ORIGINAL 11-044

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

RECEIVED
JUL 6 2011
HEALTH FACILITIES & SERVICES REVIEW BOARD

Facility/Project Identification

Facility Name:	Provena St. Mary's Hospital		
Street Address:	500 West Court Street		
City and Zip Code:	Kankakee, IL 60901		
County: Kankakee	Health Service Area IX	Health Planning Area: A-14	

Applicant /Co-Applicant Identification
[Provide for each co-applicant [refer to Part 1130.220].

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

Type of Ownership of Applicant/Co-Applicant

X	Non-profit Corporation	☐	Partnership		
☐	For-profit Corporation	☐	Governmental		
☐	Limited Liability Company	☐	Sole Proprietorship	☐	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

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Provena St. Mary's Hospital
Street Address:	500 West Court Street
City and Zip Code:	Kankakee, IL 60901
County: Kankakee	Health Service Area IX Health Planning Area: A-14

Applicant /Co-Applicant Identification
[Provide for each co-applicant [refer to Part 1130.220].

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

Type of Ownership of Applicant/Co-Applicant

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☐ For-profit Corporation ☐ Governmental
☐ Limited Liability Company ☐ Sole Proprietorship ☐ Other

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E-mail Address:	Anne.Murphy@hklaw.com
Fax Number:	312/578-6666

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

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

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Provena St. Mary's Hospital
Street Address:	500 West Court Street
City and Zip Code:	Kankakee, IL 60901
County: Kankakee	Health Service Area IX Health Planning Area: A-14

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

X Non-profit Corporation ☐ Partnership
☐ For-profit Corporation ☐ Governmental
☐ Limited Liability Company ☐ Sole Proprietorship ☐ Other

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
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APPEND DOCUMENTATION AS ATTACHMENT-1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

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

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

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

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Provena St. Mary's Hospital
Street Address:	500 West Court Street
City and Zip Code:	Kankakee, IL 60901
County: Kankakee	Health Service Area IX Health Planning Area: A-14

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

X	Non-profit Corporation	☐	Partnership		
☐	For-profit Corporation	☐	Governmental		
☐	Limited Liability Company	☐	Sole Proprietorship	☐	Other

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
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Primary Contact

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

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

Additional Contact

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

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

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:	Michael Arno
Title:	President & CEO
Company Name:	Provena St. Mary's Hospital
Address:	500 West Court Street Kankakee, IL 60901
Telephone Number:	815/937-2401
E-mail Address:	michael.arno@provena.org
Fax Number:	815/937-8778

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Provena Health

Address of Site Owner: 19065 Hickory Creek Drive Mokena, IL 60448

Street Address or Legal Description of Site:

Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.

APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

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

Exact Legal Name: Provena Hospitals

Address: 19065 Hickory Creek Drive Mokena, IL 60448

X	Non-profit Corporation	☐	Partnership		
☐	For-profit Corporation	☐	Governmental		
☐	Limited Liability Company	☐	Sole Proprietorship	☐	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.
- **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)]

Part 1110 Classification:	Part 1120 Applicability or Classification: [Check one only.]
☐ Substantive	☐ Part 1120 Not Applicable
X Non-substantive	☐ Category A Project
	X Category B Project
	☐ DHS or DVA Project

2. Narrative Description

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

The proposed project is limited to a change of ownership of Provena St. Mary's Hospital, a 182-bed community hospital located in Kankakee, Illinois. The proposed change of ownership is a result of the impending merger of the Resurrection and Provena systems through a common "super parent' corporation that will become the parent entity of Resurrection Health Care Corporation (the current Resurrection system parent) and Provena Health (the current Provena system parent).

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

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

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

Project Costs and Sources of Funds — Provena St. Mary's Hospital

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			$195,430,000
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS			$195,996,667
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities			$566,667
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Fair Market Value of Hospital			$195,430,000
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS			$195,996,667

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

Related Project Costs

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

Land acquisition is related to project X 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
X Yes ☐ No

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

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

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:

X 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
X Project obligation will occur after permit issuance.

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

State Agency Submittals

Are the following submittals up to date as applicable:

X Cancer Registry
X APORS **please see documentation requested by State Agency staff on following pages**
X All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
X 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 Cente

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 t 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 tl 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 a 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 tha children achieve their full potential through the early case-management services provided t 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 proce 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 b 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.**

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

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

Facility Bed Capacity and Utilization

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

FACILITY NAME: Provena St. Mary's Hospital		**CITY: Kankakee**			
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	105	4,471	20,036	None	105
Obstetrics	12	466	1,094	None	12
Pediatrics	14	542	2,156	None	14
Intensive Care	26	1,417	5,935	None	26
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness	25	649	3,491	None	25
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:	182	7,545	32,712	None	182

CERTIFICATION

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

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

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

SIGNATURE

Guy Wiebking
PRINTED NAME

President and CEO
PRINTED TITLE

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

Yvette B. Porter
Signature of Notary

Seal

OFFICIAL SEAL
YVETTE B PORTER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:09/07/14

SIGNATURE

Anthony Filer
PRINTED NAME

Assistant Treasurer
PRINTED TITLE

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

Yvette B. Porter
Signature of Notary

Seal

OFFICIAL SEAL
YVETTE B PORTER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:09/07/14

*Insert EXACT legal name of the applicant

CERTIFICATION

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- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist;
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

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

SIGNATURE

Guy Wiebking
PRINTED NAME

President and CEO
PRINTED TITLE

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

Yvette B. Porter
Signature of Notary

Seal

OFFICIAL SEAL
YVETTE B PORTER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:09/07/14

SIGNATURE

Anthony Filer
PRINTED NAME

Assistant Treasurer
PRINTED TITLE

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

Yvette B. Porter
Signature of Notary

Seal

OFFICIAL SEAL
YVETTE B PORTER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:09/07/14

*Insert EXACT legal name of the applicant

CERTIFICATION

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

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

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

SIGNATURE

Sandra Bruce

PRINTED NAME

President and CEO

PRINTED TITLE

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

Signature of Notary

Seal

OFFICIAL SEAL
FLORITA DE JESUS-ORTIZ
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:09/09/14

SIGNATURE

Jeannie C. Frey

PRINTED NAME

Secretary

PRINTED TITLE

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

Signature of Notary

Seal

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

*Insert EXACT legal name of the applicant

CERTIFICATION

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

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

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

Sandra Bruce
SIGNATURE

Sandra Bruce
PRINTED NAME

President
PRINTED TITLE

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

Florita de Jesus-Ortiz
Signature of Notary

Seal

OFFICIAL SEAL
FLORITA DE JESUS-ORTIZ
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:09/29/14

Jeannie C. Frey
SIGNATURE

Jeannie C. Frey
PRINTED NAME

Secretary
PRINTED TITLE

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

Linda M Noyola
Signature of Notary

Seal

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

*Insert EXACT legal name of the applicant

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

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

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

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.

2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.

3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**

4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

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

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.

2. Define the planning area or market area, or other, per the applicant's definition.

3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]

4. Cite the sources of the information provided as documentation.

5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.

6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals as appropriate.

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

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

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

ALTERNATIVES

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

Alternative options **must** include:

A) Proposing a project of greater or lesser scope and cost;

B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;

C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and

D) Provide the reasons why the chosen alternative was selected.

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short term (within one to three years after project completion) and long term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**

3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

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

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

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

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

A. Criterion 1110.240(b), Impact Statement

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

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

B. Criterion 1110.240(c), Access

Read the criterion and provide the following:

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

C. Criterion 1110.240(d), Health Care System

Read the criterion and address the following:

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

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

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

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

VIII. - 1120.120 - Availability of Funds

Provena St. Mary's Hospital

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;
$195,430,000	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project---FMV of hospital
$195,996,667	**TOTAL FUNDS AVAILABLE**	

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

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

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

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

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

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

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

2. Variance

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

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

X. 1120.140 - Economic Feasibility

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

A. Reasonableness of Financing Arrangements

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

1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or

2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:

A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or

B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

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

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

1) That the selected form of debt financing for the project will be at the lowest net cost available;

2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;

3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. 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 Medicaidpatients. 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)			
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

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

XII. Charity Care Information — Provena St. Mary's Hospital

Charity Care information MUST be furnished for ALL projects.

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

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

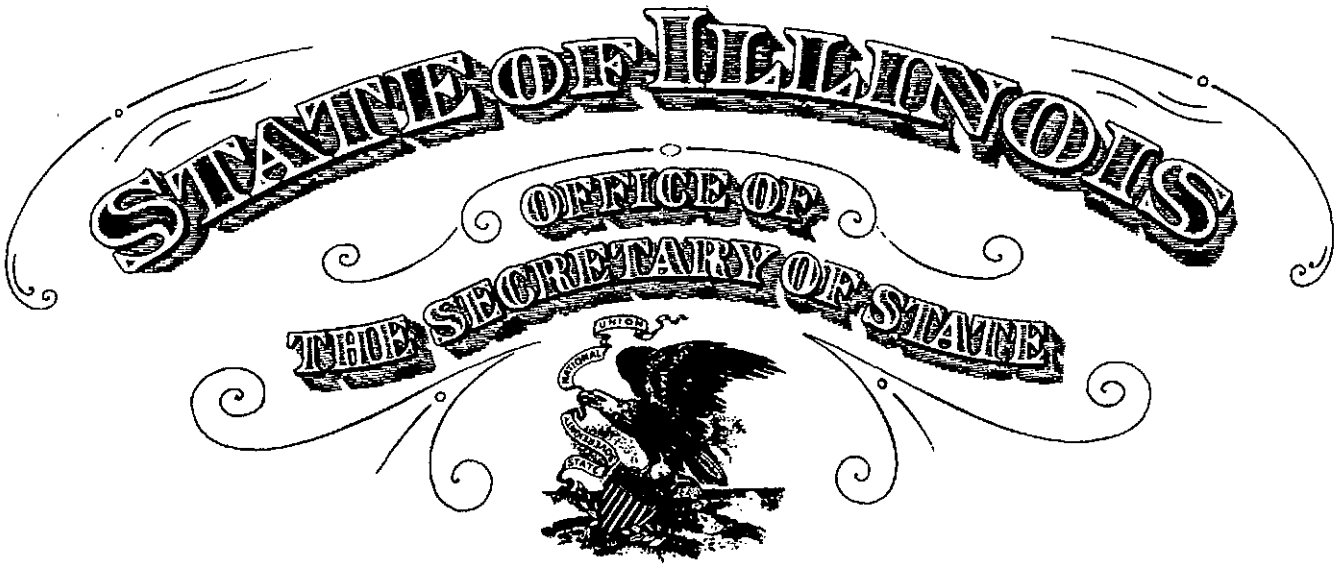
A table in the following format must be provided for all facilities as part of Attachment 44.

CHARITY CARE			
	2007	2008	2009
Net Patient Revenue	$125,308,173	$135,582,958	$141,620,934
Amount of Charity Care (charges)	$4,948,587	$8,705,799	$12,521,391
Cost of Charity Care	$1,437,776	$2,359,409	$2,657,530

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

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

File Number 5968-176-1



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

Authentication #: 1104200730

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* 11TH *day of* FEBRUARY *A.D.* 2011 .

Jesse White

SECRETARY OF STATE

ATTACHMENT 1

File Number 5380-798-4

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

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

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

Jesse White

SECRETARY OF STATE

Authentication #: 1104200726

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

ATTACHMENT 1

File Number 3128-198-9

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.

Authentication #: 1101700285

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* 17TH *day of* JANUARY *A.D.* 2011

Jesse White

SECRETARY OF STATE

ATTACHMENT 1

File Number 2595-936-1

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

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

SECRETARY OF STATE

Authentication #: 1106302140

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

ATTACHMENT 1

Evidence of Site Control- Provena hospitals

PROVENA Health

PROPERTY

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

INSURER:	FM Global
NAMED INSURED:	Provena Health and any subsidiary, and Provena Health's interest in any partnership or joint venture in which Brush Engineered Material Inc. has management control or ownership as now constituted or hereafter is acquired, as the respective interest of each may appear; all hereafter referred to as the "Insured", including legal representatives.
POLICY NO.:	FC999
POLICY PERIOD:	June 1, 2010 – June 1, 2011 beginning and ending at 12:01 AM at the location of the property insured
PERILS INSURED: (LOSS OR DAMAGE INSURED)	"All Risk "of physical loss or damage including flood, earthquake, and Boiler & and Machinery Insurance as more fully stated in the policy form. (see enclosed FM Quote)
PERILS EXCLUDED:	• Indirect or Remote Loss • Interruption of business (except as provided under BI Coverage) • Loss of Market • Mysterious disappearance • Law or Ordinance (except as provided under Demolition and Increased Cost of Construction and Decontamination Costs) • Voluntary Parting of Property • Nuclear Reaction / Radiation • Hostile Warlike Action • Terrorism (except as provided under Terrorism Coverage) • Fraudulent or Dishonest Act or Acts • Lack of Incoming Services (except as provided by Service Interruption) • Defective Design / Faulty Material /Faulty Workmanship • Wear and Tear • Settling, Cracking, Shrinking, bulging of pavements, floors, foundations... • Changes in temperature • Insect, animal or vermin damage • Rain, sleet or Snow damage to Interior of buildings under construction • Pollution • Wind damage to Landscaping, lawns, trees, shrubs, etc. (all as more fully stated in the policy form)

PROVENA Health

PROPERTY AND INTERESTS INSURED:

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

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

(all as more fully stated in the policy form)

COVERAGES/EXTENSIONS OF COVERAGE:

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

(all as more fully stated in the attached policy form)

ATTACHMENT 2

PROVENA Health

SPECIAL CONDITIONS:

- Brands and Labels
- Control of Damaged Merchandise
- Pair and Set/Consequential Reduction in Value
- Errors and Omissions
- Loss Adjustment Expenses/Professional Fees

(all as more fully stated in the policy form)

PROPERTY EXCLUDED:

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

(all as more fully stated in the policy form)

VALUATION:

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

(all as more fully stated in the policy form)

POLICY LIMITS:

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

SUBLIMITS:

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

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

ATTACHMENT 2

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

DEDUCTIBLES:

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

ATTACHMENT 2

$100,000 min. 5% per location	Names Storm Wind (all affected locations are subject to this deductible)
$100,000	Flood (surface water exposure) • Provena Pineview Care Center 611 Allen Lane St. Charles, IL
	Transit
$25,000	• Property
48 hrs. waiting period and 48 hr. ded. Min. $100,000	Data, Programs, and Software/Malicious Introduction of Machine Code
48 hrs. waiting period and 48 hr. ded. Min. 100,000	Computer Systems – Non Physical Damage
$100,000	Dependent Time Element Location Per occurrence/location except;
$100,000	• Per location for Earthquake Shock
$100,000	• Per location for Flood
$100,000 5% of Values*	• Per location for Named Storm Wind* except; (*at all affected locations, are subject to this deductible)
$100,000 min/loc.	
24 hrs. Policy deductible(s) per location	Service Interruption Waiting Period Terrorism – TRIPRA, and ACV portion of fire damage caused by Terrorism
$100,000	Property Damage and Time Element deductible combined applies at the following locations: • Covenant Medical Center 130-1412 West Park (excluding 1307 and 1405 West Park) Urbana, IL • Provena United Samaritans Medical Center 812 North Logan Danville, IL • St. Mary's Hospital (including bridge over West Court Street) 500 West Court Street Kankakee, IL • Provena St. Joseph Medical Center Madison Street, Glenwood and Springfield 333 North Madison Joliet, IL

PROVENA Health

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

ANNUAL PREMIUM: $1,029,000

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

AON

ATTACHMENT 2

File Number 5968-176-1

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

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

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

Jesse White

SECRETARY OF STATE

Authentication #: 1104200730

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

ATTACHMENT 3

CURRENT ORGANIZATIONAL CHARTS

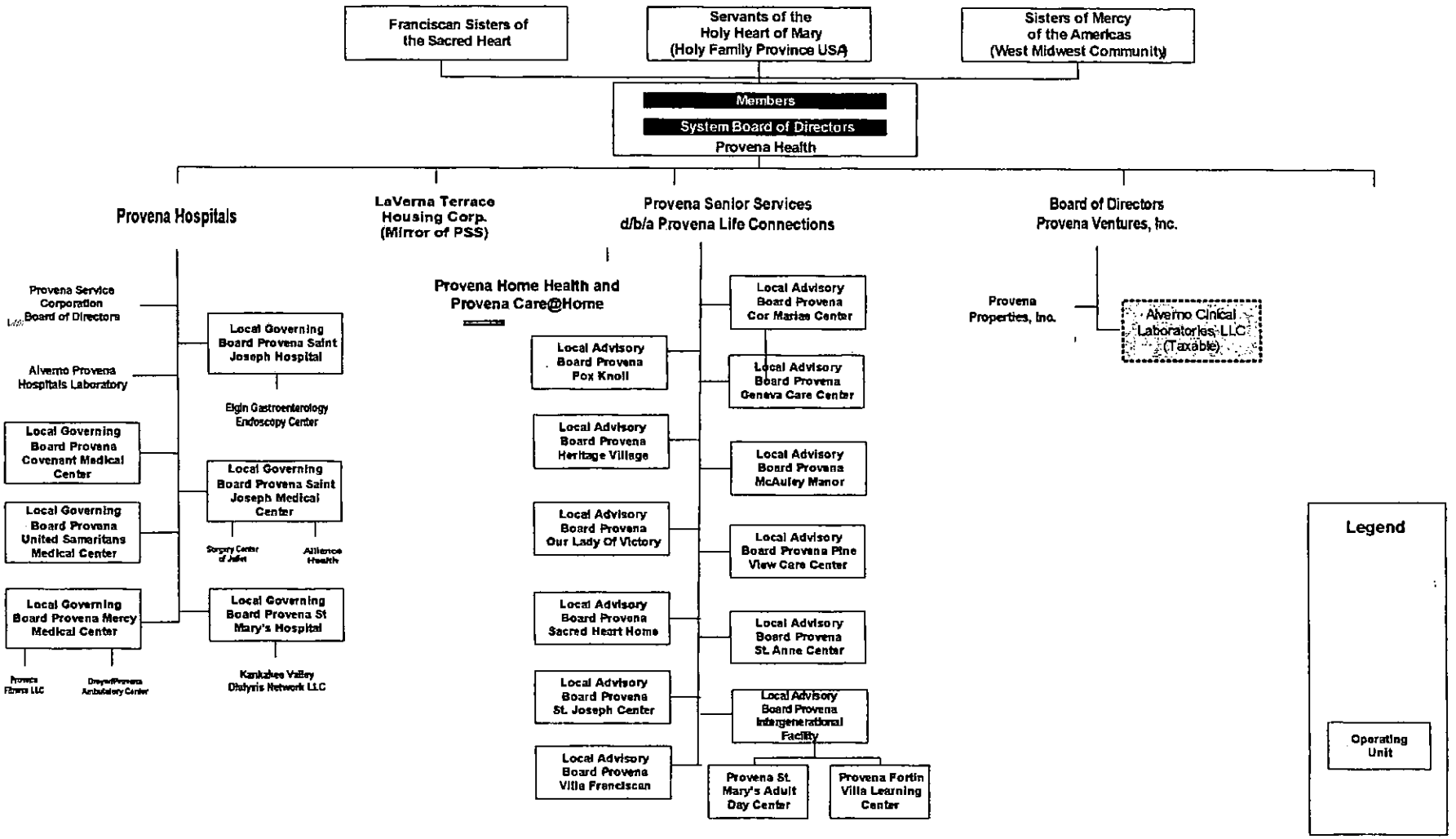
ATTACHMENT 4

Provena Health

Organizational Governance Structure

January 2011

PROVENA Health

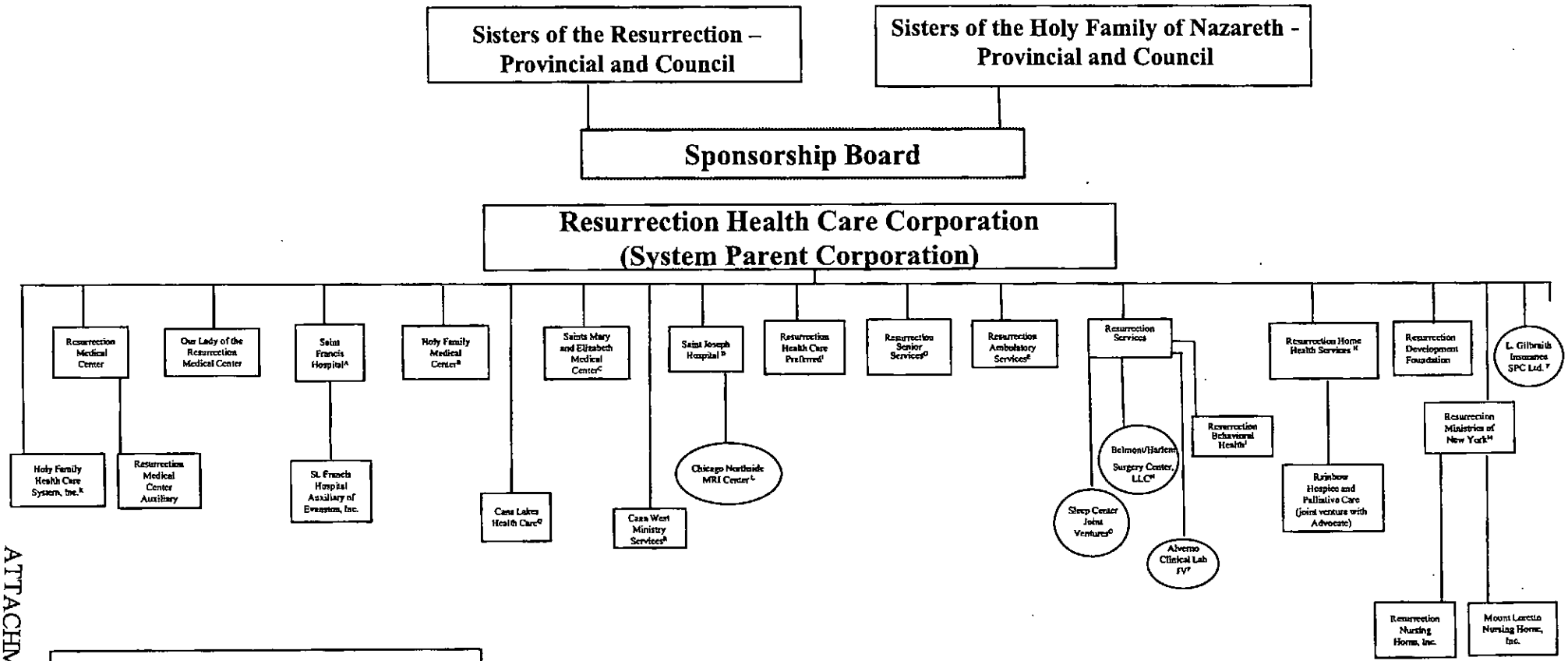


ATTACHMENT 4

Resurrection Health Care Corporation

Corporate Organizational and Governance Structure

October 21, 2010



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

ATTACHMENT 4

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

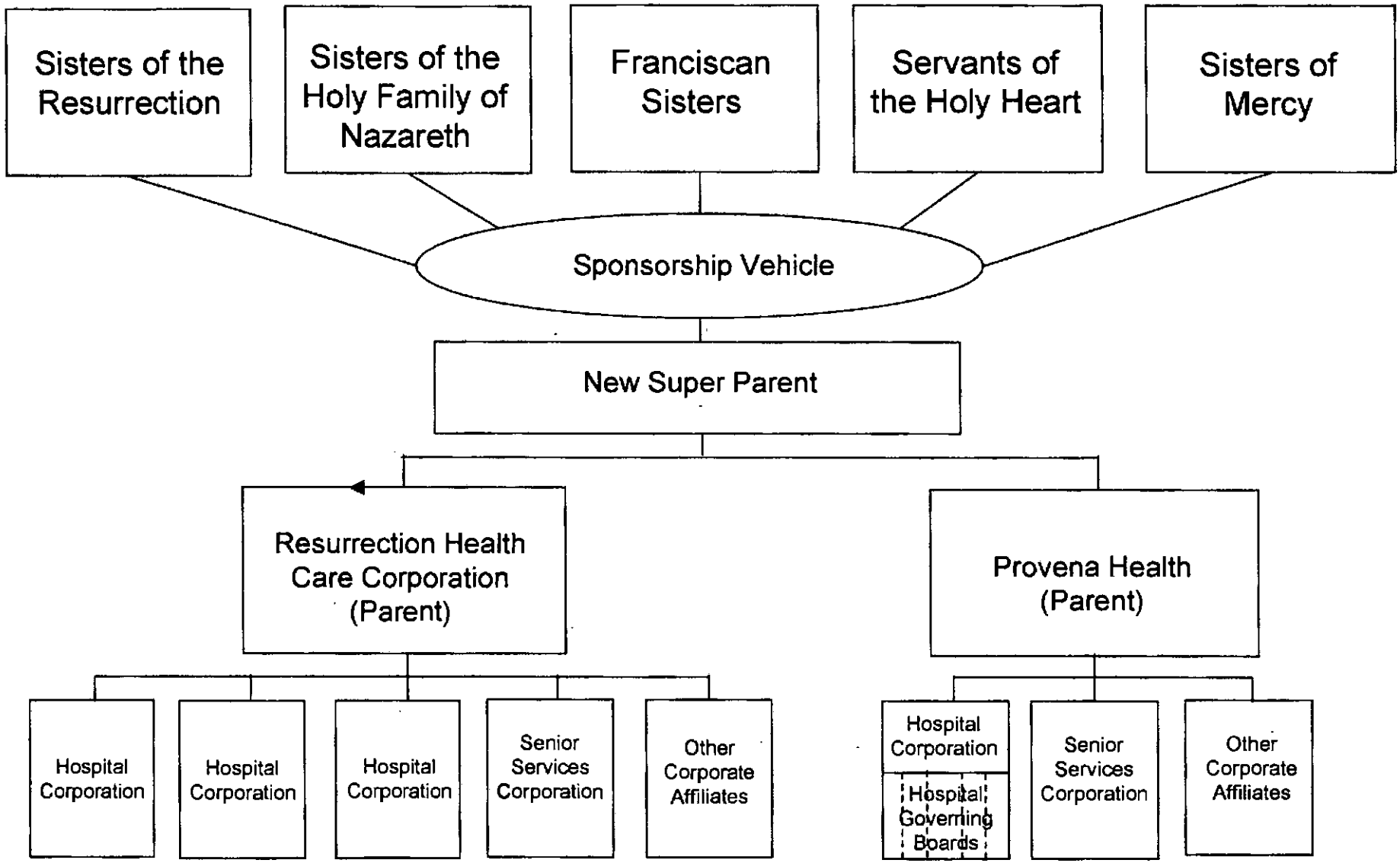
R Formerly named West Suburban Medical Center; all the assets of this corporation were sold to VHS West Suburban Medical Center, Inc., effective August 1, 2010

ATTACHMENT 4

PROPOSED ORGANIZATIONAL CHART

ATTACHMENT 4

Super Parent Structure



ATTACHMENT 4

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

Resurrection Health Care®

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,

Sandra Bruce

Sandra Bruce, FACHE
President & CEO

SB/fdjo

19065 Hickory Creek Drive, Suite 300
Mokena, IL 60448
708 478-6300 Tel
708 478-5960 Fax

PROVENA
Health

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,

Meghan Kieffer
System Senior Vice President/General Counsel

OFFICIAL SEAL
YVETTE B PORTER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:09/07/14

Yvette B Porter

ATTACHMENT 11

FACILITIES LICENSED IN ILLINOIS

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

ATTACHMENT 11

ATTACHMENT 11

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	CATEGORY	I.D. NUMBER
12/31/11	060B	0002584

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/11

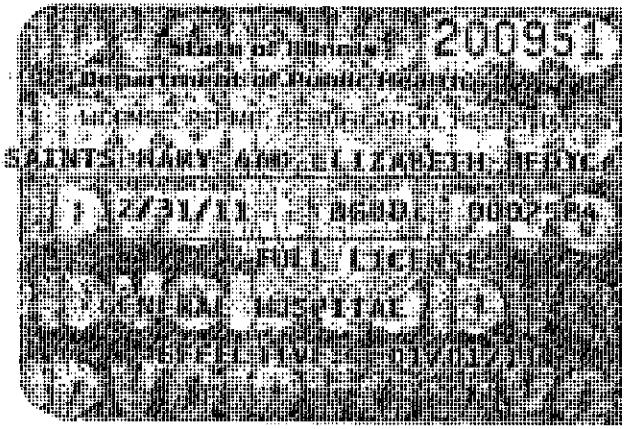
BUSINESS ADDRESS

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 4/97

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION



11/05/10

SAINTS MARY AND ELIZABETH MED
D/B/A SAINT MARY OF NAZARETH H
2233 WEST DIVISION STREET
CHICAGO IL 60622

FEE RECEIPT NO.

