ORIGINAL

12-079

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED

SEP 10 2012

HEALTH FACILITIES & SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Holy Cross Hospital				
Street Address:	2701 West 68th Street				
City and Zip Code:	Chicago, IL 60629				
County: Cook	Health Service Area	VI	Health Planning Area:	A-03	

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

Exact Legal Name:	Holy Cross Hospital
Address:	2701 West 68th Street Chicago, IL 60629
Name of Registered Agent:	
Name of Chief Executive Officer:	Wayne Lerner
CEO Address:	2701 West 68th Street Chicago, IL 60629
Telephone Number:	773/471-8000

Type of Ownership of Applicant/Co-Applicant

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

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

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

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

Name:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	675 North Court Suite 210 Palatine, IL 60067
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7004

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

Name:	David Frankel
Title:	Vice President
Company Name:	Sinai Health System
Address:	California at 15th Street Chicago, IL 60608
Telephone Number:	773/542-2000
E-mail Address:	david.frankel@sinai.org
Fax Number:	

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

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City and Zip Code:	Chicago, IL 60629				
County: Cook	Health Service Area	VI		Health Planning Area:	A-03

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

Exact Legal Name:	Sinai Health System
Address:	California at 15th Street Chicago, IL 60608
Name of Registered Agent:	
Name of Chief Executive Officer:	Alan H. Channing, President & CEO
CEO Address:	California at 15th Street Chicago, IL 60608
Telephone Number:	773/542-2000

Type of Ownership of Applicant/Co-Applicant

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ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Holy Cross Hospital		
Street Address:	2701 West 68th Street		
City and Zip Code:	Chicago, IL 60629		
County: Cook	Health Service Area VI		Health Planning Area: A-03

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

Exact Legal Name:	Mount Sinai Hospital Medical Center of Chicago
Address:	California at 15th Street Chicago, IL 60608
Name of Registered Agent:	
Name of Chief Executive Officer:	Alan H. Channing, President & CEO
CEO Address:	California at 15th Street Chicago, IL 60608
Telephone Number:	773/542-2000

Type of Ownership of Applicant/Co-Applicant

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

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
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Title:	Vice President
Company Name:	Sinai Health System
Address:	California at 15th Street Chicago, IL 60608
Telephone Number:	773/542-2000
E-mail Address:	david.frankel@sinai.org
Fax Number:	

Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance-**THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960**

Name:	Ms. Rachel Dvorken
Title:	Executive Vice President and General Counsel
Company Name:	Sinai Health System
Address:	California at 15th Street Chicago, IL 60608
Telephone Number:	773/542-2000
E-mail Address:	Rachel.dvorken@sinai.org
Fax Number:	

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Holy Cross Hospital
Address of Site Owner:	2701 West 68th Street Chicago, IL 60629
Street Address or Legal Description of Site:	2701 West 68th Street Chicago, IL 60629

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:	Holy Family Hospital
Address:	2701 West 68th Street Chicago, IL 60629

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

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

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

Organizational Relationships

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

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

Flood Plain Requirements **not applicable**

[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 **not applicable**

[Refer to application instructions.]

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

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

DESCRIPTION OF PROJECT

1. Project Classification

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

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

2. Narrative Description

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

The proposed project is limited to a change of the control and ownership of Holy Cross Hospital, which is the only licensed health care facility sponsored by the Sisters of St. Casimir ("Sisters"). Holy Cross Hospital operates independently from the Sisters, and is governed by a separate Board of Directors. Following the change of ownership and control, Holy Cross Hospital will become a member of Sinai Health System ("SHS"), and SHS will become the sole corporate member of Holy Cross Hospital.

The Archdiocese of Chicago has approved the continued Catholicity of Holy Cross Hospital, and the Sisters, through a stewardship agreement will provide oversight of the Hospital's Catholicity.

Holy Cross Hospital and Sinai Health System enjoy a congruence of mission, service areas that, to a large extent, overlap, and many physicians that practice at both Holy Cross Hospital and Mount Sinai Hospital Medical Center. Discussions related to the potential of Holy Cross Hospital joining SHS were initiated by Holy Cross Hospital after Vanguard Health System elected not to exercise its Permit (#10-081) to acquire the hospital.

Holy Cross Hospital is located at 2701 West 68th Street in Chicago, Illinois.

The proposed project is designated as "non-substantive" because it does not meet the definition of a "substantive" project.

LETTER OF INTENT

THIS LETTER OF INTENT ("**LOI**") evidences the intent of Sinai Health System ("**Sinai**"), an Illinois not-for-profit corporation that is exempt from federal income taxation pursuant to Section 501(c)(3) of the Internal Revenue Code (the "**Code**"), and Sisters of St. Casimir ("**SSC**"), an institute of women religious under the Roman Catholic Church, to ensure the transfer of individual membership interests in Holy Cross Hospital ("**HCH**") of sisters who serve as the General Superior and General Council of SSC to Sinai (the "**Proposed Combination**"). Each of Sinai, SSC and HCH are referred to individually in this LOI as a "**Party**," and collectively, as the "**Parties**."

ARTICLE I

RATIONALE AND OBJECTIVES OF PROPOSED COMBINATION

1.1 <u>Rationale and Vision</u>. The Governing Bodies ("**Boards**") of Sinai and HCH, along with the SSC, in keeping with their responsibilities to oversee their respective organization's charitable assets and mission, have engaged in a deliberative process to explore ways to more seamlessly, efficiently and effectively serve the patients in the region. It is each respective Board's vision to create a locally-based and governed mission-driven health system that would support significant improvements in health care delivery and outcomes, preserve needed health care services in the community, and be financially sustainable. This effort has culminated in the Parties' mutual desire to explore the Proposed Combination. To achieve the vision, the Proposed Combination shall have the following objectives:

(a) To provide more effective and efficient delivery of patient care;

(b) To develop and grow a combined service capability with seamless access for caregivers and patients;

(c) To develop a platform for enhanced quality and patient safety;

(d) To combine the strengths of Sinai and HCH to support future growth and financial sustainability;

(e) To maintain the community focus of each of Sinai and HCH; and

(f) To support the formation of a broad network of clinically integrated providers.

1.2 <u>Ensuring Success</u>. The Parties have determined that in order for objectives to be achieved, certain key philosophical and structural components of the Proposed Combination are critical. These include the following:

(a) Delivery of superior value to patients, physicians and payers;

(b) Fostering collaboration and decisions that are in the best interests of the communities served; and

(c) Respecting, celebrating and maintaining the unique aspects of each Party through a continued focus on community benefit, the retention of HCH's Catholic identity, and recognition of those individuals and groups which have and shall continue to contribute to the success of Sinai and HCH, including community members, patients, employers, contributors, physicians and other professional staff.

ARTICLE II

STRUCTURE OF THE PROPOSED COMBINATION

2.1 **Good Faith Negotiations.** The Parties shall work expeditiously and in good faith to negotiate such definitive agreements and instruments as they may agree are necessary to effect the Proposed Combination, containing terms consistent with those set forth in this LOI, and such other provisions upon which the Parties mutually may agree (collectively, the "**Definitive Agreements**"); provided, however, that nothing herein shall require the parties to execute the Definitive Agreements or to consummate the Proposed Combination. The closing date of the Proposed Combination (the "**Closing Date**") shall be set in the Definitive Agreements as the date on which all regulatory approvals are received, including, but not limited to, by the Illinois Certificate of Need program, the Federal Trade Commission, and the U.S. Department of Housing and Urban Development, each of which shall be pursued as expeditiously as possible. The target Closing Date shall be October 1, 2012.

2.2 **Membership.** The Definitive Agreements shall provide that on the Closing Date, the sole corporate member of HCH shall be Sinai. No consideration shall be paid by Sinai to SSC, individual sisters of SSC, or HCH upon change of membership. There shall be no indemnification of Sinai post-Closing Date by SSC or any other party related to any assets, liabilities, or operations of HCH.

2.3 **Governance.** The Definitive Agreements shall provide that, on and following the Closing Date, the business and affairs of HCH shall be governed and managed by the HCH Board of Directors ("**HCH Board**") as appointed by Sinai. SSC shall nominate at least one (1) individual to serve as a member of the Sinai Board with final approval of appointment by Sinai consistent with Sinai's Bylaws.

2.4 **Medical Staffs.** The Definitive Agreements shall provide that the medical staff of HCH and the medical staffs of other Sinai affiliates shall remain independent from each other, but shall integrate wherever possible and shall share information amongst themselves for the purpose of establishing a continuum of care and safer and more efficient and effective outcomes for patients (the "**Medical Staff Integration**"). Except as provided below, the HCH Medical Staff Bylaws shall remain in place at the Closing Date, shall be reviewed periodically as is done with all Sinai affiliates, and shall be adjusted in accordance with the amendment terms of such Medical Staff Bylaws to facilitate Medical Staff Integration and to move toward quality programs consistent across all of Sinai and HCH. HCH shall, as a condition of Closing, cause the following amendments to its Medical Staff Bylaws to be effective as of the Closing Date: (i) Appointments to the Provisional Staff shall be for six months with no restriction on voting rights; (ii) The Chief Medical Officers of Sinai Health System and Sinai Medical Group shall be ex officio members of the Medical Executive Committee; (iii) Medical Staff Bylaws amendments shall be adopted by a vote of two-thirds (2/3) of present, voting members (eliminating the requirement that a quorum of 20% of the active Medical Staff must be present); and (iv) Members of the Active Medical Staff of Mount Sinai Hospital or Schwab Rehabilitation Hospital who apply for and are granted membership and privileges on the HCH medical staff will be granted immediate Active Staff status. Also, after the Closing Date, Sinai shall ensure that Active Staff members at HCH who apply for and receive privileges on the Mount Sinai Hospital medical staff shall be granted immediate Active Staff status. Further, in order to advance the purposes of the transaction, those members of the MSH and SRH medical staffs that are listed in Exhibit E (or a substantially similar list as reasonably requested by Sinai in light of ongoing recruitment and development of Medical Integration Plans), will be granted membership and appropriate clinical privileges on the HCH Medical Staff at the outset, and appointment as members of the active staff of such physicians would be a condition of and occur simultaneous with the Closing Date.

2.5 **Future Sale of HCH.** If the HCH hospital operations or facilities material to such operations are sold by Sinai within a five (5) year period after the Closing Date, Sinai shall share the proceeds of said sale with SSC less all capital expenditures made by Sinai net of government grants applied to such capital expenditures, above recorded depreciation expense for the twelve (12) month period prior to the Closing Date, so long as such sharing does not materially adversely affect pledges or covenants made by Sinai under financing arrangements with HUD or any other creditor essential to ongoing operations of the combined Sinai/HCH enterprise.; provided that Sinai shall use good faith efforts to obtain the consent of any lender of Sinai to permit Sinai to share the proceeds with SSC in accordance with this Section.

If in Year:	Percentage of Proceeds provided to SSC:
1	50%
2	40%
3	30%
4	20%
5	10%
6	0%

2.6 **Pension Plan.** HCH currently maintains a frozen defined benefit pension plan (**"Plan"**) for certain of its current and former employees that is qualified as a Church Plan and not subject to the Employee Retirement and Income Security Act of 1974. SSC, or its designee, shall become on the Closing Date the Sponsor of the Plan upon transfer of such status by HCH. SSC through its advisors overseeing administration of the Plan shall, following the Closing Date, petition Sinai for additional funding of the Plan, as needed, consistent with Plan objectives as modified from time-to-time by SSC, but in no case with such additional funding creating greater benefits accorded the beneficiaries of such Plan than would be expected were the Plan terminated by HCH at the Closing Date, and provided further that notwithstanding anything else to the contrary herein, it is entirely at Sinai's discretion to provide any funding.

ARTICLE III

PROPOSED COMMITMENTS

3.1 **Proposed Commitments.** The Definitive Agreements shall include a process and timeframe for consideration and, as applicable, implementation of each of the following proposed commitments, which are deemed by the Parties as important. All of the following proposed commitments shall be prioritized and included in the Strategic Plan:

(a) Commitment to Current HCH Employees. Sinai plans to retain and utilize the current HCH and Sinai workforce to achieve the shared missions of the organizations. Current HCH employees shall be able to receive credit for their time at HCH should they become enrolled in the Sinai benefits program. Sinai reserves the right to evaluate the combined operations of Sinai and HCH, identify areas with the potential for duplication and make re-assignments or consolidate positions, including the elimination of positions, as required. Sinai shall apply industry-wide best practices consistent with prudent use of resources to achieve the best use of the workforce of Sinai and HCH to meet patient care needs in the most efficient manner.

(b) Catholic Identity. Catholic identity shall be retained pursuant to the Catholicity Agreement at Exhibit A, which shall be executed as part of the Definitive Agreements.

(c) Charity Care Commitment. Sinai has been, and shall continue to be, committed to providing care for all in the community served by Sinai and HCH. Sinai shall maintain policies, consistent with Sinai's existing charity care policies, for HCH patients whereby HCH shall care for all patients regardless of ability to pay with a self-pay/charity care policy that respects the dignity of the patient.

(d) Capital Commitment to HCH. Sinai views the HCH physical plant and medical equipment as critical assets in achieving the similar missions of the Parties. Sinai's intention is to continue to utilize these assets to strengthen the care programs that can be provided to the community. Pending an assessment of the physical plant and equipment during the due diligence period, Sinai shall continue funding HCH capital investments primarily with proceeds from operations and governmental grants received by HCH. Planning for future investments shall take into consideration the existing capital plan of HCH, but shall be modified as necessary to continue with operation of the facilities for healthcare purposes in accordance with a broader strategic plan to be developed upon combining the two organizations. Sinai and HCH shall engage in joint advocacy efforts seeking philanthropic and other sources of funding to support capital improvements.

(e) Continued Services Commitment. Sinai shall continue to provide the HCH services offered as of the Closing Date, but reserves the right to evaluate a methodology which would be most beneficial to patients and cost-effective for combined operations so as not to create unnecessary duplication. Such methodology may include, but not be limited to, offering some services at one physical location only with strong coordination of referrals and facilitation of access for the patients in the communities served by Sinai and HCH. Sinai's transportation services shall also support access between the campuses.

(f) Operation as a Licensed Hospital. HCH shall be operated as a licensed hospital for five (5) years post-Closing Date, unless there is a significant change in Medicaid and government support payments making fulfillment of the pledge financially unfeasible or a change is needed to meet compelling community care needs.

(g) Annual Stewardship Fee. An annual stewardship fee amounting to Three Hundred Thousand Dollars ($300,000) per annum shall be provided by Sinai to SSC consistent with Section 4.1 of the Catholicity Agreement at Exhibit A.

(h) Medical Office Buildings. At the Closing Date, HCH shall transfer title of its medical office building located on Archer Avenue to Sinai or a designated affiliate thereof.

(i) Settlement Agreement. HCH is in process of finalizing a certain Settlement Agreement with the United States of America, acting through the Department of Justice and on behalf of the Office of the Inspector General of the Department of Health and Human Services ("**Settlement Agreement**"). Sinai agrees that upon consummation of the Proposed Combination it shall be the Successor-in-Interest described in Section 3 of the Settlement Agreement, and shall be bound by the terms of the settlement as the Successor-in-Interest, including that if any of the events identified in paragraphs 2(A) through 2(E) of the Settlement Agreement occurs within five (5) years of the effective date of the Settlement Agreement, then Sinai as Successor-in-Interest will promptly, either: (a) pay the United States $1,500,000; or (b) transfer title of the property located at 6084 S. Archer Avenue, Chicago, Illinois, to the United States, and support all claims of the United States with respect to that property. Execution of the Settlement Agreement shall be a condition of Closing.

ARTICLE IV

CONFIDENTIALITY

The Parties hereby reaffirm the confidentiality commitments set forth in that certain Agreement for Use and Non-Disclosure of Confidential Information by and between Sinai and HCH dated June 1, 2012 (the "**Confidentiality Agreement**"), which Confidentiality Agreement is attached hereto as Exhibit B and is incorporated herein by reference, and hereby agree to the following amendments to the Confidentiality Agreement: (i) this LOI shall be Confidential Information protected therein; (ii) the second line of Section 18 is amended to substitute September 30, 2012 in lieu of July 31, 2012 regarding the Exclusive Period; (iii) the parties hereby adopt an amended Communication Plan as set forth in Exhibit F hereto effective as of the effective date of this Letter of Intent set forth below. Nothing herein shall be deemed to modify or negate any other commitments in the Confidentiality Agreement, all of which remain in full force and effect.

ARTICLE V

ANTITRUST PROTOCOLS AND DUE DILIGENCE

5.1 Antitrust Protocols. The Parties acknowledge and agree that, in evaluating the Proposed Combination, exchanging and evaluating due diligence information and conducting meetings and discussions, the Parties have adopted and shall continue to abide by the antitrust protocols attached as Exhibit C and incorporated herein by reference (the "**Antitrust Protocols**").

5.2 Due Diligence. To assist the Parties in evaluating the Proposed Combination, HCH shall grant to Sinai, and Sinai's representatives, reasonable access to HCH's books and records in accordance with mutually agreeable procedures, and subject to the Antitrust Protocols and the terms of the Confidentiality Agreement. Sinai shall conduct due diligence in a manner which is as least disruptive as possible to the normal business operations of HCH and SSC.

ARTICLE VI

TERM AND TERMINATION

The term of this LOI shall commence on August 10, 2012 (the "**Effective Date**") and shall continue in full force and effect until the earlier of: (i) the execution of the Definitive Agreements upon which the Parties may agree; or (ii) the Termination Date. The "**Termination Date**" shall mean the earlier of ten (10) days from the date on which one Party shall deliver to the other written notice of its intent to withdraw from negotiations and terminate this LOI, or one hundred twenty (120) days from the Effective Date.

ARTICLE VII

BINDING AND NON-BINDING PROVISIONS

7.1 Binding Provisions. The terms and provisions set forth in Section 2.1, Article IV, Article V, this Section 7.1 and Article VIII shall be contractual obligations which are binding upon the Parties.

7.2 Non-Binding Provisions. Except as set forth in Section 7.1, all other provisions of this LOI shall be non-binding. Neither Party shall be obligated to consummate the Proposed Combination.

ARTICLE VIII

MISCELLANEOUS

8.1 Interim Conduct. During the term of this LOI, HCH shall use reasonable commercial efforts to:

(a) Preserve, protect and maintain its business, properties and assets;

(b) Operate its business as a going concern consistent with its current approved budgets, prior practices and not other than in the ordinary course of its business; and

(c) Preserve the goodwill of all individuals having business or other relations with it, including patients, payors and suppliers.

