ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD APPLICATION FOR PERMIT

11-110

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.	ORIGINAL
Facility/Project Identification Facility Name: Norwegian American Hospital	
Street Address: 1044 North Francisco Avenue	
City and Zip Code: Chicago, IL 60622	
County: Cook Health Service Area: 6 Health Plann	ing Area: A02
County. Cook Media Scriptory	
Applicant/Co-Applicant Identification [Provide for each co-applicant - [refer to Part 1130.220].	
Exact Legal Name: Norwegian American Hospital, Inc.	RECEIVED
Address: 1044 North Francisco Avenue, Chicago, IL 60622	CECEIVED
Name of Registered Agent: CT Corporation	01.0 4.5 7011
Name of Chief Executive Officer: Jose R. Sanchez	DEC 0 5 2011
CEO Address: 1044 North Francisco Avenue, Chicago, IL 60622	HEALTH FACILITIES &
Telephone Number: 773-292-8204	RVICES REVIEW BOARD
Type of Ownership of Applicant/Co-Applicant	
⊠ Non-profit Corporation	
Image: Support of the property	
Limited Liability Company Sole Proprietorship	Other
partner specifying whether each is a general or limited partner. APPEND DOCUMENTATION AS ATTACHMENT-1, IN NUMERIC SEQUENTIAL ORDER A APPLICATION FORM.	FTER THE LAST PAGE OF THE
Primary Contact [Person to receive all correspondence or inquiries during the review period]	
Name: Clare Connor Ranalli, Esq.	
Title: Partner	
Company Name: Holland & Knight LLP	
Address: 131 S. Dearborn St., Suite 3000, Chicago, IL 60603	
Telephone Number: 312-578-6567	
E-mail Address: clare.ranalli@hklaw.com	
Fax Number: 312-578-6666	
Additional Contact [Person who is also authorized to discuss the application for permit]	
Name: Amee Patel, Esq.	
Title: Corporate Counsel	
Company Name: Norwegian American Hospital, Inc.	
Address: 1044 North Francisco Avenue, Chicago, IL 60622	
Telephone Number: 773-292-8896	
E-mail Address: apatel@nahospital.org	
Fax Number: 773-278-0492	

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]

BA IME TIC	CENSED HEALTH CARE LACIELLI AS DELICITED IN THE STATE OF			
Name: A	Amee Patel, Esq.			
Title:	orporate Counsel			
Company N	ame: Norwegian American Hospital, Inc.			
	1044 North Francisco Avenue, Chicago, IL 60622			
Address:	1044 North Francisco Avende, Chicago, 12 00022			
Telephone N	Number: 773-292-8896			
E-mail Addr	ess: apatel@nahospital.org			
Fax Number	r: 773-278-0492			
Tax Number				

Site Ownership

[Provide this information for each applicable site]
Exact Legal Name of Site Owner: Norwegian American Hospital, Inc.
Address of Site Owner: 1044 North Francisco Avenue, Chicago, IL 60622
Street Address or Legal Description of Site: 1044 North Francisco Avenue, Chicago, IL 60622
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.

Operating Identity/Licensee

ρετα Provid	le this informat	ion for each application	able facility, a	and insert after this page]		
		orth Francisco Ave	nue, Chicago,	IL 60622		
000	Non-profit Co For-profit Cor Limited Liabil Corporations Partnerships	rporation rporation ity Company and limited liability must provide the n	companies n	Partnership Governmental Sole Proprietorship nust provide an Illinois Cert ate in which organized and	the name ar	no address or each
0		n 5 percent or gi	catel litter			
PPEN	D DOCUMENTA	TION AS <u>ATTACHM</u>	ENT-3, IN NU	MERIC SEQUENTIAL ORDER	AFTER THE	LAST PAGE OF THE
	Provid xact I ddres	Provide this informativact Legal Name: ddress: 1044 Non-profit Composit Co	xact Legal Name: Norwegian Ame ddress: 1044 North Francisco Ave Non-profit Corporation For-profit Corporation Limited Liability Company Corporations and limited liability Partnerships must provide the n partner specifying whether each Persons with 5 percent or grownership. PPEND DOCUMENTATION AS ATTACHM	Provide this information for each applicable facility, a xact Legal Name: Norwegian American Hospital ddress: 1044 North Francisco Avenue, Chicago, Non-profit Corporation For-profit Corporation Limited Liability Company Corporations and limited liability companies in Partnerships must provide the name of the st partner specifying whether each is a general of Persons with 5 percent or greater intercommership.	Provide this information for each applicable facility, and insert after this page xact Legal Name: Norwegian American Hospital, Inc.	Provide this information for each applicable facility, and insert after this page xact Legal Name: Norwegian American Hospital, Inc. ddress: 1044 North Francisco Avenue, Chicago, IL 60622 Non-profit Corporation

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	Require	ments
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[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 <u>ATTACHMENT 5.</u> 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 <u>ATTACHMENT-6</u>, 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
Non-substantive Non-substantive	Category A Project Category B Project DHS or DVA Project

2. Narrative Description

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

This project requests approval of the Board to discontinue a category of service. The applicant requests approval to discontinue its five bed pediatric category of service. There are no costs associated with the discontinuation.

Project Costs and Sources of Funds

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. See 20 ILCS 3960 for definition of non-clinical. Note, the use and sources of funds must equal.

Project Cos	ts and Sources of F	unas	
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs			zero
Site Survey and Soil Investigation			zero
Site Preparation			zero
Off Site Work			<u> zего</u>
New Construction Contracts			zero
Modernization Contracts			zero
Contingencies			zero
Architectural/Engineering Fees			zero
Consulting and Other Fees			zего
Movable or Other Equipment (not in construction contracts)			zero
Bond Issuance Expense (project related)			zего
Net Interest Expense During Construction (project related)			zero
Fair Market Value of Leased Space or Equipment			zero
Other Costs To Be Capitalized			zero
Acquisition of Building or Other Property (excluding land)			zero
TOTAL USES OF FUNDS			zero
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities		_	
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS			N/A

NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT <u>ATTACHMENT-7</u>, 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 on the beginning the last two calendar years:
Land acquisition is related to project Yes No Purchase Price: \$ Fair Market Value: \$
The project involves the establishment of a new facility or a new category of service Yes No
If yes, provide the dollar amount of all non-capitalized operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.
Estimated start-up costs and operating deficit cost is \$ <u>N/A</u>
Project Status and Completion Schedules
Indicate the stage of the project's architectural drawings:
☑ None or not applicable ☐ Preliminary
☐ Schematics ☐ Final Working
Anticipated project completion date (refer to Part 1130.140): May 15, 2012
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.
APPEND DOCUMENTATION AS <u>ATTACHMENT-8</u> , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.
State Agency Submittals
Are the following submittals up to date as applicable:
 ∑ Cancer Registry ∑ APORS ∑ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted ∑ All reports regarding outstanding permits
Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

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				<u>. </u>			
Intensive Care							<u> </u>
Diagnostic Radiology							
MRI		<u> </u>					<u> </u>
Total Clinical						. <u> </u>	
NON REVIEWABLE							
Administrative					<u> </u>		<u> </u>
Parking				·			
Gift Shop		ļ. <u> </u>	<u> </u>				
							
Total Non-clinical							<u> </u>
TOTAL							<u> </u>

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

Facility Bed Capacity and Utilization

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

FACILITY NAME: Norwegian	American Hospi	accip arion	CITY: Chic	ago	
REPORTING PERIOD DATES:	From:	10/01/2010	То:	09/30/201	L
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	96			N/A	
Obstetrics	48			N/A	
Pediatrics	5			-5	0
Intensive Care	12			N/A	
Comprehensive Physical Rehabilitation	N/A				
Acute/Chronic Mental Illness	37			N/A	
Neonatal Intensive Care	N/A				
General Long Term Care	N/A				
Specialized Long Term Care	N/A				
Long Term Acute Care	N/A			ļ	
Other (identify)	N/A				
TOTALS:	200			-5	195

CERTIFICATION

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

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

This Application for Permit is filed on behalf of	Norwegian American Hospital, Inc.
in accordance with the requirements and proc	edures of the Illinois Health Facilities Planning Act
permit on hehalf of the applicant entity. The	the authority to execute and file this application for the undersigned further certifies that the data and
information provided herein, and appended he	ereto, are complete and correct to the best of his o
her knowledge and belief. The undersigned a	lso certifies that the permit application fee required
for this application is sent herewith or will be p	aid upon request

SIGNATURE

<u>Jose R. Sancheź</u> PRINTED NAME

Chief Executive Officer

PRINTED TITLE

Notarization:

Subscribed and sworn to before me this 29 day of novembee

Signature of Notary

Seal

"OFFICIAL SEAL"
SUSANA DORANTES
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 12/11/2011

*Insert EXACT legal name of the applicant

Anthony Evers

PRINTED NAME

Chief Financial Officer
PRINTED TITLE

Notarization:

Subscribed and sworn to before me this 25 day of November

Signature of Notary

Seal

SECTION II. DISCONTINUATION

This Section is applicable to any project that involves discontinuation of a health care facility or a category of service. **NOTE:** If the project is solely for discontinuation and if there is no project cost, the remaining Sections of the application are not applicable.

Criterion 1110.130 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

- 1. Identify the categories of service and the number of beds, if any that are to be discontinued.
- Identify all of the other clinical services that are to be discontinued.
- 3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
- 4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
- 5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.
- 6. For applications involving the discontinuation of an entire facility, certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 60 days following the date of discontinuation.

REASONS FOR DISCONTINUATION

The applicant shall state the reasons for discontinuation and provide data that verifies the need for the proposed action. See criterion 1110.130(b) for examples.

IMPACT ON ACCESS

- 1. Document that the discontinuation of each service or of the entire facility will not have an adverse effect upon access to care for residents of the facility's market area.
- Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility.
- Provide copies of impact statements received from other resources or health care facilities located within 45 minutes travel time, that indicate the extent to which the applicant's workload will be absorbed without conditions, limitations or discrimination.

APPEND DOCUMENTATION AS <u>ATTACHMENT-10</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The following Sections <u>DO NOT</u> 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):

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

III. 1120,120 - Availability of Funds

NOT APPLICABLE

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:**

	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to:
		 the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and
		 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, estimate 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:
		 For general obligation bonds, proof of passage of the required referendum or evidence that the government 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 specific amount and interest rate;
		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.;
		 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)	Government 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;
	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
	TOTA	AL FUNDS AVAILABLE

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

IV. 1120.130 - Financial Viability

NOT APPLICABLE

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
- 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
- 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 <u>ATTACHMENT-40</u>, 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 <u>ATTACHMENT-41</u>, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

V. 1120,140 - Economic Feasibility

NOT APPLICABLE

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:

- 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
- That the total estimated project costs and related costs will be funded in total or in party by borrowing because:
 - 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 60day period.

B. Conditions of Debt Financing

This criteria 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:

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

 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 AN	D GROSS	SQUARE	FEET BY	DEPARTI	MENT OR	SERVICE		
	A	В	С	D	E	F		H	Total
Department (list below)	Cost/Square Foot New Mod.		Gross Sq. Ft. New Circ.*		Gross Sq. Ft. Mod. Circ.*		Const. \$ (A x C)	Mod. \$ (B x E)	Cost (G + H)
Contingency									
TOTALS						<u> </u>			

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 <u>ATTACHMENT 42,</u> IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

VI. Safety Net Impact Statement

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

- 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.
- 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 Statement shall also include all of the following:

- 1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.
- 2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.
- 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 90	5-0031	
CHARITY C	ARE		
Charity (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Charity (cost in dollars)			
Inpatient			<u> </u>
Outpatient			
Total			
MEDICA	ID		·
Medicaid (# of patients)	Year	Үеаг	Year
Inpatient			
Outpatient			
Total			

Medicaid	(revenue)	
	Inpatient	
	Outpatient	
Total		

APPLICATION FORM.

VII. **Charity Care Information**

Charity Care Information MUST be furnished for ALL projects.

