

ORIGINAL

11-043

RECEIVED

JUL 6 2011

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

HEALTH FACILITIES &
SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Our Lady of the Resurrection Medical Center		
Street Address:	5645 West Addison Street		
City and Zip Code:	Chicago, IL 60634		
County:	Cook	Health Service Area	VI Health Planning Area: A-01

Applicant /Co-Applicant Identification

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

Exact Legal Name:	Our Lady of the Resurrection Medical Center
Address:	5645 West Addison Street Chicago, IL 60634
Name of Registered Agent:	Ms. Sandra Bruce
Name of Chief Executive Officer:	John Short
CEO Address:	5645 West Addison Street Chicago, IL 60634
Telephone Number:	773/794-7673

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

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

APPEND DOCUMENTATION AS ATTACHMENT-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**

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Street Address:	5645 West Addison Street		
City and Zip Code:	Chicago, IL 60634		
County:	Cook	Health Service Area	VI Health Planning Area: A-01

Applicant /Co-Applicant Identification

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

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

Type of Ownership of Applicant/Co-Applicant

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

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Title:	Partner
Company Name:	Holland + Knight
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Telephone Number:	312/578-6544
E-mail Address:	Anne.Murphy@hklaw.com
Fax Number:	312/578-6666

Additional Contact

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

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

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

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

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Facility/Project Identification

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Street Address:	5645 West Addison Street		
City and Zip Code:	Chicago, IL 60634		
County:	Cook	Health Service Area	VI Health Planning Area: A-01

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 60631
Name of Registered Agent:	Mr. Guy Wiebking
Name of Chief Executive Officer:	Mr. Guy Wiebking
CEO Address:	19065 Hickory Creek Drive Mokena, IL 60631
Telephone Number:	708/478-6300

Type of Ownership of Applicant/Co-Applicant

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

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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
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Telephone Number:	
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City and Zip Code:	Chicago, IL 60634		
County:	Cook	Health Service Area	VI Health Planning Area: A-01

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

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Title:	Partner
Company Name:	Holland + Knight
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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:	John Short
Title:	Interim Executive Vice President/CEO
Company Name:	Our Lady of the Resurrection Medical Center
Address:	5645 West Addison Street Chicago, IL
Telephone Number:	773/794-7673
E-mail Address:	Jshort@reshealthcare.org
Fax Number:	773/990-7626

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Our Lady of the Resurrection Medical Center
Address of Site Owner:	5645 West Addison Street Chicago, IL
Street Address or Legal Description of Site:	5645 West Addison Street Chicago, IL
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:	Our Lady of the Resurrection Medical Center	
Address:	5645 West Addison Street Chicago, IL	
<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 Our Lady of the Resurrection Medical Center, a 299-bed community hospital located in Chicago, 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 Our Lady of the Resurrection 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 Our Lady of the Resurrection 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

**Our Lady of the Resurrection
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			\$214,961,258
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS			\$215,527,925
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			\$214,961,258
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS			\$215,527,925

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-3, 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**.

Our Lady of the Resurrection FACILITY NAME: Medical Center		CITY: Chicago			
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	213	6,884	36,011	None	213
Obstetrics					
Pediatrics					
Intensive Care	20	1,154	6,429	None	20
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care	66	1,372	13,966	None	66
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify))					
TOTALS:	299	9,410	56,406	None	299

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 Our Lady of the Resurrection Medical Center * 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

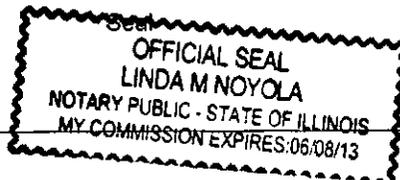
Notarization:
Subscribed and sworn to before me
this 22 day of March

Florita de Jesus Ortiz
Signature of Notary

Linda M. Noyola
Signature of Notary

Seal

*Insert EXACT legal name of the applicant



CERTIFICATION

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Sandra Bruce
SIGNATURE
Sandra Bruce
PRINTED NAME
President and CEO
PRINTED TITLE

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

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

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

Florita de Jesus Ortiz
Signature of Notary

Linda M Noyola
Signature of Notary

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

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

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

Guy Wiebking
SIGNATURE

Guy Wiebking
PRINTED NAME

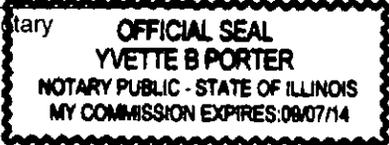
President and CEO
PRINTED TITLE

Anthony Filer
SIGNATURE

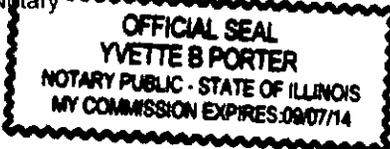
Anthony Filer
PRINTED NAME

Assistant Treasurer
PRINTED TITLE

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

Yvette B. Porter
Signature of Notary
Seal


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

Yvette B. Porter
Signature of Notary
Seal


*Insert EXACT legal name of the applicant

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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

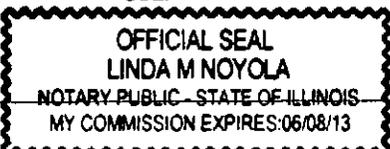
Florita de Jesus Ortiz
Signature of Notary

Seal

*Insert Notary Seal of Notary Public in this space

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

Linda M. Noyola
Signature of Notary

Seal


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

Our Lady of the Resurrection 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:
		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:
		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;
\$214,961,258	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
\$215,527,925	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 **Our Lady of Resurrection Medical Center**

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

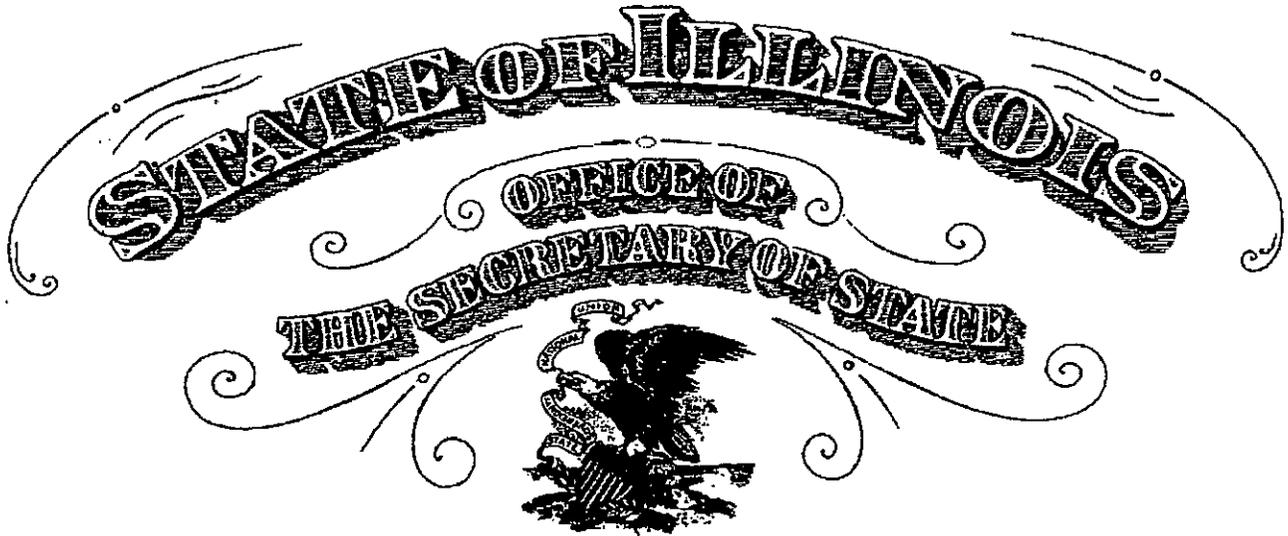
1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
2. If the applicant owns or operates one or more facilities, the reporting shall be for 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			
	2008	2009	2010
Net Patient Revenue	\$136,090,747	\$135,295,767	\$125,229,717
Amount of Charity Care (charges)	\$5,831,710	\$6,713,421	\$14,344,178
Cost of Charity Care	\$1,417,592	\$1,613,275	\$3,293,147

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



To all to whom these Presents Shall Come, Greeting:

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

OUR LADY OF THE RESURRECTION MEDICAL CENTER, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JANUARY 18, 1966, 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.



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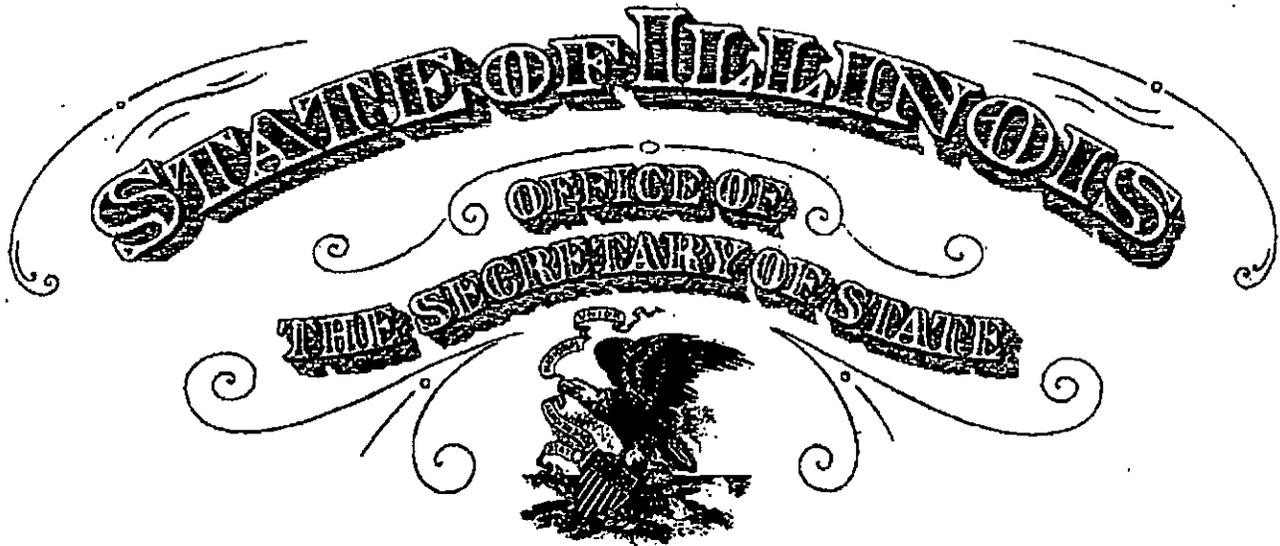
Authenticate at: <http://www.cyberdriveillinois.com>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 14TH day of FEBRUARY A.D. 2011 .

Jesse White

SECRETARY OF STATE

ATTACHMENT 1



To all to whom these Presents Shall Come, Greeting:

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

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

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 .



Authentication #: 1104200726

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

Jesse White

SECRETARY OF STATE
ATTACHMENT 1



To all to whom these Presents Shall Come, Greeting:

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

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



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

Jesse White

0011093950

9879/0147 08 001 Page 1 of 3
2001-11-20 15:29:24
Cook County Recorder 25.50

QUIT CLAIM DEED

STATUTORY (ILLINOIS)

CORPORATION TO CORPORATION

THE GRANTOR, Resurrection Services, an Illinois not-for-profit corporation, having an office at 7435 W. Talcott Avenue, Chicago, Illinois 60631, for and in consideration of TEN and NO/100 Dollars (\$10.00), and other good and valuable consideration, in hand paid, CONVEYS AND QUITCLAIMS to Our Lady of the Resurrection Medical Center, an Illinois not-for-profit corporation, having an office at 5645 W. Addison, Chicago, Illinois 60634,

all of Grantor's right, title and interest in and to the following described Real Estate situated in the County of Cook and the State of Illinois, to wit:

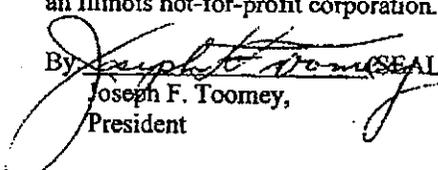
LOT 38 IN BLOCK 2 IN BRITIGAN'S RESUBDIVISION IN BLASE AND HANSENS ADDITION TO CHICAGO IN THE SOUTHEAST ¼ OF SECTION 20, TOWNSHIP 40 NORTH, RANGE 13 EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS

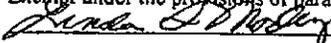
Permanent Real Estate Index Number: 13-20-407-015-0000

Address of Real Estate: 5645 W. Addison, Chicago, Illinois 60634.

DATED this 9 day of November, 2001.

RESURRECTION SERVICES,
an Illinois not-for-profit corporation.

By  (SEAL)
Joseph F. Toomey,
President

Exempt under the provisions of paragraph (e), Section 4 of the Real Estate Transfer Tax Act.
 Grantor or Agent Date: 11-20-01

STATE OF ILLINOIS)
COUNTY OF COOK)

I, the undersigned, a notary public in and for said County, in the State aforesaid, DO HEREBY CERTIFY that Joseph F. Toomey, President of Resurrection Services, an Illinois not-for-profit corporation, and personally known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me this day in person and acknowledged that he signed, sealed and delivered said instrument in such capacity and as his free and voluntary act, and as the free and voluntary action of the corporation, for the uses and purposes therein set forth.

Given under my hand and official seal, this day 9 of November, 2001.

Commission expires:
August 26, 2002

Florita de Jesus-Ortiz
Notary Public



THIS INSTRUMENT WAS
PREPARED BY AND AFTER
RECORDING MAIL TO:

Donna J. Pugh, Esq.
Vedder, Price, Kaufman & Kammholz
222 North LaSalle Street
Chicago, Illinois 60601

SEND SUBSEQUENT TAX BILLS TO:

Frank Madl
Our Lady of the Resurrection Medical Center
5645 W. Addison
Chicago, Illinois 60634

STATEMENT BY GRANTOR AND GRANTEE

The grantor or his agent affirms that, to the best of his knowledge, the name of the grantee shown on the deed or assignment of beneficial interest in a land trust is either a natural person, an Illinois corporation or foreign corporation authorized to do business or acquire and hold title to real estate in Illinois, a partnership authorized to do business or acquire and hold title to real estate in Illinois, or other entity recognized as a person and authorized to do business or acquire title to real estate under the laws of the State of Illinois.

Dated 11-28, 2001
Signature: [Handwritten Signature]

Grantor or Agent

Subscribed and sworn to before

me by the said Agent

this 20th day of November, 2001.

[Handwritten Signature]

Notary Public



The grantee or his agent affirms and verifies that the name of the grantee shown on the deed or assignment of beneficial interest in a land trust is either a natural person, an Illinois corporation or a foreign corporation authorized to do business or acquire and hold title to real estate in Illinois, a partnership authorized to do business or acquire and hold title to real estate in Illinois, or other entity recognized as a person and authorized to do business or acquire and hold title to real estate under the laws of the State of Illinois.

Dated November 20, 2001
[Handwritten Signature]

Signature:

Grantee or Agent

Subscribed and sworn to before

me by the said Agent

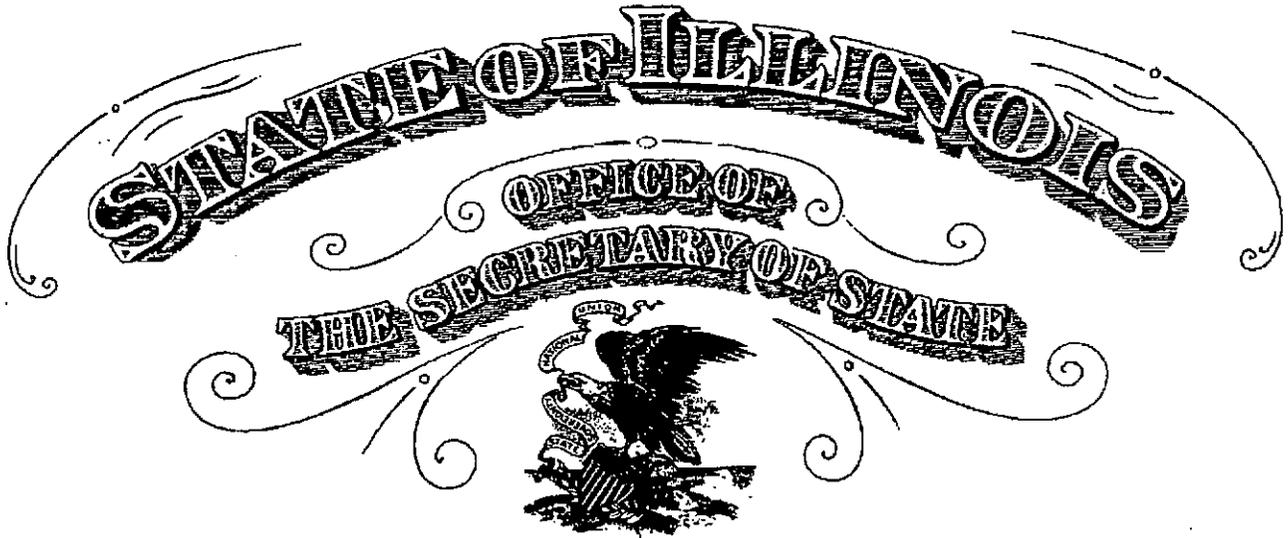
this 20th day of November, 2001.

[Handwritten Signature]

Notary Public



NOTE: Any person who knowingly submits a false statement concerning the identity of a grantee shall be guilty of a Class C misdemeanor for the first offense and of a Class A misdemeanor for subsequent offenses.



To all to whom these Presents Shall Come, Greeting:

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

OUR LADY OF THE RESURRECTION MEDICAL CENTER, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JANUARY 18, 1966, 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 #: 1104501304

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 14TH day of FEBRUARY A.D. 2011 .

Jesse White

SECRETARY OF STATE

CURRENT ORGANIZATIONAL CHARTS

Resurrection Health Care Corporation

Corporate Organizational and Governance Structure

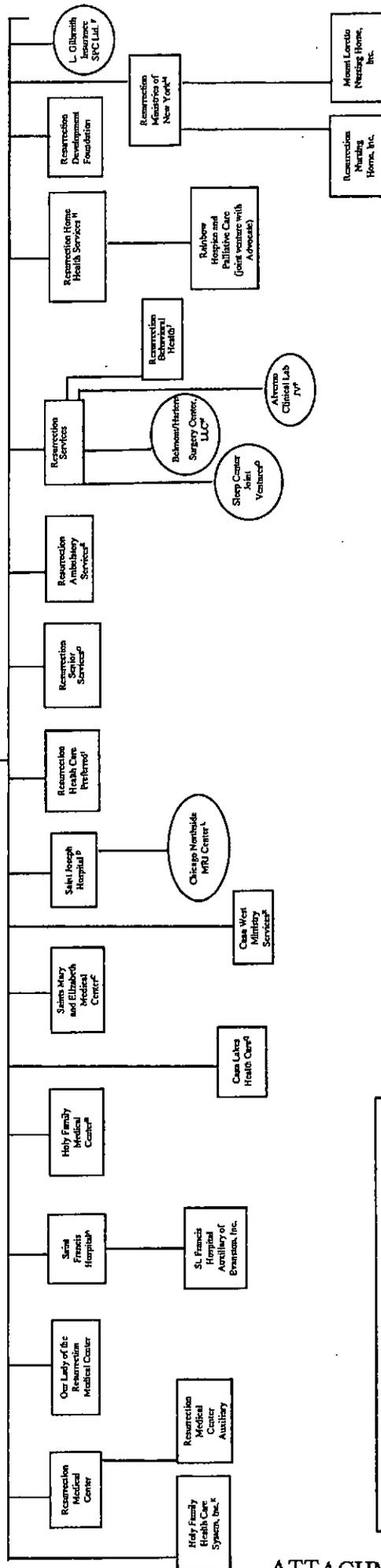
October 21, 2010

Sisters of the Resurrection –
Provincial and Council

Sisters of the Holy Family of Nazareth –
Provincial and Council

Sponsorship Board

Resurrection Health Care Corporation
(System Parent Corporation)



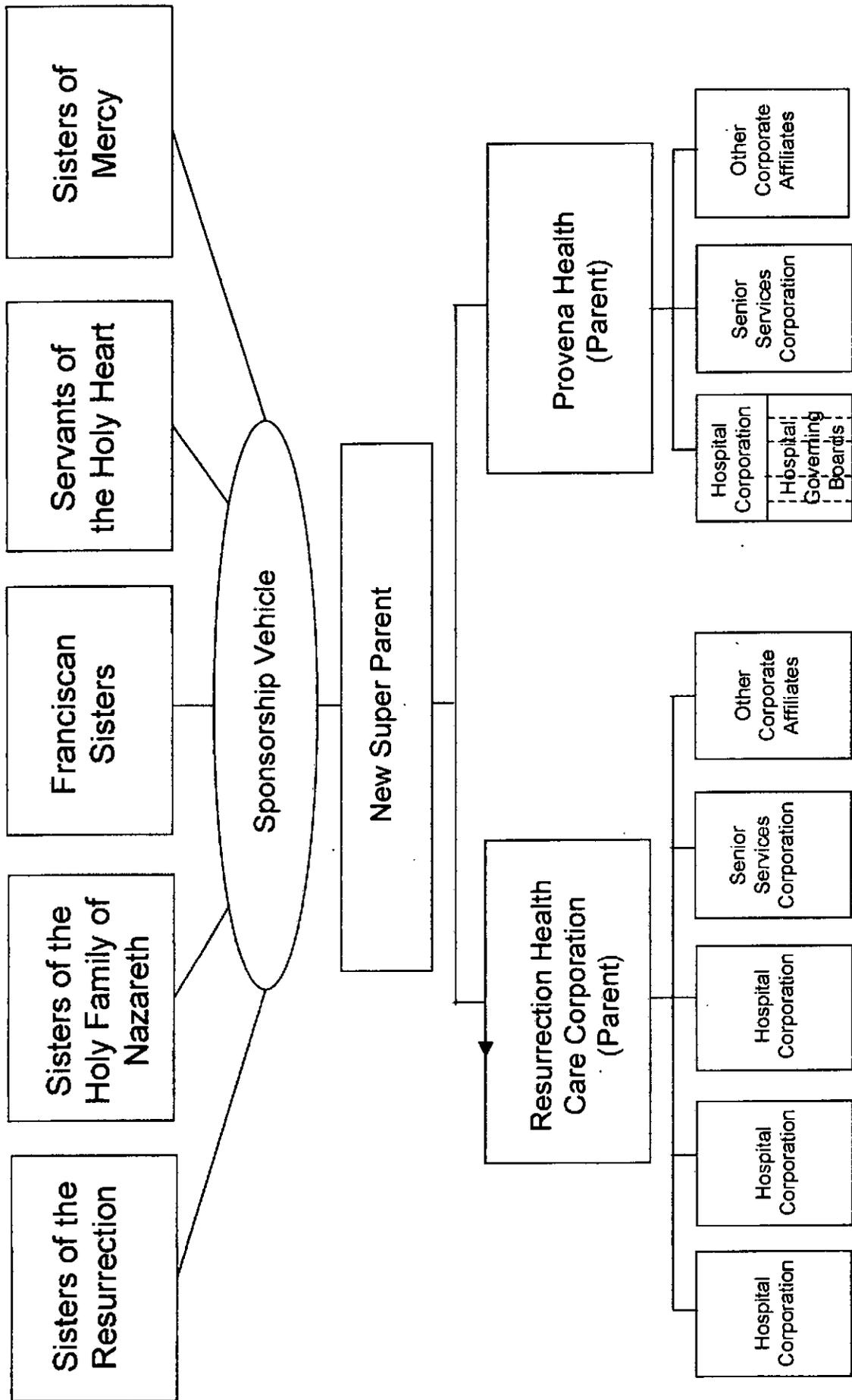
Key:
 Boxes denote not for profit corporations.
 Circles denote for profit corporations or other entities.
 Text of footnotes A through P are on the next page.

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

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

PROPOSED ORGANIZATIONAL CHART

Super Parent Structure



IDENTIFICATION OF PROJECT COSTS

Fair Market Value of Hospital

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

Consulting and Other Fees

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

7435 West Talcott Avenue
Chicago, Illinois 60631
773.792.5555



Sandra Bruce, FACHE
President & Chief Executive Officer

March 24, 2011

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

To Whom It May Concern:

In accordance with Review Criterion 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	1992816
	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 BGBB	ID NUMBER 0002584
FULL LICENSE GENERAL HOSPITAL EFFECTIVE: 01/01/11		

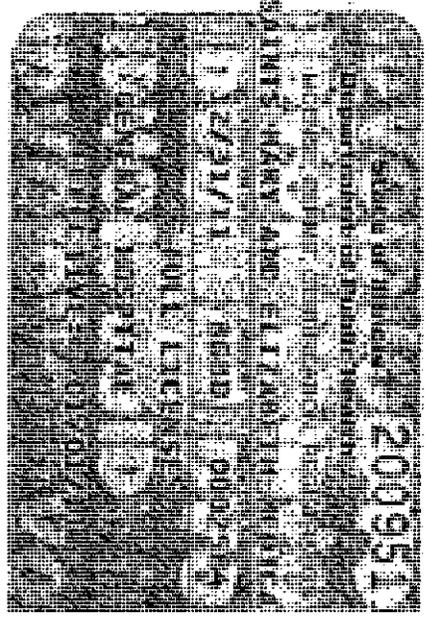
BUSINESS ADDRESS

**SAINTS MARY AND ELIZABETH MEDICAL CENTE
 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 2-197*

↑
 DISPLAY THIS PART IN A
 CONSPICUOUS PLACE

↓
 REMOVE THIS CARD TO CARRY AS AN
 IDENTIFICATION



11/06/10

**SAINTS MARY AND ELIZABETH MED
 D/B/A SAINT MARY OF NAZARETH H
 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.

DAMON T. ARNOLD, M.D.
DIRECTOR

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

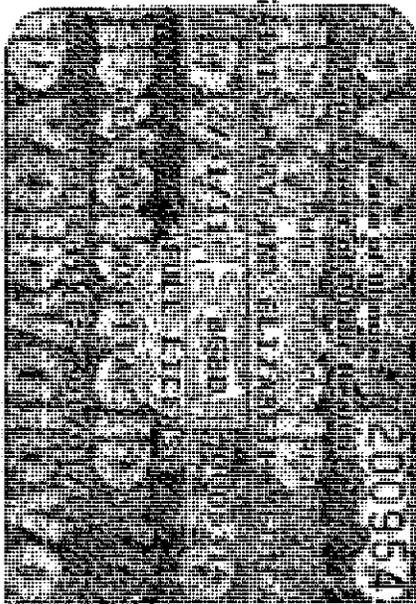
EXPIRATION DATE	CATEGORY	ID NUMBER
12/31/11	B58D	0005314
FULL LICENSE		
GENERAL HOSPITAL		
EFFECTIVE- 10/01/11		
BUSINESS ADDRESS		

**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.

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

EXPIRATION DATE 12/31/11	CATEGORY 86BD	IDENTIFIER 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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REMOVE THIS CARD TO CARRY AS AN
 IDENTIFICATION

State of Illinois 2009495
Department of Public Health

RESURRECTION MEDICAL CENTER
LICENSE, PERMIT, CERTIFICATION, REGISTRATION

EXPIRATION DATE 12/31/11	CATEGORY 86BD	IDENTIFIER 0001974
FULL LICENSE		
GENERAL HOSPITAL		
EFFECTIVE: 01/01/11		

GENERAL HOSPITAL
EFFECTIVE: 01/01/11

11/06/10

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	HGHE	0005181

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 07/03/11

06/04/11

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.

DAMON 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	563B	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. ARNOLD, M.D.
DIRECTOR
Issued under the authority of
 The State of Illinois
 Department of Public Health

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

BUSINESS ADDRESS

HOLY FAMILY MEDICAL CENTER
100 NORTH RIVER ROAD
DES PLAINES IL 60016 1278

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State of Illinois 2035973
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

EXPIRATION DATE	CATEGORY	ID. NUMBER
06/30/12	BGED	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 ph 312 202 8258 | 800- 621 -1773 X 8258

January 7, 2011

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

Dear Mr Baird :

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

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

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

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

No further action is required.

