evidence of such insurance upon the other Party's reasonable request. Each Party shall notify the other Party within ten (10) days of any material change or cancellation in any policy of insurance required to be secured or maintained by such Party.

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

ARTICLE IV

Miscellaneous

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

4.2. Relationship of the Parties. The Parties expressly acknowledge that in performing their respective obligations under this Agreement, they are each acting as independent contractors. Nothing herein shall be construed to authorize either Party to act as an agent for the other Party. Neither Party, by virtue of this Agreement, assumes any liability for any debts or obligations of either a financial or legal nature incurred by the other Party. Each Party shall disclose in its respective dealings that they are separate entities.

4.3. Notices. Except for those communications related to a specific patient transfer, all notices and other communications under this Agreement shall be in writing and shall be deemed received when delivered personally or sent via a nationally recognized and receipted overnight courier service, to the Parties at their respective principal office of record as set forth below or designated in writing from time to time. No notice of a change of address shall be effective until received by the other Party:

To Transferring Facility:

Provena Mercy Medical Center
1325 N. Highland Ave.
Aurora, IL 60506
Attn: President & CEO

With a copy to:

Provena Health
19065 Hickory Creek Dr.
Ste 115
Mokena, IL 60448
Attn: System Senior VP/
General Counsel

To Receiving Facility:

Central Dupage Facility
25 N. Winfield Road
Winfield, Illinois 6019025
Attention:

With a copy to:

Attn: Vice President of Legal Affairs
(same address)

4.4. Assignment. Neither Party may assign its rights or delegate its obligations under this Agreement without the prior written consent of the other, except that either Party may assign all

or part of its rights and delegate all or part of its obligations under this Agreement to any entity controlled by or under common control with such Party.

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

4.6. Governing Law. This Agreement shall be construed and all of the rights, powers and liabilities of the Parties hereunder shall be determined in accordance with the laws of the State of Illinois.

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

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

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

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

4.11. Waiver. No failure by a Party to insist upon the strict performance of any covenant, agreement, term or condition of this Agreement, shall constitute a waiver of any such breach of such covenant, agreement, term or condition. Any Party may waive compliance by the other Party with any of the provisions of this Agreement if done so in writing. No waiver of any provision shall be construed as a waiver of any other provision or any subsequent waiver of the same provision.

* * * * *

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

Provena Hospitals, d/b/a Provena Mercy
Medical Center

Signature: James D. Witt

Printed Name: James D. Witt

Title: President & CEO

Robert Traversery
CENTRAL DUPAGE HOSPITAL

Signature:

Printed Name: ROBERT TRAVERSERY

Title: Vice President

EXHIBIT A

Treatment of Aneurysms

- Aneurysm coiling; bare platinum, self expanding, coated and liquid embolics
- Intracranial stenting and/or “remolding” techniques for wide neck aneurysms
- Permanent balloon occlusion for giant cavernous aneurysms
- Intra-operative and 3 D angiography

Treatment of Strokes

- Intra-cranial angioplasty and stenting
- Secondary prevention – carotid and vertebral artery angioplasty and stenting
- Balloon angioplasty for proximal vasospasm
- Drug infusion for distal vasospasm
- Tertiary prevention – intra-arterial thrombolysis
- Mechanical clot removal with FDA approved Merci device up to 8 hours
- Randomized research trials

Treatment of Arterio-Venous Malformations (AVMS)

- Injections for AVMs, dural/pial fistulas, cerebral/spinal
- Liquid embolics and glue

ADVOCATE LUTHERAN GENERAL HOSPITAL AND
PROVENA MERCY MEDICAL CENTER
TRANSFER AGREEMENT
FOR TRAUMA PATIENTS

THIS AGREEMENT is entered into as of this 1st day of November, 2005, between ADVOCATE HEALTH AND HOSPITALS CORPORATION d/b/a ADVOCATE LUTHERAN GENERAL HOSPITAL hereinafter referred to as "LGH", and PROVENA MERCY MEDICAL CENTER, hereinafter referred to as "Hospital".

