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 Planning Area: A02

Applicant/Co-Applicant Identification

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

Exact Legal Name:	Norwegian American Hospital, Inc.
Address:	1044 North Francisco Avenue, Chicago, IL 60622
Name of Registered Agent:	CT Corporation
Name of Chief Executive Officer:	Jose R. Sanchez
CEO Address:	1044 North Francisco Avenue, Chicago, IL 60622
Telephone Number:	773-292-8204

RECEIVED
DEC 05 2011
HEALTH FACILITIES & SERVICES REVIEW BOARD

Type of Ownership of Applicant/Co-Applicant

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

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

APPEND DOCUMENTATION AS ATTACHMENT-1, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact

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

Name:	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**]

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

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.

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

Operating Identity/Licensee

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

Exact Legal Name:	Norwegian American Hospital, Inc.
Address:	1044 North Francisco Avenue, Chicago, IL 60622

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

- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.
- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**

APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Organizational Relationships

Provide (for each co-applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

APPEND DOCUMENTATION AS ATTACHMENT-4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2005-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at **www.FEMA.gov** or **www.illinoisfloodmaps.org**. **This map must be in a readable format.** In addition please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2005-5 **(http://www.hfsrb.illinois.gov)**.

APPEND DOCUMENTATION AS ATTACHMENT 5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS ATTACHMENT-6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.40 and Part 1120.20(b).]

Part 1110 Classification:	Part 1120 Applicability or Classification: [Check one only.]
☐ Substantive ☒ Non-substantive	☒ Part 1120 Not Applicable ☐ 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 Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs			zero
Site Survey and Soil Investigation			zero
Site Preparation			zero
Off Site Work			zero
New Construction Contracts			zero
Modernization Contracts			zero
Contingencies			zero
Architectural/Engineering Fees			zero
Consulting and Other Fees			zero
Movable or Other Equipment (not in construction contracts)			zero
Bond Issuance Expense (project related)			zero
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 ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Related Project Costs

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

Land acquisition is related to project ☐ Yes ☒ No
Purchase Price: $_____
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 $ N/A

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.
☒ Project obligation will occur after permit issuance.

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

State Agency Submittals

Are the following submittals up to date as applicable:

☒ Cancer Registry
☒ APORS
☒ 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							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							

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

Facility Bed Capacity and Utilization

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

FACILITY NAME: Norwegian American Hospital, Inc. **CITY:** Chicago

REPORTING PERIOD DATES: **From:** 10/01/2010 **To:** 09/30/2011

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				
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:

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

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

SIGNATURE

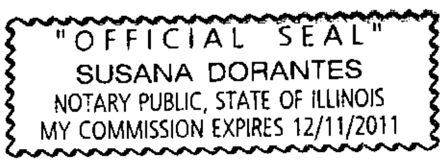
Jose R. Sanchez
PRINTED NAME

Chief Executive Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 29 day of November

Signature of Notary

Seal


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

SIGNATURE

Anthony Evers
PRINTED NAME

Chief Financial Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 29 day of November

Signature of Notary

Seal

*Insert EXACT legal name of the applicant

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.
2. 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.
2. 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.
3. 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 DO NOT need to be addressed by the applicants or co-applicants responsible for funding or guaranteeing the funding of the project if the applicant has a bond rating of A- or better from Fitch's or Standard and Poor's rating agencies, or A3 or better from Moody's (the rating shall be affirmed within the latest 18 month period prior to the submittal of the application):

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

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: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
____	b) Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, 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: 1) 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; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions.
____	e) 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.
	TOTAL FUNDS AVAILABLE

APPEND DOCUMENTATION AS ATTACHMENT-39, 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**
2. **The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent**
3. **The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.**

See Section 1120.130 Financial Waiver for Information to be provided

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

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

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

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

2. Variance

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

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

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:

1. That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or
2. That the total estimated project costs and related costs will be funded in total or in party by borrowing because:
   a. A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
   b. Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

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:

1. That the selected form of debt financing for the project will be at the lowest net cost available;
2. That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;
3. That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

APPEND DOCUMENTATION AS ATTACHMENT 42, IN 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 ALL SUBSTANTIVE AND DISCONTINUATION PROJECTS:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.
2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact 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.
3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 43.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Charity (cost in dollars)			
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			

Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

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

VII. Charity Care Information

Charity Care Information MUST be furnished for ALL projects.

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.
3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

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

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

CHARITY CARE			
	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

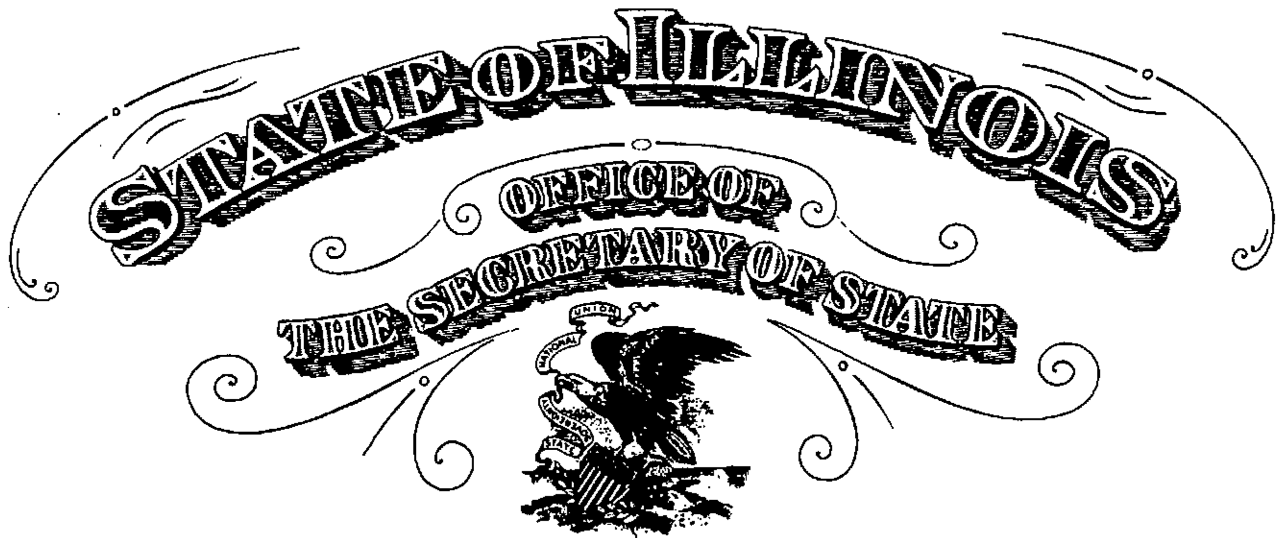
ATTACHMENT NO.		PAGES
1	Applicant/Co-applicant Identification including Certificate of Good Standing	17-18
2	Site Ownership	20
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	N/A
4	Organizational Relationships (Organizational Chart) Certificate 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	25-135C
11	Background of the Applicant	
12	Purpose of the Project	
13	Alternatives to the Project	
14	Size of the Project	
15	Project Service Utilization	
16	Unfinished or Shell Space	
17	Assurances for Unfinished/Shell Space	
18	Master Design Project	
19	Mergers, Consolidations and Acquisitions	
	Service Specific:	
20	Medical Surgical Pediatrics, Obstetrics, ICU	
21	Comprehensive Physical Rehabilitation	
22	Acute Mental Illness	
23	Neonatal Intensive Care	
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	
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 Waiver	
41	Financial Viability	
42	Economic Feasibility	
43	Safety Net Impact Statement	136-137
44	Charity Care Information	138-144

Certificate of Good Standing

See attached

Attachment 1

File Number 2408-233-4



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.

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 .

Authentication #: 1132201542

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

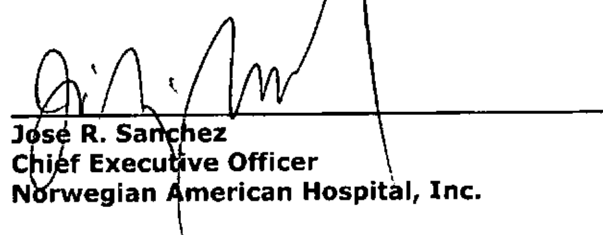
SECRETARY OF STATE

Proof of Site Ownership

See attached

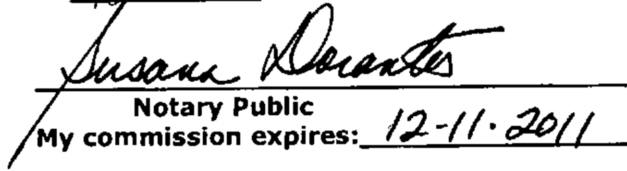
Proof of Site Ownership

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.



José R. Sanchez
Chief Executive Officer
Norwegian American Hospital, Inc.

Subscribe to before me this 29 **day of** November**, 2011**



Notary Public
My commission expires: 12-11-2011

Attachment 2

See previous Certificate of Good Standing (Attachment 1)

Attachment 3

Organizational Relationships

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

Attachment 4

Flood Plain

This project does not involve any construction.