ATTACHMENT 11

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.

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

RAMON T. ARNOLD, M.D.
DIRECTOR

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/11	8680	0005314

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE- 01/01/11

BUSINESS ADDRESS

SAINTS MARY AND ELIZABETH MEDICAL CENTE
D/B/A SAINT ELIZABETH HOSPITAL
1431 NORTH CLAREMONT AVENUE

CHICAGO IL 60622

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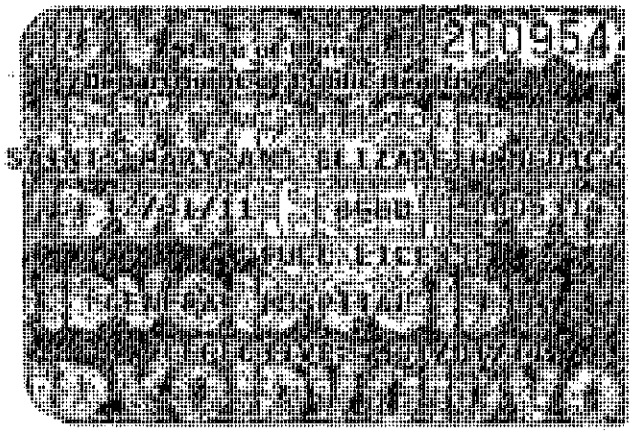

11/06/10

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

FEE RECEIPT NO.

HFAP
Healthcare Facilities Accreditation Program

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,

Troy Repuszka

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

ATTACHMENT 11

ATTACHMENT 11

State of Illinois 2009495
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

DAMON T. ARNOLD, M.D.
DIRECTOR

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

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/11	086D	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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State of Illinois 2009495
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

RESURRECTION MEDICAL CENTER

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/11	086D	0001974

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/11

11/06/10

RESURRECTION MEDICAL CENTER
7435 WEST TALCOTT AVENUE

CHICAGO IL 60631

FEE RECEIPT NO.

HFAP
Healthcare Facilities Accreditation Program

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.

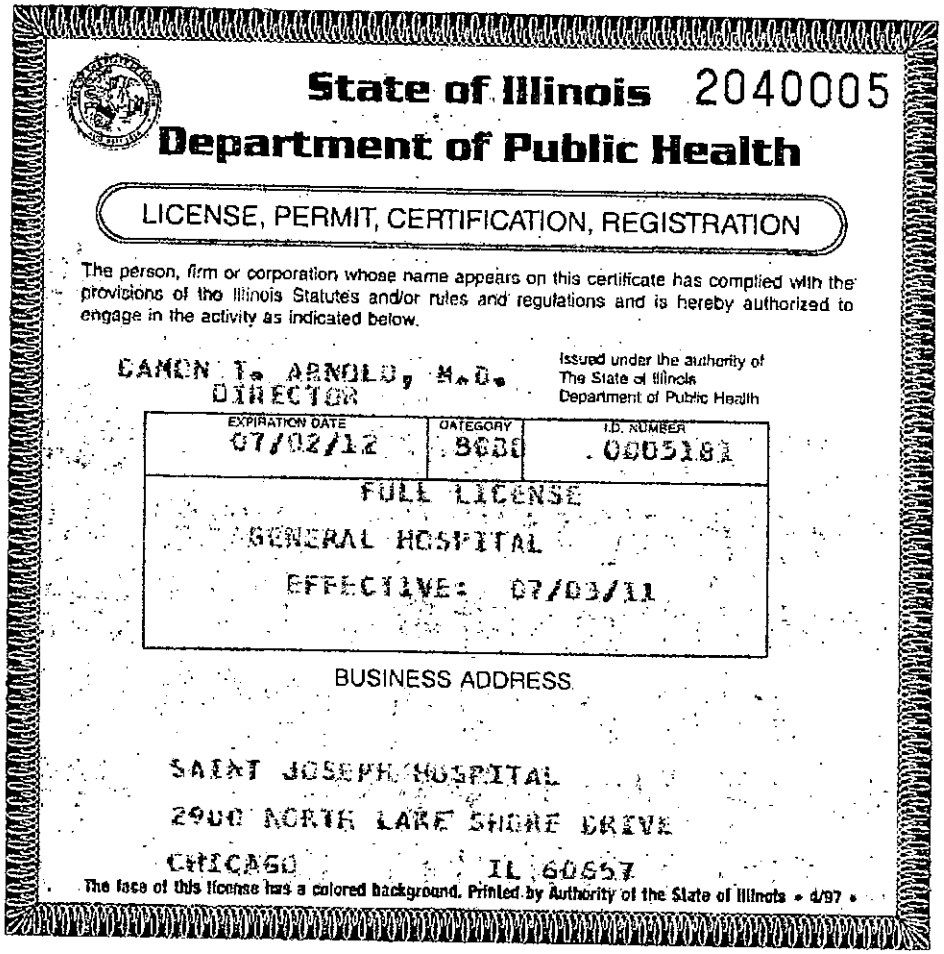
You may use a copy of this letter with external organizations to demonstrate your accreditation status. Questions about the HFAP may be directed to my attention via phone at 312-202-8060.

Sincerely,

Troy Repuszka

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

ATTACHMENT 11



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.

CAMON T. 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	[illegible]	.0005161

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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State of Illinois 2040005

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

SAINT JOSEPH HOSPITAL

EXPIRATION DATE	CATEGORY	I.D. NUMBER
07/02/12	[illegible]	.0005161

FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 07/03/11

06/14/11

SAINT JOSEPH HOSPITAL
2900 NORTH LAKE SHORE DRIVE
CHICAGO IL 60657

FEE RECEIPT NO.

ATTACHMENT 11

HFAP
Healthcare Facilities Accreditation Program

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,

Troy Repuszka

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

ATTACHMENT 11

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.

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

DAMON T. ARNOLD, M.D.
DIRECTOR

EXPIRATION DATE	CATEGORY	I.D. NUMBER
06/30/12	060D	0001006

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

HOLY FAMILY MEDICAL CENTER

EXPIRATION DATE	CATEGORY	I.D. NUMBER
06/30/12	060D	0001006

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.

ATTACHMENT 11

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 citiations, if applicable):

No further action is required.

Sincerely,

George A. Reuther

George A. Reuther
Secretary

GAR/pmh

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

ATTACHMENT 11

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	CATEGORY	I.D. NUMBER
12/31/11	6680	0002402

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/11

BUSINESS ADDRESS

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

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DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

State of Illinois 2009508
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

ST. FRANCIS HOSPITAL OF EVANSTON

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/11	6680	0002402

FULL LICENSE

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 citiations, if applicable):

No further action is required.

Sincerely,

George A. Reuther

George A. Reuther
Secretary

GAR/pmh

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

State of Illinois 2035984
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

DAMON T. ARNOLD, M.D.
DIRECTOR

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

EXPIRATION DATE	CATEGORY	I.D. NUMBER
06/30/12	2680	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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REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

State of Illinois 2035984
Department of Public Health
LICENSE, PERMIT, CERTIFICATION, REGISTRATION

OUR LADY OF THE RESURRECTION MEDICA

EXPIRATION DATE	CATEGORY	I.D. NUMBER
06/30/12	2680	0001719

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 07/01/11

05/07/11

OUR LADY OF THE RESURRECTION MED
5645 WEST ADDISON STREET

CHICAGO IL 60634

FEE RECEIPT NO.

ATTACHMENT 11

HFAP
Healthcare Facilities Accreditation Program

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,

Troy Repuszka

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

ATTACHMENT 11

ATTACHMENT 11

State of Illinois 2009538
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

DAMON T. ARNOLD, M.D.
DIRECTOR

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

EXPIRATION DATE	CATEGORY	ID NUMBER
12/31/11	BGBD	0004861

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/11

BUSINESS ADDRESS

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

URBANA IL 61801

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Provena Covenant Medical Center

Urbana, IL

has been Accredited by

The Joint Commission

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

Hospital Accreditation Program

July 12, 2008

Accreditation is customarily valid for up to 39 months.

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

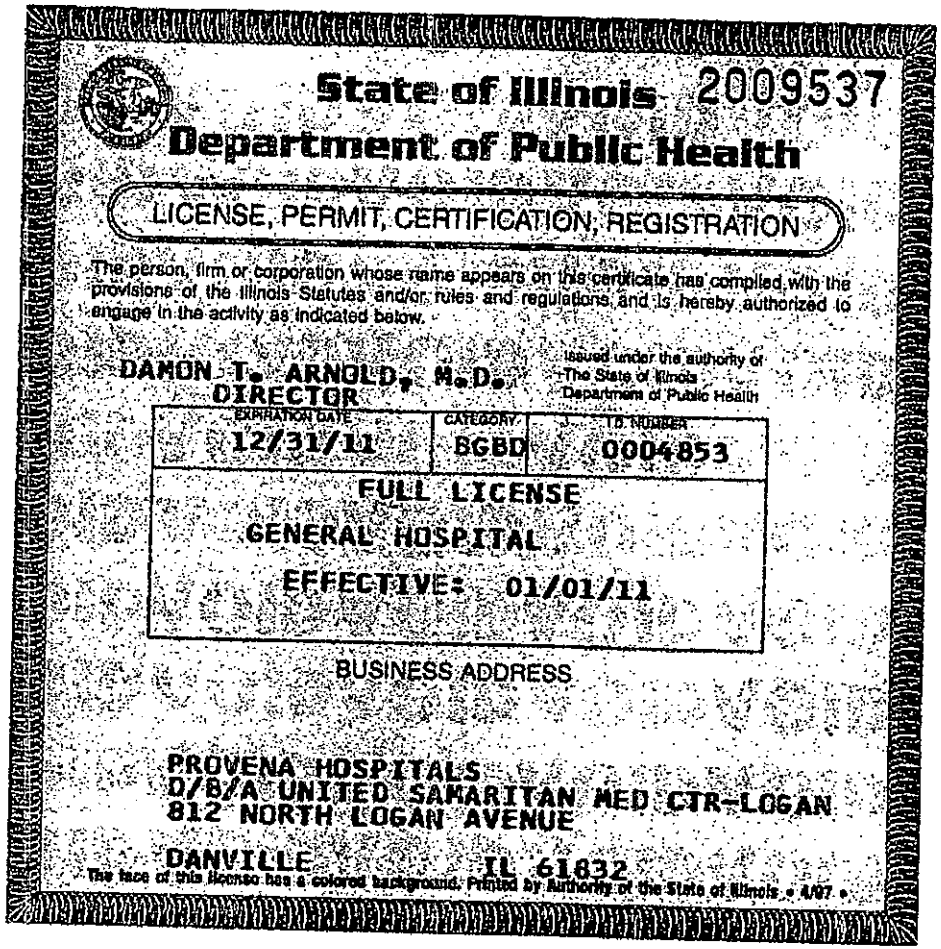
4968
Organization ID #

Mark Chassin, M.D.
President

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

ATTACHMENT 11

ATTACHMENT 11



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.

DAMON T. ARNOLD, M.D.
DIRECTOR

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

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/11	BGBD	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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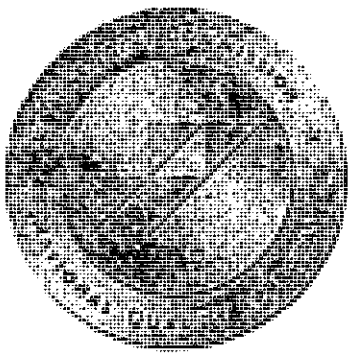
Provena United Samaritans Medical Center

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, M.D.
Chairman of the Board

4928
Organization ID #

Mark Chassin, M.D.
President

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

ATTACHMENT 11

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.

DAMON T. ARNOLD, M.D.
DIRECTOR

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

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/11	BGBD	0004838

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/11

VOID

BUSINESS ADDRESS

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

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State of Illinois 2009536
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

PROVENA HOSPITALS

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/11	BGBD	0004838

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/11

11/06/10

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

FEE RECEIPT NO.

ATTACHMENT 11

The Joint Commission

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.

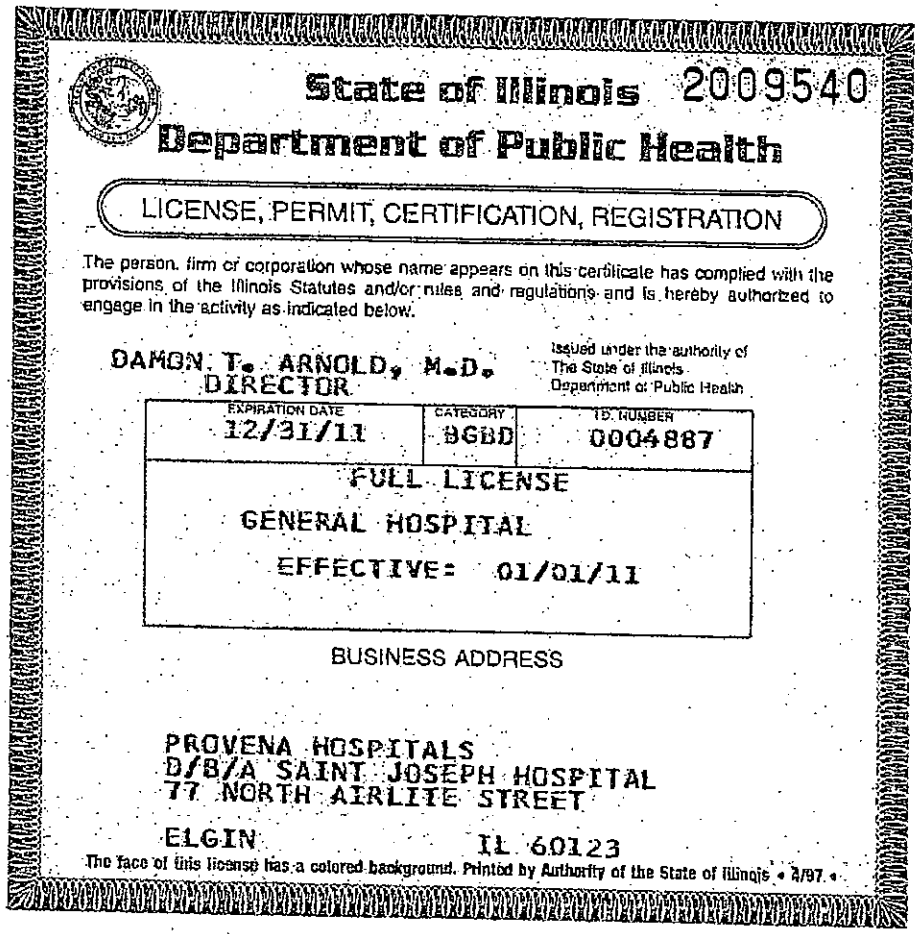
Sincerely,

Ann Scott Blouin RN, PhD

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

ATTACHMENT 11

ATTACHMENT 11



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	CATEGORY	I.D. NUMBER
12/31/11	BGBD	0004887

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/11

BUSINESS ADDRESS

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

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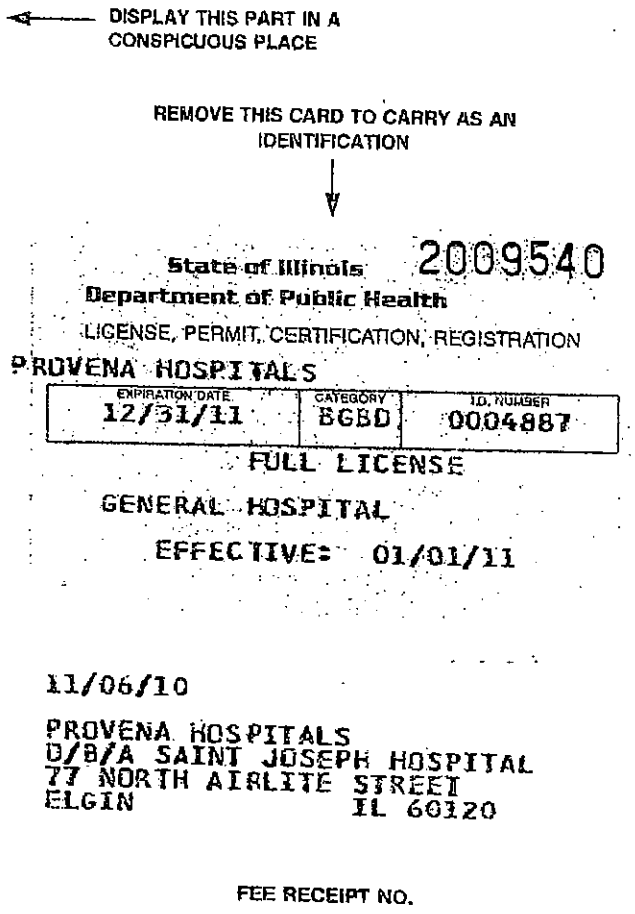

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State of Illinois 2009540

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

PROVENA HOSPITALS

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/11	BGBD	0004887

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/11

11/06/10

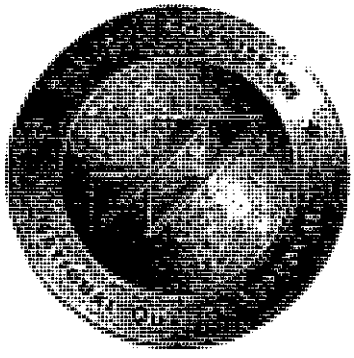
PROVENA HOSPITALS
D/B/A SAINT JOSEPH HOSPITAL
77 NORTH AIRLITE STREET
ELGIN IL 60120

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.

ATTACHMENT 11

ATTACHMENT 11

State of Illinois 2009541
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

This person has in compliance 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	LICENSE NUMBER
12/31/11	0610	0004903

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/11

BUSINESS ADDRESS

PROVENA MERCY CENTER

1325 NORTH HIGHLAND AVENUE

AURORA IL 60506

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State of Illinois 2009541
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

PROVENA MERCY CENTER

EXPIRATION DATE	CATEGORY	LICENSE NUMBER
12/31/11	0610	0004903

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/11

11/06/10

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

FEE RECEIPT NO.

The Joint Commission

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.

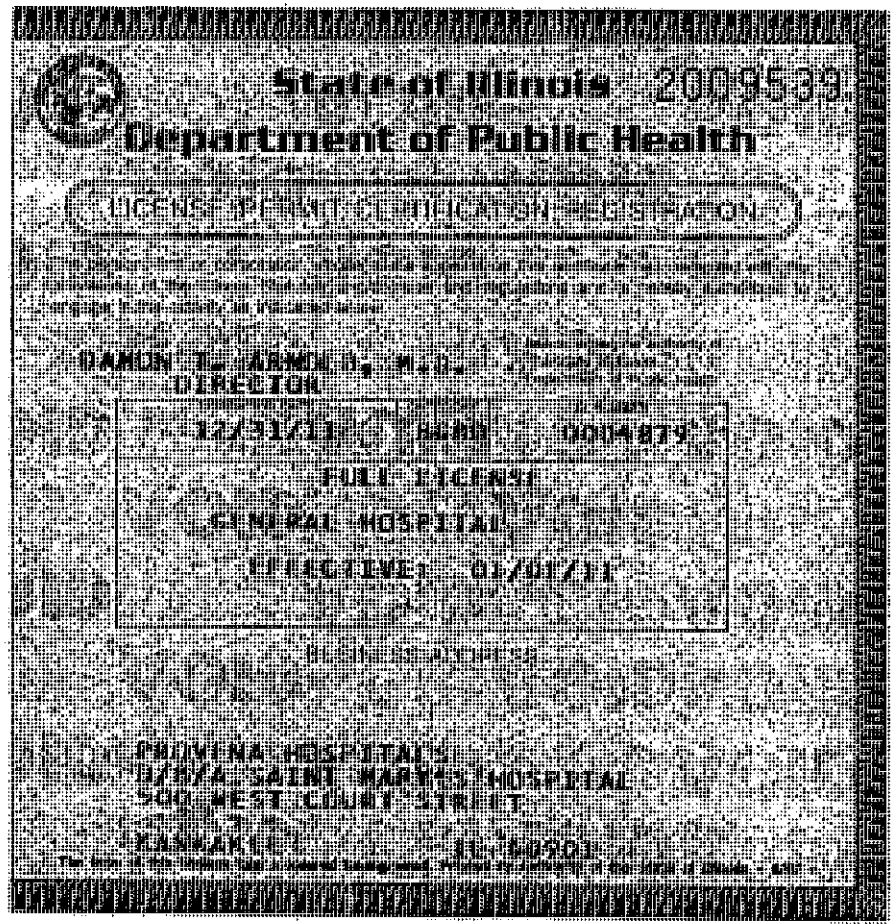
Sincerely,

Ann Scott Blouin RN, PhD

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

ATTACHMENT 11

ATTACHMENT 11


State of Illinois 2009539
Department of Public Health
LICENSE/PERMIT/CERTIFICATION/REGISTRATION
RAMON T. ARMOUR, M.D.
DIRECTOR
12/31/11 HG88 0014879
FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 01/01/11
PROVENA HOSPITALS
D/B/A SAINT MARY'S HOSPITAL
500 WEST COURT STREET
KANKAKEE IL 60901

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State of Illinois 2009539
PROVENA HOSPITALS
12/31/11 HG88 0014879
FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 01/01/11

11/06/10

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

FEE RECEIPT NO.

The Joint Commission

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, PhD

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

ATTACHMENT 11

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.