WHEREAS, LGH is licensed under Illinois law as an acute care Hospital and has been designated a Level I Regional Trauma Center by the State of Illinois;

WHEREAS, Hospital is licensed under Illinois law as an acute care Hospital and has been designated a Level I Trauma Center by the State of Illinois;

WHEREAS, the parties mutually desire to enter into an affiliation agreement for the medically appropriate transfer or referral of patients from Hospital to LGH for the provision of Level I trauma services and other medically appropriate inpatient care, for the purpose of providing coordinated trauma services within the Trauma Center Region in compliance with State of Illinois regulations; and

WHEREAS, the parties desire to provide a full statement of their agreement in connection with the services to be provided hereunder.

NOW, THEREFORE, BE IT RESOLVED that in consideration of the mutual covenants, obligations and agreements set forth herein, the parties agree as follows:

I. TERM

1.1 This Agreement shall be effective from the date hereof into, and shall remain in full force and effect for an initial term ending October 31, 2006. **Thereafter, this Agreement shall be automatically extended for successive one (1) year periods unless terminated as hereinafter set forth.** All the terms and provisions of this Agreement shall continue in full force and effect during the extension period(s).

II. TERMINATION

2.1 Either party may terminate this Agreement, with or without cause, upon thirty (30) days prior written notice to the other party. Additionally, this Agreement shall automatically

terminate should either party fail to maintain the licensure or certification necessary to carry out the provisions of this Agreement.

III. OBLIGATIONS OF THE PARTIES

3.1 Hospital agrees:

a. To refer and transfer to LGH subject to the provisions of paragraph 4.8 hereof, patients determined to be in need of Level I trauma care services, when such referral and transfer has been determined to be medically appropriate by the patient's attending physician and/or the emergency physician and accepted by the LGH trauma surgeon or his or her physician designee;

b. That for the purposes of transporting patients to LGH, the following procedure shall be followed:

i. Hospital shall require that physicians use reasonable medical judgment in assessing the benefits and risks of the transfer and to document in the patients medical record the patient's medical stability and reason for transfer.

ii. The parties agree that patients shall be transferred in accordance with the "Guidelines for Transferring Patients," as developed by the American College of Surgeons and more fully described on Exhibit A attached hereto, and as may be amended from time to time.

c. To maintain and provide proof to LGH on request of professional and public liability insurance coverage in the amount of not less than One Million Dollars (\$1,000,000.00) per occurrence or claim made with respect to the actions of its employees and agents connected with or arising out of services provided under this Agreement.

3.2 LGH agrees:

a. To verify the transport and acceptance of patients from Hospital in need of Level I trauma care services and other inpatient hospital care, when such transfer and referral has been determined to be medically appropriate by the patient's attending physician and/or emergency physician at Hospital and accepted by the LGH trauma surgeon or his or her physician designee; and

b. To maintain and provide proof to Hospital on request of professional and public liability insurance coverage in the amount of One Million Dollars (\$1,000,000.00) per occurrence or claim made with respect to the actions of its employees and agents connected with or arising out of services provided under this Agreement.

IV. GENERAL COVENANTS AND CONDITIONS

4.1 Release of Medical Information. In all cases of patients transferred under the terms of this Agreement, the parties agree that all medical information and any other information necessary or useful in the care and treatment of patients referred and transferred from Hospital to LGH will accompany the patient upon transfer or be provided to LGH as promptly as possible thereafter, subject to the provisions of applicable State and Federal laws governing the confidentiality of such information. Information to be exchanged shall include completed transfer and referral forms mutually agreed upon for the purpose of providing the medical and administrative information necessary to determine the appropriateness of treatment or placement and to enable continuing care to be provided to the patient. The medical records in the care and custody of LGH and Hospital shall remain the property of the respective institution.

4.2 Personal Effects. The parties agree to follow appropriate procedures to assure security and accountability for the personal effects of patients who are transferred under the terms of this Agreement. Hospital, as the institution from which a patient is referred or transferred, shall be responsible for arranging the transfer or other appropriate disposition of personal effects, including money and valuables, and information related to these items. Hospital shall provide an inventory of personal effects of the patient in transit, which shall be acknowledged and signed by LGH after the personal effects have been delivered to LGH. Hospital shall bear the risk of loss for negligence, theft, damage or distribution of the valuables during transit until the personal effects are received by LGH.