- 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.
- 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.
- 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					
	Year	Year	Year		
Net Patient Revenue			 .		
Amount of Charity Care (charges)					
Cost of Charity Care					

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

After paginating the entire, completed application, indicate in the chart below, the page numbers for the attachments included as part of the project's application for permit:

	INDEX OF ATTACHMENTS	
TACHMI	ENT	PAGE
1	Applicant/Co-applicant Identification including Certificate of Good Standing	17-18
2	Site Ownership	20
3	Persons with 5 percent or greater interest in the licensee must be identified with the	
ر آ	% of ownership.	N/A_
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing,	
	Etc.	22
5	Flood Plain Requirements	23
6	Historic Preservation Act Requirements	24
7	Project and Sources of Funds Itemization	N/A
. 8	Obligation Document if required	N/A
9	Cost Space Requirements	N/A
10	Discontinuation	25-1350
11	Background of the Applicant	
12	Purpose of the Project	<u> </u>
13	Alternatives to the Project	ļ
14_	Size of the Project	
15	Project Service Utilization	
16	Unfinished or Shell Space	
17	Assurances for Unfinished/Shell Space	
18	Master Design Project	<u> </u>
19	Mergers, Consolidations and Acquisitions	<u> </u>
		
	Service Specific:	
20	Medical Surgical Pediatrics, Obstetrics, ICU	
21	Comprehensive Physical Rehabilitation	
22	Acute Mental Illness	
23	Neonatal Intensive Care	ļ
24	Open Heart Surgery	
25	Cardiac Catheterization	
26	In-Center Hemodialysis	
27	Non-Hospital Based Ambulatory Surgery	
28	General Long Term Care	
29	Specialized Long Term Care	
30	Selected Organ Transplantation	ļ
31	Kidney Transplantation	
32	Subacute Care Hospital Model	
33	Post Surgical Recovery Care Center	
34	Children's Community-Based Health Care Center	+
35	Community-Based Residential Rehabilitation Center	
36	Long Term Acute Care Hospital	
37	Clinical Service Areas Other than Categories of Service	
38	Freestanding Emergency Center Medical Services	
		
	Financial and Economic Feasibility:	
39	Availability of Funds	
40	Financial Walver	
41	Financial Viability	
42	Economic Feasibility	136-137
43	Safety Net Impact Statement	136-137 138-144
44	Charity Care Information	120-14

Certificate of Good Standing See attached



To all to whom these Presents Shall Come, Greeting:

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

NORWEGIAN AMERICAN HOSPITAL INC., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 11, 1935, 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 #: 1132201542

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

In Testimony Whereof, I hereto set

my hand and cause to be affixed the Great Seal of the State of Illinois, this 18TH

day of NOVEMBER

A.D.

2011

Desse White

SECRETARY OF STATE

Proof of Site Ownership

See attached

Proof of Site Ownership

Norwegian American Hospital, Inc. owns the land on which it is located, commonly referred to as 1044 N. Francisco/Chicago, Illinois 60622, in Cook County, Illinois.

Jose R. Sanchez Chief Executive Officer

Norwegian American Hospital, Inc.

Notary Public

My commission expires: 12-11. 2011

See previous Certificate of Good Standing (Attachment 1)

Organizational Relationships

Norwegian American Hospital, Inc. is a non-member not for profit. There is no related person or entity involved in this project.

Flood Plain

This project does not involve any construction.

Historic Preservation

This project does not involve construction or modernization.

Discontinuation General Information Requirements

- 1. Discontinue five (5) bed pediatric category of services.
- 2. No other services are to be discontinued.
- 3. The anticipated date of discontinuation will occur on or before May 1, 2012 although not prior to HFSRB approval.
- 4. The space will be used for expansion of the Hospital's behavioral health unit.
- 5. The medical records for the pediatric unit will be maintained by the Hospital in accord with the Illinois Hospital Licensing Act.
- 6. N/A This application is solely to discontinue a category of service, not an entire facility.

Discontinuation Reason for Discontinuation

NAH has seen low utilization in its pediatric unit. For example, its average utilization in 2009 was 48.4%, in 2010 was 37% and in 2011 to date is 18.4%. In addition, with Children's Memorial Hospital moving closer to Norwegian American Hospital anticipated in 2012, the affiliation which Norwegian American Hospital has with Northwestern's residency program and the pediatric service offered at other hospitals close by, the Hospital does not believe its utilization will increase and there is ample access to this service in the community. For example, there is an excess of 572 medical surgical/pediatric beds in the Health Service/Planning Area. Norwegian American Hospital is a safety net hospital. In 2010, 60% of its patients were Medicaid, 47% were African American and 38% were Latino. The Hospital serves an economically challenged area and needs to focus on service lines and capital needs that are appropriate and not duplicative of other services in the area. Staffing and maintaining a pediatric unit that is significantly under utilized and not necessary for access in the community is a poor use of its limited financial resources.

Discontinuation Impact on Access

The discontinuation will not impact the service (planning) area. Children's Memorial Hospital will commence services at its new location within 2012 and will be located 2.5 miles away. In addition, other hospitals in the area, such as Sts. Mary & Elizabeth, located 1 mile away, as well as Illinois Masonic, Rush and Mt. Sinai offer pediatric services and appear to have capacity based on the HFSRB target utilization rate of 90%. Norwegian American Hospital's utilization has been well below the HFSRB target utilization rate for the past three years: 2009-30.6%, 2010-22.02% and 2011-18.4%. Generally speaking, pediatric services are trending toward outpatient visits. Norwegian American Hospital will continue to offer same, and to partner with PCC and Erie Family Health, two FQHCs which offer services at its site, in providing out patient pediatric services.

Discontinuation Impact on Access

All hospitals within 45 minutes received a request for impact on their facility if Norwegian American Hospital were to discontinue its pediatric service. See attached letters, sent certified mail.

Via Certified Mail

Little Company of Mary Hospital and Health Care Center 2800 West 95th Street Evergreen Park IL 60642-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

Please advise me if you believe that the discontinuation of this service will have any impact on your facility.

Thank you for your consideration.

Sincerely,

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY
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2800 West 95th Street

Evergreen Park IL 60642-0000

Via Certified Mail

MacNeal Memorial Hospital 3249 South Oak Park Avenue Berwyn IL 60402-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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	Berwyn IL 60402-0000							

Via Certified Mail

Jackson Park Hosp. Foundation 7531 Stony Island Avenue Chicago IL 60649-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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Via Certified Mail

Our Lady of Resurrection Medical Center 5645 West Addison Street Chicago IL 60634-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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Via Certified Mail

Thorek Memorial Hospital 850 West Irving Park Chicago IL 60613-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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850 West Irving Park	
Chicago IL 60613-0000	
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Via Certified Mail

Mercy Hospital & Medical Center 2525 South Michigan Avenue Chicago IL 60616-2477

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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Via Certified Mail

Northwestern Memorial Hospital 251 East Huron St Chicago IL 60611-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

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251 East Huron St	
Chicago IL 60611-0000	
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Via Certified Mail

St. Francis Hospital 355 Ridge Avenue Evanston IL 60202-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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Via Certified Mail

Evanston Hospital 2650 Ridge Avenue Evanston IL 60201-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

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Via Certified Mail

Highland Park Hospital 718 Glenview Avenue Highland Park IL 60035-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

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718 Glenview Avenue	
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Via Certified Mail

Louis A. Weiss Memorial Hospital 4646 North Marine Drive Chicago IL 60640-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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Via Certified Mail

Saint Joseph Health Centers & Hospital 2900 North Lake Shore W Chicago IL 60657-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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	Sent To Saint Jo	oseph Health Cen	ters & Hospital
7011	L	2900 North Lake	Shore W
	City, Si	Chicago IL 6065	7-0000
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Via Certified Mail

Advocate Good Samaritan Hospital 3815 Highland Avenue Downers Grove IL 60515-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

Please advise me if you believe that the discontinuation of this service will have any impact on your facility.

Thank you for your consideration.

Sincerely,

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY		
Complete Items 1, 2, and 3. Also complete Item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. 1. Article Addressed to: Advocate Good Samaritan Hospital 3815 Highland Avenue	A. Signature X. Agent Addressee B. Received by (Printed Name) C. Date of Delivery D. Is delivery address different from Item 1? Yes If YES, enter delivery address below:		
Downers Grove IL 60515-0000	3. Service Type Certified Mail		
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DO Form 3911 February 2004 Domestic B	teturn Receipt 102595-02-M-1540		

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<u> </u>	Total Postage & Fees	\$						

Advocate Good Samaritan Hospital 3815 Highland Avenue Downers Grove IL 60515-0000

Via Certified Mail

Adventist Hinsdale Hospital 120 North Oak Street Hinsdale IL 60521-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

Please advise me if you believe that the discontinuation of this service will have any impact on your facility.

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Sincerely,

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Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the maliplece, or on the front if space permits. 1. Article Addressed to: Adventist Hinsdale Hospital 120 North Oak Street	A. Signature A. Signature A. Signature A. Agent Addressee B. Received by (Printed Name) C. Date of Delivery C. Date of Delivery D. Is delivery address different from Item 1? If YES, enter delivery address below: No 3. Service Type Certified Mail Registered Insured Mail C.O.D. A. Restricted Delivery? (Extra Fee) Yes	
Hinsdale 1L 60521-0000		
	4. Restricted Delivery? (Extra Fee) ☐ Yes	
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PS Form 3811, February 2004 Domestic Re	turn Receipt 102595-02-M-1540	

U.S. Postal Service Mail College Adventist Hinsdale Hospital 120 North Oak Street Hinsdale IL 60521-0000

Via Certified Mail

Adventist Glen Oaks Medical Center 701 Winthrop Avenue Glendale Heights IL 60139-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

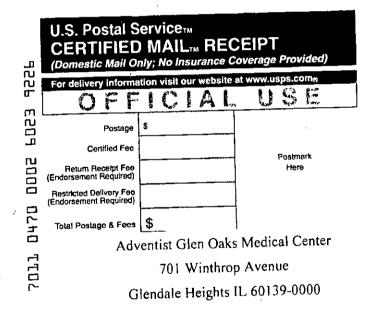
Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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Sincerely,

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Adventist Glen Oaks Medical Center	If YES, enter delivery address below:
Adventist Glen Oaks Wedical Center	
701 Winthrop Avenue	
Glendale Heights IL 60139-0000	
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	4. Restricted Delivery? (Extra Fee)
2. Article Number (Transfer from service label) 1111 1470	0002 6023 9226
PS Form 3811, February 2004 Domestic Retu	urn Receipt 102595-02-M-1540



Via Certified Mail

Alexian Brothers Medical Center 800 Biesterfield Road Elk Grove Villa IL 60007-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

Please advise me if you believe that the discontinuation of this service will have any impact on your facility.

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Sincerely,

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ותםל	Ser		rs Medical Center
7	Sin or I	800 Bieste	erfield Road
•	Člij	Elk Grove Villa	a IL 60007-0000

Via Certified Mail

Elmhurst Memorial Hospital York Rd & Roosevelt Rd Elmhurst IL 60126-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

Please advise me if you believe that the discontinuation of this service will have any impact on your facility.