Historic Preservation

This project does not involve construction or modernization.

Attachment 6

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.**

Attachment 10

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.

Attachment 10

October 21, 2011

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,

Jose R. Sanchez
President & CEO

SENDER: *COMPLETE THIS SECTION*

- 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.

Little Company of Mary Hospital and Health Care Center

2800 West 95th Street

Evergreen Park IL 60642-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature X ☐ Agent ☐ Addressee

...ame) C. Date of Delivery 10/25/11

...ent from item 1? ☑ Yes

...ldress below: ☐ No

3. Service Type

☑ Certified Mail ☐ Express Mail

☐ Registered ☑ Return Receipt for Merchandise

☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? *(Extra Fee)* ☐ Yes

2. Article Number *(Transfer from service label)* 7011 0470 0002 6023 9332

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7011 0470 0002 6023 9332

Little Company of Mary Hospital and Health Care Ce

2800 West 95th Street

Evergreen Park IL 60642-0000

October 21, 2011

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).

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,

Jose R. Sanchez
President & CEO

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 [signature] ☐ Agent ☐ Addressee B. Received by (*Printed Name*) C. Date of Delivery 10/25/11
1. Article Addressed to: MacNeal Memorial Hospital 3249 South Oak Park Avenue Berwyn IL 60402-0000	D. Is delivery address different from item 1? ☐ Yes If YES, enter delivery address below: ☐ No
	3. Service Type ☑ Certified Mail ☐ Express Mail ☐ Registered ☐ Return Receipt for Merchandise ☐ Insured Mail ☐ C.O.D.
	4. Restricted Delivery? *(Extra Fee)* ☐ Yes
2. Article Number *(Transfer from service label)*	7011 0470 0002 6023 9295

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Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

Postmark Here

7011 0470 0002 6023 9295

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

October 21, 2011

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).

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,

Jose R. Sanchez
President & CEO

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 [signature] ☑ Agent ☐ Addressee B. Received by (*Printed Name*) [handwritten] C. Date of Delivery [handwritten] D. Is delivery address different from item 1? ☐ Yes If YES, enter delivery address below: ☐ No
1. Article Addressed to: Jackson Park Hosp. Foundation 753[illegible]y Island Avenue Chicago IL 60649-0000	3. Service Type ☑ Certified Mail ☐ Express Mail ☐ Registered ☑ Return Receipt for Merchandise ☐ Insured Mail ☐ C.O.D. 4. Restricted Delivery? (*Extra Fee*) ☐ Yes
2. Article Number (*Transfer from service label*)	7011 0470 0002 6023 9387

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Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

Postmark Here

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

October 21, 2011

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

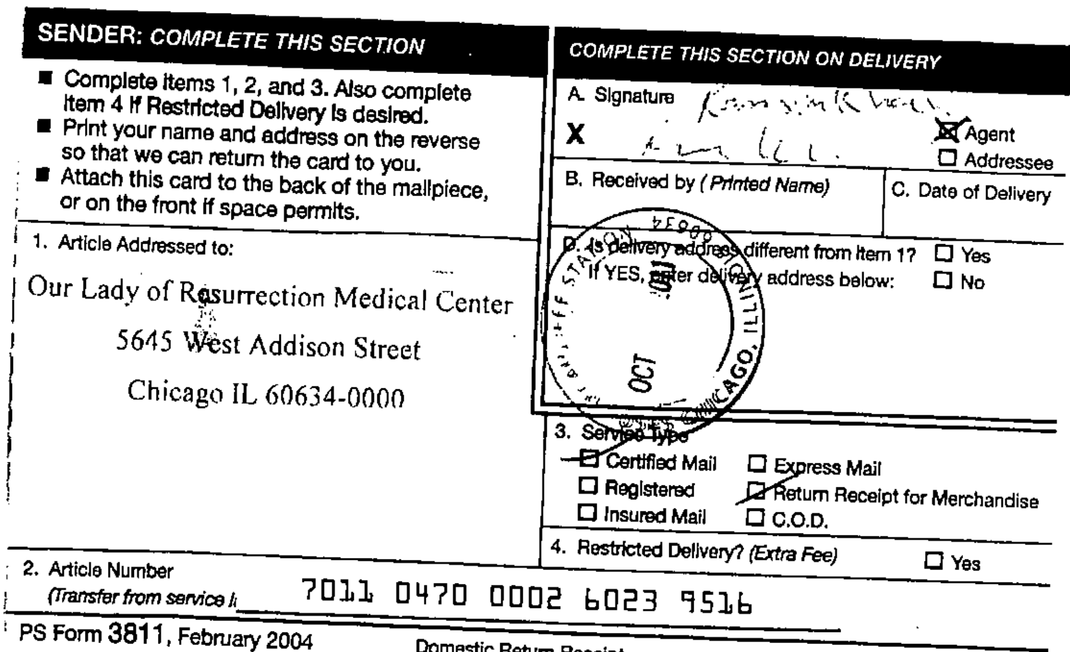
Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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,

Jose R. Sanchez
President & CEO



SENDER: COMPLETE THIS SECTION

- 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:

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

COMPLETE THIS SECTION ON DELIVERY

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: ☐ No

OCT

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number
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Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

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

October 21, 2011

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).

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,

Jose R. Sanchez
President & CEO

SENDER: *COMPLETE THIS SECTION*

- 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:

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☑ Addressee

B. Received by (*Printed Name*) YVES AUXI[illegible] C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

[Postmark stamp: STATION ... CHICAGO ... 60613 USPS]

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (*Extra Fee*) ☐ Yes

2. Article Number
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Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

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Sent To Thorek Memorial Hospital
Street, Apt or PO Box 850 West Irving Park
City, State, Chicago IL 60613-0000

PS Form

October 21, 2011

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).

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,

Jose R. Sanchez
President & CEO

SENDER: *COMPLETE THIS SECTION*

- 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:

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (*Printed Name*) Marcus [handwritten] C. Date of Delivery 12/2016

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☒ Return Receipt for Merchandise
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4. Restricted Delivery? (*Extra Fee*) ☐ Yes

2. Article Number
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Total Postage & Fees	$

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Street, A... or PO B...
City, Sta...

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

PS Form ... ...tions

October 21, 2011

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

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,

Jose R. Sanchez
President & CEO

SENDER: *COMPLETE THIS SECTION*

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- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [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: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (*Extra Fee*) ☐ Yes

2. Article Number
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Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

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Sent To
Street, Apt. or PO Box
City, State,

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

PS Form 3 ... tions

October 21, 2011

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).

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,

Jose R. Sanchez
President & CEO

SENDER: *COMPLETE THIS SECTION*

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Dan Vall ☒ Agent ☐ Addressee

B. Received by (*Printed Name*) DAN VARALLO

C. Date of Delivery 10-25-11

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (*Extra Fee*) ☐ Yes

2. Article Number
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Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

Postmark Here

Sent T[o]
Street, [Apt. No.;] or PO [Box No.]
City, S[tate]

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

PS Fo[rm] ... [Inst]ructions

October 21, 2011

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

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,

Jose R. Sanchez
President & CEO

SENDER: *COMPLETE THIS SECTION*

- 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:

Evanston Hospital
2650 Ridge Avenue
Evanston IL 60201-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☑ Agent ☐ Addressee

B. Received by (Printed Name) ANDRE ICILE
C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? *(Extra Fee)* ☐ Yes

2. Article Number *(Transfer from service label)* 7011 0470 0002 6023 9745

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Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

Postmark Here

Sent To
Street, Apt or PO Box
City, State

Evanston Hospital
2650 Ridge Avenue
Evanston IL 60201-0000

PS Form ... uctions

October 21, 2011

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

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,

Jose R. Sanchez
President & CEO

SENDER: *COMPLETE THIS SECTION*

- 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:

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature X [signature] ☒ Agent ☐ Addressee

B. Received by (Printed Name) [handwritten] C. Date of Delivery 10-26-11

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? *(Extra Fee)* ☐ Yes

2. Article Number *(Transfer from service label)* 7011 0470 0002 6023 9752

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7011 0470 0002 6023 9752

Postage	$
Certified Fee	
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

Postmark Here

Sent To: Highland Park Hospital
Street, Apt. No., or PO Box No.: 718 Glenview Avenue
City, State, ZIP+4: Highland Park IL 60035-0000

PS F

October 21, 2011

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).

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,

Jose R. Sanchez
President & CEO

SENDER: *COMPLETE THIS SECTION*

- 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:

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☑ Addressee

B. Received by (Printed Name) [signature] | C. Date of Delivery 10/25/11

D. Is delivery address different from item 1? ☑ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? *(Extra Fee)* ☐ Yes

2. Article Number
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Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

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Sent To
Louis A. Weiss Memorial Hospital
Street, Apt. No., or PO Box No.
4646 North Marine Drive
City, State, ZIP+4
Chicago IL 60640-0000

PS Form 3800,

October 21, 2011

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).