HCH shall not knowingly enter into any transaction which could have a material adverse effect on its business or which would materially affect its ability to enter into the Definitive Agreements or to consummate the Proposed Combination.

8.2 Expenses. Unless the Parties agree otherwise in writing, each Party shall bear all fees and expenses and those of its agents, advisors, attorneys and accountants which it or they incur with respect to this LOI and the Proposed Combination, including, without limitation:

(a) The negotiation of this LOI;

(b) The conduct of due diligence as provided above;

(c) The negotiation of the Definitive Agreements; and

(d) If the Definitive Agreements are executed, the closing of the Proposed Combination.

Notwithstanding the above, HCH shall reimburse Sinai for one-half (1/2) of all reasonable expenses with HCH's share not to exceed Two Hundred Thousand Dollars ($200,000) incurred by Sinai in pursuit and negotiation of this Proposed Combination whether such Proposed Combination is consummated or not, as previously agreed upon, portions of which reimbursement have already been made. All governmental filings and other proceedings required in connection with the Proposed Combination and this LOI, including the filing fees for the Certificate of Need and Hart-Scott-Rodino filings, shall be shared equally by the Parties.

8.3 Publicity. The Parties shall determine in advance, by mutual agreement and consent, the timing and content of any announcement, press release or other public statement concerning the Proposed Combination.

8.4 Governing Law. This LOI shall be governed by and construed in accordance with the internal substantive laws of the State of Illinois without regard to conflict of laws principles.

8.5 Counterparts and Signatures. This LOI may be executed in any number of counterparts, and each counterpart shall be deemed to be an original, and all such counterparts shall together constitute one and the same instrument. Electronic and facsimile signatures shall be deemed to be original signatures.

8.6 Amendments. This LOI may not be amended in whole or in part except by a written instrument signed by both Parties.

ARTICLE IX

NOTICES

9.1 **Notices.** All notices, requests, demands and other communications which are required or may be given pursuant to the terms of this LOI shall be in written or electronic form and shall be deemed delivered: (a) on the date of delivery when delivered by hand; (b) one (1) day after dispatch when sent by overnight courier maintaining records of receipt; or (c) three (3) days after dispatch when sent by certified mail, postage prepaid, return-receipt requested; provided that, in any such case, such communication is addressed as provided in this Section 9.2.

9.2 **Contacts.** All notices, requests, demands and other communications which are required or may be given pursuant to the terms of this LOI shall be addressed as follows:

If to Sinai:	Sinai Health System California Avenue at 15th Street Chicago, IL 60608 Attention: Alan Channing President & Chief Executive Officer
With a copy to:	Sinai Health System California Avenue at 15th Street Chicago, IL 60608 Attention: Rachel Dvorken General Counsel
With a copy to:	McDermott Will & Emery LLP 227 W. Monroe Street Chicago, IL 60606 Attention: Michael F. Anthony, P.C.
If to HCH:	Holy Cross Hospital 2701 W. 68th Street Chicago, IL 60629 Attention: Wayne Lerner President & Chief Executive Officer
With a copy to:	Chuhak & Tecson 30 S. Wacker Drive Chicago, IL 60606-7512 Attention: Andrew Tecson
If to SSC:	The Sisters of St. Casimir 2601 W. Marquette Road Chicago, IL 60629 Attention: Sr. Immacula Wendt General Superior/President

With a copy to: Lawrence E. Singer
Lawrence E. Singer, P.C.
2323 Grey Avenue
Evanston, IL 60201

or to such other addresses as either Party shall have designated by written notice in the foregoing manner to the other Party.

9.3 **Waiver.** No waiver of any provision, condition or covenant of this LOI shall be effective as against the waiving Party unless such waiver is in writing and signed by the waiving Party.

9.4 **Headings.** The division of this LOI into Articles and Sections and the insertion of headings are for convenience of reference only and shall not affect the construction or interpretation of this LOI.

9.5 **Assignment.** This LOI may not be assigned by either Party without the prior written consent of the other Party.

9.6 **Remedies.** Each Party agrees that if it violates or breaches any binding obligation under this LOI, the other Party shall be entitled to preliminary and permanent injunctive relief either pending or following a trial on the merits, together with any other remedies that may be available at law or in equity, without being required to post bond or other security. Should a Party seek or obtain a remedy against a Party, such action shall not be considered an election of remedies or a waiver of any right by the Party to assert any other remedy or remedies it may have at law or in equity.

9.7 **Severability.** If any covenant or provision hereof is determined to be void or unenforceable in whole or in part, it shall not be deemed to affect or impair the validity of any other covenant or provision, each of which shall be separate and distinct. If any binding provision of this LOI is so broad as to be unenforceable, such provision shall be interpreted to be only so broad as is enforceable. If any binding provision of this LOI is declared invalid or unenforceable for any reason other than over-breadth, the offending provision shall be modified so as to maintain the essential benefits of the bargain between the Parties to the maximum extent possible, consistent with law and public policy.

9.8 **Joint Defense Agreement.** The Parties shall require their counsel to enter into a Joint Defense Agreement with terms substantially similar to those set forth in Exhibit D to cooperate in the defense of the Parties related to the Proposed Combination and to avoid the waiver of any privilege with respect to any communications by and between the Parties (including their counsel).

[Signatures on following page.]

IN WITNESS WHEREOF, accepted and agreed to as of this 10th day of August, 2012.

SINAI HEALTH SYSTEM

By: ______________________
Alan Channing
President & Chief Executive Officer

HOLY CROSS HOSPITAL

By: ______________________
Wayne Lerner
President & Chief Executive Officer

SISTERS OF ST. CASIMIR

By: Sister Immacula Wendt
Sr. Immacula Wendt
General Superior/President

IN WITNESS WHEREOF, accepted and agreed to as of this 10th day of August, 2012.

SINAI HEALTH SYSTEM

By:
Alan Channing
President & Chief Executive Officer

HOLY CROSS HOSPITAL

By: Wayne M. Lerner DPH
Wayne Lerner
President & Chief Executive Officer

SISTERS OF ST. CASIMIR

By:__________________________
Sr. Immacula Wendt
General Superior/President

EXHIBIT A

CATHOLICITY AGREEMENT

THIS CATHOLICITY AGREEMENT ("**Agreement**"), dated _______________, _____ ("**Effective Date**"), is between the Sisters of St. Casimir ("**SSC**") and Sinai Health System ("**Sinai**").

RECITALS:

A. The SSC is a congregation of women religious organized as a public juridic person under the laws of the Roman Catholic Church and serves as the sponsor of Holy Cross Hospital. The SSC conduct their activities through an Illinois not-for-profit corporation recognized as an organization exempt from taxes under the laws of the State of Illinois and the United States; and

B. Holy Cross Hospital, an Illinois not-for-profit organization ("**HCH**"), is the owner and operator of a hospital located in Chicago, Illinois (the "**Hospital**"). HCH is recognized as an organization exempt from taxes under the laws of the State of Illinois and the United States; and

C. Sinai is a party to a Membership Change Agreement dated ___________, _____ (the "**Membership Change Agreement**") with the SSC and HCH, pursuant to which SSC agreed to ensure the transfer of individual membership interests in the Hospital of sisters who are part of SSC to Sinai; and

D. HCH is Roman Catholic in origin and philosophy, and has a strong and long-lasting tradition founded in and has operated the Hospital in accordance with the principles and tenets of the Catholic faith; and

E. Sinai acknowledges that for more than 80 years health care services provided by the Hospital have been delivered in accordance with the values of the Catholic faith recognizing the dignity of the individual with reverence, acceptance, compassion and hospitality in order to improve the health of the whole person and Sinai desires that services will continue to be delivered by the Hospital in such manner under its ownership; and

F. Sinai has agreed that the Hospital will continue to be operated as a Catholic hospital as provided herein in accordance with the traditions of Catholic health care; and

G. The continued operation of the Hospital as a Catholic hospital with oversight by the SSC under the terms of this Agreement with respect to HCH's Catholic identity is a primary consideration of the SSC's and HCH's agreement to transfer ownership and control of the Hospital to Sinai; and

H. The parties agree to maintain the Catholic identity of the Hospital and to use this Agreement as a framework within which to continue the moral, ethical, and Catholic traditions, practices and teachings within the Hospital; and

I. The parties have consulted with the Roman Catholic Archdiocese of Chicago ("**RCAC**") in the development of this Agreement and the RCAC has determined that the relationship this Agreement creates between the SSC and Sinai, if properly implemented and enforced, will enable the Hospital to operate as a Catholic institution and to continue to be recognized by the RCAC as such; and

J. Sinai believes that it is in the best interests of the communities served by the Hospital to affect the transfer by individuals who are part of SSC of their membership interests in the Hospital to Sinai and enter into this Agreement to preserve the Hospital as a Catholic institution.

NOW, THEREFORE, in consideration of the foregoing premises and the mutual promises contained in this Agreement, and intending to be legally bound, the parties agree as follows:

ARTICLE 1

FUNDAMENTAL PRINCIPLES

1.1 Fundamental Principles of Governance.

(a) Ownership and control of the Hospital will be transferred to Sinai at the closing of the transaction described in the Membership Change Agreement and as of the date and time set forth therein (the "**Closing**"). Notwithstanding the oversight authority granted by this Agreement to the SSC with respect to the Catholic identity of the Hospital, the SSC has no right, title, claim or other interest in and to any property of Sinai, including the Hospital, as ecclesiastical property or otherwise, whether such property is now owned or hereafter acquired.

(b) The SSC shall perform the oversight, monitoring and other responsibilities associated with maintaining and strengthening the Catholic identity and mission of the Hospital as set forth in this Agreement. The SSC will not have any authority with respect to Sinai, or any subsidiary or affiliate of Sinai, other than the contractual rights provided in this Agreement, the Membership Change Agreement or any agreement between the parties with respect to the moral, ethical, and Catholic traditions, practices and teachings of the Hospital.

(c) Nothing contained in the Membership Change Agreement or this Agreement will be construed to prohibit or limit the authority of Sinai to consolidate at any time administrative, management, or other business functions of the Hospital with any other hospitals owned or operated by Sinai or its subsidiaries.

1.2 Fundamental Principles Regarding Catholic Identity. Sinai will cause the Hospital to be operated in a manner that maintains its designation and identity as Catholic by the RCAC. As such, Sinai will be operated and shall operate the Hospital in a manner that is consistent with the moral, ethical and social teachings of the Roman Catholic Church including, but not limited to, those teachings and prescriptions expressed in the *Ethical and Religious Directives for Catholic Health Care Services* (the "**Directives**") as amended from time to time and approved by the United States Conference of Catholic Bishops and interpreted by the RCAC. A Summary of the current Directives is attached as Exhibit 1.2 and the full version is incorporated herein by reference (if the Directives are amended, such amended Directives will be deemed incorporated herein by reference).

1.3 Commitment to Protect Catholic Identity of the Hospital.

(a) For purposes of this Agreement, the term "**affiliate**" means an entity which controls, is controlled by, or is under common control with an entity, whether pre- or post-Closing. The term "**control**" means the ability to vote 50% or more of the voting stock or other equity interest in an entity. "**Fiscal Year**" means the period from July 1 through June 30.

(b) Sinai acknowledges that grave scandal can be caused under Catholic ethical teachings by the Hospital referring, recommending and/or performing Abortions, Euthanasia or Physician Assisted Suicide; or by any employee or other party providing services at the Hospital (including a physician, pharmacist, technician or tenant) providing any referral and/or recommendation for and/or prescribing, distributing, fitting of devices, prescribing/offering medications to and/or providing or performing procedures (including the provision of contraceptive services) whose sole intended outcome is either temporary or permanent sterilization as well as the prescribing, referral and/or recommendation for assistance in any reproductive measure beyond diagnosis, providing assisted reproductive services (including, but not limited to in vitro fertilization), or providing or performing any other services, procedures or techniques violative of the Directives ("**Prohibited Practices**") at Hospital. Accordingly, Sinai will assure that Prohibited Practices will not occur at Hospital. Violation of the foregoing commitment shall constitute a material breach of this Agreement remedied by specific performance pursuant to Section 5.4. On an annual basis Sinai will certify to the SSC that no Prohibited Practices have occurred within Hospital.

(c) For purposes of this Section 1.3:

(i) "**Abortion**" means the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus. Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion, which, in its moral context, includes the interval between conception and implantation of the embryo;

(ii) "**Assisted Reproductive Services**" means any action whose intent, measures and outcome(s) replace heterosexual intercourse as the means and context for the unassisted conception of new human life. It also includes any participation in or with measures involving embryonic sale, freezing, cell retrieval or implantation as well as the retrieval, use or sale of human gametes;

(iii) "**Euthanasia**" means an action or omission that of itself or by intention causes death in order to alleviate all suffering;

(iv) "**Physician-Assisted Suicide**" means euthanasia attended by a physician; and

(v) "**Sterilization**" means any action whose sole intent and outcome is to prevent natural conception from occurring as the result of heterosexual intercourse between consenting parties.

(d) Sinai shall assure that any monies generated from procedures performed at any health care facility owned by Sinai or any affiliate of Sinai that violate the Directives will not be used to support, in any way, the Hospital.

1.4 **Non-Disparagement.** No member of the management of Sinai will, in their professional capacity, speak against or in any way communicate to any audience criticism of the values, principles and guidelines of the Catholic Church as evidenced in the Directives.

1.5 **Sponsorship.** The SSC will continue as the Catholic sponsor of the Hospital and will be designated as the sponsor in all Hospital signage, informational materials and other media, as appropriate. The RCAC recognizes the continued sponsorship of the Hospital by the SSC and its continuous recognition as a Catholic hospital. A copy of a statement affirming the RCAC's recognition of sponsorship and Catholicity is attached hereto as Exhibit 1.5.

1.6 **Access Agreement.** Sinai agrees that should it accept assignment of that certain Affiliation Agreement dated February 17, 2010, entered into by and between HCH and Access Community Health Network, Inc. ("**ACHN**"), or enter into a new agreement with ACHN relating to services within the Hospital, that Sinai will cause the catholicity terms contained in the February 17, 2010 Agreement to be incorporated into the assigned or new agreement, it being recognized that Sinai may modify any of the other terms of agreement given its longstanding relationship with ACHN. A true and complete copy of the February 17, 2010 Agreement is attached hereto as Exhibit 1.6.

ARTICLE 2

CATHOLIC SERVICES AND OFFICES AT THE HOSPITAL

2.1 **Vice President of Mission Effectiveness.** Sinai will maintain the position of Vice President of Mission Effectiveness as a member of the Hospital's senior management team with competitive salary and benefits. The Vice President of Mission Effectiveness shall be of the Catholic faith and in communion with the Church. The SSC shall be consulted in determining the qualifications appropriate for the office of Vice President of Mission Effectiveness and shall participate in the selection of the person to hold such office. The person selected to be the Vice President of Mission Effectiveness shall be satisfactory to the SSC.

2.2 **Mission Effectiveness Department.**

(a) Because the parties believe that health care is a social good and human right, Sinai will maintain, adequately fund and resource a Mission Effectiveness Department at the Hospital. The Mission Effectiveness Department will assist Hospital leadership in promoting the values and teachings of the Roman Catholic Church. The initial budget for the Mission Effectiveness Department (including pastoral care) is attached as Exhibit 2.2.

(b) The Mission Effectiveness Department will ensure that the Hospital continues to deliver health care services in accordance with the Catholic values of dignity of the individual with reverence, acceptance, compassion and hospitality in order to improve the health of the whole person.

(c) The Mission Effectiveness Department and the SSC will provide continuing education on Catholic ethical and social teachings to the Hospital board, Hospital management personnel and Hospital employees to insure that ethical decisions are an integral part of the Hospital business, human resource and patient care decisions.

2.3 **<u>Ethics Committee</u>.** Sinai will establish an Ethics Committee relating to the Hospital as contemplated by the Directives. At least one designee of the SSC will serve as a member of the Ethics Committee. The Vice President for Mission Effectiveness will serve on the Ethics Committee and will conduct mandatory education and training sessions for the other members of the Ethics Committee concerning Catholic principles of medical ethics and, in particular, the Directives, with oversight of the contents of such education and training by the SSC. The Ethics Committee will assist the SSC in conducting bi-annual audits of the Hospital to ensure compliance with this Agreement. An ethicist of the Catholic faith, in communion with the Church and approved by the RCAC shall serve in an advisory capacity to the Ethics Committee.

2.4 **<u>Pastoral Care</u>.** Sinai will maintain and financially support a Pastoral Care Director and maintain a properly staffed and adequately funded Pastoral Care Department for Hospital, in substantially the same manner as it has historically been maintained and supported. The Pastoral Care Department will be available to all patients, family members, health care professionals and employees at the Hospital. The services of the Pastoral Care Department will be provided throughout the continuum of care provided by the Hospital. The budget for the Pastoral Care Department is encompassed within the Mission Effectiveness budget set forth in <u>Exhibit 2.2</u>.

2.5 **<u>Chapel(s)</u>.** Sinai will maintain the chapel at the Hospital as a Catholic chapel with the Blessed Sacrament. The chapel will be under the authority of the Pastoral Care Director of the Hospital.

2.6 **<u>Catholic Symbols and Items</u>.** Sinai will maintain all existing signage, symbols and images of Catholic identity, both within and without the facilities and will maintain insurance for religious items and artifacts located in the Hospital, including the chapel.

2.7 **<u>Sister Presence</u>.** To support the Catholicity of the Hospital, Sinai shall encourage the presence of members of the SSC through the retention of those Sisters currently employed by the Hospital (so long as they continue to be qualified to fulfill the responsibilities of their positions) and welcoming Sisters to fill volunteer positions at the Hospital, so long as they are willing and able.

2.8 **<u>Catholic Health Organizations</u>.** Sinai will cause the Hospital to maintain in good standing its membership in the Catholic Health Association or its successor organization ("**CHA**"), the Illinois Catholic Health Association ("**ICHA**"), as long as such membership is permitted by CHA and ICHA.

2.9 **<u>Name and Marketing</u>.** Sinai will continue to market the Hospital and its services under the existing Hospital name. Any websites or marketing materials maintained by Sinai or any affiliate shall indicate the Hospital's designation as a Catholic Hospital and its compliance with the Directives. Any marketing materials for Hospital in the Chicago area, including materials on the world wide web, shall not contain materials promoting services or procedures violative of the Directives.