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Sincerely,

SENDER: COMPLETE THIS SECTION COMPLETE THIS SECTION ON DELIVERY Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. A. Signature 🞾 Agent ■ Print your name and address on the reverse ☐ Addressee so that we can return the card to you. B. Received by (Printed Name) C. Date of Delivery Attach this card to the back of the mailpiece, or on the front if space permits. D. Is delivery address different from item 1? **'**□ Yes Article Addressed to □ No If YES, enter delivery address below: Elmhurst Memorial Hospital York Rd & Roosevelt Rd Elmhurst IL 60126-0000 3. Service Type Certified Mail ☐ Express Mail ☐ Registered Feturn Receipt for Merchandise ☐ Insured Mail ☐ C.O.D. 4. Restricted Delivery? (Extra Fee) ☐ Yes 2. Article Number 2017 0450 0805 POS3 4540 (Transfer from service label) PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540 :

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7077	Ši or	York Rd & R	loosevelt Rd
•	<i>ci</i>	Elmhurst IL	60126-0000
	ps		

Via Certified Mail

Northwest Community Hospital 800 West Central Road Arlington Heights IL 60005-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. 1. Article Addressed to: Northwest Community Hospital 800 West Central Road	A. Signature A. Signature Adjusted Addressee B. Received by (Printed Name) C. Date of Delivery 10 -25 -11 D. Is delivery address different from Item 1? Yes If YES, enter delivery address below:		
Arlington ghts IL 60005-0000	3. Service Type Certified Mall Express Mail Registered C.O.D. 4. Restricted Delivery? (Extra Fee) Yes		
2. Article Number 7011 0470 [1002 6023 9257		
PS Form 3811, February 2004 Domestic Re	turn Receipt 102595-02-M-1540		

52	U.S. Postal Service _{TM} CERTIFIED MAIL _{TM} RECEIPT (Domestic Mail Only; No Insurance Coverage Provided)						
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1	Total Postage & Fees	\$					
7077	,	Northwest Community Hospital					
7.0	800 West Central Road						
	Arlington Heights IL 60005-0000						

Via Certified Mail

Palos Community Hospital 12251 South 80th Avenue Palos Heights IL 60463-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

Please advise me if you believe that the discontinuation of this service will have any impact on your facility.

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Complete Items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailplece, or on the front if space permits. 1. Article Addressed to: Palos Community Hospital 12251 South 80th Avenue	A. Signature Agent Addressee B. Received by (Printed Name) C. Date of Delivery D. Is delivery address different from item 1? Yes If YES, enter delivery address below:					
Palos Heights IL 60463-0000	3. Service Type Certified Mail Registered Insured Mail C.O.D. 4. Restricted Delivery? (Extra Fee) Yes					
(Transfer from service lab 7011 0470 0002 6023 9264						
PS Form 3811, February 2004 Domestic Ret	turn Receipt 102595-02-M-1540					



Via Certified Mail

Advocate Christ Hospital and Medical Center 9500 South Kenneth Ave Oak Lawn IL 60453-0000

Dear Sir or Madam,

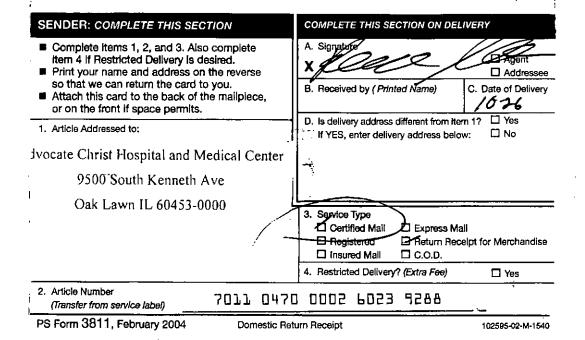
Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

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Please advise me if you believe that the discontinuation of this service will have any impact on your facility.

Thank you for your consideration.

Sincerely,



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9500 South Kenneth Ave					enneth Ave			
•	Oak Lawn IL 60453-0000							

Via Certified Mail

Adventist 'LaGrange Memorial Hospital 5101 Gilbert Avenue LaGrange IL 60525-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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 Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. 	A. Signature Agent Addressee B. Received by (Printed Name) C. Date of Delivery C. Date				
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7017	5101 Gilbert Avenue							
	LaGrange IL 60525-0000							

Via Certified Mail

MetroSouth Medical Center 12935 South Gregory Street Blue Island IL 60406-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

Please advise me if you believe that the discontinuation of this service will have any impact on your facility.

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Sincerely,

COMPLETE THIS SECTION ON DELIVERY SENDER: COMPLETE THIS SECTION Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. A. Signature ☐ Agent ☐ Addressee_ Print your name and address on the reverse so that we can return the card to you. C. Date of Delivery B. Received by (Printed Name) Attach this card to the back of the mailpiece, 0-25-11 or on the front if space permits. D. Is delivery address different from item 1? 1. Article Addressed to: If YES, enter delivery address below: MetroSouth Medical Center P. 12935 South Gregory Street Blue Island IL 60406-0000 Service Type Certified Mail ☐ Express Mail Return Receipt for Merchandise ☐ Registered ☐ Insured Mail ☐ C.O.D. 4. Restricted Delivery? (Extra Fee) ☐ Yes 2. Article Number 3011 0470 0002 6023 9318 (Transfer from service label) PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

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7077	12935 South Gregory Street					
	Blue Island IL 60406-0000					

Via Certified Mail

Advocate South Suburban Hospital 17800 South Kedzie Avenue Hazel Crest IL 60429-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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Via Certified Mail

St. Bernard Hospital 326 West 64th Street Chicago IL 60621-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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SENDER: COMPLETE THIS SECTION .	COMPLETE THIS SECTION ON DELIVERY		
Complete items 1, 2, and 3. Also complete Item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. 1. Article Addressed to: St. Bernard Hospital 326 West 64th Street Chicago IL 60621-0000	A. Signature Agent Addressee		
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	Chicago IL 60621-0000						

Via Certified Mail

Ingalls Memorial Hospital One Ingalls Drive Harvey IL 60426-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

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 Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. 	A Signature X /
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Harvey IL 60426-0000	3. Service Type Certified Mall
	4. Restricted Delivery? (Extra Fee) ☐ Yes
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707	One Ingalls Drive					
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	5 5					

Via Certified Mail

Roseland Community Hospital 45 West 111th Street Chicago 1L 60628-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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Chicago IL 60628-0000	
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1	Chicago 1L 60628-0000						

Via Certified Mail

University Of Chicago Medical Center 5841 South Maryland Chicago IL 60637-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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Thank you for your consideration.

Sincerely,

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1017	St. or	5841 South Maryland					
I.	Ġ.	Chicago IL	60637-0000				
	DS:						

Via Certified Mail

Advocate Trinity Hospital 2320 East 93rd Street Chicago 1L 60617-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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 Complete Items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. 	Agent Addressee B. Received by (Printed Name) C. Data of Delivery
Article Addressed to:	D. Is delivery address different from Item 1? If YES, enter delivery address below:
Advocate Trinity Hospital	
2320 East 93rd Street	
Chicago IL 60617-0000	
	3. Service Type Certified Mail
	4. Restricted Delivery? (Extra Fee) ☐ Yes
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Via Certified Mail

Provident Hospital of Cook County 500 East 51st Street Chicago IL 60615-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

Please advise me if you believe that the discontinuation of this service will have any impact on your facility.

Thank you for your consideration.

Sincerely,

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY
 Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. 	A Signature X CLU Author Agent Addressee B. Received by (Printed Name) C. Date of Delivery
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ovident Hospital of Cook County	
500 East 51st Street	
Chicago IL 60615-0000	3. Septice Type O Certified Mail Registered Return Receipt for Merchandise C.O.D.
	4. Restricted Delivery? (Extra Fee) Yes
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Provident Hospital of Cook Cou								
7033			50	0	East	51	st Street	
1-	Chicago IL 60615-0000							

Via Certified Mail

South Shore Hospital 8012 South Crandon Chicago IL 60617-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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 Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. 	A. Gignature Addressee B. Received by (Printed Name) C. Date of Delivery
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South Shore Hospital	
8012 South Crandon	
Chicago IL 60617-0000	
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-	4. Restricted Delivery? (Extra Fee) ☐ Yes
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Via Certified Mail

LaRabida Children's Hospital 6501 S. Promontory Drive Chicago 60649

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

Please advise me if you believe that the discontinuation of this service will have any impact on your facility.

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Sincerely,

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 Complete Items 1, 2, and 3. Also complete Item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. 	A Signature X Navy Agent Addressee B. Received by (Printed Name) C., Date of Delivery David Gan Not Cab/1 D. Is delivery address different from Item 1? ■ Yes
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LaRabida Children's Hospital	63 lake Shoreth.
6501 S. Promontory Drive	6) 69165
Chicago 60649	3. Service Type Certified Mall Registered Insured Mail C.O.D.
	4. Restricted Delivery? (Extra Fee) ☐ Yes
2. Article Number 7011 0	470 0002 6023 9424
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	LaRabida Children's Hospital							
גנטר								
~	Chicago 60649							

Via Certified Mail

Loyola University Medical Center/Foster G. McGaw 2160 South 1st Avenue Maywood IL 60153-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

Please advise me if you believe that the discontinuation of this service will have any impact on your facility.

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University Medical Center/F	oster G. McGaw				
2160 South 1st Avenu Maywood IL 60153-00	<u>.</u>				
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r	Loyola University Medical Center/Foster G. McGaw								G. McGaw
נ נ	2160 South 1st Avenue								
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Via Certified Mail

VHS Westlake Hospital 1225 W Lake St Melrose Park IL 60160-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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 Complete Items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. 	A. Signature X			
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VHS Westlake Hexpital	Fo. 12			
1225 W Lake St				
Melrose Park IL 60160-0000	<u> </u>			
	3. Service Type Certified Mall Registered Insured Mail C.O.D.			
	4. Restricted Delivery? (Extra Fee) ☐ Yes			
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PS Form 3811, February 2004 Domestic Retu	rrn Receipt 102595-02-M-1540 ;			



Via Certified Mail

Resurrection Medical Center 7435 West Talcott Avenue Chicago IL 60631-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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7011	7435 West Talcott Avenue							
		Chic	ago IL 6	50631-0000				

Via Certified Mail

Gottlieb Memorial Hospital 701 West North Avenue Melrose Park IL 60160-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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Sincerely,

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7077	701 West North Avenue							
	Ċ	Melro	ose Park	IL 60160-0000				

Via Certified Mail

Rush Oak Park Hospital 520 South Maple Street Oak Park IL 60304-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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	If YES, enter delivery address below:			
Rush Oak Park Hospital				
520 South Maple Street				
Oak Park IL 60304-0000				
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	4. Restricted Delivery? (Extra Fee) ☐ Yes			
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п 2 h	Total Postage & Fees	\$				

Rush Oak Park Hospital 520 South Maple Street Oak Park IL 60304-0000

Via Certified Mail

VHS West Suburban Medical Center 622 North Austin Ave Oak Park IL 60302-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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Oak Park IL 66302-0000	3. Sendce Type Certified Mall				
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2033 0470	VHS West Suburban Medical Center Si 622 North Austin Ave Oak Park IL 60302-0000						

Via Certified Mail

Shriner's Hospitals for Children 2211 North Oak Park Elmwood Park IL 60707

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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 Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. 	A. Signature X. M. A.
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. 2211 North Oak Park	
Elmwood Park IL 60707	
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th Oak Park					
Elmwood Park IL 60707					

Via Certified Mail

Loretto Hospital 645 South Central Avenue Chicago IL 60644-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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Thank you for your consideration.

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COMPLETE THIS SECTION ON DELIVERY SENDER: COMPLETE THIS SECTION ■ Complete items 1, 2, and 3. Also complete A. Signature Item 4 if Restricted Delivery is desired. ☐ Agent Print your name and address on the reverse ☐ Addressee so that we can return the card to you. B. Received by (Printed Name) C. Date of Delivery Attach this card to the back of the mailpiece, ع.را.د محق44 10-26-11 or on the front if space permits. D. Is delivery address different from item 1? ☐ Yes 1. Article Addressed to: If YES, enter delivery address below: Loretto Hospital 64 South Central Avenue Chicago IL 60644-0000 3. Service Type 2 Certified Mall ☐ Express Mail ☐ Registered Return Receipt for Merchandise □ C.O.D. Insured Mail 4. Restricted Delivery? (Extra Fee) ☐ Yes 2. Article Number 7011 0470 0002 6023 9486 (Transfer from service label) PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

U.S. Postal Service™ CERTIFIED MAIL, RECEIPT (Domestic Mail Only; No Insurance Coverage Provided) **602** Certified Fee Return Receipt Fee (Endorsement Required) Postmark Here Restricted Dolivery Fee (Endorsement Required) Total Postage & Fees | \$ Loretto Hospital 645 South Central Avenue Chicago IL 60644-0000

Via Certified Mail

Glenbrook Hospital 2100 Pfingsten Road Glenview IL 60025-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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Via Certified Mail

Holy Family Hospital 100 North River Road Des Plaines IL 60016-1278

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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Holy Family Hospital	No
100 North River Road]]
Des Plaines IL 60016-1278	
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Via Certified Mail

Advocate Lutheran General Hospital 1800 Parkside Dr Park Ridge IL 60068-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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■ Complete Items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. ■ Print your name and address on the reverse so that we can return the card to you. ■ Attach this card to the back of the mailpiece, or on the front if space permits. 1. Article Addressed to: Advente: Lutheran General Hospital	A. Signature X. Addressee B. Received by (Printed Name) C. Date of Delivery
Park Ridge IL 60068-0000 L	3. Service Type Certifled Mail
2. Article Number 7011 04	470 0002 6023 9523
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Advocate Lutheran General Hospital
1800 Parkside Dr

Park Ridge IL 60068-0000

Via Certified Mail

St. Anthony Hospital 2875 West 19th Street Chicago IL 60623-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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Chicago IL 60623-0000	3. Service Type Certified Mail
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102595-02-M-1540

Via Certified Mail

Skokie Hospital 9600 Gross Point Road Skokie IL 60076-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

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 Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. Article Addressed to: Skokie Hospital 9600 Gross Point Road 	As delivery address different from item 1? Yes ES, enter delivery address below: No
Skokie IL 60076-0000	3. Service Type Certified Mail
2. Article Number (Transfer from service label) 701.	1 0470 0002 6023 9554
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Via Certified Mail

Sacred Heart Hospital 3240 West Franklin Blvd Chicago IL 60624-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

Please advise me if you believe that the discontinuation of this service will have any impact on your facility.