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,

Jose R. Sanchez
President & CEO

SENDER: *COMPLETE THIS SECTION*

- 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:

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

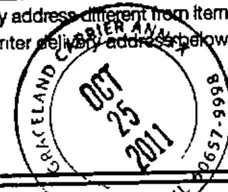
COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ 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: ☐ No



3. Service Type
☐ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (*Extra Fee*) ☐ Yes

2. Article Number
(*Transfer from service label*) 7011 0470 0002 6023 9691

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Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

Postmark Here

Sent To
Street, or PO
City, St

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

PS For ... tions

October 21, 2011

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,

Jose R. Sanchez
President & CEO

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 ☐ Agent ☐ Addressee B. Received by (*Printed Name*) C. Date of Delivery
1. Article Addressed to: Advocate Good Samaritan Hospital 3815 Highland Avenue Downers Grove IL 60515-0000	D. Is delivery address different from item 1? ☐ Yes If YES, enter delivery address below: ☐ No 3. Service Type ☑ Certified Mail ☐ Express Mail ☐ Registered ☐ Return Receipt for Merchandise ☐ Insured Mail ☐ C.O.D. 4. Restricted Delivery? (*Extra Fee*) ☐ Yes
2. Article Number (*Transfer from service label*)	7011 0470 0002 6023 9202

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Certified Fee	
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Total Postage & Fees	$

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

October 21, 2011

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.

Thank you for your consideration.

Sincerely,

Jose R. Sanchez
President & CEO

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 ☐ Agent ☐ Addressee B. Received by (*Printed Name*) J-CASR42 C. Date of Delivery
1. Article Addressed to: Adventist Hinsdale Hospital 120 North Oak Street Hinsdale IL 60521-0000	D. Is delivery address different from item 1? ☐ Yes If YES, enter delivery address below: ☐ No
	3. Service Type ☒ Certified Mail ☐ Express Mail ☐ Registered ☒ Return Receipt for Merchandise ☐ Insured Mail ☐ C.O.D. 4. Restricted Delivery? (*Extra Fee*) ☐ Yes

2. Article Number (*Transfer from service label*) 7011 0470 0002 6023 9219

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Certified Fee		
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Restricted Delivery Fee (Endorsement Required)		
Total Postage & Fees	$	

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

October 21, 2011

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).

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,

Jose R. Sanchez
President & CEO

SENDER: *COMPLETE THIS SECTION*

- 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:

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X M. [signature] ☐ Agent ☐ Addressee

B. Received by (*Printed Name*) M. [illegible]

C. Date of Delivery 10/25/11

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (*Extra Fee*) ☐ Yes

2. Article Number
(*Transfer from service label*) 7011 0470 0002 6023 9226

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Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

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

7011 0470 0002 6023 9226

October 21, 2011

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.

Thank you for your consideration.

Sincerely,

Jose R. Sanchez
President & CEO

SENDER: *COMPLETE THIS SECTION*

- 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:

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature ☐ Agent ☐ 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: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number
(Transfer from service label) 7011 0470 0002 6023 9233

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Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

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7011 0470 0002 6023 9233

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

October 21, 2011

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

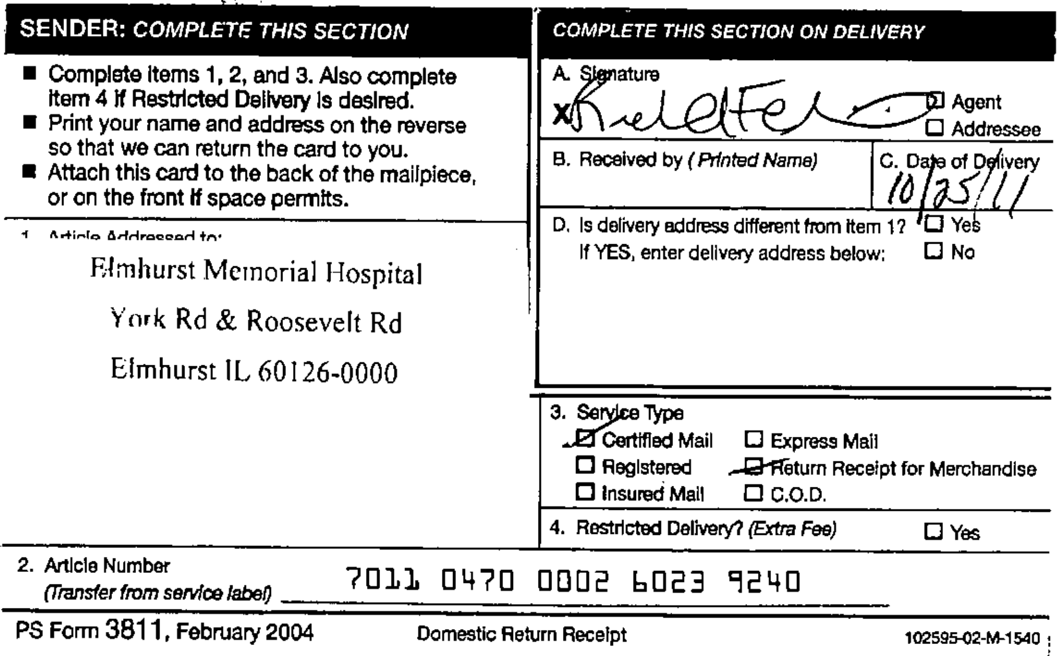
Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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

Thank you for your consideration.

Sincerely,

Jose R. Sanchez
President & CEO


SENDER: COMPLETE THIS SECTION

- 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:

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature ☒ Agent ☐ 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: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number
(Transfer from service label) 7011 0470 0002 6023 9240

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Certified Fee	
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

Postmark Here

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

October 21, 2011

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).

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,

Jose R. Sanchez
President & CEO

SENDER: *COMPLETE THIS SECTION*

- 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
Arlington Heights IL 60005-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature X [signature] ☐ Agent ☐ 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: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (*Extra Fee*) ☐ Yes

2. Article Number (*Transfer from service label*) 7011 0470 0002 6023 9257

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Certified Fee	
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

Postmark Here

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

October 21, 2011

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.

Thank you for your consideration.

Sincerely,

Jose R. Sanchez
President & CEO

SENDER: *COMPLETE THIS SECTION*

- 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:

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X W. L. Cotter ☐ Agent ☐ Addressee

B. Received by (*Printed Name*) William Cotter
C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (*Extra Fee*) ☐ Yes

2. Article Number
(*Transfer from service lab*) 7011 0470 0002 6023 9264

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Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

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7011 0470 0002 6023 9264

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

October 21, 2011

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

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,

Jose R. Sanchez
President & CEO

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 [signature] ☑ Agent ☐ Addressee B. Received by (*Printed Name*) C. Date of Delivery 10-26
1. Article Addressed to: Advocate Christ Hospital and Medical Center 9500 South Kenneth Ave Oak Lawn IL 60453-0000	D. Is delivery address different from item 1? ☐ Yes If YES, enter delivery address below: ☐ No
	3. Service Type ☑ Certified Mail ☐ Express Mail ☐ Registered ☑ Return Receipt for Merchandise ☐ Insured Mail ☐ C.O.D.
	4. Restricted Delivery? (*Extra Fee*) ☐ Yes

2. Article Number
(*Transfer from service label*) 7011 0470 0002 6023 9288

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Postage	$
Certified Fee	
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

Postmark Here

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

October 21, 2011

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).

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,

Jose R. Sanchez
President & CEO

SENDER: *COMPLETE THIS SECTION*

- 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:

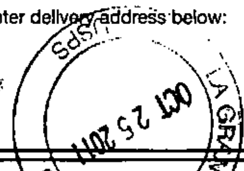
Adventist 'LaGrange Memorial Hospital
5101 Gilbert Avenue
LaGrange IL 60525-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (*Printed Name*) B. Morris
C. Date of Delivery 10/25

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No



3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (*Extra Fee*) ☐ Yes

2. Article Number
(*Transfer from service label*) 7011 0470 0002 6023 9271

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Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

Postmark Here

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

October 21, 2011

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.

Thank you for your consideration.

Sincerely,

Jose R. Sanchez
President & CEO

SENDER: *COMPLETE THIS SECTION*

- 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:

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Gary Lend ☐ Agent ☐ Addressee

B. Received by (*Printed Name*) GARY LEND

C. Date of Delivery 10-25-11

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (*Extra Fee*) ☐ Yes

2. Article Number
(*Transfer from service label*) 7011 0470 0002 6023 9318

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Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

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

October 21, 2011

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).

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,

Jose R. Sanchez
President & CEO

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 [signature] ☐ Agent ☐ Addressee B. Received by (*Printed Name*) [handwritten] C. Date of Delivery [handwritten]
1. Article Addressed to: Advocate South Suburban Hospital 17800 South Kedzie Avenue Hazel Crest IL 60429-0000	D. Is delivery address different from item 1? ☐ Yes If YES, enter delivery address below: ☐ No
	3. Service Type ☒ Certified Mail ☐ Express Mail ☐ Registered ☒ Return Receipt for Merchandise ☐ Insured Mail ☐ C.O.D.
	4. Restricted Delivery? (*Extra Fee*) ☐ Yes

2. Article Number
(*Transfer from service label*) 7011 0470 0002 6023 9301

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Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

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7011 0470 0002 6023 9301

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

October 21, 2011

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).