2.10 **Consultation.** The President and Chief Executive Officer of Sinai and a designee appointed by the SSC will each have the right to consult with the other regarding the moral, ethical and Catholic traditions, practices and teachings of the Hospital or the operation of the Hospital as a Catholic institution generally.

2.11 **Powers of the SSC.** The SSC shall have the following powers with respect to the Hospital:

(a) The right to nominate an individual to serve as a member of the Sinai Board with final approval of appointment by Sinai consistent with Sinai's Bylaws;

(b) Reasonable approval of the appointment of all members of the Ethics Committee;

(c) Reasonable approval of the mission, philosophy and values statements of the Hospital;

(d) The right to be consulted by Sinai regarding the selection of the Chief Executive Officer of the Hospital ("**CEO**"), provided that such consultation shall be limited to assuring that the CEO is able to oversee the mission and operation of the Hospital in a manner which will assure its continued Catholicity;

(e) Reasonable approval of the Vice President of Mission Effectiveness;

(f) Ability to remove the Vice President of Mission Effectiveness in the event of "**grave scandal**" as determined in the sole discretion of the RCAC or the failure of the Vice President of Mission Effectiveness to keep the Hospital in material compliance with the terms of this Agreement; and

(g) Reasonable approval of the Hospital's charity care policy.

ARTICLE 3

CONTRACTUAL AUTHORITY OF THE SSC OVER CATHOLIC ISSUES

3.1 **Catholic Monitoring Committee.** Sinai will establish a Catholic Monitoring Committee ("**CMC**") as an independent committee within Sinai's governance structure. The purpose of the CMC is to provide a means through which the SSC may identify, monitor and audit the activities of the Hospital to ensure it remains faithful to the moral, ethical, and Catholic traditions, practices and teachings of the Roman Catholic Church. The CMC shall consist of three to six members, all of whom will be appointed by and serve at the pleasure of the SSC; provided, that Sinai shall have the right to approve the individuals to be appointed by the SSC, which approval will be not unreasonably withheld. The CMC will provide a written report to the SSC and Sinai on an annual basis concerning its monitoring and auditing functions, which report shall be shared with the RCAC. Sinai will provide the SSC and CMC with reasonable access to Hospital personnel, facilities and other resources to assist the CMC in the performance of its duties.

ARTICLE 4

STEWARDSHIP FEE; OUT-OF-POCKET EXPENSES

4.1 Amount and Payment of Stewardship Fee. In recognition of the sponsorship oversight provided by the SSC pursuant to this Agreement, Sinai will pay the SSC Three Hundred Thousand Dollars ($300,000) per Fiscal Year, subject to proration for any partial Fiscal Year. The fee will be payable in advance in quarterly installments of Seventy-Five Thousand Dollars ($75,000) on the first business day of each fiscal quarter during the term of this Agreement.

4.2 Reimbursement of Expenses. All members of the CMC who are not employees of Sinai or its affiliates will be entitled to reimbursement by Sinai for reasonable travel expenses and out-of pocket costs which are approved in advance when attending CMC meetings.

ARTICLE 5

RESOLUTION OF DISPUTES REGARDING CATHOLIC ISSUES

5.1 CMC Dispute Resolution Process.

(a) Except with respect to violations of Section 1.2, Section 1.3 and/or Section 1.4, which violations shall be subject to specific performance under Section 5.4, if the Hospital takes any action or holds any public position, or if Sinai or any civil law requires the Hospital to take any action or public position, in any case that is inconsistent with the moral, ethical, and Catholic traditions, practices and teachings of the Roman Catholic Church as expressed in the Directives (a "**Catholic Issue**"), the members of the CMC will first discuss with the President and CEO of Sinai their concerns regarding that Catholic Issue and any proposed actions relating to such issue in an effort to reach an agreement as to the appropriate action to be taken to cause the Catholic Issue to be consistent with the Directives.

(b) Following such discussions, the CMC may make a written recommendation to Sinai with respect to the Catholic Issue, the proposed actions relating to such issue, and the grounds for such proposed actions.

(c) If Sinai has concerns regarding a Catholic Issue, it may discuss such matter with the CMC or the RCAC.

5.2 Dispute Resolution Process.

(a) If, after following the procedures described in Section 5.1, the CMC and Sinai are unable to agree on an appropriate course of action to alleviate the CMC's concern about the Catholic Issue, either Sinai or the CMC may institute the following process by written notice to the other:

(i) Representatives of Sinai and the SSC will meet within fifteen (15) days after the date of written notice. Such representatives will include the CEO of Sinai and such other representatives of Sinai and the SSC as they may choose; and

(ii) If the disagreement remains unresolved, either party may request a consultation with the Archbishop of Chicago or his representative as the final interpreter of the Directives.

(b) If the dispute is not resolved through the process described above, the Archbishop of Chicago or his representative, as the final interpreter of the Directives, shall decide the matter and Sinai shall comply with the decision of the Archbishop of Chicago or his representative consistent with applicable civil law. Following the above dispute resolution process is a condition precedent to exercising termination provisions or commencing legal action.

5.3 **Legal Proceedings.** Sinai will advise the CMC of, and solicit the CMC's opinion and consultation regarding, any suit, proceeding, claim, investigation or other proceeding undertaken by any person, governmental agency, court, or other entity against or involving the Hospital and alleging any matter that, if true, would reasonably constitute a Catholic Issue.

5.4 **Specific Performance.** In the event Sinai violates the provisions of Section 1.2, Section 1.3, Section 1.4 and/or clauses (ii) and (iii) of Section 6.3, the parties agree that the SSC would be irreparably damaged and that any remedy at law for a breach of these provisions of this Agreement would be inadequate. Therefore, the SSC shall be entitled to seek injunctive or other equitable relief in a court of competent jurisdiction against Sinai or Sinai's agents, employees, affiliates, partners or other associates for any breach or threatened breach of Section 1.2, Section 1.3, Section 1.4 and/or clauses (ii) and (iii) of Section 6.3 of this Agreement without the necessity of proving actual monetary loss. Therefore, in the event that Sinai violates this Agreement, then in any suit which may be brought by the SSC for the violation of Section 1.2, Section 1.3, Section 1.4 and/or clauses (ii) and (iii) of Section 6.3 in any court having jurisdiction in such event, Sinai agrees that an order may be made in such suit enjoining Sinai from violating said provisions, and an order to that effect may be made pending the litigation as well as a final determination thereof, without the requirement to post bond. Furthermore, such application for such injunction shall be without prejudice to any other right of action which may accrue to the SSC or its successors or assigns by reason of the breach of these provisions.

ARTICLE 6

TERM AND TERMINATION

6.1 **Term.** The term of this Agreement will commence as of the date of the Closing and continue in full force and effect unless and until terminated in accordance with this Article 6.

6.2 **Termination.**

(a) This Agreement may be terminated by the mutual written consent of Sinai and the SSC.

(b) This Agreement may be terminated upon not less than thirty (30) days' prior written notice (the "**Termination Notice**") by the SSC, if a Catholic Issue remains unresolved following the procedures specified in Article 5.

(c) This Agreement will be automatically terminated upon the revocation of the Catholicity of the Hospital by the RCAC.

6.3 Effect of Termination. If this Agreement is terminated, then at the request or demand of the SSC: (i) the identity of the Hospital as a Catholic institution will immediately terminate; (ii) Sinai will remove and return to the SSC, at Sinai' expense, all religious symbols, artifacts and ecclesiastical property at the Hospital within sixty (60) days after the effective date of termination; (iii) the Hospital and each other Sinai Facility shall cease using the name "Holy Cross Hospital" or other such designation causing a reasonable individual to presume an affiliation or other relationship with an entity named "Holy Cross Hospital"; (iv) Sinai shall reimburse the Archdiocese of Chicago for reasonable expenses associated with the removal of Catholic identity of the Hospital; and (v) all other obligations of the parties arising from and after the effective date of termination will terminate.

6.4 Exclusive Procedures and Remedies. The procedures set forth in Article 5 and Article 6 are the exclusive procedures for resolving a disagreement concerning a Catholic Issue. In no event will either party be entitled to any monetary damages (other than unpaid fees due pursuant to Section 4.1 or reimbursable expenses not reimbursed), including direct, indirect, consequential, special or punitive damages as a result of any Catholic Issue or as a result of termination pursuant to Article 6.

ARTICLE 7

GENERAL PROVISIONS

7.1 Notice. Any notice, demand or communication required, permitted or desired to be given hereunder shall be deemed effectively given if given in writing: (i) on the date tendered by personal delivery; (ii) on the date received by fax or other electronic means; (iii) on the date tendered for delivery by nationally recognized overnight courier; or (iv) on the date tendered for delivery by United States mail, with postage prepaid thereon, certified or registered mail, return receipt requested, in any event addressed as follows:

If to Sinai:	Sinai Health System California Avenue at 15th Street Chicago, IL 60608 Attention: Alan Channing
With a copy to:	McDermott Will & Emery LLP 227 W. Monroe Street Chicago, IL 60606 Attention: Michael F. Anthony

If to the SSC:	The Sisters of St. Casimir Attention: General Superior 2601 West Marquette Rd. Chicago, IL 60629
With a copy to:	Lawrence E. Singer Lawrence E. Singer, P.C. 2323 Grey Ave. Evanston, IL 60201

or to such other address or number, and to the attention of such other person, as any party may designate in writing in conformity with this section.

7.2 **Amendment**. No modification, waiver, amendment, discharge, or change of this Agreement will be valid unless in writing and signed by the party against whom enforcement of such modification, waiver, amendment, discharge or change is sought.

7.3 **Successor and Assigns; Sale of Hospital.**

(a) All of the terms and provisions of this Agreement will be binding upon and will inure to the benefit of and be enforceable by the respective successors and permitted assigns of the parties. No party may assign any of its rights or delegate any of its duties under this Agreement without the prior written consent of the other party, provided that the SSC may assign or delegate all or some of its responsibilities and undertakings set forth in this Agreement to another organization recognized by the Roman Catholic Church if such delegation does not: (i) prevent the Hospital from continuing to be recognized and sanctioned as being Catholic as provided herein; or (ii) increase the financial obligations of Sinai under this Agreement; and provided that if such proposed assignee is not controlled by the SSC, then such assignment can be made only with Sinai's approval which shall not be unreasonably withheld.

(b) If Sinai or any of its subsidiaries intends to sell the Hospital it shall notify the SSC of such sale not less than sixty (60) days in advance of the proposed date of sale; provided, that the SSC shall maintain such information strictly confidential unless such information has been announced publicly. A condition of any such proposed sale shall be an agreement by the purchaser to assume the obligations of Sinai set forth in this Agreement. The SSC may, in its sole and absolute discretion: (i) consent to the assignment of this Agreement in relevant part to the proposed transferee; or (ii) terminate this Agreement with respect to the Hospital effective at the time of the closing of the sale of the Hospital. In the event of termination, the provisions of Section 6.3 shall apply. If the SSC does not notify Sinai within thirty (30) days after receipt of the notice that it elects to terminate this Agreement, the SSC will be deemed to have consented to an assignment of this Agreement in relevant part. At the closing of the sale of the Hospital, Sinai and the purchaser shall enter into an agreement pursuant to which the purchaser assumes the obligations of Sinai under this Agreement, except that Sinai and the transferee may allocate between themselves the portion of the stewardship fee to be paid by Sinai and by the transferee. Sinai shall deliver to the SSC a copy of the executed agreement promptly after closing.

7.4 Severability. If any one or more of the provisions of this Agreement should be ruled wholly or partly invalid or unenforceable by a court or other government body of competent jurisdiction, then: (a) the validity and enforceability of all provisions of this Agreement not ruled to be invalid or unenforceable will be unaffected; (b) the effect of the ruling will be limited to the jurisdiction of the court or other government body making the ruling; (c) the provision(s) held wholly or partly invalid or unenforceable will be deemed amended, and the court or other government body is authorized to reform the provision(s), to the minimum extent necessary to render them valid and enforceable in conformity with the parties' intent as manifested herein and a provision having a similar economic effect will be substituted; and (d) if the ruling and/or the controlling principle of law or equity leading to the ruling, is subsequently overruled, modified, or amended by legislative, judicial, or administrative action, the provision(s) in question as originally set forth in this Agreement will be deemed valid and enforceable to the maximum extent permitted by the new controlling principle of law or equity. This severability clause shall apply only if the integrity of the entire Agreement can otherwise be preserved.

7.5 Choice of Law; Canon Law Conflict. The legal interpretation of this Agreement and the rights and obligations of the parties hereunder will be governed by the laws of the State of Illinois, without regard to choice of law provisions, as to the civil legal terms. Notwithstanding the foregoing, the final arbiter of the applicability of the Directives or other moral, ethical and social teaching of the Roman Catholic Church shall be the RCAC. In the event of a conflict between canon law and civil law with respect to the conduct of the business of the Hospital, civil law will prevail, and nothing in this Agreement will prevent or limit Sinai from complying with civil law at all times.

7.6 Personal Jurisdiction and Venue Selection. Sinai expressly understands and agrees that the SSC conduct their activities through an Illinois not-for-profit corporation with a principal place of business within the State of Illinois. Sinai further agrees that the state and federal courts within the State of Illinois shall have personal jurisdiction over Sinai and Sinai expressly waives any objection to personal jurisdiction over it in the state or federal courts in Illinois. The parties hereto agree that all actions or proceedings arising in connection with this Agreement shall be filed and litigated exclusively in the State courts located in Cook County, State of Illinois and/or in the Federal court for the Northern District of Illinois. The aforementioned choice of venue is intended by the parties to be mandatory and not permissive in nature. Each party hereby waives any right it may have to assert the doctrine of forum non conveniens or similar doctrine or to object to venue with respect to any proceeding brought in accordance with this paragraph, and stipulates that the State courts located in Cook County, State of Illinois and the Federal court for the Northern District of Illinois shall have in personam jurisdiction and venue over each of them for the purpose of litigating any dispute, controversy, or proceeding arising out of or related to this Agreement.

7.7 Headings; Use of Terms. All headings in this Agreement are for reference purposes only and are not intended to affect in any way the meaning or interpretation of this Agreement. All words used in this Agreement will be construed to be of such gender or number as the circumstances require.

7.8 **Counterparts.** This Agreement may be executed in two or more counterparts, each and all of which shall be deemed an original and all of which together shall constitute but one and the same instrument. This Agreement, and any executed counterpart of a signature page to this Agreement, may be transmitted by fax or e-mail, and delivery of an executed counterpart of a signature page to this Agreement by fax or e-mail shall be effective as delivery of a manually executed counterpart of this Agreement.

7.9 **Attorneys' Fees.** In any litigation arising in connection with the interpretation or enforcement of the terms, conditions or provisions of this Agreement, the prevailing party shall be entitled to recover from the other party its reasonable attorneys' fees and costs.

7.10 **Waiver.** The waiver by any party of a breach or violation of any provision of this Agreement will not operate or be construed as a waiver of any subsequent breach of such provision or any other provision of this Agreement.

7.11 **Construction.** This Agreement will not be construed more strictly against any party hereto by virtue of the fact that this Agreement may have been drafted or prepared by such party or its counsel, it being recognized that all of the parties hereto have contributed substantially and materially to its preparation and that this Agreement has been the subject of and is the product of negotiations between the parties.

7.12 **Entire Agreement.** This Agreement, the exhibits and schedules, and the documents referred to herein, contain the entire understanding between the parties with respect to the subject matter hereof and supersedes all prior or contemporaneous agreements, understandings, representations and statements, oral or written, between the parties on the subject matter hereof.

[Signature Page Follows]

IN WITNESS WHEREOF, the undersigned duly authorized representatives of the parties have executed this Agreement as of the date above.

SINAI

By: ______________________________

Alan Channing
President and Chief Executive Officer

SISTERS OF ST. CASIMIR

By: ______________________________

Sr. Immacula Wendt, the SSC
President

EXHIBIT 1.2

SUMMARY OF ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES

For guidance and moral foundation, we use *Ethical and Religious Directives for Catholic Health Care Services*, published by the United States Conference of Catholic Bishops.

Note: The summary below does not substitute for a careful reading of the *Ethical and Religious Directives for Catholic Health Care Services* in order to develop a more thorough understanding of its contents.

Goals

There are two aims of the Ethical and Religious Directives for Catholic Health Care Services (ERDs):

- Reaffirm the ethical standards that flow from the Church's teaching about human dignity.
- Provide authoritative guidance on some specific moral issues facing Catholic healthcare.

The Social Responsibility of Catholic Healthcare Services

Catholic healthcare is guided by four normative principals.

1. A commitment to promote human dignity,
2. To care for the poor,
3. To contribute to the common good, and
4. To be responsible stewards of available resources.

Catholic healthcare is marked by respect among caregivers, which leads to treating all with sensitivity and compassion. It is also distinguished by service and advocacy to the poor and vulnerable.

Catholic healthcare institutions treat associates respectfully and justly, and associates and physicians respect and uphold the ERDs.

The Pastoral and Spiritual Responsibility of Catholic Healthcare

Catholic healthcare extends to and embraces the spiritual nature of the person: physical, psychological, social and spiritual.

Pastoral and spiritual care staff minister to the religious and spiritual needs of all patients, residents and families. They work collaboratively with community clergy and have appropriate professional preparation.

Sacramental ministry is available to Catholic patients and residents.

The Professional-Patient Relationship

Respect: Mutual respect, trust, honesty, and confidentiality mark this relationship. The personal nature of care must not be lost, even when a team of caregivers is involved.

The dignity of the person is respected, regardless of health problem or social status, (*e.g.*, race, creed, color, national origin, ancestry, religion, sex, sexual orientation, marital status, age, newborn status, handicap or source of payment).

Advance Directives: Patients receive information about their rights, under the laws of their state, to make an advance directive for their medical treatment. Advance directives, consistent with moral teaching, are respected and honored.

Informed Consent: Free and informed consent requires that the patient or his or her surrogate receive all reasonable information about the essential nature of the proposed treatment and its benefits; its risks, side-effects, consequences, and cost; and any reasonable and morally legitimate alternatives, including no treatment at all.

Organ Donation: Organ donation is encouraged. The transplantation of organs from living donors is morally permissible when such a donation will not sacrifice or seriously impair any essential bodily function and the anticipated benefit to the recipient is proportionate to the harm done to the donor. Furthermore, the freedom of the prospective donor must be respected, and economic advantages should not accrue to the donor.