4.3 Responsibility for Transfer. Hospital shall be responsible for arranging the transfer of the referred patient, including arranging for appropriate transportation and care for the patient during the transfer. The parties agree that the method of transportation shall be determined in accordance with the best interests of the patient, based upon a consideration of various factors including, but not limited to, patient stability, availability of qualified personnel

and transportation equipment, time of transport, distance, terrain, weather conditions and cost effectiveness. The parties shall mutually agree on the appropriate means of transportation.

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

4.5 Publicity and Advertising. Neither the name of LGH nor Hospital shall be used for any form of publicity or advertising by the other without the express written consent of the other.

4.6 Cooperative Efforts. The parties agree to devote their best efforts to promoting cooperation and effective communication between the parties in the transfer of patients and the performance of services hereunder, to foster the prompt and effective evaluation, treatment and continuing care of recipients of these services which shall include cooperative efforts to reduce the time between initial injury and definitive surgical intervention of patients in need of such intervention and may also include modification of this Agreement in accordance with section 4.12, as necessary, to reflect current medical practice and to resolve problems identified by medical evaluation.

4.7 Nondiscrimination. The parties agree to comply with Title VI of the Civil Rights Act of 1964, all requirements imposed by regulations issued pursuant to that title, section 504 of the Rehabilitation Act of 1973, and all related regulations, to insure that neither party shall discriminate against any recipient of services hereunder on the basis of race, color, sex, creed,

national origin, age or handicap, under any program or activity receiving Federal Financial assistance.

4.8 Affiliation. Each party shall retain the right to affiliate or contract under similar agreements with other institutions while this Agreement is in effect. Notwithstanding anything else herein to the contrary, this Agreement shall not limit the authority of the Hospital to transfer a patient to a Level I institution or equivalent trauma center other than LGH as determined to be medically appropriate by the patient's attending physician or the emergency physician.

4.9 Applicable Laws. The parties agree to fully comply with applicable federal, and state laws and regulations affecting the provision of services under the terms of this Agreement including but not limited to the obligations of either the Hospital or LGH under the provisions of the Consolidated Omnibus Reconciliation Act and its implementing regulations or any policies of Hospital or LGH related to the implementation thereof, with respect to the transfer of patients.

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

4.11 Writing Constitutes Full Agreement. This Agreement embodies the complete and full understanding of LGH and Hospital with respect to the services to be provided hereunder. There are no promises, terms, conditions, or obligations other than those contained herein; and this Agreement shall supersede all previous communications, representations, or agreements, either verbal or written, between the parties hereto. Neither this Agreement nor any rights hereunder may be assigned by either party without the written consent of the other party.

4.12 Written Modification. There shall be no modification of this Agreement, except in writing and exercised with the same formalities of this Agreement.


4.13 Severability. It is understood and agreed by the parties hereto that if any part, term, or provision of this Agreement is held to be illegal by the courts or in conflict with any law of the state where made, the validity of the remaining portions or provisions shall be construed and enforced as if the Agreement did not contain the particular part, term, or provision held to be invalid.

4.14 Notices. All notices required to be served by provisions of this Agreement may be served on any of the parties hereto personally or may be served by sending a letter duly

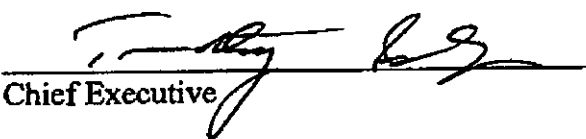
addressed by registered or certified mail. Notices to be served on LGH shall be served at or mailed to: 1775 Dempster Street, Park Ridge, Illinois, 60068, Attention: Chief Executive, with a copy to the General Counsel, 2025 Windsor Drive, Oak Brook, Illinois 60523 unless otherwise instructed. Notices to be served on Hospital shall be served at or mailed to: Provena Mercy Medical Center, 1325 North Highland Avenue, Aurora, IL 60506, Attention: Timothy Selz, CEO, with copies to: Eric Kruger, VP/CFO, unless otherwise instructed.

IN WITNESS WHEREOF, this Agreement has been executed by LGH and Hospital on the date first above written.