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,

Jose R. Sanchez
President & CEO

SENDER: *COMPLETE THIS SECTION*

- 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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (*Printed Name*) Charles Thomas

C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
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☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (*Extra Fee*) ☐ Yes

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

October 21, 2011

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

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,

Jose R. Sanchez
President & CEO

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 [signature] ☐ Agent ☐ Addressee B. Received by (*Printed Name*) [handwritten] C. Date of Delivery 10-15-11
1. Article Addressed to: Ingalls Memorial Hospital One Ingalls Drive Harvey IL 60426-0000	D. Is delivery address different from item 1? ☐ Yes If YES, enter delivery address below: ☐ No
	3. Service Type ☑ Certified Mail ☐ Express Mail ☐ Registered ☑ Return Receipt for Merchandise ☐ Insured Mail ☐ C.O.D.
	4. Restricted Delivery? (*Extra Fee*) ☐ Yes
2. Article Number (*Transfer from service label*)	0470 0002 6023 9325

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Ingalls Memorial Hospital
One Ingalls Drive
Harvey IL 60426-0000

October 21, 2011

Via Certified Mail

Roseland Community Hospital
45 West 111th Street
Chicago IL 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).

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,

Jose R. Sanchez
President & CEO

SENDER: COMPLETE THIS SECTION

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- 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:

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) [handwritten]

C. Date of Delivery 10/25/11

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number
(Transfer from service label) 7011 0470 0002 6023 9363

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

7011 0470 0002 6023 9363

October 21, 2011

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).

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,

Jose R. Sanchez
President & CEO

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- 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:

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (*Printed Name*)

C. Date of Delivery
10-20-11

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (*Extra Fee*) ☐ Yes

2. Article Number
(*Transfer from service label*) 7011 0470 0002 6023 9394

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Total Postage & Fees	$

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Se
St
or
Ci

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

PS

October 21, 2011

Via Certified Mail

Advocate Trinity Hospital
2320 East 93rd Street
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).

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,

Jose R. Sanchez
President & CEO

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- 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 Trinity Hospital
2320 East 93rd Street
Chicago IL 60617-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☒ Agent ☐ Addressee

B. Received by (*Printed Name*) [handwritten]

C. Date of Delivery 10/25/11

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (*Extra Fee*) ☐ Yes

2. Article Number
(*Transfer from service label*) 7011 0470 0002 6023 9370

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7011 0470 0002 6023 9370

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

October 21, 2011

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).

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Thank you for your consideration.

Sincerely,

Jose R. Sanchez
President & CEO

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 [signature] ☐ Agent ☐ Addressee B. Received by *(Printed Name)* De OJackson C. Date of Delivery
1. Article Addressed to: ovident Hospital of Cook County 500 East 51st Street Chicago IL 60615-0000	D. Is delivery address different from item 1? ☐ Yes If YES, enter delivery address below: ☐ No
	3. Service Type ☒ Certified Mail ☐ Express Mail ☐ Registered ☒ Return Receipt for Merchandise ☐ Insured Mail ☐ C.O.D. 4. Restricted Delivery? *(Extra Fee)* ☐ Yes

2. Article Number *(Transfer from service label)* 7011 0470 0002 6023 9400

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Total Postage & Fees	$	

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

October 21, 2011

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

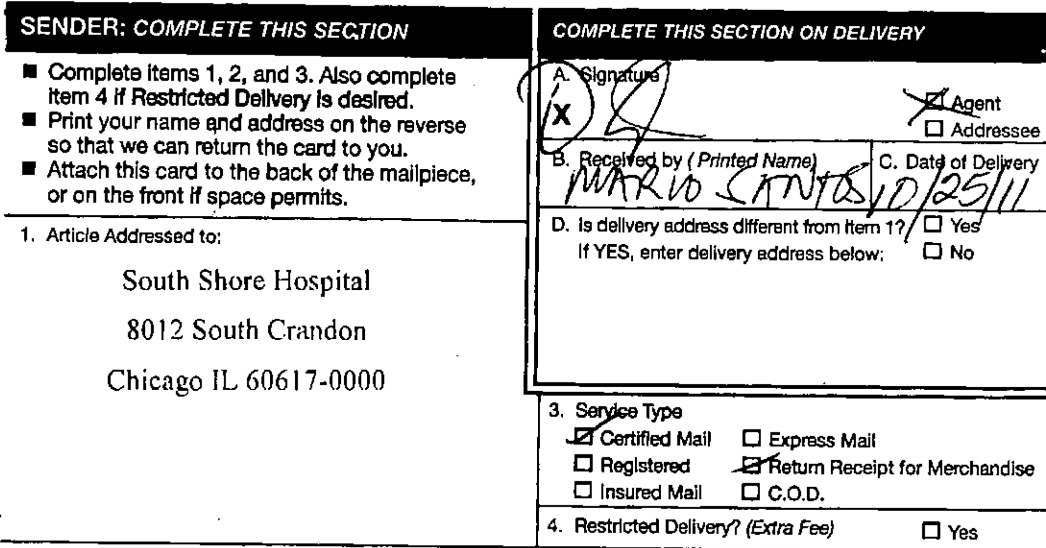
Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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,

Jose R. Sanchez
President & CEO



SENDER: *COMPLETE THIS SECTION*

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- 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:

South Shore Hospital
8012 South Crandon
Chicago IL 60617-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X
☒ Agent
☐ Addressee

B. Received by (*Printed Name*) MARIO SANTOS
C. Date of Delivery 10/25/11

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (*Extra Fee*) ☐ Yes

2. Article Number
(*Transfer from service label*) 7011 0470 0002 6023 9417

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Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

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7011 0470 0002 6023 9417

South Shore Hospital
8012 South Crandon
Chicago IL 60617-0000

October 21, 2011

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.

Thank you for your consideration.

Sincerely,

Jose R. Sanchez
President & CEO

SENDER: *COMPLETE THIS SECTION*

- 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:

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X David Garrett ☐ Agent ☐ Addressee

B. Received by (Printed Name) David Garrett

C. Date of Delivery 10/26/11

D. Is delivery address different from item 1? ☑ Yes ☐ No
If YES, enter delivery address below:
63 Lake Shore Dr.

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? *(Extra Fee)* ☐ Yes

2. Article Number *(Transfer from service label)* 7011 0470 0002 6023 9424

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Total Postage & Fees	$

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

7011 0470 0002 6023 9424

October 21, 2011

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.

Thank you for your consideration.

Sincerely,

Jose R. Sanchez
President & CEO

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 Charles Bell ☐ Agent ☐ Addressee B. Received by (*Printed Name*) Charles Bell C. Date of Delivery
1. Article Addressed to: University Medical Center/Foster G. McGaw 2160 South 1st Avenue Maywood IL 60153-0000	D. Is delivery address different from item 1? ☐ Yes If YES, enter delivery address below: ☐ No
	3. Service Type ☑ Certified Mail ☐ Express Mail ☐ Registered ☑ Return Receipt for Merchandise ☐ Insured Mail ☐ C.O.D.
	4. Restricted Delivery? (*Extra Fee*) ☐ Yes

2. Article Number (*Transfer from service label*) 7011 0470 0002 6023 9448

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

October 21, 2011

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

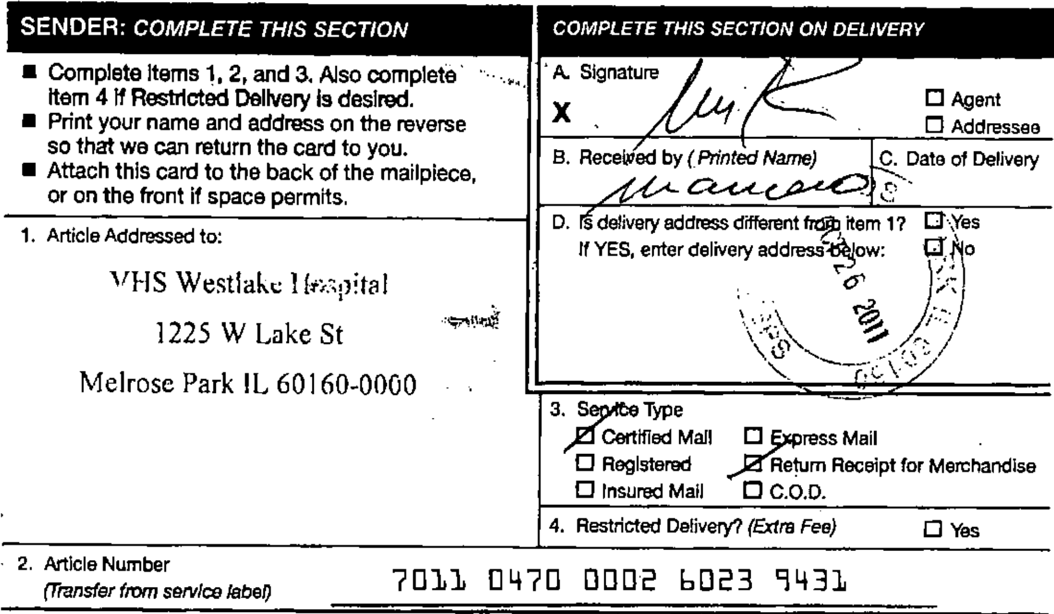
Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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,