DAMON T. ARNOLD, M.D.
DIRECTOR

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

EXPIRATION DATE	CATEGORY	I.D. NUMBER
04/30/12	EGSD	7003131

FULL LICENSE

AMBUL SURGICAL TREAT CNTR

EFFECTIVE: 05/01/11

BUSINESS ADDRESS

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

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State of Illinois 2032822
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

BELMONT/HARLEM SURGERY CENTER, LLC

EXPIRATION DATE	CATEGORY	I.D. NUMBER
04/30/12	EGSD	7003131

FULL LICENSE

AMBUL SURGICAL TREAT CNTR

EFFECTIVE: 05/01/11

04/15/11

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

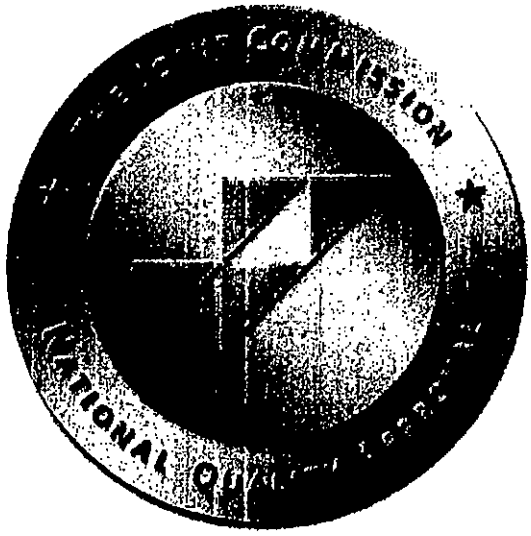
FEE RECEIPT NO. 14561

ATTACHMENT 11

elmont/Harlem Surgical Center, LLC

Chicago, IL

has been Accredited by



The Joint Commission

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

Ambulatory Health Care Accreditation Program

July 8, 2010

Accreditation is customarily valid for up to 39 months.

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

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

Mark Chassin, M.D.
President

ATTACHMENT 11

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

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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	INITIAL COMMENTS 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. 11384	V 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lisa Pattelune RN — TITLE: CEO — (X6) DATE: 11/14/05

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

ATTACHMENT 11

PURPOSE OF PROJECT

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

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

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

ZIP Code	Community	Adm.	%	Cumulative %
60901	Kankakee	2,536	35.1%	35.1%
60914	Bourbonais	1,248	17.3%	52.3%
60915	Bradley	639	8.8%	61.2%
60950	Manteno	533	7.4%	68.5%
60954	Momence	478	6.6%	75.1%
60964	Saint Anne	248	3.4%	78.6%
60922	Chebance	105	1.5%	80.0%
60970	Watseka	104	1.4%	81.5%
60938	Gilman	97	1.3%	82.8%
60958	Pembroke	92	1.3%	84.1%
60481	Wilmington	89	1.2%	85.3%
60927	Clifton	88	1.2%	86.5%
60640	Grant Park	81	1.1%	87.7%
60941	Herscher	80	1.1%	88.8%
60468	Peotone	78	1.1%	89.8%
other ZIP Code areas contributing <1%		735	10.2%	100.0%
		7,231	100.0%	

As can be noted from the table above, fifteen ZIP Code areas accounted for nearly 90% of the hospital's admissions. This analysis clearly demonstrates that Provena St. Mary's Hospital provides services primarily to area residents.

The measurable goals resulting from the consolidating of the systems will be continually high patient satisfaction reports, strong utilization levels, and improved access to capital to ensure that the hospital's physical plant is well maintained and that

needed equipment can be acquired. These goals will each be measurable within two years.

ALTERNATIVES

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

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

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

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

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

IMPACT STATEMENT

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

Reason for the Transaction

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

Anticipated Changes to the Number of Beds or Services Currently Offered

No changes are anticipated either to the number of beds (182) or to the scope of services currently provided at Provena St. Mary's Hospital.

The current and proposed bed complement, consistent with Provena St. Mary's Hospital 's 2009 IDPH Hospital Profile is:

- 105 medical/surgical beds
- 14 pediatrics beds
- 26 intensive care beds
- 12 obstetrics/gynecology beds
- 25 acute mental illness

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

Operating Entity

Upon the change of ownership, the operating entity/licensee will remain Provena St. Mary's Hospital.

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 7,500 patients, provided approximately 103,500 outpatient visits, and treated over 31,000 patients in its emergency department.

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

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

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

Finally, with over 900 employees (FTEs), Provena St. Mary's Hospital is a major area employer, and, as noted above, no changes in clinical or non-system administrative staffing, aside from those routine changes typical of hospitals, are anticipated during the first two years following the proposed change of ownership.

ACCESS

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

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

Provena St. Mary's Hospital will, as is the case now, operate without any restrictive admissions policies, related to race, ethnic background, religion, payment

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

19065 Hickory Creek Drive, Suite 300
Mokena, IL 60448
708 478-6300 Tel
708 478-5960 Fax

PROVENA Health

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

OFFICIAL SEAL
YVETTE B PORTER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 09/07/14

Notarized: Yvette B. Porter

ATTACHMENT 19B

7435 West Talcott Avenue
Chicago, Illinois 60631
773.792.5555

Resurrection Health Care

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,

Sandra Bruce, FACHE
President & CEO

Notarized:

OFFICIAL SEAL
FLORITA DE JESUS-ORTIZ
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:09/20/14

CURRENT ADMISSIONS
and
CHARITY CARE POLICIES

ATTACHMENT 19B

PROVENA
St. Mary's Hospital

Section: Administration

Subject: Patient Non-Discrimination

Number: 211.38
Page: 1 of 1
Board Approval: N/A
Effective Date: 2/28/06
Supersedes: 2/29/04

PURPOSE

It is the policy of Provena St. Mary's Hospital to treat all patients without regard to race, color, national origin, handicap or age.

SPECIAL INSTRUCTIONS/FORMS TO BE USED

N/A

PROCEDURE

The same requirements are applied to all, and patients are assigned without regard to race, color, national origin, handicap or age. There is no distinction in eligibility for, or in the manner of providing, patient services. All services are available without distinction to all patients and visitors regardless of race, color, national origin, handicap or age. All persons and organizations having occasion either to refer patients for services or to recommend Provena St. Mary's Hospital, are advised to do so without regard to patient's race, color, national origin, handicap or age.

The person designated to coordinate compliance with Section 504 of the Rehabilitation Act of 1973 (nondiscrimination against the handicapped) is the Vice President of Clinical Operations who can be reached at extension 2401.

_____ DATE: _____
Administrative Representative

NOTE: Policies with original signatures are on file in Administration and signed copies are available in the House Operation Manager's Office.

Reviewed By:	Date

ATTACHMENT 19B

PROVENA
Health

SYSTEM POLICY

Section: Finance
Patient Financial Services

Policy Number: 5.1

Subject: Provision for Financial Assistance – Provena Hospitals

Page: 1 of 10

Executive Owner: System Senior VP, Chief Financial Officer

Approval Date: 05/01/06
Effective Date: 02/2011
Last Review Date: 1/17/11
Revised Date: 1/17/11
Supersedes: 8/4/10

POLICY

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

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

PURPOSE

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

We also continue to play a leadership role in the community by helping to promote community-wide responses to patient needs, in partnership with government and private organizations.
This policy identifies circumstances when the ministry or related joint venture may provide care without charge or at a discount commensurate with the ability to pay, for a patient whose financial status makes it impractical or impossible to pay for medically necessary services. This policy applies only to hospital ministry charges and not independent physicians or independent company billings. The provision of free and discounted care through our Financial Assistance program is consistent, appropriate and essential to the execution of our mission, vision and values, and is consistent with our tax-exempt, charitable status.

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

SPECIAL INSTRUCTIONS/ DEFINITIONS

I. Definitions

A. Assets: Provena Health may use assets in the determination of the 25% maximum collectible amount in 12-month period. Assets will not be used for initial financial assistance eligibility. Patient may be excluded if patient has substantial assets (defined as a value in excess of 600% Federal Poverty Level – attachment I) Certain assets will not be considered: the uninsured patient's primary residence; personal property exempt from judgment under Section12-1001 of the Code of Civil Procedure; or any amounts held in a pension or retirement plan. Distributions and payments from pension or retirement plans may be included as income. Acceptable documentation of assets include: statements from financial institutions or some other third party verification of an asset's value. If no other third party exists the patient shall certify as to the estimated value of the asset.

B. Charity Care: Health care services that were never expected to result in cash. Charity care results from providing health care services free or at a discount to individuals who do not have the ability to pay based upon income and family size compared to established federal poverty guidelines. .

C. Financial Assistance Committee: A group of people consisting of local ministry staff and leadership that meets monthly to review requests for financial assistance. The committee will consist of the Chief Executive Officer, Chief Financial Officer, VP Mission Services, Revenue Integrity Director (or designee), Risk Manager, Director of Case/Care Management, Patient Financial Counselor/Customer Service Representative/Collection Manager and the Director of Pastoral Care or a similar mix of individuals for ministries associated with Provena Health.

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

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

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

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

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

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

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

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

I. **Catastrophic Discount:** a discount provided when the patient responsibility payments specific to medical care at Provena Health Hospitals, even after payment by third-party payers, exceed 25% of the patient's family annual gross income. Any patient responsibility in excess of the 25% will be written off to charity.

J. **Medically Necessary Service:** any inpatient or outpatient hospital service, including pharmaceuticals or supplies provided by a hospital to a patient, covered under Title XVIII of the federal Social Security Act for beneficiaries with the same clinical presentation as the uninsured patient. A "medically necessary" service does not include any of the following:

1. Non-medical services such as social and vocational services.
2. Elective cosmetic surgery, but not plastic surgery designed to correct disfigurement caused by injury, illness, or congenital defect or deformity.
3. Services deemed not necessary by the patient's insurance provider.

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

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

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

B. All patients will be treated with respect and fairness regardless of their ability to pay.

C. The Eligibility Criteria discount percentage will be updated annually based on the calculation set forth by the Illinois Uninsured Patient Discount Act. The Federal Poverty Guideline calculations will also be updated annually in conjunction with the published updates by the United States Department of Health and Human Services.

D. Individuals who are deemed eligible by the State of Illinois to receive assistance under the Violent Crime Victims Compensation Act or the Sexual Assault Victims Compensation Act shall be deemed eligible for financial assistance at a level to be determined on a case-by-case basis by the Financial Assistance Committee.

E. A financial assistance application will not need to be repeated for dates of services incurred up to six (6) months after the date of application approval. Once financial assistance eligibility has been granted, all open accounts from 12 months before the date of approval are grandfathered in as financial assistance.

F. A patient may apply for financial assistance at any time during the revenue cycle process.

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

III. Presumptive Financial Assistance Eligibility

A. Presumptive eligibility may be determined on the basis of individual life circumstances. In these situations, a patient is deemed to be eligible for a 100 percent reduction from charges (i.e. full write-off). A patient is presumed to be eligible and therefore does not need to complete a financial assistance application if they meet one of the following criteria:

1. Participation in state funded prescription programs.
2. Participation in Women's Infants, and Children's Programs (WIC)
3. Food stamp eligibility
4. Subsidized school lunch program eligibility.
5. Eligibility for other state or local assistance program that is unfunded.
6. Low income/subsidized housing is provided as a valid address
7. Patient is deceased with no known estate.
8. Patient receiving free care from a community clinic and the community clinic refers the patient to the ministry for treatment or for a procedure.
9. Patient states that he/she is homeless. The due diligence efforts are to be documented.
10. Patient is mentally or physically incapacitated and has no one to act on his/her behalf.
11. Patient is currently eligible for Medicaid, but was not eligible on a prior date of service, instead of making the patient duplicate the required paperwork; the ministry will rely on the financial assistance determination process from Medicaid.
12. Patient receives a MANG denial due to asset availability.

B. When a patient does not complete an application and there is adequate information to support the patient's inability to pay these cases will be submitted to the ministry's Financial Assistance Committee for approval. If approved, 100% write off to financial assistance will be granted for all open accounts from 12 months before the date of approval. Assistance will not be granted for future dates of service.

PROCEDURE

I. Identification of Potentially Eligible Patients

A. Where possible, prior to the admission or pre-registration of the patient, the ministry will conduct a pre-admission/pre-registration interview with the patient, the guarantor, and/or his/her legal representative. If a pre-admission/pre-registration interview is not possible, this interview should be conducted upon admission or registration or as soon as possible thereafter. In case of an emergency admission, the ministry's evaluation of payment alternatives should not take place until the required medical screening-has been provided. At the time of the initial patient interview, the following information should be gathered:

1. Routine and comprehensive demographic data and employment information.
2. Complete information regarding all existing third party coverage.

B. Those patients who may qualify for financial assistance from a governmental program should be referred to the appropriate program, such as Medicaid, prior to consideration for financial assistance.

C. Prior to an account being authorized for the filing of suit, a final review of the account will be conducted and approved by the Revenue Cycle Representative (or designee) to make sure that no application of financial assistance was ever received. Prior to a summons being filed, the Chief Financial Officer's (CFO) approval is required. Provena Health Ministries will not request nor support the use of body attachments from the court system for payment of an outstanding account; however, it is recognized that the court system may take this action in dependently.

II. Determination of Eligibility

A. All patients identified as potential financial assistance recipients should be offered the opportunity to apply for financial assistance. If this evaluation is not conducted until after the patient leaves the ministry, or in the case of outpatients or emergency services, a Patient Financial Services representative will mail a financial assistance application to the patient for completion upon request. In addition, whenever possible, patient billing and collection communications will inform patients of the availability of financial assistance with appropriate contact information. When no representative of the patient is available, the ministry should take the required action to have a legal guardian/trustee appointed or to act on behalf of the patient.

B. Patients are responsible for completing the required application forms and cooperating with the information gathering and assessment process, in order to determine eligibility for financial assistance. (See Special Instructions, III Presumptive Eligibility for exceptions).

C. In the evaluation of an application for financial assistance, a patient's family size, income and medical expenses will be determining factors for eligibility and discount.

D. The Catastrophic Discount will be available to patients who have medical expenses from a Provena Health Hospital that exceed 25% of the patient's family annual gross income, even after payment by third-party payers. Any patient responsibility in excess of the 25% will be written off to charity. Services that are determined not medically necessary by a third-party payer will not be eligible for this discount.

E. The Financial Assistance Committee will consider patient accounts on a case-by-case basis that are exceptions to the eligibility criteria. The Committee has the authority to approve/reject any ministry specific exceptions to the Provision for Financial Assistance policy based on unusual or uncommon circumstances. This includes the review of all non-IL resident applications. All decisions, whether approved or rejected, must have the rationale clearly and formally documented by the committee and maintained in the account file.

III. Notification of Eligibility Determination

A. Clear guidelines as to the length of time required to review the application and provide a decision to the patient should be provided at the time of application. A prompt turn-around and written decision, which provides a reason(s) for denial (if appropriate) will be provided, generally within 45 days of the ministry's Financial Assistance Committee's decision after reviewing a completed application. Patients will be notified in the denial letter that they may appeal this decision and will be provided contact information to do so.

B. If a patient disagrees with the decision, the patient may request an appeal process in writing within 45 days of the denial. The ministry's Financial Assistance Committee will review the application. Decisions reached will normally be communicated to the patient within 45 days, and reflect the Committee's final and executive review.

C. Collection activity will be suspended during the consideration of a completed financial assistance application or an application for any other healthcare bracket (i.e., Medicare, or Medicaid, etc.). A note will be entered into the patient's account to suspend collection activity until the financial assistance process is completed. If the account has been placed with a collection agency, the agency will be notified by telephone to suspend collection efforts until a determination is made. This notification will be documented in the account notes. The patient will also be notified verbally that the collection activity will be suspended during consideration. If a financial assistance determination allows for a percent reduction but leaves the patient with a self-pay balance, payment terms will be established on the basis of disposable income.

D. If a determination is made that the patient has the ability to pay all or a portion of a bill, such a determination does not prevent a reassessment of the person's ability to pay at a later date.

E. Refunding Patient Payments – No refunds will be given for payments made prior to the financial assistance approval date.

F. If the patient has a change in his/her financial status, the patient should promptly notify the Central Billing Office (CBO) or ministry designee. The patient may request and apply for financial assistance or a change in their payment plan terms.

IV. Patient Awareness of Policy

A. Signage

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

B. Hospital Bill

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

C. Policy

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

D. Application Form

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

V. Monitoring and Reporting

1. A financial assistance log from which periodic reports can be developed shall be maintained aside from any other required financial statements.

2. Financial assistance logs will be maintained for a period of ten (10) years. At a minimum, the financial assistance logs are to include:
   a. Account number
   b. Date of Service
   c. Application mailed (y / n)
   d. Application returned and complete (y/n)
   e. Total charges
   f. Self-pay balances
   g. Amount of financial assistance approved
   h. Date financial assistance was approved/rejected

3. The financial assistance log will be printed monthly for review at the ministry Financial Assistance Committee meeting.
   a. The financial assistance log must be signed and dated by the ministry CFO.
   b. Financial Assistance meeting minutes must be signed by the ministry CFO.

4. The ministry's Collection Manager / Patient Financial Services Representative will approval financial assistance for amounts up to $1,000. Amounts greater than $1,000 but lower than $5,000 will be approved by the ministry's Revenue Cycle Representative, those greater than $5,000 will be approved by the ministry's CFO.

5. A record, paper or electronic, should be maintained reflecting authorization of financial assistance. These documents shall be kept for a period of ten (10) years.

6. The cost of financial assistance will be reported annually in the Community Benefit Report to the Community, IRS 990 schedule H and in compliance with the IL Community Benefit Act. Charity Care will be reported as the cost of care provided (not charges) using the documented criteria for the reporting requirement.

ATTACHMENTS

Eligibility Criteria for the Provena Health Financial Assistance Program – Attachment # 1
Hospital Financial Assistance Program Cover Letter and Application – Attachment # 2
Room and Board Statement – Attachment #3

REFERENCES

Section 12-1001 Code Civil Procedure
Title XVIII Federal Social Security Act
Illinois Uninsured Patient Discount Act
Illinois Fair Patient Billing Act
Violent Crime Victims Compensation Act
Sexual Crime Victims Compensation Act
Women's, Infant, Children Program (WIC)
IL Community Benefit Act
Internal Revenue Service (IRS) 990 Schedule
Ethical and Religious Directives, Part 1
Provena Health System Policy – Payment Arrangements

PROVENA
Health

ATTACHMENT #1

ELIGIBILITY CRITERIA FOR THE PROVENA HEALTH FINANCIAL ASSISTANCE PROGRAM

The table below is based upon 2009 Federal Poverty Guidelines.

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

CALCULATION PROCESS

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

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

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

ATTACHMENT #2

PROVENA Health

HOSPITAL FINANCIAL ASSISTANCE APPLICATION COVER LETTER

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

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

The Provena Health Financial Assistance Programs include:

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

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

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

If applicable, please submit the following:

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

Return completed form and supporting documents to:

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

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

*Financial Counselors: Provena Covenant Medical Center:217-337-2257•Provena Saint Joseph Hospital:847-931-5562• Provena Saint Joseph Medical Center:815-741-7146• Provena St. Mary's Hospital: 815-937-2028•Provena Mercy Medical Center:630-801-2558•Provena United Samaritans Medical Center:217-443-5000 ext.5128,5151,5497

Program Applying For:
☐ Uninsured Financial Assistance (Free/Discounted Care)
☐ Catastrophic Discount

Attachment #2

PROVENA Health

Hospital Financial Assistance Program Application

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

Please complete both sides of this form. Return the signed form with all required documents to the address below.
Provena Health, Central Billing Office, 1000 Remington Blvd., Suite 110, Bolingbrook, IL 60440

Date of Application:_____ Date Application Mailed:_____

1. PATIENT INFORMATION *: -PLEASE PRINT ALL INFORMATION-

Last Name	First Name	Middle Initial

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

2. APPLICANT (PATIENT/PARENT) INFORMATION:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Last Name	First Name	Middle Initial	Social Security Number	Date of Birth

Street Address	City	State	Zip	Home Phone ( )

Current Employer	Street Address	Phone	Position	Years Employed

Total Number of Dependents: (other than self and co-applicant)	Dependent Name	Date of Birth	Relationship

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

Relationship to Patient ☐ Spouse ☐ Parent ☐ Other

Last Name	First Name	Middle Initial	Social Security Number	Date of Birth

Street Address	City	State	Zip	Home Phone ( )

Current Employer	Street Address	Phone	Position	Years Employed

Total Number of Dependents: (other than self and co-applicant)	Dependent Name	Date of Birth	Relationship

4. INCOME INFORMATION:

List all contributing gross income. Include gross wages, salaries, dividends, interest, social security benefits, workers compensation, training stipends, regular support from family members not living in the household, government pensions, private pensions, insurance and annuity payments, income from rents, royalties, estates, trusts, and veteran stipends.

Monthly Income Sources	Applicant	Co-Applicant	Combined **Monthly** Income
Employment Income	$	$	$
Social Security	$	$	$
Disability	$	$	$
Unemployment	$	$	$
Spousal/Child Support	$	$	$
Rental Property	$	$	$
Investment Income	$	$	$
Other:	$	$	$
Other:	$	$	$
Other:	$	$	$
Other:	$	$	$
		Total Combined Monthly Income	$
		Add all income above	

ATTACHMENT 19B

PROVENA Health

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

5. ASSETS:

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

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

6. PROVENA HOSPITAL SERVICES:

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

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

7. ADDITIONAL INFORMATION/COMMENTS:

8. SIGNATURE:

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

Applicant Signature	Date	Co-applicant Signature	Date

Please submit the following information with your application:

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

If applicable, please submit the following:

- ☐ Social Security Award Letter
- ☐ Financial Award Letter(s) for any student loans or grants
- ☐ Room and Board Statement (if no income) – Attachment #3
- ☐ Unemployment Compensation Benefit Award Letter

Return completed form and supporting documents to:

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

If you have any questions or need additional assistance, please contact us at 888-740-4111 or www.Provena.org/FinancialAssistance to obtain additional information on the Provena Health Financial Assistance Programs.

ATTACHMENT 19B

HEALTH CARE SYSTEM

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

Impact of the Proposed Transaction on Other Area Providers

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

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

Upon the completion of the merger, twelve other hospitals will be in the new Health Care System. All of those hospitals, with the exception of Holy Family Medical

Center, which operates as a Long-Term Acute Care Hospital (LTACH), operate as general acute care hospitals. The table below identifies the distance and driving time (MapQuest, unadjusted) from Provena St. Mary's Hospital to each of the other hospitals in the Health Care System.

Proximity of Provena St. Mary's Hospital (500 West Court Street Kankakee) to:

			Miles	Minutes
Saint Francis Hospital	355 Ridge Avenue	Evanston	76.2	97
Provena St. Mary's Hospital	7435 W. Talcott Avenue	Chicago	72.6	88
Saint Mary of Nazareth Hospital			63.2	77
and St. Elizabeth's Med. Ctr.	2233 W. Division Street	Chicago	63.2	77
Saint Joseph Hospital	2900 N. Lake Shore Drive	Chicago	65	82
Our Lady Resurrection Med. Ctr.	5645 West Addison St.	Chicago	68.96	87
Holy Family Medical Center	100 North River Road	Des Plaines	79.1	96
Provena United Samaritans Med. Ctr.	812 North Logan Street	Danville	86.8	109
Provena Covenant Medical Center	1400 West Park Avenue	Urbana	79.7	84
Provena Mercy Medical Center	1325 N. Highland Avenue	Aurora	61.8	87
Provena Saint Joseph Hospital	77 North Airlite Street	Elgin	83.7	111
Provena Saint Joseph Medical Ctr.	333 North Madison Street	Joliet	42.3	53

Source: MapQuest, 02/22/2011

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

Referral Agreements

Copies of Provena St. Mary's Hospital's current referral agreements related to IDPH "categories of service" not provided directly by the hospital are attached. It is the

intent of the applicants to retain all of Provena St. Mary's Hospital's referral agreements, and each provider with which a referral agreement exists will be notified of the change of ownership. Each of the existing referral agreements will continue in their current form until those agreements are revised and/or supplemented, if and as necessary. That revision process is anticipated to take 6-12 months from the date of the change of ownership.

The table below identifies the driving time and distance between Provena St. Mary's Hospital and each hospital with which PSMH maintains a referral agreement.

Referral Site	Service	Miles*	Minutes*
Provena Saint Joseph Medical Center 333 North Madison Street Joliet	neurosurgery	42.3	53
Riverside Medical Center 350 North Wall Street Kankakee	open heart surgery	0.67	1
OSF St. Francis Medical Center 530 N.E. Glen Oak Ave. Peoria	general	119.2	128

*MapQuest (unadjusted) March 3, 2011

Duplication of Services

As certified in this application, the applicants fully intend to retain Provena St. Mary's Hospital's clinical programmatic complement for a minimum of two years. An initial evaluation of the clinical services provided by Provena St. Mary's Hospital would suggest that the hospital provides few, if any, clinical services not typically provided by general acute care hospitals. In addition, and as can be seen from the proximity data

provided in the table above, the hospitals in the Health Care System do not have service areas that overlap.