Sincerely,

George A. Reuther
Secretary

GAR/pmh

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

ATTACHMENT 11



State of Illinois 2009508
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

DAMON T. ARNOLD, M.D.
DIRECTOR

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

EXPIRATION DATE 12/31/11	CATEGORY 668D	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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 IDENTIFICATION

State of Illinois 2009508
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION
ST. FRANCIS HOSPITAL OF EVANSTON

EXPIRATION DATE 12/31/11	CATEGORY 868D	I.D. NUMBER 0002402
FULL LICENSE		
GENERAL HOSPITAL		
EFFECTIVE: 01/01/11		

GENERAL HOSPITAL
EFFECTIVE: 01/01/11

11/05/10
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.

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

DAMON Y. ARNOLD, M.D. DIRECTOR

EXPIRATION DATE	CATEGORY	I.D. NUMBER
06/30/12	0680	0001719

FULL LICENSE
 GENERAL HOSPITAL
 EFFECTIVE: 07/01/11

BUSINESS ADDRESS

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

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State of Illinois 2035984

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

OUR LADY OF THE RESURRECTION MEDICAL

EXPIRATION DATE	CATEGORY	I.D. NUMBER
06/30/12	0680	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	TS NUMBER
12/31/11	BGRD	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.

A handwritten signature in cursive script, reading "David L. Nahrwold".

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

4968
Organization ID #

A handwritten signature in cursive script, reading "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

EXPIRATION DATE	CATEGORY	TS NUMBER
12/31/11	BCBD	0004853

FULL LICENSE
 GENERAL HOSPITAL
 EFFECTIVE: 01/01/11

BUSINESS ADDRESS

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

DANVILLE

IL 61832

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



The Joint Commission

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

July 26, 2008

Accreditation is customarily valid for up to 39 months.

David L. Nahrwold

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

4928
Organization ID #

Mark Chassin

Mark Chassin, M.D.
President

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 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.

DANON T. ARNOLD, M.D.
DIRECTOR

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

EXPIRATION DATE 12/31/11	CATEGORY B6B9	LS 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
 IDENTIFICATION

State of Illinois 2009536
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

EXPIRATION DATE 12/31/11	CATEGORY B6B9	LS 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

11/06/10

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	LT NUMBER 0004887
FULL LICENSE		
GENERAL HOSPITAL		
EFFECTIVE: 01/01/11		

BUSINESS ADDRESS

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

IL 60123

The face of this license has a colored background. Printed by Authority of the State of Illinois • 8/07 •

← DISPLAY THIS PART IN A
 CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN
 IDENTIFICATION

State of Illinois 2009540
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

PROVENA HOSPITALS

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

11/06/10

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

FEE RECEIPT NO.

Provena Saint Joseph Hospital

Elgin, IL

has been Accredited by



The Joint Commission

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

May 10, 2008

Accreditation is customarily valid for up to 39 months.

David L. Nahrwold

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

7338
Organization ID #

Mark Chassin

Mark Chassin, M.D.
President

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





State of Illinois 2009541

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The primary form of identification for the license holder is the license card. The license holder must carry the license card with them at all times and it is hereby authorized to display in the primary or installed location.

DAMON T. ARNOLD, M.D.
DIRECTOR

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

12/31/11	68800	0004903
FULL LICENSE		
GENERAL HOSPITAL		
EFFECTIVE: 01/01/11		

BUSINESS ADDRESS

PROVENA MERCY CENTER
1325 NORTH HIGHLAND AVENUE
AURORA

AURORA

IL 60506

The form of this license may be changed without notice by the State of Illinois - APR -

DISPLAY THIS PART IN A
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REMOVE THIS CARD TO CARRY AS AN
IDENTIFICATION

State of Illinois 2009541

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

PROVENA MERCY CENTER

12/31/11	68800	0004903
FULL LICENSE		
GENERAL HOSPITAL		
EFFECTIVE: 01/01/11		

GENERAL HOSPITAL
EFFECTIVE: 01/01/11

11/06/10

PROVENA HOSPITALS D/U/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

State of Illinois 2009539
Department of Public Health

LICENSEE IDENTIFICATION REGISTRATION

DANIEL J. WANDERLICH, M.D.
 DIRECTOR
 12/21/10 11/06/10 00044079
 GENERAL HOSPITAL
 EFFECTIVE: 01/09/11

PROVIDENCE HOSPITALS
 D/B/A SAINT MARY'S HOSPITAL
 500 WEST COURT STREET
 KANKAKEE, IL 60901

State of Illinois
 Department of Public Health
2009539
 DANIEL J. WANDERLICH, M.D.
 DIRECTOR
 12/21/10 11/06/10 00044079
 GENERAL HOSPITAL
 EFFECTIVE: 01/09/11

↑
 DISPLAY THIS PART IN A
 CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN
 IDENTIFICATION

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

FEE RECEIPT NO.



May 27, 2011

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

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

Dear Mr. Arno:

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

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

Comprehensive Accreditation Manual for Hospitals

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

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

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

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

Sincerely,

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

DISPLAY THIS PART IN A CONSPICUOUS PLACE.

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State of Illinois 2032822
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

EXPIRATION DATE	CATEGORY	ID NUMBER
04/30/12	EGSB	7003151

FULL LICENSE

ABDUL SURGICAL TREAT CNTR

EFFECTIVE: 05/01/11

04/10/12

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

FEE RECEIPT NO. 54561

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.

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

EXPIRATION DATE	CATEGORY	ID NUMBER
04/30/12	EGSB	7003151

FULL LICENSE
ABDUL SURGICAL TREAT CNTR
EFFECTIVE: 05/01/11

BUSINESS ADDRESS

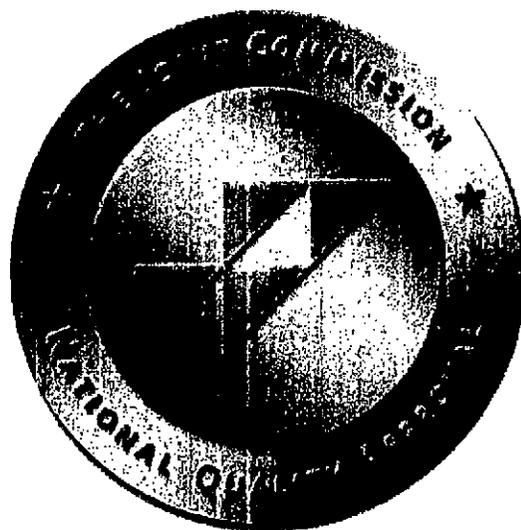
BELMONT/HARLEM SURGERY CENTER, LLC
3101 NORTH HARLEM AVENUE
CHICAGO IL 60634

The face of this license has a colored background. Printed by authority of the State of Illinois • 4/07 •

Belmont/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 Chassin

Mark Chassin, 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>Jusa Partolone 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 Our Lady of the Resurrection 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	Admissions	%	Cumulative %
60634	Chicago-Dunning	1,537	20.6%	20.6%
60641	Chicago-Irving Park	1,452	19.5%	40.1%
60639	Chicago-Cragin	1,145	15.4%	55.4%
60630	Chicago-Jefferson Park	547	7.3%	62.8%
60707	Chicago-Elmwood Park	462	6.2%	69.0%
60706	Harwood Heights	377	5.1%	74.0%
60618	Chicago-Avondale	343	4.6%	78.6%
60647	Chicago-Logan Square	181	2.4%	81.1%
60714	Niles	149	2.0%	83.0%
60651	Chicago-Humboldt Park	95	1.3%	84.3%
60631	Chicago-Norwood Park	92	1.2%	85.6%
other ZIP Code areas contributing <1%		<u>1,077</u>	<u>14.4%</u>	100.0%
		7,457	100.0%	

As can be noted from the table above, eleven ZIP Code areas accounted for nearly 86% of the hospital's admissions. This analysis clearly demonstrates that Our Lady of the Resurrection 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 Our Lady of the Resurrection 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, Resurrection Health Care Corporation (“Resurrection”) and its sponsoring congregations have concluded that its hospitals can better serve their patients and their communities if the Resurrection system were to merge with that of Provena Health (“Provena”). By doing so, Resurrection 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 Our Lady of the Resurrection Medical Center.

The current and proposed bed complement, consistent with Our Lady of the Resurrection Medical Center’s 2009 IDPH Hospital Profile are:

- 213 medical/surgical beds
- 20 intensive care beds
- 66 long term care

Among the other clinical services currently offered and proposed to continue to be provided are: surgery, 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 Our Lady of the Resurrection 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 9,400 patients, provided approximately 106,00 outpatient visits, and treated approximately 38,000 patients in its emergency department.

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

Each of the hospitals included in the system merger will provide both charity care and services to Medicaid recipients. According to IDPH data, during 2009 the admission of Medicaid recipients to Resurrection hospitals ranged between 8.6% and 65.2%, and for

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

Finally, with nearly 800 employees (FTEs), Our Lady of the Resurrection 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 Non-Discrimination in Patient Care policy, and Resurrection's Financial Assistance/Charity Care and Uninsured Patient Discount Programs 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.

Our Lady of the Resurrection 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 Our Lady of the Resurrection Medical Center are anticipated to be discontinued as a result of the proposed change of ownership.

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.

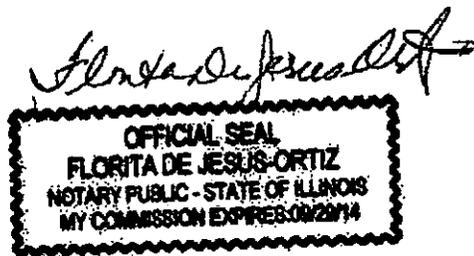
Resurrection and Provena, in consultation with the Illinois Attorney General's office, are currently revising the charity care policy to be used following the system merger. That revised policy will be provided to the State Agency upon completion.

Sincerely,

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

Sandra Bruce, FACHE
President & CEO

Notarized:



CO-SPONSORS

Sisters of the Holy Family of Nazareth & Sisters of the Resurrection

ATTACHMENT 19B



March 23, 2011

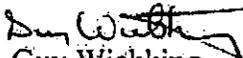
Illinois Health Facilities
and Services Review Board
Springfield, Illinois

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.

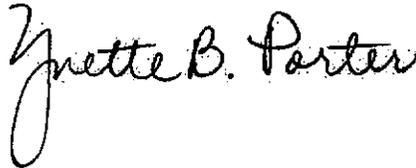
Provena and Resurrection, in consultation with the Illinois Attorney General's office, are currently revising the charity care policy to be used following the system merger. That revised policy will be provided to the State Agency upon completion.

Sincerely,


Guy Wiebking
President & CEO



Notarized:



CURRENT ADMISSIONS
and
CHARITY CARE POLICIES

POLICY PROTOCOL		
CATEGORY: Mission		NUMBER: 300.60
TITLE: Non-Discrimination in Patient Care		TITLE NUMBER: 371.06
		PAGE: 1 OF 2
EFFECTIVE DATE: March 1996	REVISION DATE: September 2009	SUPERSEDES: March 2007
REFER TO:		LOCATION:

PHILOSOPHY

Mission Policies are intended to delineate the values, behaviors and directives that guide the Resurrection Health Care System as an organization whose identity and practices are consistent with the Roman Catholic tradition and its teachings.

PURPOSE

This policy defines non-discriminatory practices applicable to all patients, visitors, physicians and employees and is endorsed by Resurrection Health Care.

PROCESS

At Our Lady of the Resurrection Medical Center (OLRMC), no person will be discriminated against or otherwise denied benefits of care or service on the basis of race, sex, national origin, religion, age, sexual preference, disability or financial means. This includes, but is not limited to the following characteristics:

1. Services will be provided in a way that protects the dignity of the person and enhances the quality of life.
2. All patients will be admitted, receive care, be transferred and discharged appropriately with no distinction in eligibility and without discrimination.
3. All patients with the same health problem will receive the same standard of care regardless of race, sex, national origin, religion, age, sexual preference, disability or financial means.
4. All patient transfers will be in compliance with EMTALA provisions.

POLICY PROTOCOL		
CATEGORY: <p style="text-align: center;">Mission</p>		NUMBER: 300.60
TITLE: <p style="text-align: center;">Non-Discrimination in Patient Care</p>		TITLE NUMBER: 371.06
		PAGE: 2 OF 2
EFFECTIVE DATE: March 1996	REVISION DATE: September 2009	SUPERSEDES: March 2007
REFER TO:		LOCATION:

5. Patient care decisions are to be based on the interests, needs and well being of the patient and will not be influenced by the patient's ability to pay.
6. Patient rooms will not be changed for any discriminatory reasons.
7. Persons and organizations referring patients to OLRMC are advised to do so without reference to race, sex, national origin, religion, age, sexual preference, disability or financial means.
8. Physician practices associated with OLRMC will appropriately serve the economically poor, disadvantaged and elderly, regardless of the source of referral and without discrimination.
9. Employees will be assigned to patient services without discrimination.
10. Employees, officers and physicians are bound by the Resurrection Health Care (RHC) Code of Conduct/Conflict of Interest Policy in the discharge of their duties for or on behalf of RHC.
11. The Chief Executive Officer is responsible for coordinating compliance with this policy.

This standard of care/policy is a guideline only. Each patient has his or her own unique set of circumstances, which may require that this standard not be followed. The needs of the patient supercede this, or any standard or policy.

POLICY PROTOCOL		
CATEGORY: Finance		NUMBER: 100.15
TITLE: Financial Assistance/Charity Care and Uninsured Patient Discount Programs (This policy applies to hospitals only)		TITLE NUMBER: 122.05
		PAGE: 1 OF 17
EFFECTIVE DATE: February 2002	REVISION DATE: January 2009	SUPERSEDES: September 2004
REFER TO:		LOCATION:

PURPOSE

Finance Policies are intended to provide guidelines to promote responsible stewardship and allocation of resources.

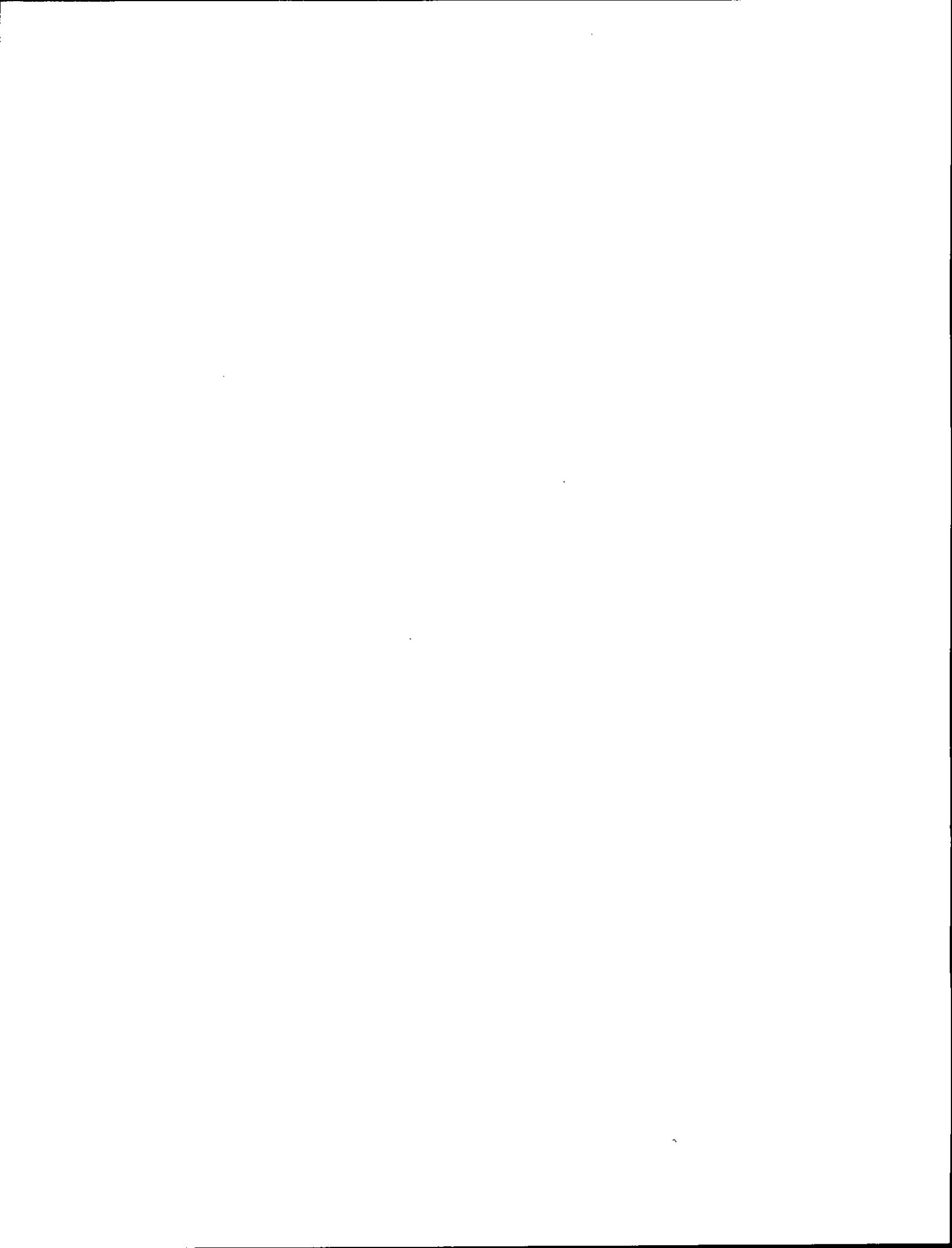
PURPOSE

This policy establishes guidelines for the development and application of financial assistance and uninsured patient discount programs, by Resurrection Health Care system (RHC) hospitals. Such programs will be designed to assist individuals in financial need and other medically underserved individuals or groups to obtain appropriate medical care and advice, and thereby improve the health of those in the communities served by RHC hospitals.

SCOPE

1. Definitions

- 1.1 Federal Poverty Level means the level of household income at or below which individuals within a household are determined to be living in poverty, based on the Federal Poverty Guidelines as annually determined by the U.S. Department of Health and Human Services.
- 1.2 Financial Assistance/Charity Care means providing a discount of up to 100% of the charges associated with a patient's hospital care, or a discounted fee schedule, based on financial need.



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- 1.3 Financial Assistance Programs means all programs set forth herein to provide assistance to those in financial need including financial assistance/charity care, uninsured patient discounts, and medical indigence discounts and payment caps.
- 1.4 Financial need means documented lack of sufficient financial resources to pay the applicable charge for medical care. Financial need may be evidenced by low household income and asset levels, or high levels of medical debt in relation to household income (medical indigence). Financial need determinations also take into consideration other relevant circumstances, such as employment status or health status of patient or other household members, which may affect a patient's ability to pay. The existence of financial need must be demonstrated by information provided by or on behalf of the patient, and/or other objective data available to the hospital. RHC hospitals may use asset or debt information to assist in making a determination regarding financial need, when income data is unavailable or inconclusive, or reported income is not supported by objective data.
- 1.5 Illinois Resident or Cook County Resident means a person who lives in Illinois (or Cook County as applicable) and intends to remain living in Illinois (or Cook County) indefinitely. Relocation to Illinois or Cook County for the sole purposes of receiving health care benefits does not satisfy the residency requirement.
- 1.6 Illinois Uninsured Patient Discount Act means the hospital uninsured patient discount act, as passed by the Illinois General Assembly in 2008, effective as of April 1, 2009, and as amended from time to time.

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1.7 Medically Necessary Hospital Services means:

- 1.7.1 Except to the extent necessary to determine services subject to the Illinois Underinsured Patient Discount, for purposes of this policy "Medically Necessary Hospital Services" means those hospital services required for the treatment or management of a medical injury, illness, disease or symptom that, if otherwise left untreated, as determined by an independent treating physician or other physician consulted by an RHC Hospital would pose a threat to the patient's ongoing health status, and that would be (a) covered by guidelines for Medicare coverage if the patient were a Medicare beneficiary with the same clinical presentation as the Uninsured Patient; or (b) a discretionary, limited resource program for which the potential for unlimited free care would threaten the hospital's ability to provide such program at all (such as substance and chemical abuse treatment, continuing care for certain chronic diseases, chemotherapy and HIV drugs, other than when provided in connection with other Medically Necessary Hospital Services).
- 1.7.2 Examples of services that are not Medically Necessary Hospital Services include, but are not limited to: (1) cosmetic health services; including elective cosmetic surgery (exclusive of plastic surgery designed to correct disfigurement caused by injury, illness, or congenital defect or deformity); (2) services that are experimental or part of a clinical research program; (3) elective goods or services that are not necessary to treat an illness or injury; (4) private and/or non-RHC medical or physician professional fees; and (5) services and/or treatments not provided at an RHC Hospital; (6) pharmaceuticals or medical equipment, except to the extent required in connection with other medically necessary inpatient or outpatient care being received by a hospital patient; and (7) procedures or services for which the hospital provides a discounted "flat rate" pricing package.

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- 1.8 Non-Retirement Household Liquid Assets includes cash, or non-cash assets that can readily be converted to cash, owned by a member of a household, including savings accounts, investment accounts, stocks, bonds, treasury bills, certificates of deposit and money market accounts, and cash value of life insurance policies. Non-retirement household liquid assets will not include a patient's equity in his or her primary residence or assets held in qualified retirement plan or other similar retirement savings account for which there would be a tax penalty for early withdrawal of savings.
- 1.9 RHC Hospital means a hospital that is part of the not-for-profit, Catholic-sponsored health care system known as "Resurrection Health Care".
- 1.10 RHC Hospital Service Area means, for all hospitals, Cook County and with respect to each individual RHC hospital those portions of any adjacent counties that are within such hospital's defined service area or core community, based on the zip code of a predominant portion of the hospital's patient population.
- 1.11 Uninsured Patient means an individual who is or was a patient of an RHC hospital and at the time of service is or was not (a) covered under a policy of health insurance or (b) not a beneficiary under a public or private health insurance, health benefit, or other health coverage program, including Medicare, Medicaid, TriCare, SCHIP and All-Kids, high deductible health insurance plans, workers' compensation, accident liability insurance, or other third party liability plan.
2. Patient Treatment Standards. All patients of RHC hospitals shall be treated with respect and dignity regardless of their ability to pay for medical care, or their need for charitable assistance.

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3. Financial Assistance/Charity Care and other Financial Assistance Programs

- 3.1 Discount for Low-Income Uninsured Patients. Financial Assistance/Charity Care discounts or discounted fee schedules will be available for Medically Necessary Hospital Services provided to Uninsured Patients who are unable to pay all or part of the otherwise applicable charge for their care due to financial need, as documented in accordance with this Policy. Patients demonstrating financial need based on household income at or below one hundred percent (100%) of the Federal Poverty Level, combined with a general lack of liquid assets, will receive a one hundred percent (100%) discount on Medically Necessary Hospital Services. Patients generally lacking liquid assets who have household income between one hundred percent (100%) and up to four hundred percent (400%) of the Federal Poverty Level will receive a sliding-scale discount for such hospital care, at levels approved by the RHC Executive Leadership Team.
- 3.2 Payment Caps Under Illinois Uninsured Patient Discount Act. To the extent required by the Illinois Uninsured Patient Discount Act, and subject to other eligibility standards and exclusions as set forth by such law including standards based on asset level, Uninsured Patients who are Illinois residents having household income of up to six hundred percent (600%) of the Federal Poverty Level shall not be required to pay to an RHC hospital more than twenty five percent (25%) of such patient's family gross income within a twelve (12) month period.
- 3.3 Other Payment Caps. An Uninsured Patient who is eligible for Financial Assistance/Charity Care at an RHC Hospital pursuant to the criteria set forth in Section 5.1 or 5.3 below shall be eligible for a payment cap based on RHC's

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charitable commitment to catastrophic medical expenses assistance based on medical indigence, as follows:

- 3.3.1 For an eligible Uninsured Patient who demonstrates that s/he has a household income of four hundred percent (400%) or less of the Federal Poverty Level, such patient's payment obligation within any 12-month period will be limited to the higher of: (a) ten percent (10%) of the patient's annual gross household income; or (b) ten percent (10%) of the patient's Non-Retirement Household Liquid Assets.
- 3.3.2 For an eligible Uninsured Patient who demonstrates that s/he has a household income over four hundred percent (400%) of the Federal Poverty Level, or less, such patient's payment obligation within any 12-month period will be limited to the higher of: (a) fifteen percent (15%) of annual gross household income; or (b) fifteen percent (15%) of the patient's Non-Retirement Household Liquid Assets.
- 3.4 Financial Assistance/Charity Care for Insured Patients. Subject to insurance and governmental program restrictions (which may limit the ability to grant a discount on co-pays or deductibles, versus discounts on co-insurance), insured individuals, federal program beneficiaries and other individuals who are not automatically eligible for Financial Assistance/Charity Care hereunder but who demonstrate medical indigence or other financial need, may receive a Financial Assistance/Charity Care discount in similar or different amounts as are available to Uninsured Patients under this policy, as determined appropriate under the circumstances by RHC Patient Financial Services.

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4. Discounts for Uninsured, Medically Indigent Patients. Uninsured Patients whose household income is greater than four hundred percent (400%) of the Federal Poverty Level or who do not meet the automatic eligibility criteria set forth in Section 5 below, will nevertheless be eligible to receive a financial assistance/charity care discount based on a determination of medical indigence, by virtue of having medical bills from an RHC hospital in an amount equal to or greater than fifteen percent (15%) of their household income and available assets. Such Financial Assistance/Charity Care discount for uninsured higher income but medically indigent patients shall be one that is reasonable in relation to the individual patient's household financial circumstances and the health status of the patient and other family members.

5. Eligibility for Financial Assistance Programs
 - 5.1 Automatic Eligibility: Cook County and Adjacent County Residents and Patients Needing Emergency Medical Care. In order to best serve the needs of the low-income and medically underserved members of their respective communities, RHC hospitals' Financial Assistance/Charity Care and other Financial Assistance Programs (other than the RHC uninsured discount, which will be available to all patients irrespective of residence) will be automatically available to all residents (regardless of citizenship or immigration status) of Cook County and those portions of any adjacent counties that are within a hospital's service area, subject to a determination of financial need or other eligibility requirements. In addition, all RHC hospitals will provide financial assistance/charity care discounts to eligible patients in connection with hospital emergency department and other medical services necessary to diagnose, treat or stabilize an emergency medical condition.

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- 5.2 Patient Responsibilities. RHC hospitals may condition receipt of charitable assistance under any Financial Assistance Program on a patient acting reasonably and in good faith, by providing the hospital, within 30 days after the hospital's request, with all reasonably-requested financial and other relevant information and documentation needed to determine the patient's eligibility for assistance, including cooperating with the hospital's financial counselors in applying for coverage under governmental programs, such as Medicaid, accident coverage, crime victims funds, and other public programs that may be available to pay for health care services provided to the patient. In addition, an RHC hospital may, in its discretion, choose not to provide Financial Assistance/Charity Care discounts to voluntarily uninsured individuals who with other household members are at least 50% owners of the business in which they work, if such business had gross receipts in the prior tax year of an amount that is greater than \$200,000.
- 5.3 Discretionary Extension of Financial Assistance. Each RHC hospital is authorized to extend the availability of its Financial Assistance Programs to residents of other Illinois counties, other U.S. states or foreign countries, including travelers or out-of-town visitors, based on reasonable, standardized criteria applicable to all patients of such hospital.
- 5.4 Conditions of Discretionary Financial Assistance Program Participation. For individuals other than those who are automatically eligible to participate in an RHC Financial Assistance Program as set forth in Section 5.1 above, RHC hospitals may, as they determine appropriate, condition the receipt of such financial assistance on disclosure by the patient's immediate relatives, host family or sponsoring organization of their financial information, sufficient to demonstrate ability or inability to pay or contribute to the costs of care for their relative or hosted guest. The hospital may further condition any discretionary grant of financial assistance on a contribution toward the costs of the patient's

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care and/or a guarantee of payment by such relatives, hosts or others (as applicable), in the event the patient fails to qualify for coverage through governmental or private insurance and the patient fails to pay the amounts for which s/he is responsible. The hospital may also take into consideration the availability of other options for the proposed patient to receive medical care.

6. Uninsured Patient Discounts

- 6.1 Charitable Need for Uninsured Patient Discount. RHC believes that a substantial portion of uninsured individuals who seek hospital care are uninsured involuntarily, due to financial need, and further, that because of their uninsured status and inability to pay, many uninsured individuals delay or refrain from seeking needed medical care. RHC also believes, based on the experience of its hospitals in asking patients to apply for Financial Assistance/Charity Care discounts, that due to privacy and other concerns many uninsured individuals with financial need will not provide sufficient information to enable RHC hospitals to verify the existence of financial need.
- 6.2 RHC Charitable Uninsured Patient Discount. Therefore, as part of their charitable commitment to the poor and underserved, RHC hospitals will provide a discount on hospital charges to all Uninsured Patients, irrespective of residency, location or any other criteria, equal to 25% of the hospital charge for which the Uninsured Patient is responsible. If an Uninsured Patient also qualifies for a discount under the hospital's Financial Assistance/Charity Care standards, the amount of such discount will be applied to the patient's charge after application of the uninsured discount. Such RHC uninsured patient discount will not apply to any patient who qualifies for a discount under the Illinois Uninsured Patient Discount Act.