Jose R. Sanchez
President & CEO



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- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

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

COMPLETE THIS SECTION ON DELIVERY

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: ☑ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number
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Total Postage & Fees	$

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7011 0470 0002 6023 9431

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

October 21, 2011

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

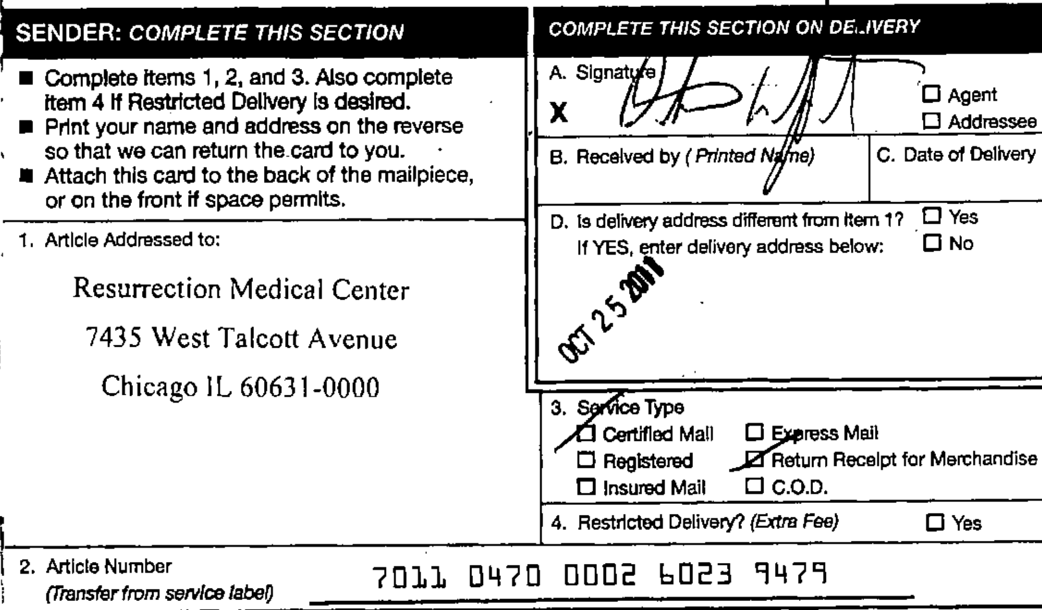
Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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,

Jose R. Sanchez
President & CEO



SENDER: COMPLETE THIS SECTION

- 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:

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

COMPLETE THIS SECTION ON DELIVERY

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: ☐ No

OCT 25 2011

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number
(Transfer from service label) 7011 0470 0002 6023 9479

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Total Postage & Fees	$

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7011 0470 0002 6023 9479

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

October 21, 2011

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).

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,

Jose R. Sanchez
President & CEO

SENDER: *COMPLETE THIS SECTION*

- 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:

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X M Lytle ☐ Agent ☐ Addressee

B. Received by (Printed Name) M LYTLE

C. Date of Delivery 10/25/11

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? *(Extra Fee)* ☐ Yes

2. Article Number *(Transfer from service label)* 7011 0470 0002 6023 9462

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Total Postage & Fees	$

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7011 0470 0002 6023 9462

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

October 21, 2011

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).

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,

Jose R. Sanchez
President & CEO

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- 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:

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature]
☐ Agent
☐ Addressee

B. Received by (*Printed Name*) [handwritten]

C. Date of Delivery 10-25-11

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (*Extra Fee*) ☐ Yes

2. Article Number
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Rush Oak Park Hospital
520 South Maple Street
Oak Park IL 60304-0000

October 21, 2011

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).

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,

Jose R. Sanchez
President & CEO

SENDER: *COMPLETE THIS SECTION*

- 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:

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (*Printed Name*) [handwritten] C. Date of Delivery 10/4/11

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
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☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? *(Extra Fee)* ☐ Yes

2. Article Number
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7011 0470 0002 6023 9509

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

October 21, 2011

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).

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,

Jose R. Sanchez
President & CEO

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- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Sherri Carmody ☐ Agent ☐ Addressee

B. Received by (*Printed Name*) SHERRI CARMODY
C. Date of Delivery 10/25/11

D. Is delivery address different from item 1? ☑ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (*Extra Fee*) ☐ Yes

2. Article Number
(*Transfer from service label*) 7011 0470 0002 6023 9493

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Total Postage & Fees	$

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7011 0470 0002 6023 9493

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

October 21, 2011

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).

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,

Jose R. Sanchez
President & CEO

SENDER: *COMPLETE THIS SECTION*

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- 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:

Loretto Hospital
645 South Central Avenue
Chicago IL 60644-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

☐ Agent
☐ Addressee

B. Received by *(Printed Name)* Willie Scott

C. Date of Delivery 10-26-11

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? *(Extra Fee)* ☐ Yes

2. Article Number *(Transfer from service label)* 7011 0470 0002 6023 9486

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Total Postage & Fees	$

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7011 0470 0002 6023 9486

Loretto Hospital
645 South Central Avenue
Chicago IL 60644-0000

October 21, 2011

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

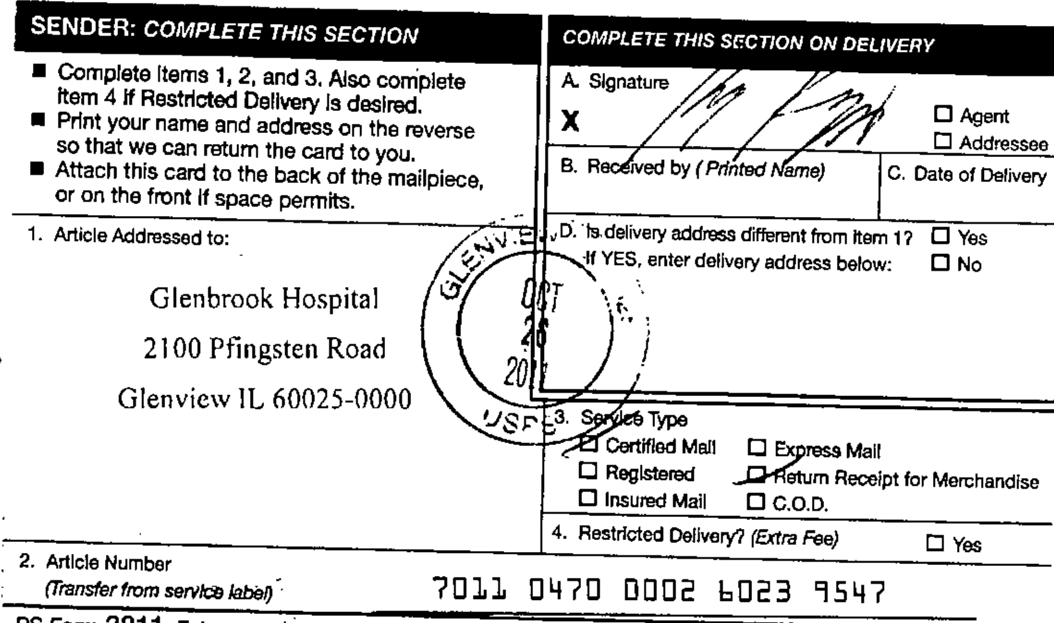
Norwegian American Hospital intends to request approval from the Illinois Health Facilities & Services Review Board to discontinue its five (5) pediatric beds. It anticipates that the service will be discontinued within six months (approximately).

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,

Jose R. Sanchez
President & CEO



SENDER: COMPLETE THIS SECTION

- 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:

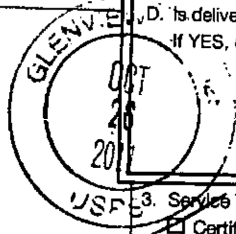
Glenbrook Hospital
2100 Pfingsten Road
Glenview IL 60025-0000

COMPLETE THIS SECTION ON DELIVERY

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: ☐ No



3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number
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7011 0470 0002 6023 9547

Glenbrook Hospital
2100 Pfingsten Road
Glenview IL 60025-0000

October 21, 2011

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).

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

Thank you for your consideration.

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Jose R. Sanchez
President & CEO

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- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X John Jadou ☐ 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: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number
(Transfer from service label) 7011 0470 0002 6023 9530

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

October 21, 2011

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).

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,

Jose R. Sanchez
President & CEO

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- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Advocate Lutheran General Hospital

~~1800 Parkside Dr~~

Park Ridge IL 60068-0000

COMPLETE THIS SECTION ON DELIVERY

A. Signature X [signature] ☑ Agent ☐ Addressee

B. Received by (*Printed Name*)

C. Date of Delivery 10-26-11

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (*Extra Fee*) ☐ Yes

2. Article Number (*Transfer from service label*) 7011 0470 0002 6023 9523

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Advocate Lutheran General Hospital

1800 Parkside Dr

Park Ridge IL 60068-0000

October 21, 2011

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).