Availability of Services to the Community

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

In addition, Provena St. Mary's Hospital 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

CITY: Chicago COUNTY: Suburban Cook (Chicago)

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

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
Dedcated Observation	*0*					*0*				
Facility Utilization	**360**			**15,812**	**83,488**	**2,612**	**5.4**	**235.9**	**65.5**	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
	62.0%	**8.6%**	**0.1%**	**26.9%**	**1.0%**	**1.4%**	
Inpatients	9805	1360	13	4253	161	220	15,812
	39.2%	**15.0%**	**0.1%**	**42.7%**	**2.2%**	**0.8%**	
Outpatients	62394	23859	137	67967	3551	1337	159,245

Inpatient and Outpatient Net Revenue by Payor Source

Financial Year Reported: 7/1/2008 *to* 6/30/2009

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals	Charity Care Expense
Inpatient Revenue ($)	**65.7%**	**4.3%**	**0.0%**	**28.6%**	**1.4%**	**100.0%**	
	127,765,641	8,348,093	0	55,727,368	2,769,114	194,610,216	1,195,049
Outpatient Revenue ($)	**26.9%**	**6.1%**	**0.0%**	**64.8%**	**2.3%**	**100.0%**	
	22,972,910	5,210,335	**0**	55,408,824	1,926,915	85,518,984	674,466

Total Charity Care Expense
1,869,515

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**

Laboratory Studies

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

Organ Transplantation

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

ATTACHMENT 19C

Surgery and Operating Room Utilization

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

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

Dedicated and Non-Dedicated Procedure Room Utilzation

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 ☐

Level of Trauma Service	Level 1	Level 2
	---	---
Operating Rooms Dedicated for Trauma Care		0
Number of Trauma Visits:		0
Patients Admitted from Trauma		0

Emergency Service Type:	Comprehensive
Number of Emergency Room Stations	21
Persons Treated by Emergency Services:	38,300
Patients Admitted from Emergency:	9,625
Total ED Visits (Emergency+Trauma):	**38,300**

Cardiac Catheterization Utilization

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

	Owned	Contract	Examinations Inpatient	Examinations Outpatient
General Radiography/Fluoroscopy	9	0	33,176	30,020
Nuclear Medicine	5	0	3,504	5,520
Mammography	2	0	19	19,164
Ultrasound	9	0	6,240	11,421
Diagnostic Angiography	0	0	0	0
Interventional Angiography	0		0	0
Positron Emission Tomography (PET)	1	0	8	724
Computerized Axial Tomography (CAT)	3	0	12,006	18,683
Magnetic Resonance Imaging	2	0	2,390	5,544

Radiation Equipment

	Owned	Contract	Therapies/ Treatments
Lithotripsy	0	0	0
Linear Accelerator	1	0	4,907
Image Guided Rad Therapy	1	0	5108
Intensity Modulated Rad Therap	0	0	0
High Dose Brachytherapy	1	0	73
Proton Beam Therapy	0	0	0
Gamma Knife	0	0	0
Cyber knife	0	0	0

Source: 2009 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development.

ATTACHMENT 19C

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

CITY: Evanston **COUNTY:** Suburban Cook County

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

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
Dedcated 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
	48.1%	**21.3%**	**0.0%**	**25.8%**	**3.3%**	**1.5%**	
Inpatients	4072	1806	0	2186	282	127	8,473
	27.5%	**20.1%**	**0.0%**	**20.3%**	**30.9%**	**1.2%**	
Outpatients	32308	23699	0	23907	36315	1404	117,633

Inpatient and Outpatient Net Revenue by Payor Source

Financial Year Reported: 7/1/2008 *to* 6/30/2009

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals	Charity Care Expense
Inpatient Revenue ($)	**47.8%**	**23.1%**	**0.0%**	**26.0%**	**3.1%**	**100.0%**	
	52,034,979	25,140,397	0	28,361,084	3,385,602	108,922,062	1,883,268
Outpatient Revenue ($)	**17.6%**	**10.5%**	**0.0%**	**58.3%**	**13.6%**	**100.0%**	
	10,022,592	5,962,992	0	33,167,642	7,755,578	56,908,804	1,461,036

Total Charity Care Expense 3,344,304

Totals: Charity Care as % of Net Revenue 2.0%

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.

ATTACHMENT 19C

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	☑	
Level of Trauma Service	**Level 1** Adult	**Level 2** ---
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

	Owned	Contract	Examinations Inpatient	Examinations Outpatient
General Radiography/Fluoroscopy	4	0	13,559	29,471
Nuclear Medicine	2	0	1,028	2,280
Mammography	3	0	0	10,623
Ultrasound	4	0	1,473	4,435
Diagnostic Angiography	0	0	0	0
Interventional Angiography	0		0	0
Positron Emission Tomography (PET)	0	1	0	128
Computerized Axial Tomography (CAT)	2	0	2,988	18,677
Magnetic Resonance Imaging	1	0	897	2,119

Radiation Equipment

	Owned	Contract	Therapies/ Treatments
Lithotripsy	0	0	0
Linear Accelerator	1	0	119
Image Guided Rad Therapy	0	0	0
Intensity Modulated Rad Therap	1	0	74
High Dose Brachytherapy	0	0	0
Proton Beam Therapy	0	0	0
Gamma Knife	0	0	0
Cyber knife	0	0	0

Source: 2009 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development.

ATTACHMENT 19C

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 **CITY:** Chicago **COUNTY:** Suburban Cook (Chicago)

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

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
Dedcated Observation	*0*					*0*				
Facility Utilization	**387**			**18,994**	**101,607**	**4,398**	**5.6**	**290.4**	**75.0**	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

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

Financial Year Reported: 7/1/2008 *to* 6/30/2009

Inpatient and Outpatient Net Revenue by Payor Source

	Medicare	*Medicaid*	*Other Public*	*Private Insurance*	*Private Pay*	*Totals*	*Charity Care Expense*
Inpatient	**36.8%**	**34.8%**	**0.0%**	**18.9%**	**9.5%**	**100.0%**	
Revenue ($)	64,870,370	61,419,970	0	33,285,730	16,816,201	176,392,271	1,394,629
Outpatient	**16.6%**	**32.9%**	**0.0%**	**31.8%**	**18.7%**	**100.0%**	
Revenue ($)	11,265,066	22,276,179	0	21,509,882	12,633,284	67,684,411	1,267,966

Total Charity Care Expense
2,662,595

Totals: Charity Care as % of Net Revenue
1.1%

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

ATTACHMENT 19C

Surgery and Operating Room Utilization

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

SURGICAL RECOVERY STATIONS Stage 1 Recovery Stations 9 Stage 2 Recovery Stations 19

Dedicated and Non-Dedicated Procedure Room Utilization

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

Cardiac Catheterization Labs

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

Emergency/Trauma Care

Certified Trauma Center by EMS ☐

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

	Owned	Contract	Examinations Inpatient	Examinations 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
Positron Emission Tomography (PET)	0	0	0	0
Computerized Axial Tomography (CAT)	2	0	4,168	18,333
Magnetic Resonance Imaging	1	0	1,315	2,749

Radiation Equipment

	Owned	Contract	Therapies/ Treatments
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

Source: 2009 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development.

ATTACHMENT 19C

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 **CITY:** Chicago **COUNTY:** Suburban Cook (Chicago)

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

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
Dedcated 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*
	43.6%	**16.2%**	**0.2%**	**37.7%**	**1.2%**	**1.1%**	
Inpatients	5747	2142	22	4972	161	144	13,188
	26.2%	**15.8%**	**0.1%**	**52.9%**	**5.1%**	**1.0%**	
Outpatients	47383	29662	158	99559	9558	1871	188,191

Financial Year Reported: 7/1/2008 *to* 6/30/2009

Inpatient and Outpatient Net Revenue by Payor Source

	Medicare	*Medicaid*	*Other Public*	*Private Insurance*	*Private Pay*	*Totals*	*Charity Care Expense*
Inpatient Revenue ($)	**46.8%** 64,832,024	**13.9%** 19,290,122	**0.0%** 0	**36.8%** 51,002,179	**2.5%** 3,520,673	**100.0%** 138,644,998	652,789
Outpatient Revenue ($)	**16.1%** 8,703,376	**3.6%** 1,963,278	**0.0%** 0	**72.0%** 38,807,662	**8.2%** 4,430,471	**100.0%** 53,904,787	834,836

Total Charity Care Expense
1,487,625

Totals: Charity Care as % of Net Revenue
0.8%

Birthing Data

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

Newborn Nursery Utilization

Level 1 Patient Days	2,892
Level 2 Patient Days	199
Level 2+ Patient Days	2,812
Total Nursery Patientdays	**5,903**

Laboratory Studies

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

Organ Transplantation

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

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

ATTACHMENT 19C

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

Dedicated and Non-Dedicated Procedure Room Utilzation

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 ☐

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

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

Source: 2009 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development.

Hospital Profile - CY 2009 — St. Elizabeth's Hospital — Chicago

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

CITY: Chicago

COUNTY: Suburban Cook (Chicago)

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

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
Dedcated 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
	28.2%	65.2%	0.0%	6.0%	0.3%	0.3%	
Inpatients	1726	3989	0	367	18	20	6,120
	21.6%	40.9%	0.1%	32.6%	3.4%	1.4%	
Outpatients	5505	10402	34	8304	856	360	25,461

Inpatient and Outpatient Net Revenue by Payor Source

Financial Year Reported: 7/1/2008 *to* 6/30/2009

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals	Charity Care Expense
Inpatient	23.9%	70.1%	0.0%	5.5%	0.6%	100.0%	
Revenue ($)	9,280,892	27,203,305	0	2,126,999	216,467	38,827,663	322,570
Outpatient	16.3%	43.1%	0.0%	36.1%	4.5%	100.0%	
Revenue ($)	3,057,316	8,058,125	0	6,755,379	838,631	18,709,451	67,435

Total Charity Care Expense: 390,005

Totals: Charity Care as % of Net Revenue: 0.7%

Birthing Data

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

Newborn Nursery Utilization

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

Laboratory Studies

Inpatient Studies	83,706
Outpatient Studies	51,107
Studies Performed Under Contract	0

Organ Transplantation

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

ATTACHMENT 19C

Surgery and Operating Room Utilization

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

SURGICAL RECOVERY STATIONS Stage 1 Recovery Stations: 8 Stage 2 Recovery Stations: 18

Dedicated and Non-Dedicated Procedure Room Utilization

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

Cardiac Catheterization Labs

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

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:	Comprehensive
Number of Emergency Room Stations	8
Persons Treated by Emergency Services:	4,286
Patients Admitted from Emergency:	341
Total ED Visits (Emergency+Trauma):	**4,286**

Cardiac Catheterization Utilization

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

Cardiac Surgery Data

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

Outpatient Service Data

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

Diagnostic/Interventional Equipment

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

Radiation Equipment

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

Source: 2009 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development.

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 CITY: Chicago COUNTY: Suburban Cook (Chicago)

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

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
Dedcated 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*
	62.7%	**15.5%**	**0.0%**	**17.4%**	**2.8%**	**1.6%**	
Inpatients	5898	1458	0	1642	263	149	9,410
	36.6%	**27.8%**	**0.1%**	**26.3%**	**7.5%**	**1.8%**	
Outpatients	38888	29528	95	27928	7995	1868	106,302

Financial Year Reported: 7/1/2008 *to* 6/30/2009

Inpatient and Outpatient Net Revenue by Payor Source

	Medicare	*Medicaid*	*Other Public*	*Private Insurance*	*Private Pay*	*Totals*	*Charity Care Expense*
Inpatient Revenue ($)	**55.8%** 45,372,692	**5.8%** 4,707,203	**0.0%** 0	**17.8%** 14,436,297	**20.6%** 16,788,176	**100.0%** 81,304,368	922,725
Outpatient Revenue ($)	**19.2%** 10,380,455	**13.3%** 7,196,801	**0.0%** 0	**31.7%** 17,126,806	**35.7%** 19,287,337	**100.0%** 53,991,399	690,550

Total Charity Care Expense **1,613,275**

Totals: Charity Care as % of Net Revenue **1.2%**

Birthing Data

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

Newborn Nursery Utilization

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

Laboratory Studies

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

Organ Transplantation

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

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

ATTACHMENT 19C

Surgery and Operating Room Utilization

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

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

Dedicated and Non-Dedicated Procedure Room Utilization

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

Cardiac Catheterization Labs

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

Emergency/Trauma Care

Certified Trauma Center by EMS ☐

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

	Owned	Contract	Examinations Inpatient	Examinations Outpatient
General Radiography/Fluoroscopy	7	0	13,247	29,193
Nuclear Medicine	2	0	1,666	2,499
Mammography	2	0	8	4,544
Ultrasound	4	0	3,487	6,636
Diagnostic Angiography	0	0	0	0
Interventional Angiography	0		0	0
Positron Emission Tomography (PET)	0	0	0	0
Computerized Axial Tomography (CAT)	2	0	4,225	15,489
Magnetic Resonance Imaging	1	1	922	1,555

Radiation Equipment

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

Source: 2009 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development

ATTACHMENT 19C

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 **CITY:** Des Plaines **COUNTY:** Suburban Cook County

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

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
Dedcated 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

Inpatient and Outpatient Net Revenue by Payor Source

Financial Year Reported: 7/1/2008 *to* 6/30/2009

	Medicare	*Medicaid*	*Other Public*	*Private Insurance*	*Private Pay*	*Totals*	*Charity Care Expense*
Inpatient Revenue ($)	**49.7%** 31,307,091	**15.0%** 9,452,199	**0.0%** 0	**30.0%** 18,919,331	**5.3%** 3,353,949	**100.0%** 63,032,570	184,754
Outpatient Revenue ($)	**49.7%** 5,291,206	**15.0%** 1,597,515	**0.0%** 0	**30.0%** 3,197,553	**5.3%** 566,851	**100.0%** 10,653,125	1,766

Total Charity Care Expense **186,520**

Totals: Charity Care as % of Net Revenue **0.3%**

Birthing Data

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

Newborn Nursery Utilization

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

Laboratory Studies

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). Current Profile denotes 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 Utilzation

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

	Owned	Contract	Examinations: Inpatient	Examinations: Outpatient
General Radiography/Fluoroscopy	8	0	6,055	4,191
Nuclear Medicine	2	0	50	410
Mammography	3	0	0	4,250
Ultrasound	5	0	769	2,692
Diagnostic Angiography	0	0	0	0
Interventional Angiography	0		0	0
Positron Emission Tomography (PET)	0	0	0	0
Computerized Axial Tomography (CAT)	1	0	1,554	1,125
Magnetic Resonance Imaging	1	0	0	722

Radiation Equipment

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

Source: 2009 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development.

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
ADDRESS	812 North Logan Street

CITY: Danville COUNTY: Vermilion County

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

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
Dedcated Observation	*0*					*0*				
Facility Utilization	**174**			**6,490**	**24,005**	**3,508**	**4.2**	**75.4**	**43.3**	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

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

Inpatient and Outpatient Net Revenue by Payor Source

Financial Year Reported: 1/1/2009 *to* 12/31/2009

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals	Charity Care Expense
Inpatient Revenue ($)	**37.6%**	**20.5%**	**0.3%**	**38.8%**	**4.8%**	**100.0%**	
	16,776,873	9,156,068	128,018	16,398,885	2,129,524	44,589,368	1,066,068
Outpatient Revenue ($)	**14.4%**	**11.7%**	**1.5%**	**59.1%**	**13.3%**	**100.0%**	
	10,036,415	8,123,116	1,056,472	41,059,236	9,246,308	69,521,547	2,953,903

Total Charity Care Expense 4,019,971

Totals: Charity Care as % of Net Revenue 3.5%

Birthing Data

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

Newborn Nursery Utilization

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

Laboratory Studies

Inpatient Studies	476,188
Outpatient Studies	538,649
Studies Performed Under Contract	69,358

Organ Transplantation

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

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

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

	Owned	Contract	Examinations Inpatient	Examinations Outpatient
General Radiography/Fluoroscopy	6	0	8,830	23,841
Nuclear Medicine	2	0	402	1,803
Mammography	1	0	0	3,925
Ultrasound	2	0	922	6,877
Diagnostic Angiography	0	0	0	0
Interventional Angiography	0		0	0
Positron Emission Tomography (PET)	0	1	0	132
Computerized Axial Tomography (CAT)	2	0	3,222	11,462
Magnetic Resonance Imeging	2	0	454	3,565

Radiation Equipment

	Owned	Contract	Therapies/ Treatments
Lithotripsy	0	0	0
Linear Accelerator	1	0	11,445
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
Gemma Knife	0	0	0
Cyber knife	0	0	0

Source: 2009 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development

Hospital Profile - CY 2009

Provena Covenant Medical Center — Urbana

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 CITY: Urbana COUNTY: Champaign County

Patients by Race

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

Patients by Ethnicity

Hispanic or Latino:	1.1%
Not Hispanic or Latino:	97.7%
Unknown:	1.2%

IDPH Number:	4861
HPA	D-01
HSA	4

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
ntensive 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*					
)bstetric/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*					
leonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
ong Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
wing Beds				0	0		0.0	0.0		
cute Mental Illness	30	25	21	923	4,246	0	4.6	11.6	38.8	46.5
ehabilitation	25	21	19	396	4,362	0	11.0	12.0	47.8	56.9
ong-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
edcated Observetion	*0*					*0*				
'acility 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
npatients	**45.8%** 3951	**16.6%** 1429	**1.9%** 164	**30.2%** 2602	**2.8%** 238	**2.8%** 242	8,626
utpatients	**16.6%** 39058	**45.8%** 107961	**1.9%** 4488	**30.4%** 71721	**4.0%** 9524	**1.3%** 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
ıpatient evenue ($)	**43.0%** 36,829,206	**15.2%** 13,070,156	**0.4%** 320,129	**38.5%** 32,988,965	**3.0%** 2,538,299	**100.0%** 85,746,755	1,846,049
ıtpatient evenue ($)	**11.9%** 9,423,391	**4.9%** 3,928,867	**2.6%** 2,085,649	**66.1%** 52,568,920	**14.4%** 11,481,099	**100.0%** 79,487,926	2,755,255

Total Charity Care Expense 4,601,304

Totals: Charity Care as % of Net Revenue 2.8%

Birthing Data

'umber of Total Births:	961
umber of Live Births:	956
irthing Rooms:	0
abor Rooms:	0
elivery Rooms:	0
abor-Delivery-Recovery Rooms:	9
abor-Delivery-Recovery-Postpartum Rooms:	0
-Section Rooms:	2
Sections Performed:	276

Newborn Nursery Utilization

Level 1 Patient Days	1,592
Level 2 Patient Days	0
Level 2+ Patient Days	798
Total Nursery Patientdays	2,390

Laboratory Studies

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

Organ Transplantation

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

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

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	0	0	178	473	495	614	1109	2.8	1.3
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	12	12	451	1199	1256	1557	2813	2.8	1.3
Gastroenterology	0	0	0	0	0	0	0	0	0	0.0	0.0
Neurology	0	0	0	0	20	54	56	70	126	2.8	1.3
OB/Gynecology	0	0	0	0	189	502	527	652	1179	2.8	1.3
Oral/Maxillofacial	0	0	0	0	11	30	31	38	69	2.8	1.3
Ophthalmology	0	0	0	0	194	514	540	666	1206	2.8	1.3
Orthopedic	0	0	0	0	413	1102	1153	1431	2584	2.8	1.3
Otolaryngology	0	0	0	0	276	734	767	953	1720	2.8	1.3
Plastic Surgery	0	0	0	0	3	7	9	10	19	3.0	1.4
Podiatry	0	0	0	0	129	342	360	443	803	2.8	1.3
Thoracic	0	0	0	0	17	46	47	59	106	2.8	1.3
Urology	0	0	0	0	237	630	660	818	1478	2.8	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
GastroIntestinal	0	0	2	2	522	3444	434	2870	3304	0.8	0.8
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	0	0	0	0	0	0	0	0.0	0.0
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

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

Emergency/Trauma Care

Certified Trauma Center by EMS ☐

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

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

Radiation Equipment

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

Source: 2009 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development.

Hospital Profile - CY 2009 — Provena Mercy Medical Center — Aurora

Ownership, Management and General Information

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

CITY: Aurora COUNTY: Kane County

Patients by Race

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

Patients by Ethnicity

Hispanic or Latino:	22.7%
Not Hispanic or Latino:	75.0%
Unknown:	2.3%

IDPH Number:	4903
HPA	A-12
HSA	8

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	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
Dedcated 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*
	36.6%	**27.3%**	**0.5%**	**30.2%**	**3.2%**	**2.1%**	
Inpatients	3809	2838	55	3140	335	220	10,397
	15.9%	**30.9%**	**0.6%**	**32.2%**	**17.8%**	**2.6%**	
Outpatients	14809	28825	557	29986	16615	2462	93,254

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

Total Charity Care Expense
5,367,773

Totals: Charity Care as % of Net Revenue
3.2%

Birthing Data

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

Newborn Nursery Utilization

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

Laboratory Studies

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

Organ Transplantation

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

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

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

Emergency/Trauma Care

Certified Trauma Center by EMS	☑	
Level of Trauma Service	Level 1 Adult	Level 2 ---
Operating Rooms Dedicated for Trauma Care		0
Number of Trauma Visits:		658
Patients Admitted from Trauma		334
Emergency Service Type:		Comprehensive
Number of Emergency Room Stations		26
Persons Treated by Emergency Services:		43,713
Patients Admitted from Emergency:		4,485
Total ED Visits (Emergency+Trauma):		**44,371**

Cardiac Catheterization Utilization

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

Cardiac Surgery Data

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

Outpatient Service Data

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

Diagnostic/Interventional Equipment

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

Radiation Equipment

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

Source: 2009 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development.

ATTACHMENT 19C

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
CITY:	Elgin
COUNTY:	Kane County

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

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2009	Staff Bed Occupancy Rate %
Medical/Surgical	99	99	99	5,890	27,862	3,810	5.4	86.8	87.6	87.6
0-14 Years				*34*	*75*					
15-44 Years				*941*	*3,341*					
45-64 Years				*1,774*	*7,903*					
65-74 Years				*1,098*	*5,495*					
75 Years +				*2,043*	*11,048*					
Pediatric	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Intensive Care	15	15	15	1,123	4,210	0	3.7	11.5	76.9	76.9
Direct Admission				*637*	*2,493*					
Transfers				*486*	*1,717*					
Obstetric/Gynecology	0	15	6	232	508	66	2.5	1.6	0.0	10.5
Maternity				*215*	*468*					
Clean Gynecology				*17*	*40*					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	30	30	25	1,185	6,055	0	5.1	16.6	55.3	55.3
Rehabilitation	34	34	34	902	9,691	0	10.7	26.6	78.1	78.1
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedcated 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
	52.9%	**11.0%**	**0.7%**	**30.6%**	**2.4%**	**2.4%**	
Inpatients	4679	975	63	2711	210	208	8,846
	25.7%	**17.9%**	**0.4%**	**42.7%**	**11.5%**	**1.7%**	
Outpatients	24364	17017	422	40545	10954	1582	94,884

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

Total Charity Care Expense
3,749,548

Totals: Charity Care as % of Net Revenue
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**

Laboratory Studies

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

Organ Transplantation

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

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

Surgery and Operating Room Utilization

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

SURGICAL RECOVERY STATIONS Stage 1 Recovery Stations 11 Stage 2 Recovery Stations 22

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	☑	
Level of Trauma Service	Level 1 Adult	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

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

Radiation Equipment

	Owned	Contract	Therapies/ Treatments
Lithotripsy	0	0	0
Linear Accelerator	2	0	4,854
Image Guided Rad Therapy	0	0	0
Intensity Modulated Rad Therap	1	0	1120
High Dose Brachytherapy	0	0	0
Proton Beam Therapy	0	0	0
Gamma Knife	0	0	0
Cyber knife	0	0	0

Source: 2009 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development.

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 **CITY:** Joliet **COUNTY:** Will County

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

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2009	Staff Bed Occupancy Rate %
Medical/Surgical	319	282	271	15,783	67,402	9,063	4.8	209.5	65.7	74.3
0-14 Years				*40*	*94*					
15-44 Years				*3,366*	*11,237*					
45-64 Years				*4,893*	*19,502*					
65-74 Years				*2,680*	*13,171*					
75 Years +				*4,804*	*23,398*					
Pediatric	13	13	13	525	1,415	692	4.0	5.8	44.4	44.4
Intensive Care	52	52	51	4,413	11,848	22	2.7	32.5	62.5	62.5
Direct Admission				*2,801*	*8,350*					
Transfers				*1,612*	*3,498*					
Obstetric/Gynecology	33	33	33	2,406	6,039	275	2.6	17.3	52.4	52.4
Maternity				*2,182*	*5,500*					
Clean Gynecology				*224*	*539*					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	31	31	31	1,390	9,613	0	6.9	26.3	85.0	85.0
Rehabilitation	32	32	30	570	6,544	0	11.5	17.9	56.0	56.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedcated 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*
	46.0%	**13.4%**	**0.9%**	**34.5%**	**3.2%**	**2.0%**	
Inpatients	10793	3154	212	8099	751	466	23,475
	27.4%	**16.9%**	**0.8%**	**48.5%**	**5.2%**	**1.3%**	
Outpatients	63576	39251	1779	112829	12070	2927	232,432

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

Total Charity Care Expense
7,284,458

Totals: Charity Care as % of Net Revenue
1.8%

Birthing Data

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

Newborn Nursery Utilization

Level 1 Patient Days	3,719
Level 2 Patient Days	0
Level 2+ Patient Days	1,943
Total Nursery Patientdays	**5,662**

Laboratory Studies

Inpatient Studies	766,465
Outpatient Studies	603,298
Studies Performed Under Contract	31,054

Organ Transplantation

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

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

ATTACHMENT 19C

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

SURGICAL RECOVERY STATIONS Stage 1 Recovery Stations 10 Stage 2 Recovery Stations 0

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	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 Anglography 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	☑	
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 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

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

iagnostic/Interventional Equipment

	Owned	Contract	Examinations Inpatient	Examinations Outpatient
ıneral Radiography/Fluoroscopy	29	0	26,372	71,389
'clear Medicine	4	0	3,667	10,206
ımmography	2	0	0	13,856
rasound	8	0	5,143	19,181
ıgnostic Angiography	0	0	0	0
erventional Angiography	0		0	0
sitron Emission Tomography (PET)	0	1	0	0
mputerized Axial Tomography (CAT)	7	0	8,981	29,106
gnetic Resonance Imaging	4	0	4,170	8,779

Radiation Equipment

	Owned	Contract	Therapies/ Treatments
Lithotripsy	0	1	27
Linear Accelerator	2	0	70
Image Guided Rad Therapy	2	0	40
Intensity Modulated Rad Therap	2	0	36
High Dose Brachytherapy	2	0	19
Proton Beam Therapy	0	0	0
Gamma Knife	0	0	0
Cyber knife	0	0	0

ATTACHMENT 19C

ırce: 2009 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development.

