ORIGINAL

11-045

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED

JUL 6 2011

HEALTH FACILITIES & SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Belmont and Harlem Surgery Center		
Street Address:	3101 N. Harlem Avenue		
City and Zip Code:	Chicago, IL 60634		
County:	Cook	Health Service Area VI	Health Planning Area: 6

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

Exact Legal Name:	Belmont/Harlem Surgery Center, LLC
Address:	3101 N. Harlem Avenue Chicago, IL 60634
Name of Registered Agent:	
Name of Chief Executive Officer:	John Bello, M.D.
CEO Address:	3101 N. Harlem Avenue Chicago, IL 60634
Telephone Number:	773/775-9755

Type of Ownership of Applicant/Co-Applicant

☐	Non-profit Corporation	☐	Partnership		
☐	For-profit Corporation	☐	Governmental		
X	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:	Belmont and Harlem Surgery Center		
Street Address:	3101 N. Harlem Avenue		
City and Zip Code:	Chicago, IL 60634		
County:	Cook	Health Service Area VI	Health Planning Area: 6

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

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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:	Belmont and Harlem Surgery Center
Street Address:	3101 N. Harlem Avenue
City and Zip Code:	Chicago, IL 60634
County: Cook	Health Service Area VI Health Planning Area: 6

Applicant /Co-Applicant Identification

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

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

Type of Ownership of Applicant/Co-Applicant

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

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Primary Contact

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

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

Additional Contact

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

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

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Belmont and Harlem Surgery Center		
Street Address:	3101 N. Harlem Avenue		
City and Zip Code:	Chicago, IL 60634		
County:	Cook	Health Service Area VI	Health Planning Area: 6

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:	John Bello, M.D
Title:	CEO
Company Name:	Belmont/Harlem Surgery Center, LLC
Address:	3101 N. Harlem Avenue, Chicago, IL 60634
Telephone Number:	773/775-9755
E-mail Address:	johnbellomd.com
Fax Number:	773/775-4306

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Resurrection Services

Address of Site Owner: 7447 West Talcott Avenue Chicago, IL 60631

Street Address or Legal Description of Site: 7435 West Talcott Avenue Chicago, IL 60631

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: Belmont/Harlem Surgery Center, LLC

Address: 3101 N. Harlem Avenue, Chicago, IL 60634

	Non-profit Corporation	☐	Partnership		
X	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 Belmont/Harlem Surgery Center, a multi-specialty ambulatory surgical treatment center (ASTC) located in Chicago, Illinois. The proposed change of ownership is a result of the impending merger of the Resurrection and Provena systems through a common "super parent' corporation that will become the parent entity of Resurrection Health Care Corporation (the current Resurrection system parent) and Provena Health (the current Provena system parent).

It is the expectation of the applicants that, for a minimum of two years following the change of ownership, Belmont/Harlem Surgery Center will continue to operate as a multi-specialty ASTC, and that all programs and services currently provided by the ASTC will continue to be provided, and consistent with IHFSRB requirements, access to the ASTC's services will not be diminished. The licensee will continue to be Belmont/Harlem Surgery Center, LLC.

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 HARLEM-BELMONT SURGERY CENTER

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

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			$566,667
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of ASTC and Equipment			$4,270,037
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS			$4,838,704
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities			$566,667
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Fair Market Value of ASTC and Equipment			$4,270,037
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS			$4,838,704

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.

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 __Belmont/Harlem Surgery Center, LLC_____* 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

John Bello, M.D.
PRINTED NAME

Member & Chairperson
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 16th day of March

Signature of Notary

Seal

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

SIGNATURE

John Walton
PRINTED NAME

Member
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 6th 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

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

Sandra Bruce
SIGNATURE

Sandra Bruce
PRINTED NAME

President and CEO
PRINTED TITLE

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:08/28/14

Jeannie C. Frey
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:08/08/13

*Insert exact legal name of the applicant

CERTIFICATION

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- 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 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

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

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:

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- 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:08/20/14

Jeannie C Frey
SIGNATURE

JEANNIE C. FREY
PRINTED NAME

Secretary
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 21st day of March

Linda M Noyola
Signature of Notary

Seal

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

*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

Harlem-Belmont Surgery Center

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

$566,667	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
_____	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions.
_____	e)	Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
_____	f)	Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
$4,270,037	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 ASTC
$4,838,704	**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 — Belmont/Harlem Surgery Center

Charity Care information MUST be furnished for ALL projects.

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

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

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

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

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

CHARITY CARE			
	2007	2008	2009
Net Patient Revenue	$1,195,009	$1,572,028	$4,658,883
Amount of Charity Care (charges)	$0	$0	$24,230
Cost of Charity Care	$0	$0	$9,016

*ASTC opened in May, 2008

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

File Number 0195292-7

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

BELMONT/HARLEM SURGERY CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON AUGUST 25, 2006, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY 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 #: 1104200682

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 #: 1101700286

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 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 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 .

Authentication #: 1106302140

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

Jesse White

SECRETARY OF STATE

ATTACHMENT 1

1586825 DT Cpc 1/0

96225758

DEPT-01 RECORDING $39.00
T#0012 TRAN 9742 03/25/96 14:31:00
#7361 # ER *-96-225758
COOK COUNTY RECORDER

THE ABOVE SPACE FOR RECORDER'S USE ONLY

39 00

This Indenture, made this 25th day of March A.D. 19 96 between LaSalle National Trust, N.A., a national banking association, Chicago, Illinois, as Trustee under the provisions of a Deed or Deeds In Trust, duly recorded and delivered to said Bank in pursuance of a trust agreement dated the 23rd day of July, 19 84, and known as Trust Number 108697 (the "Trustee"), and **RESURRECTION AMBULATORY CARE SERVICES, an Illinois not for profit corporation** (the "Grantees")

(Address of Grantee(s): 7435 West Talcott Avenue, Chicago, Illinois 60631

Witnesseth, that the Trustee, in consideration of the sum of **Ten Dollars and no/100 ($10.00)** and other good and valuable considerations in hand paid, does hereby grant, sell and convey unto the Grantee(s), the following described real estate, situated in Cook County, Illinois, to wit:

Lots 1, 2, 3, 4 and 5 in subdivision of part of the South 5 acres of the North 10 acres of the West 1/2 of the North 40 acres of the West 1/2 of the Northwest 1/4 of Section 30, Township 40 North, Range 13, East of the Third Principal Meridian, in Cook County, Illinois.

96225758

Exempt under provisions of Paragraph 3, Section 4, Real Estate Transfer Tax Act.

3/25/96
Date

Buyer, Seller or Representative

Property Address: 3101 North Harlem Avenue
Chicago, Illinois 60634

Permanent Index Number: 13-30-100-011, 13-30-100-012, 13-30-100-013; 13-30-100-014, 13-30-100-015

together with the tenements and appurtenances thereunto belonging.

BOX 333-CTI

FORM NO:096-8026A AUG 95

1

ATTACHMENT 2

To Have And To Hold the same unto the Grantee(s) as aforesaid and to the proper use, benefit and behoof of the Grantee(s) forever.

This Deed is executed pursuant to and in the exercise of the power and authority granted to and vested in said Trustee by the terms of said Deed or Deeds in Trust delivered to said Trustee in pursuance of the trust agreement above mentioned. This Deed is made subject to the lien of every Trust Deed or Mortgage (if any there be) of record in said county affecting the said real estate or any part thereof, given to secure the payment of money and remaining unreleased at the date of the delivery hereof.

In Witness Whereof, the Trustee has caused its corporate seal to be hereto affixed, and has caused its name to be signed to these presents by its ~~Assistant~~ Vice President and attested by its Assistant Secretary, the day and year first above written.

Attest:

Nancy A. Stack
Assistant Secretary

* **LaSalle National Trust, N.A.**
as Trustee as aforesaid,

By
~~Assistant~~ Vice President

***LaSalle National Trust, N.A., Successor Trustee to LaSalle National Bank**

This instrument was prepared by:	**LaSalle National Trust, N.A.**
Nancy A. Stack (jf)	Real Estate Trust Department 135 South LaSalle Street Chicago, Illinois 60603-4192

State of Illinois
County of Cook } SS:

I, Jackie Felden a Notary Public in and for said County,

in the State aforesaid, **Do Hereby Certify** that Corinne Bek

~~Assistant~~ Vice President of LaSalle National Trust, N.A., and Nancy A. Stack

Assistant Secretary thereof, personally known to me to be the same persons whose names are subscribed to the foregoing Instrument as such ~~Assistant~~ Vice President and Assistant Secretary respectively, appeared before me this day in person and acknowledged that they signed and delivered said instrument as their own free and voluntary act, and as the free and voluntary act of said Trustee, for the uses and purposes therein set forth; and said Assistant Secretary did also then and there acknowledge that he as custodian of the corporate seal of said Trustee did affix said corporate seal of said Trustee to said instrument as his own free and voluntary act, and as the free and voluntary act of said Trustee for the uses and purposes therein set forth.