Treatment Options: The well-being of the whole person must be taken into account in deciding about any therapeutic intervention or use of technology. Therapeutic procedures that are likely to cause harm or undesirable side-effects can be justified only by a proportionate benefit to the patient.

Ethics Committee: An ethics committee or some alternate form of ethical consultation should be available to assist by advising on particular ethical situations, by offering educational opportunities, and by reviewing and recommending policies.

Issues in Care for the Beginning of Life

Catholic healthcare ministry honors the sanctity of life from conception until death. With the advance of the biological and medical sciences, society has at its disposal new technologies for responding to the problem of infertility. While we rejoice in the potential for good inherent in many of these technologies, we cannot assume that what is technically possible is always morally right.

Avoiding Pregnancy: For legitimate reasons of responsible parenthood, married couples may limit the number of their children by natural means. Catholic health institutions may not promote or condone contraceptive practices but should provide, for married couples and the medical staff who counsel them, instruction both about the Church's teaching on responsible parenthood and in methods of natural family planning. Abortion and elective sterilization are not allowed. However, compassionate care is provided to those who have had an abortion.

Achieving Pregnancy: Some specific forms of procreative assistance are permissible. Any technique used to achieve conception by the use of gametes coming from at least one donor other than the spouses is prohibited. Participation in contracts or arrangements for surrogate motherhood is also prohibited. A Catholic healthcare institution that provides treatment for infertility should offer not only technical assistance to infertile couples but also should help couples pursue other solutions (*e.g.*, counseling, adoption). Prenatal diagnosis and treatments must not threaten the life of the unborn child.

Issues in Care for the Dying

A Catholic healthcare institution will be a community of respect, love, and support to patients and residents and their families as they face the reality of death. The task of medicine is to care even when it cannot cure. Catholic healthcare avoids the use of futile or burdensome technology that offers no reasonable benefit to patient or resident.

Euthanasia: Medical staff must not withdraw technology with the intention of causing death. Euthanasia and physician-assisted dying is not permitted.

Medically Assisted Nutrition: In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally. Medically assisted nutrition and hydration become morally optional when they cannot reasonably be expected to prolong life or when they would be "excessively burdensome for the patient or [would] cause significant physical discomfort, for example resulting from complications in the use of the means employed."

Pain Relief: Patients and residents should be kept as free of pain as possible. Pain suppressing or alleviating medicine that may indirectly shorten a person's life is permitted so long as the intent is not to hasten death.

Forming New Partnerships with Healthcare Organizations and Providers

In ever-increasing ways, Catholic health care providers have become involved with other health care organizations and providers.

New partnerships can be viewed as opportunities for Catholic healthcare institutions and services to witness to their religious and ethical commitments and so influence the healing profession. For example, new partnerships can help to implement the Church's social teaching.

On the other hand, new relationships may pose serious challenges to Catholic identity. Systematic and objective moral analysis is necessary when considering new relationships. Reliable theological experts are to be consulted when considering arrangements with other organizations.

Partnerships that affect the mission or religious and ethical identity of the Catholic healthcare institution must respect Church teaching and discipline. Decisions leading to serious consequences for the identity or reputation of Catholic healthcare services are made in consultation with local church leadership.

Implementation of arrangements with other organizations must be periodically reviewed to ensure alignment with Church teaching.

EXHIBIT 1.5

STATEMENT OF RCAC RECOGNITION

[See attached]

EXHIBIT 1.6

AFFILIATION AGREEMENT BETWEEN HCH AND ACCESS COMMUNITY HEALTH NETWORK, INC.

[See attached]

EXHIBIT 2.2

INITIAL BUDGET FOR THE MISSION EFFECTIVENESS DEPARTMENT (INCLUDING PASTORAL CARE)

EXHIBIT B

AGREEMENT FOR USE AND NON-DISCLOSURE OF CONFIDENTIAL INFORMATION

This Agreement for Use and Non-Disclosure of Confidential Information, dated June 1, 2012 ("**Effective Date**") is made by and between Sinai Health System, an Illinois not for profit corporation ("**Recipient**"), and Holy Cross Hospital (the "**Company**") to assure the protection and preservation of the confidential and/or proprietary nature of information to be disclosed or made available by the Company to Recipient in connection with a proposed transaction between the parties.

WHEREAS, Company and Recipient are interested in exploring a possible transaction between the parties (the "**Purpose**");

WHEREAS, in order to determine the parties' ability to consummate such a transaction, it may be necessary for Recipient to receive or be exposed to certain confidential and proprietary business and technical information of Company;

WHEREAS, the parties desire to assure the confidential status of information disclosed to Recipient;

WHEREAS, Recipient agrees to be bound by the terms of this Agreement and to safeguard and keep in strict confidence all Confidential Information (as hereinafter defined) disclosed to Recipient by Company and any and all data or analysis generated by Recipient using the Confidential Information of Company;

WHEREAS, Recipient acknowledges that Recipient's execution of this Agreement is a condition to Company's willingness to engage in discussions with Recipient regarding the Purpose and that these facts constitute sufficient consideration to Recipient in exchange for this Agreement; and

WHEREAS, as more fully described in Section 18 of this Agreement, Company will negotiate exclusively with Recipient and not solicit other offers or negotiate with any third party for the sale of the Company's assets or any Change of Control (as hereinafter defined) of the Company for the period of time described in Section 18. For purposes hereof, a "Change of Control" shall mean the transfer of control over the appointment and replacement of at least fifty percent (50%) of the board of directors of the Company.

NOW, THEREFORE, in consideration of the promises set forth herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree:

1. Subject to the provisions of Section 4, all information disclosed to Recipient by the Company and all analyses derived from such information shall be deemed to be "**Confidential Information**". Recipient may use the Confidential Information only to the extent required to permit Recipient to evaluate the Purpose. No other rights are implied or granted under this Agreement. Confidential Information supplied shall not be reproduced in any form except for internal use or with the prior written authorization of the parties. Each such

reproduction shall include any ownership and confidentiality legends of the Company included in the original.

2. Recipient shall use all reasonable efforts to protect the Confidential Information received with the same degree of care used to protect its own Confidential Information from unauthorized use or disclosure by its officers, partners, members, co-investors, potential financing sources, agents, advisors and employees (collectively, the "**Representatives**"), except that such Confidential Information may be used by or disclosed to its Representatives as may be reasonably required to accomplish the intent of this Agreement during the term of this Agreement. Recipient shall require its Representatives to abide by the terms of this Agreement, and Recipient shall be responsible for any disclosure by its Representatives of Company's Confidential Information which Recipient would not be permitted to make pursuant to this Agreement. If discussions continue, Recipient and Company will develop procedures to continue the due diligence review of a possible transaction that continue to preserve the confidentiality of the possible transaction.

3. All Confidential Information, unless otherwise specified in writing, shall remain the property of the Company, shall be used by Recipient only for the purposes intended, and shall be returned to the Company (including all whole or partial copies thereof) promptly upon termination of this Agreement if so requested by the Company, provided that, in lieu of returning such information, Recipient may affirm in writing that it has destroyed all such information.

4. The term "**Confidential Information**" does not include information that (i) is now or thereafter in the public domain through no fault of Recipient, (ii) prior to receipt hereunder, is properly within the rightful possession of Recipient, (iii) prior to or subsequent to receipt hereunder, is lawfully received from a third party with no restriction on further disclosure, (iv) was developed independently by the Recipient without the use of the Confidential Information, or (v) is obligated to be produced under order of a court of competent jurisdiction, unless made the subject of a confidentiality agreement or order in connection with such proceeding.

5. All notices required under, and other communications with respect to, this Agreement shall be in writing and shall be considered given and delivered when personally delivered to the party to whom such notice or communication is addressed or when delivered by courier, or when received by facsimile properly addressed to a party at the address set forth below, or at such other address as such party shall have specified by notice given in accordance with this Agreement:

Holy Cross Hospital
2701 W. 68th Street
Chicago, IL 60629
Attention: Dr. Wayne Lerner, President/CEO

Sinai Health System
2750 West 15th Street
Chicago, IL 60608
Attention: Alan H. Channing

6. There are no understandings, agreements, or representations, express or implied, not specified herein. This Agreement may not be amended except in a writing executed by both parties hereto. Except as set forth in communication plan attached as Exhibit A or any amendment thereto agreed on in writing by the parties or any definitive agreement governing the Purpose or pursuant to Section 19 of this Agreement, neither party shall at any time, without the prior written consent of the other party, make any announcement, issue any press release or make any statement to any third party with respect to any matters discussed related to the Purpose.

7. Recipient confirms that any Confidential Information disclosed to it and any discussions held between the parties relating to the subject matter of this Agreement prior to the date of this Agreement shall also be subject to and governed by the terms of this Agreement.

8. This Agreement is the complete and exclusive statement by the parties of their understanding in connection with the discussions and disclosures of Confidential Information referred to above, and it revokes and supersedes all other prior agreements related to the object hereof.

9. This Agreement shall continue in full force and effect until terminated. This Agreement may be terminated at any time by either of the parties upon ten days written notice to the other party. Termination of this Agreement shall not relieve Recipient of its obligations imposed by Sections 1, 2 and 3 with respect to Confidential Information exchanged prior to the effective date of termination, which shall survive this Agreement and shall not expire upon the mere operation of time.

10. In the event that Recipient is required by judicial or administrative process to disclose Company's Confidential Information or any other information concerning Company, Recipient shall: (a) promptly notify Company and allow Company to (i) oppose such disclosure through protective order or other remedy, (ii) consult with Company with respect to Company taking steps to resist or narrow the scope of such request or legal process; and (b) if disclosure of Company's Confidential Information is required, disclose only that portion of any requested information which Recipient is required to disclose upon the advice of counsel.

11. Recipient shall not acquire any license under the intellectual property rights of Company pursuant to this Agreement nor any rights in the Confidential Information disclosed hereunder. Recipient acknowledges that all Confidential Information of Company shall remain the property of Company.

12. Recipient acknowledges and agrees that Company and Company's directors, officers, employees, sponsor, agents, and advisors (including without limitation financial advisors, counsel, and accountants) have not made any express or implied representation or warranty as to the accuracy or completeness of the Confidential Information provided.

13. Recipient recognizes that any prohibited disclosure, divulgence, use or reproduction of Company's Confidential Information will cause irreparable harm to Company, including but not limited to, damage to Company's existing physician and patient relationships. Recipient acknowledges that in the event of a breach of the terms of this Agreement, irreparable damage would result if this Agreement is not specifically enforced. The rights and obligations of Company hereunder shall be enforced in a court of equity by a decree of specific performance,

and appropriate injunctive relief may be applied for and granted in connection therewith. Such remedy and all other remedies provided for in this Agreement shall, however, be cumulative and not exclusive and shall be available in addition to any other remedies which Company may have under this Agreement or otherwise.

14. It is further understood and agreed that failure or delay by Company in exercising any right, power, or privilege under this Agreement shall not operate as a waiver thereof, nor shall any single or partial exercise thereof preclude any other or further exercise thereof or the exercise of any right, power or privilege under this Agreement.

15. This Agreement shall be construed in accordance with and shall be governed by the laws of the State of Illinois, United States of America, without regard to its conflict of laws principles, and any case or controversy arising out of or related to this Agreement shall be filed with any court within the Cook of County, Illinois, United States of America, with respect to any state court action, and within the City of Chicago, Illinois, United States of America, with respect to federal court action.

16. This Agreement shall not be assigned by either party, by operation of law or otherwise, without the prior written consent of the other party, except that Company may, without the other party's prior consent, assign this Agreement to any affiliate or to any company or entity which acquires all or substantially all of its assets. An affiliate shall be an entity which is controlled by, controls, or is under common control with, another entity.

17. All additions or modifications to this Agreement must be made in writing and must be signed by both parties hereto. The provisions of this Agreement are severable. If any provision of this Agreement is found to be invalid, the remaining provisions shall continue to be in full force and effect. The recitals of this Agreement are part of this Agreement.

18. For the period of time commencing on the Effective Date and ending on the earlier of July 31, 2012 or the date on which Recipient provides written notice to Company that it does not wish to pursue a transaction ("**Exclusive Period**"), Company agrees to (a) negotiate exclusively with Recipient for the purpose of entering into definite transaction agreements related to the Purpose; and (b) not solicit, entertain, accept other offers or negotiate with any third party for the sale of the Company's business or any of the Company's assets outside of the ordinary course of business or a Change of Control of the Company. Recipient agrees that Recipient shall promptly notify Company in writing in the event Recipient decides to not pursue entering into a transaction with Company. During the Exclusive Period, Recipient agrees to devote such efforts as necessary to evaluate the viability of a transaction with Company and shall provide Company with updates on their progress every thirty (30) days. In the event Company determines that Recipient has ceased devoting the resources necessary to evaluate a potential transaction, Company shall provide Recipient with written notice of such determination and the Exclusive Period shall end effective as of the date of such notice.

19. The parties agree that responses to media inquiries shall be in accordance with the communication plan set forth in Exhibit A as amended from time to time by written agreement of the parties.

offers or negotiate with any third party for the sale of the Company's business or any of the Company's assets outside of the ordinary course of business or a Change of Control of the Company. Recipient agrees that Recipient shall promptly notify Company in writing in the event Recipient decides to not pursue entering into a transaction with Company. During the Exclusive Period, Recipient agrees to devote such efforts as necessary to evaluate the viability of a transaction with Company and shall provide Company with updates on their progress every thirty (30) days. In the event Company determines that Recipient has ceased devoting the resources necessary to evaluate a potential transaction, Company shall provide Recipient with written notice of such determination and the Exclusive Period shall end effective as of the date of such notice.

19. The parties agree that responses to media inquiries shall be in accordance with the communication plan set forth in Exhibit A as amended from time to time by written agreement of the parties.

20. The parties acknowledge that Company may receive or be exposed to certain Confidential Information of Sinai Health System during the course of exploring a possible Transaction. Accordingly, Company agrees to adhere to the same confidentiality obligations of Recipient contained herein when Company is the recipient of Sinai's Confidential Information.

The parties declare that they have full power, authority and legal right to execute, deliver and comply with the terms and conditions set forth in this Agreement, and that the person signing on behalf of a party has the authority to execute this Agreement.

EXECUTED as of the date set forth above.

RECIPIENT:	COMPANY:
Sinai Health System	Holy Cross Hospital
By: Alan Channing	By:
Title:	Title: President / CEO

EXHIBIT A

COMMUNICATION PLAN

EXHIBIT C

ANTITRUST PROTOCOL FOR MEETINGS AND SHARING OF INFORMATION

Following the execution of a Letter of Intent, the Parties will continue pursuing discussions about a Proposed Combination to reduce health care costs, improve quality of service, and better serve the communities. Because any ensuing transaction ultimately may be subject to review by the antitrust enforcement agencies, and because discussions between health care competitors can be misconstrued, it is important that the Parties take appropriate precautions to ensure their compliance with the antitrust laws. To that end, this memorandum sets forth a general protocol for the Parties to follow at all their meetings to ensure that: (1) any exchange of information between the Parties does not "spill over" into areas or markets beyond the scope of the Proposed Combination; and (2) if no transaction goes forward, the Parties have not learned more than they should have about each other's competitive operations, which could be perceived as leading to other unlawful conspiratorial conduct. This principle is otherwise stated as "need to know" to advance the Proposed Combination beyond the current phase. With execution of the Letter of Intent, and target to execute definitive agreements in late September 2012, the Parties will share more sensitive information that is necessary to complete definitive documents than was shared in earlier phases of due diligence. Activities remain guided by the "need to know" principle.

1. **Purpose of Meetings.** The Parties should bear in mind the specific potential procompetitive benefits of their possible collaboration at all times, and those procompetitive benefits should be reflected by the Parties in the discussions they have, the documents they create, and the decisions they make. The following issues can and should be discussed:

(a) The current and future health services needs of the people in the Parties' service areas;

(b) The inability of each Party to fully or cost-effectively meet these needs on their own;

(c) How the collaboration shall help meet the needs of the community; and

(d) How the collaboration shall result in cost efficiencies that shall be passed on to consumers and/or third party payors.

2. **Limitation of Participants at Meetings.** Care should be taken to limit the participants in the meetings to the smallest realistic number of Representatives of the Parties including professional advisors. Restricting attendance in this manner shall encourage free and frank discussion while preserving confidentiality, and, where applicable, the attorney-client privilege.

3. **Meeting Minutes.** As a general rule, participants should not take notes at the meetings. If minutes of meetings are desired, one participant should be designated to take minutes. *A draft should be submitted to the Parties' counsel for review prior to distribution.* The purpose of these minutes should not necessarily be to record each and every aspect of discussions, but rather to summarize important decisions, list actions to be taken, and give status

updates. Rather than duplicating this effort by taking extensive notes themselves, meeting participants should develop a practice of relying on the minutes, which should be finalized and distributed to meeting participants. Minutes should not be distributed to anyone other than meeting participants and counsel.

4. **Creation of Written Documentation, Generally.** All notes, minutes, memos, and other documentation created by Parties, their affiliates and Representatives in connection with the transaction might be reviewed by government investigators in the event that the federal or state antitrust authorities commence an inquiry about the transaction. Therefore, those notes and other documents should be kept to a minimum and should not address issues that are competitively sensitive and not justified for sharing by the "need to know" principle. Any reports, and any documents that discuss competitively sensitive issues, should be prepared in and designated as a "draft" and submitted to counsel for review and approval before they are finalized. No documents should be sent unless marked "PRIVILEGED AND CONFIDENTIAL: ATTORNEY-CLIENT COMMUNICATION." They can be put into final form for the addressee after review by counsel.

5. **Limitation on Discussion, Information Exchange and Coordinated Activity.** The antitrust enforcement agencies view with suspicion discussion and information exchanges between Parties arguably operating in the same market. Accordingly, it shall be important to structure the scope of discussions and the information exchanged at meetings to avoid any suggestion that the meetings are merely a "sham" attempt to engage in collusive behavior. *Under no circumstances should the Parties engage in any of the following activities without first consulting counsel:*

(a) Coordinating or exchanging information on pricing or fees;

(b) Coordinating or exchanging information on bids or proposals to managed care or other payors, or proposals to "customers" or vendors;

(c) Sharing or allocating "customers" (*e.g.*, steering a "customer" to the other provider or declining to bid on a "customer" that the provider historically bid on or would have bid on);

(d) Allocating existing or future services among them;

(e) Sharing strategic planning information and other items of a proprietary nature;

(f) Jointly refusing to deal with any providers, physician group, supplier of goods or services, or potential customers;

(g) Exchanging formulas, strategies, or plans from which bids or pricing could be calculated;

(h) Exchanging information on wages or salaries of professional or nonprofessional staff; or

(i) Prematurely combining operations or engaging in coordinated business activities of any type before the transaction has been formally consummated.