Ownership, Management and General Information

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

CITY: Kankakee COUNTY: Kankakee County

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

Facility Utilization Data by Category of Service

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

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
	46.0%	**17.8%**	**1.2%**	**28.8%**	**4.2%**	**1.9%**	
Inpatients	3474	1343	94	2171	320	143	7,545
	26.9%	**15.1%**	**1.4%**	**40.9%**	**14.1%**	**1.5%**	
Outpatients	27886	15592	1481	42310	14624	1582	103,475

Inpatient and Outpatient Net Revenue by Payor Source

Financial Year Reported: 1/1/2009 *to* 12/31/2009

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

Total Charity Care Expense 2,657,530

Totals: Charity Care as % of Net Revenue 1.9%

Birthing Data

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

Newborn Nursery Utilization

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

Laboratory Studies

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

Organ Transplantation

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

* Note: According to Board action on 4/22/09, Board reduced 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 when the 2009 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

Dedicated and Non-Dedicated Procedure Room Utilization

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

Cardiac Catheterization Labs

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

Emergency/Trauma Care

Certified Trauma Center by EMS	☑	
Level of Trauma Service	**Level 1** Adult	**Level 2** - - -
Operating Rooms Dedicated for Trauma Care		1
Number of Trauma Visits:		291
Patients Admitted from Trauma		223
Emergency Service Type:		Comprehensive
Number of Emergency Room Stations		22
Persons Treated by Emergency Services:		31,174
Patients Admitted from Emergency:		5,913
Total ED Visits (Emergency+Trauma):		**31,465**

Cardiac Catheterization Utilization

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

Cardiac Surgery Data

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

Outpatient Service Data

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

Diagnostic/Interventional Equipment

	Owned	Contract	Examinations Inpatient	Examinations Outpatient
General Radiography/Fluoroscopy	7	0	7,780	30,258
Nuclear Medicine	2	0	1,405	1,861
Mammography	4	0	0	4,584
Ultrasound	4	0	2,102	6,361
Diagnostic Angiography	0	0	0	0
Interventional Angiography	0		0	0
Positron Emission Tomography (PET)	0	1	0	0
Computerized Axial Tomography (CAT)	2	0	2,494	15,811
Magnetic Resonance Imaging	2	0	609	255

Radiation Equipment

	Owned	Contract	Therapies/ Treatments
Lithotripsy	0	1	156
Linear Accelerator	0	0	0
Image Guided Rad Therapy	0	0	0
Intensity Modulated Rad Therap	0	0	0
High Dose Brachytherapy	0	0	0
Proton Beam Therapy	0	0	0
Gamma Knife	0	0	0
Cyber knife	0	0	0

Source: 2009 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development.

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	0	0	0
Insurance	488	433	921
Private Pay	10	16	26
Charity Care	3	1	4
TOTAL	940	1,327	2,267

NET REVENUE BY PAYOR SOURCE for Fiscal Year

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

OPERATING ROOM UTILIZATION FOR THE REPORTING YEAR

SURGERY AREA	TOTAL SURGERIES	SURGERY TIME (HOURS)	SURGERY PREP and CLEAN-UP TIME (HOURS)	TOTAL SURGERY (HOURS)	AVERAGE CASE 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
Opthalmology	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 TIME (HOURS)	PREP and CLEAN-UP TIME (HOURS)	TOTAL SURGERY (HOURS)	AVERAGE CASE 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

ATTACHMENT 19C

Reference Numbers Facility Id 7003131
Health Service Area 006 Planning Service Area 030

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

Number of Operating Rooms	4
Procedure Rooms	0
Exam Rooms	0
Number of Recovery Stations Stage 1	5
Number of Recovery Stations Stage 2	8

Administrator
FAITH MCHALE

Date Completed
4/26/2010

Registered Agent
NANCY ARMATAS

Property Owner
RESURRECTION SERVICES

Legal Owner

Type of Ownership
Limited Liability Company (RA required)

HOSPITAL TRANSFER RELATIONSHIPS

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

STAFFING PATTERNS

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

DAYS AND HOURS OF OPERATION

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

FACILITY NOTES

ATTACHMENT 19C

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.

ATTACHMENT 19C

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

Date Completed
4/29/2010

FACILITY OWNERSHIP
NON-PROF CORPORATION

CONTINUING CARE COMMUNITY No
LIFE CARE FACILITY No

ADMISSION RESTRICTIONS

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

Note: Reported restictions 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

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED
Nursing Care	73	73	69	73	69	4	73	16
Skilled Under 22	0	0	0	0	0	0		0
Intermediate DD	0	0	0	0	0	0		0
Sheltered Care	61	61	53	61	53	8		
TOTAL BEDS	134	134	122	134	122	12	73	16

ADMISSIONS AND DISCHARGES - 2009

Residents on 1/1/2009	113
Total Admissions 2009	484
Total Discharges 2009	475
Residents on 12/31/2009	122
Identified Offenders	0

FACILITY UTILIZATION - 2009
BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

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

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

AGE GROUPS	NURSING CARE Male	NURSING CARE Female	SKL UNDER 22 Male	SKL UNDER 22 Female	INTERMED. DD Male	INTERMED. DD Female	SHELTERED Male	SHELTERED Female	TOTAL Male	TOTAL Female	GRAND TOTAL
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	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

Source:Long-Term Care Facility Questionnaire for 2009, Illinois Department of Public Health, Health Systems Development

PROVENA COR MARIAE CENTER
3330 MARIA LINDEN DRIVE
ROCKFORD, IL. 61114

Reference Numbers Facility ID 6005771
Health Service Area 001 Planning Service Area 201

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

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

AVERAGE DAILY PAYMENT RATES

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

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SklUnd22	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	SklUnd22	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.

Source:Long-Term Care Facility Questionnaire for 2009, Illinois Department of Public Health, Health Systems Development

ATTACHMENT 19C 10/8/2010

PROVENA GENEVA CARE CENTER
1101 EAST STATE STREET
GENEVA, IL. 60134

Reference Numbers Facility ID 6003503
Health Service Area 008 Planning Service Area 089

Administrator
Dawn Renee Furman

Contact Person and Telephone
DAWN. R. FURMAN
630-232-7544

Registered Agent Information

Date Completed
5/12/2010

FACILITY OWNERSHIP
NON-PROF CORPORATION

CONTINUING CARE COMMUNITY No
LIFE CARE FACILITY No

ADMISSION RESTRICTIONS

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

Note: Reported restictions denoted by '1'

RESIDENTS BY PRIMARY DIAGNOSIS

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

Total Residents Diagnosed as Mentally Ill 15

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

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED
Nursing Care	107	106	106	106	81	26	63	69
Skilled Under 22	0	0	0	0	0	0		0
Intermediate DD	0	0	0	0	0	0		0
Sheltered Care	0	0	0	0	0	0		
TOTAL BEDS	107	106	106	106	81	26	63	69

ADMISSIONS AND DISCHARGES - 2009

Residents on 1/1/2009	89
Total Admissions 2009	190
Total Discharges 2009	198
Residents on 12/31/2009	81
Identified Offenders	0

FACILITY UTILIZATION - 2009
BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

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

	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND
AGE GROUPS	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	TOTAL
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	1	0	0	0	0	0	0	0	1	0	1
60 to 64	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

Source:Long-Term Care Facility Questionnaire for 2009, Illinois Department of Public Health, Health Systems Development

PROVENA GENEVA CARE CENTER
1101 EAST STATE STREET
GENEVA, IL. 60134

Reference Numbers Facility ID 6003503
Health Service Area 008 Planning Service Area 089

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Insurance	Private Pay	Charity Care	TOTALS
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	SklUnd22	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	SklUnd22	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
901 NORTH ENTRANCE
KANKAKEE, IL. 60901

Reference Numbers Facility ID 6004246
Health Service Area 009 Planning Service Area 091

Administrator
Carol McIntyre

Contact Person and Telephone
CAROL D MCINTYRE
815-939-4506

Registered Agent Information

Date Completed
4/9/2010

FACILITY OWNERSHIP
NON-PROF CORPORATION

CONTINUING CARE COMMUNITY No
LIFE CARE FACILITY No

ADMISSION RESTRICTIONS

Aggressive/Anti-Social	1
Chronic Alcoholism	1
Developmentally Disabled	0
Drug Addiction	1
Medicaid Recipient	1
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 restictions denoted by '1'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	
Neoplasms	0
Endocrine/Metabolic	0
Blood Disorders	0
*Nervous System Non Alzheimer	0
Alzheimer Disease	19
Mental Illness	0
Developmental Disability	1
Circulatory System	31
Respiratory System	10
Digestive System	5
Genitourinary System Disorders	0
Skin Disorders	0
Musculo-skeletal Disorders	0
Injuries and Poisonings	0
Other Medical Conditions	8
Non-Medical Conditions	0
TOTALS	74

Total Residents Diagnosed as Mentally Ill 0

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

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED
Nursing Care	51	51	51	51	42	9	51	0
Skilled Under 22	0	0	0	0	0	0		0
Intermediate DD	0	0	0	0	0	0		0
Sheltered Care	79	36	36	36	32	47		
TOTAL BEDS	130	87	87	87	74	56	51	0

ADMISSIONS AND DISCHARGES - 2009

Residents on 1/1/2009	72
Total Admissions 2009	225
Total Discharges 2009	223
Residents on 12/31/2009	74
Identified Offenders	0

FACILITY UTILIZATION - 2009
BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

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

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

	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND
AGE GROUPS	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	TOTAL
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	1	0	0	0	0	0	0	0	1	0	1
60 to 64	0	0	0	0	0	0	0	0	0	0	0
65 to 74	0	4	0	0	0	0	0	0	0	4	4
75 to 84	5	10	0	0	0	0	0	4	5	14	19
85+	3	19	0	0	0	0	4	24	7	43	50
TOTALS	9	33	0	0	0	0	4	28	13	61	74

Source:Long-Term Care Facility Questionnaire for 2009, Illinois Department of Public Health, Health Systems Development

PROVENA HERITAGE VILLAGE
901 NORTH ENTRANCE
KANKAKEE, IL. 60901

Reference Numbers Facility ID 6004246
Health Service Area 009 Planning Service Area 091

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Insurance	Private Pay	Charity Care	TOTALS
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	SklUnd22	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	SklUnd22	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.

Source:Long-Term Care Facility Questionnaire for 2009, Illinois Department of Public Health, Health Systems Development

ATTACHMENT 19C

10/8/2010

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

Date Completed 5/7/2010

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

Note: Reported restictions 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

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED
Nursing Care	87	87	74	87	63	24	87	9
Skilled Under 22	0	0	0	0	0	0		0
Intermediate DD	0	0	0	0	0	0		0
Sheltered Care	0	0	0	0	0	0		
TOTAL BEDS	87	87	74	87	63	24	87	9

ADMISSIONS AND DISCHARGES - 2009

Residents on 1/1/2009	62
Total Admissions 2009	517
Total Discharges 2009	516
Residents on 12/31/2009	63
Identified Offenders	0

FACILITY UTILIZATION - 2009
BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

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

	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND
AGE GROUPS	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	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

Source:Long-Term Care Facility Questionnaire for 2009, Illinois Department of Public Health, Health Systems Development

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 Public	Insurance	Private Pay	Charity Care	TOTALS
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	SklUnd22	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	SklUnd22	ICF/DD	Shelter	Totals
Hispanic	2	0	0	0	2
Non-Hispanic	61	0	0	0	61
Ethnicity Unknown	0	0	0	0	0
Total	63	0	0	0	63

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	7.00
LPN's	3.00
Certified Aides	22.00
Other Health Staff	6.00
Non-Health Staff	32.00
Totals	72.00

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
48.8%	2.4%	0.0%	3.0%	45.8%	100.0%		0.1%
3,259,177	161,944	0	201,199	3,056,364	6,678,684	7,530	

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

PROVENA OUR LADY OF VICTORY
20 BRIARCLIFF LANE
BOURBONNAIS, IL. 60914

Reference Numbers Facility ID 6007009
Health Service Area 009 Planning Service Area 091

Administrator
Robin Gifford

Contact Person and Telephone
ROBIN GIFFORD
815-937-2022

Registered Agent Information

Date Completed
5/6/2010

FACILITY OWNERSHIP
NON-PROF CORPORATION

CONTINUING CARE COMMUNITY No
LIFE CARE FACILITY No

ADMISSION RESTRICTIONS

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

Note: Reported restictions denoted by '1'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	
Neoplasms	2
Endocrine/Metabolic	5
Blood Disorders	2
*Nervous System Non Alzheimer	5
Alzheimer Disease	1
Mental Illness	1
Developmental Disability	0
Circulatory System	25
Respiratory System	17
Digestive System	2
Genitourinary System Disorders	8
Skin Disorders	2
Musculo-skeletal Disorders	9
Injuries and Poisonings	5
Other Medical Conditions	10
Non-Medical Conditions	0
TOTALS	94

Total Residents Diagnosed as Mentally Ill 1

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

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED
Nursing Care	107	107	107	107	94	13	55	90
Skilled Under 22	0	0	0	0	0	0		0
Intermediate DD	0	0	0	0	0	0		0
Sheltered Care	0	0	0	0	0	0		
TOTAL BEDS	107	107	107	107	94	13	55	90

ADMISSIONS AND DISCHARGES - 2009

Residents on 1/1/2009	95
Total Admissions 2009	205
Total Discharges 2009	206
Residents on 12/31/2009	94
Identified Offenders	0

FACILITY UTILIZATION - 2009
BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL	Licensed Beds	Peak Beds Set Up
LEVEL OF CARE	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

	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND
AGE GROUPS	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

Source:Long-Term Care Facility Questionnaire for 2009, Illinois Department of Public Health, Health Systems Development

ATTACHMENT 19C

PROVENA OUR LADY OF VICTORY
20 BRIARCLIFF LANE
BOURBONNAIS, IL. 60914
Reference Numbers Facility ID 6007009
Health Service Area 009 Planning Service Area 091

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	21	64	0	0	9	0	94
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD		0	0	0	0	0	0
Sheltered Care			0	0	0	0	0
TOTALS	21	64	0	0	9	0	94

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	177	173
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SklUnd22	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	SklUnd22	ICF/DD	Shelter	Totals
Hispanic	0	0	0	0	0
Non-Hispanic	94	0	0	0	94
Ethnicity Unknown	0	0	0	0	0
Total	94	0	0	0	94

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	10.00
LPN's	16.00
Certified Aides	27.00
Other Health Staff	0.00
Non-Health Staff	37.00
Totals	92.00

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
38.1%	46.8%	0.0%	2.6%	12.5%	100.0%		0.0%
2,380,646	2,919,597	0	162,995	777,678	6,240,916	0	

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

PROVENA PINE VIEW CARE CENTER
611 ALLEN LANE
ST. CHARLES, IL. 60174

Reference Numbers Facility ID 6007439
Health Service Area 008 Planning Service Area 089

Administrator
MELISSA ADAMS

Contact Person and Telephone
HOLLY ORLAND
630-377-2211

Registered Agent Information

Date Completed
5/7/2010

FACILITY OWNERSHIP
NON-PROF CORPORATION

CONTINUING CARE COMMUNITY No
LIFE CARE FACILITY No

ADMISSION RESTRICTIONS

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

Note: Reported restictions denoted by '1'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	
Neoplasms	4
Endocrine/Metabolic	0
Blood Disorders	0
*Nervous System Non Alzheimer	5
Alzheimer Disease	1
Mental Illness	3
Developmental Disability	0
Circulatory System	12
Respiratory System	11
Digestive System	3
Genitourinary System Disorders	5
Skin Disorders	4
Musculo-skeletal Disorders	11
Injuries and Poisonings	4
Other Medical Conditions	36
Non-Medical Conditions	4
TOTALS	103

Total Residents Diagnosed as Mentally Ill 24

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

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED
Nursing Care	120	110	110	110	103	17	120	60
Skilled Under 22	0	0	0	0	0	0		0
Intermediate DD	0	0	0	0	0	0		0
Sheltered Care	0	0	0	0	0	0		
TOTAL BEDS	120	110	110	110	103	17	120	60

ADMISSIONS AND DISCHARGES - 2009

Residents on 1/1/2009	88
Total Admissions 2009	270
Total Discharges 2009	255
Residents on 12/31/2009	103
Identified Offenders	**0**

FACILITY UTILIZATION - 2009
BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare Pat. days	Medicare Occ. Pct.	Medicaid Pat. days	Medicaid Occ. Pct.	Other Public Pat. days	Private Insurance Pat. days	Private Pay Pat. days	Charity Care Pat. days	TOTAL Pat. days	Licensed Beds Occ. Pct.	Peak Beds Set Up 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 Male	NURSING CARE Female	SKL UNDER 22 Male	SKL UNDER 22 Female	INTERMED. DD Male	INTERMED. DD Female	SHELTERED Male	SHELTERED Female	TOTAL Male	TOTAL Female	GRAND TOTAL
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	1	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

Source:Long-Term Care Facility Questionnaire for 2009, Illinois Department of Public Health, Health Systems Development

ATTACHMENT 19C

10/8/2010

PROVENA PINE VIEW CARE CENTER
611 ALLEN LANE
ST. CHARLES, IL. 60174
Reference Numbers Facility ID 6007439
Health Service Area 008 Planning Service Area 089

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

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

AVERAGE DAILY PAYMENT RATES

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

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SklUnd22	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	SklUnd22	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.

Source:Long-Term Care Facility Questionnaire for 2009, Illinois Department of Public Health, Health Systems Development

ATTACHMENT 19C

10/8/2010

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

Date Completed
4/28/2010

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 restictions denoted by '1'

RESIDENTS BY PRIMARY DIAGNOSIS

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

Total Residents Diagnosed as Mentally Ill 0

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

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED
Nursing Care	179	179	163	179	143	36	119	60
Skilled Under 22	0	0	0	0	0	0		0
Intermediate DD	0	0	0	0	0	0		0
Sheltered Care	0	0	0	0	0	0		
TOTAL BEDS	179	179	163	179	143	36	119	60

ADMISSIONS AND DISCHARGES - 2009

Residents on 1/1/2009	153
Total Admissions 2009	724
Total Discharges 2009	734
Residents on 12/31/2009	143
Identified Offenders	0

FACILITY UTILIZATION - 2009
BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL	Licensed Beds	Peak Beds Set Up
LEVEL OF CARE	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.	Pat. days	Pat. days	Pat. days	Pat. days	Pat. days	Occ. Pct.	Occ. Pct.
Nursing Care	15823	36.4%	19188	87.6%	0	3254	16973	0	55238	84.5%	84.5%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	0	0	0	0.0%	0.0%
TOTALS	15823	36.4%	19188	87.6%	0	3254	16973	0	55238	84.5%	84.5%

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

	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND
AGE GROUPS	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	TOTAL
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	1	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

Source:Long-Term Care Facility Questionnaire for 2009, Illinois Department of Public Health, Health Systems Development

ATTACHMENT 19C

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	Medicaid	Other Public	Insurance	Private Pay	Charity Care	TOTALS
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	SklUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	7	0	0	0	7
Hawaiian/Pac. Isl.	0	0	0	0	0
White	136	0	0	0	136
Race Unknown	0	0	0	0	0
Total	143	0	0	0	143

ETHNICITY	Nursing	SklUnd22	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-Medicate	0
Ventilator Dependent	1
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	0

Note: Reported restictions 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

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED
Nursing Care	120	111	111	108	102	18	120	94
Skilled Under 22	0	0	0	0	0	0		0
Intermediate DD	0	0	0	0	0	0		0
Sheltered Care	0	0	0	0	0	0		
TOTAL BEDS	120	111	111	108	102	18	120	94

ADMISSIONS AND DISCHARGES - 2009

Residents on 1/1/2009	103
Total Admissions 2009	193
Total Discharges 2009	194
Residents on 12/31/2009	102
Identified Offenders	0

FACILITY UTILIZATION - 2009
BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

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

	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND
AGE GROUPS	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	TOTAL
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	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

Source:Long-Term Care Facility Questionnaire for 2009, Illinois Department of Public Health, Health Systems Development

ATTACHMENT 19C

10/8/2010

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 Public	Insurance	Private Pay	Charity Care	TOTALS
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	SklUnd22	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	SklUnd22	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 restictions 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

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED
Nursing Care	176	176	173	176	158	18	176	82
Skilled Under 22	0	0	0	0	0	0		0
Intermediate DD	0	0	0	0	0	0		0
Sheltered Care	0	0	0	0	0	0		
TOTAL BEDS	176	176	173	176	158	18	176	82

ADMISSIONS AND DISCHARGES - 2009

Residents on 1/1/2009	166
Total Admissions 2009	517
Total Discharges 2009	525
Residents on 12/31/2009	158
Identified Offenders	0

FACILITY UTILIZATION - 2009
BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare Pat. days	Medicare Occ. Pct.	Medicaid Pat. days	Medicaid Occ. Pct.	Other Public Pat. days	Private Insurance Pat. days	Private Pay Pat. days	Charity Care Pat. days	TOTAL Pat. days	Licensed Beds Occ. Pct.	Peak Beds Set Up 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 Male	NURSING CARE Female	SKL UNDER 22 Male	SKL UNDER 22 Female	INTERMED. DD Male	INTERMED. DD Female	SHELTERED Male	SHELTERED Female	TOTAL Male	TOTAL Female	GRAND TOTAL
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	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

Source:Long-Term Care Facility Questionnaire for 2009, Illinois Department of Public Health, Health Systems Development

ATTACHMENT 19C

10/8/2010

PROVENA VILLA FRANCISCAN
210 NORTH SPRINGFIELD AVENUE
JOLIET, IL. 60435

Reference Numbers Facility ID 6012678
Health Service Area 009 Planning Service Area 197

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Insurance	Private Pay	Charity Care	TOTALS
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	SklUnd22	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	SklUnd22	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.

Source:Long-Term Care Facility Questionnaire for 2009, Illinois Department of Public Health, Health Systems Development

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

Date Completed
5/6/2010

Registered Agent Information
Sandra Bruce
7435 West Talcott
Chicago, IL 60631

FACILITY OWNERSHIP
NON-PROF CORPORATION

CONTINUING CARE COMMUNITY No
LIFE CARE FACILITY No

ADMISSION RESTRICTIONS

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

Note: Reported restictions 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

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED
Nursing Care	99	99	99	99	96	3	99	99
Skilled Under 22	0	0	0	0	0	0		0
Intermediate DD	0	0	0	0	0	0		0
Sheltered Care	0	0	0	0	0	0		
TOTAL BEDS	99	99	99	99	96	3	99	99

ADMISSIONS AND DISCHARGES - 2009

Residents on 1/1/2009	96
Total Admissions 2009	150
Total Discharges 2009	150
Residents on 12/31/2009	96
Identified Offenders	0

FACILITY UTILIZATION - 2009
BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare Pat. days	Medicare Occ. Pct.	Medicaid Pat. days	Medicaid Occ. Pct.	Other Public Pat. days	Private Insurance Pat. days	Private Pay Pat. days	Charity Care Pat. days	TOTAL Pat. days	Licensed Beds Occ. Pct.	Peak Beds Set Up 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 Male	NURSING CARE Female	SKL UNDER 22 Male	SKL UNDER 22 Female	INTERMED. DD Male	INTERMED. DD Female	SHELTERED Male	SHELTERED Female	TOTAL Male	TOTAL Female	GRAND TOTAL
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	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

Source:Long-Term Care Facility Questionnaire for 2009, Illinois Department of Public Health, Health Systems Development

ATTACHMENT 19C 10/8/2010

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	SklUnd22	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	SklUnd22	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.

Source:Long-Term Care Facility Questionnaire for 2009, Illinois Department of Public Health, Health Systems Development

ATTACHMENT 19C

10/8/2010

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 restictions denoted by '1'

RESIDENTS BY PRIMARY DIAGNOSIS

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

Total Residents Diagnosed as Mentally Ill 16

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

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED
Nursing Care	147	147	146	147	146	1	112	112
Skilled Under 22	0	0	0	0	0	0		0
Intermediate DD	0	0	0	0	0	0		0
Sheltered Care	15	15	15	15	15	0		
TOTAL BEDS	162	162	161	162	161	1	112	112

ADMISSIONS AND DISCHARGES - 2009

Residents on 1/1/2009	161
Total Admissions 2009	264
Total Discharges 2009	264
Residents on 12/31/2009	161
Identified Offenders	0

FACILITY UTILIZATION - 2009
BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL	Licensed Beds	Peak Beds Set Up
LEVEL OF CARE	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.	Pat. days	Pat. days	Pat. days	Pat. days	Pat. days	Occ. Pct.	Occ. Pct.
Nursing Care	8445	20.7%	24529	60.0%	0	0	19603	0	52577	98.0%	98.0%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	5475	0	5475	100.0%	100.0%
TOTALS	8445	20.7%	24529	60.0%	0	0	25078	0	58052	98.2%	98.2%

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

	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND
AGE GROUPS	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	TOTAL
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	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

Source:Long-Term Care Facility Questionnaire for 2009, Illinois Department of Public Health, Health Systems Development

RESURRECTION LIFE CENTER
7370 WEST TALCOTT
CHICAGO, IL. 60631

Reference Numbers Facility ID 6014575
Health Service Area 006 Planning Service Area 601

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Insurance	Private Pay	Charity Care	TOTALS
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	SklUnd22	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	SklUnd22	ICF/DD	Shelter	Totals
Hispanic	1	0	0	0	1
Non-Hispanic	145	0	0	15	160
Ethnicity Unknown	0	0	0	0	0
Total	146	0	0	15	161

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	21.02
LPN's	7.00
Certified Aides	51.71
Other Health Staff	11.77
Non-Health Staff	30.40
Totals	123.90

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
29.0%	22.2%	0.0%	0.0%	48.8%	100.0%		0.0%
3,599,478	2,752,857	0	0	6,046,287	12,398,622	0	

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

FACILITY NOTES

Bed Change	7/15/2009	Added 10 nursing care beds and discontinued 10 sheltered care beds. Facility now has 147 nursing care and 15 sheltered care beds.