96225758

Given under my hand and Notarial Seal this 25th day of March A.D. 19 96

Jackie Felden
Notary Public

"OFFICIAL SEAL"
JACKIE FELDEN
NOTARY PUBLIC STATE OF ILLINOIS
My Commission Expires 12/12/98

Box No. _____

TRUSTEE'S DEED

Address of Property

LaSalle National Trust, N.A.
Trustee
To

LaSalle National Trust, N.A.
135 South LaSalle Street
Chicago, Illinois 60603-4192

2

ATTACHMENT 2

LaSalle National Bank Trust No. 108697

EXHIBIT A

Legal Description

LOTS 1, 2, 3, 4 AND 5 IN SUBDIVISION OF PART OF THE SOUTH 5 ACRES OF THE NORTH 10 ACRES OF THE WEST 1/2 OF THE NORTH 40 ACRES OF THE WEST 1/2 OF THE NORTHWEST 1/4 OF SECTION 30, TOWNSHIP 40 NORTH, RANGE 13, EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS

Property Address: 3101 North Harlem Avenue
Chicago, Illinois 60634

Permanent Index Numbers: 13-30-100-011
13-30-100-012
13-30-100-013
13-30-100-014
13-30-100-015

96225758

After Recording Return To:

Ann Duker
McDermott, Will & Emery
227 W. Monroe
Chicago, IL 60606
Box 307

PLAT ACT AFFIDAVIT

STATE OF ILLINOIS
} SS.
COUNTY OF COOK

Peter W. Rauman ; being duly sworn on oath, states that

_____ resides at Evanston, IL . That the attached deed is not in violation of 765 ILCS 205/1 for one of the following reasons:

1. Said Act is not applicable as the grantors own no adjoining property to the premises described in said deed;

- OR -

the conveyance falls in one of the following exemptions as shown by Amended Act which became effective July 17, 1959.

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

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

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

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

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

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

8. Conveyances made to correct descriptions in prior conveyances.

9. The sale or exchange of parcels or tracts of land existing on the date of the amendatory Act into no more than two parts and not involving any new streets or easements of access.

96257586

CIRCLE NUMBER ABOVE WHICH IS APPLICABLE TO ATTACHED DEED.

Affiant further states that ____ makes this affidavit for the purpose of inducing the Recorder of Deeds of Cook County, Illinois, to accept the attached deed for recording.

Peter W. Rauman

SUBSCRIBED and SWORN to before me

this 25 day of March, 1996.

Patricia I. Bowman
Notary Public

"OFFICIAL SEAL"
PATRICIA I. BOWMAN
Notary Public, State of Illinois
My Commission Expires Oct. 14, 1998

CKPLATAF

ATTACHMENT 2

STATEMENT BY GRANTOR AND GRANTEE

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

Dated March 25, 1996 Signature: _____
Grantor or Agent

Subscribed and sworn to before me by the

said Fred W. Parsay

this 25 day of March

19 96.

"OFFICIAL SEAL"
PATRICIA I. BOWMAN
Notary Public, State of Illinois
My Commission Expires Oct. 14, 1996

Patricia I. Bowman
Notary Public

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

96225758

Dated 3/25, 19 96 Signature: _____
~~Grantee or~~ Agent

Subscribed and sworn to before me by the

said Agent

this 25th day of March

19 96.

"OFFICIAL SEAL"
PATRICIA I. BOWMAN
Notary Public, State of Illinois
My Commission Expires Oct. 14, 1996

Patricia I. Bowman
Notary Public

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

[Attach to deed or ABI to be recorded in Cook County, Illinois, if exempt under provisions of Section 4 of the Illinois Real Estate Transfer Tax Act.]

SGRTORES

43388

MAP SYSTEM
CHANGE OF INFORMATION FORM

SCANABLE DOCUMENT - READ THE FOLLOWING RULES

1. Changes must be kept in the space limitations shown
2. DO NOT use punctuation
3. Print in CAPITAL LETTERS with BLACK PEN ONLY
4. Allow only one space between names, numbers and addresses

SPECIAL NOTE:

If a TRUST number is involved, it must be put with the NAME, leave one space between the name and number

If you do not have enough room for your full name, just your last name will be adequate

Property index numbers (PIN #) MUST BE INCLUDED ON EVERY FORM

PIN:

13 - 30 - 100 - 011 - 0000

NAME

RESURRECTION AMB CARE

MAILING ADDRESS:

STREET NUMBER STREET NAME = APT or UNIT

7435 W TALCOTT AVE

CITY

CHICAGO

STATE: ZIP:

IL 60631 - 3746

96225758

PROPERTY ADDRESS:

STREET NUMBER STREET NAME = APT or UNIT

5101 N HARLEM AVE

CITY

CHICAGO

STATE: ZIP:

IL 60634 -

43388

MAP SYSTEM
CHANGE OF INFORMATION FORM

SCANABLE DOCUMENT - READ THE FOLLOWING RULES

1. Changes must be kept in the space limitations shown
2. DO NOT use punctuation
3. Print in CAPITAL LETTERS with BLACK PEN ONLY
4. Allow only one space between names, numbers and addresses

SPECIAL NOTE:

If a TRUST number is involved, it must be put with the NAME, leave one space between the name and number

If you do not have enough room for your full name, just your last name will be adequate

Property index numbers (PIN #) MUST BE INCLUDED ON EVERY FORM

PIN:

13 - 30 - 100 - 012 - 0000

NAME

RESURRECTION AMB CARE

MAILING ADDRESS:

STREET NUMBER STREET NAME = APT or UNIT

7435 W TALCOTT AVE

CITY

CHICAGO

STATE: IL ZIP: 60631 - 3746

96225758

PROPERTY ADDRESS:

STREET NUMBER STREET NAME = APT or UNIT

5101 W HARLEM AVE

CITY

CHICAGO

STATE: IL ZIP: 60634 -

43388

MAP SYSTEM
CHANGE OF INFORMATION FORM

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Property index numbers (PIN #) MUST BE INCLUDED ON EVERY FORM

PIN:

13 - 30 - 100 - 013 - 0000

NAME

RESURRECTION AMB CARE

MAILING ADDRESS:

STREET NUMBER STREET NAME = APT or UNIT

7435 W TALCOTT AVE

CITY

CHICAGO

STATE: ZIP:

IL 60631 - 3746

96225758

PROPERTY ADDRESS:

STREET NUMBER STREET NAME = APT or UNIT

5101 W HARLEM AVE

CITY

CHICAGO

STATE: ZIP:

IL 60634 -

ATTACHMENT 2

43388

MAP SYSTEM
CHANGE OF INFORMATION FORM

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Property index numbers (PIN #) MUST BE INCLUDED ON EVERY FORM

PIN:

13 - 30 - 100 - 014 - 0000

NAME

RESURRECTION AMB CARE

MAILING ADDRESS:

STREET NUMBER STREET NAME = APT or UNIT

7435 W TALCOTT AVE

CITY

CHICAGO

STATE: ZIP:

IL 60631 - 3746

96225758

PROPERTY ADDRESS:

STREET NUMBER STREET NAME = APT or UNIT

5101 W HARLEM AVE

CITY

CHICAGO

STATE: ZIP:

IL 60634 -

43388

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Property index numbers (PIN #) MUST BE INCLUDED ON EVERY FORM

PIN:

13 - 30 - 100 - 015 - 0000

NAME

ASSURECTIOW AMB CARE

MAILING ADDRESS:

STREET NUMBER STREET NAME = APT or UNIT

7435 W TALCOTT AVE

CITY

CHFCAGO

STATE: FL ZIP: 60631 - 3746

96225758

PROPERTY ADDRESS:

STREET NUMBER STREET NAME = APT or UNIT

5101 W HARLEM AVE

CITY

CHICAGO

STATE: IL ZIP: 60634 -

ATTACHMENT 2

7586825 DS CG 2 1

GEORGE E. COLE®
LEGAL FORMS

No. 801
November 1994

WARRANTY DEED
Statutory (Illinois)
(Corporation to Corporation)

CAUTION: Consult a lawyer before using or acting under this form. *Neither the publisher nor the seller of this form makes any warranty with respect thereto, including any warranty of merchantability or fitness for a particular purpose.*

96225759

THE GRANTOR Medical Management of America, Inc., a Delaware corporation

a corporation created and existing under and by virtue of the laws of the State of Delaware and duly authorized to transact business in the State of Illinois, for and in consideration of ten and 00/100 - ($10.00) DOLLARS, and other good and valuable consideration in hand paid, and pursuant to authority given by the Board of Directors of said corporation, CONVEYS and WARRANTS to Resurrection Ambulatory Care Services an Illinois not for profit corporation

DEPT-01 RECORDING $37.00
T#0012 TRAN 9742 03/25/96 14:31:00
#7362 # ER *-96-225759
COOK COUNTY RECORDER

a corporation organized and existing under and by virtue of the laws of the State of Illinois having its principal office at the following address 7435 West Talcott Avenue, Chicago, Illinois 60631

Above Space for Recorder's Use Only

37.00

the following described Real Estate situated in the County of Cook and State of Illinois, to wit:

See Exhibit A legal description attached hereto and made a part hereof.
See Exhibit B permitted exceptions attached hereto and made a part hereof.