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,

Jose R. Sanchez
President & CEO

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- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (*Printed Name*) C. Date of Delivery [handwritten]

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (*Extra Fee*) ☐ Yes

2. Article Number
(*Transfer from service label*) 7011 0470 0002 6023 9561

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Total Postage & Fees	$

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

October 21, 2011

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

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,

Jose R. Sanchez
President & CEO

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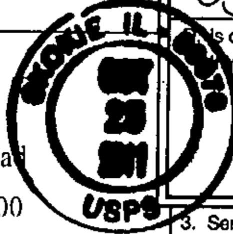
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Skokie Hospital
9600 Gross Point Road
Skokie IL 60076-0000



COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) Joey M. Gonzales
C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? *(Extra Fee)* ☐ Yes

2. Article Number
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7011 0470 0002 6023 9554

Skokie Hospital
9600 Gross Point Road
Skokie IL 60076-0000

October 21, 2011

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,

Jose R. Sanchez
President & CEO

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1. Article Addressed to:

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Serena L Sumrell ☐ Agent ☐ Addressee

B. Received by (Printed Name) Serena L Sumrell
C. Date of Delivery 10/25/11

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? *(Extra Fee)* ☐ Yes

2. Article Number *(Transfer from service label)* 7011 0470 0002 6023 9592

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Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

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

October 21, 2011

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,

Jose R. Sanchez
President & CEO

SENDER: *COMPLETE THIS SECTION*

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- 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:

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature ☐ Agent ☐ 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: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (*Extra Fee*) ☐ Yes

2. Article Number (*Transfer from service label*) 7011 0470 0002 6023 9578

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7011 0470 0002 6023 9578

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

October 21, 2011

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,

Jose R. Sanchez
President & CEO

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- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

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

COMPLETE THIS SECTION ON DELIVERY

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: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (*Extra Fee*) ☐ Yes

2. Article Number
(*Transfer from service label*) 7011 0470 0002 6023 9615

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Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

Postmark Here

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

October 21, 2011

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.

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Sincerely,

Jose R. Sanchez
President & CEO

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- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

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

COMPLETE THIS SECTION ON DELIVERY

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: ☐ No

OCT 27 2011

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? *(Extra Fee)* ☐ Yes

2. Article Number
(Transfer from service label) 7011 0470 0002 6023 9608

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Certified Fee	
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

Postmark Here

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

October 21, 2011

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).

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Jose R. Sanchez
President & CEO

SENDER: *COMPLETE THIS SECTION*

- 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:

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) I FLORES

C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

OCT 28

3. Service Type
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☐ Registered ☐ Return Receipt for Merchandise
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4. Restricted Delivery? *(Extra Fee)* ☐ Yes

2. Article Number *(Transfer from service label)* 7011 0470 0002 6023 9684

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Total Postage & Fees	$

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Street, Apt or PO Box
City, State,

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

PS Form 3 ... tions

October 21, 2011

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,

Jose R. Sanchez
President & CEO

SENDER: *COMPLETE THIS SECTION*

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

B. Received by (*Printed Name*) C. Date of Delivery 10/26/11

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

OCT 26 2011

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☐ Registered ☑ Return Receipt for Merchandise
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4. Restricted Delivery? (*Extra Fee*) ☐ Yes

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Total Postage & Fees	$

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Street, Ap... or PO Bo...
City, State...

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

PS Form

October 21, 2011

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,

Jose R. Sanchez
President & CEO

SENDER: *COMPLETE THIS SECTION*

- 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:

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ 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: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (*Extra Fee*) ☐ Yes

2. Article Number
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City, Sta...

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

PS Form ... ons

October 21, 2011

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.

Thank you for your consideration.

Sincerely,

Jose R. Sanchez
President & CEO

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 ☐ Agent ☐ Addressee B. Received by (*Printed Name*) C. Date of Delivery 10/25/11
1. Article Addressed to: Swedish Covenant Hospital 5145 North California Avenue Chicago IL 60625-0000	D. Is delivery address different from item 1? ☐ Yes If YES, enter delivery address below: ☐ No
	3. Service Type ☑ Certified Mail ☐ Express Mail ☐ Registered ☑ Return Receipt for Merchandise ☐ Insured Mail ☐ C.O.D.
	4. Restricted Delivery? (*Extra Fee*) ☐ Yes
2. Article Number (*Transfer from service label*)	7011 0470 0002 6023 9646

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Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

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Street, Ap or PO Bo
City, State

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

PS Form

October 21, 2011

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,

Jose R. Sanchez
President & CEO

SENDER: *COMPLETE THIS SECTION*

- 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:

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (*Printed Name*) [handwritten] C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
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4. Restricted Delivery? (*Extra Fee*) ☐ Yes

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

October 21, 2011

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.

Thank you for your consideration.

Sincerely,

Jose R. Sanchez
President & CEO

SENDER: *COMPLETE THIS SECTION*

- 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:

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X R Tansa ☐ Agent ☐ Addressee

B. Received by (*Printed Name*) C. Date of Delivery 10/28/11

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (*Extra Fee*) ☐ Yes

2. Article Number (*Transfer from service label*) 7011 0470 0002 6023 9639

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Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

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Sent
Street or P(
City,

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

PS F

October 21, 2011

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.

Thank you for your consideration.

Sincerely,

Jose R. Sanchez
President & CEO

SENDER: *COMPLETE THIS SECTION*

- 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:

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (*Printed Name*)

C. Date of Delivery 10-28-11

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (*Extra Fee*) ☐ Yes

2. Article Number
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Certified Fee	
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

Postmark Here

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

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.

Attachment 10

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

Palos Community Hospital

12251 S. 80th Avenue Palos Heights, Illinois 60463 (708) 923-4000

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

NORTHWESTERN UNIVERSITY

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

Westlake Hospital

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
Chief Executive Officer

WAB/lll

WLHOSPITAL.COM

COMER
CHILDREN'S
HOSPITAL

THE UNIVERSITY OF
CHICAGO

ADMINISTRATION

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 Avenue
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

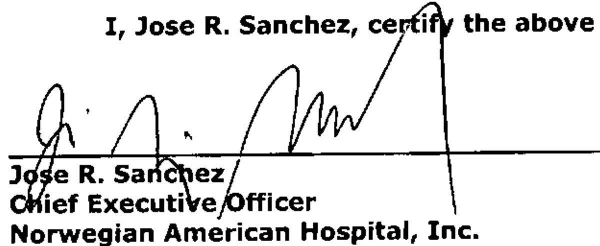
Safety Net
Impact Statement

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 Information per PA 96-0031			
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**
MEDICAID			
Medicaid (# 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.



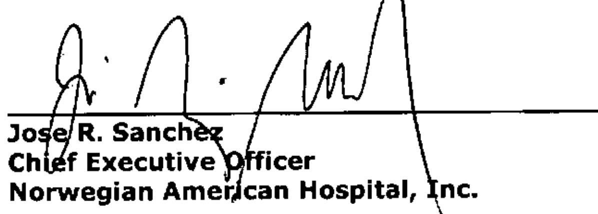
Jose R. Sanchez
Chief Executive Officer
Norwegian American Hospital, Inc.

Subscribe to before me this 29 **day of** November**, 2011**

Notary Public
My commission expires: 11.29.11

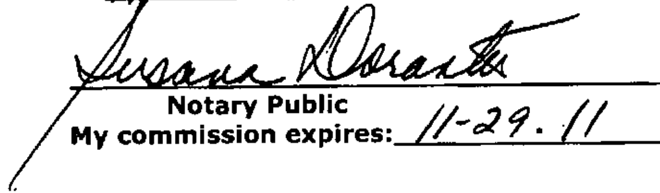
CHARITY CARE			
	Year 2008	**Year 2009**	**Year 2010**
Net Patient Revenue	94,478	95,254	91,550
Amount of Charity Care (charges)	8,339,792	10,604,171	13,507,293
Cost of Charity Care	3,087,860	3,857,906	4,745,667
Percent of Charity Care as Percent of Net Revenue	3%	3.3%	4.4%

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 29 **day**
of November**, 2011**



Notary Public
My commission expires: 11-29.11

#10694312_v1

Attachment 44

HOSPITAL PROFILE - Calendar year 2008 **Norwegian American Hospital** Chicago Page 1

Ownership, Management and General Information

ADMINISTRATOR NAME:	Michael J. O'Grady, Jr.
ADMINSTRATOR PHONE	773-292-8204
OWNERSHIP:	Norwegian American Hospital
OPERATOR:	Norwegian American Hospital
MANAGEMENT:	Non-Government Other Non-Profit
CERTIFICATION:	None
FACILITY DESIGNATION:	Disproportionate Share Hospital
ADDRESS	1044 North Francisco Avenue