6. **Media Matters.** Discussion in the media of any Proposed Combination by Representatives of the Parties can have extremely negative antitrust implications unless carefully structured. The specific concern is that statements may be attributed to the transaction participants and draw undue attention from antitrust regulators or, more significantly, contradict an antitrust position that the Parties may ultimately assert. Accordingly, all contact with the media should be coordinated through legal counsel.

7. **Other Safeguards.** Any questions regarding the scope of permissible information exchange and coordinated activity should be brought to the attention of counsel immediately.

EXHIBIT D

JOINT DEFENSE AGREEMENT

THIS JOINT DEFENSE AGREEMENT ("**Agreement**") is made and entered into this 10th day of August, 2012 ("**Effective Date**") by and between legal counsel for Sinai Health System, an Illinois not-for-profit corporation ("**Sinai**"), and legal counsel for Holy Cross Hospital, an Illinois not-for-profit corporation ("**HCH**"), and the Sisters of St. Casimir ("**SSC**"). Sinai, HCH and SSC, together with their respective affiliates and subsidiaries, are each referred to herein as a "**Party**," and are collectively referred to herein as the "**Parties**" to this Agreement.

RECITALS:

WHEREAS, the Parties are considering a possible transaction between them ("the **Proposed Combination**");

WHEREAS, the Parties anticipate that the Proposed Combination shall require the Parties to submit notification and report forms to the Federal Trade Commission ("**FTC**") and Department of Justice ("**DOJ**") pursuant to the Hart-Scott-Rodino Antitrust Improvements Act of 1976 (the process of preparing and submitting the forms and working toward the termination of the HSR waiting period is referred to herein as the "**HSR Process**");

WHEREAS, the Parties and their respective legal counsel recognize that the Proposed Combination may lead to the initiation of an investigation and subsequent litigation ("**Legal Proceeding**") by the FTC, the DOJ and/or the Attorney General of Illinois (collectively, the "**Antitrust Authorities**"), and/or a private party under federal or state antitrust laws;

WHEREAS, we, as legal counsel for our respective clients, wish to continue to pursue our individual, but common, interests; to cooperate in the defense of our clients; and to avoid the waiver of any privilege with respect to any communications by and between the Parties (including their counsel);

WHEREAS, the purpose of this Agreement is to: (i) establish terms and conditions for the formation of a joint defense for the HSR Process and to respond to any Legal Proceeding and, if necessary, to defend against any Legal Proceeding; and (ii) confirm the Parties' understanding with regard to the Parties' commitment regarding the distribution of written or oral communications and information that the Parties (and any consultant they may retain) have received or shall receive from each other pertaining to the Proposed Combination, the HSR Process and any Legal Proceeding in contemplation of any Legal Proceeding;

WHEREAS, the Parties entered into an Agreement for Use and Non-Disclosure of Confidential Information, dated June 1, 2012, governing the use and disclosure of their confidential information ("**Confidentiality Agreement**");

WHEREAS, the Parties have undertaken and may undertake factual, legal and economic research, and the Parties are of the opinion that it is in the best interest of the Parties for the Parties to exchange certain information, pool certain individual work product and cooperate in a joint defense effort;

WHEREAS, cooperation in such a joint defense effort shall necessarily involve the exchange of confidential business, financial, technical and other information, as well as information which is otherwise privileged as an attorney-client communication and/or attorney work product;

WHEREAS, the Parties recognize that a joint defense effort and a common strategy would best promote adequate and complete preparation of their respective defenses; and

WHEREAS, the Parties rely on the joint defense exception to the waiver of the attorney-client and attorney work product privileges.

NOW, THEREFORE, we, as legal counsel for our respective clients, agree as follows:

1. Any and all information or documents, including but not limited to discussions, conferences, phone calls, e mails, memos, correspondence, memoranda of law, debriefing memoranda, factual summaries, interviews, transcript digests, analyses, appraisals and other materials or communications, exchanged between counsel prior to, on or after the Effective Date relating to or concerning the Proposed Combination, the HSR process or any Legal Proceeding ("**Confidential Information**"), whether or not designated as confidential, shall be considered confidential and subject to the Confidentiality Agreement and the joint defense privilege and any other applicable privileges. Confidential Information may only be used in connection with the Parties' joint defense efforts and for purposes consistent with the Confidentiality Agreement and for no other purpose without the prior written consent of the Party that provided the Confidential Information.

2. The Parties agree that they shall cooperate through counsel in the joint defense of the Parties' common interests to the extent permitted by law pursuant to the joint defense doctrine. Any disclosure or exchange of Confidential Information by the Parties in connection with the HSR Process or any Legal Proceeding has been and shall be accomplished pursuant to the doctrine referred to as the "common interest" and/or "joint defense" doctrine to the maximum extent recognized by law. Nothing contained in this Agreement shall obligate any Party to consult or agree with the other Party on any specific decision or strategy.

3. The sharing under this Agreement of any documents or information subject to the attorney-client privilege, work product doctrine, or any other applicable privileges with respect to matters of joint defense shall not constitute a waiver. Any inadvertent disclosure of Confidential Information exchanged pursuant to this Agreement shall not constitute a waiver of any privilege or protection of the Party providing such material. Any waiver of privilege must be expressly stated in writing. No Party to this Agreement shall have the authority to waive any privilege on behalf of the other Party. In the event that a Party or its counsel becomes aware of a disclosure of Confidential Information that is not expressly permitted under this Agreement, such Party or its counsel shall immediately notify the other Party of such disclosure and, if the notifying Party was responsible for such unauthorized disclosure, shall make best efforts to preserve any privileges and protections applicable to the information and to prevent further unauthorized disclosures or use of the information.

4. Any Party may withdraw from this Agreement by providing written notice of that intention to the other Parties. A Party's withdrawal from this Agreement shall not affect the duty of confidentiality which that Party has undertaken by virtue of having entered into this Agreement, and such Party shall remain obligated to preserve the privileges, protections, immunities and confidentiality of all information exchanged pursuant to this Agreement prior to the date that Party withdrew. The privileges and confidentiality obligations set forth herein shall survive the conclusion of the joint defense efforts and/or any Party's withdrawal from the joint defense.

5. Nothing contained herein obligates any Party to divulge, communicate, or exchange any Confidential Information. In addition, each Party may, as it deems advisable and necessary, reasonably designate all or part of its Confidential Information as competitively sensitive and for "Outside Counsel Only." If all or part of any Confidential Information are designated for "Outside Counsel Only," such Confidential Information shall be provided only to outside legal counsel and shall not be provided to in-house counsel or other employees or agents of the receiving Party unless such materials or information can be redacted or limited, to the satisfaction of the providing Party, to delete references to information or data deemed confidential by the providing Party.

6. No Party may use the existence of this Agreement or any other Confidential Information obtained hereunder against the other Parties except as set forth in this Agreement and the Confidentiality Agreement. Our respective clients shall not seek, by virtue of this Agreement or any information exchanged pursuant to this Agreement, the disqualification of the other law firm as counsel for the client that it represents in this matter in the event of a future adversity of interests between our respective clients.

7. If a person or entity not a Party to this agreement requests or demands, by subpoena or otherwise, any documents or information obtained under this Agreement, counsel shall immediately notify each of the Parties to this Agreement. The person or entity from whom the documents or information is sought shall inform the person or entity seeking the document or information that such materials are protected by the joint defense doctrine and may not be disclosed, and shall afford full opportunity to the Party whose documents or information are sought to seek full legal protection, and shall cooperate in seeking said protection.

8. Nothing in this Agreement shall restrict any Party from using or disclosing Confidential Information solely originating with that Party in any manner that it chooses. Nothing in this Agreement shall restrict any Party from using or disclosing any public information or materials received independently of this Agreement. This Agreement shall not govern information that is not obtained under this Agreement.

9. Nothing in this Agreement shall be construed to affect the separate and independent representation of each Party by its respective counsel according to what counsel believes to be in the Party's best interest, nor to preclude counsel from representing any interest that may be construed to be adverse to the other Parties in any other matter. Nothing in this Agreement shall obligate any Party to consult or agree with the other Parties regarding any specific decision or strategy concerning the Proposed Combination.

10. The Parties acknowledge and agree that money damages alone would not be a sufficient remedy for any actual or threatened breach of any provision of this Agreement. In addition to all other remedies that the non-breaching Parties may have, such non-breaching Parties shall be entitled to specific performance and injunctive or other equitable relief as a remedy for such actual or threatened breach, and each Party further waives any requirement for the securing or posting of any bond in connection with any such remedy.

11. Each Party affirms that this Agreement does not establish an attorney-client relationship between HCH or SSC and McDermott Will & Emery LLP, or between Sinai and Chuhak & Tecson or Lawrence E. Singer, P.C. It is further understood and agreed that by entering into this Agreement none of the Parties to this Agreement is engaged in a partnership or joint venture with any other Party to this Agreement, and that outside counsel are acting only as counsel for their respective clients and not as counsel for any other Party to this agreement.

12. Any Party that intends to engage in separate, independent bilateral settlement discussions with any third Party regarding any Legal Proceeding, and makes material plans to so engage, must first withdraw from this Agreement pursuant to paragraph 4 hereof.

13. As the need arises, the Parties may decide to enter into more detailed supplemental agreements, as appropriate, regarding protection of documents, the return of documents, their joint strategy, or any other pertinent matter.

14. This Agreement shall be binding on and inure to the benefit of the Parties and their respective representatives, agents and successors in interest. No Party may assign or otherwise transfer any of its rights or obligations under this Agreement.

15. This document may be signed in separate counterparts, with copies of all signatures circulated to all signatories and each Party to this Agreement.

16. Nothing in this Agreement shall be deemed to amend or supersede the obligations of the Parties under the Confidentiality Agreement, which shall remain in full force and effect in accordance with the terms thereof.

17. Each signatory to this Agreement represents that he or she has advised his or her client Party of this Agreement and its import, and has been expressly authorized to execute this Agreement on behalf of his or her client.

[Signatures on following page.]

IN WITNESS WHEREOF, accepted and agreed to as of this 10th day of August, 2012.

By:______________________________
Andrew Tecson
Chuhak & Tecson
30 S. Wacker Drive
Chicago, IL 60606-7512
Counsel for Holy Cross Hospital

By:______________________________
Michael F. Anthony, P.C.
McDermott Will & Emery LLP
227 W. Monroe Street
Chicago, IL 60606-5096
Counsel for Sinai Health System

By:______________________________
Lawrence E. Singer
Lawrence E. Singer, P.C.
2323 Grey Avenue
Evanston, IL 60201
Counsel of Sisters of St. Casimir

By:______________________________
Rachel Dvorken
Sinai Health System
California Avenue at 15th Street
Chicago, IL 60608
Counsel for Sinai Health System

IN WITNESS WHEREOF, accepted and agreed to as of this 10th day of August, 2012.

By:____________________________
Andrew Tecson
Chuhak & Tecson
30 S. Wacker Drive
Chicago, IL 60606-7512
Counsel for Holy Cross Hospital

By:____________________________
Michael F. Anthony, P.C.
McDermott Will & Emery LLP
227 W. Monroe Street
Chicago, IL 60606-5096
Counsel for Sinai Health System

By:____________________________
Lawrence E. Singer
Lawrence E. Singer, P.C.
2323 Grey Avenue
Evanston, IL 60201
Counsel of Sisters of St. Casimir

By:____________________________
Rachel Dvorken
Sinai Health System
California Avenue at 15th Street
Chicago, IL 60608
Counsel for Sinai Health System

DM_US 33826568-9.037235.0013

IN WITNESS WHEREOF, accepted and agreed to as of this 10th day of August, 2012.

By:______________________________
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Chicago, IL 60608
Counsel for Sinai Health System

EXHIBIT E

SINAI PHYSICIANS TO BE APPOINTED TO THE ACTIVE STAFF OF HCH

Cardiology	Aziz Ahmed, MD Daniel Benatar, MD Enrique Garcia Siyan, MD Sandeep Khosla, MD
Cardio Vascular Surgery	Malek Massid, MD
Endocrinology	Paul Butler, MD Marla Barkoff, MD Priya Khanna, MD
Family Practice	Ihab Aziz, MD Kishore Bobba, MD Rafael Dafonseca, MD Viviane Bishay, MD
Internal Medicine	Alejandro Santos Leal, MD Jesus Casas, MD
Gastroenterology	Kris Anand, MD Walter Guthrie, MD Rahul Julka, MD
General Surgery	Anngell Jones, MD Sachin Kukreja, MD Hasmukh Patel, MD
*Interventional Radiology	Carl Valentin, MD Kenneth Ekechukwu, MD
Neurology	Mir Yadullahi, MD Jeffrey Yu, MD
Neurosurgery	Leonard Kranzler, MD Michael Sturgill, MD Hernando Torres, MD
Oncology	Mohammad Kassem, MD Pam Khosla, MD
Ophthalmology	Anu Gupta, MD Jocelyn Rowe, MD
Orthopedics	Luis Carrilero, MD Nishitkumar Patel, MD
Otolaryngology	David Weber, MD
Urology	Doreen Chung, MD Dennis Liu, MD David Rebuck, MD
Vascular Surgery	Daniel Katz, MD

* Pending further discussions of exclusive agreements in place.

APPENDIX ONE – NOTIFICATION SCRIPT – SHS AND HCH

Sinai Health System and Holy Cross Hospital have taken the next step toward an affiliation by signing a Letter of Intent.

Sinai Health System and Holy Cross Hospital already have a common mission. By combining our high quality services, we will be stronger for those we serve.

HCH would retain its Catholic identity. That would mean that at HCH, all would continue to observe the Ethical and Religious Directives for Catholic Healthcare, but it would not affect the current or future components of Sinai Health System outside the Holy Cross Hospital campus.

Since affiliation discussions were announced in May, the response has been overwhelmingly positive.

A final phase of due diligence will continue as regulatory reviews and approvals are completed. We expect the affiliation to be finalized early in 2013.

APPENDIX TWO – CAREGIVER AND PHYSICIAN LETTER – SHS

August 10, 2012

Dear Fellow Caregiver:

I am happy to let you know that Sinai Health System and Holy Cross Hospital have taken the next step toward an affiliation by signing a Letter of Intent, marking completion of a substantial portion of the due diligence process.

Sinai Health System and Holy Cross Hospital already have a common mission. By combining our high-quality services, we will be stronger for those we serve.

HCH would retain its Catholic identity. That would mean that at HCH, all would continue to observe the Ethical and Religious Directives for Catholic Healthcare, but it would not affect the current Sinai Health System.

A final phase of due diligence will continue as regulatory reviews and approvals are completed. After the financial and legal details are settled, we expect to sign a Definitive Agreement in September or October. We then hope to come before the Illinois Health Facilities and Services Review Board in December, receive our Certificate of Need and finalize the affiliation by early 2013.

After the Definitive Agreement is signed, I will be conducting a series of town hall meetings, both at current SHS locations and at Holy Cross Hospital, to describe and discuss the future of the new, stronger SHS and your potential role in that future.

Since affiliation discussions were announced in May, the response has been overwhelmingly positive. Thank you for getting behind this bold initiative. I know I can count on your support as the affiliation moves forward.

Sincerely,

Alan H. Channing
President and CEO

APPENDIX THREE – EMPLOYEE AND PHYSICIAN LETTER – HCH

I am happy to let you know that Sinai Health System and Holy Cross Hospital have taken the next step toward an affiliation by signing a Letter of Intent.

Sinai Health System and Holy Cross Hospital already have a common mission. By combining our high-quality services, we will be stronger for those we serve.

HCH would retain its Catholic identity. That would mean that at HCH, we would continue to observe the Ethical and Religious Directives for Catholic Healthcare, but it would not affect the current Sinai Health System.

A final phase of due diligence will continue as regulatory reviews and approvals are completed. After the financial and legal details are settled, we expect to sign a Definitive Agreement in September or October. We then hope to come before the Illinois Health Facilities and Services Review Board in December, receive our Certificate of Need and finalize the affiliation by early 2013.

After the Definitive Agreement is signed, Alan Channing, president and CEO of SHS, and I will be conducting a series of town hall meetings at Holy Cross Hospital to describe and discuss the future of the new, stronger SHS and your potential role in that future.

Since affiliation discussions were announced in May, the response has been overwhelmingly positive. Thank you for getting behind this bold initiative. I know I can count on your support as the affiliation moves forward.

Sincerely,

Wayne Lerner
President and CEO

APPENDIX FOUR– LETTER FOR SISTERS OF SAINT CASIMIR

Dear Sisters:

Sinai Health System and Holy Cross Hospital have taken the next step toward an affiliation by signing a Letter of Intent.

This is good news for the people we serve because Sinai Health System and Holy Cross Hospital already have a common mission. By combining our high-quality services, we will be stronger.

And it's good news for the Sisters of Saint Casimir because Sinai Health System would be an outstanding, mission-focused partner for Holy Cross Hospital to continue the mission of Mother Maria.

As we've said, HCH would retain its Catholic identity. That would mean that at HCH, caregivers would continue to observe the Ethical and Religious Directives for Catholic Healthcare, but it would not affect the current Sinai Health System.

A final phase of due diligence will continue as regulatory reviews and approvals are completed. After the financial and legal details are settled, we expect to sign a Definitive Agreement in September or October. We then hope to come before the Illinois Health Facilities and Services Review Board in December, receive our Certificate of Need and finalize the affiliation by early 2013.

After the Definitive Agreement is signed, Alan Channing, president and CEO of SHS, and Wayne Lerner, D.P.H., president and CEO, HCH, will be conducting a series of town hall meetings at Holy Cross Hospital to describe and discuss the future of the new, stronger SHS and employees and physicians' role in that future.

Since affiliation discussions were announced in May, the response has been overwhelmingly positive. Thank you for getting behind this bold initiative. I know I can count on your support as the affiliation moves forward.

APPENDIX FIVE – LETTER FOR CHURCH LEADERSHIP

Sinai Health System and Holy Cross Hospital have taken the next step toward an affiliation by signing a Letter of Intent.

This is good news for the people we serve because Sinai Health System and Holy Cross Hospital already have a common mission. By combining our high-quality services, we will be stronger.

And it's good news for the Sisters of Saint Casimir because Sinai Health System would be an outstanding, mission-focused partner for Holy Cross Hospital to continue the mission of Mother Maria.