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6.3 Discount Under Illinois Uninsured Patient Discount Act. To the extent required by law, RHC hospitals shall provide an alternative form of discount to uninsured Illinois residents with gross family income of up to 600% of the Federal Poverty Level, and the 25% uninsured discount methodology set forth above shall not apply to any portion of such patients' bill.

6.4 Eligibility for Additional Financial Assistance. Patients receiving a discount based on uninsured status, whether under the RHC Charitable Uninsured Discount or pursuant to the Illinois Uninsured Patient Act, shall be eligible for an additional financial assistance described in this policy, pursuant to the eligibility standards set forth herein.

7. Hospital Responsibilities for Communicating Availability of Financial Assistance/Charity Care and Other Charitable Assistance Programs

7.1 Communicating Availability of Financial Assistance/Charity Care Discounts. Each RHC hospital will maintain effective methods of communicating the availability of Financial Assistance/Charity Care discounts to all patients, in multiple appropriate media and in multiple appropriate languages. The mechanisms that the Hospital will use to communicate the availability of Financial Assistance/Charity Care will include, but are not limited to the following:

7.1.1 Signage. Signs shall be conspicuously posted in the admission, registration and other appropriate areas of the hospital stating that patients may be eligible for Financial Assistance/Charity Care discounts, and describing how to obtain more information, including identification of appropriate hospital representatives by title. Such signs shall be prepared

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in English, Spanish, and any other language that is the primary language of at least 5% of the patients served by the hospital annually.

- 7.1.2 Provision of Financial Assistance Materials to Uninsured Patients. RHC hospitals will provide a summary of its Financial Assistance Programs and a Financial Assistance application to all persons receiving hospital care that it identifies as Uninsured Patients at the time of in-person registration, admission, or such later time at which the patient is first identified as an Uninsured Patient. For patients presenting in the Emergency Department, all RHC hospitals will provide such Financial Assistance materials at such time and in such manner as is consistent with their obligations under EMTALA to assess and stabilize the patient before making inquiry of the patient's ability to pay.
- 7.1.3 Brochures. Brochures, information sheets and/or similar forms of written communication regarding the hospital's Financial Assistance/Charity Care policy shall be maintained in appropriate areas of the hospital (e.g., the Emergency Department, organized registration areas, and the Business Office) stating in at least English, Spanish and Polish, that the hospital offers Financial Assistance/Charity Care discounts, and describing how to obtain more information.
- 7.1.4 Website. Each RHC's section of the Resurrection Health Care website must include: a notice in a prominent place that financial assistance is available at the hospital; a description of the financial assistance application process; and a copy of the RHC hospital financial assistance application form.

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7.1.5 Billing Notices. Each RHC hospital shall include a note on or with the Hospital bill and/or statement regarding the hospital's Financial Assistance/Charity Care program, and how the patient may apply for consideration under this program.

7.1.6 Financial Counselors. Each RHC hospital shall have one or more financial counselors whose contact information is listed or provided with other information concerning the hospital's Financial Assistance/Charity Care discount program, who are available to discuss eligibility and other questions concerning the program, and to provide assistance with applications.

8. Communication with Patients Regarding Eligibility Determination for Financial Assistance/Charity Care.

8.1 Notification of Determination. When an RHC hospital has made a determination that a patient's bill will be discounted or adjusted in whole or in part based on a determination of financial need, the hospital will notify the patient of such eligibility determination, and that there will be no further collection action taken on the discounted portion of the patient's bill.

8.2 Changes in Patient Financials Circumstances. Adverse changes on the patient's financial circumstances may result in an increase in any Financial Assistance/Charity Care discount provided by the hospital. Under no condition, however, would adverse or other changes in a patient's financial circumstances affect the hospital's continuation of any ongoing treatment during an episode of care.

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9. Application of Financial Assistance/Charity Care Determination to Past-Due Bills. When a patient has been granted a discount on his or her bill under the hospital's Financial Assistance/Charity Care program, the hospital will automatically apply a similar discount or adjustment to all other outstanding patient bills. The hospital will advise the patient of such adjustment of prior accounts, and that the hospital will forego any further attempted to collect the amounts written off on such accounts.
10. Updating Prior Financial Need Determinations
- 10.1 Effective Time of Financial Assistance Qualification Determination. A determination of a patient's household income in connection with the patient's qualification for any form of Financial Assistance under this Policy will remain in effect the patient's entire episode of care, provided that if an episode of care continues for more than thirty (30) days, the hospital may request the patient to re-verify or supplement household income information or other eligibility information as the hospital reasonably deems appropriate, including cooperating with the hospital financial counselor to re-evaluate the patient's potential eligibility for coverage under Medicaid or other governmental programs and for the hospital's Financial Assistance/Charity Care program.
- 10.2 Re-Verification Within Six Months. When a patient (or the member of the household of a patient) who has received a determination of financial need under an RHC hospital's Financial Assistance/Charity Care program subsequently receives or applies for care from the same or any other RHC hospital more than 30 days but less than 6 months later, the hospital shall request appropriate information necessary to update the patient's or prospective patient's Financial Assistance/Charity Care application and re-verify the prior financial need determination. Hospital Financial Counselors will work with the patient to make the updating process as convenient as possible while assuring accuracy of

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information. The hospital shall consider the patient's (or prospective patient's) eligibility for Financial Assistance/Charity Care based on current income and assets, and other objective information obtained by the hospital relating to financial need, such as credit reports, new W-2s, tax returns or other data.

- 10.3 New Application Requirements. If more than six (6) months has expired since a patient's Financial Assistance eligibility determination, the patient must submit a new Financial Assistance application.
11. Financial Assistance/Charity Care Determinations Required Prior to Non-Emergency Services. RHC hospitals will make all reasonable efforts to expedite the evaluation of patients for eligibility for coverage under governmental programs and otherwise for Financial Assistance/Charity Care. Such evaluations must generally be made by an RHC hospital prior to provision of non-emergency hospital services. Persons who have come to a RHC hospital emergency department seeking care for a potential emergency medical condition will first receive a medical screening exam conducted in compliance with the Emergency Medical Treatment and Active Labor Act, as amended (EMTALA) and all care needed to stabilize any emergency medical condition, prior to an evaluation for coverage eligibility under governmental programs or Financial Assistance/Charity Care.
12. Staff Training and Understanding of Hospital Financial Assistance/Charity Care Program
- 12.1 General Program Knowledge. Employed staff of each RHC hospitals shall be trained, at the levels appropriate to their job function, with respect to the availability of the Financial Assistance/Charity Care discount program offered by such hospital for the benefit of poor and underserved members of such hospital's community.

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- 12.2 Specific Program Knowledge. Hospital staff who regularly interact with patients, including all staff in each hospital's Patient Financial Services, Patient Access and Registration departments will understand the hospital's Financial Assistance/Charity Care discount program, and be able to either accurately answer questions or direct questions regarding such programs to financial counselors or other contact persons.
- 12.3 Annual Training. All Patient Financial Services and Access department staff, and other applicable staff shall attend an annual in-service on the RHC hospital Financial Assistance/Charity Care discount program for RHC hospitals, which will be prepared and supervised by the RHC Finance Division, in consultation with the RHC Office of Legal Affairs, the System Compliance Officer and hospital senior management.
13. Collection Activity
- 13.1 General. All RHC hospitals shall engage in reasonable collection activities for collection of the portions of bills for which patients are responsible after application of any Financial Assistance/Charity Care discount, uninsured patient discount, insurance allowances and payment and other applicable adjustments.
- 13.2 Cessation of Collection Efforts on Discounted Amounts. No RHC hospital will engage in or direct collections activity with respect to any discounts on health care charges provided as a result of a determination of eligibility under the hospital's Financial Assistance/Charity Care program, unless it is later determined that the patient omitted relevant information relating to actual income or available assets, or provided false information regarding financial need or other eligibility

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criteria. Balances remaining after financial assistance discounts are applied will be subject to reasonable collection activity, consistent with this Policy.

- 13.3 Use of Reasonable Legal Processes to Enforce Patient Debt. Reasonable legal process, including the garnishment of wages, may be taken by any RHC Hospital to collect any patient debt remaining after any adjustment or discount for Financial Assistance/Charity Care, uninsured status or other reason, under the following circumstances:

13.3.1 For Uninsured Patients:

- The hospital has given the patient the opportunity to assess the accuracy of the hospital's bill;
- The hospital has given the Uninsured Patient the opportunity to apply for Financial Assistance/Charity Care and/or (a) a reasonable payment plan, or (b) a discount for which the patient is eligible pursuant to the Illinois Patient Uninsured Discount Act;
- The hospital has given the Uninsured Patient at least 60 days after discharge or receipt of services to apply for Financial Assistance/Charity Care;
- If the patient has indicated, and the hospital is able to verify, that the patient is unable to pay the full amount due in one payment, the hospital has offered the patient a reasonable payment plan;
- If the hospital and patient have entered into a reasonable payment plan, the patient has failed to make payments when due; and
- There is objective evidence that the patient's household income and/or assets are sufficient to meet his or her financial obligation to the hospital.

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13.3.2 For Insured Patients:

- The hospital has provided the patient the opportunity, for at least 30 days after the date of the initial bill, to request a reasonable payment plan for the portion of the bill for which the patient is responsible;
- If the patient requests a reasonable payment plan, and fails to agree to a plan within 30 days after such request; and
- If the hospital and patient have entered into a reasonable payment plan, the patient has failed to make payments when due.

13.4 Residential Liens. No RHC hospital will place a lien on the primary residence of a patient who has been determined to be eligible for Financial Assistance/Charity Care, for payment of the patient's undiscounted balance due. Further, consistent with long-standing RHC policy, in no case will any RHC provider execute a lien by forcing the sale or foreclosure of the primary residence of any patient to pay for any outstanding medical bill.

13.5 No Use of Body Attachments. In accordance with long-standing practice, no RHC hospital will use body attachment to require any person, whether receiving Financial Assistance/Charity Care discounts or not, to appear in court.

13.6 Collection Agency Referrals. RHC hospitals will ensure that all collection agencies used to collect patient bills promptly refer any patient who indicates financial need, or otherwise appears to qualify for Financial Assistance/Charity Care discounts, to a financial counselor to determine if the patient is eligible for such a charitable discount.

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, Our Lady of the Resurrection 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 Our Lady of the Resurrection 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 Our Lady of the Resurrection 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 Our Lady of the Resurrection Medical Center to each of the other hospitals in the Health Care System.

Proximity of Our Lady of Resurrection Med. Ctr. (5645 West Addison Street Chicago) to:			Miles	Minutes
Saint Francis Hospital	355 Ridge Avenue	Evanston	10.2	24
Resurrection Medical Center	7435 W. Talcott Avenue	Chicago	5.9	13
Saint Mary of Nazareth Hospital and St. Elizabeth's Med. Ctr.	2233 W. Division Street	Chicago	8.1	18
Saint Joseph Hospital	2900 N. Lake Shore Drive	Chicago	8	22
Holy Family Medical Center	100 North River Road	Des Plaines	13.5	23
Provena United Samaritans Med. Ctr.	812 North Logan Street	Danville	178.5	191
Provena Covenant Medical Center	1400 West Park Avenue	Urbana	147.5	161
Provena Mercy Medical Center	1325 N. Highland Avenue	Aurora	41.5	59
Provena Saint Joseph Hospital	77 North Airlite Street	Elgin	37.4	53
Provena Saint Joseph Medical Ctr.	333 North Madison Street	Joliet	52.1	72
Provena St. Mary's Hospital	500 West Court Street	Kankakee	68.96	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 Our Lady of the Resurrection 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 Our Lady of the Resurrection 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 Our Lady of the Resurrection Medical Center and each hospital with which OLRMC maintains a referral agreement.

Referral Site	Service	Miles*	Minutes*
Chicago-Read Mental Health Center 42 N. Oak Park Ave. Chicago	AMI	2.4	7
Children's Memorial Hospital 2300 Children's Plaza Chicago	pediatrics	6.8	18
Loyola University Medical Center 2160 S. First Ave. Maywood	perinatal	9.4	23
St. Francis Hospital 355 Ridge Avenue Evanston	open heart surgery	9.9	25

*MapQuest (unadjusted) March 3, 2011

Duplication of Services

As certified in this application, the applicants fully intend to retain Our Lady of the Resurrection Medical Center's clinical programmatic complement for a minimum of two years. An initial evaluation of the clinical services provided by Our Lady of the Resurrection 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, Our Lady of the Resurrection Medical Center is a primary provider of both hospital- and community-based health care programs in its community, and it is the intent of the applicants to provide a very similar community-based program complement,

understanding that in the case of all hospitals, the complement of community programs is not static, and that from time-to-time programs are added or eliminated.

Ownership, Management and General Information

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

Patients by Race

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

Patients by Ethnicity

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

CITY: Chicago

COUNTY: Suburban Cook (Chicago)

Facility Utilization Data by Category of Service

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

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Pavor Source

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

Financial Year Reported:	7/1/2008 to	6/30/2009	Inpatient and Outpatient Net Revenue by Payor Source					Charity Care Expense	Total Charity Care Expense
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals			
Inpatient Revenue (\$)	65.7%	4.3%	0.0%	28.6%	1.4%	100.0%	1,195,049	1,869,515	
Outpatient Revenue (\$)	26.9%	6.1%	0.0%	64.8%	2.3%	100.0%	674,466	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
Dedicated Observation	0					0				
Facility Utilization	271			8,473	39,293	4,480	5.2	119.9	44.3	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	48.1%	21.3%	0.0%	25.8%	3.3%	1.5%	8,473
	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		
Outpatient Revenue (\$)	17.6%	10.5%	0.0%	58.3%	13.6%	100.0%	1,461,036	2.0%	
	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
Laboratory Studies
 Inpatient Studies 402,225
 Outpatient Studies 229,844
 Studies Performed Under Contract 7,672

Organ Transplantation

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

* Note: On 4/22/2009, Board approved the voluntary reduction of 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	2
Number of Trauma Visits:	851
Patients Admitted from Trauma	491
Emergency Service Type:	Comprehensive
Number of Emergency Room Stations	20
Persons Treated by Emergency Services:	34,500
Patients Admitted from Emergency:	5,956
Total ED Visits (Emergency+Trauma):	35,351

Cardiac Catheterization Utilization

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

Cardiac Surgery Data

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

Outpatient Service Data

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

Diagnostic/Interventional Equipment

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

Ownership, Management and General Information

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

Patients by Race

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

Patients by Ethnicity

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

CITY: Chicago

COUNTY: Suburban Cook (Chicago)

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2009	Staff Bed Occupancy Rate %
Medical/Surgical	186	186	152	10,373	48,081	3,623	5.0	141.7	76.2	76.2
0-14 Years				10	20					
15-44 Years				2,528	8,045					
45-64 Years				3,883	17,282					
65-74 Years				1,831	9,616					
75 Years +				2,121	13,118					
Pediatric	14	14	14	925	2,092	535	2.8	7.2	51.4	51.4
Intensive Care	32	32	30	2,010	7,979	5	4.0	21.9	68.4	68.4
Direct Admission				1,204	4,536					
Transfers				806	3,443					
Obstetric/Gynecology	20	20	20	2,199	5,113	235	2.4	14.7	73.3	73.3
Maternity				2,193	5,103					
Clean Gynecology				6	10					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	120	120	120	3,968	34,495	0	8.7	94.5	78.8	78.8
Rehabilitation	15	15	15	325	3,847	0	11.8	10.5	70.3	70.3
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
<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 2,662,595
	7/1/2008 to	6/30/2009	Medicare	Medicaid	Other Public	Private Insurance		
Inpatient Revenue (\$)	36.8%	34.8%	0.0%	18.9%	9.5%	100.0%	1,394,629	Totals: Charity Care as % of Net Revenue
	64,870,370	61,419,970	0	33,285,730	16,816,201	176,392,271		
Outpatient Revenue (\$)	16.6%	32.9%	0.0%	31.8%	18.7%	100.0%	1,267,966	1.1%
	11,265,066	22,276,179	0	21,509,882	12,633,284	67,684,411		

Birthing Data

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

Newborn Nursery Utilization

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

Laboratory Studies

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

Organ Transplantation

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

Surgery and Operating Room Utilization

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

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

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

Cardiac Catheterization Labs

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

Emergency/Trauma Care

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

Cardiac Catheterization Utilization

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

Cardiac Surgery Data

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

Outpatient Service Data

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

Diagnostic/Interventional Equipment

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

Radiation Equipment

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

Ownership, Management and General Information

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

Patients by Race

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

Patients by Ethnicity

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

CITY: Chicago

COUNTY: Suburban Cook (Chicago)

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2009	Staff Bed Occupancy Rate %
Medical/Surgical	219	186	186	7,862	36,064	2,485	4.9	105.6	48.2	56.8
0-14 Years				1	6					
15-44 Years				1,901	9,333					
45-64 Years				2,550	11,595					
65-74 Years				1,060	4,252					
75 Years +				2,350	10,878					
Pediatric	11	7	7	293	754	137	3.0	2.4	22.2	34.9
Intensive Care	23	21	21	1,587	6,734	65	4.3	18.6	81.0	88.7
Direct Admission				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
Dedicated Observation	0					0				
Facility Utilization	360			13,188	67,634	2,791	5.3	192.9	53.6	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	43.6%	16.2%	0.2%	37.7%	1.2%	1.1%	13,188
	5747	2142	22	4972	161	144	
Outpatients	25.2%	15.8%	0.1%	52.9%	5.1%	1.0%	188,191
	47383	29662	158	99559	9558	1871	

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 (\$)	46.8%	13.9%	0.0%	36.8%	2.5%	100.0%	652,789	1,487,625
	64,832,024	19,290,122	0	51,002,179	3,520,673	138,644,998		Totals: Charity Care as % of Net Revenue
Outpatient Revenue (\$)	16.1%	3.6%	0.0%	72.0%	8.2%	100.0%	834,836	0.8%
	8,703,376	1,963,278	0	38,807,662	4,430,471	53,904,787		

Birthing Data

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

Newborn Nursery Utilization

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

Organ Transplantation

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

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

Surgery and Operating Room Utilization

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

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

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

Cardiac Catheterization Labs

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

Emergency/Trauma Care

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

Cardiac Catheterization Utilization

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

Cardiac Surgery Data

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

Outpatient Service Data

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

Diagnostic/Interventional Equipment

	Examinations				Radiation Equipment			Therapies/ Treatments
	Owned	Contract	Inpatient	Outpatient	Owned	Contract		
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 390,005
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals			
Inpatient Revenue (\$)	23.9%	70.1%	0.0%	5.5%	0.6%	100.0%	322,570	Totals: Charity Care as % of Net Revenue 0.7%	
	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%	67,435		
	3,057,316	8,058,125	0	6,755,379	838,631	18,709,451			

Birthing Data

Number of Total Births: 0
 Number of Live Births: 0
 Birthing Rooms: 0
 Labor Rooms: 0
 Delivery Rooms: 0
 Labor-Delivery-Recovery Rooms: 0
 Labor-Delivery-Recovery-Postpartum Rooms: 0
 C-Section Rooms: 0
 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
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Dedicated and Non-Dedicated Procedure Room Utilization

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

Cardiac Catheterization Labs

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

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/ Treatments
	Owned	Contract	Inpatient	Outpatient	Owned	Contract		
General Radiography/Fluoroscopy	7	0	860	8,260	Lithotripsy	1	1	34
Nuclear Medicine	0	0	0	0	Linear Accelerator	0	0	0
Mammography	1	0	0	3,110	Image Guided Rad Therapy	0	0	0
Ultrasound	2	0	109	274	Intensity Modulated Rad Therap	0	0	0
Diagnostic Angiography	0	0	0	0	High Dose Brachytherapy	0	0	0
Interventional Angiography	0	0	0	0	Proton Beam Therapy	0	0	0
Positron Emission Tomography (PET)	0	0	0	0	Gamma Knife	0	0	0
Computerized Axial Tomography (CAT)	1	0	112	552	Cyber knife	0	0	0
Magnetic Resonance Imaging	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
Dedicated Observation	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:	Inpatient and Outpatient Net Revenue by Payor Source						Charity Care Expense	Total Charity Care Expense
	7/1/2008 to	6/30/2009	Medicare	Medicaid	Other Public	Private Insurance		
Inpatient Revenue (\$)	55.8%	5.8%	0.0%	17.8%	20.6%	100.0%	922,725	1,613,275
	45,372,692	4,707,203	0	14,436,297	16,788,176	81,304,368		
Outpatient Revenue (\$)	19.2%	13.3%	0.0%	31.7%	35.7%	100.0%	690,550	1.2%
	10,380,455	7,196,801	0	17,126,806	19,287,337	53,991,399		

Birthing Data		Newborn Nursery Utilization		Organ Transplantation	
Number of Total Births:	1	Level 1 Patient Days	0	Kidney:	0
Number of Live Births:	1	Level 2 Patient Days	0	Heart:	0
Birthing Rooms:	0	Level 2+ Patient Days	0	Lung:	0
Labor Rooms:	0	Total Nursery Patientdays	0	Heart/Lung:	0
Delivery Rooms:	0			Pancreas:	0
Labor-Delivery-Recovery Rooms:	0	Laboratory Studies		Liver:	0
Labor-Delivery-Recovery-Postpartum Rooms:	0	Inpatient Studies	396,802	Total:	0
C-Section Rooms:	0	Outpatient Studies	297,369		
CSections Performed:	0	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
<i>Gastrointestinal</i>	1	1	0	2	1148	1403	1200	1501	2701	1.0	1.1
<i>Laser Eye Procedures</i>	0	0	0	0	0	0	0	0	0	0.0	0.0
<i>Pain Management</i>	0	1	0	1	0	1225	0	18375	18375	0.0	15.0
<i>Cystoscopy</i>	0	0	1	1	141	169	191	196	387	1.4	1.2
Multipurpose Non-Dedicated Rooms											
Minor/Local Procedur	0	1	0	1	0	89	0	59	59	0.0	0.7
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

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

Emergency/Trauma Care

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

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	625
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	479
Interventional Catheterizations (0-14):	0
Interventional 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
	Owned	Contract	Inpatient	Outpatient	
General Radiography/Fluoroscopy	7	0	13,247	29,193	Lithotripsy 0 0 0
Nuclear Medicine	2	0	1,666	2,499	Linear Accelerator 0 0 0
Mammography	2	0	8	4,544	Image Guided Rad Therapy 0 0 0
Ultrasound	4	0	3,487	6,636	Intensity Modulated Rad Therap 0 0 0
Diagnostic Angiography	0	0	0	0	High Dose Brachytherapy 0 0 0
Interventional Angiography	0	0	0	0	Proton Beam Therapy 0 0 0
Positron Emission Tomography (PET)	0	0	0	0	Gamma Knife 0 0 0
Computerized Axial Tomography (CAT)	2	0	4,225	15,489	Cyber knife 0 0 0
Magnetic Resonance Imaging	1	1	922	1,555	

Ownership, Management and General Information

ADMINISTRATOR NAME: John Baird
 ADMINSTRATOR PHONE: 847-813-3161
 OWNERSHIP: Holy Family Medical Center
 OPERATOR: Holy Family Medical Center
 MANAGEMENT: Not for Profit Corporation
 CERTIFICATION: LongTerm 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
	33.6%	14.0%	0.0%	48.9%	1.2%	2.3%	
Inpatients	525	218	0	763	19	36	1,561
	32.0%	24.6%	0.0%	38.5%	4.2%	0.6%	
Outpatients	7164	5521	11	8624	950	135	22,405

Financial Year Reported:	7/1/2008 to	6/30/2009	Inpatient and Outpatient Net Revenue by Payor Source					Charity Care Expense	Total Charity Care Expense
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals			
Inpatient Revenue (\$)	49.7%	15.0%	0.0%	30.0%	5.3%	100.0%	184,754	186,520	
	31,307,091	9,452,199	0	18,919,331	3,353,949	63,032,570		Totals: Charity Care as % of Net Revenue	
Outpatient Revenue (\$)	49.7%	15.0%	0.0%	30.0%	5.3%	100.0%	1,766	0.3%	
	5,291,206	1,597,515	0	3,197,553	566,851	10,653,125			

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). Attached exhibit 10C shows 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
Gastrointestinal	0	0	3	3	13	103	12	89	101	0.9	0.9
Laser Eye Procedures	0	0	1	1	0	145	0	37	37	0.0	0.3
Pain Management	0	0	0	0	0	0	0	0	0	0.0	0.0
Cystoscopy	0	0	1	1	7	0	9	0	9	1.3	0.0
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

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

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 Catheterization (15+) 0
 EP Catheterizations (15+) 0

Cardiac Surgery Data

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

Outpatient Service Data

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

Diagnostic/Interventional Equipment

Examinations

Radiation Equipment

Therapies/

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

Ownership, Management and General Information

ADMINISTRATOR NAME: Mike Brown
ADMINSTRATOR PHONE: 217-443-5201
OWNERSHIP: Provena Health
OPERATOR: Provena Health
MANAGEMENT: Church-Related
CERTIFICATION: None
FACILITY DESIGNATION: General Hospital

Patients by Race

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

Patients by Ethnicity

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

ADDRESS: 812 North Logan Street **CITY:** Danville **COUNTY:** Vermilion County

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2009	Staff Bed Occupancy Rate %
Medical/Surgical	134	82	76	4,629	19,701	3,248	5.0	62.9	46.9	76.7
0-14 Years				0	0					
15-44 Years				708	2,035					
45-64 Years				1,318	5,251					
65-74 Years				830	3,906					
75 Years +				1,773	8,509					
Pediatric	9	8	8	168	329	94	2.5	1.2	12.9	14.5
Intensive Care	14	12	12	996	1,910	46	2.0	5.4	38.3	44.7
Direct Admission				642	1,231					
Transfers				354	679					
Obstetric/Gynecology	17	15	15	1,051	2,065	120	2.1	6.0	35.2	39.9
Maternity				916	1,738					
Clean Gynecology				135	327					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
<i>Dedicated Observation</i>	0					0				
Facility Utilization	174			6,490	24,005	3,608	4.2	75.4	43.3	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

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

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

Birthing Data

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

Newborn Nursery Utilization

Level 1 Patient Days 1,217
 Level 2 Patient Days 33
 Level 2+ Patient Days 0
 Total Nursery Patientdays 1,250

Organ Transplantation

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

Laboratory Studies

Inpatient Studies 476,188
 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 was not available for 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:	56
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	56
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	0
EP Catheterizations (15+)	0

Emergency/Trauma Care

Certified Trauma Center by EMS	<input type="checkbox"/>
Level of Trauma Service	Level 1 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	
General Radiography/Fluoroscopy	6	0	8,830	23,841	Lithotripsy 0 0 0
Nuclear Medicina	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
 Black
 American Indian
 Asian
 Hawaiian/ Pacific
 Unknown:

82.4%
 14.0%
 0.1%
 1.2%
 0.0%
 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 Payor 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 Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals	Charity Care Expense	Total Charity Care Expense
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

Organ Transplantation

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

Laboratory Studies

Inpatient Studies: 225,927
 Outpatient Studies: 271,900
 Studies Performed Under Contract: 58,884

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

ATTACHMENT

Surgery and Operating Room Utilization

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

SURGICAL RECOVERY STATIONS Stage 1 Recovery Stations 15 Stage 2 Recovery Stations 0

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
Dedicated Observation	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	38.6% 3809	27.3% 2838	0.5% 55	30.2% 3140	3.2% 335	2.1% 220	10,397
Outpatients	15.9% 14809	30.9% 28825	0.6% 557	32.2% 29986	17.8% 16615	2.6% 2462	93,254

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 5,367,773
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals			
Inpatient Revenue (\$)	39.1% 30,667,645	33.6% 26,391,096	0.4% 350,575	24.9% 19,532,576	1.9% 1,501,912	100.0% 78,443,804	2,638,341	Totals: Charity Care as % of Net Revenue 3.2%	
Outpatient Revenue (\$)	17.1% 15,493,796	23.7% 21,553,255	0.4% 323,234	54.8% 49,733,701	4.1% 3,677,093	100.0% 90,781,079	2,729,432		