RESURRECTION NSG & REHAB CTR
1001 NORTH GREENWOOD AVENUE
PARK RIDGE, IL. 60068

Reference Numbers Facility ID 6007892
Health Service Area 007 Planning Service Area 702

Administrator
James Farlee

Contact Person and Telephone
BRENDA DAVIS
847-813-3712

Registered Agent Information
Sandra Bruce
7435 West Talcott
Chicago, IL 60631

Date Completed
5/6/2010

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 restictions denoted by '1'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	
Neoplasms	31
Endocrine/Metabolic	0
Blood Disorders	0
*Nervous System Non Alzheimer	58
Alzheimer Disease	26
Mental Illness	0
Developmental Disability	0
Circulatory System	69
Respiratory System	41
Digestive System	0
Genitourinary System Disorders	12
Skin Disorders	0
Musculo-skeletal Disorders	25
Injuries and Poisonings	0
Other Medical Conditions	0
Non-Medical Conditions	0
TOTALS	262

Total Residents Diagnosed as Mentally Ill 0

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

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED
Nursing Care	298	285	262	262	262	36	298	298
Skilled Under 22	0	0	0	0	0	0		0
Intermediate DD	0	0	0	0	0	0		0
Sheltered Care	0	0	0	0	0	0		
TOTAL BEDS	298	285	262	262	262	36	298	298

ADMISSIONS AND DISCHARGES - 2009

Residents on 1/1/2009	243
Total Admissions 2009	603
Total Discharges 2009	584
Residents on 12/31/2009	262
Identified Offenders	1

FACILITY UTILIZATION - 2009
BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare Pat. days	Medicare Occ. Pct.	Medicaid Pat. days	Medicaid Occ. Pct.	Other Public Pat. days	Private Insurance Pat. days	Private Pay Pat. days	Charity Care Pat. days	TOTAL Pat. days	Licensed Beds Occ. Pct.	Peak Beds Set Up 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 Male	NURSING CARE Female	SKL UNDER 22 Male	SKL UNDER 22 Female	INTERMED. DD Male	INTERMED. DD Female	SHELTERED Male	SHELTERED Female	TOTAL Male	TOTAL Female	GRAND TOTAL
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	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

Source:Long-Term Care Facility Questionnaire for 2009, Illinois Department of Public Health, Health Systems Development

ATTACHMENT 19C

10/8/2010

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 Public	Insurance	Private Pay	Charity Care	TOTALS
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	SklUnd22	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	SklUnd22	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

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	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 restictions denoted by '1'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	
Neoplasms	3
Endocrine/Metabolic	4
Blood Disorders	0
*Nervous System Non Alzheimer	5
Alzheimer Disease	38
Mental Illness	0
Developmental Disability	1
Circulatory System	22
Respiratory System	3
Digestive System	1
Genitourinary System Disorders	1
Skin Disorders	0
Musculo-skeletal Disorders	33
Injuries and Poisonings	0
Other Medical Conditions	4
Non-Medical Conditions	0
TOTALS	115

Total Residents Diagnosed as Mentally Ill 6

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

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED
Nursing Care	135	135	122	135	115	20	135	135
Skilled Under 22	0	0	0	0	0	0		0
Intermediate DD	0	0	0	0	0	0		0
Sheltered Care	0	0	0	0	0	0		
TOTAL BEDS	135	135	122	135	115	20	135	135

ADMISSIONS AND DISCHARGES - 2009

Residents on 1/1/2009	110
Total Admissions 2009	157
Total Discharges 2009	152
Residents on 12/31/2009	115
Identified Offenders	0

FACILITY UTILIZATION - 2009
BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL	Licensed Beds	Peak Beds Set Up
LEVEL OF CARE	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.	Pat. days	Pat. days	Pat. days	Pat. days	Pat. days	Occ. Pct.	Occ. Pct.
Nursing Care	5974	12.1%	21182	43.0%	0	0	15550	0	42706	86.7%	86.7%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	0	0	0	0.0%	0.0%
TOTALS	5974	12.1%	21182	43.0%	0	0	15550	0	42706	86.7%	86.7%

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

	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND
AGE GROUPS	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	TOTAL
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	0	2	0	0	0	0	0	0	0	2	2
60 to 64	1	3	0	0	0	0	0	0	1	3	4
65 to 74	3	3	0	0	0	0	0	0	3	3	6
75 to 84	8	20	0	0	0	0	0	0	8	20	28
85+	15	60	0	0	0	0	0	0	15	60	75
TOTALS	27	88	0	0	0	0	0	0	27	88	115

MARYHAVEN NSG. & REHAB. CTR.
1700 EAST LAKE AVENUE
GLENVIEW, IL. 60025

Reference Numbers Facility ID 6005854
Health Service Area 007 Planning Service Area 702

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Insurance	Private Pay	Charity Care	TOTALS
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	SklUnd22	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	SklUnd22	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

Date Completed
5/6/2010

Registered Agent Information
Sandra Bruce
7435 West Talcott Avenue
Chicago, IL 60631

FACILITY OWNERSHIP
NON-PROF CORPORATION

CONTINUING CARE COMMUNITY No
LIFE CARE FACILITY No

ADMISSION RESTRICTIONS

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

Note: Reported restictions denoted by '1'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	
Neoplasms	0
Endocrine/Metabolic	11
Blood Disorders	4
*Nervous System Non Alzheimer	17
Alzheimer Disease	3
Mental Illness	10
Developmental Disability	0
Circulatory System	26
Respiratory System	24
Digestive System	1
Genitourinary System Disorders	5
Skin Disorders	8
Musculo-skeletal Disorders	14
Injuries and Poisonings	13
Other Medical Conditions	24
Non-Medical Conditions	0
TOTALS	160

Total Residents Diagnosed as Mentally Ill 10

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

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED
Nursing Care	251	231	170	231	160	91	149	247
Skilled Under 22	0	0	0	0	0	0		0
Intermediate DD	0	0	0	0	0	0		0
Sheltered Care	0	0	0	0	0	0		
TOTAL BEDS	251	231	170	231	160	91	149	247

ADMISSIONS AND DISCHARGES - 2009

Residents on 1/1/2009	153
Total Admissions 2009	580
Total Discharges 2009	573
Residents on 12/31/2009	160
Identified Offenders	0

FACILITY UTILIZATION - 2009
BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare Pat. days	Medicare Occ. Pct.	Medicaid Pat. days	Medicaid Occ. Pct.	Other Public Pat. days	Private Insurance Pat. days	Private Pay Pat. days	Charity Care Pat. days	TOTAL Pat. days	Licensed Beds Occ. Pct.	Peak Beds Set Up 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 Male	NURSING CARE Female	SKL UNDER 22 Male	SKL UNDER 22 Female	INTERMED. DD Male	INTERMED. DD Female	SHELTERED Male	SHELTERED Female	TOTAL Male	TOTAL Female	GRAND TOTAL
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

Source:Long-Term Care Facility Questionnaire for 2009, Illinois Department of Public Health, Health Systems Development

HOLY FAMILY NURSING & REHABILITA CENTER
2380 DEMPSTER STREET
DES PLAINES, IL. 60016

Reference Numbers Facility ID 6004543
Health Service Area 007 Planning Service Area 702

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	27	99	0	6	22	6	160
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD		0	0	0	0	0	0
Sheltered Care			0	0	0	0	0
TOTALS	27	99	0	6	22	6	160

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	261	220
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SklUnd22	ICF/DD	Shelter	Totals
Asian	5	0	0	0	5
Amer. Indian	0	0	0	0	0
Black	5	0	0	0	5
Hawaiian/Pac. Isl.	0	0	0	0	0
White	150	0	0	0	150
Race Unknown	0	0	0	0	0
Total	160	0	0	0	160

ETHNICITY	Nursing	SklUnd22	ICF/DD	Shelter	Totals
Hispanic	11	0	0	0	11
Non-Hispanic	149	0	0	0	149
Ethnicity Unknown	0	0	0	0	0
Total	160	0	0	0	160

STAFFING

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

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

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

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

Source:Long-Term Care Facility Questionnaire for 2009, Illinois Department of Public Health, Health Systems Development

ATTACHMENT 19C

10/8/2010

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 No
LIFE CARE FACILITY No

Date Completed
5/6/2010

ADMISSION RESTRICTIONS

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

Note: Reported restictions 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

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED
Nursing Care	246	253	230	253	224	22	171	202
Skilled Under 22	0	0	0	0	0	0		0
Intermediate DD	0	0	0	0	0	0		0
Sheltered Care	7	0	0	0	0	7		
TOTAL BEDS	253	253	230	253	224	29	171	202

ADMISSIONS AND DISCHARGES - 2009

Residents on 1/1/2009	230
Total Admissions 2009	414
Total Discharges 2009	420
Residents on 12/31/2009	224
Identified Offenders	0

FACILITY UTILIZATION - 2009
BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

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

	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND
AGE GROUPS	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	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

Source:Long-Term Care Facility Questionnaire for 2009, Illinois Department of Public Health, Health Systems Development

VILLA SCALABRINI NSG & REHAB
480 NORTH WOLF ROAD
NORTHLAKE, IL. 60164

Reference Numbers Facility ID 6009591
Health Service Area 007 Planning Service Area 704

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	44	126	0	6	47	1	224
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD		0	0	0	0	0	0
Sheltered Care			0	0	0	0	0
TOTALS	44	126	0	6	47	1	224

AVERAGE DAILY PAYMENT RATES

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

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SklUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	18	0	0	0	18
Hawaiian/Pac. Isl.	0	0	0	0	0
White	197	0	0	0	197
Race Unknown	9	0	0	0	9
Total	224	0	0	0	224

ETHNICITY	Nursing	SklUnd22	ICF/DD	Shelter	Totals
Hispanic	16	0	0	0	16
Non-Hispanic	208	0	0	0	208
Ethnicity Unknown	0	0	0	0	0
Total	224	0	0	0	224

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	34.61
LPN's	7.05
Certified Aides	75.20
Other Health Staff	13.30
Non-Health Staff	64.89
Totals	197.05

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
41.3%	31.6%	0.0%	0.0%	27.2%	100.0%		0.5%
7,596,699	5,807,508	0	0	4,996,309	18,400,516	89,396	

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

Source:Long-Term Care Facility Questionnaire for 2009, Illinois Department of Public Health, Health Systems Development

ATTACHMENT 19C

10/8/2010

TRANSFER AGREEMENT
between
OSF HEALTHCARE SYSTEM,
OSF Saint Francis Medical Center
and
PROVENA ST. MARY'S HOSPITAL

THIS TRANSFER AGREEMENT ("Agreement") is made and executed on the last date written below, by and between OSF HEALTHCARE SYSTEM, an Illinois not-for-profit corporation, having its Corporate Office in Peoria, Illinois, owner and operator of OSF SAINT FRANCIS MEDICAL CENTER, located and doing business in Peoria, Illinois (such System and Hospital are collectively referred to as "Receiving Hospital") and PROVENA ST. MARY'S HOSPITAL, an operating unit of PROVENA HOSPITALS, an Illinois not for profit corporation located and doing business in Kankakee, Illinois (hereinafter referred to as "Transferring Facility").

RECITALS:

A. The Transferring Facility and the Receiving Hospital desire, by means of this Agreement, to assist physicians in the treatment of patients.

B. The parties hereto specifically wish to facilitate: (a) the timely transfer of patients and the medical records and other information necessary or useful for the care and treatment of patients transferred; (b) the determination as to whether such patients can be adequately cared for other than by either of the parties hereto; (c) the continuity of care and treatment appropriate to the needs of the transferred patient; and (d) the utilization of knowledge and other resources of both healthcare entities in a coordinated and cooperative manner to improve the professional healthcare of patients.

NOW, THEREFORE, in consideration of the mutual covenants contained herein, and in reliance upon the recitals, set forth above and incorporated by reference herein, the parties hereto agree as follows:

I. DUTIES AND RESPONSIBILITIES.

1.1 Joint Responsibilities. In accordance with the policies and procedures of the Transferring Facility and upon the recommendation of the patient's attending physician that such a transfer is medically appropriate, such patient shall be transferred from the Transferring Facility to the Receiving Hospital as long as the Receiving Hospital has bed availability, staff availability, is able to provide the services requested by the Transferring Facility, including on-call specialty physician availability, and pursuant to any other necessary criteria established by the Receiving Hospital. In such cases, the Receiving Hospital and the Transferring Facility agree to exercise best efforts to provide for prompt admission of the patient. If applicable, the parties shall comply with all EMTALA requirements with respect to such transfers. Receiving Hospital and Transferring Facility

shall meet periodically to review the transfer process, of policies and procedures in order to improve the process, including efficiency, clinical care and patient safety.

1.2 Receiving Hospital. The Receiving Hospital shall accept patients in need of transfer from the Transferring Facility pursuant to the criteria set forth in Section 1.1. Further, Receiving Hospital shall designate a person to coordinate with Transferring Facility in order to establish acceptable and efficient transfer guidelines.

1.3 Transferring Facility. Transferring Facility shall request transfers of patients to Receiving Hospital pursuant to the criteria set forth in Section 1.1. Further, Transferring Facility shall:

a. Have responsibility for obtaining the patient's informed consent for the potential transfer to Receiving Hospital, if the patient is competent. If the patient is not competent, the consent of the legal guardian, agent with power of attorney for health care, or surrogate decision maker of the patient shall be obtained.

b. Notify Receiving Hospital as far in advance as possible of the impending transfer.

c. If applicable, transfer to Receiving Hospital the personal effects, including money and valuables, and information related thereto. Personal effects will be listed and sent with appropriate documentation at the time of the patient transfer.

d. Affect the transfer to Receiving Hospital through qualified personnel and appropriate transfer equipment and transportation, including the use of necessary and medically appropriate life support measures. Receiving Hospital's responsibility for the patient's care shall begin when the patient presents to Receiving Hospital. Notwithstanding anything to the contrary set forth above, in the event the patient is transferred by Receiving Hospital's Life Flight program, Receiving Hospital's responsibility shall begin when the patient leaves Transferring Hospital's Emergency Department.

e. Transfer, and supplement as necessary, all relevant medical records, or in the case of an emergency, as promptly as possible, transfer an abstract of the pertinent medical and other records necessary in order to continue the patient's treatment without interruption and to provide identifying and other information, including contact information for referring physician, name of

physician(s) at Receiving Hospital contacted with regard to the patient (and to whom the patient is to be transferred), medical, social, nursing and other care plans. Such information shall also include, without limitation and if available, current medical and lab findings, history of the illness or injury, diagnoses, advanced medical directives, rehabilitation potential, brief summary of the course of treatment at the Transferring Facility, medications administered, known allergies, nursing, dietary information, ambulation status and pertinent administrative, third party billing and social information.

1.4 Non Discrimination. The parties hereto acknowledge that nothing in this Agreement shall be construed to permit discrimination by either party in the transfer process set forth herein based on race, color, national origin, handicap, religion, age, sex or any other characteristic protected by Illinois state laws, Title VI of the Civil Rights Act of 1964, as amended or any other applicable state or federal laws. Further, Section 504 of the Rehabilitation Act of 1973 and the American Disabilities Act require that no otherwise qualified individual with an handicap shall, solely by reason of the handicap, be excluded from participation in, or denied the benefits of, or be subjected to discrimination in a facility certified under the Medicare or Medicaid programs.

1.5 Name Use. Neither party shall use the name of the other party in any promotional or advertising material unless the other party has reviewed and approved in writing in advance such promotional or advertising material.

1.6 Standards. Receiving Hospital shall ensure that its staff provide care to patients in a manner that will ensure that all duties are performed and services provided in accordance with any standard, ruling or regulation of The Joint Commission, the Department of Health and Human Services or any other federal, state or local government agency, corporate entity or individual exercising authority with respect to or affecting Receiving Hospital. Receiving Hospital shall ensure that its professionals shall perform their duties hereunder in conformance with all requirements of the federal and state constitutions and all applicable federal and state statutes and regulations.

1.7 Exclusion/Debarment. Both parties certify that they have not been debarred, suspended, or excluded from participation in any state or federal healthcare program, including, but not limited to, Medicaid, Medicare and Tricare. In addition, each party agrees that it will notify the other party immediately if it subsequently becomes debarred, suspended or excluded

or proposed for debarment, suspension or exclusion from participation in any state or federal healthcare program.

1.8 Confidentiality. Receiving Hospital agrees to maintain confidentiality. Receiving Hospital acknowledges that certain material, which will come into its possession or knowledge in connection with this Agreement, may include confidential information, disclosure of which to third parties may be damaging to Transferring Facility. Receiving Hospital agrees to hold all such material in confidence, to use it only in connection with performance under this Agreement and to release it only to those persons requiring access thereto for such performance or as may otherwise be required by law and to comply with the Health Insurance Portability and Accountability Act.

1.9 Access to Books and Records. Both parties will maintain records relating to their responsibilities under this Agreement for a period of one (1) year from the date of services. During normal working hours and upon prior written and reasonable notice, each party will allow the other party reasonable access to such records for audit purposes and also the right to make photocopies of such records (at requesting party's expense), subject to all applicable state and federal laws and regulations governing the confidentiality of such records.

1.10 Non-Exclusivity. This Agreement does not establish an exclusive arrangement between the parties, and both the Transferring Facility and the Receiving Hospital may enter into similar agreements with other hospitals. In addition, Transferring Facility's patients are not restricted in any way in their choice of emergency care providers.

1.11 Regulatory Compliance. The parties hereto agree that nothing contained in this Agreement shall require either party to refer patients to the other party for emergency care services or to purchase goods and services. Neither party will knowingly and intentionally conduct its behavior in such a manner as to violate the prohibition against fraud and abuse in connection with Medicare and Medicaid programs.

II. FINANCIAL ARRANGEMENTS.

2.1 Billing and Collection. The patient is primarily responsible for payment for care provided by Transferring Facility or Receiving Hospital. Each party shall bill and collect for services rendered by each party pursuant to all state and federal guidelines and those set by third party payors. Neither the Transferring Facility nor the Receiving Hospital shall have any liability to the other for billing, collection or other financial matters

relating to the transfer or transferred patient. Since this Agreement is not intended to induce referrals, there should be no compensation or anything of value, directly or indirectly, paid between the parties.

2.2 Insurance. Each party shall, at its expense, maintain through insurance policies, self-insurance or any combination thereof, such policies of comprehensive general liability and professional liability insurance with coverage limits of at least One Million Dollars ($1,000,000.00) per occurrence and Three Million Dollars ($3,000,000.00) annual aggregate to insure such party and its Board, officers, employees and agents acting within the scope of their duties and employment against any claim for damages arising by reason of injuries to property or personal injuries or death occasioned directly or indirectly in connection with services provided by such party and activities performed by such party in connection with this Agreement. Either party shall notify the other party thirty (30) days prior to the termination or modification of such policies.

III. TERM AND TERMINATION.

3.1 Term. The promises and obligations contained herein shall commence as of August 1, 2009, for a term of three (3) years therefrom and shall expire on July 31, 2012, subject, however, to termination under Section 3.2 herein.

3.2 Termination. This Agreement may be sooner terminated on the first to occur of the following:

a. Written agreement by both parties to terminate this Agreement.

b. In the event of breach of any of the terms or conditions of this Agreement by either party and the failure of the breaching party to correct such breach within ten (10) business days after written notice of such breach by either party, such other party may terminate this Agreement immediately with written notice of such termination to the breaching party.

c. In the event either party to this Agreement shall, with or without cause, at any time give to the other at least thirty (30) days advanced written notice, this Agreement shall terminate on the future date specified in such notice.

d. Debarment, suspension or exclusion, as set forth in Section 1.7.

3.3 Effects of Termination. Upon termination of this Agreement, as hereinabove provided, no party shall have any further obligations hereunder, except for obligations accruing prior to the date of termination.

IV. MISCELLANEOUS.

4.1 This Agreement constitutes the entire agreement between the parties and contains all of the terms and conditions between the parties with respect to the subject matter hereunder. Receiving Hospital and Transferring Facility shall be entitled to no benefits or services other than those specified herein. This Agreement supersedes any and all other agreements, either written or oral, between the parties with respect to the subject matter hereof.

4.2 This Agreement shall be construed and interpreted in accordance with the laws of Illinois. It may only be amended, modified or terminated by an instrument signed by the parties. This Agreement shall inure to the benefit of and be binding upon the parties, their successors, legal representatives and assigns, and neither this Agreement nor any right or interest of Receiving Hospital or Transferring Facility arising herein shall be voluntarily or involuntarily sold, transferred or assigned without written consent of the other party, and any attempt at assignment is void.

4.3 The parties are independent contractors under this Agreement. Nothing in this Agreement is intended nor shall be construed to create an employer/employee relationship or a joint venture relationship between the parties, or to allow any party to exercise control or direction over the manner or method by which any of the parties perform services herein. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as, or be construed to be, a waiver of any subsequent breach of the same or other provisions hereof. Notices required herein shall be considered effective when delivered in person, or when sent by United States certified mail, postage prepaid, return receipt requested and addressed to:

Receiving Hospital:	Transferring Facility:
Keith Steffen	Michael Arno
President & CEO	President & CEO
Saint Francis Medical Center	Provena St. Mary's Hospital
530 N.E. Glen Oak Avenue	500 W Court Street
Peoria, Illinois 61637	Kankakee, IL 60901

or to other such address, and to the attention of such other person(s) or officer(s) as a party may designate by written notice.

4.4 It is understood and agreed that neither party to this Agreement shall be legally liable for any negligent nor wrongful act, either by commission or omission, chargeable to the other, unless such liability is imposed by law and that this Agreement shall not be construed as seeking to either enlarge or diminish any obligations or duty owed by one party against the other or against a third party. The invalidity or unenforceability of any particular provision of this Agreement shall not affect the other provisions hereof, and this Agreement shall be construed in all respects as if such invalid or unenforceable provision were omitted. The section titles and other headings contained in this Agreement are for reference only and shall not affect in any way the meaning or interpretation of this Agreement.

4.5 This Agreement is a result of negotiations between the parties, none of whom have acted under any duress or compulsion, whether legal, economic or otherwise. Accordingly, the parties hereby waive the application of any rule of law that otherwise would be applicable in connection with the construction of this Agreement that ambiguous or conflicting terms or provisions should be construed against the party who (or whose attorney) prepared the executed Agreement or any earlier draft of the same.

IN WITNESS WHEREOF, the parties have hereto executed this Agreement in multiple originals as of the last date written below.

RECEIVING HOSPITAL:

OSF HEALTHCARE SYSTEM,
an Illinois not-for-profit
corporation, owner and operator of
OSF Saint Francis Medical Center

By: _____
Keith Steffen
President & CEO

Dated: 6/13/09

TRANSFERRING FACILITY:

Provena St. Mary's Hospital

By: _____
Michael Arno
President & CEO

Dated: 6/24/09

JJJ 6/12/08

OPEN HEART PATIENT TRANSFER AGREEMENT

THIS OPEN HEART PATIENT TRANSFER AGREEMENT (hereinafter "Agreement"), is made and entered into this 7 day of February, 2001, by and between Provena St. Mary's Hospital, an operating unit of Provena Hospitals, an Illinois not-for-profit corporation (hereinafter "PSMH"), and Riverside Medical Center, an Illinois not-for-profit corporation (hereinafter "RMC").

RECITALS

a. PSMH is a not-for-profit hospital, exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, that provides health care services including certain cardiology services such as cardiac catheterization services to residents of Kankakee, Illinois and surrounding communities; and

b. PSMH seeks to offer additional cardiology services, including elective and emergency coronary angioplasty in its cardiac catheterization lab, and these additional services require the availability of an open heart surgery program to provide surgical backup as may be needed from time to time; and

c. RMC is a not-for-profit hospital, exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, that provides health care services including open heart surgical services to residents of Kankakee, Illinois and surrounding communities; and

d. RMC and PSMH have determined that it is in the best interest of patient care and promotes optimum use of facilities to enter into a transfer agreement for transfer of patients needing open heart surgery from PSMH to RMC in accord with the transfer protocols mutually developed and approved by RMC and PSMH.

PSMH and RMC agree as follows:

1. ***Term.*** This Agreement shall be effective upon the date established in the attached Settlement Agreement. It shall be renewed automatically for successive periods of one (1) year, unless terminated as herein provided.

2. ***Purpose of Agreement.*** PSMH agrees to transfer to RMC and RMC agrees to accept patients from PSMH who require open heart surgical services, in accord with the applicable provisions of this Agreement and with the mutually developed and approved patient transfer protocols as amended from time to time which are attached hereto and incorporated herein. This Agreement is in no way intended to interfere with physician treatment decisionmaking or patient freedom of choice, or to guarantee patient referrals. Rather, it is intended to establish a system for patient transfer where appropriate for individual patients at PSMH.