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

Patients by Race

White	8.9%
Black	42.5%
American Indian	0.2%
Asian	0.7%
Hawaiian/ Pacific	0.0%
Unknown:	47.7%

Patients by Ethnicity

Hispanic or Latino:	47.0%
Not Hispanic or Latino:	53.0%
Unknown:	0.0%

IDPH Number:	1727
HPA	A-02
HSA	6

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 4/22/2009	Authorized CON Beds 12/31/2008	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy Rate % as of 12/31/2008	CON Occupancy Rate % as of 4/22/2009	Staff Bed Occupancy Rate %
Medical/Surgical	98	98	94	94	6,503	25,210	1,710	4.1	73.8	75.3	75.3	78.5
0-14 Years					0	0						
15-44 Years					2,578	7,377						
45-64 Years					2,537	10,401						
65-74 Years					701	3,535						
75 Years +					687	3,897						
Pediatric	5	5	5	5	506	974	338	2.6	3.6	71.9	71.9	71.9
Intensive Care	12	12	12	12	514	3,147	18	6.2	8.7	72.3	72.3	72.3
Direct Admission					241	1,956						
Transfers					273	1,191						
Obstetric/Gynecology	48	48	35	35	1,948	4,569	297	2.5	13.3	27.8	27.8	38.1
Maternity					1,873	4,335						
Clean Gynecology					75	234						
Neonatal	0	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0
Swing Beds					0	0		0.0	0.0			
Acute Mental Illness	37	37	37	37	1,401	9,765	0	7.0	26.8	72.3	72.3	72.3
Rehabilitation	0	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0											
Dedicated Observation		0					0					
Facility Utilization	200	200			10,599	43,665	2,363	4.3	126.1	63.1		

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	*Medicaid*	*Other Public*	*Private Insurance*	*Private Pay*	*Charity Care*	*Totals*
	24.7%	56.3%	0.0%	12.9%	5.7%	0.4%	
Inpatients	2621	5964	0	1368	599	47	10,599
	11.2%	49.9%	0.0%	30.2%	8.6%	0.2%	
Outpatients	8137	36366	0	22040	6254	125	72,922

Financial Year Reported: 10/1/2007 *to* 9/30/2008

Inpatient and Outpatient Net Revenue by Payor Source

	Medicare	*Medicaid*	*Other Public*	*Private Insurance*	*Private Pay*	*Totals*	*Charity Care Expense*
	33.0%	59.1%	0.0%	3.2%	4.7%	100.0%	
Inpatient Revenue ($)	22,959,244	41,045,177	0	2,243,567	3,244,941	69,492,929	1,407,902
	14.6%	16.9%	0.0%	56.9%	11.6%	100.0%	
Outpatient Revenue ($)	4,894,277	5,647,732	0	19,018,204	3,871,976	33,432,189	1,679,958

Total Charity Care Expense	3,087,860
Totals: Charity Care as % of Net Revenue	3.0%

Birthing Data

Number of Deliveries:	1,649
Number of Live Births:	1,643
Birthing Rooms:	0
Labor Rooms:	5
Delivery Rooms:	0
Labor-Delivery-Recovery Rooms:	5
Labor-Delivery-Recovery-Postpartum Rooms:	0
C-Section Rooms:	0
CSections Performed:	0

Newborn Nursery Utilization

Level 1 Patient Days	56
Level 2 Patient Days	186
Level 2+ Patient Days	1,372
Total Nursery Patientdays	1,614

Laboratory Studies

Inpatient Studies	233,716
Outpatient Studies	174,661
Studies Performed Under Contract	8,170

Organ Transplantation

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

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	0	0	92	22	296	55	351	3.2	2.5
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	5	5	526	661	695	611	1306	1.3	0.9
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	217	564	227	549	776	1.0	1.0
Oral/Maxillofacial	0	0	0	0	0	0	0	0	0	0.0	0.0
Ophthalmology	0	0	0	0	2	260	3	220	223	1.5	0.8
Orthopedic	0	0	0	0	63	110	111	135	246	1.8	1.2
Otolaryngology	0	0	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	32	180	51	257	308	1.6	1.4
Thoracic	0	0	0	0	0	0	0	0	0	0.0	0.0
Urology	0	0	0	0	44	177	46	107	153	1.0	0.6
Totals	**0**	**0**	**5**	**5**	**976**	**1974**	**1429**	**1934**	**3363**	**1.5**	**1.0**

SURGICAL RECOVERY STATIONS Stage 1 Recovery Stations 8 Stage 2 Recovery Stations 0

Dedicated and Non-Dedicated Procedure Room Utilzation

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

Cardiac Catheterization Labs

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

Emergency/Trauma Care

Certified Trauma Center by EMS	☐	
Level of Trauma Service	Level 1 (Not Answered)	Level 2 (Not Answered)
Operating Rooms Dedicated for Trauma Care		0
Number of Trauma Visits:		0
Patients Admitted from Trauma		0
Emergency Service Type:		Comprehensive
Number of Emergency Room Stations		12
Persons Treated by Emergency Services:		29,684
Patients Admitted from Emergency:		5,130
Total ED Visits (Emergency+Trauma):		**29,684**

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	**164**
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	148
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	16
EP Catheterizations (15+)	0

Cardiac Surgery Data

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

Outpatient Service Data

Total Outpatient Visits	**72,922**
Outpatient Visits at the Hospital/ Campus:	72,922
Outpatient Visits Offsite/off campus	0

Diagnostic/Interventional Equipment	Owned	Contract	Examinations: Inpatient	Examinations: Outpatient	Examinations: Contract
General Radiography/Fluoroscopy	3	0	5,636	18,090	0
Nuclear Medicine	1	0	502	355	0
Mammography	1	0	16	2,028	0
Ultrasound	3	0	2,537	9,560	0
Diagnostic Angiography	0	0	0	0	0
Interventional Angiography	0	0		0	
Positron Emission Tomography (PET)	0	0	0	0	0
Computerized Axial Tomography (CAT)	1	0	1,532	6,813	0
Magnetic Resonance Imaging	0	1	0	0	603

Radiation Equipment	Owned	Contract	Therapies/ Treatments
Lithotripsy	0	0	(
Radiation Therapy Equipment			
Linear Accelerator	0	0	0
Proton Beam Therapy	0	0	0
Gamma Knife	0	0	0
Cyber knife	0	0	0

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

Ownership, Management and General Information

ADMINISTRATOR NAME:	Myrna E. Pedersen
ADMINSTRATOR PHONE	773-292-8204
OWNERSHIP:	Norwegian American Hospital
OPERATOR:	Norwegian American Hospital
MANAGEMENT:	Other Not For Profit (specify below)
CERTIFICATION:	None
FACILITY DESIGNATION:	General Hospital
ADDRESS	1044 North Francisco Avenue CITY: Chicago COUNTY: Suburban Cook (Chicago)

Patients by Race

White	10.4%
Black	44.9%
American Indian	0.0%
Asian	0.8%
Hawaiian/ Pacific	0.0%
Unknown:	43.9%

Patients by Ethnicity

Hispanic or Latino:	43.0%
Not Hispanic or Latino:	56.5%
Unknown:	0.5%
IDPH Number:	1727
HPA	A-02
HSA	5

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2009	Staff Bed Occupancy Rate %
Medical/Surgical	98	91	91	5,876	21,565	2,450	4.1	65.8	67.1	72.3
0-14 Years				*1*	*2*					
15-44 Years				*2,121*	*6,257*					
45-64 Years				*2,550*	*9,305*					
65-74 Years				*645*	*2,983*					
75 Years +				*559*	*3,018*					
Pediatric	5	5	5	256	549	334	3.4	2.4	48.4	48.4
Intensive Care	12	12	12	495	2,889	26	5.9	8.0	66.6	66.6
Direct Admission				*216*	*1,801*					
Transfers				*279*	*1,088*					
Obstetric/Gynecology	48	15	15	1,807	4,126	148	2.4	11.7	24.4	78.1
Maternity				*1,757*	*3,728*					
Clean Gynecology				*50*	*398*					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	37	36	36	1,556	10,836	0	7.0	29.7	80.2	82.5
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedcated Observation	*0*					*0*				
Facility Utilization	200			9,711	39,965	2,958	4.4	117.6	58.8	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	*Medicaid*	*Other Public*	*Private Insurance*	*Private Pay*	*Charity Care*	*Totals*
	26.2%	58.9%	0.0%	10.3%	4.0%	0.6%	
Inpatients	2541	5718	0	998	391	63	9,711
	10.5%	51.7%	0.0%	30.2%	7.4%	0.2%	
Outpatients	8156	40182	0	23470	5772	161	77,741

Financial Year Reported: 10/1/2008 *to* 9/30/2009

Inpatient and Outpatient Net Revenue by Payor Source

	Medicare	*Medicaid*	*Other Public*	*Private Insurance*	*Private Pay*	*Totals*	*Charity Care Expense*
Inpatient	31.2%	60.5%	0.0%	5.2%	3.0%	100.0%	
Revenue ($)	26,744,207	51,808,950	0	4,463,870	2,593,112	85,610,139	1,568,559
Outpatient	19.1%	22.0%	0.0%	46.6%	12.3%	100.0%	
Revenue ($)	5,870,022	6,762,725	0	14,304,392	3,784,706	30,721,845	2,289,347