ADVOCATE HEALTH AND HOSPITALS CORPORATION
d/b/a ADVOCATE LUTHERAN GENERAL HOSPITAL

BY: 
President

PROVENA MERCY MEDICAL CENTER

BY: 
Chief Executive

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EXHIBIT A

GUIDELINES FOR TRANSFERRING PATIENTS

As developed by the American College of Surgeons
Appendix C to Hospital Resources Document
Interhospital Transfer of Patients

1. The responsibility for the transfer of the patient is a shared one by the referring and receiving physicians. The referring physician wishing to transfer the patient must be in direct communication with the authorized receiving physician. The responsibility should not be left to the nurse or other Health Care professionals. The primary responsibility rests with the party that arranges the transportation.
2. The receiving physician should be consulted in regard to arrangements and details of the transfer, including transportation. Where local ambulances are used to move the patient to the out-of-town facility, the transferring (referring) physician should be intimately involved with the details of transfer to ensure optimal care of the patient.
3. Appropriately trained personnel and proper equipment are needed to manage problems specific to the patient's condition, whether transportation is by air or ground.
4. Instructions should be given to the personnel transporting the patient by the transferring (referring) physician.
5. Prior to transfer:
 - A. Resuscitate the patient and attempt to stabilize his condition.
 1. Respiratory
 - a. Insert an airway or endotracheal tube, if needed.
 - b. Determine rate and method of administration of oxygen.
 - c. Provide suction.
 - d. Provide mechanical ventilation when indicated.
 - e. Insert chest tube if indicated.
 - f. Insert a nasogastric tube to prevent aspiration.
 2. Cardiovascular
 - a. Control external bleeding.
 - b. Establish two large-bore IV lines and begin crystalloid solutions.
 - c. Restore blood volume losses with crystalloid or blood and continue replacement during transfer.
 - d. Insert a Foley catheter to monitor urine output.
 3. Central nervous system
 - a. Controlled hyperventilation in head injury victims.
 - b. Administer Mannitol, diuretics, or steroids, if indicated, after neurosurgical consultation.

- c. Immobilize the cervical spine.
4. Diagnostic studies as indicated
- a. X-ray of:
 - 1. Cervical Spine
 - 2. Chest
 - 3. Extremities
 - b. Hemoglobin, hematocrit, and blood gases.
 - c. Electrocardiogram
 - d. Urinalysis
5. Wounds
- a. Clean and dress.
 - b. Tetanus toxoid.
 - c. Tetanus immune globulin, if indicated.
 - d. Antibiotics, when indicated.
6. Management during transport:
- A. Support of cardiorespiratory system.
 - B. Blood volume replacement.
 - C. Monitoring of vital signs.
 - D. Use of appropriate medications as ordered by physician or as provided by written protocol.
 - E. Maintain communication with a physician or institution during the transfer.
7. A written record of the problem, treatment given, and the status at the time of transfer, as well as certain items such as laboratory results and x-ray films, are essential. These should accompany the patient, and should include:
- A. Initial diagnostic impression.
 - B. Patient's name, address, hospital number, age; and name, address, and phone number of next of kin.
 - C. History of injury or illness.
 - D. Condition on admission.
 - E. Vital signs prehospital, during stay in emergency department, and at time of transfer.
 - F. Treatment rendered to the patient, including medications given and route of administration.
 - G. Laboratory and x-ray findings, appropriate laboratory specimens (i.e., lavage) and all x-ray films.
 - H. Fluids given by type and volume.
 - I. Name of physician referring the patient.
 - J. Address and phone number of referring physician.
 - K. Name of physician at the receiving institution who has been contacted about the patient.
8. Information regarding the patient's condition and needs during transfer should be communicated to the transporting personnel. This should include, but not be limited to:
- A. Airway maintenance.
 - B. Fluid volume replacement.
 - C. Special procedures that may be necessary.

D. Initial Trauma Score (see Sections B & C) and changes en route.

PEDIATRIC TRANSFER AGREEMENT
FOR TRAUMA PATIENTS

THIS AGREEMENT is entered into as of this 1st day of _____, 2005,
between ADVOCATE HEALTH AND HOSPITALS CORPORATION d/b/a ADVOCATE
LUTHERAN GENERAL HOSPITAL hereinafter referred to as "LGH", and Provena Hospital
d/b/a Provena Mercy Medical Center, hereinafter referred to as "Hospital".