96225759

Permanent Real Estate Index Number(s): 12-25-207-020, -021, 13-30-100-022
Address(es) of Real Estate: 3101 North Harlem Avenue, Chicago, Illinois 60634

In Witness Whereof, said Grantor has caused its corporate seal to be hereto affixed, and has caused its name to be signed to these presents by its ____ President, and attested by its ____ Secretary, this 25th day of March, 19 96.

Medical Management of America, Inc.
(Name of Corporation)

Impress Corporate Seal Here

By ____ President

Attest: ____ Secretary

BOX 333-CTI

ATTACHMENT 2

WARRANTY DEED

Corporation to Corporation

Medical Management of America, Inc.

TO

Resurrection Ambulatory Care Services

GEORGE E. COLE®
LEGAL FORMS

Exempt under provisions of Paragraph e, Section 4, Real Estate Transfer Tax Act.

3/25/96
Date

Buyer, Seller or Representative

96225759

State of Illinois, County of Cook ss. I, the undersigned, a Notary Public, in and for the County and State aforesaid, DO HEREBY CERTIFY, that James H. Desrick personally known to me to be the president of the Medical Management of America, Inc. corporation, and _____ personally known to me to be the _____ Secretary of said corporation, and personally known to me to be the same persons whose names are subscribed to the foregoing instrument, appeared before me this day in person and severally acknowledged that as such _____ President and _____ Secretary, they signed and delivered the said instrument and caused the corporate seal of said corporation to be affixed thereto, pursuant to authority given by the Board of Directors of said corporation, as their free and voluntary act, and as the free and voluntary act and deed of said corporation, for the uses and purposes therein set forth.

"OFFICIAL SEAL"
Kimberly Neufuss
Notary Public, State of Illinois
My Commission Expires 10/7/98

IMPRESS NOTARIAL SEAL HERE

Given under my hand and official seal, this 25th day of March 19 96

Commission expires October 7 19 98

Kimberly Neufuss
NOTARY PUBLIC

This instrument was prepared by Reed W. Ramsey, Winston & Strawn, 35 West Wacker Drive, Chicago, Illinois 60601
(Name and Address)

MAIL TO: Ann Duker, McDermott, Will Emery
(Name)
227 West Monroe Street
(Address)
Chicago, Illinois 60606-5096
(City, State and Zip)

OR RECORDER'S OFFICE BOX NO. 301

SEND SUBSEQUENT TAX BILLS TO:
Resurrection Ambulatory Care Services
(Name)
3101 North Harlem Avenue
(Address)
Chicago, Illinois 60634
(City, State and Zip)

ATTACHMENT 2

Medical Management of America, Inc.

EXHIBIT A

Legal Description

PARCEL 1:

LOTS 12 AND 13 IN BLOCK 1 IN H. O. STONE AND COMPANY SUBDIVISION OF THE EAST 60 ACRES OF THE NORTH 1/2 OF THE NORTHEAST 1/4 OF SECTION 25, TOWNSHIP 40 NORTH, RANGE 12 EAST OF THE THIRD PRINCIPAL MERIDIAN, (EXCEPT THAT PART NORTH OF STREET), IN COOK COUNTY, ILLINOIS.

PARCEL 2:

THE NORTH 127.06 FEET OF THE WEST 342.84 FEET (EXCEPT THE NORTH 31.75 FEET OF THE EAST 168.76 FEET AND EXCEPT THE EAST 184.77 FEET OF THE SOUTH 95.31 FEET THEREOF) OF THE SOUTH 5 ACRES OF THE NORTH 10 ACRES OF THE WEST 1/2 OF THE WEST 1/2 OF THE NORTHWEST 1/4 OF SECTION 30, TOWNSHIP 40 NORTH, RANGE 13, EAST OF THE THIRD PRINCIPAL MERRIDIAN, IN COOK COUNTY, ILLINOIS.

96225759

Property Address: 3101 North Harlem Avenue
Chicago, Illinois 60634

Permanent Index Numbers: 12-25-207-020
12-25-207-021
13-30-100-022

Exhibit B

PERMITTED EXCEPTIONS

~~1. Rights of way for drainage tiles, ditches, feeders and laterals, if any (affects Parcel 2).~~

2. Rights of the public, municipality and the State of Illinois in and to the West 33 feet of the land taken for Harlem Avenue. (Affects Parcel 2)

3. Encroachment of the chain link fence located mainly on the land onto the property North and adjoining by approximately 0.52 feet, as shown on Plat of Survey No. 3101 prepared by Central Survey Company, Inc. dated February 19, 1996. (Affects Parcel 1)

4. Encroachment of the brick building located mainly on the property South and adjoining onto the land by approximately 0.07 feet, as shown on Plat of Survey No. 3101 prepared by Central Survey Company, Inc. dated February 19, 1996. (Affects Parcel 1)

5. Encroachment of the chain link fence located mainly on the land onto the property North and adjoining by approximately 0.19 feet to 0.28 feet, as shown on Plat of Survey No. 3101 prepared by Central Survey Company, Inc. dated February 19, 1996. (Affects Parcel 2)

6. Encroachment of the concrete located mainly on the land onto the property North and adjoining by approximately 0.23 feet, as shown on Plat of Survey No. 3101 prepared by Central Survey Company, Inc. dated February 19, 1996; provided Title Insurer issues an encroachment endorsement. (Affects Parcel 2)

7. Encroachment of the concrete located mainly on the land onto the property East and adjoining by approximately 0.22 feet to 0.30 feet, as shown on Plat of Survey No. 3101 prepared by Central Survey Company, Inc. dated February 19, 1996; provided Title Insurer issues an encroachment endorsement. (Affects Parcel 2)

8. Encroachment of the garage eave and gutter located mainly on the property East and adjoining onto the land by approximately 0.50 feet to 0.56 feet, as shown on Plat of Survey No. 3101 prepared by Central Survey Company, Inc. dated February 19, 1996. (Affects Parcel 2)

9. Possible utility easement as disclosed by letter from the Commonwealth Edison Company and by Plat of Survey No. 3101 by Central Survey Company, Inc. dated February 19, 1996. (Affects the North 31.75 feet along the East line of Parcel 2)

10. Possible utility easements as disclosed by fire hydrant, gas valve, light poles, catch basin, sewer manhole and city water pipes, as shown on Plat of Survey No. 3101 by Central Survey Company, Inc. dated February 19, 1996. (Affects the West 33 feet of Parcel 2)

96225759

PLAT ACT AFFIDAVIT

STATE OF ILLINOIS
} SS:
COUNTY OF COOK

Reed N Parmer, being duly sworn on oath, states that

resides at Evanston. That the attached deed is not in violation of 765 ILCS 205/1 for one of the following reasons:

1. Said Act is not applicable as the grantors own no adjoining property to the premises described in said deed;

- OR -

the conveyance falls in one of the following exemptions as shown by Amended Act which became effective July 17, 1959.

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

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

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

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

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

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

8. Conveyances made to correct descriptions in prior conveyances.

9. The sale or exchange of parcels or tracts of land existing on the date of the amendatory Act into no more than two parts and not involving any new streets or easements of access.

96225259

CIRCLE NUMBER ABOVE WHICH IS APPLICABLE TO ATTACHED DEED.

Affiant further states that ____ makes this affidavit for the purpose of inducing the Recorder of Deeds of Cook County, Illinois, to accept the attached deed for recording.

SUBSCRIBED and SWORN to before me

this 21st day of May, 19 91.

Patricia I. Bowman
Notary Public

"OFFICIAL SEAL"
PATRICIA I. BOWMAN
Notary Public, State of Illinois
My Commission Expires Oct. 14, 1996

ATTACHMENT 2

STATEMENT BY GRANTOR AND GRANTEE

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

Dated 3/25/96, 19 96 Signature: _____
Grantor or Agent

Subscribed and sworn to before me by the

said Robert L. Hoban

this 25th day of March

19 96.

Patricia I. Bowman
Notary Public

"OFFICIAL SEAL"
PATRICIA I. BOWMAN
Notary Public, State of Illinois
My Commission Expires Oct. 14, 1996

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

96225759

Dated 3/25, 19 96 Signature: _____
Grantee or Agent

Subscribed and sworn to before me by the

said Agent

this 25th day of March

19 96.

Patricia I. Bowman
Notary Public

"OFFICIAL SEAL"
PATRICIA I. BOWMAN
Notary Public, State of Illinois
My Commission Expires Oct. 14, 1996

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

[Attach to deed or ABI to be recorded in Cook County, Illinois, if exempt under provisions of Section 4 of the Illinois Real Estate Transfer Tax Act.]