Thank you for your consideration.

Sincerely,

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Via Certified Mail

Mount Sinai Hospital Medical Center 1501 S California Ave Chicago IL 60608-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

Please advise me if you believe that the discontinuation of this service will have any impact on your facility.

Thank you for your consideration.

Sincerely,

SENDER: COMPLETE THIS SECTION COMPLETE THIS SECTION ON DELIVERY Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. A. Signature □ Agent Print your name and address on the reverse ☐ Addressee so that we can return the card to you. C. Date of Delivery Attach this card to the back of the mailpiece, or on the front if space permits. D. is delivery address different from Item 1? 1. Article Addressed to: If YES, enter delivery address below: Mount Sinai Hospital Medical Center 1501 S California Ave Chicago IL 60608-0000 3. Service Type Certified Mail ☐ Express Mail Return Receipt for Merchandise ☐ Registered ☐ Insured Mail □ C.O.D. 4. Restricted Delivery? (Extra Fee) ☐ Yeş 2. Article Number 7011 0470 0002 6023 9578 (Transfer from service label) PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

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Via Certified Mail

St. Elizabeth's Hospital 1431 North Claremont Chicago IL 60622-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

Please advise me if you believe that the discontinuation of this service will have any impact on your facility.

Thank you for your consideration.

Sincerely,

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Chicago IL 60622-0000	
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7011	1431 North Claremont								
•	č	Chicago IL 6	60622-0000						
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Via Certified Mail

Saint Mary Of Nazareth Hospital 2233 West Divison Street Chicago IL 60622-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

Please advise me if you believe that the discontinuation of this service will have any impact on your facility.

Thank you for your consideration.

Sincerely,

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7011	Si or	2233 West D	Divison Street
•	ä	Chicago IL	60622-0000
	PŞ		

Via Certified Mail

Children's Memorial Hospital 2300 Childrens Plaza Chicago IL 60614-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

Please advise me if you believe that the discontinuation of this service will have any impact on your facility.

Thank you for your consideration.

Sincerely,

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Chicago IL 60614-0000	\chi_{\chi_{\chi}} \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
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Via Certified Mail

Advocate Illinois Masonic Medical Center 836 West Wellington Chicago IL 60657-5193

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

Please advise me if you believe that the discontinuation of this service will have any impact on your facility.

Thank you for your consideration.

Sincerely,

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Via Certified Mail

Methodist Hospital of Chicago 5025 North Paulina Street Chicago IL 60640-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

Please advise me if you believe that the discontinuation of this service will have any impact on your facility.

Thank you for your consideration.

Sincerely,

COMPLETE THIS SECTION ON DELIVERY SENDER: COMPLETE THIS SECTION A. Signature Complete Items 1, 2, and 3. Also complete Item 4 if Restricted Delivery is desired. □ Agent ☐ Addressee Print your name and address on the reverse so that we can return the card to you. C. Date of Delivery B. Received by (Printed Name) Attach this card to the back of the mailplece, W 25 or on the front if space permits. ☐ Yes D. Is delivery address different from Item 1? 1. Article Addressed to: □ No If YES, enter delivery address below: Methodist Hospital of Chicago 5025 North Paulina Street Chicago IL 60640-0000 3. Service Type Certifled Mail ■ Express Mail Hetum Receipt for Merchandise ☐ Registered ☐ C.O.D. ☐ Insured Mail 4. Restricted Delivery? (Extra Fee) ☐ Yes 2. Article Number 7011 0470 0002 6023 9653 (Transfer from service label) 102595-02-M-1540 P\$ Form 3811, February 2004 Domestic Return Receipt

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PS Form

Via Certified Mail

Swedish Covenant Hospital 5145 North California Avenue Chicago IL 60625-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

Please advise me if you believe that the discontinuation of this service will have any impact on your facility.

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Sincerely,

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Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. Article Addressed to: Swedish Covenant Hospital 5145 North California Avenue	A. Signature X. Agent Addressee B. Received by (Printed Name) C. Date of Delivery NO(25) ((D. Is delivery address different from Item 1? Yes If YES, enter delivery address below:
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•	City, State	Chicago IL 606	525-0000 <u>]</u>				
	DC Court !						

Via Certified Mail

John H. Stroger Hospital of Cook County 1901 West Harrison Street - Suite 5650 Chicago IL 60612-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

Please advise me if you believe that the discontinuation of this service will have any impact on your facility.

Thank you for your consideration.

Sincerely,

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PS Form 3811, February 2004

Domestic Return Receipt

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Via Certified Mail

Rush University Medical Center 1653 West Congress Parkway Chicago IL 60612-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

Please advise me if you believe that the discontinuation of this service will have any impact on your facility.

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Sincerely,

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Rush University Medical Center

1653 West Congress Parkway Chicago IL 60612-0000

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City,

Via Certified Mail

University of Illinois Hospital 1740 West Taylor Avenue Chicago IL 60612-0000

Dear Sir or Madam,

Re: Norwegian American Hospital/Discontinuation of five (5) bed pediatric in patient category of service

Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

Please advise me if you believe that the discontinuation of this service will have any impact on your facility.

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Discontinuation Impact on Access

Norwegian American Hospital received the following responses to its request for impact letter (see attached). No entity has indicated to date that it will be negatively impacted by Norwegian American Hospital's discontinuation of its pediatric category of service. Any letters received in the future will be immediately forwarded to the HFSRB.



MERCY HOSPITAL & MEDICAL CENTER 2525 SOUTH MICHIGAN AVENUE CHICAGO, ILLINOIS 60616-2477 phone 312.567.2000

October 26, 2011

Jose R. Sanchez President & Chief Executive Officer Norwegian American Hospital 1044 N. Francisco Avenue Chicago, IL 60622

Dear Mr. Sancez:

Thank you for informing us of your plans to discontinue five (5) pediatric beds within (approximately) six months.

We do not anticipate this will have any impact on our facility.

Sincerely,

Sister Sheila Lyne, RSM

President and Chief Executive Officer

SSL/ss

Executive Offices

October 26, 2011

Mr. Jose R. Sanchez Norwegian American Hospital 1044 N. Francisco Avenue Chicago, IL 60622

Dear Mr. Sanchez:

In response to your letter, the discontinuation of five (5) pediatric beds at Norwegian American Hospital would have no impact on Palos Community Hospital.

Sincerely,

Timothy J. Brosnan

Vice President, Planning & Community Relations

TJB:gmk

Children's Memorial Hospital

2300 Children's Plaza, Chicago, Illinois 60614-3363 773.880.4000 www.childrensmemorial.org



Children's Memorial Foundation

Children's Memorial Medical Group

Children's Memorial Research Center

Pediatric Faculty Foundation



Faculty of Northwestern University's Feinberg School of Medicine

November 10, 2011

Mr. Jose R. Sanchez President and CEO Norwegian American Hospital 1044 N. Francisco Avenue Chicago, IL 60622

Dear Mr. Sanchez:

I am in receipt of your letter of October 21st regarding your proposed discontinuation of five pediatric beds, with approval by the Illinois Health Facilities and Services Review Board pending. We do not believe this change will adversely impact services provided by Children's Memorial Hospital.

Please let me know if I can be of further assistance on this matter.

Sincerely,

Patrick M. Magoon President and CEO



1225 LAKE STREET MELROSE PARK, IL 60160 (708) 938-7201

WILLIAM A. BROWN, FACHE Chief Executive Officer

October 28, 2011

Jose R. Sanchez President & CEO Norwegian American Hospital 1044 N. Francisco Avenue Chicago, IL 60622

Dear Mr. Sanchez:

I am writing in response to your October 21, 2011 letter regarding Norwegian American Hospital's discontinuation of its five (5) pediatric beds.

Westlake Hospital does not expect any adverse impact as a result of this proposed project.

Please contact me if you have any questions.

Sincerely,

William A. Brown, FACHE

William A. Brown

Chief Executive Officer

WAB/III



MC 8000 5721 South Maryland Avenue Room K-160 Chicago, Illinois 60637 phone (773) 702-6239 fax (773) 702-4753 www.uchicagokidshospital.org

November 7, 2011

Mr. Jose R. Sanchez President & CEO Norwegian American Hospital 1044 N. Francisco Avenile Chicago, IL 60622

Dear Mr. Sanchez:

Norwegian American Hospital's discontinuation of your five bed pediatric in-patient service will have no impact on Comer Children's Hospital

Sincerely.

Jeffrey A. Finesilver

Vice President, University of Chicago Medical Center

Director, Comer Children's Hospital

JF/pjp

Safety Net Impact Statement

Given the reasons stated for discontinuation, Norwegian American Hospital does not believe the discontinuation of its 5 bed pediatric unit will negatively impact safety net services in the area. While the population served is one which requires safety net services, Children's and other area providers are equipped to provide the service and the number of patients is minimal enough it should not strain their resources.

See attached chart

Safety Net Inform	ation per PA 9	6-0031					
CHARITY CARE							
Charity (# of patients)	Year 2008	Year 2009	Year 2010				
Inpatient	47	63	354				
. Outpatient	125	161	5,917				
Total	172	224	6,271				
Charity (cost in dollars)							
Inpatient	1,047,902	1,568,559	2,077,991				
Outpatient	1,679,958	2,289,347	2,737,676				
Total	3,087,860	3,857,906	4,745,667				
MEC	ICAID						
Medicald (# of patients)	Year 2008	Year 2009	Year 2010				
Inpatient	5,964	5,718	5,478				
Outpatient	36,366	40,182	35,456				
Total	42,330	45,900	40,934				
Medicaid (revenue)							
Inpatient	41,045,177	51,808,950	49,217,906				
Outpatient	5,647,732	6,762,765	6,801,444				
Total	46,692,909	58,571,715	56,019,350				

I, Jose R. Sanchez, certify the above information is true and accurate.

Jose R. Sanchez

Chief Executive Officer

Norwegian American Hospital, Inc.

Notary Public

My commission expires:_

CHARITY CARE											
	Year 2008	Year 2009	Year 2010								
Net Patient Revenue	94,478	95,254	91,550								
Amount of Charity Care (charges)	8,339,792	10,604,171	13,507,293								
Cost of Charity Care	3,087,860	3,857,906	4,745,667								
Percent of Charity Care as Percent of Net Revenue	3%	3.3%	4.4%								

I, Jose R. Sanchez, certify the above information is true and accurate.

Jose R. Sanchez

Chief Executive Officer Norwegian American Hospital, Inc.