As we've said, HCH would retain its Catholic identity. That would mean that at HCH, caregivers would continue to observe the Ethical and Religious Directives for Catholic Healthcare, but it would not affect the current Sinai Health System.

A final phase of due diligence will continue as regulatory reviews and approvals are completed. After the financial and legal details are settled, we expect to sign a Definitive Agreement in September or October. We then hope to come before the Illinois Health Facilities and Services Review Board in December, receive our Certificate of Need and finalize the affiliation by early 2013.

Since affiliation discussions were announced in May, the response has been overwhelmingly positive. Thank you for your continued support of this initiative.

APPENDIX SIX – SINAI DONOR TALKING POINTS

There is good news to share with you.

Sinai Health System and Holy Cross Hospital have taken the next step toward an affiliation by signing a Letter of Intent, marking completion of a substantial portion of the due diligence process.

Sinai Health System and Holy Cross Hospital are a good fit. They are both mission-driven, neighboring organizations providing essential health care and related social services for communities on Chicago's west and southwest sides.

Sinai Health System and Holy Cross Hospital already have a common mission. By combining our high quality services, we will be stronger for those we serve.

The increasing challenges of providing health care for under-resourced communities need to be addressed through best medical practice and greater efficiency. Sinai Health System is eager to expand access to patient-centered health care with Holy Cross Hospital and members of its medical staff as key participants in our system.

Holy Cross Hospital, currently sponsored by the Sisters of Saint Casimir, will retain its Catholic identity and continue to follow the Ethical and Religious Directives for Catholic Healthcare, but it would not affect the current or future components of Sinai Health System outside the Holy Cross Hospital campus.

This affiliation will offer the communities that Holy Cross Hospital has served since 1928 a stronger, cohesive, more comprehensive array of health services that are near their homes.

Holy Cross Hospital would be the fourth hospital in the Sinai Health System, joining Mount Sinai Hospital, Sinai Children's Hospital, and Schwab Rehabilitation Hospital.

A final phase of due diligence will continue as regulatory reviews and approvals are completed. After the financial and legal details are settled, we expect to sign a Definitive Agreement in September. We then hope to come before the Illinois Health Facilities and Services Review Board in December, receive our Certificate of Need and finalize the affiliation by early 2013.

Since affiliation discussions were announced in May, the response has been overwhelmingly positive. I hope that we can count on your support as the affiliation moves forward.

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. Note, the use and sources of funds must equal.

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of All Real Assets			$18,655,000
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS			$18,655,000
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			$18,655,000
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Note: transaction-related costs will not be capitalized

Related Project Costs

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

Land acquisition is related to project X Yes ☐ No
Purchase Price: $____________ **not applicable, please see terms**
Fair Market Value: $____________ **of acquisition**

The project involves the establishment of a new facility or a new category of service
☐ Yes X No

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

Estimated start-up costs and operating deficit cost is $ ____none______.

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:

X None or not applicable ☐ Preliminary

☐ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): __March 31, 2013________

Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):

☐ Purchase orders, leases or contracts pertaining to the project have been executed.
☐ Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies
X Project obligation will occur after permit issuance.

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

State Agency Submittals

Are the following submittals up to date as applicable:
X Cancer Registry
X APORS
X All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
X All reports regarding outstanding permits
Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

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: **Holy Cross Hospital** | **CITY:** **Chicago**

REPORTING PERIOD DATES: **From:** **January 1, 2011** **to:** **December 31, 2011**

Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	204	7,343	29,997	None	204
Obstetrics	16	433	5,235	None	16
Pediatrics					
Intensive Care	20	1,340	1,040	None	20
Comprehensive Physical Rehabilitation	34	470	5,015	None	34
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:	274	9,586	41,287	None	274

CERTIFICATION

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

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

This Application for Permit is filed on the behalf of Holy Cross Hospital * **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.**

W. Lerner	Sister Regina Marie Dubickas, SSC
SIGNATURE	SIGNATURE
Wayne M. Lerner, D.P.H., F.A.C.H.E.	Sister Regina Marie Dubickas
PRINTED NAME	PRINTED NAME
President & Chief Executive Officer	Secretary
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this 4th day of September 2012	Notarization: Subscribed and sworn to before me this 4th day of September 2012
Deborah Wohler	Deborah Wohler
Signature of Notary	Signature of Notary
Seal: NOTARY PUBLIC OFFICIAL SEAL STATE OF ILLINOIS DEBORAH WOHLER MY COMMISSION EXPIRES OCTOBER 25, 2014	Seal: NOTARY PUBLIC OFFICIAL SEAL STATE OF ILLINOIS DEBORAH WOHLER MY COMMISSION EXPIRES OCTOBER 25, 2014

*Insert EXACT legal name of the applicant

CERTIFICATION

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

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

This Application for Permit is filed on the behalf of Sinai Health System* **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	SIGNATURE
Alan H. Channing	Karen Teitelbaum
PRINTED NAME	PRINTED NAME
President/CEO	EVP/COO
PRINTED TITLE	PRINTED TITLE

Notarization: Subscribed and sworn to before me this 4 day of September, 2012	Notarization: Subscribed and sworn to before me this 4 day of September, 2012
Signature of Notary	Signature of Notary
Seal "OFFICIAL SEAL" Rosa M Arellano Notary Public, State of Illinois My Commission Expires 11/30/2012	Seal "OFFICIAL SEAL" Rosa M Arellano Notary Public, State of Illinois My Commission Expires 11/30/2012

*Insert EXACT legal name of the applicant

CERTIFICATION

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

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

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

SIGNATURE

Alan H. Channing
PRINTED NAME

President / CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 4 day of September, 2012

Signature of Notary

Seal
"OFFICIAL SEAL"
Rosa M Arellano
Notary Public, State of Illinois
My Commission Expires 11/30/2012

SIGNATURE

Karen Teitelbaum
PRINTED NAME

EVP / COO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 4 day of September, 2012

Signature of Notary

Seal
"OFFICIAL SEAL"
Rosa M Arellano
Notary Public, State of Illinois
My Commission Expires 11/30/2012

*Insert EXACT legal name of the applicant

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

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

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

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

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

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]
4. Cite the sources of the information provided as documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate**.

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

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

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

ALTERNATIVES

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

Alternative options **must** include:

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

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

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

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

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

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

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

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

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

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

A. Criterion 1110.240(b), Impact Statement

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

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

B. Criterion 1110.240(c), Access

Read the criterion and provide the following:

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

C. Criterion 1110.240(d), Health Care System

Read the criterion and address the following:

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

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

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

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

VIII. - 1120.120 - Availability of Funds

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, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_______	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
_______	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions.
_______	e)	Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
_______	f)	Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
_______	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
$0		**TOTAL FUNDS AVAILABLE**

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

IX. **1120.130 - Financial Viability**

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 **not applicable, no capital cost**

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

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

See Section 1120.130 Financial Waiver for information to be provided

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

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

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

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

2. Variance

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

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

X. 1120.140 - Economic Feasibility

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

A. Reasonableness of Financing Arrangements **not applicable, project does not Involve any funding**

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

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

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

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

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

B. Conditions of Debt Financing **not applicable, no debt to be incurred**

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

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

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

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

C. **Reasonableness of Project and Related Costs** **not applicable**

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

APPEND DOCUMENTATION AS ATTACHMENT -42, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XI. Safety Net Impact Statement   not applicable

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

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.

2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

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

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

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

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

XII. Charity Care Information

Holy Cross Hospital

Charity Care information MUST be furnished for ALL projects.

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

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

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

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

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

CHARITY CARE			
	2009	**2010**	**2011**
Net Patient Revenue	**$101,200,591**	**$93,555,098**	**$91,776,624**
Amount of Charity Care (charges)	$10,435,701	$16,158,075	$16,753,963
Cost of Charity Care	$4,501,238	$7,595,653	$7,615,439

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

XII. Charity Care Information

Mount Sinai Hospital Medical Center

Charity Care information MUST be furnished for ALL projects.

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

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

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

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

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

CHARITY CARE			
	2009	2010	2011
Net Patient Revenue	**$288,615,746**	**$293,509,014**	**$289,796,016**
Amount of Charity Care (charges)	$65,429,637	$66,507,459	$78,028,438
Cost of Charity Care	$17,879,490	$16,440,644	$19,288,630

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

XII. **Charity Care Information** **Schwab Rehabilitation Hospital**

Charity Care information MUST be furnished for ALL projects.

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

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

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

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

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

CHARITY CARE			
	2009	**2010**	**2011**
Net Patient Revenue	**$41,888,408**	**$41,718,403**	**$43,028,171**
Amount of Charity Care (charges)	$902,913	$2,062,724	$2,111,857
Cost of Charity Care	$513,757	$958,961	$981,802

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

File Number 2073-273-3

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

HOLY CROSS HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON OCTOBER 10, 1929, 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* 22ND *day of* AUGUST *A.D.* 2012 .

Authentication #: 1223501268

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

Jesse White

SECRETARY OF STATE

ATTACHMENT 1

File Number 1475-644-2

STATE OF ILLINOIS
OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

MOUNT SINAI HOSPITAL MEDICAL CENTER OF CHICAGO, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 26, 1918, 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* 22ND *day of* AUGUST *A.D.* 2012 .

SEAL OF THE STATE OF ILLINOIS AUG. 26TH 1818

Authentication #: 1223501218

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

Jesse White

SECRETARY OF STATE

ATTACHMENT 1

File Number 5255-749-6

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

SINAI HEALTH SYSTEM, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 04, 1981, 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* 22ND *day of* AUGUST *A.D.* 2012 .

SEAL OF THE STATE OF ILLINOIS AUG. 26TH 1818

Authentication #: 1223501336

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

Jesse White

SECRETARY OF STATE

ATTACHMENT 1

Endurance American Specialty Insurance Company
(Wilmington, Delaware)

FOLLOWING FORM EXCESS LIABILITY INSURANCE POLICY DECLARATIONS

Policy No: HLC10003507400
Replaces: HLC10002928000

Producer: Marsh, Inc.
Address: 540 West Madison
Chicago, IL 60661

Item 1. Named Insured:

Mailing Address of Named Insured: Holy Cross Hospital
2701 West 68th Street
Chicago, IL 60629

☐ Individual
☐ Partnership/Joint Venture
☐ Trust
☒ Organization
☐ Limited Liability Company

Item 2. Policy Period: From: January 1, 2012 To: January 1, 2013
(12:01 A.M. Standard Time at the address stated in Item 1)

Item 3. Coverage:
☐ Following Form Excess Liability (Occurrence)
☐ Following Form Excess Liability (Claims-Made)
☒ Following Form Excess Liability (Occurrence <u>and</u> Claims-Made)

Item 4. Limits of Liability:

(a)	U.S. $15,000,000	Each Occurrence or Medical Incident Limit
(b)	U.S. $15,000,000	General Aggregate Limit (maximum limit for all occurrences and medical incidents paid under this Policy)
(c)	U.S. $50,000	Retained Limit

Should any single event or accident result in both an occurrence and a medical incident for which coverage is provided by the terms and conditions of the coverage parts of this Policy, our total liability for such single event shall not exceed the amount set forth in item 4(a), above.

Item 5. Attachment Point and Followed Policy: See Schedule of Underlying Insurance.

Item 6. Premium for Policy: $359,000

Minimum Earned Premium: 25%

NOTE – SEE ENCLOSED NOTICE FOR "SURPLUS LINES NOTIFICATION"

Date of Issuance: January 26, 2012
Endurance American Specialty Insurance Company

☐ You have elected to purchase coverage offered under the Terrorism Risk Insurance Extension Act as amended and reauthorized in 2007. The charge for this coverage is U.S. $000 and is not included in the Premium stated above

☒ You have not elected to purchase coverage offered under the Terrorism Risk insurance Extension Act as amended and reauthorized.

☐ The Terrorism Risk Insurance Extension Act as amended and reauthorized in 2007 does not apply.

Item 7. Retroactive Date January 1, 2003

If no date is shown, we will consider the umbrella retroactive date for Professional Healthcare Services Liability (including Patient General Liability) -- Claims Made to be the same as the beginning date of this policy.

If this policy provides coverage on a claims made basis to more than one insured and they maintain different retroactive dates, they will be named with their respective retroactive dates on a separate Named Insured and Retroactive Date Endorsement.

Item 8. Forms Attached:
See Forms and Endorsement Schedule

Signed By: Authorized Representative

Date: January 26, 2012

NOTE – SEE ENCLOSED NOTICE FOR "SURPLUS LINES NOTIFICATION"

Issuing Office:
16253 Swingley Ridge Road
Suite 200
St. Louis, MO 63017
Endurance American Specialty Insurance Company

Endurance American Specialty Insurance Company

(Wilmington, Delaware)

FOLLOWING FORM EXCESS LIABILITY INSURANCE POLICY DECLARATIONS

Policy No: HLC10003507400
Replaces: HLC10002928000

Producer: Marsh, Inc.
Address: 540 West Madison
Chicago, IL 60661

Item 1. Named Insured:

Mailing Address of Named Insured:
Holy Cross Hospital
2701 West 68th Street
Chicago, IL 60629

☐ Individual
☐ Partnership/Joint Venture
☐ Trust
☒ Organization
☐ Limited Liability Company

Item 2. Policy Period: From: January 1, 2012 To: January 1, 2013
(12:01 A.M. Standard Time at the address stated in Item 1)

Item 3. Coverage:
☐ Following Form Excess Liability (Occurrence)
☐ Following Form Excess Liability (Claims-Made)
☒ Following Form Excess Liability (Occurrence and Claims-Made)

Item 4. Limits of Liability:

(a) U.S. $15,000,000 Each Occurrence or Medical Incident Limit
(b) U.S. $15,000,000 General Aggregate Limit (maximum limit for all occurrences and medical incidents paid under this Policy)
(c) U.S. $50,000 Retained Limit

Should any single event or accident result in both an occurrence and a medical incident for which coverage is provided by the terms and conditions of the coverage parts of this Policy, our total liability for such single event shall not exceed the amount set forth in item 4(a), above.

Item 5. Attachment Point and Followed Policy: See Schedule of Underlying Insurance.

Item 6. Premium for Policy: $359,000

Minimum Earned Premium: 25%

NOTE – SEE ENCLOSED NOTICE FOR "SURPLUS LINES NOTIFICATION"

Date of Issuance: January 26, 2012
Endurance American Specialty Insurance Company

☐ You have elected to purchase coverage offered under the Terrorism Risk Insurance Extension Act as amended and reauthorized in 2007. The charge for this coverage is U.S. $000 and is not included in the Premium stated above

☒ You have not elected to purchase coverage offered under the Terrorism Risk insurance Extension Act as amended and reauthorized.

☐ The Terrorism Risk Insurance Extension Act as amended and reauthorized in 2007 does not apply.

Item 7. Retroactive Date January 1, 2003

If no date is shown, we will consider the umbrella retroactive date for Professional Healthcare Services Liability (including Patient General Liability) -- Claims Made to be the same as the beginning date of this policy.

If this policy provides coverage on a claims made basis to more than one insured and they maintain different retroactive dates, they will be named with their respective retroactive dates on a separate Named Insured and Retroactive Date Endorsement.

Item 8. Forms Attached:

See Forms and Endorsement Schedule

Signed By: Authorized Representative

Date: January 26, 2012

NOTE – SEE ENCLOSED NOTICE FOR "SURPLUS LINES NOTIFICATION"

Issuing Office:
16253 Swingley Ridge Road
Suite 200
St. Louis, MO 63017
Endurance American Specialty Insurance Company

Health Care Organization Umbrella Liability Insurance Policy Declarations

darwin

☐ **Darwin National Assurance Company** — **Policy Number:** 0306-2205

☒ **Darwin Select Insurance Company**

THIS POLICY MAY CONTAIN BOTH CLAIMS MADE AND OCCURRENCE COVERAGE PARTS. UNLESS OTHERWISE SPECIFIED, THE COVERAGE PROVIDED BY THIS POLICY SHALL ONLY APPLY IN EXCESS OF SCHEDULED UNDERLYING INSURANCE OR SELF-INSURANCE. THE APPLICABLE LIMIT OF LIABILITY AVAILABLE TO PAY DAMAGES, SETTLEMENTS OR JUDGMENTS WILL BE REDUCED AND MAY BE EXHAUSTED BY THE PAYMENT OF DEFENSE EXPENSES. PLEASE READ THE ENTIRE POLICY CAREFULLY.

Item 1. Name and Mailing Address of Named Insured:

Holy Cross Hospital
2701 W. 68th Street
Chicago, IL 60629

Item 2. Policy Period:

(a) Inception Date: January 1, 2012
(b) Expiration Date: January 1, 2013
At 12:01AM Standard Time at the Mailing Address shown above

Item 3. Limit of Liability:

(a) Specific Loss Limit: $10,000,000
(b) Aggregate Limit: $10,000,000

Item 4. Retained Amount:

$50,000

Item 5. Notices required to be given to the Insurer must be addressed to:

Darwin Professional Underwriters, Inc.
9 Farm Springs Road
Farmington, CT 06032

Item 6. Premium:

$910,000

Notice to Policyholder: This contract is issued, pursuant to Section 445 of the Illinois Insurance Code, by a company not authorized and licensed to transact business in Illinois and as such is not covered by the Illinois Insurance Guaranty Fund.

DRWN H7005 (6/2005)

ATTACHMENT 2

Item 7. Retroactive Date:

(a) Insuring Agreement A.:	January 1, 2003
(b) Insuring Agreement B.2:	N/A

Item 8. Applicable Insuring Agreements:

Insuring Agreement A: ☒
Insuring Agreement B.1: ☒
Insuring Agreement B.2: ☐
Insuring Agreement C: ☒

Item 9. Endorsements Attached at Issuance:

1. s1006 DSI (01/2010) Service Of Suit
2. v1089 (07/2005) Nuclear Energy Liability Exclusion
3. v1224 (11/2009) Punitive Damages
4. v1226 (08/2010) Minimum Earned Premium
5. v1247 (10/2004) Auto Coverage Limitation
6. ~~v1418 (05/2005) Recovery Of Defense Expenses~~
7. v1439 (07/2005) Sexual Misconduct - Defense Expense Only
8. v1832 (08/2006) Amend Definition of "Insured"
9. v2363 (08/2008) Blanket Additional Insureds
10. v2712 (7/2011) Separate Aggregate For Professional Liability

THESE DECLARATIONS, THE POLICY FORM, ANY ENDORSEMENTS AND THE APPLICATION CONSTITUTE THE ENTIRE AGREEMENT BETWEEN THE INSURER AND THE INSURED RELATING TO THIS INSURANCE.