SGRTORGE

ATTACHMENT 2

43388

MAP SYSTEM
CHANGE OF INFORMATION FORM

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Property index numbers (PIN #) MUST BE INCLUDED ON EVERY FORM

PIN:

12 - 25 - 207 - 020 - 0000

NAME

RESURRECTION WMB CARE

MAILING ADDRESS:

STREET NUMBER STREET NAME = APT or UNIT

7435 W TALCOTT AVE

CITY

CHFCAGO

STATE: IL ZIP: 60631 - 3746

96225759

PROPERTY ADDRESS:

STREET NUMBER STREET NAME = APT or UNIT

5101 W HARLEM AVE

CITY

CHICAGO

STATE: IL ZIP: 60634 -

ATTACHMENT 2

43388

MAP SYSTEM
CHANGE OF INFORMATION FORM

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PIN:

12 - 25 - 207 - 021 - 0000

NAME

RESURRECTION AMB CARE

MAILING ADDRESS:

STREET NUMBER STREET NAME = APT or UNIT

7435 W TALCOTT AVE

CITY

CHICAGO

STATE: IL ZIP: 60631 - 3746

96225759

PROPERTY ADDRESS:

STREET NUMBER STREET NAME = APT or UNIT

5101 N HARLEM AVE

CITY

CHICAGO

STATE: IL ZIP: 60634 -

ATTACHMENT 2

43368

MAP SYSTEM
CHANGE OF INFORMATION FORM

SCANABLE DOCUMENT - READ THE FOLLOWING RULES

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Property index numbers (PIN #) MUST BE INCLUDED ON EVERY FORM

PIN:

13 - 30 - 100 - 022 - 0000

NAME

RESURRECTION AMB CARE

MAILING ADDRESS:

STREET NUMBER STREET NAME = APT or UNIT

7435 W TALCOTT AVE

CITY

CHICAGO

STATE: IL ZIP: 60631 - 3746

96225759

PROPERTY ADDRESS:

STREET NUMBER STREET NAME = APT or UNIT

5101 N HARLEM AVE

CITY

CHICAGO

STATE: IL ZIP: 60634 -

ATTACHMENT 2

File Number 0195292-7

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

BELMONT/HARLEM SURGERY CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON AUGUST 25, 2006, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

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

Authentication #: 1104200682

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

Jesse White

SECRETARY OF STATE

ATTACHMENT 3

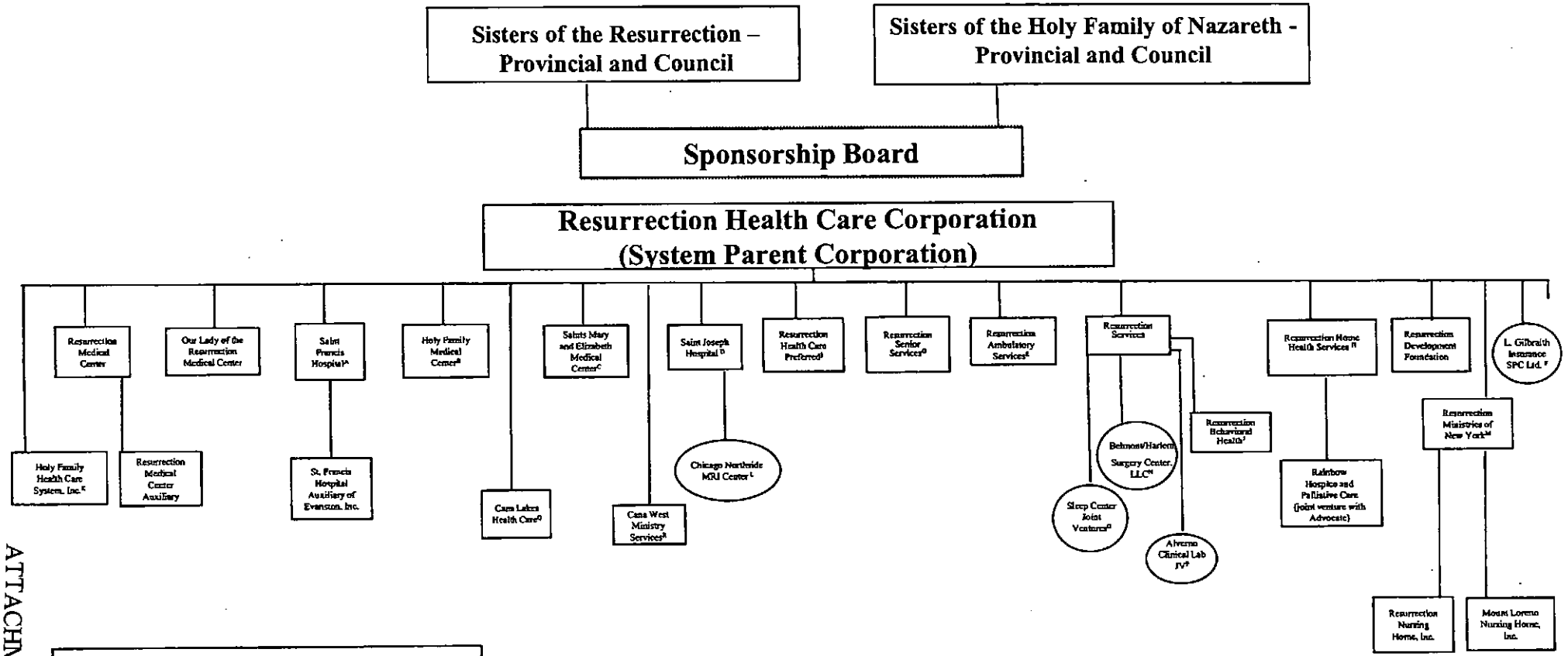
CURRENT ORGANIZATIONAL CHARTS

ATTACHMENT 4

Resurrection Health Care Corporation

Corporate Organizational and Governance Structure

October 21, 2010



ATTACHMENT 4

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

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

A Formerly named Saint Francis Hospital of Evanston (name change effective November 22, 2004)

B Became part of the Resurrection system effective March 1, 2001, as part of the agreement of co-sponsorship between the Sisters of the Resurrection, Immaculate Conception Province and the Sisters of the Holy Family of Nazareth, Sacred Heart Province

C Created from merger of Saint Elizabeth Hospital into Saint Mary of Nazareth Hospital Center, and name change of latter (surviving) corporation, both effective 12/1/03. Saint Mary of Nazareth Hospital Center (now part of Saints Mary and Elizabeth Medical Center) became part of Resurrection system under the co-sponsorship agreement referenced in Footnote B above

D Saint Joseph Hospital, f/k/a Cana Services Corporation, f/k/a Westlake Health System

E Formerly known as West Suburban Health Services, this 501(c)(3) corporation had been the parent corporation of West Suburban Medical Center prior to the hospital corporation becoming part of the Resurrection Health Care system. Effective January 1, 2010, Resurrection Ambulatory Services assumed the assets and liabilities of Resurrection Services' ambulatory care services division.

F A Cayman Islands corporation registered to do business as an insurance company

G Corporation formerly known as Westlake Nursing and Rehabilitation Center (also f/k/a Leyden Community Extended Care Center, Inc.)

H Resurrection Home Health Services, f/k/a Health Connections, Inc., is the combined operations of Extended Health Services, Inc., Community Nursing Service West, Resurrection Home Care, and St. Francis Home Health Care (the assets of all of which were transferred to Health Connections, Inc. as of July 1, 1999).

I Holy Family Health Preferred is a former d/b/a of Saints Mary and Elizabeth Health Preferred, and Saint Joseph Health Preferred. Operates under the d/b/a names of Resurrection Health Preferred, Saint Francis Health Preferred, and Holy Family Health Preferred

J D/B/A name for Proviso Family Services, a/k/a ProCare Centers, a/k/a Employee Resource Centers

K Former parent of Holy Family Medical Center; non-operating 501(c)(3) "shell" available for future use

L An Illinois general partnership between Saint Joseph Hospital and Advocate Northside Health System, an Illinois not for profit corporation

M Resurrection Health Care is the Corporate Member of RMNY, with extensive reserve powers, including appointment/removal of all Directors and approval of amendments to the Corporation's Articles and Bylaws. The Sponsoring Member of the Corporation is the Sisters of the Resurrection New York, Inc.