3. ***Patient Transfer.*** The request for transfer of a patient from PSMH to RMC shall be made by the patient's attending physician. When a determination of the

need for transfer has been made by the patient's attending physician, PSMH shall immediately notify RMC and otherwise act in accordance with the approved protocols for patient transfer. Each hospital shall provide the other hospital with the names or classifications of persons authorized to initiate, confirm, and accept the transfer of patients on behalf of the hospital. RMC agrees to admit the patient as promptly as possible, provided that the protocols are followed, all conditions of eligibility for transfer are met and the surgical team and bed space are available to accommodate that patient. Prior to moving the patient, PSMH must receive confirmation from RMC that it can immediately accept the patient.

4. ***Provision Records and Personal Effects.*** Both parties agree to adopt standard forms for medical and administrative information to accompany the patient from one hospital to the other. The information shall include, when appropriate, the following:

A. Patient's name, address, hospital number, age, and name, address, and telephone number of the next of kin;

B. History of the injury or illness;

C. Condition on admission;

D. Vital signs pre hospitalization, during stay in emergency department or during a cardiac catheterization, angioplasty or other cardiac service at PSMH, and at time of transfer;

E. Treatment provided to patient, including medications given and route of administration;

F. Laboratory and X-ray findings, including films;

G. Fluids given, by type and volume;

H. Name, address, and phone number of physician referring patient;

I. Name of physician in receiving hospital to whom patient is to be transferred;

J. Name of physician at receiving hospital who has been contacted about patient; and

K. Patient's third party billing data.

Each party agrees to supplement the above information as necessary for the maintenance of the patient during transport and treatment upon arrival at the receiving hospital.

5. ***Transfer Consent.*** PSMH shall have responsibility for obtaining the patient's written informed consent for the potential transfer to RMC prior to performing

coronary angioplasty, if the patient is competent. If the patient is not competent, the written consent of a family member shall be obtained. Such consent shall indicate that neither PSMH nor RMC are agents or employees of the other and that neither hospital is authorized or permitted to act as an agent or employee of the other.

6. ***Payment for Services.*** In the event that a patient is covered by a third party payor which does not reimburse or pay for services rendered by or at RMC by reason of RMC being an out of system provider, PSMH guarantees payment for services rendered by and at RMC to such patients. In addition, in all cases which, in the determination of RMC's cardiac surgeon, require formal standby resources, PSMH will pay RMC for the direct cost of the perfusionist and Operating Room personnel made available within 30 days of receipt of an itemized bill for such services.

7. ***Transportation of Patient.*** PSMH is responsible for arranging transportation of the patient to RMC including selection of the mode of transportation and providing appropriate health care practitioner(s) to accompany the patient. RMC's responsibility for the patient's care shall begin when the patient is admitted to RMC.

8. ***Independent Contractor Status.*** Both PSMH and RMC are independent contractors. Neither hospital is authorized or permitted to act as an agent or employee of the other. Neither party, by virtue of this Agreement, assumes any liability for any debts or obligations of either a financial or a legal nature incurred by the other party to this Agreement.

9. ***Advertising and Public Relations.*** Neither hospital shall use the name of the other hospital in any promotional or advertising material. Both hospitals shall deal with each other publicly and privately in an atmosphere of mutual respect and support, and each hospital shall attempt to maintain good public and patient relations and efficiently handle complaints and inquiries with respect to transferred or transferring patients.

10. ***Indemnification.*** PSMH and RMC each agree to indemnify and hold harmless the other from and against all liability, loss or damage that either may incur as a result of claims, demands or judgments arising from the acts and omissions of the other party. Without limiting the foregoing, the obligations of PSMH stated in the preceding sentence shall apply to claims, demands or judgments arising from PSMH's moving or attempting to transfer patients to RMC in a manner which does not comply with the applicable provisions of this Agreement or the approved protocols for patient transfer.

11. ***Termination.*** This Agreement may be terminated by either party for any reason, by giving sixty (60) days' prior written notice of its intention to withdraw from this Agreement. In the event of a material breach of this agreement by either party, the other party shall have the right to terminate this agreement by service of written notice upon the defaulting party ("Default Notice"). In the event such breach is not cured to the satisfaction of the non-breaching party within thirty (30) days after service of the Default Notice, this agreement shall terminate immediately at the election of the non-defaulting party upon written notice of termination to the breaching party. The termination

provisions of this paragraph 11 with the exception of termination for breach shall not be applicable in the first one year term.

12. ***Nonwaiver.*** No waiver of any term or condition of this Agreement by either party shall be deemed a continuing or further waiver of this same term or condition or a waiver of any other term or condition of this Agreement.

13. ***Invalid Provision.*** In the event that any portion of this Agreement shall be determined to be invalid or unenforceable, the remainder of this Agreement shall be deemed to continue to be binding upon the parties hereto in the same manner as if the invalid or unenforceable provision were not a part of this Agreement.

14. ***Amendment.*** This Agreement may be amended at any time by a written agreement signed by the parties hereto.

15. ***Assignment.*** This Agreement shall not be assigned in whole or in part by either party hereto without the express written consent of the other party.

16. ***Authorization for Agreement.*** The execution and performance of this Agreement by each party has been duly authorized by all necessary laws, resolutions, or corporate actions, and this Agreement constitutes the valid and enforceable obligations of each party in accordance with its terms. Each person signing this Agreement on behalf of a party hereby warrants and represents that he or she is authorized to sign this Agreement on behalf of the party for which he or she has so signed.

17. ***Notice.*** All notices provided for in this Agreement shall be in writing, duly signed by the party giving such notice, and shall be sent by Federal Express or other reliable overnight courier, sent by fax or mailed by registered or certified mail, return receipt requested, postage prepaid, as follows:

If to PSMH, addressed to:

Ms. Paula Jacobi
President and CEO
Provena St. Mary's Hospital
500 West Court Street
Kankakee, Illinois 60901

If to RMC, addressed to:

Mr. Dennis Millirons
President and CEO
Riverside Medical Center
350 North Wall Street
Kankakee, Illinois 60901

The parties have caused this Agreement to be executed as of February 7, 2001.

PROVENA ST. MARY'S HOSPITAL,
an operating unit of Provena Hospitals

By: Paula Jacobi
Its: President

RIVERSIDE MEDICAL CENTER

By: Margaret Scoggin
Its: President
Vice - President

Acknowledged and Approved
Rush Presbyterian St. Lukes Medical Center

By: Emery Shiller
Its: Senior Vice President

ATTACHMENT 19C
Exhibit B

Protocol for Surgical Back-up at RMC for Angioplasties at Provena St. Mary's

1. All angioplasties (non-emergency) should be scheduled no sooner than 9:30 a.m. and no later than 3:00 p.m.

2. The Riverside Medical Center cardiac surgeon is to be notified of all scheduled cases by 3:00 p.m. the day before.

3. The surgeon will review all films on possible angioplasty patients and discuss options with the cardiologist.

4. If a cardiologist decides to proceed with an angioplasty on a non-scheduled patient, the surgeon (or his designee) needs to be notified directly.

5. For emergency angioplasty cases, the cardiovascular surgeon is to be called directly by the cardiologist.

6. Only the surgeon or his designee may accept the surgical case to be transferred and activate the surgical team.

NUEROSURGERY TRANSFER AGREEMENT

THIS NUEROSURGERY TRANSFER AGREEMENT ("**Agreement**") is made this 26th day of July, 2010 (the "**Effective Date**") by and between **Provena Hospitals d/b/a Provena St. Mary's Hospital**, a health care service provider, an Illinois not-for-profit corporation (the "**Transferring Facility**"), and **Provena Hospitals, d/b/a Provena Saint Joseph Medical Center**, an Illinois not-for-profit corporation ("**Receiving Hospital**"). (Transferring Facility and Receiving Hospital may each be referred to herein as a "**Party**" and collectively as the "**Parties**").

RECITALS

WHEREAS, Transferring Facility provides health care services to the community; and

WHEREAS, patients of Transferring Facility ("**Patients**") may require transfer to a Hospital for neurosurgical care services; and

WHEREAS, Receiving Hospital owns and operates a licensed and Medicare certified acute care Hospital in reasonable proximity to Transferring Facility, which has a twenty-four (24) hour emergency room and provides neurosurgical care services; and

WHEREAS, the Parties desire to enter into this Agreement in order to specify the rights and duties of each of the Parties and to specify the procedure for ensuring the timely transfer of patients to Receiving Hospital.

NOW, THEREFORE, to facilitate the timely transfer of patients to Receiving Hospital, the Parties hereto agree as follows:

ARTICLE I
TRANSFER OF PATIENTS

In the event that any Patient needs neuroendovascular, or spine care and has either requested to be taken to Receiving Hospital, or is unable to communicate a preference for Hospital services at a different Hospital, and a timely transfer to Receiving Hospital would best serve the immediate medical needs of Patient, a designated staff member of Transferring Facility shall contact the Transfer Line of Receiving Hospital to facilitate admission. Receiving Hospital shall receive Patient in accordance with applicable federal and state laws and regulations, the standards of The Joint Commission ("**TJC**") and any other applicable accrediting bodies, and reasonable policies and procedures of Receiving Hospital's responsibility for patient care shall begin when Patient arrives upon Receiving Hospital's property.

ARTICLE II
RESPONSIBILITIES OF TRANSFERRING FACILITY

Transferring Facility shall be responsible for performing or ensuring the performance of the following:

(a) Designating a person who has authority to represent Transferring Facility and coordinate the transfer of Patient to Receiving Hospital;

(b) Notifying Receiving Hospital's designated representative prior to transfer to alert him or her of the impending arrival of Patient and provide information on Patient to the extent allowed pursuant to Article IV;

(c) Notifying Receiving Hospital of the estimated time of arrival of the Patient;

(d) Recognizing and complying with the requirements of any federal and state law and regulations or local ordinances that apply to the care and transfer of individuals to Receiving Hospitals for neurosurgical care.

ARTICLE III
RESPONSIBILITIES OF RECEIVING HOSPITAL

Receiving Hospital shall be responsible for performing or ensuring performance of the following:

(a) Designating a person who has authority to represent and coordinate the transfer and receipt of Patients; and

(b) Arranging for ambulance or helicopter service to Receiving Hospital;

(c) Timely admission of Patient to Receiving Hospital when transfer of Patient is medically appropriate as determined by Receiving Hospital attending physician subject to Hospital capacity and patient census issues; and

(d) Recognizing and complying with the requirements of any federal and state law and regulations or local ordinances that apply to Patients who present at Emergency Departments.

ARTICLE IV
PATIENT INFORMATION

In order to meet the needs of Patients with respect to timely access to neurosurgical care, Transferring Facility shall provide information on Patients to Receiving Hospital, to the extent approved in advance or authorized by law and to the extent Transferring Facility has such information available. Such information may include: Patient Name, Social Security Number, Date of Birth, insurance coverage and/or Medicare beneficiary information (if applicable), known

allergies or medical conditions, treating physician, contact person in case of emergency and any other relevant information Patient has provided Transferring Facility in advance, to be given in connection with seeking neurosurgical care. Transferring Facility shall maintain the confidentiality of medical/insurance information provided by Patient and received from Patient, in connection with Patient's provision of such information, Patient's authorization to disclose such information to neurosurgical personnel, all in accordance with applicable state and federal rules and regulations governing the confidentiality of patient information.

ARTICLE V
NON EXCLUSIVITY

This Agreement shall in no way give Receiving Hospital an exclusive right of transfer of Patients of Transferring Facility. Transferring Facility may enter into similar agreements with other Receiving Hospitals, and Patients will continue to have complete autonomy with respect to choice of Receiving Hospital service providers, as further described in Article VI.

ARTICLE VI
FREEDOM OF CHOICE

In entering into this Agreement, Transferring Facility in no way is acting to endorse or promote the services of Receiving Hospital. Rather, Transferring Facility intends to coordinate the timely transfer of Patients for neurosurgical care. Patients are in no way restricted in their choice of neurosurgical care providers.

ARTICLE VII
BILLING AND COLLECTIONS

Receiving Hospital shall be responsible for the billing and collection of all charges for services rendered at Receiving Hospital. Transferring Facility shall in no way share in the revenue generated by services delivered to Patients at Receiving Hospital.

ARTICLE VIII
INDEPENDENT RELATIONSHIP

Section 8.1 In performing services pursuant to this Agreement, Receiving Hospital and all employees, agents or representatives of Receiving Hospital are, at all times, acting and performing as independent contractors and nothing in this Agreement is intended and nothing shall be construed to create an employer/employee, principal/agent, partnership or joint venture relationship. Transferring Facility shall neither have nor exercise any direction or control over the methods, techniques or procedures by which Receiving Hospital or its employees, agents or representatives perform their professional responsibilities and functions. The sole interest of Transferring Facility is to coordinate the timely transfer of Patients to Receiving Hospital for neurosurgical care.

Section 8.2 Receiving Hospital shall be solely responsible for the payment of compensation and benefits to its personnel and for compliance with any and all payments of all taxes, social security, unemployment compensation and worker's compensation.

Section 8.3 Notwithstanding the terms of this Agreement, in no event shall Receiving Hospital or any Receiving Hospital personnel be responsible for the acts or omissions of non-Receiving Hospital personnel.

ARTICLE IX
INSURANCE

Both Parties shall maintain, at no cost to the other Party Facility, professional liability insurance in an amount customary for its business practices. Receiving Hospital shall provide evidence of the coverage required herein to Transferring Facility on an annual basis.

ARTICLE X
INDEMNIFICATION

Each Party shall indemnify, defend and hold harmless the other Party from and against any and all liability, loss, claim, lawsuit, injury, cost, damage or expense whatsoever (including reasonable attorneys' fees and court costs), imposed by a third party and arising out of, incident to or in any manner occasioned by the performance or nonperformance of any duty or responsibility under this Agreement by such indemnifying Party, or any of its employees, agents, contractors or subcontractors.

ARTICLE XI
TERM AND TERMINATION

Section 11.1 **Term.** The term of this Agreement shall commence on the Effective Date and shall continue in effect for one (1) year (the "**Initial Term**") and SHALL RENEW ON AN ANNUAL BASIS ("**RENEWAL TERM**") ABSENT WRITTEN NOTICE BY EITHER PARTY OF NON-RENEWAL TO THE OTHER PARTY THIRTY (30) CALENDAR DAYS PRIOR TO THE EXPIRATION OF THE INITIAL TERM OR ANY SUBSEQUENT RENEWAL TERM OF THIS AGREEMENT.

Section 11.2 **Events of Termination.** Notwithstanding the foregoing, this Agreement may be terminated upon the occurrence of any one (1) of the following events:

(a) Either Party may terminate this Agreement at any time upon sixty (60) days' prior written notice to the other Party.

(b) If either Party shall apply for or consent to the appointment of a receiver, trustee or liquidator of itself or of all or a substantial part of its assets, file a voluntary petition in bankruptcy, or admit in writing its inability to pay its debts as they become due, make a general assignment for the benefit of creditors, file a petition or an answer seeking reorganization or arrangement with creditors or take advantage of any insolvency law, or if an order, judgment, or decree shall be entered by a court of competent jurisdiction or an application of a creditor, adjudicating such Party to be bankrupt or insolvent, or approving a petition seeking reorganization of such Party or appointing a receiver, trustee or liquidator of such Party or of all or a substantial part of its assets, and such order, judgment, or decree shall continue in effect and unstayed for a period of thirty

(30) consecutive calendar days, then the other Party may terminate this Agreement upon ten (10) business days' prior written notice to such Party.

Section 11.3 **Immediate Termination.** Notwithstanding anything to the contrary herein, this Agreement will be terminated immediately upon the following events: (a) the suspension or revocation of the license, certificate or other legal credential authorizing Receiving Hospital to provide neurosurgical care services; (b) termination of Receiving Hospital's participation in or exclusion from any federal or state health care program for any reason; (c) the cancellation or termination of Receiving Hospital's professional liability insurance required under this Agreement without replacement coverage having been obtained.

ARTICLE XII
MISCELLANEOUS PROVISIONS

Section 12.1 **Entire Agreement**. This Agreement constitutes the entire understanding between the Parties with respect to the subject matter hereof. This Agreement supersedes any and all other prior agreements either written or oral, between the Parties with respect to the subject matter hereof.

Section 12.2 **Counterparts.** This Agreement may be executed in two or more counterparts, each of which shall be deemed an original, but all such counterparts together shall constitute one and the same instrument.

Section 12.3 **Waiver.** Any waiver of any terms and conditions hereof must be in writing, and signed by the Parties. A waiver of any of the terms and conditions hereof shall not be construed as a waiver of any other terms and conditions hereof.

Section 12.4 **Severability.** The provisions of this Agreement shall be deemed severable, and, if any portion shall be held invalid, illegal or unenforceable for any reason, the remainder of this Agreement shall be effective and binding upon the Parties.

Section 12.5 **Headings.** All headings herein are inserted only for convenience and ease of reference and are not to be considered in the construction or interpretation of any provision of this Agreement.

Section 12.6 **Assignment.** This Agreement, being intended to secure the services of Receiving Hospital, shall not be assigned, delegated or subcontracted by Receiving Hospital without prior written consent of Transferring Facility.

Section 12.7 **Governing Law.** This Agreement shall be construed under the laws of the state of Illinois, without giving affect to choice of law provisions.

Section 12.8 **Notices.** Any notice herein required or permitted to be given shall be in writing and shall be deemed to be duly given on the date of service if served personally on the other Party, or on the fourth (4th) day after mailing, if mailed to the other Party by certified mail, return receipt requested, postage pre-paid, and addressed to the Parties as follows:

To Transferring Facility
PSMH
500 West Court Street
Kankakee, IL 60901

To Receiving Hospital
Provena St. Joe's Medical Center
333 North Madison
Joliet, IL 60435
Copy to:
General Counsel
Provena Health
19065 Hickory Creek Drive, Suite 115
Mokena, IL 60448

or such other place or places as either Party may designate by written notice to the other.

Section 12.9 **Amendment.** This Agreement may be amended upon mutual, written agreement of the Parties.

Section 12.10 **Regulatory Compliance.** The Parties agree that nothing contained in this Agreement shall require Transferring Facility to refer patients to Receiving Hospital for neurosurgical care services or to purchase goods and services. Notwithstanding any unanticipated effect of any provision of this Agreement, neither Party will knowingly and intentionally conduct its behavior in such a manner as to violate the prohibition against fraud and abuse in connection with the Medicare and Medicaid programs.

Section 12.11 **Access to Books and Records.** If applicable, upon written request of the Secretary of Health and Human Services or the Comptroller General of the United States, or any of their duly authorized representatives, Receiving Hospital shall make available to the Secretary or to the Comptroller General those contracts, books, documents and records necessary to verify the nature and extent of the costs of providing its services under this Agreement. Such inspection shall be available for up to four (4) years after the rendering of such service. This Section is included pursuant to and is governed by the requirements of Public Law 96-499 and Regulations promulgated thereunder. The Parties agree that any attorney-client, accountant-client or other legal privileges shall not be deemed waived by virtue of this Agreement.

IN WITNESS THEREOF, the Parties have caused this Agreement to be executed by their duly authorized officers hereto setting their hands as of the date first written above.

PROVENA ST MARY'S HOSPITAL

By Its: President | CEO

PROVENA ST JOSEPH'S MEDICAL CENTER

By Its: EVP/COO

University of Chicago Hospitals Perinatal Network
Affiliation Agreement

The University of Chicago Hospitals, on behalf of its Perinatal Center, (the "Perinatal Center") enters into this affiliation agreement with St. Mary's Hospital (the"Hospital") on _____. The Perinatal Center is recognized and designated by the Illinois Department of Public Health as a Level III Perinatal Center providing obstetrical and neonatal care. The Hospital wishes to serve as a Level II affiliated perinatal facility designated by the Illinois Department of Public Health. This agreement is consistent with the Adopted Rules of the Illinois Department of Public Health, Regionalized Perinatal Health Code 77: Public Health, Chapter I: Department of Public Health, Subchapter i: Maternal and Child Health, Part 640 Regionalized Perinatal Health Care Administrative Code (the "Administrative Regulations").

I. COMPONENTS OF LETTER OF AGREEMENT

The goals of the perinatal services of the "Perinatal Center" are to make preconception, maternal-fetal, neonatal and infant care available to the families in our region. It is our belief that pregnancy outcomes are most effectively and cost efficiently improved by working together as a regional network (the "Network").

As the Designated Perinatal Center, the University of Chicago Perinatal Center provides regional administration, education, and intensive care services. Individualized high-risk prenatal obstetrical services are provided in a variety of settings in the clinic system at the University of Chicago Hospitals. Inpatient obstetrical and neonatal services are provided by a highly trained professional team including Perinatologists, Neonatologists, Anesthesiologists, Administrators, Clinical Nurse Specialists, Neonatal/Perinatal Nurse Clinicians, Registered Nurses, Social Service and other support services. The Center for Healthy Families Program provides medical care and developmental evaluation and intervention for patients within the Network at risk for developmental delays.

II. PERINATAL CENTER OBLIGATIONS

A. A 24 hour obstetrical and neonatal "Hotline" for immediate consultation, referral, and/or transport of perinatal patients is available.

Call Perinatal Transport facilitator directly at (773) 204-8414 and enter your number and they will return the call. If, for some reason, that system is not working, back up call to Cathy Gray at (773) 702-6800 pager #8110.

B. The Perinatal Center will accept all Illinois medically eligible obstetrical/neonatal patients, which shall mean all high risk perinatal patients as defined in the Administrative Regulations.

C. If the Perinatal Center is unable to accept a referred maternal or neonatal patient because

of bed unavailability, the Center will arrange for admission of the patient to another facility capable of providing the appropriate level of care. The Perinatal Center shall provide or arrange for transportation of both neonatal and obstetrical patients referred to the Unit. Decisions regarding transfer/transport and mode of transport will be made by the Perinatal Center in collaboration with the referring physician.

D. Written protocols for the mechanism of referral/transfer/transport will be distributed to all affiliated hospital physicians, administration and nursing service. (Appendix A and B)

E. A written summary of patient management and outcome will be sent to the referring physician of record on referral transfers and transports.

F. The Perinatal Center will conduct quarterly Mortality and Morbidity reviews at the Hospital. A representative will attend the conference from Maternal-Fetal Medicine, Neonatology, Outreach Education and Administration from the Perinatal Center. The Hospital's obstetrician, neonatologist, and/or pediatrician will conduct the conference. The review will include but will not be limited to all-fetal deaths, neonatal deaths, maternal deaths and maternal and neonatal transports/transfers. The Hospital will prepare written summaries of cases to be available to the Perinatal Center one week prior to the conference. The parties agree that information disclosed or developed in these conferences shall be used for the exclusive purpose of evaluating and improving the quality of care, and is privileged and strictly confidential and may only be used for the purposes described in the Illinois Medical Studies Act. ("Medical Study Act")

G. The Perinatal Center will transfer patients back to the Hospital when medically feasible in coordination with the referring physician and nursing service. (Appendix C)

H. The Perinatal Center will establish, maintain and coordinate outreach education programs to staffs at the Hospital and community agencies. This will include but not be limited to:

- Workshops on current obstetrical and neonatal topics
- Preceptor programs for nurses at the Level III
- Physician Standard Guidelines for recommended patient management
- Annual Business and Educational Meeting
- Fetal Monitoring and Neonatal Resuscitation Programs for providers

I. The Perinatal Center will provide Comprehensive Neonatal Developmental Follow-up for high-risk infants, including but not limited to participating in APORS, home nursing and developmental screening and referral as described in Appendix D.

J. The Perinatal Center will seek input from the Hospital through the Perinatal Network Advisory Council (PNAC). This Council will be comprised of a representative from each affiliated hospital and community agencies and:

- will meet on a regular basis to plan management strategies
- evaluate network data and identify new data collection systems, as needed
- evaluate the effectiveness of current programs and services
- develop goals and objectives for the Network

- PNAC Council will also participate in the quality oversight of the Network's programs. The parties agree that information disclosed to or developed by the PNAC Council relating to monitoring, evaluating or improving patient care at the Perinatal Center or the Hospital is privileged and strictly confidential and may only be used for the purposes described in the Medical Studies Act.

K. The Perinatal Center will provide statistical analysis of currently available data on the affiliate hospitals, at their request, and develop data systems as needed. All data will be presented in aggregate or coded form and neither institutional nor patient specific data will be shared with any other institution within the Network. Aggregated, coded network data will be presented at the Annual Meeting for educational and priority setting purposes.

III. HOSPITALS OBLIGATIONS

A. The Hospital will utilize the "Hotline" established by the Perinatal Center/Level III affiliate for referral, consultations, and transfer/transports.

B. In accordance with a the guidelines set forth in Appendix E and upon consultation with a Maternal Fetal Medicine or Neonatal sub-specialist of the Perinatal Center/Level III, the Hospital will transfer to the Perinatal Center/Level III obstetrical and neonatal patients requiring the services of the Center/Level III, including but not limited to patients outlined in the Perinatal Rules and Regulations. (Appendix E).

C. The Hospital will care for the maternal and neonatal patients described in Appendix F.

D. The Hospital will comply with all federal, state and local standards for the transfer of patients.

E. The Hospital will accept back both maternal and neonatal transfer/transports after consultation with the referring physician including neonates delivered of maternal transfers/transports. If a referring physician is unavailable, the Hospital will assign a physician to the case.

F. The Hospital staff will assist in the development of and participate in continuing educational programs provided by the Perinatal Center/Level III. Hospital staff will develop an ongoing in-house continuing educational program for the obstetrical and neonatal/pediatric medical staff, perinatal nursing staff and other health care professionals.