Subscribe to before me this <u>29'</u> of <u>November</u>, 2011

Notary Public

My commission expires:_

#10694312_v1

HOSPITAL PROFILE -	Calenda	r year 200	8 Norw	egian A	merican H	lospital			Chl	cago		Page 1
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			<u>Faci</u> Peak Beds	ity Utiliza	ation Data by			Average		CON Occup		
co	thorized N Boda	Authorized CON Beds	Setup and	Peak			Observation	Length	Daily Census	as of 12/31/2008	as of 4/22/2009	Occupant Rate %
Clinical Sorvice	22/2009	12/31/2008	Staffed	Census	Admissions	Days 25,210	Days 1,710	of Stay 4.1	73.8	75.3	75.3	78.5
ledical/Surgical	98	98	94	94	6,503 0	25,210	1,710	41	1 3.0	10.0	10.0	, 0.0
0-14 Years					2,578	7,377						
15-44 Years					2,537	10,401						
45-64 Years					2,557 701	3,535						
65-74 Years						3,897						
75 Years +					687	974	338	2.6	3.6	71.9	71,9	71.9
ediatric	5	5	5	5	506						72.3	72.3
ntensive Care	12	12	12	12	514	3,147	18	6.2	8.7	72.3	12.0	12.3
Direct Admission					241	1,956						
Transfers					273	1,191	g consequence					
Obstetric/Gynocology	48	48	35	35	1,948	4,569	297	2.5	13.3	27.8	27.8	38.1
Matemily					1,873	4,335						
Clean Gynecology					<i>7</i> 5	234						
•	0	0	0	0	0	0_	0	0.0	0.0	0.0	Q. <u>0</u>	0.0
Veonatal			0	0	0	0	0	0.0	0.0	0.0	0.0	0.0
Long Term Care	0	0	U	·	0	0		0.0	0.0			
Swing Beds				0.7	_	9,765	0	7.0	26.8	72.3	72.3	72.3
Acute Mental Illness	37	37	37	37	1,401				0.0	0.0	0.0	0.0
Rehabilitation	0	0	0	0	0	00	00	0.0	0.0	0.0	. 0.0	
Long-Torm Acute Care	0					·, ·	*****	ger -washington Hills				
Dadcated Observation	,						0			63.1		
Facility Utilization	200	200	_		10,599	43,665	2,363	4.3	126.1	03.1		
			(Inc	udes ICU	Direct Admis	sions Only)	41 0	6				
					nts and Out			Or SOUIC	vate Pay	Charity (Care	Totals
	Medi	care	Medicald	0	ther Public	Private	nsurance		5.7%		0.4%	
	2	24.7%	56.3%	,	0.0%		12.9%				47	10,599
Inpatients		2621	5964		. 0		1368		599			,.
	11	1.2%	49.9%		0.0%		30.2%		8.6%		.2% 125	72,922
		8137	36366		0		22040		6254			tel Cherity
Outpationts						attent Net	Pavanua hv	Payor Se		Charl	ty Co	re Expens
		2007 10	9/30/2008	Inpati	ent and Outp	191101111111	VOADIIDA DA			s Care		,087,860
Outpationts Financial Year Reported	10/1/2		-	<u>inpati</u> ther Publ		insurance	Private P	ву	Tota	C		-
Financial Year Reported	: 10/1/2 Medica	are Me	dicald O	ther Publ	lic Private		Private Pa	ay	100.0		: Tota	is: Charity
Financial Year Reported	10/1/2 Medica 33.0	are Me	dicald O 69.1%	-	lic Private i %	insurance 3.2%	Private P	ay '%		% ·	7,902 Tota	re as % of
Financial Year Reported	. 10/1/2 Medica 33.0 22,959,24	are Me 0% 44 41,04	dicaid 0 69.1% 5,177	ther Publ 0.0	lic Private	3.2% 2,243,567	Private Pa 4.7 3,244.9	ay '% 41	100.0 69,492,92	% 9 1,407	7,902 Tota	re as % of
Financial Year Reported Inpatient Revenue (\$) Outpatient	: 10/1/2 Medica 33.0 22,959,24	ere Me 0% 44 41,04	dicald O 69.1% 15,177 16.9%	0.0 0.0	lic Private	3.2% 2,243,567 56.9%	97/vate Pi 4.7 3,244.9	8 <i>y</i> 7% 41 5%	100.0 69,492,92 100.0	% 1,407 %	7,902 Ca	als: Charity re as % of t Revenue 3.0%
Financial Year Reported Inpatient Revenue (\$) Outpatient	. 10/1/2 Medica 33.0 22,959,24	ere Me 0% 44 41,04	dicaid 0 69.1% 5,177	0.0 0.0	lic Private	3.2% 2,243,567	Private Pa 4.7 3,244.9	8 <i>y</i> 7% 41 5%	100.0 69,492,92	% 1,407 %	7,902 Ca	re as % of t Revenue
Financial Year Reported Inpatient Revenue (\$) Outpatient Revenue (\$)	: 10/1/2 Medica 33.0 22,959,24 14.6 4,894,27	ore Me 1% 44 41,04 6% 77 5,64	dicald O 69.1% 15,177 16.9%	0.0 0.0	% 0 19 Newt	3.2% 2,243,567 56.9% 9,018,204	97/vate Pi 4.7 3,244.9	9y 7% 41 5% 76 :	100.0 69,492,92 100.0	% 9 1,407 % 9 1,679,	7,902 Ca	re as % of t Revenue 3.0%
Financial Year Reported Inpatient Revenue (\$) Outpatient Revenue (\$)	: 10/1/2 Medica 33.0 22,959,24	ore Me 1% 44 41,04 6% 77 5,64	dicald O 69.1% 15,177 16.9%	ther Publ 0.0 0.0	## Private	3.2% 2,243,567 56.9% 9,018,204 porn Nurse ent Days	Private Pr 4.7 3,244.9 11.6 3,871,97	7% 41 5% 6 :	100.0 69,492,92 100.0 33,432,18	% 9 1,407 % 9 1,679,	7,902 Ca Ne 958	re as % of t Revenue 3.0% tion
Financial Year Reported Inpatient Revenue (\$) Outpatient Revenue (\$) Bit Number of Deliveries:	: 10/1/2 Medica 33.0 22,959,24 14.6 4,894,27	ore Me 1% 44 41,04 6% 77 5,64	dicald 0 69.1% 15,177 16.9% 7,732	0.0 0.0	Newter 1 Patie	3.2% 2,243,567 56.9% 9,018,204 Dorn Nurse ent Days ent Days	Private Pr 4.7 3,244.9 11.6 3,871,97	9y 41 41 6 6 1 56 186	100.0 69,492,92 100.0 33,432,18	% 1,407 9 1,679 Organ	7,902 Ca Ne 958	re as % of t Revenue 3.0% tion 0
Financial Year Reported Inpatient Revenue (\$) Outpatient Revenue (\$)	: 10/1/2 Medica 33.0 22,959,24 14.6 4,894,27	ore Me 1% 44 41,04 6% 77 5,64	dicaid O 69.1% 5,177 16.9% 7,732 1,649 1,643	0.0 0.0	## Private	3.2% 2,243,567 56.9% 9,018,204 Dorn Nurse ent Days ent Days	Private Pr 4.7 3,244.9 11.6 3,871,97	9y 7% 41 3% 76 : 1 56 186 1.372	100.0 69,492,92 100.0 33,432,18	% 9 1,407 % 9 1,679, Organ 1 Kidney: Heart: Lung:	958 Transplants	3.0% .tion 0 0
Financial Year Reported Inpatient Revenue (\$) Outpatient Revenue (\$) Bit Number of Deliveries: Number of Live Births:	: 10/1/2 Medica 33.0 22,959,24 14.6 4,894,27	ore Me 1% 44 41,04 6% 77 5,64	dicaid O 69.1% 5,177 16.9% 7,732 1,649 1,643	0.0 0.0	Newter 1 Patie	3.2% 2,243,567 56.9% 9,018,204 Doorn Nurse ant Days lent Days	971/2016 Private Priva	9y 41 41 6 6 1 56 186	100.0 68,492,92 100.0 33,432,18	% 9 1,407 % 9 1,679, Organ 1 Kidney: Heart: Lung: Heart/Lung:	958 Transplants	tion 0 0 0 0
Inpatient Revenue (\$) Outpatient Revenue (\$) Bit Number of Deliveries: Number of Live Births: Birthing Rooms: Labor Rooms: Delivery Rooms:	: 10/1/2 Medica 33.0 22,959,24 14.6 4,894,27	nre Me 1% 44 41,04 5% 17 5,64	dicaid O 69.1% 15,177 16.9% 7,732 1,649 1,643	0.0 0.0	Newt Level 1 Patic Level 2 Patic Total Nursen	3.2% 2,243,567 56.9% 9,018,204 corn Nurse ent Days ent Days lent Days y Petientday	97/vate Private 9y 7% 41 3% 76 : 1 56 186 1.372	100.0 68,492,97 100.0 33,432,18	9 1,407 9 1,679, Organ 1 Kidney: Heart: Lung: Heart/Lung: Pancreas:	958 Transplants	tion 0 0 0 0 0 0 0	
Inpatient Revenue (\$) Outpatient Revenue (\$) Number of Deliveries: Number of Live Births: Birthing Rooms: Labor Rooms: Delivery Rooms: Lebor-Delivery-Recove	10/1/2 Medica 33.0 22,959,24 14.6 4,894,27 thing Date	ere Me 1% 44 41,04 5% 17 5,64	dicaid O 69.1% 15,177 16.9% 7,732 1,649 1,643	0.0 0.0	Newthere 1 Patie Level 1 Patie Level 2 Patie Level 2+ Pati Total Nursen	3.2% 2,243,567 56.9% 9,018,204 Dorn Nurse ent Days ent Days y Petientday aboratory:	97/vate Private 9y 7% 41 3% 76 : 1 56 186 1.372	100.0 68,492,92 100.0 33,432,18	% 9 1,407 % 9 1,679, Organ 1 Kidney: Heart: Lung: Heart/Lung:	958 Transplants	### 100 mg	
Inpatient Revenue (\$) Outpatient Revenue (\$) Number of Deliveries: Number of Live Births: Birthing Rooms: Labor Rooms: Delivery Rooms:	10/1/2 Medica 33.0 22,959,24 14.6 4,894,27 thing Date	ere Me 1% 44 41,04 5% 17 5,64	dicaid O 69.1% 15,177 16.9% 7,732 1,649 1,643	0.0 0.0 0.0	Newt Level 1 Patic Level 2 Patic Total Nursen	3.2% 2,243,567 56.9% 9,018,204 corn Nurse ent Days ent Days lent Days y Petientday aboratory s	97/vate Private 9y 7% 441 37% 16 186 1.372 1,614	100.0 68,492,92 100.0 33,432,18	9 1,407 9 1,679, Organ 1 Kidney: Heart: Lung: Heart/Lung: Pancreas:	958 Transplants	1 Revenue 3.0% tion 0 0 0 0 0	