Birthing Data

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

Newborn Nursery Utilization

Level 1 Patient Days: 1,746
 Level 2 Patient Days: 989
 Level 2+ Patient Days: 0
 Total Nursery Patientdays: 2,735

Organ Transplantation

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

Laboratory Studies

Inpatient Studies: 238,354
 Outpatient Studies: 122,789
 Studies Performed Under Contract: 28,893

* 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

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

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

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:	0
Patients Admitted from Trauma	658
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 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

Radiation Equipment

Therapies/

	Owned		Contract		Inpatient	Outpatient	Owned		Contract		Therapies/ Treatments
General Radiography/Fluoroscopy	4	0	12,923	26,254			Lithotripsy	0	1	20	
Nuclear Medicine	2	0	1,035	3,306			Linear Accelerator	0	0	0	
Mammography	2	0	0	3,497			Image Guided Rad Therapy	0	0	0	
Ultrasound	3	0	2,531	9,994			Intensity Modulated Rad Therap	0	0	0	
Diagnostic Angiography	0	0	0	0			High Dose Brachytherapy	0	0	0	
Interventional Angiography	0	0	0	0			Proton Beam Therapy	0	0	0	
Positron Emission Tomography (PET)	0	0	0	0			Gamma Knife	0	0	0	
Computerized Axial Tomography (CAT)	3	0	4,665	13,917			Cyber knife	0	0	0	
Magnetic Resonance Imaging	2	0	658	2,465							

Ownership, Management and General Information

ADMINISTRATOR NAME: Stephen O. Scogna
ADMINSTRATOR 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	Admlsions	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						Charity Care Expense	Total Charity Care Expense				
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals	Charity Care Expense							
Inpatient Revenue (\$)	62.0%	17.7%	0.3%	28.1%	1.9%	100.0%	39,020,448	13,249,904	210,860	21,061,538	1,439,586	74,982,336	1,675,691	3,749,548
Outpatient Revenue (\$)	22.5%	14.4%	0.4%	60.1%	2.6%	100.0%	20,044,749	12,794,644	327,225	53,398,003	2,348,798	88,913,419	2,073,857	2.3%

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

Organ Transplantation

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

Laboratory Studies

Inpatient Studies 238,112
 Outpatient Studies 152,236
 Studies Performed Under Contract 80,753

* Note: According to project #09-033, approved on 10/13/09, facility discontinued 15 bed OB category of service. The data shown is prior to its discontinuation. Actual Cost of Services Provided to Charity Care Inpatients and Outpatients was calculated using the 2009 IRS 990 Schedule H instructions to determine the cost to charge ratio. This methodology was used because the 2009 Medicare Cost Report was not available until 190 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	6901	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
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

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

Emergency/Trauma Care

Certified Trauma Center by EMS	<input checked="" type="checkbox"/>
Level of Trauma Service	Level 1 Adult
Level of Trauma Service	Level 2 ---
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

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

Patients by Race

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

Patients by Ethnicity

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

CITY: Joliet

COUNTY: Will County

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Dally 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 Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	46.0%	13.4%	0.9%	34.5%	3.2%	2.0%	23,475
	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:	Inpatient and Outpatient Net Revenue by Payor Source							Charity Care Expense	Total Charity Care Expense
	1/1/2009 to	12/31/2009	Medicare	Medicaid	Other Public	Private Insurance	Private Pay		
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

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

Newborn Nursery Utilization

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

Organ Transplantation

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

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

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

SURGICAL RECOVERY STATIONS	Stage 1 Recovery Stations	Stage 2 Recovery Stations
	10	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	506,576
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

<u>Clinical Service</u>	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	

<u>Financial Year Reported:</u>	1/1/2009 to 12/31/2009		<u>Inpatient and Outpatient Net Revenue by Payor Source</u>					Charity Care Expense	Total Charity Care Expense
	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	2,657,530	
	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			

<u>Birthing Data</u>		<u>Newborn Nursery Utilization</u>		<u>Organ Transplantation</u>	
Number of Total Births:	424	Level 1 Patient Days	781	Kidney:	0
Number of Live Births:	420	Level 2 Patient Days	242	Heart:	0
Birthing Rooms:	0	Level 2+ Patient Days	20	Lung:	0
Labor Rooms:	0	Total Nursery Patientdays	1,043	Heart/Lung:	0
Delivery Rooms:	0			Pancreas:	0
Labor-Delivery-Recovery Rooms:	1	<u>Laboratory Studies</u>		Liver:	0
Labor-Delivery-Recovery-Postpartum Rooms:	4	Inpatient Studies	167,326	Total:	0
C-Section Rooms:	1	Outpatient Studies	204,947		
CSections Performed:	116	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 until after 4/30/09 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	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

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	658
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	522
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	113
EP Catheterizations (15+)	23

Emergency/Trauma Care

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

Cardiac 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	Owned	Contract		
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	488	433	921
Charity Care	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
 4/28/2010

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
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	Residents on 1/1/2009	
									Residents on 1/1/2009	Total Admissions 2009
Nursing Care	73	73	69	73	69	4	73	16	113	484
Skilled Under 22	0	0	0	0	0	0	0	0	0	475
Intermediate DD	0	0	0	0	0	0	0	0	0	122
Sheltered Care	61	61	53	61	53	8	0	0	0	0
TOTAL BEDS	134	134	122	134	122	12	73	16	113	122

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		Beds	Set Up
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 CENTER3330 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	Other			Private Insurance	Charity Care	TOTALS	
	Medicare	Medicaid	Public				
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

No
No

FACILITY OWNERSHIP

NON-PROF CORPORATION

CONTINUING CARE COMMUNITY

LIFE CARE FACILITY

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 'I'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS
Neoplasms 0
Endocrine/Metabolic 1
Blood Disorders 0
*Nervous System Non Alzheimer 5
Alzheimer Disease 24
Mental Illness 11
Developmental Disability 1
Circulatory System 10
Respiratory System 10
Digestive System 3
Genitourinary System Disorders 1
Skin Disorders 0
Musculo-skeletal Disorders 2
Injuries and Poisonings 1
Other Medical Conditions 12
Non-Medical Conditions 0
TOTALS 81

Total Residents Diagnosed as Mentally Ill 15

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

ADMISSIONS AND DISCHARGES - 2009

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	ADMISSIONS AND DISCHARGES - 2009	
									Residents on 1/1/2009	
Nursing Care	107	106	106	106	81	26	63	69	89	190
Skilled Under 22	0	0	0	0	0	0	0	0		198
Intermediate DD	0	0	0	0	0	0	0	0		81
Sheltered Care	0	0	0	0	0	0	0	0		0
TOTAL BEDS	107	106	106	106	81	26	63	69		
									Residents on 12/31/2009	81
									Identified Offenders	0

FACILITY UTILIZATION - 2009

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

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

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

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

PROVENA GENEVA CARE CENTER

1101 EAST STATE STREET
GENEVA, IL. 60134

Reference Numbers Facility ID 6003503

Health Service Area 008 Planning Service Area 089

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

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

AVERAGE DAILY PAYMENT RATES

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

RESIDENTS BY RACIAL/ETHNICITY GROUPING

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

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

STAFFING

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

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

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

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

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

LEVEL OF CARE	LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS							ADMISSIONS AND DISCHARGES - 2009		
	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	Residents on 1/1/2009	
Nursing Care	51	51	51	51	42	9	51	0	72	
Skilled Under 22	0	0	0	0	0	0		0	225	
Intermediate DD	0	0	0	0	0	0		0	223	
Sheltered Care	79	36	36	36	32	47			74	
TOTAL BEDS	130	87	87	87	74	56	51	0		Identified Offenders 0

LEVEL OF CARE	FACILITY UTILIZATION - 2009									TOTAL	Licensed Beds Occ. Pct.	Peak Beds Set Up Occ. Pct.
	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care				
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.	Pat. days	Pat. days	Pat. days	Pat. days	Pat. days			
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%	

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	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

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

Administrator
 Jennifer Roach

Contact Person and Telephone
 Bill Erue
 630-859-3700

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

FACILITY OWNERSHIP
 NON-PROF CORPORATION

CONTINUING CARE COMMUNITY No
LIFE CARE FACILITY No

ADMISSION RESTRICTIONS

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

Note: Reported restrictions denoted by '1'

RESIDENTS BY PRIMARY DIAGNOSIS

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

Total Residents Diagnosed as Mentally Ill 1

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

ADMISSIONS AND DISCHARGES - 2009

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

FACILITY UTILIZATION - 2009

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

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

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

AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	1	0	0	0	0	0	0	0	1	0	1
45 to 59	0	1	0	0	0	0	0	0	0	1	1
60 to 64	2	0	0	0	0	0	0	0	2	0	2
65 to 74	5	1	0	0	0	0	0	0	5	1	6
75 to 84	5	10	0	0	0	0	0	0	5	10	15
85+	6	32	0	0	0	0	0	0	6	32	38
TOTALS	19	44	0	0	0	0	0	0	19	44	63

PROVENA MCAULEY MANOR

400 W. SULLIVAN ROAD

AURORA, IL. 60506

Reference Numbers Facility ID 6005912

Health Service Area 008 Planning Service Area 089

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other		Private Pay	Charity Care	TOTALS
			Public	Insurance			
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			ADMISSION RESTRICTIONS		RESIDENTS BY PRIMARY DIAGNOSIS		
20 BRIARCLIFF LANE			Aggressive/Anti-Social	0	DIAGNOSIS		
BOURBONNAIS, IL. 60914			Chronic Alcoholism	0	Neoplasms	2	
Reference Numbers	Facility ID	6007009	Developmentally Disabled	0	Endocrine/Metabolic	5	
Health Service Area 009 Planning Service Area 091			Drug Addiction	0	Blood Disorders	2	
Administrator			Medicaid Recipient	0	*Nervous System Non Alzheimer	5	
Robin Gifford			Medicare Recipient	0	Alzheimer Disease	1	
Contact Person and Telephone			Mental Illness	0	Mental Illness	1	
ROBIN GIFFORD			Non-Ambulatory	0	Developmental Disability	0	
815-937-2022			Non-Mobile	0	Circulatory System	25	
Registered Agent Information	Date Completed		Public Aid Recipient	0	Respiratory System	17	
	5/6/2010		Under 65 Years Old	0	Digestive System	2	
FACILITY OWNERSHIP			Unable to Self-Medicate	0	Genitourinary System Disorders	8	
NON-PROF CORPORATION			Ventilator Dependent	1	Skin Disorders	2	
CONTINUING CARE COMMUNITY			Infectious Disease w/ Isolation	0	Musculo-skeletal Disorders	9	
LIFE CARE FACILITY			Other Restrictions	0	Injuries and Poisonings	5	
No			No Restrictions	0	Other Medical Conditions	10	
No			<i>Note: Reported restrictions denoted by '1'</i>			Non-Medical Conditions	0
						TOTALS	94
						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	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

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	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	TOTAL
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	Other		Private Insurance	Charity Pay	Charity Care	TOTALS	
	Medicare	Medicaid					
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	60	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	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	8895	20.3%	17874	81.6%	0	607	7533	0	34909	79.7%	86.9%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	0	0	0	0.0%	0.0%
TOTALS	8895	20.3%	17874	81.6%	0	607	7533	0	34909	79.7%	86.9%

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

AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	1	1	0	0	0	0	0	0	1	1	2
60 to 64	3	2	0	0	0	0	0	0	3	2	5
65 to 74	2	5	0	0	0	0	0	0	2	5	7
75 to 84	8	13	0	0	0	0	0	0	8	13	21
85+	12	56	0	0	0	0	0	0	12	56	68
TOTALS	26	77	0	0	0	0	0	0	26	77	103

PROVENA PINE VIEW CARE CENTER

611 ALLEN LANE
ST. CHARLES, IL. 60174

Reference Numbers Facility ID 6007439

Health Service Area 008 Planning Service Area 089

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Other					Private Pay	Charity Care	TOTALS
	Medicare	Medicaid	Public	Insurance				
Nursing Care	25	50	0	1	27	0	103	
Skilled Under 22	0	0	0	0	0	0	0	
ICF/DD		0	0	0	0	0	0	
Sheltered Care			0	0	0	0	0	
TOTALS	25	50	0	1	27	0	103	

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	327	227
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	0	0	0	0	0
Hawaiian/Pac. Isl.	0	0	0	0	0
White	103	0	0	0	103
Race Unknown	0	0	0	0	0
Total	103	0	0	0	103

ETHNICITY	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Hispanic	0	0	0	0	0
Non-Hispanic	103	0	0	0	103
Ethnicity Unknown	0	0	0	0	0
Total	103	0	0	0	103

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	20.00
LPN's	5.00
Certified Aides	38.00
Other Health Staff	0.00
Non-Health Staff	41.00
Totals	106.00

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
38.1%	30.5%	0.0%	2.6%	28.8%	100.0%		0.0%
2,855,512	2,289,829	0	193,073	2,163,888	7,502,302	0	

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

PROVENA ST. ANN CENTER

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-Medicate	0
Ventilator Dependent	1
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	0

Note: Reported restrictions denoted by 'I'

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	
Nursing Care	179	179	163	179	143	36	119	60	153	724
Skilled Under 22	0	0	0	0	0	0		0	724	734
Intermediate DD	0	0	0	0	0	0		0	734	143
Sheltered Care	0	0	0	0	0	0			143	0
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.		Pat. days	Pat. days	Pat. days	Pat. days				
Nursing Care	15823	36.4%	19188	87.6%	0	3254	16973	0	55238	84.5%	84.5%		
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%		
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%		
Sheltered Care					0	0	0	0	0	0.0%	0.0%		
TOTALS	15823	36.4%	19188	87.6%	0	3254	16973	0	55238	84.5%	84.5%		

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

AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	1	1	0	0	0	0	0	0	1	1	2
60 to 64	0	2	0	0	0	0	0	0	0	2	2
65 to 74	5	8	0	0	0	0	0	0	5	8	13
75 to 84	8	27	0	0	0	0	0	0	8	27	35
85+	23	68	0	0	0	0	0	0	23	68	91
TOTALS	37	106	0	0	0	0	0	0	37	106	143

PROVENA ST. ANN CENTER

4405 HIGHCREST ROAD

ROCKFORD, IL. 61107

Reference Numbers Facility ID 6008817

Health Service Area 001 Planning Service Area 201

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare		Other		Private	Charity	TOTALS
	Medicare	Medicaid	Public	Insurance	Pay	Care	
Nursing Care	44	52	0	8	39	0	143
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD		0	0	0	0	0	0
Sheltered Care			0	0	0	0	0
TOTALS	44	52	0	8	39	0	143

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	231	195
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	7	0	0	0	7
Hawaiian/Pac. Isl.	0	0	0	0	0
White	138	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	0		194
Intermediate DD	0	0	0	0	0	0	0	0		102
Sheltered Care	0	0	0	0	0	0	0	0		
TOTAL BEDS	120	111	111	108	102	18	120	94		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	Medicaid	Other		Private Insurance	Private Pay	Charity Care	TOTALS
			Public	Insurance				
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	166	517
Skilled Under 22	0	0	0	0	0	0		0		525
Intermediate DD	0	0	0	0	0	0		0		158
Sheltered Care	0	0	0	0	0	0				0
TOTAL BEDS	176	176	173	176	158	18	176	82		

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	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	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 No
LIFE CARE FACILITY No

ADMISSION RESTRICTIONS

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

Note: Reported restrictions denoted by '1'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	
Neoplasms	3
Endocrine/Metabolic	5
Blood Disorders	0
*Nervous System Non Alzheimer	8
Alzheimer Disease	0
Mental Illness	0
Developmental Disability	0
Circulatory System	26
Respiratory System	28
Digestive System	10
Genitourinary System Disorders	4
Skin Disorders	0
Musculo-skeletal Disorders	0
Injuries and Poisonings	0
Other Medical Conditions	12
Non-Medical Conditions	0
TOTALS	96
Total Residents Diagnosed as Mentally Ill 0	

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

ADMISSIONS AND DISCHARGES - 2009

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	ADMISSIONS AND DISCHARGES - 2009	
									Residents on 1/1/2009	96
Nursing Care	99	99	99	99	96	3	99	99	Total Admissions 2009	150
Skilled Under 22	0	0	0	0	0	0	0	0	Total Discharges 2009	150
Intermediate DD	0	0	0	0	0	0	0	0	Residents on 12/31/2009	96
Sheltered Care	0	0	0	0	0	0	0	0	Identified Offenders	0
TOTAL BEDS	99	99	99	99	96	3	99	99		

FACILITY UTILIZATION - 2009

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL	Licensed Beds Occ. Pct.	Peak Beds Set Up Occ. Pct.
	Pat. days	Occ. Pct.	Pat. days	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

7370 WEST TALCOTT
 CHICAGO, IL. 60631
Reference Numbers Facility ID 6014575
 Health Service Area 006 Planning Service Area 601

Administrator
 Nancy Razo

Contact Person and Telephone
 BRENDA DAVIS
 847-813-3712

Registered Agent Information
 Sandra Bruce
 7435 West Talcott
 Chicago, IL 60631
 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	1
Drug Addiction	1
Medicaid Recipient	0
Medicare Recipient	0
Mental Illness	1
Non-Ambulatory	0
Non-Mobile	0
Public Aid Recipient	0
Under 65 Years Old	0
Unable to Self-Medicate	0
Ventilator Dependent	1
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	0

Note: Reported restrictions denoted by 'I'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	
Neoplasms	4
Endocrine/Metabolic	10
Blood Disorders	0
*Nervous System Non Alzheimer	14
Alzheimer Disease	9
Mental Illness	16
Developmental Disability	0
Circulatory System	22
Respiratory System	10
Digestive System	4
Genitourinary System Disorders	3
Skin Disorders	4
Musculo-skeletal Disorders	23
Injuries and Poisonings	0
Other Medical Conditions	42
Non-Medical Conditions	0
TOTALS	161
Total Residents Diagnosed as Mentally Ill 16	

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

ADMISSIONS AND DISCHARGES - 2009

LEVEL OF CARE	LICENSED BEDS	PEAK 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	147	147	146	147	146	1	112	112	161	264
Skilled Under 22	0	0	0	0	0	0		0	264	264
Intermediate DD	0	0	0	0	0	0		0	161	161
Sheltered Care	15	15	15	15	15	0			0	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 Occ. Pct.	Peak Beds Set Up Occ. Pct.
	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	Other				Private Pay	Charity Care	TOTALS
	Medicare	Medicaid	Public Insurance				
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	Drug Addiction	1	Blood Disorders	0	
Planning Service Area	702	Medicaid Recipient	0	*Nervous System Non Alzheimer	58	
Administrator		Medicare Recipient	0	Alzheimer Disease	26	
James Farlee		Mental Illness	1	Mental Illness	0	
Contact Person and Telephone		Non-Ambulatory	0	Developmental Disability	0	
BRENDA DAVIS		Non-Mobile	0	Circulatory System	69	
847-813-3712		Public Aid Recipient	0	Respiratory System	41	
Registered Agent Information	Date Completed	Under 65 Years Old	0	Digestive System	0	
Sandra Bruce	5/6/2010	Unable to Self-Medicate	0	Genitourinary System Disorders	12	
7435 West Talcott		Ventilator Dependent	1	Skin Disorders	0	
Chicago, IL 60631		Infectious Disease w/ Isolation	0	Musculo-skeletal Disorders	25	
FACILITY OWNERSHIP		Other Restrictions	0	Injuries and Poisonings	0	
NON-PROF CORPORATION		No Restrictions	0	Other Medical Conditions	0	
CONTINUING CARE COMMUNITY	No	<i>Note: Reported restrictions denoted by 'I'</i>			Non-Medical Conditions	0
LIFE CARE FACILITY	No				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
Intermediate DD	0	0	0	0	0	0		0		262
Sheltered Care	0	0	0	0	0	0		0		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	Medicaid	Other		Private Pay	Charity Care	TOTALS
			Public	Insurance			
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

LIFE CARE FACILITY

No

No

ADMISSION RESTRICTIONS

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

Note: Reported restrictions denoted by 'I'

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	110	157
Skilled Under 22	0	0	0	0	0	0	0	0		152
Intermediate DD	0	0	0	0	0	0	0	0		115
Sheltered Care	0	0	0	0	0	0	0	0		0
TOTAL BEDS	135	135	122	135	115	20	135	135		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 Occ.	Peak Beds Set Up Occ.
	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	0.0%	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	Other					Private Pay	Charity Care	TOTALS
	Medicare	Medicaid	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-Medicare	0
Ventilator Dependent	0
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	0

Note: Reported restrictions denoted by 'I'

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	
Nursing Care	251	231	170	231	160	91	149	247	153	580
Skilled Under 22	0	0	0	0	0	0	0	0	573	160
Intermediate DD	0	0	0	0	0	0	0	0		
Sheltered Care	0	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	RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE					TOTALS	
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay		Charity Care
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	RESIDENTS BY RACIAL/ETHNICITY GROUPING					Totals
	Nursing	SkUnd22	ICF/DD	Shelter	Totals	
Asian	5	0	0	0	5	5
Amer. Indian	0	0	0	0	0	0
Black	5	0	0	0	5	5
Hawaiian/Pac. Isl.	0	0	0	0	0	0
White	150	0	0	0	150	150
Race Unknown	0	0	0	0	0	0
Total	160	0	0	0	160	160

ETHNICITY	RESIDENTS BY RACIAL/ETHNICITY GROUPING					Totals
	Nursing	SkUnd22	ICF/DD	Shelter	Totals	
Hispanic	11	0	0	0	11	11
Non-Hispanic	149	0	0	0	149	149
Ethnicity Unknown	0	0	0	0	0	0
Total	160	0	0	0	160	160

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	28.40
LPN's	3.20
Certified Aides	51.02
Other Health Staff	14.60
Non-Health Staff	48.50
Totals	147.72

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
34.7%	41.4%	0.0%	0.0%	23.9%	100.0%		1.7%
3,796,733	4,533,430	0	0	2,623,018	10,953,181	181,416	

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

VILLA SCALABRINI NSG & REHAB

480 NORTH WOLF ROAD
NORTHLAKE, IL. 60164

Reference Numbers Facility ID 6009591

Health Service Area 007 Planning Service Area 704

Administrator

Jim Kouzious

Contact Person and Telephone

BRENDA DAVIS

847-813-3712

Registered Agent Information

Sandra Bruce

7435 West Talcott

Chicago, IL 60631

FACILITY OWNERSHIP

NON-PROF CORPORATION

CONTINUING CARE COMMUNITY

LIFE CARE FACILITY

No

No

ADMISSION RESTRICTIONS

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

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 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	246	253	230	253	224	22	171	202	230	414
Skilled Under 22	0	0	0	0	0	0		0		420
Intermediate DD	0	0	0	0	0	0		0		224
Sheltered Care	7	0	0	0	0	7				0
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 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	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	RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE						TOTALS
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	
Nursing Care	44	126	0	6	47	1	224
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD		0	0	0	0	0	0
Sheltered Care			0	0	0	0	0
TOTALS	44	126	0	6	47	1	224

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	252	212
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	RESIDENTS BY RACIAL/ETHNICITY GROUPING					Totals
	Nursing	SkUnd22	ICF/DD	Shelter	Totals	
Asian	0	0	0	0	0	0
Amer. Indian	0	0	0	0	0	0
Black	18	0	0	0	18	18
Hawaiian/Pac. Isl.	0	0	0	0	0	0
White	197	0	0	0	197	197
Race Unknown	9	0	0	0	9	9
Total	224	0	0	0	224	224

ETHNICITY	RESIDENTS BY RACIAL/ETHNICITY GROUPING					Totals
	Nursing	SkUnd22	ICF/DD	Shelter	Totals	
Hispanic	16	0	0	0	16	16
Non-Hispanic	208	0	0	0	208	208
Ethnicity Unknown	0	0	0	0	0	0
Total	224	0	0	0	224	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.

STATE OF ILLINOIS
DEPARTMENT OF HUMAN SERVICES
COMMUNITY SERVICES AGREEMENT
FISCAL YEAR 2005

This Agreement is by and between the Illinois Department of Human Services, with its principal office at Chicago-Read Mental Health Center, 4200 N. Oak Park Ave., Chicago, IL 60634, hereinafter referred to as the "Department" and, Our Lady of the Resurrection Medical Center, hereinafter referred to as the "Provider" with its principal address at: 5645 West Addison St., Chicago, IL 60634.

WHEREAS, it is the intent of the parties herein to implement services consistent with all Attachments hereto and pursuant to the duties and responsibilities imposed by the Department under the laws of the State of Illinois and in accordance with the terms, conditions and provisions hereof, it is agreed as follows:

1. **TERM**

This Agreement shall be effective July 1, 2004, and shall expire June 30, 2005, unless extended pursuant to the terms hereof.

2. **TAXPAYER CERTIFICATION** (Provider **MUST** complete)

Under penalties of perjury, the Provider certifies that 36-2644178 is the Provider's correct Federal Taxpayer Identification Number/Social Security Number (circle one). The Provider is doing business as a (please check one).

- | | |
|--|---|
| <input type="checkbox"/> Individual | <input type="checkbox"/> Pharmacy-Non Corporate |
| <input type="checkbox"/> Sole Proprietorship | <input type="checkbox"/> Nonresident Alien |
| <input type="checkbox"/> Partnership | <input type="checkbox"/> Pharmacy/Funeral Home/Cemetery |
| <input type="checkbox"/> Corporation (includes Not For Profit) | <input type="checkbox"/> Corporation |
| <input type="checkbox"/> Medical Corporation | <input type="checkbox"/> Tax Exempt/Hospital/Extended |
| <input type="checkbox"/> Governmental Unit | <input type="checkbox"/> Care Facility |
| <input type="checkbox"/> Estate or Trust | |

The Provider also certifies that it does and will comply with all provisions of the Federal Internal Revenue Code, the Illinois Revenue Act, and all rules promulgated thereunder, including withholding provisions and timely deposits of employee taxes and unemployment insurance taxes.

3. **PAYMENT**

A. The estimated amount payable by the Department to the Provider under this Agreement is \$ 50,000. The Provider agrees to accept DHS payment for services rendered as specified in the Attachments incorporated as part of this Agreement.

- B. Obligations of the State will cease immediately without penalty or further payment being required if, in any fiscal year, the Illinois General Assembly or Federal funding source fails to appropriate or otherwise make available sufficient funds for this Agreement. The Department shall notify the Provider of such funding failure.
- C. If the funds awarded are subject to the provisions of the Grant Funds Recovery Act, (30 ILCS 705), any funds remaining at the end of the Agreement period which are not expended or legally obligated by the Provider shall be returned to the Department within 45 days after the expiration of this Agreement. The provisions of 89 Ill Adm Code 511 shall apply to any funds awarded that are subject to the Grant Funds Recovery Act.
- D. If applicable, federal funds received under this Agreement shall be managed in accordance with the Cash Management Improvement Act of 1990, (31 U.S.C. 6501 et seq.) and any other applicable federal laws or regulations.
- E. The Provider agrees to hold harmless the Department when the Department acts in good faith to redirect all or a portion of any Provider payment to a third party. The Department will be deemed to have acted in good faith if it is in possession of information that indicates the Provider authorized the Department to intercept or redirect payments to a third party or when so ordered by a court of competent jurisdiction.
- F. The Agreement amount is established on an estimated basis and may be increased at any time during the term. The Department may decrease the estimated amount of this Agreement at any time during the term if the Department believes the Provider will not utilize the funds during the term, or has utilized funds in a manner that was not authorized by this Agreement. The Provider will be notified, in writing, of any adjustment, and/or reason for the adjustment, of the estimated agreement amount.
- G. Grant funds disbursed under this Agreement and held 30 days by the Provider will be placed in an interest-bearing account. All interest earned shall be considered grant funds and are subject to the same restrictions. Any exceptions to this requirement must be approved, in writing, by the Department. The provisions of the Illinois Grant Funds Recovery Act shall apply.

4. **SCOPE OF SERVICES**

The Provider will provide the services as described herein and in accordance with all conditions and terms set forth herein and all applicable administrative rules. All programmatic reporting required under this Agreement is described in the Attachment(s) and Program Manual(s).

5. **REQUIRED CERTIFICATIONS**

The Provider shall be responsible for compliance with the enumerated certifications to the extent that the certifications legally apply to the Provider, its subcontractors, or subrecipients. The Department recognizes that not all certifications may apply to the Provider, its subcontractors or subrecipients. It is the Provider's responsibility to determine which certifications apply to the Provider.