N Resurrection Services owns over 50% of the membership interests of Belmont/Harlem, LLC, an Illinois limited liability company, which owns and operates an ambulatory surgery center

O Resurrection Services owns a majority interest in the following Illinois limited liability companies which own and operate sleep disorder diagnostic centers: RES-Health Sleep Care Center of River Forest, LLC; RES-Health Sleep Care Center of Lincoln Park, LLC; RES-Health Sleep Care Center of Evanston, LLC; RES-Health Sleep Care Center of Chicago Northwest, LLC

P Joint Venture for clinical lab services for 2 other Catholic health care systems, Provena and Sisters of Saint Francis Health Services, Inc., consisting of an Indiana limited liability company of which Resurrection Services is a 1/3 member, and a tax-exempt cooperative hospital service corporation, of which all Resurrection tax-exempt system hospitals collectively have a 1/3 interest

Q Formerly named Westlake Community Hospital; all the assets of this corporation were sold to VHS Westlake Hospital Inc., effective August 1, 2010

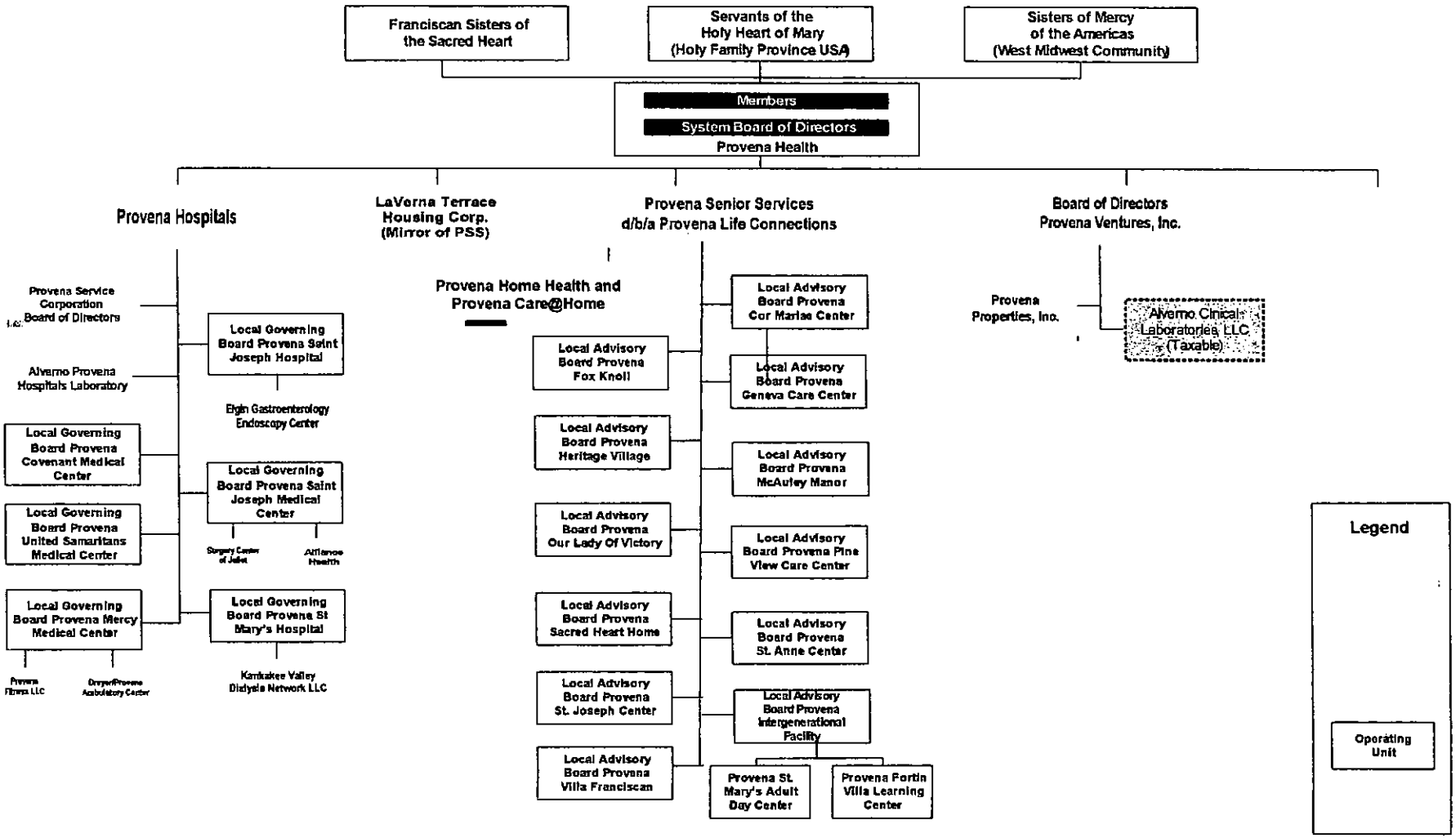
R Formerly named West Suburban Medical Center; all the assets of this corporation were sold to VHS West Suburban Medical Center, Inc., effective August 1, 2010

Provena Health

Organizational Governance Structure

January 2011

PROVENA Health

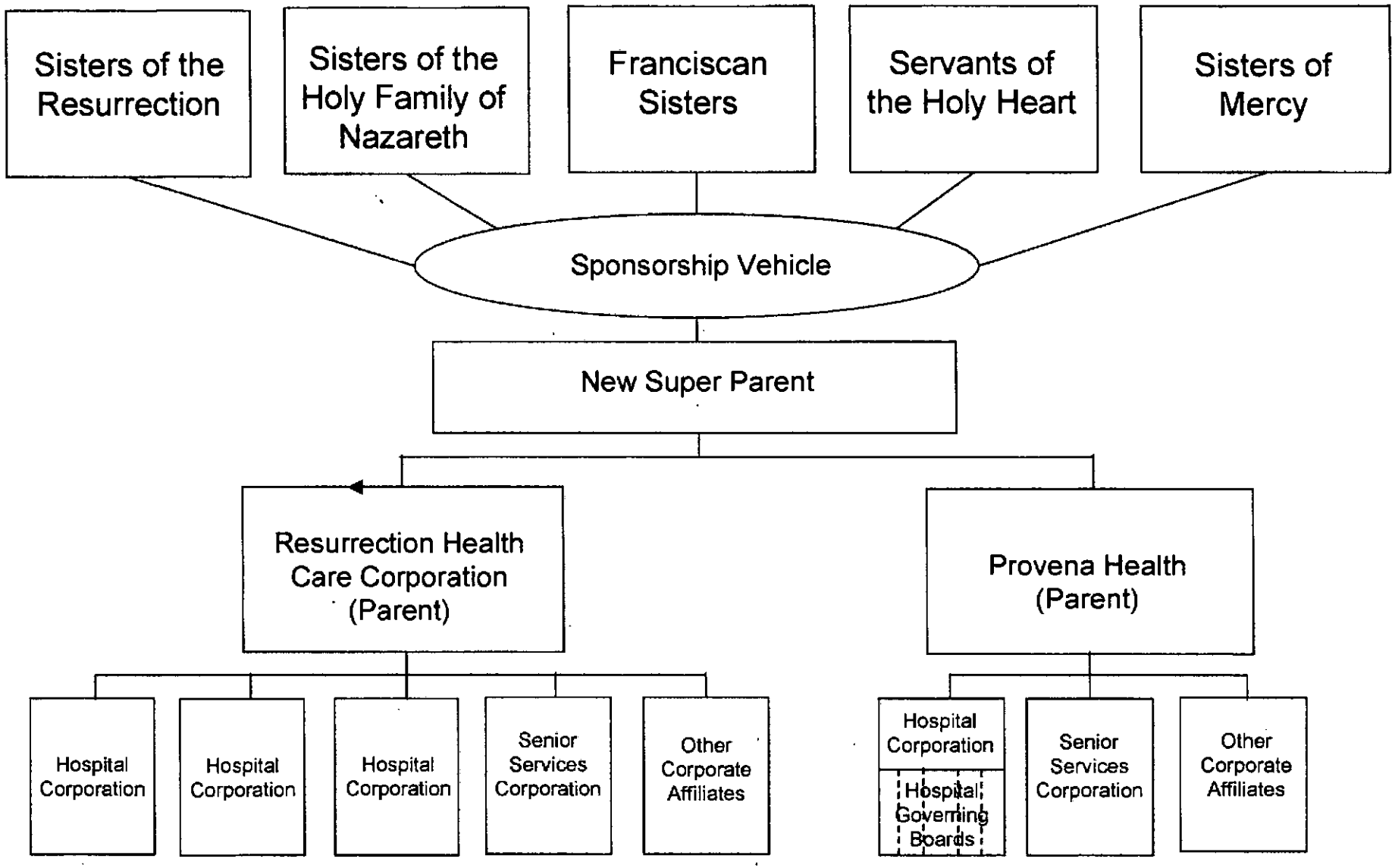


ATTACHMENT 4

PROPOSED ORGANIZATIONAL CHART

ATTACHMENT 4

Super Parent Structure



ATTACHMENT 4

IDENTIFICATION OF PROJECT COSTS

Fair Market Value of the ASTC and Equipment

51% of the insured value of the ASTC ($4,098,637), consistent with Resurrection's ownership share, was used to identify the Fair Market Value facility, consistent with a discussion of methodology with IHFSRB staff. The depreciated value of the ASTC's equipment was estimated at 51% of 20% of the replacement value of the equipment typical to a 4-OR multi-specialty ASTC ($173,400).