G. The Hospital will designate a representative and an alternate to serve on the Perinatal Network Advisory Council (PNAC) and any other standing Network committee. It is recommended that Obstetrics, Neonatology/Pediatrics and Nursing or Hospital Administration be represented on PNAC.

H. The Hospital will develop and maintain a Perinatal Development Committee composed of medical and nursing representatives from both obstetrical and neonatal/pediatric areas, administration and any other individuals deemed appropriate.

I. The Hospital will participate in the Universal Database and be responsible for data collection at the Hospital. The Hospital will share this data with the Perinatal Center.

J. The Hospital physicians will make appropriate referrals for high-risk infants and neonates with handicapping conditions to appropriate follow-up programs.

JOINT RESPONSIBILITIES

A. This Agreement will become effective _____and remain in effect until it is terminated in accordance with this Article.

B. If either the Perinatal Center or the Hospital wishes to amend this Agreement, either may initiate the discussion, but amendment shall only be in writing by mutual consent and following review by the Perinatal Advisory Council.

C. If either party wishes to terminate this agreement, they may do so upon 180-day prior written notification to the other. In addition, either party may terminate this Agreement upon thirty (30) days written notice to the other party if the party to whom such notice is given is in breach of any material provision of this Agreement. Such notice shall set forth the facts underlying the alleged breach. If the breach is cured within the notice period, then this Agreement shall continues in effect for its remaining term, subject to any other provision of this Agreement. The Illinois Department of Public Health shall be notified of the intent to terminate under either circumstance.

D. Notices under this Agreement shall be given by personal or messenger delivery (with receipt), overnight (prepaid) delivery service or by United States mail postage prepaid at the following address:

If to the Perinatal Center: Perinatal Administrator
Cathy Gray
University of Chicago
Perinatal Network
5841 S. Maryland, Box 89 MC2001
Chicago Illinois 60637

If to the Hospital: _____

_____

_____

Notices shall be deemed given upon personal or messenger delivery, or the day after sending by overnight delivery service, or 5 days after mailing by United States postal service. Either party may change its address for notice by giving notice to the other in accordance with this Section.

E. This Agreement represents the complete agreement of the parties with respect to the subject matter hereof and supersedes any prior agreement between the parties with respect to the subject matter hereof.

F. There are no intended third party beneficiaries to this Agreement.

G. Neither party shall use the name of the other party to this Agreement, or of The University of Chicago, in any marketing or advertising, without the prior written consent of the other party.

H. This Agreement may not be assigned by either party.

I. No provision of this Agreement, nor any course of action undertaken by the parties pursuant to this Agreement, shall be construed or interpreted as creating a joint venture or partnership between the parties, and the employees, residents, and physicians of Hospital shall not be considered employees of Perinatal Center for any purpose.

J. This Agreement shall be governed by Illinois law.

THE UNIVERSITY OF CHICAGO HOSPITALS

By: _____
Michael C. Riordan, CEO

HOSPITAL

By: _____

Reviewed by:

_____

_____

_____

_____

_____

APPENDIX A

UNIVERSITY OF CHICAGO PERINATAL NETWORK

MATERNAL TRANSFER/TRANSPORT PROTOCOL

Effective 7/1/89

The ability to refer a patient with obstetrical or medical complications of pregnancy for admission to a perinatal center (PNC) has become a routine part of perinatal medicine. This will serve as a guideline for such referrals in our network for future references. Such referrals can be accomplished by either of two different mechanisms: maternal transfer or maternal transport. The following are the guidelines for each. **NOTE**: A telephone call initiates a consultation only. **Responsibility for ongoing care remains with the referring physician and/or hospital until the transfer/transport is accepted.**

I. MATERNAL TRANSFER

A. **Definition** - A maternal transfer implies that a referred patient can be sent to the PNC/Level III for admission by her referring physician without a medical team

B. **Indications** - refer to Appendix E in each individual affiliation agreement
- Premature rupture of membranes, not in labor
- Intrauterine fetal death, (in conjunction with other complications)
- RH isoimmunization
- Other conditions agreed upon by the Network and Center/Level III physicians

C. **Responsibility** - The referring physician and/or hospital is responsible for the patient until admission at the PNC/Level III. Therefore, any recommended therapy, activity, etc., is at the discretion of the primary physician/hospital.

D. **Logistics**
1. Referring physician will call PNC/Level III, see attached protocol for procedure
2. The Center/Level III physician will contact the Transport Facilitator/nurse to make the arrangements
3. If services are available:
   A. The Transport Facilitator/nurse will return call to referring physician and notify him/her that the patient is accepted
   B. The community hospital will arrange for transportation of the patient to the PNC/LevelIII by:
      1) Ambulance
      2) Private transportation

C. The referring physician will send a copy of all relevant information with the patient.

4. If services are not available for maternal transfer/transport:
   A. The Perinatal Facilitator will contact another PNC for the patient referral
   B. After notification, the referring physician will follow same pattern as above (3 B & C)

II. MATERNAL TRANSPORT

A. **Definition** - A maternal transport involves the referral of a patient with complications to the PNC/Level III utilizing a transport team composed of an APN/nurse and the UCAN nurse or Level III team. The transport team leaves from the PNC/Level III, evaluates the patient, and if appropriate, will transport the patient back to the PNC/Level III.

B. **Indications** - refer to Appendix E in each affiliation agreement

- History of unexplained perinatal death and/or habitual miscarriages
- Intrauterine growth retardation
- Labor between 22 and 34 weeks
- Premature or prolonged rupture of membranes with anticipated neonatal sepsis
- Severe isoimmune disease
- Severe pre-eclampsia and eclampsia
- Medical conditions which may alter the usual obstetric management such as: chronic hypertension; diabetes mellitus requiring insulin; hemoglobinopathy; malignancy; serious cardiac or renal disease

C. **Responsibility** - **The responsibility for patient care rests with the referring physician/hospital until the transport team has arrived and evaluated the patient first hand and has agreed that transport is indicated.** If, in the judgment of the transport team (with or without consultation by PNC/Level III perinatologist) transport is not advisable, the transport team will not institute therapy.

The reason for on-site refusal of a maternal transport will generally fall in one of the following categories:

1. Unstable medical condition
2. Imminent delivery
3. Inappropriate referral

Should this occur, direct phone consultation between the referring physician and the PNC/Level III perinatologist is recommended in order to determine what is in the patient's best interest.

D. **Logistics**

1. *Preparation for transport at network hospital*

A. The patient arrives at the network hospital

B. Obstetrician/attending physician and nurses at network hospital evaluate the condition of the patient

1) Record history

2) Record physical exam

3) Record initial lab data

C. Obstetrician/attending physician and nurses begin therapy to stabilize patient

D. Obstetrician/attending physician decides upon need for maternal transport

E. Obstetrician/attending physician informs patient and family about the decision to transport the patient to the PNC/Level III

F. Obstetrician/attending physician at network hospital calls perinatologist at Perinatal Center/Level III to discuss patient's condition and request transport team

G. **REFUSALS ARE MADE <u>ONLY</u> THROUGH THE ATTENDING PHYSICIAN.**

2. *Awaiting Transport Team at Network Hospital*

A. Obstetrician/attending physician and nurse continue to stabilize patient

B. Collect and copy information for transport team:

1. Antepartum record

2. Current hospital record

3. Lab data

4. Fetal heart rate monitor record

3. *Arrival of transport team at network hospital*

A. Transport nurse and the APN/nurse are given report by network obstetrician/attending physician and nurse

B. Transport nurse and the APN/nurse evaluate patient

C. Decision will be made by the transport team to accept the patient for transport if indicated

D. Transport nurse and the APN/nurse will assume responsibility for the patient care during transport

E. Initiate and update Maternal Transport Record/Level III record

F. Obtain informed consent for maternal transport from patient

G. Inform family about Perinatal Center/Level III

H. Patient transferred to ambulance or helicopter

I. Transport nurse and APN/nurse call Center/Level III to tell them they are on the way

4. *En Route to Perinatal Center/Level III*

A. Continued monitoring of maternal and fetal status

B. Continued therapy as required

5. *Arrival of Transport Team and Patient at Perinatal Center/Level III*

A. Patient taken to labor and delivery area

B. Transport nurse and the APN/nurse give OB resident/physician and nurse report

1) Review history and physical exam

2) Review lab data

3) Review condition of patient since initiation of transport

C. Transport nurse and the APN/nurse turn case of patient over to OB resident/physician and nurse

C. Transport team completes paperwork

D. Resident/physician evaluates patient's condition and outlines management plan

E. OB resident/physician informs Chief OB Resident/physician about status of patient and plan of management

F. Chief OB Resident/physician calls perinatologist to discuss patient's condition and his plan of management

6. *Follow Up With Network Hospital*

A. Network Physician will be contacted by perinatologist concerning patient's status within 24 hours

B. A written summary will be sent to network hospital and physician following discharge.

Revised 9/91
10/92
10/93
10/94
10/96
10/97
10/98
10/99
12/01
6/03
9/04

APPENDIX B

UNIVERSITY OF CHICAGO PERINATAL NETWORK

NEONATAL TRANSPORT PROTOCOL

Effective 7/1/89

Objectives of the newborn transport are 1) to provide intensive care for those low birth weight infants and sick full term infants who are in need at the community hospitals and **2)** to provide a continuing tertiary neonatal care for these infants at the center hospitals.

Indications for the transport are varied depending upon the availability of physicians and or nurse resources and facilities among the individual community hospitals. Categories indicative of newborns at risk include:

1) Birth weight of less than 1500 grams

2) Gestation of less than 32 weeks

3) Respiratory distress requiring greater than 40% Fi02

4) Congenital anomalies requiring neonatal surgery

5) Congenital anomalies requiring extensive work-up

6) Persistent hypoglycemia

7) Seizures

8) Severe sepsis or meningitis

9) Infants identified as having handicapping or developing disabilities which threaten life

Protocols currently for transport are as follows:

1) Expected delivery of a high-risk newborn infant in need of tertiary care.

2) Maternal transport is not feasible.

3) Pediatrician on call is called to attend delivery.

4) Infant is delivered and if necessary appropriate resuscitative and stabilization care is given.

5) Attending physician determines the need for transport.

6) The parents are informed of the infant's status and the need for transport.

7) Appropriate parental consent is obtained.

8) The physician calls the Hot-Line number to request the transport.

9) Mother's blood and infant's cord blood are ready.

10) Copies of mother's and infant's charts are ready.

11) Copies of x-rays or other tests are ready.

12) If necessary, physician or nurse consults with a center physician for an interim management plan.

13) The referring community hospital physician is responsible for the infant's care until the transport team arrives and accepts care.

At the Center/Level III

1) The attending physician accepts a newborn transport. The Transport Team and the Intensive Care Nursery is notified.

2) The Transport Facilitator/nurse will call the network hospital to tell them that the transport team is enroute and their estimated time of arrival.

3) If the Center/Level III is unable to accommodate the transport, the Transport Facilitator at the PNC arranges for the transport to another intensive care nursery.

Arrival of Transport Team at the Network Hospital

1) Evaluation and stabilization of infant.

2) Obtain all information, documents, specimens, and consent for the transport and continuing care.

3) Briefly show the infant to parents and give a nursery booklet/information.

4) Call the intensive care nursery of the Center/Level III to report the infant's condition and give E.T.A.

Follow-up with Community Hospital

1) Community physician is notified by a center/Level III physician concerning patient's status within 24 hours either by telephone call or a brief letter.

2) A written discharge summary will be sent to the community physician soon after discharge of the infant or at the time of the transport of infant back to the original community hospital.

Revised 9/91
10/92
10/93
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10/98
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6/03
9/04

APPENDIX C

Transport, Neonate To Regional Hospital

I. PURPOSE: To provide appropriate neonatal bed utilization within the perinatal network. To return the stable infant to the referring hospital for continuation of care and enhancement of parent-child interaction until the baby is ready for discharge.

II. DEFINITION: Neonatal return transport refers to the transfer of an infant or infant of maternal transport from the Perinatal Center/Level III back to the referring hospital for continuation of care.

III. PROCEDURE:

A. The neonatal attending/fellow will:

1. contact the physician at the regional hospital to arrange for transfer of care;

2. will confirm acceptance of the neonate by the physician at the receiving hospital and the unit head nurse:

3. will verify parent's knowledge of discharge/transfer to regional hospital and obtain reverse transport permission.

B. The neonate's primary nurse will:

1. contact the nurse at the receiving hospital to inform him/her of the patient's history, current condition, equipment requirements, parents involvement, and estimated time of arrival.

2. A written summary of this report will accompany the infant.

C. The transport nurse will:

1. inform the referring hospital of the transport departure;

2. give report to the admitting RN;

3. give a copy of nursing and physician discharge summary and care plan to the admitting RN

APPENDIX D

CENTER FOR HEALTHY FAMILIES

The Section of Neonatology currently follows its neonatal intensive care nursery graduates in the Center for Healthy Families. The program provides comprehensive medical and social service support for high-risk infants born at the Perinatal Network Hospitals and their families. In a single visit, a family may receive one or all of the following services: primary care, nursing, social services, physical and speech therapy, nutritional counseling, occupational therapy, speech and swallow therapy and subspecialty referrals. This holistic approach ensures greater participation and compliance by the families who receive our services.

The Center services:

1) Babies discharged from the NICU with birth weight = 1,500 grams,
    a. birth weight = 1,500 grams with history of Grade II or IV intraventricular hemorrhage,
    b. Seizures,
    c. Abnormal neurological examination,
    d. Meconium aspiration and/or at risk for poor neurological outcome and
    e. Congenital anomalies and

2) Children who are victims of medical neglect or abuse.

The main site of the program is the University of Chicago Hospital's Center for Advanced Medicine where clinic is held twice a week (Monday and Wednesday) and every 1st and 3rd Friday.

The Center for Healthy Families has received support from the Comdisco Foundation and the University of Chicago Hospitals.

Infants from Level III hospitals may make other follow-up arrangements for their patients

Program Director:
Kwang-sun Lee, M.D.

Associate Program Director:
Jaideep Singh, M.D.

Program Contact:
Linda Mack (773) 702-0606

APPENDIX E

For the following maternal conditions, consultations with Maternal Fetal Medicine sub-specialist as described in the letter agreement with subsequent management and delivery at the appropriate facility as determined by mutual collaboration is recommended.

I. Maternal conditions recommending consultation:

A. Current obstetrical history suggestive of potential difficulties such as:
- intrauterine growth restriction
- prior neonatal death
- two or more previous preterm deliveries less than 34 weeks
- a single preterm delivery less than 30 weeks
- birth of a neonate with serious complications resulting in a handicapping condition
- recurrent spontaneous abortions or fetal demise
- family history of genetic disease.

B. Active chronic medical problems with known increase in perinatal mortality, such as:
- cardiovascular disease Class I and II
- autoimmune disease
- reactive airway disease requiring systemic corticosteroids
- seizure disorder
- controlled hyperthyroidism on replacement therapy
- hypertension controlled on a single medication
- idiopathic thrombocytopenia pupura
- thromboembolic disease
- malignant disease (especially when active)
- renal disease with functional impairment
- human immunodeficiency viral infection (consultation may be with MFM or infectious disease subspecialist)

C. Selected obstetric complication that present prior to 34 weeks gestation, such as:
- Polyhydramnios
- Oligohydramnios
- pre-eclampsia/pregnancy induced hypertension
- congenital viral disease
- maternal surgical conditions
- suspected fetal abnormality or anomaly
- isoimmunization with antibody titers greater than 1:8
- antiphospholipid syndrome

D. Abnormalities of the reproductive tract known to be associated with an increase in

preterm delivery, such as: uterine anomalies or diethyl-stilbesterol exposure

E. Insulin dependent diabetes Class A2 and B or greater (White's criteria)

For the following maternal conditions, referral to a maternal-fetal medicine subspecialist for evaluation shall occur. Subsequent patient management and sit eof dclivery shall be determined by mutual collaboration between the patient's physician and the maternal-fetal medicine subspecialist:

II. Maternal conditions requiring consultation:

A. Selected chronic medical conditions with a known increase in perinatal mortality, such as:
- cardiovascular disease with functional impairment (Class III or greater)
- respiratory failure requiring mechanical ventilation
- acute coagulopathy,
- intractable scizures
- coma
- sepsis
- solid organ transplantation
- active autoimmune disease requiring corticosteroids treatments
- unstable reactive airway disease
- renal disease requiring dialysis or with a serum creatinine concentration greater than 1.5mg%
- active hyperthyroidism
- hypertension that is unstable or requires more than one medication to control
- severe hemoglobinopathy

B. Selected obstetrical complications that present prior to 32 weeks, such as:
- multiple gestation with more than two fetuses
- twin gestation complicated by demise, discordancy, or maldevelopment of one fetus or by fetal-fetal transfusion
- premature labor unresponsive to first line tocolytics
- premature rupture of membranes
- medical and obstetrical complications of pregnancy possibly requiring induction of labor or non-emergent caesarean section for maternal or fetal indication, such as severe preeclampsia

C. Isoimmunization with possible need for intrauterine transfusions

D. Insulin-dependent diabetes mellitus Classes C, D, R, F, or H (White's criteria)

E. Suspected congenital anomaly or abnormality requiring an invasive fetal procedure, neonatal surgery or postnatal medical intervention to preserve life, such as:

- ☐ fetal hydrops
- ☐ pleural effusion
- ☐ ascites
- ☐ persistent fetal arrhythmia
- ☐ major system malformation-malfunction
- ☐ selected genetic condition

For the following neonatal conditions, neonatal consultation is recommended as detailed in the letter of agreement:

III. Neonatal conditions recommending consultation

A. Gestation less than 32 weeks but greater than or equal to 30 weeks.

B. Infants with a birth weight or less than 1500 grams but greater than 1250

C. Infants with a 10 minute Apgar score of 5 or less

D. Stable infants having handicapping conditions or developmental disabilities that threaten subsequent development

For the following conditions, consultation and transfer shall occur upon recommendation of the Perinatal Center as outlined in the letter of agreement:

A. Premature birth that is less than 30 weeks gestation

B. Birth weight less than or equal to 1250 grams

C. Infants requiring mechanical ventilation beyond the initial stabilization period of 6 hours

D. Infants who require a sustained inhaled oxygen concentration in excess of 50% in order to maintain a transcutaneous or arterial oxygen saturation greater than or equal to 92%

E. Infants with significant congenital heart disease associated with cyanosis, congestive heart failure, or impaired peripheral blood flow

F. Infants with major congenital malformations requiring immediate comprehensive evaluation or neonatal surgery;

G. Infants requiring neonatal surgery with general anesthesia

H. Infants with sepsis, unresponsive to therapy, associated with persistent shock or

other organ system failure

I. Infants with uncontrolled seizures

J. Infants with stupor, coma, hypoxic ischemic encephalopathy Stage II or greater

K. Infants requiring double volume exchange transfusions;

L. Infant with metabolic derangement persisting after initial correction therapy

M. Infants identified as having handicapping conditions that threaten life for which transfer can improve outcome

APPENDIX F

The following maternal and neonatal patients are considered to be appropriate for management and delivery by the primary physician at Level II facilities without requirement for consultation:

I. Maternal

A. The maternal patient with uncomplicated current pregnancy;

B. Normal current pregnancy although previous history may be suggestive of potential difficulties;

C. Selected medical conditions controlled with treatment such as:
- Mild chronic hypertension
- Thyroid disease
- Illicit drug use
- Urinary tract infection
- Non-systemic steroid dependent reactive airway disease

D. Selected obstetric complications that present after 32 weeks gestation, such as:
- Mild pre-eclampsia-pregnancy related hypertension
- Placenta previa
- Abruptio placenta
- Premature rupture of membranes
- Preterm labor

E. Other selected obstetric conditions that do not adversely affect maternal health or fetal well-being, such as:
- Normal twin gestation
- Hyperemesis gravidium
- Suspected fetal macrosomia
- Incompetent cervical os

F. Gestational Diabetes, Class A1 (White's criteria)

II. Neonatal

A. Neonatal patients at or greater than 32 weeks gestation or greater than 1500 grams without risk factors;

B. Mild to moderate respiratory distress (not requiring mechanical ventilation in excess of 6 hours);

C. Suspected neonatal sepsis, hypoglycemia responsive to glucose transfusion, and asymptomatic neonates of diabetic mothers

3/03

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

ATTACHMENT 39

19065 Hickory Creek Drive, Suite 300
Mokena, IL 60448
708 478-6300 Tel
708 478-5960 Fax

PROVENA
Health

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: Yvette B. Porter

OFFICIAL SEAL
YVETTE B PORTER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:09/07/14

ATTACHMENT 42A

7435 West Talcott Avenue
Chicago, Illinois 60631
773.792.5555

Resurrection Health Care®

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,

Sandra Bruce

Sandra Bruce, FACHE
President & Chief Executive Officer

Notarized:

OFFICIAL SEAL
FLORITA DE JESUS ORTIZ
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 09/29/14

OPERATING and CAPITAL COSTS
per ADJUSTED PATIENT DAY

Provena St. Mary's Hospital
2012 Projection

ADJUSTED PATIENT DAYS:

	$ 81,295,000	
	$ 2,449	33,192

OPERATING COSTS

salaries & benefits	$ 59,512,000
supplies	$ 17,086,000
TOTAL	$ 76,598,000

Operating cost/adjusted patient day:	$ 2,307.72

CAPITAL COSTS

depreciation, amortization and interest	$ 8,746,000

Capital cost/adjusted patient day:	$ 263.50

ATTACHMENTS 42D 42E

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.

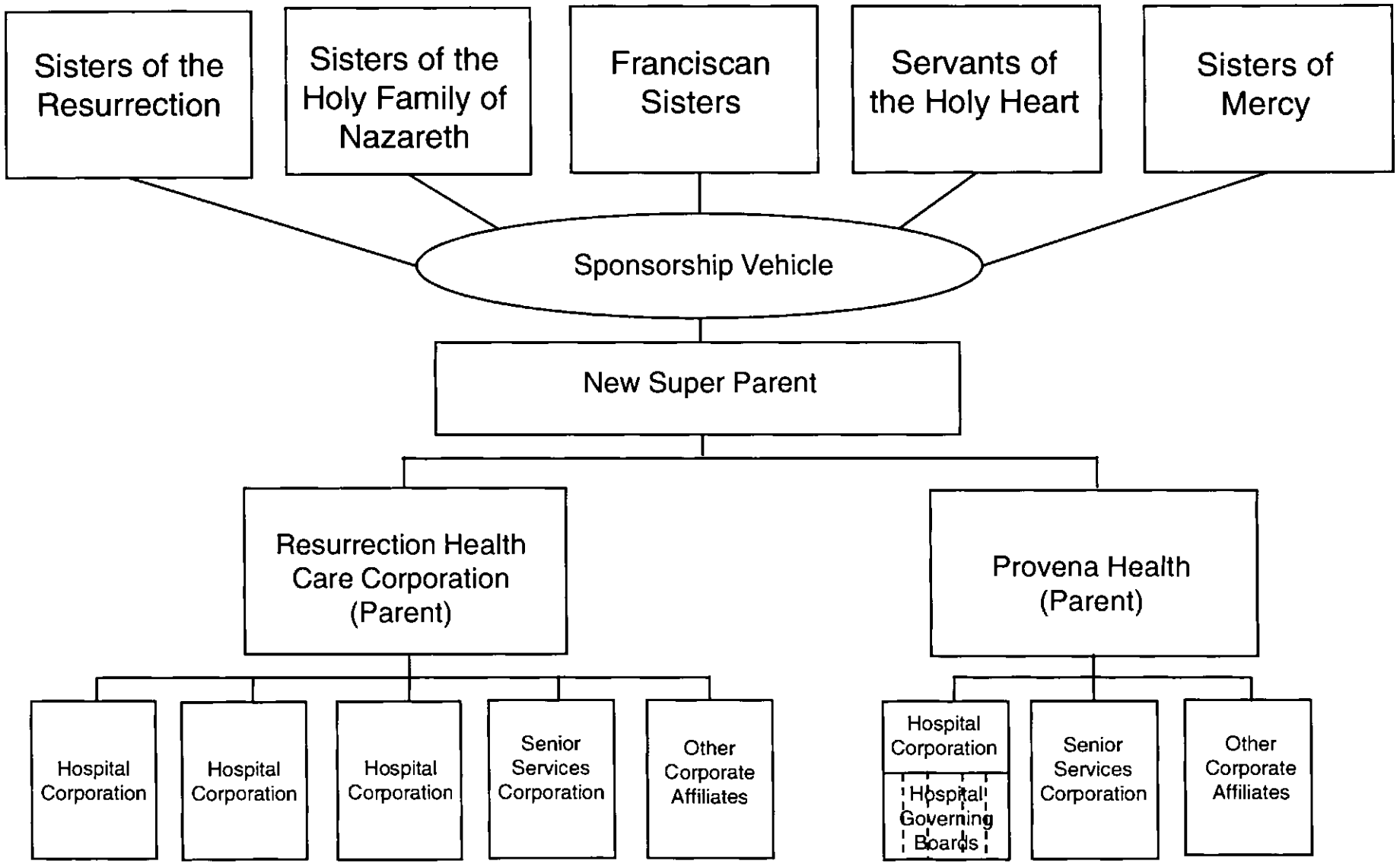
A co-applicant in each Certificate of Need application is Cana Lakes Health Care, which is an existing Illinois not-for-profit corporation. The Cana Lakes corporation will be reconstituted to serve as the super parent entity, through amendment of its corporate documents to reflect unified governance 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

Archbishop Quigley Center * 835 North Rush Street * Chicago, IL 60611-2030 * 312-534-8230 * Fax: 312-534-6379

PROVENA Health

Resurrection Health Care®

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