In Witness Whereof, the Insurer has caused this Policy to be executed by its authorized officers.

SECRETARY

PRESIDENT

AUTHORIZED SIGNATURE

File Number 2073-273-3

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

HOLY CROSS HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON OCTOBER 10, 1929, 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* 22ND *day of* AUGUST *A.D.* 2012 .

SEAL OF THE STATE OF ILLINOIS
AUG. 26TH 1818

Authentication #: 1223501268

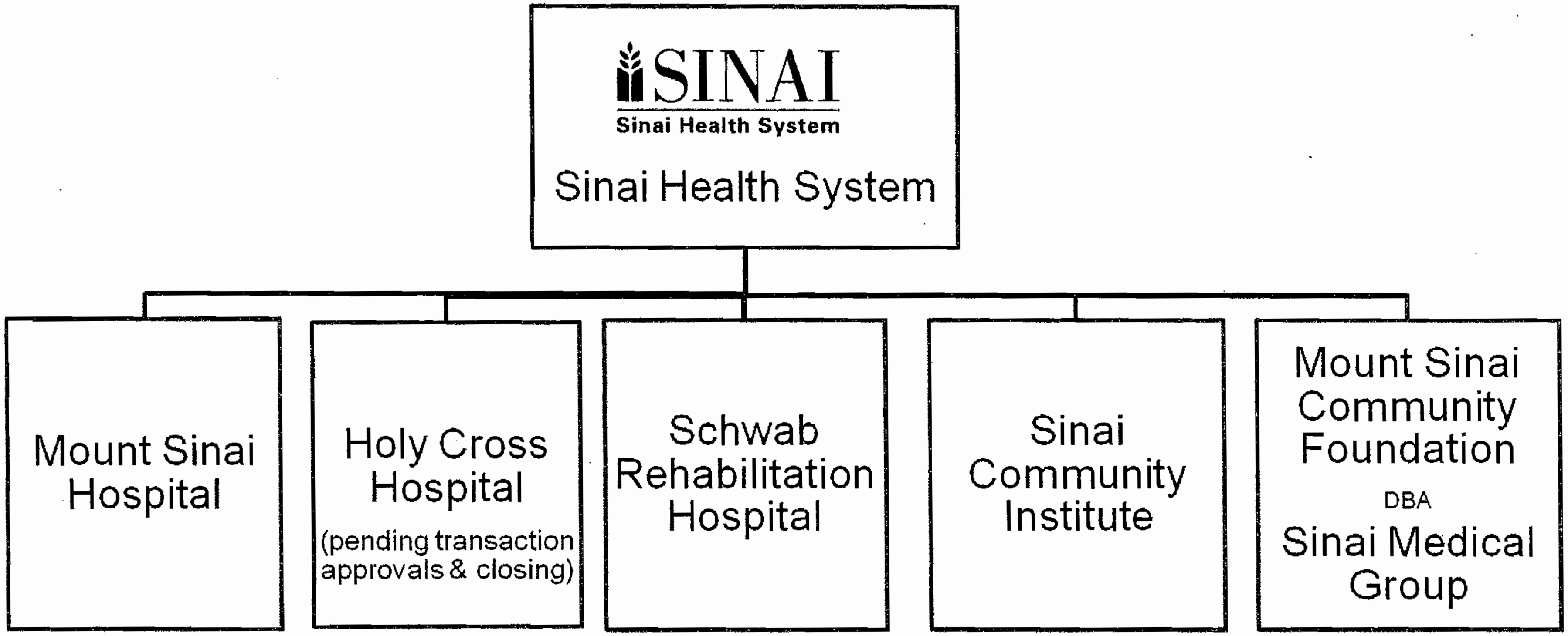
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

ATTACHMENT 3

Sinai Health System
Corporate Entity Organizational Chart



All entities are Illinois not-for-profit corporations and are exempt from Federal Income Tax under 501 (c)(3)

PROJECT COSTS

Fair Market Value of All Real Assets ($18,655,000)

Value of assets addressed through the proposed transaction, consistent with a technical assistance conference conducted with IHFSRB staff on August 6, 2012. The identified amount is consistent with a formal offer made by Vanguard Health Systems, Inc. to acquire Holy Cross Hospital in 2010. Documentation of that offer is included in IHFSRB project file #10-081.

State of Illinois 2065051
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

CRAIG CONOVER, M.D.
ACTING DIRECTOR

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

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/12	BGBD	0000992

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/12

BUSINESS ADDRESS

HOLY CROSS HOSPITAL
2701 WEST 68TH STREET
CHICAGO IL 60629

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

ATTACHMENT 11

State of Illinois 2065

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

CRAIG CONOVER, M.D.
ACTING DIRECTOR

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

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/12	BGBD	0001644

FULL LICENSE
GENERAL HOSPITAL

EFFECTIVE: 01/01/12

BUSINESS ADDRESS

MT. SINAI HOSPITAL MEDICAL CENTER
CALIFORNIA AT 15TH STREET
CHICAGO IL 60608

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

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

State of Illinois 2065

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

MT. SINAI HOSPITAL MEDICAL CENTER

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/12	BGBD	0001644

FULL LICENSE
GENERAL HOSPITAL

EFFECTIVE: 01/01/12

11/08/11

MT. SINAI HOSPITAL MEDICAL CENTER
CALIFORNIA AT 15TH STREET
CHICAGO IL 60608

FEE RECEIPT NO.

98

ATTACHMENT 11

State of Illinois 2065079
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

RAIG CONOVER, M.D.
CTING DIRECTOR

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

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/12	BGBD	0002147

FULL LICENSE
REHABILITATION HOSP
EFFECTIVE: 01/01/12

BUSINESS ADDRESS

SCHWAB REHABILITATION CENTER
1401 SOUTH CALIFORNIA BOULEVARD
CHICAGO IL 60608

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

DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

State of Illinois 2065079
Department of Public Health
LICENSE, PERMIT, CERTIFICATION, REGISTRATION

SCHWAB REHABILITATION CENTER

EXPIRATION DATE	CATEGORY	I.D. NUMBER
12/31/12	BGBD	0002147

FULL LICENSE
REHABILITATION HOSP
EFFECTIVE: 01/01/12

11/06/11

SCHWAB REHABILITATION CENTER
1401 SOUTH CALIFORNIA BOULEVARD
CHICAGO IL 60608

FEE RECEIPT NO.

ATTACHMENT 11

AMERICAN OSTEOPATHIC ASSOCIATION

BUREAU OF HEALTHCARE FACILITIES ACCREDITATION
HEALTHCARE FACILITIES ACCREDITATION PROGRAM

142 E. Ontario Street, Chicago, IL 60611-2864 ph 312 202 8258 | 800- 621 -1773 X 8258

September 6, 2011

Wayne Lerner
Chief Executive Officer
Holy Cross Hospital
2701 W. 68th Street
Chicago, IL 60629

Dear Mr Lerner :

The American Osteopathic Association's Bureau of Healthcare Facilities Accreditation Executive Committee, at its meeting on August 30, 2011 reviewed the recertification survey report and found all Medicare conditions have been met. Your facility has been granted **Full Accreditation with Interim Report,** with resurvey within 3 years and AOA/HFAP **recommends continued deemed status.**

Holy Cross Hospital
2701 W. 68th Street
Chicago, IL 60629

Holy Cross Hospital Physician Pavilion
2701 West 68th Street, 2nd Floor
Chicago, IL 60629

Program: Acute Care Hospital
CCN # 140133
HFAP ID: 161571
Survey Dates: 02/7/2011 – 02/9/2011
Effective Date of Recommended Continued Deemed Status: 03/28/2011 - 03/28/2014

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

In reviewing your report, the Executive Committee made the observations that are contained on the enclosed sheets and requires that in Interim Report by your facility, indicating continued progress made toward correction of cited deficiencies, be received in the AOA Division of Healthcare Facilities Accreditation prior to **October 17, 2011.**

Sincerely,

Michael J. Zarski

Mike Zarski
Acting Secretary

MJZ/pmh

C: Laura Weber, Health Insurance Specialist, CMS

ATTACHMENT 11

Mount Sinai Hospital Medical Center

Chicago, IL

has been Accredited by

The Joint Commission

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

Hospital Accreditation Program

August 13, 2011

Accreditation is customarily valid for up to 36 months.

Isabel V. Hoverman, MD, MACP Chair, Board of Commissioners	Organization ID #7294 Print/Reprint Date: 11/29/11	Mark R. Chassin, MD, FACP, MPP, MPH President

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

ATTACHMENT 11

Schwab

Rehabilitation Hospital and Care Network

Chicago, IL

has been Accredited by

The Joint Commission

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

Hospital Accreditation Program

October 28, 2011

Accreditation is customarily valid for up to 36 months.

Isabel V. Hoverman, MD, MACP
Chair, Board of Commissioners

Organization ID #7300
Print/Reprint Date: 1/6/12

Mark R. Chassin, MD, FACP, MPP, MPH
President

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

SINAI

Sinai Health System California Avenue at 15th Street • Chicago, IL 60608 • (773) 542-2000 • TDD (773) 542-0040

Alan H. Channing
President and Chief Executive Officer
Office: 773-257-6434 • Fax: 773-257-6953
alan.channing@sinai.org

August 28, 2012

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

Dear Ms. Avery:

In accordance with Review Criterion 1110.230.b, Background of the Applicant, we are submitting this letter assuring the Illinois Health Facilities and Services Review Board that:

1. Sinai Health System has not had any adverse actions against any facility owned and operated by the applicant during the three (3) year period prior to the filing of this application, and
2. Sinai Health System authorizes the State Board and Agency access to information to verify documentation or information submitted in response to the requirements of Review Criterion 1110.230.b or to obtain any documentation or information which the State Board or Agency finds pertinent to this application.

If we can in any way provide assistance to your staff regarding these assurances or any other issue relative to this application, please do not hesitate to call me.

Sincerely,

Alan H. Channing

"OFFICIAL SEAL"
Rosa M Arellano
Notary Public, State of Illinois
My Commission Expires 11/30/2012

Subscribed and sworn to me
this 28 day of August, 2012

Notary Public

ATTACHMENT 11

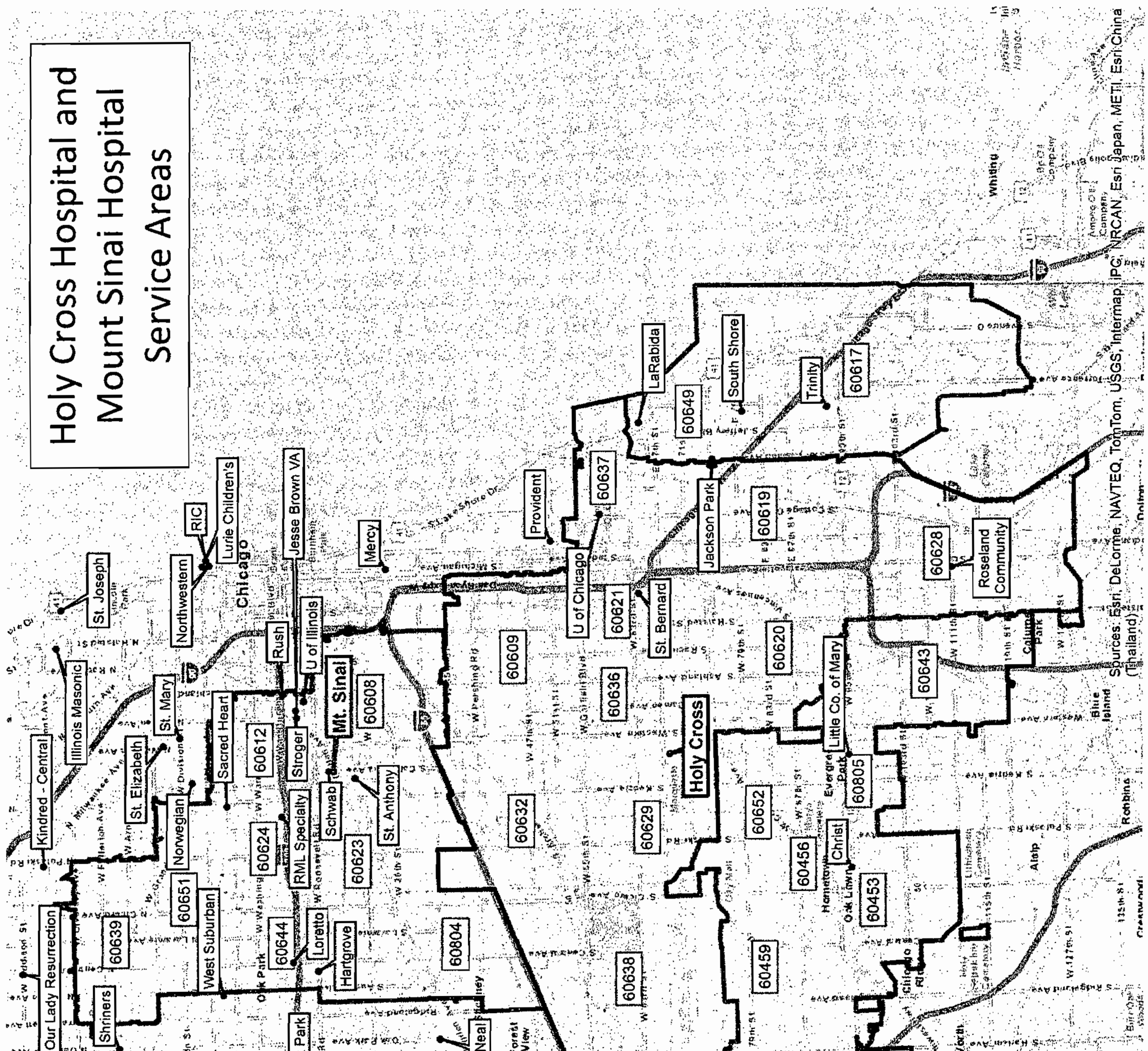
PURPOSE

The purpose of the proposed project, which is limited to a change of ownership and control, is to strengthen the proposed system hospitals, protect the sustainability of the combined system, and ensure that inpatient and outpatient hospital services remain accessible to the residents of the southwestern Chicago neighborhoods traditionally served by Holy Cross Hospital through the combining of the Sinai and Holy Cross organizations.

As well documented, residents of the southwestern quadrant of Chicago (and, to a lesser extent, the Cook County suburban communities to the west), particularly when compared to virtually any other part of the metropolitan Chicago area, have minimal access to hospital services. These neighborhoods and communities, as identified in the ZIP Code-specific patient origin analysis presented in this ATTACHMENT, constitute Holy Cross Hospital's current and anticipated service area. The closest hospitals to Holy Cross and their drive times (all drive times per MapQuest, adjusted consistent with IHFSRB rule) are the following:

- Little Company of Mary Hospital, Evergreen Park (15 minutes)
- St. Bernard Hospital, Chicago (15 minutes)
- Advocate Christ Medical Center, Oak Lawn (16 minutes)
- St. Anthony Hospital, Chicago (22 minutes)
- Mount Sinai Hospital, Chicago (25 minutes)
- MetroSouth Medical Center, Blue Island (30 minutes)
- MacNeal Hospital, Berwyn (34 minutes)

The map on the following page identifies the service areas of Holy Cross Hospital and Mount Sinai Hospital, demonstrating the overlapping of the two.



ATTACHMENT 12

The table below presents the 2011 patient origin for Mount Sinai Hospital and Holy Cross Hospital, identifying each ZIP Code area that contributed 1.0% of the respective hospital's admissions, and highlighting the ZIP Code areas that contribute a minimum of 1.0% of each of the hospital's patients.

Mount Sinai Hospital			Holy Cross Hospital		
60623	Chicago	25.1%	60629	Chicago	27.5%
60624	Chicago	9.9%	60636	Chicago	21.7%
60632	Chicago	6.6%	60620	Chicago	10.0%
60608	Chicago	5.7%	60632	Chicago	8.1%
60612	Chicago	5.4%	60609	Chicago	7.3%
60629	Chicago	5.3%	60621	Chicago	4.7%
60644	Chicago	4.3%	60652	Chicago	2.9%
60804	Cicero	3.8%	60638	Chicago	2.0%
60609	Chicago	3.5%	60643	Chicago	1.1%
60651	Chicago	2.7%	60619	Chicago	1.0%
60636	Chicago	2.1%	60455	Bridgeview	1.0%
60621	Chicago	1.9%		others <1.0%	12.3%
60620	Chicago	1.6%			100.0%
60637	Chicago	1.3%			
60649	Chicago	1.2%			
60617	Chicago	1.2%			
60619	Chicago	1.2%			
60628	Chicago	1.1%			
60639	Chicago	1.1%			
	others <1.0%	15.0%			
		100.0%			

Holy Cross Hospital is located in ZIP Code area 60629, which accounts for over one-quarter of the hospital's admissions. As can be noted from the table above, three ZIP Code areas account for nearly 60% of Holy Cross Hospital's admissions, with two of those ZIP Code areas (60636 and 60620) also providing Mount Sinai Hospital with 3.7% of its admissions.

The primary issues faced by the Holy Cross Hospital that have led to this project are: 1) the desire of the hospital to remain a viable provider of services, 2) the desire that the hospital maintain its Catholic identity, and 3) the hospital's inability to continue to operate and make the needed improvements that will assure its future. The need for the Sisters of St. Casimir to divest was identified both through a hospital-directed strategic planning process as well as through independent outside analyses over the past four years.

The proposed change of ownership will assure that services historically provided by the hospital will remain accessible to the community. Sinai Health System certifies that no clinical programs have been identified for discontinuation, and that Holy Cross Hospital's admissions policies will not become more restrictive as a result of the proposed change of ownership and control.

As is the case with many changes of ownership, an initial drop in utilization may occur as the result of physicians modifying their admitting practices. In terms of a quantifiable objective, the goal will be to increase market shares for all services within twelve months of the change of ownership.

ALTERNATIVES

Holy Cross Hospital's decision to become a member of Sinai Health System was precipitated by the hospital's realization that in order to continue to serve its community, it would need to become more efficient in its operations, improve its physical plant and continue to replace and update its systems and equipment. Two alternatives to the proposed change-of-ownership were considered over the past four years, and a summary of those alternatives and the reasons for rejecting the alternatives are presented below.