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	B68B	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

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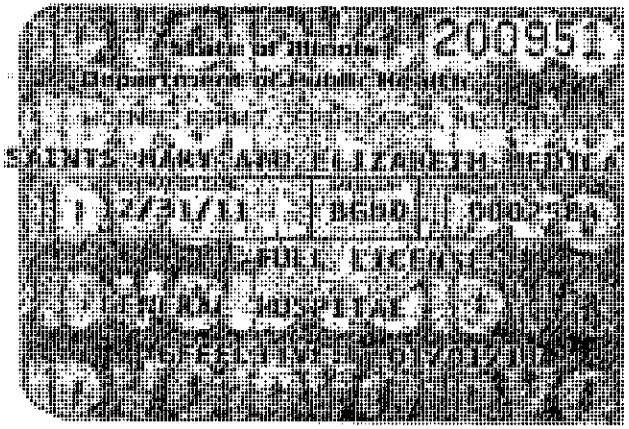
← DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION



11/06/10

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

FEE RECEIPT NO.

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

DAMON T. ARNOLD, M.D.
DIRECTOR

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

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/11

VOID

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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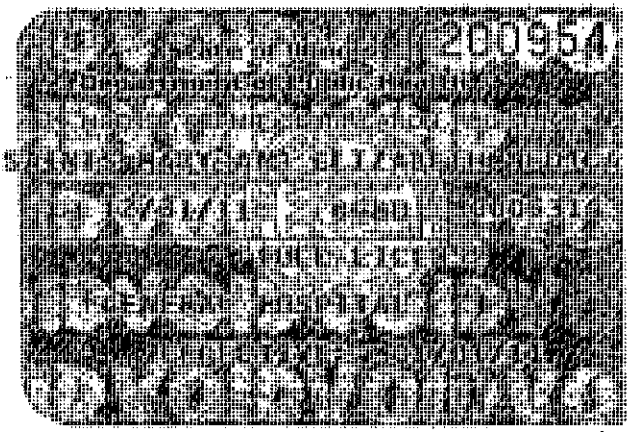

11/06/10

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	BGBD	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	BGBD	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.

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
07/02/12	8600	0005181

FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 07/03/11

BUSINESS ADDRESS

SAINT JOSEPH HOSPITAL
2900 NORTH LAKE SHORE DRIVE
CHICAGO IL 60657

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State of Illinois 2040005
Department of Public Health
LICENSE, PERMIT, CERTIFICATION, REGISTRATION

SAINT JOSEPH HOSPITAL

EXPIRATION DATE	CATEGORY	I.D. NUMBER
07/02/12	8600	0005181

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	BGBD	0001008

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 07/01/11

BUSINESS ADDRESS

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

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State of Illinois 2035973

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

HOLY FAMILY MEDICAL CENTER

EXPIRATION DATE	CATEGORY	I.D. NUMBER
06/30/12	BGBD	0001008

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 07/01/11

05/07/11

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

FEE RECEIPT NO.

ATTACHMENT 11

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	8680	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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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	8680	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	0680	0001719

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 07/01/11

BUSINESS ADDRESS

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

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

OUR LADY OF THE RESURRECTION MEDIC/

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

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 07/01/11

05/07/11

OUR LADY OF THE RESURRECTION 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	I.D. 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

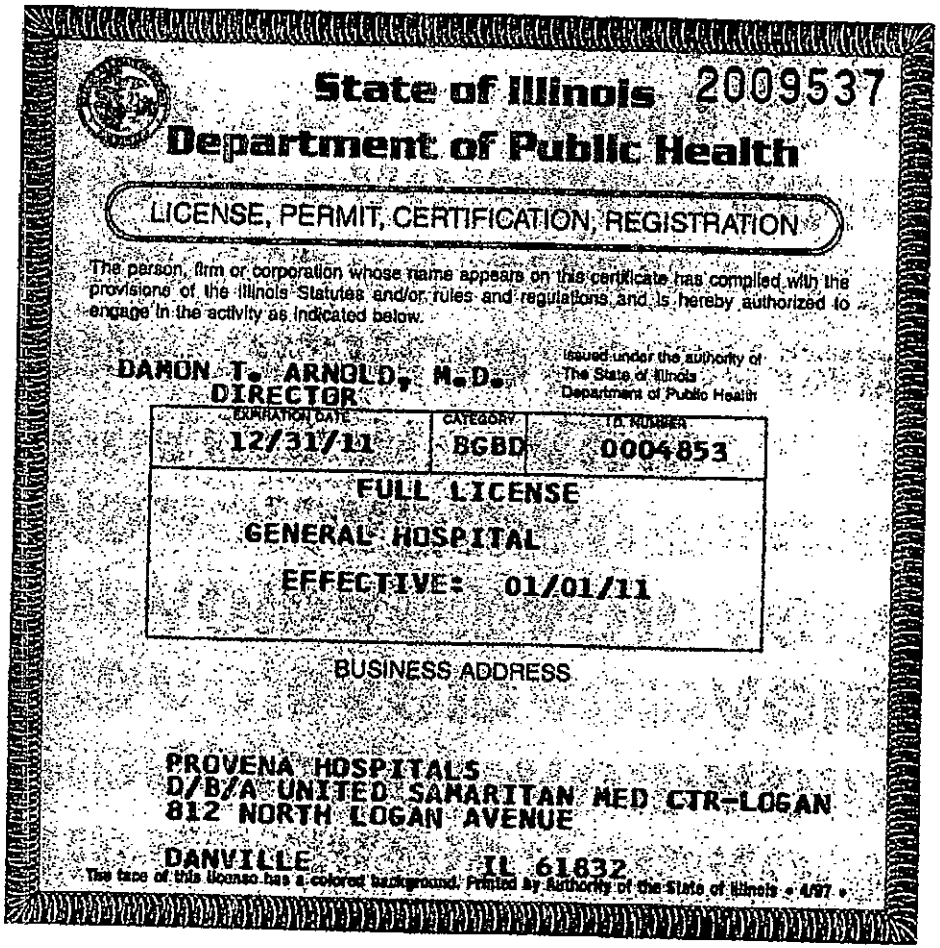
4968
Organization ID #

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

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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

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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

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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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, M.D.
Chairman of the Board

7338
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 2009541
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	0680	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	ID NUMBER
12/31/11	0680	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.

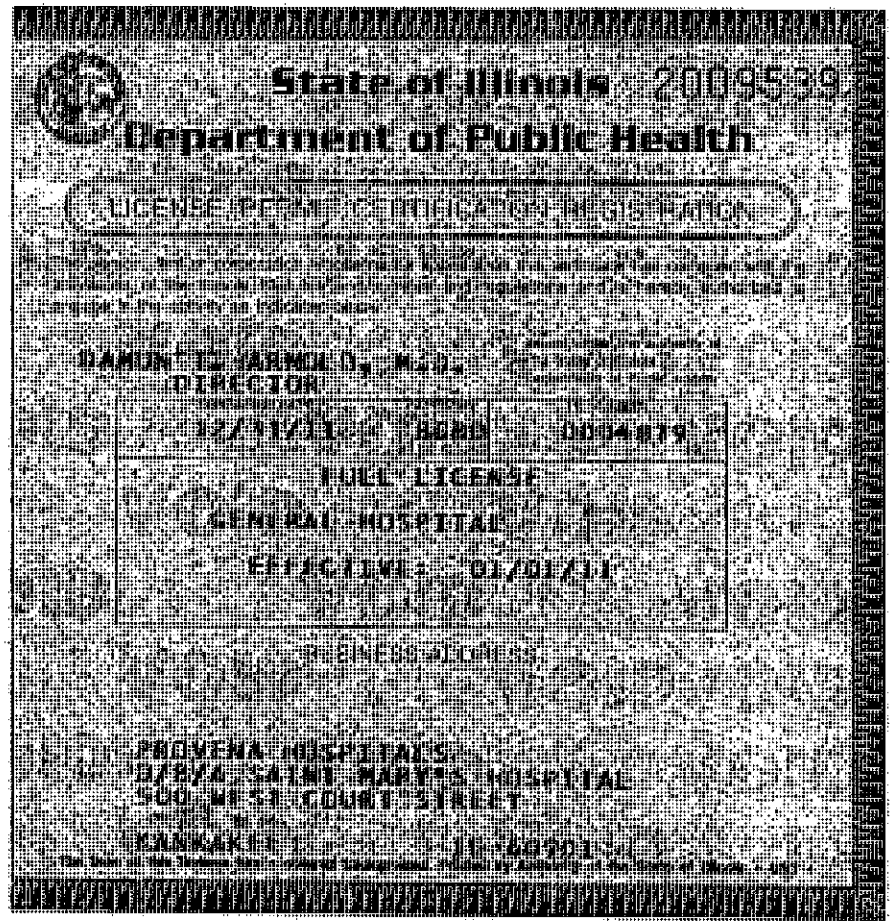
Sincerely,

Ann Scott Blouin RN, PhD

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

ATTACHMENT 11

ATTACHMENT 11



DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

11/06/10

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

FEE RECEIPT NO.

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.