Total Charity Care Expense	3,857,906
Totals: Charity Care as % of Net Revenue	3.3%

Birthing Data

Number of Total Births:	1,789
Number of Live Births:	1,775
Birthing Rooms:	0
Labor Rooms:	0
Delivery Rooms:	0
Labor-Delivery-Recovery Rooms:	6
Labor-Delivery-Recovery-Postpartum Rooms:	0
C-Section Rooms:	2
CSections Performed:	518

Newborn Nursery Utilization

Level 1 Patient Days	240
Level 2 Patient Days	276
Level 2+ Patient Days	629
Total Nursery Patientdays	**1,145**

Laboratory Studies

Inpatient Studies	183,958
Outpatient Studies	258,530
Studies Performed Under Contract	6,592

Organ Transplantation

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

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	0	0	115	10	292	30	322	2.5	3.0
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	5	5	501	853	645	739	1384	1.3	0.9
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	0	0	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	0	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 RECOVERY STATIONS Stage 1 Recovery Stations 8 Stage 2 Recovery Stations 0

Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	2	2	430	683	253	401	654	0.6	0.6
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	0	0	0	0	0	0	0	0.0	0.0
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

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

Emergency/Trauma Care

Certified Trauma Center by EMS	☐	
Level of Trauma Service	Level 1	Level 2
	---	---
Operating Rooms Dedicated for Trauma Care		0
Number of Trauma Visits:		0
Patients Admitted from Trauma		0
Emergency Service Type:		Comprehensive
Number of Emergency Room Stations		12
Persons Treated by Emergency Services:		30,219
Patients Admitted from Emergency:		5,631
Total ED Visits (Emergency+Trauma):		**30,219**

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	**327**
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	99
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	10
EP Catheterizations (15+)	0

Cardiac Surgery Data

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

Outpatient Service Data

Total Outpatient Visits	**77,741**
Outpatient Visits at the Hospital/ Campus:	77,741
Outpatient Visits Offsite/off campus	0

Diagnostic/Interventional Equipment

	Owned	Contract	Examinations Inpatient	Examinations Outpatient
General Radiography/Fluoroscopy	7	0	5,856	18,460
Nuclear Medicine	1	0	545	318
Mammography	1	0	0	2,256
Ultrasound	5	0	2,313	10,091
Diagnostic Angiography	0	0	0	0
Interventional Angiography	0		0	0
Positron Emission Tomography (PET)	0	0	0	0
Computerized Axial Tomography (CAT)	1	0	1,308	9,109
Magnetic Resonance Imaging	0	1	0	0

Radiation Equipment

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

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

Hospital Profile - CY 2010	Norwegian American Hospital	Chicago	Page 1

Ownership, Management and General Information

ADMINISTRATOR NAME:	Jose R. Sanchez
ADMINSTRATOR PHONE	773-292-8204
OWNERSHIP:	NORWEGIAN AMERICAN HOSPITAL
OPERATOR:	NORWEGIAN AMERICAN HOSPITAL
MANAGEMENT:	Other Not For Profit (specify below)
CERTIFICATION:	
FACILITY DESIGNATION:	
ADDRESS	1044 North Francisco Avenue
CITY:	Chicago
COUNTY:	Suburban Cook (Chicago)

Patients by Race

White	9.9%
Black	47.0%
American Indian	0.1%
Asian	0.9%
Hawaiian/ Pacific	0.0%
Unknown:	42.1%

Patients by Ethnicity

Hispanic or Latino:	38.0%
Not Hispanic or Latino:	61.6%
Unknown:	0.5%

IDPH Number:	1727
HPA	A-02
HSA	6

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2010	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2010	Staff Bed Occupancy Rate %
Medical/Surgical	98	83	83	5,267	20,354	2,074	4.3	61.4	62.7	74.0
0-14 Years				*1*	*1*					
15-44 Years				*1,794*	*5,290*					
45-64 Years				*2,403*	*9,103*					
65-74 Years				*553*	*2,831*					
75 Years +				*516*	*3,129*					
Pediatric	5	5	5	183	440	245	3.7	1.9	37.5	37.5
Intensive Care	12	12	12	470	2,263	50	4.9	6.3	52.8	52.8
Direct Admission				*213*	*1,376*					
Transfers				*257*	*887*					
Obstetric/Gynecology	48	29	29	1,778	4,021	134	2.3	11.4	23.7	39.3
Maternity				*1,656*	*3,761*					
Clean Gynecology				*122*	*260*					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	37	36	36	1,619	10,636	0	6.6	29.1	78.8	80.9
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedcated Observation	*0*					*0*				
Facility Utilization	200			9,060	37,714	2,503	4.4	110.2	55.092	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	*Medicaid*	*Other Public*	*Private Insurance*	*Private Pay*	*Charity Care*	*Totals*
	26.9%	60.5%	0.0%	7.5%	1.2%	3.9%	
Inpatients	2437	5478	0	681	110	354	9,060
	10.3%	51.6%	0.0%	29.4%	0.1%	8.6%	
Outpatients	7038	35456	0	20151	93	5917	68,655

Inpatient and Outpatient Net Revenue by Payor Source

Financial Year Reported: 10/1/2009 *to* 9/30/2010

	Medicare	*Medicaid*	*Other Public*	*Private Insurance*	*Private Pay*	*Totals*	*Charity Care Expense*
	32.2%	58.5%	0.0%	7.2%	2.1%	100.0%	
Inpatient Revenue ($)	27,061,162	49,217,906	0	6,097,759	1,737,505	84,114,332	2,007,991
	19.0%	28.3%	0.0%	42.8%	9.9%	100.0%	
Outpatient Revenue ($)	4,577,702	6,801,444	0	10,295,103	2,368,897	24,043,146	2,737,676

Total Charity Care Expense	4,745,667
Totals: Charity Care as % of Net Revenue	4.4%

Birthing Data

Number of Total Births:	1,648
Number of Live Births:	1,624
Birthing Rooms:	0
Labor Rooms:	0
Delivery Rooms:	0
Labor-Delivery-Recovery Rooms:	6
Labor-Delivery-Recovery-Postpartum Rooms:	0
C-Section Rooms:	2
CSections Performed:	480

Newborn Nursery Utilization

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

Laboratory Studies

Inpatient Studies	163,909
Outpatient Studies	227,941
Studies Performed Under Contract	5,986

Organ Transplantation

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

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	0	0	96	9	363	21	384	3.8	2.3
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	5	5	468	810	639	685	1324	1.4	0.8
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	423	472	521	435	956	1.2	0.9
Oral/Maxillofacial	0	0	0	0	0	0	0	0	0	0.0	0.0
Ophthalmology	0	0	0	0	1	258	1	222	223	1.0	0.9
Orthopedic	0	0	0	0	46	73	74	98	172	1.6	1.3
Otolaryngology	0	0	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	53	267	83	367	450	1.6	1.4
Thoracic	0	0	0	0	0	0	0	0	0	0.0	0.0
Urology	0	0	0	0	36	123	30	95	125	0.8	0.8
Totals	**0**	**0**	**5**	**5**	**1123**	**2012**	**1711**	**1923**	**3634**	**1.5**	**1.0**

SURGICAL RECOVERY STATIONS Stage 1 Recovery Stations 8 Stage 2 Recovery Stations 0

Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	2	2	402	684	257	405	662	0.6	0.6
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	0	0	0	0	0	0	0	0.0	0.0
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

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

Emergency/Trauma Care

	Level 1	Level 2
Certified Trauma Center		No
Level of Trauma Service	Not Applicable	Not Applicable
Operating Rooms Dedicated for Trauma Care		0
Number of Trauma Visits:		0
Patients Admitted from Trauma		0
Emergency Service Type:		Comprehensive
Number of Emergency Room Stations		12
Persons Treated by Emergency Services:		24,564
Patients Admitted from Emergency:		5,985
Total ED Visits (Emergency+Trauma):		24,564

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	113
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	92
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	21
EP Catheterizations (15+)	0

Cardiac Surgery Data

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

Outpatient Service Data

Total Outpatient Visits	68,655
Outpatient Visits at the Hospital/ Campus:	68,655
Outpatient Visits Offsite/off campus	0

Diagnostic/Interventional Equipment	Own	Contract	Examinations Inpatient	Outpt	Contract
General Radiography/Fluoroscopy	7	0	5,354	16,745	0
Nuclear Medicine	1	0	504	225	0
Mammography	1	0	7	1,894	0
Ultrasound	5	0	2,145	10,067	0
Angiography	0	0			
Diagnostic Angiography			0	0	0
Interventional Angiography			0	0	0
Positron Emission Tomography (PET)	0	0	0	0	0
Computerized Axial Tomography (CAT)	1	0	1,231	7,379	0
Magnetic Resonance Imaging	0	1	0	0	495

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

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