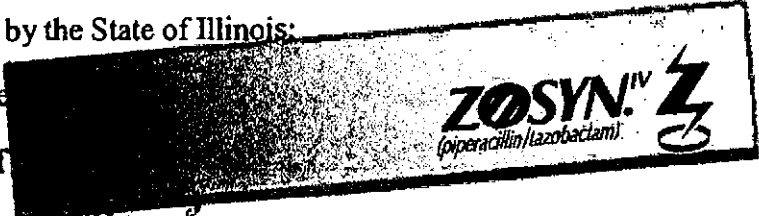
WHEREAS, LGH is licensed under Illinois law as an acute care Hospital and has been
designated a Level I Regional Trauma Center by the State of Illinois;

WHEREAS, Hospital is licensed under Illinois law as an acute care Hospital and has
been designated a Level III Trauma Center by the State of Illinois;

WHEREAS, the parties mutually desire to provide for the
medically appropriate transfer or referral of patients to Hospital for
Level I trauma services and other medically necessary services
providing coordinated trauma services within the
State of Illinois regulations; and

WHEREAS, the parties desire to provide for the
connection with the services to be provided hereunder;

NOW, THEREFORE, BE IT RESOLVED that the parties agree to the
obligations and agreements set forth herein, the



Ellen
Please replace page one? paragraph 3 on the original contract should have read "Level II" - not I.

I.
1.1 This Agreement shall be effective

Please see attached Prescribing Information

full force and effect for an initial term of one (1) year. **Hereafter, this Agreement shall be automatically extended for successive one (1) year periods unless terminated as hereinafter set forth.** All the terms and provisions of this Agreement shall continue in full force and effect during the extension period(s).

II. TERMINATION

2.1 Either party may terminate this Agreement, with or without cause, upon thirty (30) days prior written notice to the other party. Additionally, this Agreement shall automatically

**PEDIATRIC TRANSFER AGREEMENT
BETWEEN
ADVOCATE HEALTH AND HOSPITALS CORPORATION
D/B/A ADVOCATE LUTHERAN GENERAL HOSPITAL
AND
PROVENA MERCY MEDICAL CENTER**

THIS AGREEMENT is entered into this 11th day of July, 2009, between ADVOCATE HEALTH AND HOSPITALS CORPORATION d/b/a ADVOCATE LUTHERAN GENERAL HOSPITAL, an Illinois not-for-profit corporation, hereinafter referred to as "LGH", and PROVENA MERCY MEDICAL CENTER, hereinafter referred to as "HOSPITAL".

WHEREAS, LGH is licensed under Illinois law as an acute care Hospital;

WHEREAS, HOSPITAL is licensed under Illinois law as an acute care Hospital;

WHEREAS, the LGH and HOSPITAL desire to cooperate in the transfer of patients between LGH and HOSPITAL, when and if such transfer may, from time to time be deemed necessary and requested by the respective patient's physician, to facilitate appropriate patient care;

WHEREAS, the parties mutually desire to enter into an affiliation agreement to provide for the medically appropriate transfer or referral of patients from HOSPITAL to LGH, for the benefit of the community and in compliance with HHS regulations; and

WHEREAS, the parties desire to provide a full statement of their agreement in connection with the services to be provided hereunder.

NOW, THEREFORE, BE IT RESOLVED, that in consideration of the mutual covenants, obligations and agreements set forth herein, the parties agree as follows:

I. TERM

1.1 This Agreement shall be effective from the date it is entered into, and shall remain in full force and effect for an initial term of one (1) year. Thereafter, this Agreement shall be

automatically extended for successive one (1) year periods unless terminated as hereinafter set forth. All the terms and provisions of this Agreement shall continue in full force and effect during the extension period(s).

II. TERMINATION

2.1 Either party may terminate this Agreement, with or without cause, upon sixty (60) days prior written notice to the other party. Additionally, this Agreement shall automatically terminate should either party fail to maintain the licensure or certification necessary to carry out the provisions of this Agreement.