- A. **Bribery** - The Provider certifies that the Provider has not been convicted of bribery or attempting to bribe an officer or employee of the State of Illinois, nor made an admission of guilt of such conduct which is a matter of record, (30 ILCS 500/50-5).
- B. **Bid Rigging** - The Provider certifies that it has not been barred from contracting with a unit of State or local government as a result of a violation of Section 33E-3 or 33E-4 of the Criminal Code of 1961, (720 ILCS 5/33E-3 or 720 ILCS 5/33E-4, respectively).
- C. **Educational Loan** - The Provider certifies that it is not barred from receiving State Agreements as a result of default on an educational loan, (5 ILCS 385).
- D. **International Boycott** - The Provider certifies that neither it nor any substantially owned affiliated company is participating or shall participate in an international boycott in violation of the provisions of the U.S. Export Administration Act of 1979, (50 U.S.C. Appx. 2401 et seq.), or the regulations of the U.S. Department of Commerce promulgated under that Act, (15 CFR Parts 730 through 774).
- E. **Dues and Fees** - The Provider certifies that the Provider is not prohibited from selling goods or services to the State of Illinois because it pays dues or fees on behalf of its employees or agents, or subsidizes or otherwise reimburses them, for payment of their dues or fees to any club which unlawfully discriminates, (775 ILCS 25/1, 25/2).
- F. **Drug Free Work Place** - The Provider certifies that neither it nor its employees shall engage in the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance in the performance of this Agreement and that the Provider is in compliance with all the provisions of the Illinois Drug Free Workplace Act, (30 ILCS 580/3 or 580/4).
- G. **Clean Air Act and Clean Water Act** - The Provider certifies that it is in compliance with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, (42 U.S.C. 7401 et seq.) and the Federal Water Pollution Control Act, as amended, (33 U.S.C. 1251 et seq.).

- H. **Debarment** - The Provider certifies that the Provider is not debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this Agreement by any federal department or agency, (45 CFR Part 76).
- I. **Pro-Children Act** - The Provider certifies that it is in compliance with the Pro-Children Act of 1994 in that it prohibits smoking in any portion of its facility used for the provision of health, day care, early childhood development services, education or library services to children under 18, which services are supported by Federal or State government assistance (except portions of the facilities which are used for inpatient substance abuse treatment), (20 U.S.C. 6081 et seq.).
- J. **Debt To State** - The Provider certifies that it, or its affiliate, is not barred from being awarded a contract because the Provider, or its affiliate, is delinquent in the payment of any debt to the State, unless the Provider, or its affiliate, has entered into a deferred payment plan to pay off the debt, and the Provider acknowledges the Department may declare the contract void if the certification is false (30 ILCS 500/50-11).
- K. **Grant For The Construction Of Fixed Works** - All projects for the construction of fixed works which are financed in whole or in part with funds provided by this Grant Agreement shall be subject to the Prevailing Wage Act (820 ILCS 130/0.01 et seq.) unless the provisions of that Act exempt its application. In the construction of the project, the Grantee shall comply with the requirements of the Prevailing Wage Act, including, but not limited to, inserting into all contracts for such construction a stipulation to the effect that not less than the prevailing rate of wages as applicable to the project shall be paid to all laborers, workers, and mechanics performing work under the contract and requiring all bonds of contractors to include a provision as will guarantee the faithful performance of such prevailing wage clause as provided by contract.
- L. **Health Insurance Portability and Accountability Act** - The Provider certifies that it is in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Public Law No. 104-191, 45 CFR Parts 160, 162 and 164, the Social Security Act 42 U.S.C. 1320d-2 through 1320s-7, in that it may not use or disclose protected health information other than as permitted or required by law and agrees to use appropriate safeguards to prevent use or disclosure of the protected health information.
- M. **Sarbanes-Oxley Act** - If Provider, or any officer, director, partner, or other managerial agent of Provider, has been convicted of a felony under the Sarbanes-Oxley Act of 2002, or a Class 3 or Class 2 felony under the Illinois Securities Law

of 1953, at least 5 years have passed since the date of the conviction. Provider further certifies that it is not barred from being awarded a contract under 30 ILCS 500/50-10.5, and acknowledges that the contracting State agency shall declare the contract void if this certification is false (30 ILCS 500/50-10.5).

N. **Forced Labor Act** - Provider complies with the State Prohibition of Goods from Forced Labor Act, and certifies that no foreign-made equipment, materials, or supplies furnished to the State under the contract have been or will be produced in whole or in part by forced labor, convict labor, or indentured labor under penal sanction (PA 93-0307).

O. **Environmental Protection Act violations** - The Provider certifies in accordance with 30 ILCS 500/50-12 that the bidder or Provider is not barred from being awarded a contract under this Section. The Provider acknowledges that the contracting agency may declare the contract void if this certification is false (PA 93-575, effective 1/1/04).

6. **BACKGROUND CHECKS**

The Provider certifies that neither the Provider, nor any employees assigned to work on the Department's premises, have a felony conviction. Any request for an exception to this rule must be made in writing, listing the name of the individual, home address, type of conviction and date of conviction. The Provider will also supply the Department with a list of individuals assigned to work on the Department's premises at least ten (10) working days prior to the start of their employment, unless circumstances prevent the Provider from giving a list within that time. If the Provider cannot provide a list, or the name of an individual at least ten (10) working days prior to their employment, it shall do so as soon as possible. The Department may conduct criminal background checks on the Provider and/or its employees assigned to work on the Department's premises. The Provider agrees to hold harmless and indemnify the Department and its employees for any liability accruing from said background checks.

7. **UNLAWFUL DISCRIMINATION**

The Provider, its employees and subcontractors under subcontract, made pursuant to this Agreement, shall comply with all applicable provisions of State and Federal laws and regulations pertaining to nondiscrimination, sexual harassment and equal employment opportunity including, but not limited to, the following laws and regulations and all subsequent amendments thereto:

- A. The Illinois Human Rights Act (775 ILCS 5)
- B. Public Works Employment Discrimination Act (775 ILCS 10)
- C. The United States Civil Rights Act of 1964 (as amended), (42 U.S.C. 2000a-2000h-6). (See also guidelines to Federal Financial Assistance Recipients regarding

Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons [Federal Register: February 18, 2002 (Volume 67, Number 13, Pages 2671-2685)]

- D. Section 504 of the Rehabilitation Act of 1973, (29 U.S.C. 794)
- E. The Americans with Disabilities Act of 1990, (42 U.S.C. 12101 et seq.)
- F. Executive Orders 11246 and 11375, (Equal Employment Opportunity) and Executive Order 13160 (2000), (Improving Access to Services for Persons with Limited English Proficiency)
- G. Charitable Choice - In accordance with Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

8. **LOBBYING**

The Provider certifies that no Federally appropriated funds have been paid or will be paid, by or on behalf of the Provider, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal Agreement, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal Agreement, grant, loan or cooperative agreement.

If any funds, other than Federal appropriated funds, have been paid, or will be paid, to any person for influencing or attempting to influence any of the above persons in connection with this Agreement, the undersigned must also complete and submit Federal form LLL, "Disclosure Form to Report Lobbying", in accordance with its instructions.

If there are any indirect costs associated with this Agreement, total lobbying costs shall be separately identified in the indirect cost rate proposal, and thereafter treated as other unallowable activity costs.

The Provider must include the language of this certification in the award documents for any subawards made pursuant to this award. All subrecipients are also subject to certification and disclosure.

This certification is a material representation of fact upon which reliance was placed to enter into this transaction and is a prerequisite for this transaction, pursuant to 31 U.S.C. 1352. Any person who fails to file the required certifications shall be subject to a civil penalty of not less than \$10,000, and not more than \$100,000, for each such failure.

9. **CONFIDENTIALITY**

The Provider shall comply with applicable State and Federal statutes, Federal regulations and Department administrative rules regarding confidential records or other information obtained by the Provider concerning persons served under this Agreement. The records and information shall be protected by the Provider from unauthorized disclosure.

10. **LIABILITY**

The Department assumes no liability for actions of the Provider under this Agreement, including, but not limited to, the negligent acts and omissions of Provider's agents, employees and subcontractors in their performance of the Provider's duties as described under this Agreement. The Provider agrees to hold harmless the Department against any and all liability, loss, damage, cost or expenses, including attorney's fees, arising from the intentional torts, negligence or breach of contract of the Provider, with the exception of acts performed in conformance with an explicit, written directive of the Department.

11. **MAINTENANCE AND ACCESSIBILITY OF RECORDS**

- A. The Provider shall maintain, for a minimum of 5 years from the later of the date of final payment under this Agreement or the expiration of this Agreement, adequate books, records, and supporting documents to comply with 89 Ill Adm Code 509.
- B. The Provider agrees to make books, records and supporting documentation relevant to this Agreement available to authorized Department representatives, auditors, (including The Illinois Auditor General) Federal authorities and any other person as may be authorized, by the Department or by the State of Illinois or Federal statute. The Provider will cooperate fully in any such audit.
- C. Failure to maintain books, records and supporting documentation shall establish a presumption in favor of the State for the recovery of any funds paid by the State under this Agreement for which adequate books, records and supporting documentation are not available to support disbursement.

12. **RIGHT OF AUDIT AND MONITORING**

The Department shall monitor the Provider's conduct under this Agreement which may include, but shall not be limited to, reviewing records of program performance in accordance with administrative rules, license status review, fiscal and audit review, Agreement compliance and compliance with affirmative action requirements of this Agreement.

The Department may request, and Provider will supply, upon request, necessary information and documentation regarding transactions constituting contractual (whether a written contract is in existence or not) or other relationships, paid for with funds received hereunder. Documentation may include, but is not limited to, information regarding Provider's contractual agreements, identity of employees, shareholders and directors of Provider and any

party providing services which will or may be paid for with funds received hereunder, including, but not limited to, management and consulting services rendered to Provider.

This does not give the Department the right to review a license that is not directly related to the program being audited nor does it allow the Department to unilaterally revoke a license without complying with all due process rights the Provider is entitled to under Federal, State, local law or applicable rules promulgated by the Department.

13. REPORTING REQUIREMENTS

Providers agree to submit programmatic reports as requested and in the format required the Department. Failure to submit reports may cause a delay in funding.

14. AUDIT REQUIREMENTS

The Provider will annually submit an independent audit report and/or supplemental revenue and expense data to the Department in accordance with 89 Ill Adm Code, 507 (Audit Requirements of the Department of Human Services), to enable the Department to perform fiscal monitoring and to account for the usage of funds paid to the Provider under this Agreement. For those organizations required to submit an independent audit report, the audit is to be conducted by a Certified Public Accountant or Certified Public Accounting Firm registered in the State of Illinois. For audits required to be performed subject to Government Auditing Standards, the Provider shall request and maintain on file, a copy of the auditor's most recent peer review report and acceptance letter.

If the Provider is subject to the audit requirements, the Department will send to the Provider, by registered or certified letter, detailed instructions related to independent audit requirements, including provisions for requesting waivers, modifications and filing extensions, by May 31, 2005.

15. INDEPENDENT CONTRACTOR

The Provider is an independent contractor and its employees do not acquire any employment rights with the Department or the State of Illinois by virtue of this Agreement.

16. SANCTIONS

The Department may impose sanctions on Providers who fail to comply with conditions stipulated herein. Sanctions include, but are not limited to, payment suspension, loss of payment, enrollment limitations and certification and licensure action (including, but not limited to, conditional, probationary and termination status), or other actions up to and including contract termination.

17. TERMINATION OF THE AGREEMENT

Either party may terminate this Agreement at any time, for any reason, upon not less than thirty (30) days written notice to the other party. The Department may terminate this Agreement immediately in the event the Provider substantially or materially breaches the Agreement. The Provider shall be paid for work satisfactorily completed prior to the date of termination.

18. POST-TERMINATION/NON-RENEWAL

Upon notice by the Department to the Provider of the termination of this Agreement or notice that the Department will not renew, extend or exercise any options to extend the term of this contract, or that the Department will not be contracting with Provider beyond the term of this Agreement, the Provider shall, upon demand:

- A. Cooperate with the Department in assuring the transition of recipients of services hereunder for whom Provider will no longer be providing the same or similar services or who chose to receive services through another provider.
- B. Provide copies of all records related to recipient services funded by the Department under this Agreement.
- C. Grant reasonable access to the Department to any and all program sites serving recipients hereunder to facilitate interviews of recipients to assure a choice process by which recipients may indicate Provider preference.
- D. Provide detailed accounting of all service recipients' funds held in trust by the Provider, as well as the identity of any recipients for whom the Provider is acting as a representative payee of last resort.

The promises and covenants of this paragraph, specifically, shall survive the term of this Agreement for the purposes of the necessary transition of recipients of services hereunder.

19. SUBCONTRACTS

The Provider may not subcontract any portion of this Agreement nor delegate any duties hereunder without prior written Departmental approval. In emergencies, the Provider will request approval in writing within 7 days of the use of a subcontractor to fulfill any obligations of this Agreement. Approved subcontractors shall adhere to all other provisions of this Agreement.

20. **INTERNET ACCESS**

The Provider must have Internet access. Internet access may be either dial-up or high speed/DSL. The Provider must maintain, at a minimum, one business email address that will be the primary receiving point for all email correspondence for the Department. The Provider may list additional addresses at contract execution. The additional addresses may be for a specific department/division of the Provider or for specific employees of the Provider. During any period that the Department directly funds the Provider's Internet service, the Provider must use the Department-assigned email address as their primary email address. The Provider may list additional email points of contact in the same manner as listed above. The Provider must notify the Department of any email changes within five (5) business days from the effective day of the change.

21. **NOTICE OF CHANGE**

The Provider shall give 30 days prior written notice to the Department (contact person[s] listed on Attachment[s]), if there is a change in the Provider's legal status, federal employment identification number (FEIN) or address. The Department reserves the right to take any and all appropriate action.

The Provider agrees to hold harmless the Department, for any acts or omissions by the Department, resulting from the Provider's failure to notify the Department of these changes.

In the event the Provider, its parent or related corporate entity, becomes a party to any litigation, investigation, or transaction that may reasonably be considered to have a material impact on the Provider's ability to perform under this Agreement, the Provider will immediately notify the Department in writing.

22. **ASSIGNMENT**

The Provider understands and agrees that this Agreement may not be sold, assigned, or transferred in any manner, to include an assignment of provider's rights to receive payment hereunder, and that any actual or attempted sale, assignment, or transfer without the prior written approval of the Department shall render this Agreement null, void, and of no further effect.

23. **MERGERS/ACQUISITIONS**

The Provider acknowledges that this agreement is made by and between the Department and the Provider, as the Provider is currently organized and constituted. No promise or undertaking made hereunder is an assurance that the Department agrees to continue this Agreement, nor any licensure related thereto, should the Provider reorganize or otherwise substantially change the character or its corporate, or other business structure. The Provider

agrees that it will give the Department prior notice of any such action and provide any and all reasonable documentation necessary for the Department to review the proposed transaction to include corporate and shareholder minutes of any corporation which may be involved as well as financial records. Failure to comply with this paragraph shall constitute a material breach of this Agreement.

24. CONFLICT OF INTEREST

The Provider agrees that payments made by the Department, under this Agreement, will not be used to compensate, directly or indirectly, any person: 1) Currently holding an elective office in this State including, but not limited to a seat in the General Assembly, or, 2) Employed by an offices or agency of State government of Illinois with annual compensation annually in excess of \$90,000.00. The Provider may request written approval from the Department for an exemption to this provision.

25. TRANSFER OF EQUIPMENT

The Department shall have the right to require transfer (including title) to the Department of any equipment purchased in whole with Department funds to adhere to the requirements under this Agreement. Equipment means any product (tangible and non-tangible) used in the administration and/or operation of the program having a useful life of two years or more and an acquisition cost of at least \$500. The Department will notify the Provider in writing upon termination or any notice required by paragraph 15 thereof of this Agreement or any subsequent Agreement for these services, if it will require the transfer of such equipment.

26. WORK PRODUCT

Except as otherwise required by law, any work product, such as written reports, memoranda, documents, recordings, drawings, data, software or other deliverables, developed in the course of or funded under this Agreement, shall be considered a work made for hire and shall remain the exclusive property of the Department. There shall be no dissemination or publication of any such work product without the prior written consent of the Department. The Provider acknowledges that the Department is under no obligation to give such consent and that the Department may, if consent is given, give consent subject to such additional terms and conditions as the Department may require.

Upon written consent of the Department, the Provider may retain copies of its work product for its own use provided that all laws, rules and regulations pertaining to confidentiality are observed.

The Provider may not copyright the material without the prior written consent of the Department. The Provider acknowledges that the Department is under no obligation to give such consent and that the Department may, if consent is given, give consent subject to such

additional terms and conditions as the Department may require.

27. **RELEASES**

In the event that Department funds are used in whole or in part to produce any written publications, announcements, reports, flyers, brochures or other written materials, the Provider agrees to include in these publications, announcements, reports, flyers, brochures and all other such material, the phrase "funding provided in whole or in part by the Illinois Department of Human Services". Exceptions to this requirement must be requested, in writing, to the Department and will be considered authorized only upon written notice to the Provider.

28. **PRIOR NOTIFICATION**

The Provider agrees to notify the Department prior to issuing public announcements or press releases concerning work done pursuant to this Agreement, or funded in whole or in part by this Agreement, and cooperate with the Department in joint or coordinated releases of information.

29. **INSURANCE**

The Provider shall purchase and maintain in full force and effect during the term of this Agreement casualty and bodily injury insurance, as well as, insurance sufficient to cover the replacement cost of any and all real and/or personal property purchased or otherwise acquired, in whole or in part, with funds disbursed pursuant to this Agreement. If a claim is submitted for real and/or personal property purchased in whole with funds from this Agreement, such money shall be surrendered to the Department. If the Provider's cost of property and casualty insurance increases by 25% or more, or if new state regulations impose additional costs to the Provider during the term of this Agreement, then the Provider may request the Department to review this Agreement and adjust the compensation or reimbursement provisions thereof in accordance with any Agreement reached, all of which shall be at the sole discretion of the Department and subject to the limitations of the Department's appropriated funds.

30. **CIVIL LAW SUITS**

Indemnification will be governed by the State Employee Indemnification Act. (5 ILCS 350/1 et seq.).

31. **GIFTS AND INCENTIVES PROVISION**

The Provider is prohibited from giving gifts to Department employees (5 ILCS 425/1 et seq.). The Provider will provide the Department with advance notice of the Provider's providing gifts, excluding charitable donations, given as incentives to community-based organizations

in Illinois and clients in Illinois to assist the Provider in carrying out its responsibilities under this Agreement.

32. **RENEWAL**

This Agreement may be renewed unilaterally by the Department for additional periods. The Provider acknowledges that this Agreement does not create any expectation of renewal.

33. **AMENDMENTS**

This Agreement may be modified or amended at any time during its term by mutual consent of the parties, expressed in writing, and signed by the parties.

34. **SEVERABILITY**

If any provision of this Agreement is declared invalid, its other provisions shall not be affected thereby.

35. **WAIVER**

No failure of the Department to assert any right or remedy hereunder will act as a waiver of its right to assert such right or remedy at a later time nor constitute a "course of business" upon which Provider may rely, for the purpose of denial of such a right or remedy to the Department.

36. **LAWS OF ILLINOIS**

This Agreement shall be governed and construed in accordance with the laws of the State of Illinois and all subsequent amendments.

37. **STATUTORY/REGULATORY COMPLIANCE**

This Agreement and the Provider's obligations and services hereunder are hereby made and must be performed in compliance with all applicable federal and state laws, federal regulations, state administrative rules, including 89 Ill Adm Code 509 and any and all licensure and/or professional certification provisions.

41. **FUNDING RESERVE**

Reductions in Amounts Payable: Notwithstanding anything to the contrary contained herein or in any attachment or exhibit made a part hereof, the amount payable, or estimated amount payable, to vendor/provider under this agreement is subject to a reduction not to exceed two percent (2%) as necessary or advisable, based upon actual or projected budgetary considerations, at the sole discretion of the Department of Human Services, or as may be directed by the Office of the Governor.

In witness whereof, the parties hereto have caused this Agreement to be executed by their duly authorized representatives.

State of Illinois
Department of Human Services

BY: _____
Carol L. Adams, Secretary

Date: _____

Our Lady of the Resurrection Medical Center
Provider (Agency Name)

BY: Ivette Estrada
(Provider or Authorized Designee
Signature)

Name: Ivette Estrada
Type or Print

Title: Executive Vice President/CEO

Date: March 14, 2005

Email Address: iestrada@reshealthcare.org

Our Lady of the Resurrection Medical Center
5645 West Addison Street
Chicago, Illinois 60634
773.282.7000



March 16, 2005

Chicago-Read Mental Health Center
4200 N. Oak Park Avenue
Chicago, IL 60634

Attn: James Brunner, M.D.

RE: State of Illinois Dept of Human Services Community Services Agreement,
Fiscal Year 2005

Dear Mr. Brunner:

Enclosed please find two copies of the agreement, signed by Ivette Estrada, Executive Vice President and Chief Executive Officer, relative to the above-captioned matter. We ask that you forward a signed copy back to us for our files.

Thank you.

Sincerely,

A handwritten signature in cursive script that reads "Christine Clancy".

Christine Clancy
Assistant on behalf of Ivette Estrada

Enclosure

CO-SPONSORS
Sisters of the Holy Family of Nazareth & Sisters of the Resurrection

ATTACHMENT 19C

Cole, Pamela

From: Gordon, Lynn
Sent: Monday, January 03, 2005 9:35 AM
To: Hillard, Mary
Cc: Cole, Pamela
Subject: RE: Proposed Agreement between OLR and IL HHS (Chicago-Read Mental Health Center)

Just use the contract they sent, marking it up as indicated below and initialing the change. Let me know if we received your only copies.

-----Original Message-----

From: Hillard, Mary
Sent: Monday, January 03, 2005 9:06 AM
To: Gordon, Lynn
Cc: Cole, Pamela
Subject: RE: Proposed Agreement between OLR and IL HHS (Chicago-Read Mental Health Center)

Is she going to send the new document or do we have to contact them. Thanks

-----Original Message-----

From: Gordon, Lynn
Sent: Thursday, December 30, 2004 1:39 PM
To: Hillard, Mary
Cc: Frey, Jeannie
Subject: RE: Proposed Agreement between OLR and IL HHS (Chicago-Read Mental Health Center)

Mary,

I spoke with Ellen Otomo at Chicago Read regarding the State of Illinois Contract (see below). I explained that we could not agree to maintaining JCAHO accreditation since OLR uses HFAP. She was fine with OLR adding the following after the JCAHO reference in the attached exhibit to the hospital agreement: "or other nationally recognized accreditation organization such as the Health Facilities Accreditation Program (HFAP)." Accordingly, OLR may sign the agreement, making this change in the attachment (5th paragraph) and initialing same.

Please do not hesitate to call or e-mail with any further questions on this.

Lynn

-----Original Message-----

From: Hillard, Mary
Sent: Monday, December 27, 2004 1:50 PM
To: Gordon, Lynn
Subject: RE: Proposed Agreement between OLR and IL HHS (Chicago-Read Mental Health Center)

Thank you.

-----Original Message-----

From: Gordon, Lynn
Sent: Monday, December 27, 2004 1:46 PM
To: Hillard, Mary
Cc: Frey, Jeannie; Garvey, Mary
Subject: Proposed Agreement between OLR and IL HHS (Chicago-Read Mental Health Center)

Mary,

Jeannie Frey asked that I follow up with you on the State of Illinois Department of Human Services Community Services Agreement Fiscal Year 2005 (Chicago-Read Mental Health Center). It is our understanding that the State presents these contracts "as is" but there is one change that simply must be made. In the attached contractor requirements there is a requirement that OLR be accredited by JCAHO. I left a message for the Department's contract intake person, Dr. James Brunner, that this must be changed to allow for accreditation by Health Facilities Accreditation Program (HFAP). I will let you know

IL DEPARTMENT OF HUMAN SERVICES

Chicago-Read Mental Health Center

Office of N/A

(Bureau of) N/A

Agency Name Our Lady of the Resurrection

FEIN: 36-2644178

Agreement #: 63X0003017

Attachment: A

FY2005

ATTACHMENT COVER SHEET

CONTACT FOR NOTIFICATION

All notices required or desired to be sent by either party shall be sent to the persons listed below.

IDHS CONTACT

Name James Brunner, MD

Title Medical Director (acting)

Contract Monitor

Address 4200 N. Oak Park Ave.

Chicago, IL 60634

Phone (773) 794-4234

TTY# _____

Fax# _____

Email Address: _____

PROVIDER CONTACT

Name Mary Hillard, RN MSN

Title Vice President Patient Care Services

Address 5645 West Addison Avenue

Chicago, IL 60634

Phone 773-282 7000 ext. 8460

TTY # _____

Fax # 773 794 4657

Email Address: mhillard@reshealthcare.org

Advance payments may be allowed under the programs listed below:

Program	CARS Service Code	Method of Payment	Subject to Grant Fund Recovery Act	Method of Reconciliation*	Service Projections	Unit of Service	Estimated Funding
Inpatient	8062-946-0000	POS	NA	NA			\$50,000

Hospital Services

NA - Not Applicable

*Expenses - Program is subject to reconciliation based on Rule 511.10a.

*Deliverables - Program is subject to reconciliation based on Rule 511. 10b.

The Contractor agrees to provide hospitalization services to CRMHC recipients upon referral and admission from CRMHC, and transported to the Contractor's Facility. All referrals will be made by CRMHC's Medical Director or designee.

Determination of admission to the Contractor's Facility will be at the discretion of the Contractor and its Medical Staff, upon recommendation of the CRMHC attending physician.

Specifically, the Contractor will provide inpatient services at the Contractor's Facility, including complete medical and surgical care as deemed necessary. Ancillary services, including laboratory, radiology and other diagnostic services, anesthesiology and pharmaceutical services will also be provided.

Except under emergency conditions, CRMHC will obtain consent forms for hospitalization. The Contractor, however, will be responsible for obtaining consent forms required for procedures determined necessary during hospitalization.

Contractor is accredited by the Joint Commission on Accreditation of Healthcare Organizations, or other nationally recognized accreditation organization such as the Health Facilities Accreditation Program (HFAP).

Physician-to-physician contact prior to admission and discharge is to be made.; i.e., the attending physician at CRMHC and the emergency room or attending physician at the Contractor's facility are to engage in a clinical assessment of the patient to assure continuity of care. MA

Cost of services rendered to CRMHC recipients referred to the Contractor will be billed to the patient's insurance, Medicare and/or any other appropriate third party payer for covered services. CRMHC will supply the Contractor with all information available regarding third-party involvement.

If the Contractor has exhausted all third-party sources of payment, CRMHC will assume responsibility for the charges. In addition, CRMHC may pay any deductibles and/or co-insurance related to private insurance or to Medicare which would bring the total up to the Medicare approved rate for that service. The Contractor shall include documentation of efforts to obtain third-party payment with the itemized statement submitted to CRMHC, e.g., the Explanation of Benefits from the insurer. The Contractor will diligently make every effort to identify, bill and collect from any appropriate third-party source before billing CRMHC for services rendered. Failure to do so will be cause for non-payment by CRMHC of any or all charges for those services.

If any third-party payments are subsequently received for charges previously billed to and paid by CRMHC, the Contractor agrees to credit CRMHC by this amount.

For CRMHC recipients not eligible for any third-party payments, the Contractor will charge CRMHC for inpatient services according to the Contractor's standard charges as recorded on the patient's itemized statement. These charges include the cost of all hospital services and services of any house staff involved in the case. Other physician services and charges are subject to review and approval by the Medical Director of CRMHC. The Contractor shall inform other physicians who provide services to CRMHC recipients of any third-party coverage and shall assist these physicians in the billing protocol which requires them to exhaust all other possible sources of payment prior to billing CRMHC.

Payment for services shall be processed upon receipt of an itemized statement for each CRMHC recipient of service for whom these services become necessary. The Contractor, for services rendered under this contract, is responsible for the billing of and the collection for all services paid by private insurance, Medicare, the Department of Public Aid or other third party payers. CRMHC shall furnish to the Contractor all information available for such billings.