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
04/30/12	ASTD	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

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

DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

State of Illinois 2032822
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

BELMONT/HARLEM SURGERY CENTER, LLC

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

FULL LICENSE

AMBUL SURGICAL TREAT CNTR

EFFECTIVE: 05/01/11

04/20/11

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

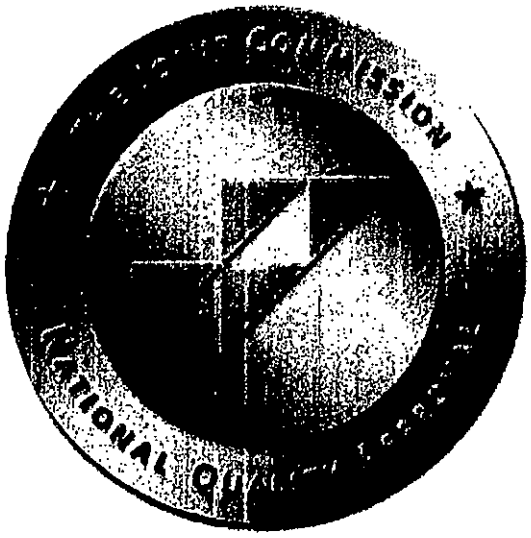
FEE RECEIPT NO. 54561

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 | TITLE | (X6) DATE

Lisa Pardelune RN | CEO | 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 THE 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, at Belmont and Harlem Center. The facility will continue operate as amulti-specialy ambulatory surgical treatment center (ASTC). 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 ASTC's patient origin for the 12-month period ending September 30, 2010; identifying each ZIP Code area that contributed a minimum of 1.0% of the ASTC's patients during that period.

ZIP Code	Community	Patients	%	Cumulative %
60634	Chicago-Dunning	299	11.1%	11.1%
60631	Chicago-Norwood park	214	7.9%	19.0%
60706	Harwood Heights.	187	6.9%	25.9%
60656	Chicago-Oriole Park	178	6.6%	32.5%
60630	Chicago-Jefferson Park	175	6.5%	39.0%
60068	Park Ridge	122	4.5%	43.5%
60641	Chicago-Irving Park	122	4.5%	48.0%
60707	Elmwood park	88	3.3%	51.3%
60714	Niles	78	2.9%	54.2%
60646	Lincolnwood	71	2.6%	56.8%
60016	Des Plaines	69	2.6%	59.3%
60639	Chicago-Cragin	69	2.6%	61.9%
60618	Chicago-Avondale	40	1.5%	63.4%
60018	Des Plaines	38	1.4%	64.8%
60176	Schiller Park	35	1.3%	66.1%
60056	Mount Prospect	32	1.2%	67.3%
60131	Franklin Park	29	1.1%	68.3%
other ZIP Code areas contributing <1%		855	31.7%	100.0%
		2,701	100.0%	

As can be noted from the table above, seventeen ZIP Code areas accounted for over 68% of the ASTC's patients. This analysis clearly demonstrates that the ASTC 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 Belmont and Harlem Surgery Center. Consistent with IHFSRB rules, this impact statement covers the two-year period following the proposed change of ownership.

Reason for the Transaction

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

Anticipated Changes to the Number of Beds or Services Currently Offered

No changes are anticipated either to the scope of services currently provided at Belmont and Harlem Surgery Center.

Operating Entity

Upon the change of ownership, the operating entity/licensee will remain Belmont/Harlem Surgery Center, LLC.

Additions or Reductions in Staff

No changes in clinical or non-system administrative staffing, aside from those routine changes typical of ambulatory surgical treatment centers (ASTCs), are anticipated during the first two years following the proposed change of ownership. The applicants fully intend to offer all current 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, 51% of the value (consistent with Resurrection's ownership interest) of the ASTC 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 any 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 ASTC treated approximately 2,300 patients.

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 Belmont and Harlem Surgery Center will continue to be provided, and consistent with IHFSRB requirements, access to the ASTC's services will not be diminished.

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.

Attached are the ambulatory surgery treatment center's (ASTC's) Admissions Process policy, addressing non-discrimination and its Charity Care policy. These policies will remain in place following the change of ownership.

Belmont and Harlem Surgery Center will, as is the case now, operate without any restrictive admissions policies, related to race, ethnic background, religion, payment source, or any other factor. In addition, no agreements with private third party payors currently in place at Belmont and Harlem Surgery Center are anticipated to be discontinued as a result of the proposed change of ownership.

7435 West Talcott Avenue
Chicago, Illinois 60631
773.792.5555

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:09/29/14

ATTACHMENT 19B

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

CURRENT ADMISSIONS
and
CHARITY CARE POLICIES

ATTACHMENT 19B

Clinical Policies and Procedures Manual

SECTION: **TX/Care of Patient**
TITLE: **ADMISSION PROCESS**

POLICY #: **BHSC.2.10**

EFFECTIVE DATE: **May 2008**

REVISION DATE: _____

The following steps should be followed when admitting a patient to the facility:

1. All patients that will be admitted and receive care appropriately with no distinction in eligibility and without discrimination.

2. No person will be discriminated against or otherwise denied benefits of care or service on the grounds of race, sex, national origin, religion, age, sexual preference, disability or financial means.

3. Patient will be treated with respect and dignity with attention to any spiritual or cultural needs.

4. Receptionist has compiled a chart prior to the day of admission with all necessary forms and labels.

5. Patient should be cheerfully greeted and identified by using two (2) patient identifiers - name and date of birth.

6. The patient's insurance cards and drivers license is scanned into the system under the patient's medical record.

7. The receptionist verifies name band and places it on patient.

8. Patient is asked to sign all necessary forms for billing and release of information, as well as make any financial payments required.

9. Pre-Op/Holding Nurse is notified that patient has arrived.

SECTION:	**RI/Patient Rights**
TITLE:	**CHARITABLE ASSISTANCE POLICY**
POLICY #:	**BHSC**
EFFECTIVE DATE:	**March 23, 2011**
REVISION DATE:	**N/A**

PHILOSOPHY

Belmont/Harlem Surgery Center (BHSC) participates in the provision of charitable assistance by making care available to Medicaid patients as well as patients whose care may be funded through charitable discounts. All patients are treated with respect and dignity regardless of their ability to pay for medical care.

PURPOSE

This policy establishes guidelines for providing charitable assistance to patients. Charitable assistance includes the provision of care to those who are typically underserved, such as Medicaid patients, as well as the provision of discounted care to patients who meet the criteria for financial assistance as set forth in this policy.

REQUIREMENT

BHSC is committed to providing a certain level of charitable assistance each year. This is accomplished by requiring each physician member to provide at least three (3) charitable assistance cases in the last two (2) years of the credential period.

PROCESS

1. Financial need will be determined by reviewing information submitted by the patient as part of an application process. A patient requesting financial assistance should request an application from BHSC within 90 days of the date of service. Applicants must return a signed application with the following documents within 20 days of the date of the request for an application (Belmont/Harlem Surgery Center reserves the right to extend this period on a case-by-case basis):

    - If employed, last two month's pay stubs
    - Unemployment checks/compensation papers/Social Security checks.
    - Most recent income tax return, including W-2s for the past two (2) years.
    - A completed Charity Care Request Form
    - Information on any other possible forms of payment

2. Each situation is reviewed independently and consideration is given to any extenuating circumstances.

3. A patient is eligible to receive a full discount (100% of billed charges) if he or she can demonstrate family income at or below 100% of the Federal Poverty Income Guidelines.

4. A patient is eligible for a partial discount – to the extent set forth below - if he or she can demonstrate family income greater than 100% but less than or equal to 400% of the Federal Poverty Income Guidelines.

Federal Poverty Income Guidelines	Discount off Billed Charges
< 100%	100%
101% - 200%	80%
201% - 300%	60%
301% - 400%	40%
Uninsured, but does not meet income guidelines	20%

5. Discounts will be given only after all possible forms of potential payment have been exhausted, including application for Public Aid.

6. Discounts will be given only for cases involving medically necessary care.

7. The Medical Staff Advisory Board shall administer this Policy. All applications will be reviewed and approved by the Medical Staff Advisory Board.

8. Adoption or amendment of this Policy requires consent from the Board of Managers.

9. This Policy shall be communicated to all patients as part of the registration process.

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.

Belmont and Harlem Surgery Center (BHSC) operates as an independent ambulatory surgical treatment center (ASTC), and is not part of an ASTC system, as is the case with many other ASTCs in the Chicago area. While Resurrection Health Care Corporation's 51% ownership interest in Belmont and Harlem Surgery Center meets the IHFSRB's definition of control, the ASTC will not operate as part of the merged system, as will be the case with the thirteen hospitals currently owned by Resurrection Health Care Corporation and Provena Health.

Impact of the Proposed Transaction on Other Area Providers

Following the change of ownership, BHSC will continue to operate with an "open" Medical Staff model, meaning that qualified physicians both can apply for surgical privileges at the ASTC.