III. OBLIGATIONS OF THE PARTIES

3.1 HOSPITAL agrees:

a. That HOSPITAL shall refer and transfer patients to LGH for medical treatment only when such transfer and referral has been determined to be medically appropriate by the patient's attending physician or, in the case of an emergency, the Medical Director for HOSPITAL, hereinafter referred to as the "Transferring Physician";

b. That the Transferring Physician shall contact LGH's Emergency Department Nursing Coordinator, prior to transport, to verify the transport and acceptance of the emergency patient by LGH. The decision to accept the transfer of the emergency patient shall be made by LGH's Emergency Department physician, hereinafter referred to as the "Emergency Physician", based on consultation with the member of LGH's Medical Staff who will serve as the accepting attending physician, hereinafter referred to as the "Accepting Physician". In the case of the non-emergency patient, the Medical Staff attending physician will act as the Accepting Physician and must indicate acceptance of the patient. HOSPITAL agrees that LGH shall have the sole discretion to accept the transfer of patients pursuant to this Agreement subject to the availability of equipment and personnel at LGH. The Transferring Physician shall report all

patient medical information which is necessary and pertinent for transport and acceptance of the patient by LGH to the Emergency Physician and Accepting Physician;

c. That HOSPITAL shall be responsible for effecting the transfer of all patients referred to LGH under the terms of this Agreement, including arranging for appropriate transportation, financial responsibility for the transfer in the event the patient fails or is unable to pay, and care for the patient during the transfer. The Transferring Physician shall determine the appropriate level of patient care during transport in consultation with the Emergency Physician and the Accepting Physician;

d. That pre-transfer treatment guidelines, if any, will be augmented by orders obtained from the Emergency Physician and/or Accepting Physician;

e. That, prior to patient transfer, the Transferring Physician is responsible for insuring that written, informed consent to transfer is obtained from the patient, the parent or legal guardian of a minor patient, or from the legal guardian or next-of-kin of a patient who is determined by the Transferring Physician to be unable to give informed consent to transfer;

f. To inform its patient of their responsibility to pay for all inpatient and outpatient services provided by LGH; and

g. To maintain and provide proof to LGH of professional and public liability insurance coverage in the amount of One Million Dollars (\$1,000,000.00) per occurrence or claim made with respect to the actions of its employees and agents connected with or arising out of services provided under this Agreement.

3.2 LGH agrees:

a. To accept and admit in a timely manner, subject to bed availability, HOSPITAL patients referred for medical treatment, as more fully described in Section 3.1, Subparagraphs a through g;

b. To accept patients from Hospital in need of inpatient hospital care, when such transfer and referral has been determined to be medically appropriate by the patient's attending physician and/or emergency physician at Hospital;

c. That LGH will seek to facilitate referral of transfer patients to specific Accepting Physicians when this is requested by Transferring Physicians and/or transfer patients;

d. That LGH shall provide HOSPITAL patients with medically appropriate and available treatment provided that Accepting Physician and/or Emergency Physician writes appropriate orders for such services; and

e. To maintain and provide proof to HOSPITAL of professional and public liability insurance coverage in the amount of One Million Dollars (\$1,000,000.00) per occurrence or claim made with respect to the actions of its employees and agents connected with or arising out of services provided under this Agreement.

IV. GENERAL COVENANTS AND CONDITIONS

4.1 Release of Medical Information. In all cases of patients transferred for the purpose of receiving medical treatment under the terms of this Agreement, HOSPITAL shall insure that copies of the patient's medical records, including X-rays and reports of all diagnostic tests, accompany the patient to LGH, subject to the provisions of applicable State and Federal laws governing the confidentiality of such information. Information to be exchanged shall include any completed transfer and referral forms mutually agreed upon for the purpose of providing the medical and administrative information necessary to determine the appropriateness of treatment or placement, and to enable continuing care to be provided to the patient. The medical records in the care and custody of LGH and HOSPITAL shall remain the property of each respective institution.

4.2 Personal Effects. HOSPITAL shall be responsible for the security, accountability and appropriate disposition of the personal effects of patients prior to and during transfer to LGH. LGH shall be responsible for the security, accountability and appropriate disposition of the personal effects of transferred patients upon arrival of the patient at LGH.

4.3 Indemnification. The parties agree to indemnify and hold each other harmless from any liability, claim, demand, judgment and costs (including reasonable attorney's fees) arising

out of or in connection with the intentional or negligent acts of their respective employees and/or agents.