If Contractor's invoice is for Public Aid recipient, charges shall not exceed rates approved by the Department of Public Aid. Additional or supplemental payment by the Department of Human Services shall not be made. When contract rates differ from approved Public Aid schedule of charges and it has been determined the recipient of services is not Public Aid eligible the invoice rate will prevail. Payment for such services shall be processed upon receipt of an itemized statement for each CRMHC recipient of service for whom these services become necessary.

**TRANSFER AGREEMENT
BY AND BETWEEN
CHILDREN'S MEMORIAL HOSPITAL AND
Our Lady of the Resurrection Medical Center**

THIS TRANSFER AGREEMENT (this "Agreement") is entered into as of the first day of August, 2004, by and between Children's Memorial Hospital, an Illinois non-profit corporation ("Receiving Hospital") and Our Lady of the Resurrection Medical Center, an Illinois not for profit corporation ("Transferring Facility") (each a "Party" and collectively "Parties").

WHEREAS, Transferring Facility owns and operates a general acute care hospital;

WHEREAS, Receiving Hospital owns and operates a general acute hospital and ancillary facilities specializing in pediatric care;

WHEREAS, Transferring Facility receives from time to time patients who are need of specialized services not available at Transferring Facility;

WHEREAS, the Parties are legally separate organizations and are not related in any way to one another through common ownership or control; and

WHEREAS, the Parties desire to establish a transfer arrangement in order to assure continuity of care for patients and to ensure accessibility of services to patients.

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 Transfers

1.1. Acceptance of Patients. Upon recommendation of an attending physician and pursuant to the provisions of this Agreement, Receiving Hospital agrees to admit a patient as promptly as possible, provided customary admission requirements are met, State and Federal laws and regulations are met, and Receiving Hospital has the capacity to treat the patient. Notice of the transfer shall be given by Transferring Facility as far in advance as possible. Receiving Hospital shall give prompt confirmation of whether it can provide health care appropriate to the patient's medical needs. Receiving Hospital agrees to exercise its best efforts to provide for prompt admission of transferred patients and, to the extent reasonably possible under the circumstances, give preference to patients requiring transfer from Transferring Facility.

1.2. Appropriate Transfer. It shall be Transferring Facility's responsibility to arrange for appropriate and safe transportation and to arrange for the care of the patient during a transfer. The Transferring Facility shall ensure that the transfer is an "appropriate transfer" under the Emergency Medical Treatment and Active Labor Act, as may be amended ("EMTALA"), and is carried out in accordance with all applicable laws and regulations. The Transferring Facility

shall provide in advance sufficient information to permit a determination as to whether the Receiving Hospital can provide the necessary patient care. The patient's medical record shall contain a physician's order transferring the patient. When reasonably possible, a physician from the Transferring Facility shall communicate directly with a physician from the Receiving Hospital before the patient is transferred.

1.3. Transfer Log. The Transferring Facility shall keep an accurate and current log of all patients transferred to the Receiving Hospital and the disposition of such patient transfers.

1.4. Admission to the Receiving Hospital from Transferring Facility. When a patient's need for admission to a center specialized in pediatric care is determined by his/her attending physician, Receiving Hospital shall admit the patient in accordance with the provisions of this Agreement as follows:

(a) Patients determined to be emergent by the attending physician shall be admitted, subject to bed, space, qualified personnel and equipment availability, provided that all usual conditions of admission to Receiving Hospital are met.

(b) All other patients shall be admitted according to the established routine of Receiving Hospital.

1.5. Standard of Performance. Each Party shall, in performing its obligations under this Agreement, provide patient care services in accordance with the same standards as services provided under similar circumstances to all other patients of such Party, and as required by federal and state laws and Medicare/Medicaid certification 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. Receiving Hospital shall maintain accreditation by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO").

1.6. Billing and Collections. Each Party shall be entitled to bill patients, payors, managed care plans and any other third party responsible for paying a patient's bill, for services rendered to patients by such Party and its employees, agents and representatives, and neither Party will have any liability to the other Party for such charges. Each Party shall be solely responsible for all matters pertaining to its billing and collection of such charges. The Parties shall reasonably cooperate with each other in the preparation and completion of all necessary forms and documentation and the determination of insurance coverage and managed care requirements for each transferred patient. Each Party shall have the sole final responsibility for all forms, documentation, and insurance verification.

1.7. Personal Effects. Personal effects of any transferred patient shall be delivered to the transfer team or admissions department of the Receiving Hospital. Personal effects include money, jewelry, personal papers and articles for personal hygiene.

ARTICLE II.

Medical Records

Subject to applicable confidentiality requirements, the Parties shall exchange all information which may be necessary or useful in the care and treatment of the transferred patient or which may be relevant in determining whether such patient can be adequately cared for by the other Party. All such information shall be provided by the Transferring Facility in advance, where possible, and in any event, at the time of the transfer. The Transferring Facility shall send a copy of all patient medical records that are available at the time of transfer to the Receiving Hospital. Other records shall be sent as soon as practicable after the transfer. The patient's medical record shall contain evidence that the patient was transferred promptly, safely and in accordance with all applicable laws and regulations. Each Party shall and shall cause its employees and agents to protect the confidentiality of all patient information (including, but not limited to, medical records, electronic data, radiology films, laboratory blocks, slides and billing information), and comply with all applicable state and federal laws and regulations protecting the confidentiality of patients' records, including the Health Insurance Portability and Accountability Act of 1996 and the corresponding Standards for Privacy of Individually Identifiable Health Information regulations.

ARTICLE III.

Term and Termination

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

3.2. 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, without cause, upon thirty (30) days prior written notice.

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

(i) If such Party determines that the continuation of this Agreement would endanger patient care.

(ii) Violation by the other Party of any material provision of this Agreement, provided such violation continues for a period of fifteen (15) days after receipt of written notice by the other Party specifying such violation with particularity.

(iii) A general assignment by the other Party for the benefit of creditors; the institution by or against the other Party, as debtor, of proceedings of any nature under any law of the United States or any state, whether now existing or currently enacted or amended, for the relief of debtors, provided that in the event such proceedings are instituted against the other Party remain unstayed or undismissed for thirty (30) days; the liquidation of the other Party for any reason; or the appointment of a receiver to take charge of the other Party's affairs, provided such appointment remains undischarged for thirty (30) days. Such termination of the provisions of this Agreement shall not affect obligations which accrued prior to the effective date of such termination.

(iv) Exclusion of either Party from participation in the Medicare or Medicaid programs or conviction of either Party of a felony.

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

ARTICLE IV.

Non-Exclusive Relationship

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.

ARTICLE V.

Certification and Insurance

5.1. Licenses, Permits, and Certification. Each Party represents to the other that it and all of its employees, agents and representatives possess and shall maintain in valid and current status during the term of this Agreement all required licenses, permits and certifications enabling such Party to provide the services set forth in this Agreement.

5.2. Insurance. Both Parties shall, at their own cost and expense, obtain and maintain in force during the term of this Agreement appropriate levels of general and professional liability insurance coverage, in accordance with good business practice for acute-care hospitals in the Chicagoland area. Such insurance shall be provided by insurance company(ies) acceptable to Parties and licensed to conduct business in the State of Illinois or by a self-insurance program. Verification of insurance shall be in the possession of both Parties at all times while this Agreement is in effect. Both Parties shall be notified at least thirty (30) days prior to cancellation, notice of cancellation, reduction, or material change in coverage to either policy. In

the event the form of insurance is claims made, both Parties warrant and represent that they will purchase appropriate tail coverage for claims demands during the term of this Agreement. In the event of insufficient coverage as defined in this Section, or lapse of coverage, the non-breaching Party reserves the right to immediately and unilaterally terminate this Agreement.

5.3. 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 VI.

Indemnification

Each Party shall indemnify and hold harmless the other Party from and against any and all manner of claims, demands, causes of action, liabilities, damages, costs, and expenses (including costs and reasonable attorney's fees) arising from or incident to the performance of such indemnifying Party's duties hereunder, except for negligent or willful acts or omissions of the other Party. Notwithstanding anything to the contrary, a Party's obligations with respect to indemnification for acts described in this article shall not apply to the extent that such application would nullify any existing insurance coverage of such Party or as to that portion of any claim of loss in which insurer is obligated to defend or satisfy.

ARTICLE VII.

Compliance With Laws

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 the services to be provided hereunder and that may be 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. A Party shall promptly notify the other Party if it receives notice of any actual or alleged infraction, violation, default or breach of the same. Neither Transferring Facility or Receiving Hospital, nor any employee, officer, director or agent thereof, is an "excluded person" under the Medicare rules and regulations.

As of the date hereof and throughout the term of this Agreement: (a) Transferring Facility represents, warrants and covenants to Receiving Hospital that Transferring Hospital is licensed to operate a general acute care hospital in Illinois and is a participating facility in Medicare and Medicaid; and (b) Receiving Hospital represents, warrants and covenants to Transferring Facility that Receiving Hospital is licensed to operate a general acute hospital and ancillary facilities specializing in pediatric care and to participate in Medicare and Medicaid.

ARTICLE VIII.

Miscellaneous

8.1. 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 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 patients.

8.2. Relationship of the Parties. The Parties expressly acknowledge that in performing their respective obligations under this Agreement, they are each acting as independent contractors. Transferring Facility and 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. Each Party shall disclose in its respective dealings that they are separate entities.

8.3. Notices. All notices and other communications under this Agreement shall be in writing and shall be deemed received when delivered personally or when deposited in the U.S. mail, postage prepaid, sent registered or certified mail, return receipt requested 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 Receiving Hospital:

Children's Memorial Hospital
2300 Children's Plaza
Chicago, IL 60614
Attention: Gordon Bass, COO
Fax No.: (773) 880-4126

To Transferring Facility:

*OUR LADY OF THE RESURRECTION MEDICAL CTR.
5645 W. ADDISON AVENUE
CHICAGO, I.L. 60634
ATTENTION: IVETTE ESTRADA, EXEC. VP. AND CEO
FAX NO: (773) 794-7651*

With a copy to:

Jeannie Carmedelle Frey, Esq.
Senior Vice President
Legal Affairs/General Counsel
Resurrection Health Care
7435 West Talcott Avenue

Chicago, IL 60631
(773) 792-5875 (fax)

8.4. 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.

8.5. 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.

8.6. 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; provided, however, that the conflicts of law principles of the State of Illinois shall not apply to the extent that they would operate to apply the laws of another state.

8.7. 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.

8.8. 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.

8.9. 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.

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

8.11. 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.

8.12 Counterparts. 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, the Parties have caused this Agreement to be executed and delivered as of the day and year written above.

Our Lady of the Resurrection Medical Center
an Illinois not for profit corporation

By: Ivette Estrada

Name: IVETTE ESTRADA

Title: EXEC. V.P. AND CEO

CHILDREN'S MEMORIAL HOSPITAL

By: Tom Schubnell MSN

Name: Tom Schubnell

Title: Administrator of Surgical & ER Services



Letter of Agreement

**Loyola University Medical Center
On Behalf of the Loyola University Medical Center Perinatal Center,**

and

**Our Lady of the Resurrection Medical Center, Chicago
A facility with no obstetric services**

Effective Date of Agreement: As of January 1, 2007

LOYOLA UNIVERSITY MEDICAL CENTER-PERINATAL CENTER
AND
OUR LADY OF THE RESURRECTION MEDICAL CENTER

The Loyola University Medical Center ("LUMC")-Perinatal Center hereafter referred to as the "Perinatal Center" is designated by the Illinois Department of Public Health (IDPH), as a referral facility intended to care for the high-risk patient before, during or after labor and delivery and characterized by sophistication and availability of personnel, equipment, laboratory, transportation techniques, consultation and other support services. (77 Illinois Administrative Code, Section 640.20) Consistent with its role as a Perinatal Center, Loyola University Medical Center establishes this Letter of Agreement with Our Lady of the Resurrection Medical Center (OLRMC) for the purpose of:

- 1) Indicating the conditions of the affiliation of Our Lady of the Resurrection Medical Center with the Perinatal Center
- 2) Delineating responsibilities of Our Lady of the Resurrection Medical Center as a facility with no obstetrical services and the Loyola University Medical Center-Perinatal Center consistent with the Regionalized Perinatal Health Care Code.

Implementation of this Letter of Agreement is the responsibility of the Medical Director of the Emergency Department and President / CEO at Our Lady of the Resurrection Medical Center in conjunction with the Perinatal Center Co-Directors (one with responsibility for Neonatology and one with responsibility in Maternal/Fetal Medicine). Specific terms and conditions of this agreement follow:

1. Obligations/Responsibilities of Parties

A: Identification, Referral and Acceptance of Patients with Problems

Physicians working in the Emergency Department at Our Lady of the Resurrection Medical Center shall utilize sections of the Regionalized Perinatal Health Care Code (77 Illinois Administrative Code) to assist in determining level of risk in an obstetric patient. Low risk patients, not in immediate risk of delivery, can be transported to Resurrection Medical Center. Obstetric patients who meet the criteria for being at risk or high risk shall obtain consultation from Maternal-Fetal Medicine specialists at the Perinatal Center regarding the need for referral or transport.

As a general guide any pregnant woman or baby who presents to OLRMC <37 weeks gestation or at term with a risk condition is appropriate for transport to Loyola University Medical Center-Perinatal Center. APPENDIX A, "Plan for the Provision of Care for ER Obstetrical Patients", (updated 7/04) details the guidelines which apply to the treatment of obstetrical patients who present to the Emergency Department at Our Lady of the Resurrection Medical Center. APPENDIX B provides guidelines for high risk maternal and neonatal conditions requiring Level III Management of women and neonates.

The Perinatal Center will accept all "medically eligible" obstetric and neonatal patients based upon the high-risk conditions considered appropriate for care in a Level III facility. Decisions regarding the transfer/transport of a perinatal patient to the Perinatal Center shall be made by the perinatologist or neonatologist of the Center on a case-by-case basis in collaboration with the attending physician. In the event that the Perinatal Center is unable to accept a patient, the Perinatal Center will make a reasonable effort to arrange for care at another facility capable of providing the appropriate level of care.

B: Communication

A 24-hour obstetrical and neonatal "hot-line" for immediate consultation, referral and/or transport of perinatal patients is available. Our Lady of the Resurrection Medical Center shall likewise ensure that a telephone line will be answered on a 24-hour basis in the Emergency Department.

1. Method of Communication:

- A. There shall be no limit on the types and frequency of communication which occur between the Emergency Department physician or the gynecologist on call at The Hospital and the perinatologists and / or neonatologists at the Perinatal Center. The Perinatal Center's 24-hour obstetrical hotline should be called for consultation and / or to arrange transport of obstetrical patients as appropriate. A neonatologist may be reached 24 hours a day at the Perinatal Center for consultation and / or to transport of neonatal patients.

<u>Telephone Numbers</u>	<u>Facsimile Machine Numbers</u>
<u>Loyola University Medical Center</u> 24-Hour Perinatal Hotline Numbers: Maternal: 800-424-5126 Neonatal : 708-216-6969	<u>Loyola University Medical Center</u> L & D 708-216-4123 NICU: 708-216-4125
<u>Perinatal Center Administrative Office</u> 708-327-9050	<u>Perinatal Center Administrative Office</u> 708-327-9057
<u>OLRMC:</u> Emergency Room: 773-794-7601	<u>OLRMC</u> Emergency Room: 773-794-7664

2. Transportation: The Provider at Our Lady of the Resurrection Medical Center Emergency Department (OLRMC ED) will be responsible for re-assessing the stability of the mother / fetus immediately prior to any transport.

- A. Term, low risk mothers and babies:
The transfers of low risk term maternal / neonatal patients to Resurrection Medical Center will be arranged by Our Lady of the Resurrection Medical Center.
- B. At risk or high risk mothers and babies: (See APPENDIX C. Requests for Maternal and Neonatal Consultations and / or transport between Network Hospitals and the Perinatal Center)

- i. **Maternal / Fetal:**
Logistics related to maternal transport will be decided between the accepting Perinatologist at the Perinatal Center and Referring Provider at OLRMC at the time of the request based on the stability of the mother and fetus.
 - ii. **Neonatal:**
Logistics related to the transport of neonates requiring tertiary care will be discussed at the time of the request and arranged by the Perinatal Center.
3. When a perinatal transfer or transport has occurred, a discharge summary will be sent to the referring physician and the Chairman of the Emergency Department at OLRMC, upon a patient's discharge from the Perinatal Center.
4. **Follow-up Care:**
The maternal and / or neonatal patient will be followed by the staff at the Perinatal Center as long as medically indicated and the staff will take responsibility for all necessary discharge procedures.
5. **Education:**
The Perinatal Staff will meet with the staff of Our Lady of the Resurrection Medical Center to determine educational priorities related to maternal and neonatal risk assessment and stabilization and will help provide the necessary professional education.
6. **Quality Monitoring:**
The Perinatal Center staff will inform the staff of Our Lady of the Resurrection Medical Center of any state laws or mandates affecting pregnant women and or neonates presenting for emergency services and will meet with OLRMC Emergency Department Administrative staff on an as-needed basis, but at least once a year to assess the perinatal transports to Loyola and to review any perinatal case resulting in mortality.
7. **Joint Responsibilities:**
 - A. This agreement will be valid for three years, at which time it may be renewed or re-negotiated.
 - B. If either OLRMC or the Perinatal Center wishes to change an individualized portion of this agreement, either may initiate the discussion. If OLRMC wishes to make a change and the Perinatal Center is not in agreement, OLRMC can request a hearing by the Perinatal Advisory Committee.
 - C. If either party decides to terminate this agreement, 90-day notice is required. The Illinois Department of Public Health shall also be notified of the intent to terminate.
 - D. Both parties to this agreement will comply fully with requirements of the Health Insurance Portability and Accountability Act (HIPPA) enacted August 21, 1996.

OUR LADY OF THE RESURRECTION MEDICAL CENTER


Ivette Estrada
Executive Vice-President, CEO

8-15-07
Date


Michael Rosenberg, M.D.
Medical Director, Emergency Medicine

8/22/07
Date


Dr. David Bordo
Assistant Medical Director, Emergency Medicine

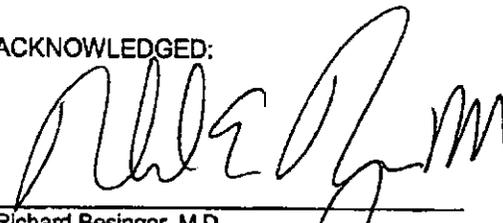
8-22-07
Date

LOYOLA UNIVERSITY MEDICAL CENTER


Paul K. Whelton, M.D., M.Sc.
President and CEO

8/21/07
Date

ACKNOWLEDGED:


Richard Besinger, M.D.
Co-Director Perinatal Center
Vice-Chairman, Dept. of Obstetrics and Gynecology

8/9/07
Date


Marc Weiss, M.D.
Co-Director Perinatal Center
Director Division of Neonatology

8/14/07
Date


Patricia H. O'Malley, RNC, APN/CNP
Network Administrator
Loyola Perinatal Center

8/14/07
Date

APPENDIX A

PLAN FOR THE PROVISION OF CARE FOR ER OBSTETRICAL PATIENTS

Our Lady of the Resurrection Medical Center (OLRMC) and Resurrection Medical Center (RMC) are separate entities in the Resurrection Healthcare Corporation, both dedicated to providing excellence in healthcare to the communities served, and have consolidated their obstetrical services. This letter of agreement/plan has been developed to maintain excellence in the delivery of care.

PURPOSE:

To provide guidelines for the treatment of obstetrical patients who present to the emergency Department at OLRMC.

To establish a written agreement between Our Lady of the Resurrection Medical Center and Resurrection Medical Center to provide safe and appropriate care to obstetrical emergency patients.

RESPONSIBILITY:

The responsibility for implementing this plan is that of the Chairman of the Emergency Services of OLRMC and the Chairman of Emergency Services at RMC.

MANAGEMENT AND TRANSFER OF OBSTETRICAL PATIENTS

A. UNCOMPLICATED OBSTETRICAL PATIENTS

1. Imminent Delivery – in the event that a patient presents to OLR Emergency Department (ED), and after exam it is felt that dilatation is too far advanced to transport the patient safely to an OB facility, the patient will be delivered at OLRMC by the ED physician and / or the Gynecologist on call. The mother and baby will be transferred to RMC, or other appropriate facility, when stable.
2. Non – Imminent Delivery – in the event an obstetrical patient presents to the OLR ED in labor and that patient is deemed stable enough to transfer to RMC, that patient will be transferred to RMC Emergency Department.

B. OBSTETRICAL PATIENTS THAT PRESENT WITH COMPLICATIONS

When obstetrical patients are identified as having complications, the physician on duty will notify the Gynecologist on Emergency Room call. Obstetrical patients that present with complications will be managed by the Gynecologist on call (refer to Emergency Department Policy on Specialty call; Code 11-08). Said complications include, but are not limited to:

1. Preterm labor: greater than 20 weeks gestation and less than 38 weeks gestation.
2. Placenta previa; abruption
3. Breech Presentation
4. Pre-eclampsia/eclampsia
5. Any other unstable condition

C. NEONATAL MANAGEMENT

1. All newborns will be immediately assessed at delivery by the Emergency Department physician.
2. Any newborn of a patient who presented with an obstetrical complication(s) will be assessed by a Pediatrician. The Pediatrician will consult with the Neonatologist on call at Resurrection Medical Center, or other appropriate facility, for transfer. In the event the Pediatrician is not readily available, the Emergency Department physician or Gynecologist will consult with the Neonatologist.
3. For any infant requiring resuscitation, the Anesthesiologist on call will be notified. The Emergency Department physician or Gynecologist will consult with the Perinatal Center for appropriate transfer of the newborn.

D. OTHER CONDITIONS

Any obstetrical patient who is stable, and in need of fetal monitoring for other reasons (e.g., trauma) will be transported to RMC or another appropriate facility, for monitoring and subsequent care.

COMMUNICATION BETWEEN OLRMC ED AND RMC ED

Communication regarding the transfer of the obstetrical patient from OLRMC ED to RMC ED will occur between the OLRMC Emergency Physician or the OLRMC Gynecologist on call and the Emergency Physician at RMC.

MODE OF TRANSFER

Any obstetrical patient presenting in the OLRMC Emergency Room when delivery is not imminent will be transferred to RMC via contracted ambulance service.

PROVISION FOR HIGH - RISK -LEVEL III OBSTETRICAL CARE

All patients presenting in the Emergency Department with conditions considered to be high risk will be transferred to a Level III facility at the designated Perinatal Center.

Communication for Level III transfers will occur between OLRMC Emergency Physician or OLRMC Gynecologist and the Perinatal Center.

Transfers will be arranged per the letter of agreement with the designated Perinatal Center

APPENDIX B

Guidelines based on the Public Health Regionalized Perinatal Health Care Code (77 Illinois Administrative Code, Part 640) delineating maternal and neonatal risk conditions requiring consultation with Loyola University Medical Center-Perinatal Center and probable transport.

Maternal Conditions

A consultation with a Loyola University Medical Center Maternal Fetal Medicine Specialist shall occur and a transport is recommended for each of the following conditions:

1. Previous Pregnancy Problems:
 - i) Premature infant
 - ii) Perinatal death or mental retardation
 - iii) Isoimmunization
 - iv) Difficult deliveries
 - v) Congenital Malformations
 - vi) Mid-trimester loss
2. Current Medical / Pregnancy Problems:
 - i) Any medical disorder (e.g. diabetes mellitus, hemoglobinopathy, chronic hypertension, heart disease, renal disease)
 - ii) Drug addiction
 - iii) Multiple gestation
 - iv) Intrauterine growth retardation
 - v) Preterm Labor <37 weeks gestation
 - vi) Premature rupture of membranes (PROM) <37 weeks gestation
 - vii) Postdates greater than or equal to 42 weeks
 - viii) Vaginal Bleeding
 - ix) Abnormal genetic evaluation
 - x) Preeclampsia, Eclampsia
 - xi) Trauma

Neonatal Conditions

A consultation with a Loyola University Medical Center Neonatologist shall occur and a transport is recommended for each of the following conditions:

1. Neonatal asphyxia
2. Low APGAR <5 at 5 minutes (any weight)
3. Respiratory Distress (any weight)
4. Gestation age less than 37 weeks gestation
5. Birth weight <2500 grams
6. Small for gestational age (less than 10th percentile)
7. Sepsis
8. Seizures
9. Congenital heart disease
10. Multiple congenital anomalies
11. Infants identified as having handicapping conditions or developmental disabilities which threaten life or subsequent development.
12. Severe anemia
13. Hyperbilirubinemia: cut off values requiring call to LUMC

<u>Hours of age</u>	<u>total Bilirubin Value: mg /dl</u>
<24 hours	>7*
25-48 hours	>12
49-72 hours	>15
>72 hours	>17

*Any Term newborn clinically jaundiced < 24 hours is not considered healthy and requires further evaluation as recommended by the American Academy of Pediatrics

14. Hypoglycemia < 45 mg/ dl (per Accucheck)

In the event the Regionalized Perinatal Health Care Code is revised subsequent to execution of this Letter of Agreement, the Loyola University Medical Center-Perinatal Center may provide Our Lady of the Resurrection Medical Center with revised recommendations regarding conditions requiring consultation and maternal and neonatal transfers/transport.

Referral and Placement Responsibilities

This Letter of Agreement is designed to make the Loyola University Medical Center the primary Level III resource to be utilized by the physicians and patients associated with Our Lady of the Resurrection Medical Center. Calls for consultation and transfer/transport should be made to Perinatologists and Neonatologists associated with the Loyola University Medical Center Perinatal Center. If the perinatal facilities of Loyola University Medical Center cannot accommodate a maternal or neonatal transfer/transport, then the Loyola University Perinatal Center will facilitate care of the patient in another facility capable of providing the appropriate level of care (if possible within the Network).

Consultation/Referral/Transportation of Perinatal Patients

The Loyola University Medical Center-Perinatal Center will periodically distribute written guidelines for the mechanisms of consultation and referral, transfer and transport of patients (APPENDIX C). Our Lady of the Resurrection Medical Center agrees to utilize the guidelines and provide recommended documentation.

APPENDIX C

Requests for Maternal and Neonatal Consultation and/or Transport between Network Hospitals and Loyola University Medical Center Perinatal Center

Standard: The Regionalized Perinatal Health Care Code for the State of Illinois mandates that a mechanism be provided for perinatal consultations between a Network Hospital and its Perinatal Center. Requirements for a consultative relationship are specified in the Letter of Agreement between each Network Hospital and the Perinatal Center.

Documentation Requirement: An appropriate system is needed to document requests for consultation (pertinent to transport/transfer) by a Network Hospital, the Perinatal Center's response and recommendations, and the outcome of the case. Logs should be utilized to document information transfer by telephone and by facsimile (FAX) machine, and a system should be maintained at both the referring hospital and the Perinatal Center, which is in accordance with each site's internal procedures for preserving the information exchanged during the consultation/transport process.

Equipment: Each hospital should have a FAX machine accessible to the perinatal staff, and the current FAX number must be provided to the Perinatal Center. FAX machines for use in the consultation/transport process are in the Labor and Delivery area and the NICU at Loyola University Medical Center.

Maternal Consultation and / or Transport

Referring Hospital

Responsibilities of Providers and Staff:

1. Primary care providers (Physicians and Certified Nurse Midwives) and Nurses will perform risk screening on all pregnant women in their care and request consultation and / or transport for any woman who has a risk condition as defined in the Regionalized Perinatal Health Care Code requiring communication with the Perinatal Center.
2. Staff will maintain a log on Labor and Delivery, which documents all requests for perinatal consultation and / or transport. The following data elements should be included in the log:
 - Date / time
 - Patient Identifiers
 - Provider Identifiers
 - Reason for call
 - Center called
 - Disposition
3. The primary care provider will assess the well-being of the maternal / fetal unit and initiate stabilizing measures prior to transport.

Procedure:

1. The primary care provider (Physician or Certified Nurse Midwife) at the Network Hospital will assess the maternal / fetal unit and identify the need for consultation or transport.
2. The primary care provider or charge nurse will call the Loyola University Medical Center HOTLINE, Number (800-424-5126) requesting consultation or transport (See Attachment 1)

3. At the time of the call the staff member must have the following information available:
 - Hospital, patient, and physician identifiers including the phone number where the provider can be reached
 - Patient's age and date of birth
 - Brief OB history including gravidity and parity
 - Current problem
 - Current status
4. The following documents should be available (as requested) to FAX (708-216-4123) to LUMC and / or accompany the mother at the time of transport.
 - Maternal prenatal record
 - Inpatient record
 - Electronic fetal monitor strips
 - Lab reports, including HIV results
 - Other pertinent reports
5. The provider will be responsible for re-assessing the stability of the mother / fetus immediately prior to any transport.