Chicago

Operating R utpatient C 0 0 0 0 0 0 0 0		Total 0 0 5 0 0 0 0 0 0 0 0 0 0	Surgica Inpatient 92 0 526 0 0 217 0	1 Cases Outpatient 22 0 661 0 564 0	Inpatient 296 0 695 0 0 227 0 3	<u>urgical Hour</u> Outpatient 55 0 611 0 0 549 0 220	Total Hours 351 0 1306 0 0 776	3.2 0.0 1.3 0.0 0.0 1.0	Outpatier 2.5 0.0 0.9 0.0 0.0 1.0
		Total 0 0 5 0 0 0 0 0 0 0 0 0 0	92 0 526 0	22 0 661 0 0 564	296 0 695 0 0 227	55 0 611 0 0 549	351 0 1306 0 0 776	3.2 0.0 1.3 0.0 0.0 1.0	2.5 0.0 0.9 0.0 0.0 1.0
0 0 0 0 0 0 0	0 0 5 0 0 0	0 0 5 0 0 0	0 526 0 0	0 661 0 0 564	0 695 0 0 227	0 611 0 0 549	0 1306 0 0 776 0	0.0 1.3 0.0 0.0 1.0 0.0	0.0 0.9 0.0 0.0 1.0
0 0 0 0 0 0 0	0 5 0 0 0	0 5 0 0 0	0 0	0 0 564 0	695 0 0 227	611 0 0 549 · 0	1306 0 0 776 0	1.3 0.0 0.0 1.0 0.0	0.9 0.0 0.0 1.0 0.0
0 0 0 0 0	5 0 0 0	5 0 0 0 0	0 0	0 0 564 0	0 0 227	0 0 549 · 0	0 0 776 0	0.0 0.0 1.0 0.0	0.0 0.0 1.0 0.0
. 0	0 0 0 0	0 0 0 0	0 0 217 0 2	0	0 227	0 549 · 0	0 776 0	0.0 1.0 0.0	0.0 1.0 0.0
. 0	0 0 0	0 0 0	0 217 0 2	0		549 · 0	0	1.0 0.0	1.0 0.0
0 0 0	0	0 0 0	217 0 2	0		. 0	0	0.0	0.0
0 0	0	0 0	0 2	•	0	•	•		
0	0	ō	2	260	3	220	722		
0	-	_				220	223	1.5	8.0
•	0	0	63	110	111	135	246	1.8	1.2
Λ	n	Ô	0	0	0	0	0	0.0	0.0
n	0	ō	0	0	. 0	0	0	0.0	0.0
n	0	ō	32	180	51	257	308	1.6	1.4
0	0	ō	0	0	0	0	0	0.0	0.0
0	0	0	44	177	46	107	153	1.0	0.6
0	5	5	976	1974	1429	1934	3363	1.5	1.0
ONS	Stag	e 1 Recov	ery Stations	8	Sta	ige 2 Recove	ery Stations	0	
		0 5	0 5 5 ONS Stage 1 Recov	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 32 180 0 0 0 0 0 0 0 0 44 177 0 5 5 976 1974 ONS Stage 1 Recovery Stations 8	0 0 0 32 180 51 0 0 0 0 0 0 0 0 0 0 44 177 46 0 5 5 976 1974 1429 DNS Stage 1 Recovery Stations 8 Sta	0 0 0 32 180 51 257 0 0 0 0 0 0 0 0 0 0 0 0 44 177 46 107 0 5 5 976 1974 1429 1934 ONS Stage 1 Recovery Stations 8 Stage 2 Recover	0 0 0 32 180 51 257 308 0 0 0 0 0 0 0 0 0 0 0 0 0 44 177 46 107 153 0 5 5 976 1974 1429 1934 3363 DNS Stage 1 Recovery Stations 8 Stage 2 Recovery Stations	0 0 0 32 180 51 257 308 1.6 0 0 0 0 0 0 0 0 0 0 0 0.0 0 0 0 44 177 46 107 153 1.0 0 5 5 976 1974 1429 1934 3363 1.5

			Dedic	ated an	d Non-Dedi	cated Proced	lure Room	Utilization			_
		Procedure				al Cases		Surgical Hou	<u>rs</u>	Hours	per Case
Procedure Type	Inpatient		Combined	Total	Inpatient	Outpatient	!npatient	Outpatient		Inpatient	Outpatient
Gastrointestinal	0	0	0	0	0	0	0	0	0	0.0	0.0
Laser Eye Procedures	n	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	0	0	0	0	0	0	0	0.0	0.0
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0
σγαισστοργ	Multip	оптрово Мо	n-Dedicate	d Room	<u>15</u>			_			0.0
	0	0	0	0	0	0	0	0	0	0.0	
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

			Cardiac Catheterization Utilization	
Cardlac Catheters Total Cath Labs (Dedicated+Nond Cath Labs used for Angiograph) Dedicated Diagnostic Catheteria Dedicated Interventional Cathet Dedicated EP Catheterization Li	edicated labs): / procedures :ation Labs erization Labs abs	1 0 1 0	Total Cardiac Cath Procedures: Diagnostic Catheterizations (0-14) Diagnostic Catheterizations (15+) Interventional Catheterizations (0-14): Interventional Catheterization (15+) EP Catheterizations (15+)	164 0 148 0 16 0
Emergency/Traum Certified Trauma Center by EMS Level of Trauma Service Operating Rooms Dedicated for T Number of Trauma Visits: Patients Admitted from Trauma	Level 1 (Not Answered (No	Level 2 ot Answered) 0 0	Cardiac Surgery Data Total Cardiac Surgery Cases: Pedlatric (0 - 14 Years): Adult (15 Years and Older): Coronary Artery Bypass Grafts (CABGs) performed of total Cerdiac Cases:	0 0 0
Emergency Service Type: Number of Emergency Room Stat Persons Treated by Emergency S Patients Admitted from Emergency Total ED Visits (Emergency+Trau	tions ervices: y;	ehensive 12 29,684 5,130 29,684	Outpatient Service Data Total Outpatient Visits Outpatient Visits at the Hospital/ Campus: Outpatient Visits Offsite/off campus	72,922 72,922 0

Diagnostic/Interventional Equipment			<u>Ex</u>	aminations					Therapies/
Diagnostic/interventional Eddibiners	Owned	Contract	Inpatient	Outpatient	Contract	Radiation Equipment	Owned	Contract	
General Radiography/Fluoroscopy	3	0	5,636	18,090	0				
Nuclear Medicine	1	0	502	355	0	Lithotripsy	0	0	-{
Mammogrephy	1	0	16	2,028	0	Rediation Therapy Equipm	nent		
Ultrasound	3	0	2,537	9,560	0	Linear Accelerator	0	0	0
Diagnostic Angiography	0	0	0	Õ	0	Proton Beam Therapy	n	0	0
Interventional Angiography	0	0		0	0	Gamma Knife	0	Ô	đ
Positron Emission Tomography (PET)	0	0	0	6.043	0	Cyber knife		0	C
Computerized Axial Tomography (CAT)	1	0	1,532	6,813	603	Cyber kinie	0	v	v
Magnetic Resonance Imaging	0	1	0	U	603	<u> </u>			

Source: 2008 Annual Hospital Questionnaire, illinois Department of Public Health, Health Systems Development.