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

4.5 Publicity and Advertising. Neither the name of LGH nor HOSPITAL shall be used for any form of publicity or advertising by the other without the express written consent of the other.

4.6 Cooperative Efforts. The parties agree to devote their best efforts to promoting cooperation and effective communication between the parties in the performance of services hereunder, to foster the prompt and effective evaluation, treatment and continuing care of recipients of these services.

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

4.8 Affiliation. Each party shall retain the right to affiliate or contract under similar agreements with other institutions while this Agreement is in effect.

4.9 Applicable Laws. The parties agree to fully comply with applicable federal, and state laws and regulations affecting the provision of services under the terms of this Agreement.

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

4.11 Writing Constitutes Full Agreement. This Agreement embodies the complete and full understanding of LGH and HOSPITAL with respect to the services to be provided hereunder. There are no promises, terms, conditions, or obligations other than those contained herein; and this Agreement shall supersede all previous communications, representations, or agreements, either verbal or written, between the parties hereto. Neither this Agreement nor any rights hereunder may be assigned by either party without the written consent of the other party.

4.12 Written Modification. There shall be no modification of this Agreement, except in writing and exercised with the same formalities of this Agreement.

4.13 Severability. It is understood and agreed by the parties hereto that if any part, term, or provision of this Agreement is held to be illegal by the courts or in conflict with any law of the state where made, the validity of the remaining portions or provisions shall be construed and enforced as if the Agreement did not contain the particular part, term, or provision held to be invalid.

4.14 Notices. All notices required to be served by provisions of this Agreement may be served on any of the parties hereto personally or may be served by sending a letter duly addressed by registered or certified mail. Notices to be served on LGH shall be served at or mailed to: 1775 Dempster Street, Park Ridge, Illinois, 60068, Attention: President, with a copy to General Counsel, 2025 Windsor Drive, Oak Brook, Illinois 60523 unless otherwise instructed. Notices to be served on HOSPITAL shall be served at or mailed to: 1325 North Highland Ave., Aurora, IL 60506 Attn: President & CEO, with a copy to Office of the General Counsel, 19065 Hickory Creek Drive, Ste 115, Mokena, IL 60448, unless otherwise instructed.

IN WITNESS WHEREOF, this Agreement has been executed by LGH and HOSPITAL on
the date first above written.

**ADVOCATE HEALTH AND HOSPITALS
CORPORATION D/B/A ADVOCATE
LUTHERAN GENERAL HOSPITAL**
An Illinois Not-for-Profit Corporation

BY: David A. Stark
President

PROVENA MERCY MEDICAL CENTER

BY: James D. Witt
James D. Witt
President & CEO

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

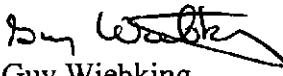
Illinois Health Facilities
and Services Review Board
Springfield, Illinois

RE: FUNDING OF PROJECT

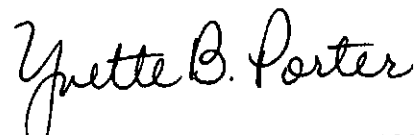
To Whom It May Concern:

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:

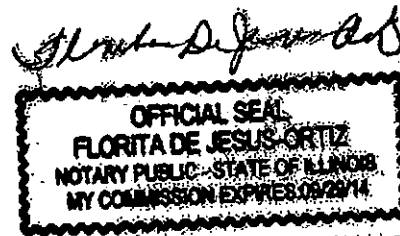
I hereby attest that all of the real costs associated with the changes of ownership of the facilities directly or indirectly owned and/or controlled by Resurrection Health Care Corporation will be funded in total with cash or equivalents.

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 Mercy Medical Center
2012 Projection

ADJUSTED PATIENT DAYS:

\$	91,134,000	
\$	2,014	45,242

OPERATING COSTS

salaries & benefits	\$	81,585,000
supplies	\$	18,687
TOTAL	\$	81,603,687

Operating cost/adjusted patient day:	\$	1,803.71
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CAPITAL COSTS

depreciation, amortization and interest	\$	13,620,000
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Capital cost/adjusted patient day:	\$	301.05
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