Perinatal Center

Responsibilities of Loyola University Medical Center Nursing and Medical Staff:

1. The Nursing and Medical Staff at Loyola University Medical Center are responsible for providing a prompt and comprehensive response to each request for perinatal consultation or transport.
2. Nursing Staff on Labor and Delivery will maintain a log, which documents all request for perinatal consultation and / or transport. The log will include the following data elements:
 - Date / time the call was received
 - Patient Identifiers
 - Provider Identifiers / phone
 - Reason for call
 - Disposition
 - Name of the responsible Perinatologist
3. Medical Staff is responsible for maintaining communication with the referring provider for each maternal transport. Prior to discharge attempts for telephone communication will be made for any patient who has an identified primary care provider. A copy of the patient's discharge summary will be sent to the identified prenatal care provider. If the patient has not had prenatal care the discharge summary will be sent to the physician who arranged for the transport.
4. If LUMC is unable to accept a Network Transport, the Staff is responsible for placing the patient at another facility capable of providing the appropriate level of care.

Procedure:

1. The Labor and Delivery Charge Nurse will answer all incoming HOTLINE calls, record all pertinent patient information on the Maternal Transport and Consultation Form (See Attachment 2), log the request and promptly notify the Perinatologist of the request.
2. The Perinatologist will call the primary care provider directly to discuss the case and determine the best plan for the mother / fetus including: additional assessments, stabilization measures and transport as needed. If the decision is made to transport, the type of transport will be part of the decision making process:

- A: Two – way Transport: Loyola University Medical Center will send a team via ambulance and bring the mother to Loyola University Medical Center, if the mother and fetus remain stable.
 - B: One – way Transport: The referring hospital will send the mother to Loyola University Medical Center via ambulance.
3. The Perinatologist will notify the charge nurse regarding the plan. If a Two – way Transport is required, the Loyola University Medical Center charge nurse will make arrangements for the transport. If a One – way Transport is appropriate, the staff at the referring hospital will make arrangements for the ambulance. The primary provider will assess the stability of the mother and fetus prior to either a Two-way or One-way Transport.
 4. Upon arrival at the referring hospital Loyola University Medical Center Transport Nurse will take report from the staff, assess the mother and fetus, collect all pertinent records, including mother's HIV status and leave information for the family. If either the mother or fetus appears unstable, the transport nurse will call the Loyola University Medical Center Perinatologist. The Loyola University Medical Center Perinatologist will call the referring provider to discuss the current situation and a determination will be made as to an action plan.
 5. After transport, communication will be maintained between Loyola University Medical Center and the referring provider. Prior to discharge, if the patient has an identified primary care provider, attempts will be made for telephone communication regarding the plan for continuity of care. The patient will be returned to the primary care provider unless otherwise indicated by the provider or patient.

Neonatal Consultation and / or Transport

Referring Hospital

Responsibilities of Providers and Staff

1. Primary care providers (Pediatricians and Neonatal Nurse Practitioners), Emergency Room Physicians and Nurses will perform risk screening on neonates in their care and request consultation and / or transport for any term or preterm baby who has a risk condition. Risk conditions include, but are not limited to, those defined in the Regionalized Perinatal Health Care Code 640. requiring communication with the Perinatal Center.
2. Staff in the nursery will maintain a log which documents all request for perinatal consultation and / or transport. The following data elements should be included in the log:
 - Date / time
 - Patient Identifiers
 - Provider Identifiers
 - Reason for call
 - Center called
 - Disposition
3. If a baby weighs between 501-1499 grams, the Staff is responsible for collecting all maternal and Neonatal data elements as required by the Very Low Birth Weight and Neonatal Outcomes Data System initiated July 1, 1999 by the Illinois Department of Public Health. The forms should be sent to Loyola University Medical Center Perinatal Center.

Procedure:

1. The primary care provider at the Network Hospital will assess the baby identifying the need for consultation or transport and call the Loyola University Medical Center Neonatal Unit (number: 708-

216-6969) requesting consultation or transport. At the time of the call the provider should have information available to complete the fields on Neonatal Consultation and Transport Request Form (Attachment 3).

2. The following documents should be available (as requested) to FAX (number: 708.216.4125) to the LUMC NICU and / or accompany the baby at the time of transport: pertinent maternal records, baby's nursery record, lab reports and other select reports such as radiology studies.
3. The provider will discuss the baby's status with the LUMC Neonatologist and implement therapies as indicated.

Perinatal Center

Responsibilities of Loyola University Medical Center Neonatal Intensive Care Nursing and Medical Staff:

1. The LUMC Nursing and Medical Staff are responsible for providing a prompt and comprehensive response to each request for neonatal consultation or transport.
2. Staff in the Neonatal Intensive Care Unit will maintain a log, which documents all requests for neonatal consultation and / or transport. The log will include the following data elements:
 - Date / time the call was received
 - Patient Identifiers
 - Provider Identifiers / phone
 - Reason for call
 - Disposition
 - Name of the Responsible Neonatologist
3. Medical Staff will be responsible for maintaining communication with the referring provider for each neonatal transport. Communication will include calls during the hospitalization and a copy of a discharge summary.
4. If LUMC is unable to accept a Network Transport, the Staff is responsible for placing the patient at another facility capable of providing the appropriate level of care.

Procedure:

1. All incoming calls and faxes for consultation and / or transport will be given upon receipt to the LUMC Attending Neonatologist and Neonatal Fellow on service.
2. The baby's condition will be discussed with the referring provider and the LUMC Physician will document all pertinent information on the Neonatal Consultation and Transport Request Form. (If the information is initially obtained by the Neonatal Fellow, the Fellow will confer with the LUMC Attending Neonatologist regarding the plan of care.)
3. The LUMC Physician will document the recommendations on the Neonatal Consultation and Transport Form and fax it to the referring provider.
4. The LUMC Physician will notify the charge nurse regarding the plan. If a transport is required, the LUMC charge nurse will make arrangements for the transport.
5. Upon arrival at the referring hospital, the LUMC Transport Team Members will take report from the Staff, assess the neonate, continue stabilization measures, collect all pertinent records, and leave information for the family.
6. After transport, communication will be maintained between LUMC and the referring provider. Prior to discharge, the primary care provider will be consulted regarding the site for continued care.

Additional comments on the procedures:

Proper transfer of consultation forms is not a substitute for physician-to-physician communication. Furthermore, at the time of discharge, a discharge summary will be sent by LUMC to the Network Hospital and to the referring physician.

The entire process of consultation (pertinent to requests for transport/transfer of patients), response, and information transfer will be reviewed by the Perinatal Center and the Network Hospitals at quarterly morbidity and mortality review meetings.

Our Lady of the Resurrection Medical Center

TRANSFER AGREEMENT

This **TRANSFER AGREEMENT** ("Agreement") is entered into and is effective as of July 1, 2009 ("Effective Date") by and between Our Lady of the Resurrection Medical Center a Illinois not-for-profit corporation ("Transferring Facility"), and Saint Francis Hospital, a not-for-profit corporation ("Receiving Hospital") (each a "Party" and collectively the "Parties").

RECITALS

WHEREAS, Transferring Facility is a General Acute Care Hospital; and

WHEREAS, Transferring Facility receives from time to time Patients ("Patient" or "Patients") who are in need of specialized services ("Coronary Bypass Surgery") not available at Transferring Facility, but available at Receiving Hospital; and

WHEREAS, the Parties desire to establish a transfer arrangement in order to assure continuity of care for Patients and to ensure accessibility of services to Patients.

NOW, THEREFORE, for and in consideration of the terms, conditions, covenants, agreements and obligations contained herein:

**ARTICLE 1
PATIENT TRANSFERS**

1.1 Acceptance of Patients. Upon recommendation of an attending physician and pursuant to the provisions of this Agreement, Receiving Hospital agrees to admit a Patient as promptly as possible, provided customary admission requirements, State and Federal laws and regulations are met, and Receiving Hospital has the capacity to treat the Patient. Notice of the transfer shall be given by Transferring Facility as far in advance as possible. After receiving a transfer request, Receiving Hospital shall give prompt confirmation of whether it can provide health care appropriate to the Patient's medical needs. Receiving Hospital agrees to exercise its reasonable best efforts to provide for prompt admission of transferred Patients and, to the extent reasonably possible under the circumstances, to give preference to Patients requiring transfer from Transferring Facility.

1.2 Appropriate Transfer. The Transferring Facility shall assure that all Patient transfers are carried out in accordance with all applicable laws and regulations. It shall be Transferring Facility's responsibility, at no cost to Receiving Hospital, to arrange for appropriate care and safe transportation of the Patient during such transport.

(a) Prior to any Patient transfer to the Receiving Hospital, the Transferring Facility shall provide sufficient information as far in advance as possible, and in any event prior

to the Patient leaving the Transferring Facility for transport, to allow the Receiving Hospital to determine whether it can provide the necessary Patient care and whether the anticipated transport time to Receiving Hospital is reasonable considering the Patient's medical needs, medical condition and proximity of other hospitals to Transferring Facility and the services offered by such alternative facilities.

(b) The Patient's medical record shall contain a physician's order to transfer the Patient, and the attending physician recommending the transfer shall communicate directly with Receiving Hospital's Patient admissions, or, in the case of an emergency services patient who has been screened and stabilized for transfer, with the Receiving Hospital's Emergency Department.

(c) In addition to a Patient's medical records and the Physician's order to transfer, Transferring Facility shall provide Receiving Hospital with all information regarding a Patient's medications, and clear direction as to who may make medical decisions on behalf of the Patient, with copies of any power of attorney for medical decision making or, in the absence of such document, a list of next of kin, if feasible, to assist the Receiving Hospital in determining appropriate medical decision makers in the event a Patient is or becomes unable to do so on his or her own behalf.

(d) Patients should be transferred back from the Receiving Hospital to the Transferring Hospital once the specialized services are rendered.

1.3 **Transfer Log.** The Transferring Facility shall keep an accurate and current log of all Patients transferred to the Receiving Hospital and the disposition of such Patient transfers.

1.4 **Admission to the Receiving Hospital from Transferring Facility.** When a Patient's need for admission to a center specialized in the Specialty is determined by his/her attending physician, Receiving Hospital shall admit the Patient in accordance with the provisions of this Agreement as follows:

(a) Patients determined to be emergent by the attending physician shall be admitted, subject to bed, space, qualified personnel and equipment availability, provided that all usual conditions of admission to Receiving Hospital are met.

(b) All other Patients shall be admitted according to the established routine of Receiving Hospital.

1.5 **Standard of Performance.** Each Party shall, in performing its obligations under this Agreement, provide Patient care services in accordance with the same standards as services provided under similar circumstances to all other Patients of such Party, and as required by federal and state laws and Medicare/Medicaid certification 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.

1.6 **Billing and Collections.** Each Party shall be entitled to bill Patients, payors, managed care plans and any other third party responsible for paying a Patient's bill, for services

rendered to Patients by such Party and its employees, agents and representatives, and neither Party will have any liability to the other Party for such charges. Each Party shall be solely responsible for all matters pertaining to its billing and collection of such charges. The Parties shall reasonably cooperate with each other in the preparation and completion of all necessary forms and documentation and the determination of insurance coverage and managed care requirements for each transferred Patient. Each Party shall have the sole final responsibility for all forms, documentation, and insurance verification.

1.7 **Personal Effects.** Personal effects of any transferred Patient shall be delivered to the transfer team or admissions department of the Receiving Hospital. Personal effects include money, jewelry, personal papers and articles for personal hygiene.

ARTICLE 2 MEDICAL RECORDS

Subject to applicable confidentiality requirements, the Parties shall exchange all information which may be necessary or useful in the care and treatment of the transferred Patient or which may be relevant in determining whether such Patient can be adequately cared for by the other Party. All such information shall be provided by the Transferring Facility in advance, where possible, and in any event, no later than at the time of the transfer. The Transferring Facility shall send a copy of all Patient medical records that are available at the time of transfer to the Receiving Hospital. Other records shall be sent as soon as practicable after the transfer. The Patient's medical record shall contain evidence that the Patient was transferred promptly, safely and in accordance with all applicable laws and regulations. Each Party shall and shall cause its employees and agents to protect the confidentiality of all Patient information (including, but not limited to, medical records, electronic data, radiology films, laboratory blocks, slides and billing information), and comply with all applicable state and federal laws and regulations protecting the confidentiality of Patients' records, including the Health Insurance Portability and Accountability Act of 1996 and the corresponding Standards for Privacy of Individually Identifiable Health Information regulations, each as amended from time to time (collectively, "HIPAA")

ARTICLE 3 TERM AND TERMINATION

3.1 **Term.** This initial term of this Agreement shall begin on the Effective Date and continue for a period of one (1) year. **Thereafter, this agreement shall automatically renew for successive one (1) year terms unless terminated pursuant to this Section.** The initial term and all renewal terms shall collectively be the "Term" of this Agreement.

3.2 **Termination.** This Agreement may be terminated as follows:

(a) **Termination Without Cause.** Either Party may terminate this Agreement, at any time without cause, upon thirty (30) days prior written notice to the other Party.

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

(i) If such Party determines that the continuation of this Agreement would endanger Patient care.

(ii) Violation by the other Party of any material provision of this Agreement, which violation continues for a period of fifteen (15) days after receipt of written notice by the other Party specifying the violation.

(iii) A general assignment by the other Party for the benefit of creditors; the institution by or against the other Party, as debtor, of proceedings of any nature under any law of the United States or any state, whether now existing or currently enacted or amended, for the relief of debtors, provided that in the event such proceedings instituted against the other Party remain unstayed or undismissed for thirty (30) days; the liquidation of the other Party for any reason; or the appointment of a receiver to take charge of the other Party's affairs, provided such appointment remains undischarged for thirty (30) days. Such termination of the provisions of this Agreement shall not affect obligations which accrued prior to the effective date of such termination.

(iv) Exclusion of the other Party from participation in the Medicare or Medicaid programs or conviction of the other Party of a felony related to the provision of health care services.

(v) Except with respect to a change from one accrediting organization to another, the other Party's loss or suspension of any certification, license, accreditation (including Healthcare Facilities Accreditation Program ("HFAP") or other applicable accreditation), or other approval necessary to render Patient care services.

(vi) In the event of insufficient coverage as defined in Section 5 herein, or lapse of coverage.

ARTICLE 4 NON-EXCLUSIVE RELATIONSHIP

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.

In entering into this Agreement, neither Party is acting to endorse or promote the services of the other Party. Rather, the Parties intend to coordinate timely and appropriate transfer for hospital inpatient services.

**ARTICLE 5
CERTIFICATION AND INSURANCE**

5.1 Licenses, Permits, and Certification. Each Party represents to the other that it and all of its employees, agents and representatives possess and shall maintain in valid and current status during the term of this Agreement all required licenses, permits and certifications enabling such Party to provide the services set forth in this Agreement.

5.2 Insurance. Each Party shall, at its own cost and expense, obtain and maintain in force during the term of this Agreement appropriate levels of general and professional liability insurance coverage, in accordance with good business practice for similarly situated health care providers. Such insurance shall be provided by insurance company(ies) acceptable to the other Party and licensed to conduct business in the State of Illinois, or by an appropriately designed and operated self-insurance program. Verification of insurance coverage shall be in the possession of each Party at all times while this Agreement is in effect and shall be promptly provided to the other Party upon request. Each Party shall notify the other Party at least thirty (30) days prior to termination, lapse or loss of adequate insurance coverage as provided herein. In the event the form of insurance held by a Party is claims made, such Party warrants and represents that it will purchase appropriate tail coverage for claims, demands, or actions reported in future years for acts of omissions during the Term of this Agreement. In the event of insufficient coverage as defined in this Section, or lapse of coverage, the non-breaching Party reserves the right to immediately and unilaterally terminate this Agreement.

5.3 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 that may result in litigation related in any way to this Agreement.

**ARTICLE 6
INDEMNIFICATION**

Each Party shall indemnify and hold harmless the other Party, together with its officers, directors, agents, employees, affiliates, successors and assigns, from and against any and all manner of claims, demands, causes of action, liabilities, damages, costs, and expenses (including costs and reasonable attorney's fees) arising from or incident to the performance of such indemnifying Party's duties hereunder.

**ARTICLE 7
COMPLIANCE WITH LAWS**

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 the services to be provided hereunder and that may be 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 HIPAA. A Party shall promptly notify the other Party if it receives notice of any actual or alleged infraction, violation, default or breach of the same. Each of Transferring

Facility and Receiving Hospital represents and warrants that neither it, nor any employee, officer, director or agent thereof is an "excluded person" under the Medicare rules and regulations.

As of the date hereof and throughout the term of this Agreement: (a) Transferring Facility represents, warrants and covenants to Receiving Hospital that Transferring Facility is licensed to operate a general acute care hospital in Illinois and is a participating facility in Medicare and Medicaid; and (b) Receiving Hospital represents, warrants and covenants to Transferring Facility that Receiving Hospital is licensed to operate a general acute hospital and ancillary facilities specializing in the Specialty and to participate in Medicare and Medicaid.

ARTICLE 8 MISCELLANEOUS

8.1 No Referrals Requirement. 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 Patients.

8.2 Relationship of the Parties. The Parties expressly acknowledge that in performing their respective obligations under this Agreement, each is acting as an independent contractor with respect to the other. Facility and Hospital are not and shall not be considered joint venturers, partners or agents of the other.

8.3 Notices: All notices that may be given under this Agreement shall be in writing, addressed to the receiving Party's address set forth below or to such other address as the receiving Party may designate by notice hereunder, and shall be delivered by hand or by traceable courier service (such as Federal Express) or sent by certified or registered mail, return receipt requested:

To Transferring Facility: Our Lady of the Resurrection Medical Center
5645 West Addison Street
Chicago, IL 60634
Attention: Ivette Estrada, Exec. V.P./CEO
Facsimile Number: 773-794-7686

To Receiving Hospital: Saint Francis Hospital
355 Ridge Avenue
Evanston, IL 60202
Attention: Jeff Murphy, Exec. V.P./CEO
Facsimile Number: 847-316-4500

All notices shall be deemed to have been given, if by hand or traceable courier service, at the time of the delivery to the receiving Party at the address set forth above or to such other address as the receiving Party may designate by notice hereunder, or if sent by certified or registered mail, on the 2nd business day after such mailing.

8.4 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, or a successor in interest to substantially all of the assets of such Party.

8.5 Entire Agreement; Amendments. 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.

8.6 Governing Law. This Agreement shall be governed by and construed according to the laws of the State of Illinois without regard to the conflict of laws provisions thereunder.

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

8.8 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.

8.9 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 of competent jurisdiction, 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 unaffected.

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

8.11 Waiver. No covenant or condition of this Agreement can be waived, except to the extent set forth in writing by the waving Party.

1.12 Counterparts. This Agreement may be executed in two (2) counterparts, each of which shall be deemed an original, but all of which, when taken together, shall constitute one and the same Agreement.

IN WITNESS WHEREOF, the Parties have executed this Agreement through their respective authorized officers, effective as of the day and year first written above.

TRANSFERRING FACILITY

Ivette Estrada
Ivette Estrada
Executive V.P./CEO

RECEIVING HOSPITAL

Signature: *Jeffrey Morphy*

Printed Name: JEFFREY MORPHY

Title: EXECUTIVE VP/CEO

TRANSFER AGREEMENT

This **TRANSFER AGREEMENT** ("Agreement") is entered into and is effective as of **February 26, 2008** ("Effective Date") by and between **BELMONT/HARLEM SURGERY CENTER, LLC** 3101 North Harlem Avenue, Chicago, Illinois, a Limited Liability Company ("Transferring Facility"), and **OUR LADY OF THE RESURRECTION CENTER**, 5645 West Addison Street, Chicago, an Illinois not for profit hospital ("Receiving Hospital") (each a "Party" and collectively the "Parties").

RECITALS

WHEREAS, Transferring Facility is a **free-standing surgical center**, and

WHEREAS, Transferring Facility receives from time to time Patients ("Patient" or "Patients") who are in need of specialized services ("Specialty") not available at Transferring Facility, but available at Receiving Hospital; and

WHEREAS, the Parties desire to establish a transfer arrangement in order to assure continuity of care for Patients and to ensure accessibility of services to Patients.

NOW, THEREFORE, for and in consideration of the terms, conditions, covenants, agreements and obligations contained herein:

ARTICLE 1 PATIENT TRANSFERS

1.1 Acceptance of Patients. Upon recommendation of an attending physician and pursuant to the provisions of this Agreement, Receiving Hospital agrees to admit a Patient as promptly as possible, provided customary admission requirements, State and Federal laws and regulations are met, and Receiving Hospital has the capacity to treat the Patient. Notice of the transfer shall be given by Transferring Facility as far in advance as possible. After receiving a transfer request, Receiving Hospital shall give prompt confirmation of whether it can provide health care appropriate to the Patient's medical needs. Receiving Hospital agrees to exercise its reasonable best efforts to provide for prompt admission of transferred Patients and, to the extent reasonably possible under the circumstances, to give preference to Patients requiring transfer from Transferring Facility.

1.2 Appropriate Transfer. The Transferring Facility shall assure that all Patient transfers are carried out in accordance with all applicable laws and regulations. It shall be Transferring Facility's responsibility, at no cost to Receiving Hospital, to arrange for appropriate care and safe transportation of the Patient during such transport.

(a) Prior to any Patient transfer to the Receiving Hospital, the Transferring Facility shall provide sufficient information as far in advance as possible, and in any event prior to the Patient leaving the Transferring Facility for transport, to allow the Receiving Hospital to

determine whether it can provide the necessary Patient care and whether the anticipated transport time to Receiving Hospital is reasonable considering the Patient's medical needs, medical condition and proximity of other hospitals to Transferring Facility and the services offered by such alternative facilities.

(b) The Patient's medical record shall contain a physician's order to transfer the Patient, and the attending physician recommending the transfer shall communicate directly with Receiving Hospital's Patient admissions, or, in the case of an emergency services patient who has been screened and stabilized for transfer, with the Receiving Hospital's Emergency Department.

(c) In addition to a Patient's medical records and the Physician's order to transfer, Transferring Facility shall provide Receiving Hospital with all information regarding a Patient's medications, and clear direction as to who may make medical decisions on behalf of the Patient, with copies of any power of attorney for medical decision making or, in the absence of such document, a list of next of kin, if feasible, to assist the Receiving Hospital in determining appropriate medical decision makers in the event a Patient is or becomes unable to do so on his or her own behalf.

1.3 Transfer Log. The Transferring Facility shall keep an accurate and current log of all Patients transferred to the Receiving Hospital and the disposition of such Patient transfers.

1.4 Admission to the Receiving Hospital from Transferring Facility. When a Patient's need for admission to a center specialized in the Specialty is determined by his/her attending physician, Receiving Hospital shall admit the Patient in accordance with the provisions of this Agreement as follows:

(a) Patients determined to be emergent by the attending physician shall be admitted, subject to bed, space, qualified personnel and equipment availability, provided that all usual conditions of admission to Receiving Hospital are met.

(b) All other Patients shall be admitted according to the established routine of Receiving Hospital.

1.5 Standard of Performance. Each Party shall, in performing its obligations under this Agreement, provide Patient care services in accordance with the same standards as services provided under similar circumstances to all other Patients of such Party, and as required by federal and state laws and Medicare/Medicaid certification 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.

1.6 Billing and Collections. Each Party shall be entitled to bill Patients, payors, managed care plans and any other third party responsible for paying a Patient's bill, for services rendered to Patients by such Party and its employees, agents and representatives, and neither Party will have any liability to the other Party for such charges. Each Party shall be solely responsible for all matters pertaining to its billing and collection of such charges. The Parties shall reasonably cooperate with each other in the preparation and completion of all necessary forms and

documentation and the determination of insurance coverage and managed care requirements for each transferred Patient. Each Party shall have the sole final responsibility for all forms, documentation, and insurance verification.

1.7 **Personal Effects.** Personal effects of any transferred Patient shall be delivered to the transfer team or admissions department of the Receiving Hospital. Personal effects include money, jewelry, personal papers and articles for personal hygiene.

ARTICLE 2 MEDICAL RECORDS

Subject to applicable confidentiality requirements, the Parties shall exchange all information which may be necessary or useful in the care and treatment of the transferred Patient or which may be relevant in determining whether such Patient can be adequately cared for by the other Party. All such information shall be provided by the Transferring Facility in advance, where possible, and in any event, no later than at the time of the transfer. The Transferring Facility shall send a copy of all Patient medical records that are available at the time of transfer to the Receiving Hospital. Other records shall be sent as soon as practicable after the transfer. The Patient's medical record shall contain evidence that the Patient was transferred promptly, safely and in accordance with all applicable laws and regulations. Each Party shall and shall cause its employees and agents to protect the confidentiality of all Patient information (including, but not limited to, medical records, electronic data, radiology films, laboratory blocks, slides and billing information), and comply with all applicable state and federal laws and regulations protecting the confidentiality of Patients' records, including the Health Insurance Portability and Accountability Act of 1996 and the corresponding Standards for Privacy of Individually Identifiable Health Information regulations, each as amended from time to time (collectively, "HIPAA")

ARTICLE 3 TERM AND TERMINATION

3.1 **Term.** This initial term of this Agreement shall begin on the Effective Date and continue for a period of one (1) year. **Thereafter, this agreement shall automatically renew for successive one (1) year terms unless terminated pursuant to this Section.** The initial term and all renewal terms shall collectively be the "Term" of this Agreement.

3.2 **Termination.** This Agreement may be terminated as follows:

(a) **Termination Without Cause.** Either Party may terminate this Agreement, at any time without cause, upon thirty (30) days prior written notice to the other Party.

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

(i) If such Party determines that the continuation of this Agreement would endanger Patient care.

(ii) Violation by the other Party of any material provision of this Agreement, which violation continues for a period of fifteen (15) days after receipt of written notice by the other Party specifying the violation.

(iii) A general assignment by the other Party for the benefit of creditors; the institution by or against the other Party, as debtor, of proceedings of any nature under any law of the United States or any state, whether now existing or currently enacted or amended, for the relief of debtors, provided that in the event such proceedings instituted against the other Party remain unstayed or undismissed for thirty (30) days; the liquidation of the other Party for any reason; or the appointment of a receiver to take charge of the other Party's affairs, provided such appointment remains undischarged for thirty (30) days. Such termination of the provisions of this Agreement shall not affect obligations which accrued prior to the effective date of such termination.

(iv) Exclusion of the other Party from participation in the Medicare or Medicaid programs or conviction of the other Party of a felony related to the provision of health care services.

(v) Except with respect to a change from one accrediting organization to another, the other Party's loss or suspension of any certification, license, accreditation (including Healthcare Facilities Accreditation Program ("HFAP") or other applicable accreditation), or other approval necessary to render Patient care services.

(vi) In the event of insufficient coverage as defined in **Section 5** herein, or lapse of coverage.

ARTICLE 4 NON-EXCLUSIVE RELATIONSHIP

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.

In entering into this Agreement, neither Party is acting to endorse or promote the services of the other Party. Rather, the Parties intend to coordinate timely and appropriate transfer for hospital inpatient services.

ARTICLE 5 CERTIFICATION AND INSURANCE

5.1 Licenses, Permits, and Certification. Each Party represents to the other that it and all of its employees, agents and representatives possess and shall maintain in valid and current status during the term of this Agreement all required licenses, permits and certifications enabling such Party to provide the services set forth in this Agreement.

Page 4 of 8

Legal Affairs Template: Transfer Agreement-Approved June 28, 2006

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ATTACHMENT 19C

5.2 Insurance. Each Party shall, at its own cost and expense, obtain and maintain in force during the term of this Agreement appropriate levels of general and professional liability insurance coverage, in accordance with good business practice for similarly situated health care providers. Such insurance shall be provided by insurance company(ies) acceptable to the other Party and licensed to conduct business in the State of Illinois, or by an appropriately designed and operated self-insurance program. Verification of insurance coverage shall be in the possession of each Party at all times while this Agreement is in effect and shall be promptly provided to the other Party upon request. Each Party shall notify the other Party at least thirty (30) days prior to termination, lapse or loss of adequate insurance coverage as provided herein. In the event the form of insurance held by a Party is claims made, such Party warrants and represents that it will purchase appropriate tail coverage for claims, demands, or actions reported in future years for acts of omissions during the Term of this Agreement. In the event of insufficient coverage as defined in this Section, or lapse of coverage, the non-breaching Party reserves the right to immediately and unilaterally terminate this Agreement.