Y 2009	Nor	wegian	American	Hospita	ı l		Chi		Page 1
gement and Gon						Race	"	Patients by Et	
				Wh	ite		10.4%	Hispanic or Latino	
•				Bla	ck		44.9%	Not Hispanic or La	
				Am	erican Indlan		0.0%	Unknown:	0.5%
•				Asi	an		0.8%	IDPH Numbe	r: 1727
		elow)		Hav	vaiian/ Pacific	3			A-02
None	,,,	•		Uni	(nown:		43.9%		5
 General Hosi 	pital				501115	e. Culso	rhan Cool		v
1044 North F						r: 3000	Dail Cool	((Officago)	
	Faci	lity Utiliz	ation Data by	Category	of Service			CON	Staff Bed
Authorized CON Bods	Peak Bods Setup and	Peak Cansus	Admissions	Inpatient Days	Observation Days	Length of Stay	Dally Consus	Occupancy 12/31/2009	Occupancy Rate %
		91	5,876	21,565	2,450	4.1	65.8	67.1	72.3
30	01		1	2					
			2,121	6,257					
			2,550	9,305					
			645	2,983					
				3,018					
		E		549	334	3.4	2.4	48.4	48.4
	5					•		88.8	86.6
12	12	12			20	¥.c	6.0	00.0	20,0
			279	1,088					
48	15	15	1,807	4,126	148	2.4	11.7	24.4	78.1
			1,757	3,728					
			50	398					
•	^	0	0	0	0	0.0	0.0	0.0	0.0
U				0	0	0.0	0.0	0.0	0.0
0	0	0		=	Ū	=	=		
			0	0			_		82.5
37	36	36	1,556	10,836	0	7.0	29.7	80.2	
0	٥	0	n	0	0	0.0	0.0	0.0	0.0
					0	0.0			0.0
U	U								The second secon
				55.005		4.4	117 6	58.8	
200						4,4	117.0		
	(Incl	udes ICL	Direct Admis	sions Only)	- cod by Day	or Source			
						Dri	vata Pav	Charity Care	Totals
Medicare	Medicald	0		Privato		,	•		
26.2%	58.9%	•	0.0%		10.3%				9,711
2541	5718		0		998				3,711
46 -61	B4 wat						7.4%		77 714
10.5%	51.7%		0.0%		30.2%				
10.5% 8156			0.0% 0		30.2% 23 <u>470</u>		5772	161	77,741
8156	40182	Inpat	0	atient Net	23470	Payor S	5772	1	Total Charity
8156 10/1/2008 to	40182 9/30/2009		0 ient and Outp		23470		5772	Charity	Total Charity Care Expens
8156 10/1/2008 to Medicare	40182 9/30/2009 Medicald Of	ther Pub.	0 ient and Outp lic Private	nsurance	23470 Revenue by Private Pa	ay .	5772 ource Tota	Charity is Care	Total Charity Care Expens 3,857,906
8156 10/1/2008 to	40182 9/30/2009		0 ient and Outp lic Private	nsurance 5.2%	23470 Revenue by Private Po 3.0	∌ <i>y</i> }%	5772 ource Tota 100.0	Charity is Care % Expense	Total Charity Care Expens 3,857,906 Totals: Charity
8156 10/1/2008 to Medicare 31.2%	40182 9/30/2009 Medicald Of	ther Pub.	0 ient and Outp lic Private	nsurance	23470 Revenue by Private Pa	∌ <i>y</i> }%	5772 ource Tota 100.0 85,610,13	Charity is Care % Expense 39 1,568,559	Total Charity Care Expens 3,857,906 Totals: Charity Care as % of
8156 10/1/2008 to Medicare 31.2% 26,744,207 51	9/30/2009 Medicald Of 60.5%	ther Pub.	0 ient and Outp lic Private i % 0	nsurance 5.2%	23470 Revenue by Private Po 3.0 2.593,1 12.3	ay 1% 12 1%	5772 ource Tota 100.0	Charity is Care % Expense 39 1,568,559	Total Charity Care Expens 3,857,906 Totals: Charity Care as % of Net Revenue
8156 10/1/2008 to Medicare 31.2% 26,744,207 51 18.1%	40182 9/30/2009 Medicald Of 60.5% 0.808,950 22.0%	ther Pub. 0.0 0.0	0 ient and Outc lic Private i % 0	5.2% 4,463,870	23470 Revenue by Private Po 3.0 2,593,1	ay 1% 12 1%	5772 ource Tota 100.0 85,610,13	Charity ds Care % Expense 39 1,568,559	Total Charity Care Expens 3,857,906 Totals: Charity
8156 10/1/2008 to Medicare 31.2% 26,744,207 51 19.1%	9/30/2009 Medicald Of 60.5%	ther Pub. 0.0 0.0	0 iont and Outp iic Private i % 0 14	5.2% 4,463,870 48.6% 1,304,392	23470 Revenue by Private Po 3.0 2,593,1 12.3 3,784,70	9% 112 3% 66	5772 ource Tota 100.0 85,610,13	Charity Is Care % Expense 39 1,568,559 1% 5 2,289,347	Total Charity Care Expens 3,857,906 Totals: Charity Care as % of Net Revenue 3.3%
8156 10/1/2008 to Medicare 31.2% 26,744,207 51 18.1%	40182 9/30/2009 Medicald Of 60.5% 0.808,950 22.0%	ther Pub. 0.0 0.0	0 ient and Outp lic Private i % 0 14 Newt	5.2% 5.2% 4,463,870 48.6% 1,304,392 orn Nurse	23470 Revenue by Private Po 3.0 2.593,1 12.3	ay 19% 112 13% 16 :	5772 ource Tota 100.0 85,610,13	Charity ds Care % Expense 39 1,568,559	Total Charity Care Expens 3,857,906 Totals: Charity Care as % of Net Revenue 3.3%
8156 10/1/2008 to Medicare 31.2% 26,744,207 51 19.1% 5,870,022 6,	40182 9/30/2009 Medicatd O: 60.5% 1.808,950 22.0% ,752,725	0.0 0.0	0 ient and Outc lic Private i % 0 14 Newt	5.2% 4,463,870 48.6% 3,304,392 orn Nurse	23470 Revenue by Private Po 3.0 2,593,1 12.3 3,784,70	ay 19% 112 13% 16 :	5772 ource Tota 100.0 85,610,13	Charity Is Care % Expense 39 1,568,559 1% 5 2,289,347	Total Charity Care Expens 3,857,906 Totals: Charity Care as % of Net Revenue 3.3%
8156 10/1/2008 to Medicare 31.2% 26,744,207 51 19.1% 5,870,022 6,	40182 9/30/2009 Medicatd O: 60.5% 1.808,950 22.0% ,752,725	0.0 0.0	0 ient and Outc lic Private i % 0 14 Newt Level 1 Patic	5.2% 4,463,870 46.6% 3,304,392 orn Nurse ant Days ent Days	23470 Revenue by Private Po 3.0 2,593,1 12.3 3,784,70	12 13% 06 240 276	5772 DUFC8 Total 100.0 85,610.13 100.0 30,721,84	Charity ds Care Expense 1,568,559 C 2,289,347 Crgan Transp	Total Charity Care Expens 3,857,906 Totals: Charity Care as % of Net Revenue 3.3%
8156 10/1/2008 to Medicare 31.2% 26,744,207 51 19.1% 5,870,022 6,	40182 9/30/2009 Medicald Of 60.5% 1,808,950 22.0% ,752,725 1,789 1,775	0.0 0.0	0 iont and Outp iic Private i % 0 1% 0 14 Newt Level 1 Patic Level 2 Patic	5.2% 4,463,870 48.6% 3,304,392 norn Nurse ant Days ent Days ent Days	23470 Revenue by Private Po 3.0 2,593,1 12.3 3,784,70 ry Utilization	9% 112 13% 166 240 276 629	5772 Durce Tota 100.0 85,610,13 100.0 30,721,84	Charity ds Care Expense 39 1,568,559 % 5 2,289,347 Organ Transe Kidney: Heart: Lung:	Total Charity Care Expens 3,857,906 Totals: Charit Care as % of Net Revenue 3.3%
8156 10/1/2008 to Medicare 31.2% 26,744,207 51 19.1% 5,870,022 6,	40182 9/30/2009 Medicald O: 60.5% 1,808,950 22.0% ,752,725 1,789 1,775 0	0.0 0.0	0 ient and Outc lic Private i % 0 14 Newt Level 1 Patic	5.2% 4,463,870 48.6% 3,304,392 norn Nurse ant Days ent Days ent Days	23470 Revenue by Private Po 3.0 2,593,1 12.3 3,784,70 ry Utilization	12 13% 06 240 276	5772 Durce Tota 100.0 85,610,13 100.0 30,721,84	Charity ds Care Expense 39 1,568,559 % 5 2,289,347 Organ Transe Kidney: Heart: Lung: Heart/Lung:	Total Charity Care Expens 3,857,906 Totals: Charity Care as % of Net Revenue 3.3%
8156 10/1/2008 to Medicare 31.2% 26,744,207 51 19.1% 5,870,022 6,	40182 9/30/2009 Medicald O: 60.5% 1,808,950 22.0% ,752,725 1,789 1,775 0	0.0	0 ient and Outr lic Private i % 0 Newt Level 1 Patic Level 2 Patic Level 2+ Pati	5.2% 4,463,870 48.6% 3,304,392 Forn Nurse ant Days ent Days ent Days y Patientda	23470 Revenue by Private P. 3.0 2.593,1 12.3 3,784,70 ry Utilization	9% 112 13% 166 240 276 629	5772 Durce Tota 100.0 85,610,13 100.0 30,721,84	Charity ds Care Expense 39 1,568,559 % 5 2,289,347 Organ Transe Kidney: Heart: Lung: Heart/Lung: Pancreas:	Total Charity Care Expens 3,857,906 Totals: Charity Care as % of Net Revenue 3.3%
8156 10/1/2008 to Medicare 31.2% 26,744,207 51 19.1% 5,870,022 6,	40182 9/30/2009 Medicald O: 60.5% 1,808,950 22.0% ,752,725 1,789 1,775 0 0 0 6	0.0	0 ient and Outr lic Private i % 0 Newt Level 1 Patic Level 2 Patic Level 2+ Pati	5.2% 4,463,870 48.6% 1,304,392 Forn Nurse ant Days ent Days ent Days / Patientda	23470 Revenue by Private P. 3.0 2.593,1 12.3 3,784,70 ry Utilization	9% 112 13% 166 240 276 629	5772 Durce Total 100.0 85,610,13 100.0 30,721,84	Charity ds Care Expense 39 1,568,559 % 5 2,289,347 Organ Transe Kidney: Heart: Lung: Heart/Lung:	Total Charity Care Expens 3,857,906 Totals: Charity Care as % of Net Revenue 3.3% clantation 0 0 0 0 0
8156 10/1/2008 to Medicare 31.2% 26,744,207 51 19.1% 5,870,022 6,	40182 9/30/2009 Medicald O: 60.5% 1,808,950 22.0% ,752,725 1,789 1,775 0 0 0 6	0.0 0.0 0.0	0 ient and Outr lic Private i % 0 Newt Level 1 Patic Level 2 Patic Level 2+ Pati	4,463,870 48.6% 4,304,392 orn Nurse ont Days ent Days ent Days Patientda aboratory	23470 Revenue by Private P. 3.0 2.593,1 12.3 3,784,70 ry Utilization	240 276 629 1,145	5772 Durce Total 100.0 85,610,13 100.0 30,721,84	Charity ds Care Expense 39 1,568,559 % 5 2,289,347 Organ Transe Kidney: Heart: Lung: Heart/Lung: Pancreas:	Total Charity Care Expens 3,857,906 Totals: Charity Care as % of Net Revenue 3.3% clantation 0 0 0 0
: :	### Myrna E. Pet #### 773-292-8204 Norwegian Al Norwegian Al Other Not Fo None #### General Hos 1044 North F Authorized CON Bods 12/31/2009 98 5 12 48 0 0 0 200 Medicare 26.2% 2541	Agement and Goneral Information Myrna E. Pedersen 773-292-8204 Norwegian American Hospital Norwegian American Hospital Other Not For Profit (specify b None General Hospital 1044 North Francisco Avenue Fact Authorized CON Bods Setup and 12/31/2009 Staffed 98 91 5 5 12 12 48 15 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Agement and Goneral Information Myrna E. Pedersen 773-292-8204 Norwegian American Hospital Norwegian American Hospital Other Not For Profit (specify below) None General Hospital 1044 North Francisco Avenue CI Facility Utiliz Authorized Peak Bods CON Bods Setup and Peak 12/31/2009 Staffed Census 98 91 91 5 5 5 6 12 12 12 48 15 15 0 0 0 0 0 0 0 37 36 36 0 0 0 0 0 0 200 (Includes ICL Inpatic Medicare Medicaid 26.2% 58.9%	### Authorized CON Bods Setup and 12/31/2009 Staffed Census Admissions 98 91 91 5,876 1 2,121 2,550 645 559 5 6 5 256 12 12 12 12 495 216 279 48 15 15 1,807 1,757 50 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	### Right and General Information ### Myrna E. Pedersen	Myrna E. Pedersen	Myrna E. Pedersen Myrna E. Pedersen Myrna E. Pedersen White Black	Tagement and General Information Patients by Race Patients Segment and Gone Information Patients by Race Patients Patients Band Outsaltents Served by Peyer Source Patients Patients Race Patients Band Outsaltents Served by Peyer Source Patients Patients Race Patients Patie	

				Sur	ns vieg	d Opera	ting Room L	<u>Itilization</u>				Cana
Surgical Specialty		Operation	ng Rooms				Cases	_	Surgical Hour			er Case
	Inpatient	Outpatier	nt Combined	Total	int	patient	Outpatient	Inpatient		Total Hours	Inpatient 2.5	Outpatien 3.0
Cardiovascular	0	0	0	Ō		115	10	292	30	322	0.0	0.0
Dermatology	0	0	0	0		0	0	0	0	0		0.9
General	0	0	5	5		501	853	645	739	1384	1.3	
Gastroenterology	0	0	0	0		0	0	0	0	0	0.0	0.0
Neurology	0	0	0	0		0	0	0	0	0	0.0	0.0
OB/Gynecology	0	0	0	0		498	606	565	545	1110	1.1	0.9
Oral/Maxillofacial	0	0	0	0		0	0	0	0	0	0.0	0.0
Ophthalmology	0	0	0	0		3	272	4	246	250	1.3	0.9
Orthopedic	0	0	0	0		75	87	120	117	237	1.6	1.3
Otolaryngology	Ō	ō	0	0		0	0	0	0	0	0.0	0.0
Plastic Surgery	0	0	0	0		0	0	0	0	0	0.0	0.0
Podiatry	0	0	0	0		65	289	94	396	490	1.4	1.4
Thoracic	0	0	0	0		D	0	0	0	0	0.0	0.0
Urology	0	0	0	0		55	135	58	93	151	1.1	0.7
Totals	0	0	5	5		1312	2252	1778	2166	3944	1.4	1.0
SURGICAL RECOV	/ERY STA	TIONS	Stag	e 1 Rec	overy St	ations	8	St	age 2 Recove	ery Stations	0	
			-	Dedica	eted and	Non-D	edicated Pro	cedure Roo	m Utilzation			
		F	Procedure Ro			Su	rgical Cases		Surgical He			рег Саве
Procedure Type	In		outpatient Co		Total	Inpatie		ent Inpatier	nt Outpatier	nt Total Hours	inpatient	Outpation
Gastrointestinal		0	0	2	2	43	0 68	ც 25	-	654	0.6	0.6
Laser Eye Procedui	res	0	0	0	0		0	0	0 0	0	0.0	0.0
Pain Management		0	0	0	0		0	0	0 0	0	0.0	0.0
Cystoscopy		0	0	0	0		0	0	0 0	0	0.0	0.0

<u>Multipurpose</u>	Non-Deal	cated Kooms			_	_	•	• •	0.0
0 0	0	0	0	0	0	U	0	0.0	
0 0	0	0	0	0	0	0	O	0.0	0.0
0 0	0	0	0	0	0	0	0	0.0	0.0
Cardiac Catheterization Lab	s			<u>(</u>	Cardiac Cati	neterization	<u>Utilization</u>		
Total Cath Labs (Dedicated+Nondedicated la		1	Т	otal Cardiac (Cath Procedu	ures:		327	7
Cath Labs used for Angiography procedure	.s.	Ò		Diagnos	tic Catheterl	zations (0-14)	()
Dedicated Diagnostic Catheterization Labs	-	0				zations (15+)		99	•
Dedicated Interventional Catheterization La	abs	Ō		Interven	tional Cathe	terizations (0	-14):	()
Dedicated EP Cathetonization Labs		0				terization (15		10	ו
Emergency/Trauma Care					eterizations		•	C)
Certified Trauma Center by EMS					0	. C.umanı Br			
Level of Trauma Service Level	1 Le	vel 2		Total Car	<u>Carolac</u> rdiac Surgen	: Surgery Da / Cases:	ifa	()
2576101 11221110 2011100		. · ·			liatric (0 - 14			()
Operating Rooms Dedicated for Trauma Car	e	0			ilt (15 Years			()
Number of Trauma Visits:		0				iss Grafts (C	ABGs)		
Patients Admitted from Traume		0		performe	d of total Ca	rdlac Cases	:	(כ
Emergency Service Type:	Compreh				Outpatien	t Service Da	rta		
Number of Emergency Room Stations		12	7	otal Outpatier			_	77,74	1
Persons Treated by Emergency Services:	3),219	1	Outpatient Vi	isits at the H	ospital/ Cam	pus:	77.74	1
Patients Admitted from Emergency:		5,631		Outpatient Vi			-		0
Total ED Visits (Emergency+Trauma):	3-	0,219							