Patient Transfer Agreements

Belmont and Harlem Surgery Center has patient transfer agreements in place with Resurrection Medical Center (3.8 miles/12 minutes, per MapQuest) and Our Lady of the Resurrection Medical Center (2.6 miles/8 minutes, per MapQuest), and copies of those agreements are attached. It is the intent of the applicants to retain both of those agreements. Each of the existing transfer 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.

Duplication of Services

As certified in this application, the applicants fully intend to retain the ASTC's clinical programmatic complement for a minimum of two years.

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.

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

Source:Ambulatory Surgical Treatment Center Questionnaire for 2009, Illinois Department of Public Health, Health Systems Development

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

TRANSFER AGREEMENT

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

RECITALS

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

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

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

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

ARTICLE 1
PATIENT TRANSFERS

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

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

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

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

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

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

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

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

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

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

1.5 **Standard of Performance**. Each Party shall, in performing its obligations under this Agreement, provide Patient care services in accordance with the same standards as services provided under similar circumstances to all other Patients of such Party, and as required by federal and state laws and Medicare/Medicaid certification standards. Each Party shall maintain all legally required certifications and licenses from all applicable governmental and accrediting bodies, and shall maintain full eligibility for participation in Medicare and Medicaid.

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

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

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

ARTICLE 2
MEDICAL RECORDS

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

ARTICLE 3
TERM AND TERMINATION

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

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

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

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

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

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

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

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

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

ARTICLE 4
NON-EXCLUSIVE RELATIONSHIP

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

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

ARTICLE 5
CERTIFICATION AND INSURANCE

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

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

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

ARTICLE 6
INDEMNIFICATION

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

ARTICLE 7
COMPLIANCE WITH LAWS

At all times, both Parties shall comply with all federal, state and local laws, rules and regulations now in effect or later adopted relating to the services to be provided hereunder and that may be applicable to the Parties including, but not limited to, laws, rules and regulations regarding confidentiality, disclosure and retention of Patient records, such as the regulations promulgated under HIPAA. A Party shall promptly notify the other Party if it receives notice of any actual or alleged infraction, violation, default or breach of the same. Each of Transferring Facility and Receiving Hospital represents and warrants that neither it, nor any employee, officer, director or agent thereof is an "excluded person" under the Medicare rules and regulations.

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

ARTICLE 8
MISCELLANEOUS

8.1 No Referrals Requirement. Neither Party is under any obligation to refer or transfer Patients to the other Party and neither Party will receive any payment for any Patient referred or transferred to the other Party. A Party may refer or transfer Patients to any facility based on the professional judgment of the treating physician and the individual needs and wishes of the Patients.

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

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

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

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

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

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

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

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

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

or part of its rights and delegate all or part of its obligations under this Agreement to any entity controlled by or under common control with such Party, or a successor in interest to substantially all of the assets of such Party.

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

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

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

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

8.9 **Severability**. If any provision of this Agreement, or the application thereof to any person or circumstance, shall be held to be invalid, illegal or unenforceable in any respect by any court of competent jurisdiction, the remainder of this Agreement, or the application of such affected provision to persons or circumstances other than those to which it is held invalid or unenforceable, shall be unaffected.

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

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

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

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

TRANSFERRING FACILITY

Signature: Starr M. Novak

Starr Novak
Assistant Secretary
Belmont/Harlem Surgery Center, LLC

RECEIVING HOSPITAL

Signature: Sister Donna Marie Wolowicki, CR

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

TRANSFER AGREEMENT

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

RECITALS

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

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

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

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PATIENT TRANSFERS

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

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

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

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

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

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

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INDEMNIFICATION

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

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COMPLIANCE WITH LAWS

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

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

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

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

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

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

8.4 **Assignment**. Neither Party may assign its rights or delegate its obligations under this Agreement without the prior written consent of the other, except that either Party may assign all or part of its rights and delegate all or part of its obligations under this Agreement to any entity controlled by or under common control with such Party, or a successor in interest to substantially all of the assets of such Party.

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8.9 **Severability**. If any provision of this Agreement, or the application thereof to any person or circumstance, shall be held to be invalid, illegal or unenforceable in any respect by any court of competent jurisdiction, the remainder of this Agreement, or the application of such affected provision to persons or circumstances other than those to which it is held invalid or unenforceable, shall be unaffected.

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

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

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

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

TRANSFERRING FACILITY

Signature: _____

Starr Novak
Assistant Secretary
Belmont/Harlem Surgery Center, LLC

RECEIVING HOSPITAL

Signature: _____

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

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

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

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

OPERATING and CAPITAL COSTS
per ADJUSTED PATIENT DAY

Belmont-Harlem Surgery center
2012 Projection

PATIENTS:	2,267

OPERATING COSTS

salaries & benefits	$	805,143
supplies	$	1,183,155
TOTAL	$	1,988,298

Operating cost/patient:	$	877.06

CAPITAL COSTS

depreciation	$	234,295
interest	$	20,530
TOTAL	$	254,825

Capital cost/adjusted patient day:	$	112.41

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.

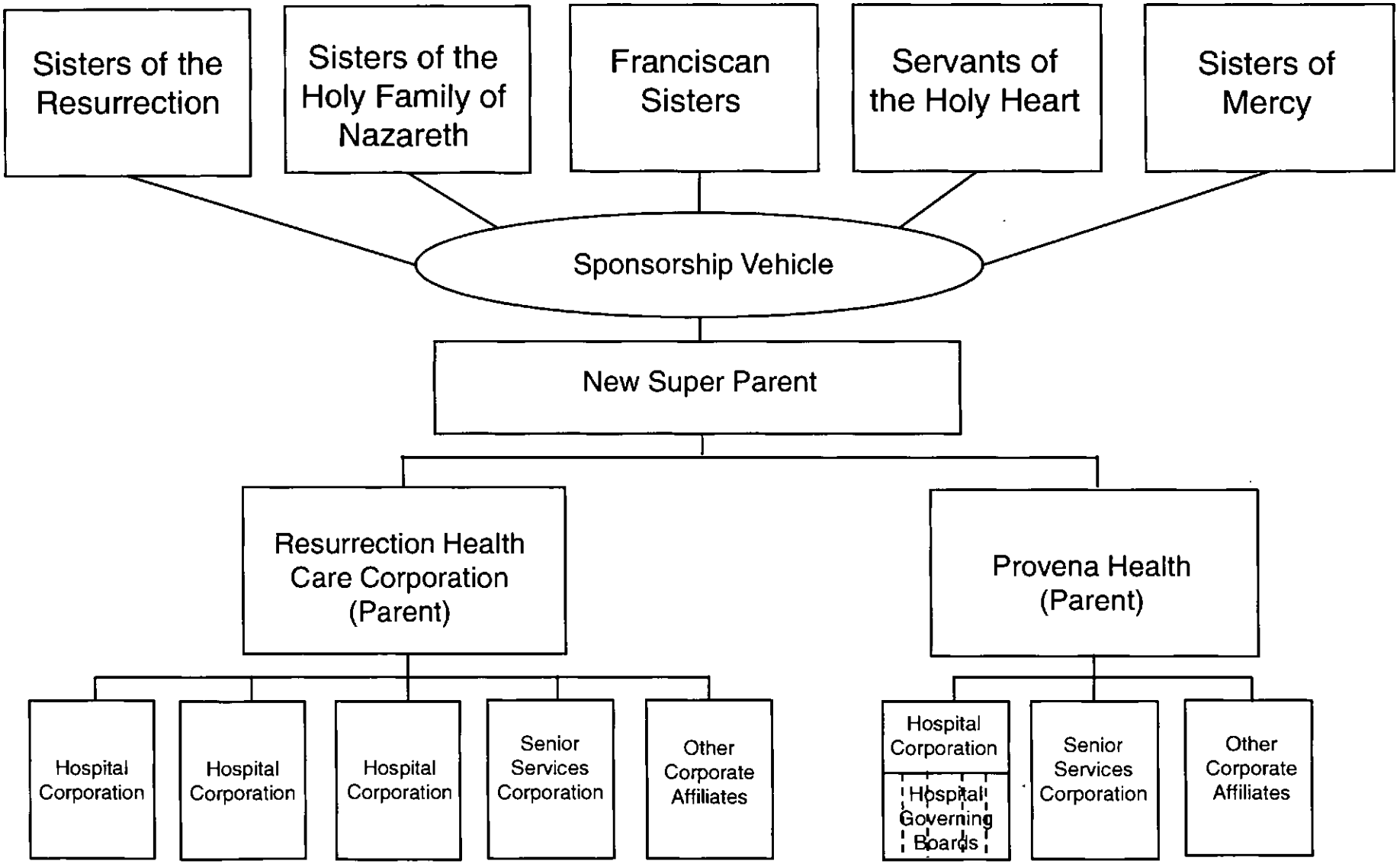
A co-applicant in each Certificate of Need application is Cana Lakes Health Care, which is an existing Illinois not-for-profit corporation. The Cana Lakes corporation will be reconstituted to serve as the super parent entity, through amendment of its corporate documents to reflect unified governance 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