5.3 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 that may result in litigation related in any way to this Agreement.

ARTICLE 6 INDEMNIFICATION

Each Party shall indemnify and hold harmless the other Party, together with its officers, directors, agents, employees, affiliates, successors and assigns, from and against any and all manner of claims, demands, causes of action, liabilities, damages, costs, and expenses (including costs and reasonable attorney's fees) arising from or incident to the performance of such indemnifying Party's duties hereunder.

ARTICLE 7 COMPLIANCE WITH LAWS

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 the services to be provided hereunder and that may be 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 HIPAA. A Party shall promptly notify the other Party if it receives notice of any actual or alleged infraction, violation, default or breach of the same. Each of Transferring Facility and Receiving Hospital represents and warrants that neither it, nor any employee, officer, director or agent thereof is an "excluded person" under the Medicare rules and regulations.

As of the date hereof and throughout the term of this Agreement: (a) Transferring Facility represents, warrants and covenants to Receiving Hospital that Transferring Facility is licensed to operate a general acute care hospital in Illinois and is a participating facility in Medicare and Medicaid; and (b) Receiving Hospital represents, warrants and covenants to Transferring Facility

that Receiving Hospital is licensed to operate a general acute hospital and ancillary facilities specializing in the Specialty and to participate in Medicare and Medicaid.

ARTICLE 8 MISCELLANEOUS

8.1 No Referrals Requirement. 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 Patients.

8.2 Relationship of the Parties. The Parties expressly acknowledge that in performing their respective obligations under this Agreement, each is acting as an independent contractor with respect to the other. Facility and Hospital are not and shall not be considered joint venturers, partners or agents of the other.

8.3 Notices. All notices that may be given under this Agreement shall be in writing, addressed to the receiving Party's address set forth below or to such other address as the receiving Party may designate by notice hereunder, and shall be delivered by hand or by traceable courier service (such as Federal Express) or sent by certified or registered mail, return receipt requested:

To Transferring Facility: Belmont/Harlem Surgery Center, LLC
3101 North Harlem Avenue
Chicago, Illinois 60634

Attention: Dr. Faisal Rahman
Facsimile Number: 773-797-3606

Attention: Starr Novak
Senior Vice President
Facsimile Number: 773-637-0129

To Receiving Hospital: Our Lady of the Resurrection Medical Center
5645 West Addison Street
Chicago, Illinois 60634

Attention: Ivette Estrada
Executive Vice President and Chief Executive Officer
Facsimile Number: 773-794-7651

All notices shall be deemed to have been given, if by hand or traceable courier service, at the time of the delivery to the receiving Party at the address set forth above or to such other address as the receiving Party may designate by notice hereunder, or if sent by certified or registered mail, on the 2nd business day after such mailing.

8.4 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, or a successor in interest to substantially all of the assets of such Party.

8.5 Entire Agreement; Amendments. 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.

8.6 Governing Law. This Agreement shall be governed by and construed according to the laws of the State of Illinois without regard to the conflict of laws provisions thereunder.

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

8.8 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.

8.9 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 of competent jurisdiction, 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 unaffected.

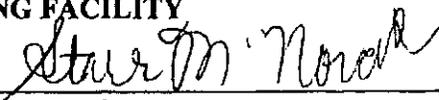
8.10 Successors and Assigns. This Agreement shall be binding upon, and shall inure to the benefit of the Parties hereto, their respective successors and permitted assigns.

8.11 Waiver. No covenant or condition of this Agreement can be waived, except to the extent set forth in writing by the waving Party.

8.12 Counterparts. This Agreement may be executed in two (2) counterparts, each of which shall be deemed an original, but all of which, when taken together, shall constitute one and the same Agreement.

IN WITNESS WHEREOF, the Parties have executed this Agreement through their respective authorized officers, effective as of the day and year first written above.

TRANSFERRING FACILITY

Signature: 
Starr Novak
Assistant Secretary
Belmont/Harlem Surgery Center, LLC

RECEIVING HOSPITAL

Signature: 
Ivette Estrada
Executive Vice President and Chief Executive Officer
Our Lady of the Resurrection Medical Center

TRANSFER AGREEMENT

This **TRANSFER AGREEMENT** ("Agreement") is entered into and is effective as of **February 26, 2008** ("Effective Date") by and between **BELMONT/HARLEM SURGERY CENTER, LLC** 3101 North Harlem Avenue, Chicago, Illinois, a limited liability company ("Transferring Facility"), and **RESURRECTION MEDICAL CENTER**, 7435 West Talcott Avenue, Chicago, an Illinois not for profit hospital ("Receiving Hospital") (each a "Party" and collectively the "Parties").

RECITALS

WHEREAS, Transferring Facility is a free-standing surgical center, and

WHEREAS, Transferring Facility receives from time to time Patients ("Patient" or "Patients") who are in need of specialized services ("Specialty") not available at Transferring Facility, but available at Receiving Hospital; and

WHEREAS, the Parties desire to establish a transfer arrangement in order to assure continuity of care for Patients and to ensure accessibility of services to Patients.

NOW, THEREFORE, for and in consideration of the terms, conditions, covenants, agreements and obligations contained herein:

ARTICLE 1 PATIENT TRANSFERS

1.1 Acceptance of Patients. Upon recommendation of an attending physician and pursuant to the provisions of this Agreement, Receiving Hospital agrees to admit a Patient as promptly as possible, provided customary admission requirements, State and Federal laws and regulations are met, and Receiving Hospital has the capacity to treat the Patient. Notice of the transfer shall be given by Transferring Facility as far in advance as possible. After receiving a transfer request, Receiving Hospital shall give prompt confirmation of whether it can provide health care appropriate to the Patient's medical needs. Receiving Hospital agrees to exercise its reasonable best efforts to provide for prompt admission of transferred Patients and, to the extent reasonably possible under the circumstances, to give preference to Patients requiring transfer from Transferring Facility.

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(a) Prior to any Patient transfer to the Receiving Hospital, the Transferring Facility shall provide sufficient information as far in advance as possible, and in any event prior to the Patient leaving the Transferring Facility for transport, to allow the Receiving Hospital to determine whether it can provide the necessary Patient care and whether the anticipated transport

time to Receiving Hospital is reasonable considering the Patient's medical needs, medical condition and proximity of other hospitals to Transferring Facility and the services offered by such alternative facilities.

(b) The Patient's medical record shall contain a physician's order to transfer the Patient, and the attending physician recommending the transfer shall communicate directly with Receiving Hospital's Patient admissions, or, in the case of an emergency services patient who has been screened and stabilized for transfer, with the Receiving Hospital's Emergency Department.

(c) In addition to a Patient's medical records and the Physician's order to transfer, Transferring Facility shall provide Receiving Hospital with all information regarding a Patient's medications, and clear direction as to who may make medical decisions on behalf of the Patient, with copies of any power of attorney for medical decision making or, in the absence of such document, a list of next of kin, if feasible, to assist the Receiving Hospital in determining appropriate medical decision makers in the event a Patient is or becomes unable to do so on his or her own behalf.

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each transferred Patient. Each Party shall have the sole final responsibility for all forms, documentation, and insurance verification.

1.7 **Personal Effects.** Personal effects of any transferred Patient shall be delivered to the transfer team or admissions department of the Receiving Hospital. Personal effects include money, jewelry, personal papers and articles for personal hygiene.

ARTICLE 2 MEDICAL RECORDS

Subject to applicable confidentiality requirements, the Parties shall exchange all information which may be necessary or useful in the care and treatment of the transferred Patient or which may be relevant in determining whether such Patient can be adequately cared for by the other Party. All such information shall be provided by the Transferring Facility in advance, where possible, and in any event, no later than at the time of the transfer. The Transferring Facility shall send a copy of all Patient medical records that are available at the time of transfer to the Receiving Hospital. Other records shall be sent as soon as practicable after the transfer. The Patient's medical record shall contain evidence that the Patient was transferred promptly, safely and in accordance with all applicable laws and regulations. Each Party shall and shall cause its employees and agents to protect the confidentiality of all Patient information (including, but not limited to, medical records, electronic data, radiology films, laboratory blocks, slides and billing information), and comply with all applicable state and federal laws and regulations protecting the confidentiality of Patients' records, including the Health Insurance Portability and Accountability Act of 1996 and the corresponding Standards for Privacy of Individually Identifiable Health Information regulations, each as amended from time to time (collectively, "HIPAA")

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3.1 **Term.** This initial term of this Agreement shall begin on the Effective Date and continue for a period of one (1) year. **Thereafter, this agreement shall automatically renew for successive one (1) year terms unless terminated pursuant to this Section.** The initial term and all renewal terms shall collectively be the "Term" of this Agreement.

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(ii) Violation by the other Party of any material provision of this Agreement, which violation continues for a period of fifteen (15) days after receipt of written notice by the other Party specifying the violation.

(iii) A general assignment by the other Party for the benefit of creditors; the institution by or against the other Party, as debtor, of proceedings of any nature under any law of the United States or any state, whether now existing or currently enacted or amended, for the relief of debtors, provided that in the event such proceedings instituted against the other Party remain unstayed or undismissed for thirty (30) days; the liquidation of the other Party for any reason; or the appointment of a receiver to take charge of the other Party's affairs, provided such appointment remains undischarged for thirty (30) days. Such termination of the provisions of this Agreement shall not affect obligations which accrued prior to the effective date of such termination.

(iv) Exclusion of the other Party from participation in the Medicare or Medicaid programs or conviction of the other Party of a felony related to the provision of health care services.

(v) Except with respect to a change from one accrediting organization to another, the other Party's loss or suspension of any certification, license, accreditation (including Healthcare Facilities Accreditation Program ("HFAP") or other applicable accreditation), or other approval necessary to render Patient care services.

(vi) In the event of insufficient coverage as defined in Section 5 herein, or lapse of coverage.

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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.

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Each Party shall indemnify and hold harmless the other Party, together with its officers, directors, agents, employees, affiliates, successors and assigns, from and against any and all manner of claims, demands, causes of action, liabilities, damages, costs, and expenses (including costs and reasonable attorney's fees) arising from or incident to the performance of such indemnifying Party's duties hereunder.

ARTICLE 7 COMPLIANCE WITH LAWS

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 the services to be provided hereunder and that may be 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 HIPAA. A Party shall promptly notify the other Party if it receives notice of any actual or alleged infraction, violation, default or breach of the same. Each of Transferring Facility and Receiving Hospital represents and warrants that neither it, nor any employee, officer, director or agent thereof is an "excluded person" under the Medicare rules and regulations.

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**ARTICLE 8
MISCELLANEOUS**

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To Transferring Facility: Belmont/Harlem Surgery Center, LLC
3101 North Harlem Avenue
Chicago, Illinois 60634

Attention: Dr. Faisal M. Rahman
Facsimile Number: 773-797-3606

Attention: Starr Novak
Senior Vice President
Resurrection Ambulatory Care Services
Facsimile Number: 773-637-0129

To Receiving Hospital: Resurrection Medical Center
7435 West Talcott Avenue
Chicago, Illinois 60631

Attention: Sister Donna Marie Wolowicki, C.R.
Executive Vice President and Chief Executive Officer
Facsimile Number: 773-792-9926

All notices shall be deemed to have been given, if by hand or traceable courier service, at the time of the delivery to the receiving Party at the address set forth above or to such other address as the receiving Party may designate by notice hereunder, or if sent by certified or registered mail, on the 2nd business day after such mailing.

8.4 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, or a successor in interest to substantially all of the assets of such Party.

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

8.11 Waiver. No covenant or condition of this Agreement can be waived, except to the extent set forth in writing by the waving Party.

8.12 Counterparts. This Agreement may be executed in two (2) counterparts, each of which shall be deemed an original, but all of which, when taken together, shall constitute one and the same Agreement.

IN WITNESS WHEREOF, the Parties have executed this Agreement through their respective authorized officers, effective as of the day and year first written above.

TRANSFERRING FACILITY

Signature: *Starr M. Novak*
Starr Novak
Assistant Secretary
Belmont/Harlem Surgery Center, LLC

RECEIVING HOSPITAL

Signature: *Sister Donna Marie Wolowicki, C.R.*
Sister Donna Marie Wolowicki, C.R.
Executive Vice President and Chief Executive Officer
Resurrection Medical Center

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

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:

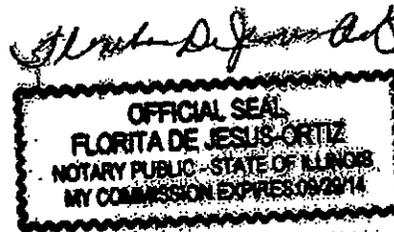
I hereby attest that all of the real costs associated with the changes of ownership of the facilities directly or indirectly owned and/or controlled by Resurrection Health Care Corporation will be funded in total with cash or equivalents.

Sincerely,

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

Sandra Bruce, FACHE
President & Chief Executive Officer

Notarized:





March 22, 2011

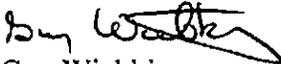
Illinois Health Facilities
and Services Review Board
Springfield, Illinois

RE: FUNDING OF PROJECT

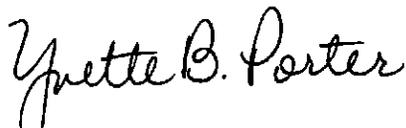
To Whom It May Concern:

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

OPERATING and CAPITAL COSTS
per ADJUSTED PATIENT DAY

Our Lady of the Resurrection Medical Center
2012 Projection

ADJUSTED PATIENT DAYS:

\$	<u>52,006,494</u>	
\$	1,586	32,794

OPERATING COSTS

salaries & benefits	\$ 57,313,003
supplies	<u>\$ 16,628,947</u>
TOTAL	\$ 73,941,950

Operating cost/adjusted patient day:	\$ 2,254.72
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CAPITAL COSTS

depreciation	\$ 4,586,864
interest	<u>\$ 1,603,119</u>
TOTAL	\$ 6,189,983

Capital cost/adjusted patient day:	\$ 188.75
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Project Overview

Resurrection Health Care Corporation (“Resurrection”) and Provena Health (“Provena”) propose a merging of the two systems that will better position the combined system’s hospitals, long-term care facilities, outpatient centers and other programs and facilities to continue to serve the patients and communities that have traditionally looked to those facilities and programs for care. As explained below and throughout the application, this system merger is intended to preserve access to Catholic health care; improve financial viability; improve patient, employee, and medical staff satisfaction through a shared culture and integrated leadership; and position the combined system for innovation and adaptation under health care reform.

This Project Overview supplements the Narrative Description provided in Section I.3. of the individual Certificate of Need applications filed to address the change of ownership of each of the thirteen (13) hospitals, one (1) ambulatory surgical treatment center (ASTC) and one (1) end stage renal dialysis (ESRD) facility currently owned or controlled by either Provena or Resurrection; and highlights the overall features of the proposed system merger.

Provena’s hospitals are located primarily in the communities to the west of Chicago and in central Illinois, and Resurrection’s hospitals are located in Chicago and communities to the north of Chicago. None of either system’s hospital service areas overlap with those of any hospitals in the other system. Therefore, the proposed merger will not result in duplicative clinical services in any geographic area.

The proposed transaction would affect thirteen (13) hospitals, twenty-eight (28) long-term care facilities, one (1) ASTC, one (1) ESRD facility, an expanding health science university, six (6) home health agencies, and approximately fifty-eight (58) other freestanding outpatient sites. Resurrection is the sole member of seven (7) of the hospitals and Provena is the sole member of six (6) of the hospitals. The ASTC is a joint venture in which Resurrection has “control” pursuant to the IHFSRB definition, and the ESRD is a joint venture in which Provena has such “control”.

About Provena Health

Provena Health is a health care system that was established in 1997 through the merging of the health care services of the Franciscan Sisters of the Sacred Heart, the Sisters of Mercy of the Americas—Chicago Regional Community (now West Midwest Community), and the Servants of the Holy Heart of Mary. These three congregations of religious women are now the sponsors of Provena Health. The primary reason for the formation of Provena Health was to strengthen the Catholic health ministry in Illinois, which at the time of formation was a major goal of the late Joseph Cardinal Bernardin, Archbishop of Chicago.

Today, Provena Health operates six acute care hospitals, twelve long-term care facilities, four senior residential facilities and a variety of freestanding outpatient facilities and programs.

About The Resurrection Health Care System

The Resurrection Health Care System grew from a single hospital, now known as Resurrection Medical Center, established by the Sisters of the Resurrection in northwest Chicago in the early 1950s. A second hospital, Our Lady of the Resurrection, was added in 1988. During the period from late 1997 through 2001, six more hospitals joined the Resurrection system. During the same period, eight Chicago area licensed long-term care facilities, three retirement communities, a home care agency, an ambulatory surgery center, and numerous freestanding outpatient facilities became part of Resurrection Health Care System. The Resurrection system is co-sponsored by two congregations of Catholic religious women, the Sisters of the Resurrection and the Sisters of the Holy Family of Nazareth.

In 2010, following a thorough discernment process, and in response to an immediate need to address financial concerns, Resurrection Health Care Corporation divested itself of two hospitals; Westlake Hospital and West Suburban Medical Center (IHFSRB Permits 10-013 and 10-014) to ensure that the two hospitals would be able to continue to serve their communities.

Decision to Merge and Goals of the Merger

In late 2010, Provena and Resurrection leadership began discussions to explore the potential benefits of a system merger. In addition to their clear mission compatibility, the two systems share many similar priorities related to clinical integration, administrative efficiencies and strategic vision. While their respective facilities are geographically proximate, their markets do not overlap, providing opportunities to strengthen all facilities through operational efficiencies and enhanced clinical collaborations.

This system merger decision was made in the larger context of a rapidly changing health care delivery environment. Across the nation, hospitals and other health care providers are addressing health care reform through various forms of integration and consolidation. These actions are thought necessary to achieve improved quality of care, efficiency of service delivery, and patient, medical staff, and employee satisfaction—all critical components of future success.

For Catholic-sponsored health care providers, including Resurrection and Provena, these adaptations to health care reform must be consistent with the mission and values inherent in the religious sponsorship of health care providers. This particular merger would afford Provena and Resurrection the opportunity to achieve essential systemic enhancements in a mission-compatible manner.

The Provena and Resurrection systems have, since 2008, been equal partners in Alverno Clinical Laboratories, LLC, which provides clinical pathology services to each of Resurrection's and Provena's thirteen hospitals, as well as a variety of other facilities.

Structure of the Transaction and Commitments

Through the proposed transaction, the Resurrection and Provena systems will merge through a common, not-for-profit, charitable "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). Both of the current parent entities will continue to exist and operate, and will continue to serve as the direct parents of their respective subsidiary entities. It is the applicants' expectation that, for a minimum of two years, no Resurrection or Provena hospital or hospitals will be eliminated or restructured in the course of the system merger, and no health care facilities will require new or modified health facilities licenses as a result of the system merger. A chart depicting this proposed merged structure is attached as Exhibit A. The executed System Merger Agreement submitted with this application, provides detail regarding the means by which the super parent will exercise unified corporate oversight for the combined system.

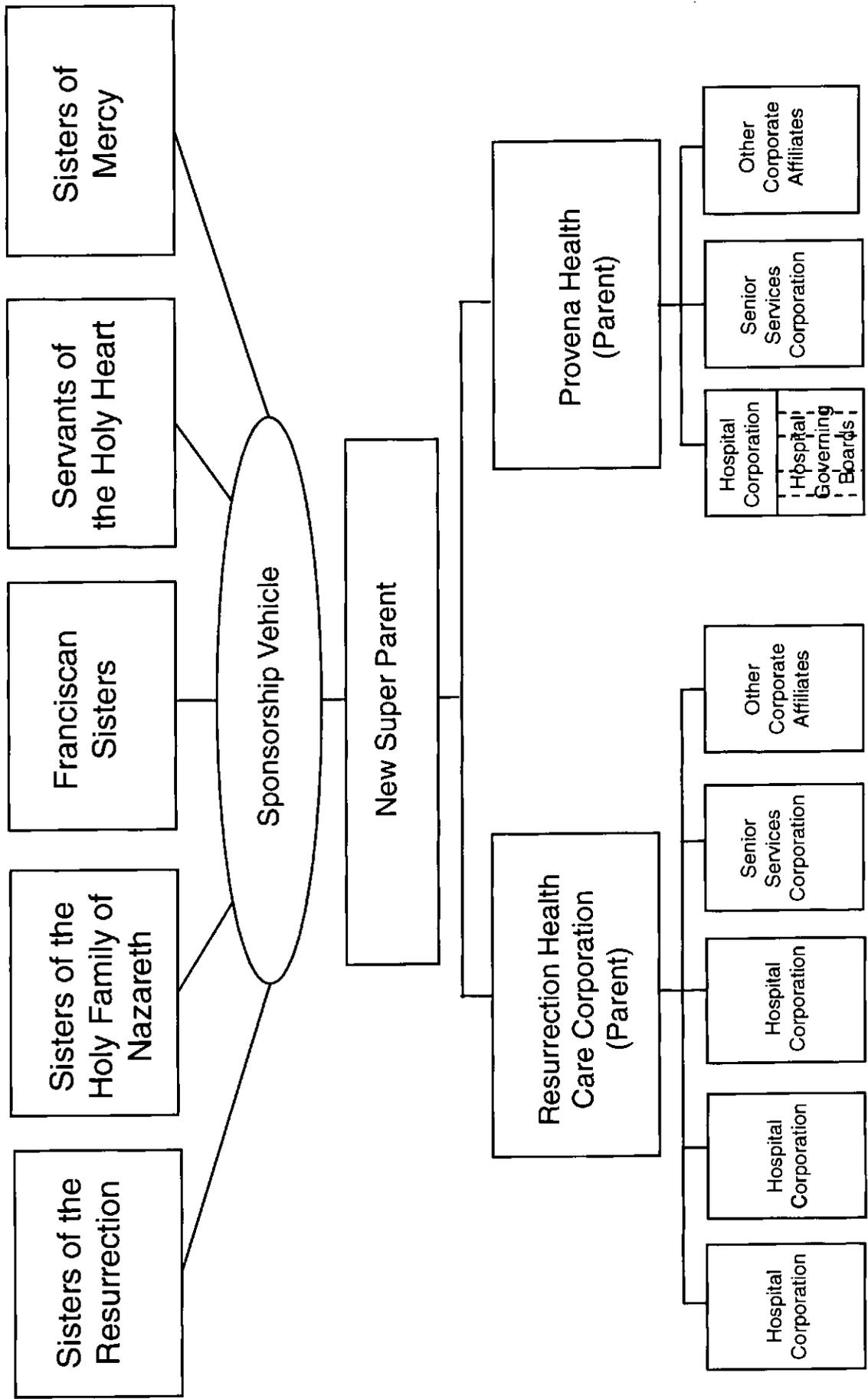
A co-applicant in each Certificate of Need application is Cana Lakes Health Care, which is an existing Illinois not-for-profit corporation. The Cana Lakes corporation will be reconstituted to serve as the super parent entity, through amendment of its corporate documents to reflect unified governance and corporate oversight. The Bylaws of the Super Parent will detail the composition of the Board of Directors; reserve powers of the five (5) religious sponsors; and other governance matters typically addressed in such documents. These Bylaws will be substantially in the form of an exhibit to the System Merger Agreement.

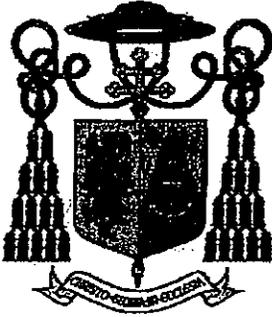
The licensees of the individual hospitals, long-term care facilities and the ASTC will not change. All of Resurrection's clinical programs and all of Provena's clinical programs will be included in the new structure.

The health care facilities and services will continue to operate as Catholic facilities, consistent with the care principles of the Ethical and Religious Directives for Catholic Health Care Services. It is the expectation of the applicants that all major clinical programs will be maintained for a minimum of two years, and each hospital will operate with non-discrimination and charity care policies that are no more restrictive than those currently in place.

The proposed transaction, while meeting the IHFSRB's definition of a "change of ownership" as the result of a new "super parent" entity, is a system merger through a straight forward corporate reorganization, without any payment to Resurrection by Provena, or to Provena by Resurrection. The only true costs associated with the transaction are those costs associated with the transaction itself. The merger is being entered into following thorough due diligence processes completed by both Provena and Resurrection, as well as independent analyses commissioned by Resurrection and by Provena.

Super Parent Structure





ARCHDIOCESE OF CHICAGO

OFFICE OF THE ARCHBISHOP

March 17, 2011

Ms. Courtney Avery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson
Springfield, Illinois 62761

Dear Ms. Avery,

Resurrection Health Care Corporation and Provena Health have proposed a merging of the two systems that will better position the combined system's hospitals, long-term care facilities, outpatient centers and other programs and facilities to continue to serve the patients and communities that have traditionally looked to them for care. This system merger is intended to improve the financial viability of both entities as well as enhance patient, employee and medical staff satisfaction. Through a shared culture and integrated leadership, this merger would also position the combined system for innovation and adaptation under health care reform.

The proposed merger will position Resurrection and Provena to strengthen and improve access to Catholic health care in Illinois. This has long been an area of great interest and concern for me, and I am grateful for the willingness of two of our state's premier Catholic providers to collaborate in order to meet the current challenges in health care. As they do now, the combined systems will operate without any restrictive admissions policies related to race, ethnic background, religion, payment source, or any other factor. The new system will continue to admit Medicare and Medicaid recipients and to care for those patients in need of charity care.

This proposed merger has my full support and I can assure you that both Resurrection Health Care and Provena Health are working together collegially and in the best interests of their communities to strengthen and improve access to high quality, highly accountable Catholic health care in the State of Illinois.

Sincerely yours,

Francis Cardinal George, O.M.I.
Archbishop of Chicago



March 28, 2011

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

RE: Merger of Provena Health and Resurrection Health Care Corporation

Dear Ms. Avery:

We represent the five communities of women religious who seek the approval of the Illinois Health Facilities and Services Review Board to form a new Catholic health system to serve the citizens of Illinois through a merger of Provena Health and Resurrection Health Care Corporation.

As individual health systems, Provena Health and Resurrection Health Care have long provided compassionate healing to those in need. In keeping with the true spirit of the Sisters who came before us, ours have been ministries deeply focused on quality care for all, regardless of one's ability to pay.

Now, as we anticipate Health Reform and the sweeping changes that will transform the delivery of care as we have come to know it, we are keenly aware that the key to sustaining and growing our person-centered Mission lies in the strength of enduring partnerships we forge today.

By coming together, our two health systems would create the single largest Catholic healthcare network in the State, spanning 12 hospitals, 28 long-term care and senior residential facilities, more than 50 primary and specialty care clinics and six home health agencies, all serving adjacent, non-conflicting markets. A combined Provena Health and Resurrection Health Care would also represent one of the State's largest health systems, with locations throughout Chicago, the suburbs of Des Plaines, Evanston, Aurora, Elgin, Joliet and Kankakee, and Rockford, Urbana, Danville, and Avilla, Indiana, providing services for patients and residents across the continuum through nearly 100 sites of care.

Rooted in the tradition of Catholic healthcare, the new system would be distinguished by an ability to deliver quality care across the continuum from a broad and complementary base of leading edge locations and physician networks. From a foundation steeped in a shared heritage and set of values, the new system would give rise to an enormous potential to truly improve the wellbeing of generations of Illinoisans to come.

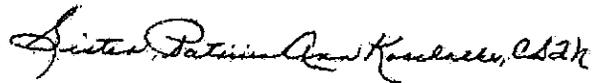
With a dedicated and talented combined team of nearly 5,000 physicians, supported by over 22,000 employees, the new system will play an important role in the economic vitality of the communities in which we serve. Above all, our partnership will remain true to the hallmarks of our Catholic identity: promoting and protecting the dignity of every individual from conception to death, caring for the poor and vulnerable and properly stewarding our precious people and financial resources.

A combined Provena Health and Resurrection Health Care will strengthen and expand access to an exceptional tradition of quality care and service millions of Illinois residents have come to know and depend upon for more than a century. On behalf of the women religious whose communities are sponsoring the proposal before you, we request your approval.

Gratefully,



Sister Mary Elizabeth Imler, OSF
Chairperson
Provena Health Member Body



Sister Patricia Ann Koschalke, CSFN
Chairperson
Resurrection Health Care Sponsorship Board