Radiation Equipment Therapies/ **Examinations** Diagnostic/Interventional Equipment **Owned Contract Treatments** Owned Contract Inpatient Outpatient 0 0 0 Lithotripsy 18,460 5,856 0 General Radiography/Fluoroscopy 0 0 0 Linear Accelerator 318 545 0 Nuclear Medicine 0 Image Guided Rad Therapy 0 2.256 0 0 0 Mammography 0 Intensity Modulated Rad Therap D 2,313 10,091 0 5 0 Ultrasound 0 0 High Dose Brachytherapy 0 0 0 Diagnostic Anglography 0 0 0 0 0 Proton Beam Therapy Interventional Angiography 0 0 0 0 0 0 0 Gamma Knife Positron Emission Tomography (PET) 9,109 1,308 0 Computerized Axial Tomography (CAT) 0 0 0 Cyber knife 0 Magnetic Resonance Imaging

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

Multipurpose Non-Dedicated Rooms

Hospital Profile - C	∨ 2010	No	rwegian	American	Hospita	ıl		Chic	ago	Page 1
Ownership, Mana	noment and G					Patients by	Race		Patients by Et	
			-		Wh			9.9% F	lispanic or Latino);
ADMINISTRATOR NAME ADMINSTRATOR PHONI					Bla			47.0% N	lot Hispanic of La	
		IAN AMERICAN H	IATIGORI			erican Indian		0.1% L	Jnknown:	0.5%
OWNERSHIP:		IAN AMERICAN I			Asi			0.9% ~	IDDU Numbe	1727
OPERATOR:		For Profit (specify				walian/ Paciflo	2	0.0%	IDPH Numbe	A-02
MANAGEMENT: CERTIFICATION:	Office 140t i	FOI FIGHT (Spoon)	Deletty			Known:	-	42.1%	HPA HSA	6
FACILITY DESIGNATION	N:									6
ADDRESS	1044 North	Francisco Avenu	ie Cl	TY: Chicago		COUNT	r: Subur	ban Cook ((Спісадо)	
HOUNEGO		Fo	cility Utiliz	ation Data by	Category	of Service				
	Authorized		<u> </u>				Average	Average	CON Occupancy	Staff Bed Occupancy
	ÇON Beds	Setup and	Peak		inpatient Days	Observation Days	Length of Stay	Daily Census	12/31/2010	Rate %
Clinical Service	12/31/2010		Cenaus	Admissions	20,354	2,074	4.3	61.4	62.7	74.0
Aedical/Surgical	98	83	63	5,267 1	20,334	2,014	7.0	U 1,		
0-14 Years				1,794	5,290					
15-44 Years				•	9,103					
45-64 Years				2,403	2,831					
65-74 Years				553						
75 Years +		·· ·· · · · · · · · · · · · · · · · ·		516	3,129				37.5	37.5
Pediatric	5	5	5	183	440	245	3.7	1.8		
ntensive Care	12	12	12	470	2,263	<i>5</i> 0	4.9	6.3	52.8	52.8
Direct Admission		,-		213	1,376					
Transfers				257	887					
	40	••	29	1,778	4,021	134	2.3	11.4	23.7	39.3
Obstetric/Gynacology	48	29	28	1,656	3,761					
Maternity				122	260					
Clean Gynecology					0	0	0.0	0.0	0.0	0.0
Neonatal	0	0	0	0	U		0. 0			0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
*	•			0	0		0.0	0.0	כ	
Swing Beds	37	36	35	1,619	10.638	0	6.6	29.	1 78.8	80.9
Acute Mentai liiness	37	30		•		^	0,0	0.0	n 0.0	0.0
Rehabilitation	0	<u>D</u>	0	0	0_	0		0.0		0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	U.I		
Dedcated Observation	0					0				
Facility Utilization	200			9,050	37,714	2,503	4.4	110.	2 55.092	
racinty ounzation		(In	cludes ICL	i Direct Admis	ssions Only)				,
			Inpatie	ents and Dut	patients Se	ryed by Pay	or Source	2		T -4-4-
	Medicare	Medicaio	1 0	ther Public	Private	Insurance	Priv	rate Pay	Charity Care	Totals
	26.9%	60.5		0.0%		7.5%		1.2%	3.9%	
1		-	-	0		681		110	354	9,060
Inpetients	2437	547				29.4%		0.1%	8.5%	
	10.3%	51.6		0.0%		20151		93	5917	68,655
Outpatients	7038	3545	6	0			Dover Se			Total Charity
Financial Year Reported:	10/1/2009 to			ent and Out					Charity	Care Expense
Tank to the same t	Medicare	Medicald	Other Pub.	iic Private	Insurance	Private Pa	a <i>y</i>	Totals	Care Expense	4,745,667
4 444	32.2%	58.5%	0.0	%	7.2%	2.1	%	100.0%	, Expense	Totals: Charity
Inpatient Revenue (\$)		49,217,906	•		6,097,759	1,737,5	D5 6	4,114,332	2,007,991	Care as % of
Ketendo (t)	27,061,162			-) %	100.0%	<u>.</u>	Net Revenue
Outpatient	19.0%	28.3%	0.0		42.8%			4,043,146		4.4%
Revenue (\$)	4,577,702	6,801,444		0 1	0,295,103	2,368,89		4,043,140	2,101,010	
				New	horn Nurse	ry Utilization	1		Organ Transs	lantation
			a	Level 1 Pati			0	1	Idney:	
	thing Data	1 64					0		leart:	Ō
Number of Total Births:		1,64 1,62		Level 2 Pati				П		0
Number of Total Births: Number of Live Births:		1,64 1,62	24	Level 2 Pati			0	1.	una:	
Number of Total Births: Number of Live Births: Birthing Rooms:				Level 2+ Pat	tient Da y s	v a	0 0		ung: leart/Lung:	0
Number of Total Births: Number of Live Births: Birthing Rooms: Lebor Rooms:			24 0	Level 2+ Pat Total Nurser	lient Da ys y Patien id a			Н	leart/Lung:	=
Number of Total Births: Number of Live Births: Birthing Rooms: Lebor Rooms: Delivery Rooms:			24 0 0 0 0	Level 2+ Pat Total Nurser	tient Da ys y Patientda _aboratory		0	H P	-	0
Number of Total Births: Number of Live Births: Birthing Rooms: Lebor Rooms: Delivery Rooms: Labor-Delivery-Recove	ry Rooms:	1,62	24 0 0 0 0 6 0 Inp	Level 2+ Pat Total Nurser Leatient Studies	tient Da y s y Patien ida "aboratory		0 163,909	Н Р L	leart/Lung: ancreas: iver:	0 0 0
Number of Total Births: Number of Live Births: Birthing Rooms: Lebor Rooms: Delivery Rooms:	ry Rooms:	1,62	24 0 0 0 0 6 0 Int	Level 2+ Pat Total Nurser	lient Da ys y Patienida <u>aboratory</u> B ies	Studies .	0	H P L	leart/Lung: ancreas:	0

C	hic	ac	10

Number of Emergency Room Stations

Patients Admitted from Emergency:

Persons Treated by Emergency Services:

68,655

68,655

OSPITAL PROFILE	- G1 ZU1	<u> </u>	171	Ol Medicall							
				Surgen		tina Room U	<u>itilization</u>	ırgical H <u>ours</u>		Hours r	er Case
Surpical Specialty		Operating Re				Cases		Outpatient T	otel Hours		Outpatie
	Inpatient O	utpatient Co		Total	Inpatient	Outpatient	Inpatient 363	21	384	3.8	2.3
Cardiovescular	0	0	0	0	96	9	303 0	0	0	0.0	0.0
Dermatology	0	0	0	0	0	0	639	685	1324	1.4	0.8
General	0	0	5	5	468	810		0	0	0.0	0.0
Gastroenterology	0	0	0	0	0	0	0	0	0	0.0	0.0
Neurology	0	0	0	0	0	0	_	435	956	1,2	0.8
OB/Gynecology	0	0	0	0	423	472	521		950	0.0	0.0
Oral/Maxillofacial	0	0	0	0	0	0	0	0	-	1.0	0.9
Ophthalmology	0	0	0	0	1	258	1	222	223 172	1.6	1.3
Orthopedic	0	0	0	0	46	73	74	98	0	0.0	0.0
Otolaryngology	0	0	0	0	0	0	0	0	0	0.0	0.0
Plastic Surgery	0	0	0	0	0	0	0	0	-	1.6	1.4
Podiatry	0	0	0	0	53	267	83	367	450	0.0	0.0
Thoracic	0	0	0	0	0	0	0	0	0	0.0	0.0
Urology	0	0	0	0	38	123	30	95	125		
Totals	0	0	5	5	1123	2012	1711	1923	3634	1.5	1.0
		200	Ste	ge 1 Recover	v Stations	8	Sta	ge 2 Recovery	Stations	0	
SURGICAL RECOV	EKTSIAIN	JNJ	J.U						370		
					and Non-D	edicated Pro	cedure Room	Surgical Hou	ra .	Hours	per Case
			dure Ro			rgical Cases		Outpatient		Inpatient	Outpatie
rocedure Type	inpa	atlent Outpa	itient Co	mbined Tota	al Inpatle	•	· ·				0.
astrointestinal		0 0		2	2 40	2 68			662	0.6	0.
asor Eye Procedure	9.9	0 0		0	0	0	0 0		0	0.0	
Pain Management		0 0		0	0	0	0 0	0	0	0.0	0,
-		0 0		0	0	0	0 0	0	0	0.0	0.
Cystoscopy		•		Dedicated Ro	ooms						_
		0 0		0	0	0	0 0	0	0	0.0	0.
		0 0		0	0	0	0 0	0	0	0.0	Q.
		0 0		0	0	0	0 0	0	0	0.0	0
							Cardisc	Catheterizați	on Utilization	1	
Care	dlac Cathet	<u>erization La</u>	<u>bs</u>			Total Ca	ordiac Cath Pro				113
Total Cath Labs (De	dicated+No	ndedicated i	aos):	1 0			iagnostic Catr)-14)		0
Cath Labs used for	or Angiograf	ony procedul	89	0			iagnostic Cath	eterizations (1	(5+)		92
Dedicated Diagno Dedicated Interve	ostic Carrett	atarizatlan l	ahs	0		le:	nterventional C	atheterization	s (0-14):		0
Dedicated interve			.408	0			iterventional C				21
				•			P Catheteriza				0
	rgency/Tra	ujila Cale		No		_		, ,			
Certified Trauma C	enter			Level 2				rdiac Surgery	<u>Data</u>		
Level of Trauma Se	ervice	Leve	i¶ Isabia N		.	To	otal Cardiac Su				0
				Not Applicable 0	•			- 14 Years):			0
Operating Rooms D		r Irauma Ca	u e	0				ears and Olde			U
Number of Trauma	Visita;			0		Co	oronary Artery	Bypass Grafts	(CABGs)		0
Patients Admitted f		1	0	prehensive		pe	rtormed of lot				U
Emergency Service		*******	Com	prenensive 12				atient Service	Data		3.655
Mumber of Emerge	nev Hoom S	เลเเกกร		14						- 0	7.U2J

Total ED Visits (Emergency+Trauma):	24,584			Obligation Visits Office of the Control of the Cont					
Diagnostic/Interventional Equipment				Inationa Outpt Contract		Radiation Equipment Owner		Contract	Therapie Treatments
	Own	Contract	inpatient	16.745	Convact	Lithotripsy	0	0	0
General Radiography/Fluoroscopy	7	0	5,354 504	225	0	Linear Accelerator	0	0	0
Nuclear Medicine	1	0	704	1,894	0	Image Guided Rad Therap	y 0	0	0
Mammography	5	0	2,145	10,067	0	Intensity Modulated Rad T	hrpy 0	0	0
Ultrasound Anglography	ő	Ō				High Dose Brachytherapy	0	0	0
Diagnostic Anglography			0	0	. 0	Proton Beam Therapy	0	0	0
Interventional Anglography			0	l	, ,	Gamma Knife	0	0	0
Positron Emission Tomography (PET)	0	0	0 1,231	7,379	0	Cyber knife	0	0	0
Computerized Axial Tomography (CAT) Magnetic Resonance Imaging	1	1	1,231	0,378	495				
Mediann resonance illiabilità									

Total Outpatient Visits
Outpatient Visits at the Hospital/ Campus:

Outpatient Visits Offsite/off campus

Source: 2010 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development.

24,564

5,985