Alternative 1: Discontinuation of the Hospital, and Sell the Buildings for Non-Health Care Uses

The "discontinuation" or closing of the hospital was immediately dismissed for three reasons. First, and as discussed in other parts of this application, the southwest side of Chicago does not enjoy the number of hospitals located in other parts of the city, and the elimination of Holy Cross Hospital as a health care resource would be a significant hardship on the communities that have been served by the hospital for over eighty years. Second, Holy Cross Hospital typically has a patient census of 14-15 patients in ICU beds and another 50-55 patients in telemetry beds. The hospitals in the general area of Holy Cross Hospital do not have the monitored bed capacity to absorb an additional 65-70 patients a day. Third, Holy Cross Hospital accepts an average of over 60 EMS transports a day—more than any other hospital in Illinois—as a result of the physical distance between hospitals on the southwest side of Chicago. The closure of Holy Cross would result in extended travel times for these EMS-transported patients, jeopardizing their well being.

Alternative 2: Sell the Hospital's Assets to an Organization that Would Continue To Operate the Hospital

An internal advisory committee consisting of selected Board members and management evaluated potential purchasers for Holy Cross Hospital, to identify area providers having the ability to effectuate the identified needs of the hospital. Two potential purchasers were identified as "having the right fit"—one being a hospital and one being a multi-hospital system. Both were approached by management, and both indicated that they were not interested in purchasing Holy Cross. In 2010 Holy Cross Hospital reached an agreement with a major hospital system to acquire the hospital for approximately $18.6M. Subsequent to receipt of the required CON Permit (#10-081), the acquiring system exercised its option to withdraw from the transaction.

IMPACT STATEMENT

Holy Cross Hospital ("HCH") and Mount Sinai Hospital Medical Center ("MSH") are located approximately 7.2 miles apart. Sinai Health System, and particularly through Mount Sinai Hospital Medical Center, and Holy Cross Hospital are among the most active providers of safety net services in the State of Illinois, with both providing a broad spectrum of inpatient, outpatient, and community-based services to largely minority populations on the West and Southwest sides of Chicago. During 2011, MSH and HCH provided inpatient charity care to 2,660 patients, representing 12.0% and 5.9% respectively of the two hospitals' admissions. In addition, 45.9% of MSH's admissions and 33.8% those admitted to HCH were Medicaid recipients.

Reason for the Transaction

The purpose of the proposed project is to strengthen the proposed system hospitals, protect the sustainability of the combined system, and ensure that inpatient and outpatient hospital services remain accessible to the residents of the southwestern Chicago neighborhoods traditionally served by Holy Cross Hospital and Sinai Health System through the combining of the Sinai and Holy Cross organizations. It is believed by the applicants that their geographic proximity, overlapping service areas, and the greater scale of the proposed combined organization will create opportunities for greater efficiencies in the delivery of health care services on both the HCH and MSH campuses, better position the organization for participation in accountable care organizations, care coordination entities and managed care plans; and along with continued resource review, best practices implementation, and cost containment strategies, will enhance the expanded organization's access to capital.

Anticipated Changes to Beds, Services, and Staffing

The proposed transaction will not result in the elimination of any "safety net services", nor will it result in the elimination of any other clinical services. There are however, both clinical and non-clinical redundancies that are being and will continue to be evaluated. As a result, the potential exists for the consolidation of services or changes to the manner in which services are provided; particularly non-clinical services such as receivables and payables management, human resources, information technology, medical records management, and purchasing/procurement over the next twelve months. Potential changes in the manner in which these services are provided will likely result in a consolidation of a currently undetermined number of positions.

As of the filing of this application, no IDPH-designated "categories of service" have been earmarked for discontinuation. The applicants fully understand however, that should a decision be made to do so in the future, prior approval of the IHFSRB must be secured. The IDPH-designated "categories of services" currently provided in common by both HCH and Sinai Health System are: medical/surgical beds, ICU beds, obstetrics beds, comprehensive physical rehabilitation beds, and cardiac catheterization services.

In addition, while the potential exists to reduce the number of approved beds, no decision to do so has been made as of the filing of this application. Should the applicants elect to do so during the next two years, the IHFSRB will be informed of such.

Operating Entity

Holy Cross Hospital will continue to be the hospital's licensee/operating entity.

Cost/Benefit Analysis of the Transaction

1. Cost

There are no capitalized costs associated with the proposed change of ownership and control. Transaction-related costs to be incurred by HCH and SHS, which will be expensed, are estimated to be $300-$400,000.

2. Benefit

Both the community and the hospital will benefit from the proposed change of ownership.

The community will most directly benefit from Holy Cross Hospital's ability to continue to operate as a result of this transaction. In 2011 the hospital provided in excess of 41,000 patient days of care, nearly 79,500 outpatient interactions, and treated over 47,000 patients through its emergency department.

Holy Cross Hospital, as a result of the change of ownership will benefit directly from the intended presence of Sinai Medical Group, which will both expand the hospital's primary care base and increase access to the Group's specialists; SHS will immediately implement and manage an integrated electronic medical records (EMR) system; and SHS will incorporate many of its clinical "best practices" and management programs into Holy Cross Hospital's operations.

ACCESS

Holy Cross Hospital's charity care/financial assistance policies are attached. Financial assistance and charity care provisions are made to patients having a household income equal to or less than 300% of the Federal Poverty Level, combined with a general lack of liquid assets. Full (100%) write-offs are provided to those having a household income of 200% or less of the Federal Poverty Level, with a sliding scale used for those with an income of more than 200% but less than 300% of the Federal Poverty Level.

Mount Sinai Hospital's admissions and charity care/financial assistance policies (attached) will be adopted by Holy Cross Hospital following the change of ownership. The policies to be used provide for financial assistance and charity care provisions to be made to patients having a household income equal to or less than 600% of the Federal Poverty Level. Full (100%) write-offs for inpatient care are provided to those having a household income of 200% or less of the Federal Poverty Level, with a sliding scale used for those with an income of more than 200% but less than 600% of the Federal Poverty Level.

Holy Cross Hospital will, as is the case now, operate without any restrictive admissions policies, related to race, ethnic background, religion, payment source, or any other factor. The hospital will continue to admit Medicare and Medicaid recipients, as well as patients in need of charity care. In addition, no agreements with private third party payors currently in place at Holy Cross Hospital are anticipated to be discontinued as a result of the proposed change of ownership.

Attached is a letter, consistent with the requirements of Section 1110.240(c), certifying that the admissions policies of Holy Cross Hospital will not become more restrictive than those now in place.

SINAI

Sinai Health System California Avenue at 15th Street • Chicago, IL 60608 • (773) 542-2000 • TDD (773) 542-0040

Alan H. Channing
President and Chief Executive Officer
Office: 773-257-6434 • Fax: 773-257-6953
alan.channing@sinai.org

August 28, 2012

Illinois Health Facilities and Services Review Board
Springfield, Illinois

RE: Change of Ownership of Holy Cross Hospital Chicago, Illinois

To Whom It May Concern:

Please be advised that upon the proposed change of ownership and control of Holy Cross Hospital, there will be no policies adopted that will result in restrictions to admissions to the hospital.

It is the intent of Sinai Health System that Holy Cross Hospital, which will be the licensee following the change of ownership, adopt the admissions-related policies currently in effect at Sinai Health System and Mount Sinai Hospital Medical Center are included in ATTACHMENT 19B of the Application for Permit addressing the change of ownership, and it is anticipated that those policies will be adopted within sixty days of the change of ownership. Until such time that the proposed policies and procedure are adopted, the hospital will operate under the policies and procedures currently in place.

As a result, upon acquisition, the admissions policies will not become more restrictive.

Sincerely,

Alan H. Channing

"OFFICIAL SEAL"
Rosa M Arellano
Notary Public, State of Illinois
My Commission Expires 11/30/2012

Subscribed and sworn to me
this 28 day of August, 2012

Notary Public

ATTACHMENT 19B

Holy Cross Hospital

Current Financial Aid Policies

ATTACHMENT 19B

HOLY CROSS
HOSPITAL

Policy Title: CODE OF ETHICS **Policy #:** HP-C-5

Originating Department: ADMINISTRATION

Current Revision Date: 7/15/2010	Supersedes Date: 3/5/2007	Original Effective Date: 6/1/1996

Purpose: The Governing Board of Holy Cross has established this statement of organization ethics in recognition of the institution's responsibility to our patients, staff, physicians and the community we serve.

Distribution/Scope: Organization Wide

GENERAL PRINCIPLES GUIDING OUR BEHAVIOR

A dedication to the principle that all patients, employees physicians, and visitors deserve to be treated with dignity, respect, and courteousness. The organization will constantly strive to adhere to these principles and will expand on these principles through the development of additional policy statements addressing the following:

A. we will fairly and accurately represent ourselves and our capabilities;

B. we will not misrepresent our capabilities to any public;

C. we will provide services to meet the identified needs of our patients and will constantly seek to avoid the provision of those services which are unnecessary or non-efficacious and

D. we will adhere to a uniform standard of care throughout the organization.

In all the various settings in which this organization provides patient service we will consistently follow well-designed standards of care based upon the needs of the patient and without regard to their ability to pay.

We will provide services and quality care to those patients to whom we can safely care for within the organization and will not turn patients away who are in need of our services based on their ability to pay or based upon any other factor that is substantially unrelated to patient care.

RESPECT FOR THE PATIENT

We will treat all patients with dignity, respect, and courteousness. These patients (or their significant others) will be involved in decisions regarding the care that we deliver to the extent that such is practical and possible. We will also seek to inform all patients about the therapeutic alternatives and the risks associated with the care they are seeking. In all circumstances, we will attempt to treat patients in a manner giving reasonable thought to their background, culture, religion, and heritage.

RESOLUTION OF CONFLICTS

We recognize that from time to time conflicts will arise among those who participate in hospital and patient care decisions. Whether this conflict is between members of administration, medical staff, employees, or the governors of this institution, or between patient care givers and the patient, we will seek to resolve all conflicts fairly and objectively. In cases where mutual satisfaction can not be achieved, it is the policy of this organization to involve the administrator on call to oversee resolution of the conflict. Other staff and second opinions will be involved as needed to pursue a mutually satisfactory resolution.

RECOGNITION OF POTENTIAL CONFLICTS OF INTEREST

We recognize that the potential for conflict of interest exists for decision makers at all levels within the hospital. It is our policy to request the disclosure of potential conflict of interest so that appropriate action may be taken to ensure that such conflict is not inappropriately influenced by important decisions. Board members, administration, and medical staff leaders are required to submit a disclosure form on a case-by-case basis, to disclose potential conflicts related to decisions that arise during the course of a year. The governing board as well as senior management and the medical staff will review all potential conflicts (when appropriate) and take appropriate action. In the event a potential conflict of interest has a direct implication for patient care, the institution may convene an ethics committee to assist in the resolution of this issue.

- Substantial ownership in a competitor, supplier or an entity which refers patients to the Hospital may create a conflict of interest. Any doubts or questions about an investment should be reported to the Compliance Officer.
- Immediate family members should not supervise or report to each other.
- Equipment, materials or proprietary information owned by the Hospital should not be used for any outside employment purpose.

FAIR BILLING PRACTICES

The hospital and its medical staff will invoice patients or third parties only for services actually provided to patients and will provide assistance to patients seeking to understand the cost relative to their care. All initial patient billing is itemized and includes dates of service.

CORPORATE COMPLIANCE

The Corporate Compliance Program is intended to define the conduct expected of Hospital Representatives, to provide guidance on how to resolve questions regarding legal and ethical issues, and to establish a mechanism for reporting of possible violations of law or ethical principles within the Hospital. The guidelines contained in this Program are meant to stand as Standards of Conduct and are designed to assist in making the right choices when confronted with difficult situations.

CONFIDENTIALITY

Holy Cross Hospital recognizes the need to maintain patient and other information in a confidential manner. Patient information and other information concerning hospital staff are to be provided to only those persons authorized to review and act upon such information.

HIPAA

Holy Cross Hospital is compliant with HIPAA policies and Business Associate Agreements. Privacy Notices are posted and given to all patients. Protected Health Information is kept private and confidential.

ADMISSIONS

- Race, Creed, or National Origin shall have no consideration or bearing on hospital admission. The need of medical care and treatment of all persons who seek admission as patients shall be determined by members of the Medical Staff of Holy Cross Hospital. All persons admitted as patients shall have equal quality safe care and treatment and full use of all hospital facilities and services.

DISCHARGES

Discharge planning is an interdisciplinary process involving the Case Manager, Social Worker, nursing, medical staff and the ancillary services.

TRANSFERS

Transfers and discharge policies are not based on patient ability to pay. Patients whose specific condition or disease cannot be safely treated transferred to an accepting organization only in accordance with the guidelines for inter-hospital transfers.

MEDICAL STAFF

It is recognized that the Medical Staff has been delegated the responsibility for the quality of medical care in the Hospital and for the ethical conduct and professional practices of its members and that it must accept and discharge these responsibilities to its patients subject to the ultimate authority of the Board of Trustees.

Holy Cross Hospital has adopted the Ethical and Religious Directives for Catholic Health Facilities and it is expected that members of the Medical Staff will strictly abide by such directives in their professional lives so long as they are members of the Medical Staff and will take no action which is contrary to such directives.

COMPLAINTS

Patients will be informed of their right to file a complaint, receive a response and receive a resolution when possible, to their complaint.

Approved: W Lerner

Wayne Lerner, President/CEO

Date: 8/25/10

HOLY CROSS
HOSPITAL

Policy Title:	**Hospital Sponsored Financial Aid**	**Policy #:**	**C.2**
Originating Department: **Patient Financial Services**		**Page 1 of 1**	

Current Revision Date: 7/2/12	***Supersedes Date:*** **9/30/10**	***Original Effective Date: 9/2001***

Purpose: *Hospital Sponsored Financial Aid*

Holy Cross's policy is to provide those who are Indigent, as defined by Regionally Adjusted Federal Poverty Guidelines, with Charity Care or Partial Charity Care to relieve the financial burden associated with medically necessary treatment. Holy Cross intends, with this policy, to establish a policy and appropriate procedures for use, in circumstances in which free care, compliant with all applicable federal, state, and local laws, shall be extended to Holy Cross's Indigent patients, who may be Uninsured/Underinsured or have suffered a catastrophic injury.

Distribution/Scope: Patient financial Services and Patient Access

The following definitions are applicable to all sections of this Policy:

1. **Charity Care (or "Free Care"):** A 100% waiver of patient financial obligation resulting from medical services provided by Holy Cross. Patients who are classified as Indigent, whether they are Uninsured or Underinsured, and who have annualized household incomes not in excess of 200% of the Regionally Adjusted Federal Poverty Guidelines will be eligible to receive Charity Care.

2. **Partial Charity Care:** A percentage discount, based on the Optimal Charity Care Sliding Scale, applied to patient financial obligation resulting from medical services provided by Holy Cross. Patients' who are Indigent, whether they are Uninsured or Underinsured, and who have annualized household incomes in excess of 300%, of the Regionally Adjusted Federal Poverty Guidelines will be eligible to receive Partial Charity Care.

3. **Indigent Patient:** An individual who is unable to pay for medical services rendered when taking into consideration his / her household income and assets as well as their requirement for other necessities of life for themselves and their dependants. Assets would be defined, but not limited to:

   a. **Equity in a home**
   b. **Other significant personal property including real estate, automobiles, boats and other substantial personal property.**
   c. **Savings, retirement account(s), investments and other forms of assets that can be liquidated.**

4. **Uninsured Patient:** An individual who is uninsured, having no third-party coverage by a commercial third-party insurer; an ERISA plan; a Federal Health Care Program (including without limitation Medicare, Medicaid, SCHIP and CHAMPUS), Workers' Compensation, Medical Savings Accounts or other coverage for all or any part of his bill, including claims against third parties covered by insurance to which Holy Cross is subrogated, but only if payment is actually made by such insurance company.

5. **Underinsured Patient:** People with public or private insurance policies that do not cover all necessary health care services (adjusted for geographical region), resulting in out-of-pocket expenses that exceed their ability to pay

6. **Holy Cross** Charity Care Discounting Guidelines: The policies and procedures for determining the optimal Charity Care Discount bestowed upon Indigent patients, whether they are Uninsured or Underinsured.

CHARITY CARE POLICY

1. Holy Cross will provide access to necessary care for patients, regardless of ability to satisfy their financial obligation, in compliance with applicable federal and state laws. Charity Care shall be extended to patients in accordance with Holy Cross's mission and values, ensuring a demonstrative benefit to the community.

2. Both Uninsured and Underinsured patients will be considered eligible to receive Charity Care benefits, either Full or Partial, from Holy Cross. However, the applicant will be required to exhaust all other payment options as a condition of their approval. Payment sources include any and all forms of Federal, State, and Local medical assistance programs, grants, and other forms of financial aid. The patient's cooperation in accessing applicable & identifiable funding sources is required.

3. Holy Cross's patients who meet criteria based upon inability to pay for services will be screened and processed for assistance without respect to their residency, gender, ethnic origin or employment status. Annualized household income, both tangible and asset based, will be the primary factor in determining eligibility and the discounted amount for qualifying patients.

4. Annualized household income and family size must be verified through Holy Cross's Patient Financial Service Department obtaining and reviewing relevant patient documents. Such documents include, but are not limited to:
   a. Previous year's tax return plus last three month's pay stubs
   b. W-2 Withholding Statement
   c. Direct deposit payroll, pension or Social Security Income Statement
   d. Written or telephone verification, if obtaining hardcopy would be impossible
   e. Hospital access to data through applicable tools such as Trans Union

(Note: hospital may choose to obtain patient attestation and verify income through additional technology enablers.)

5. Holy Cross will document any and all Charity Care assistance, whether it is Full or Partial, in order to maintain information integrity and accessibility as well as to meet all internal and external compliance requirements.

Procedure

1. Notice of Charity Care Policy

    a. Holy Cross will post, at inpatient and outpatient admission areas and on its website, notice of its Charity Care policy. This will include taking steps to ensure that Charity Care literature (e.g. brochures, etc.) and Applications are readily accessible to patients at said locations.

    b. At the earliest feasible time, Holy Cross personnel will obtain necessary patient financial records and documentation regarding eligibility for any and all types of alternative funding to expedite processing of patient Charity Care Application. This time shall not exceed 90 days from date application was submitted.

2. Calculation of Charity Care Benefits (if Patient is Ineligible for Alternative Funding)

    a. Holy Cross personnel will apply the appropriate Uninsured / Underinsured discount to outstanding patient financial obligation.

    b. Holy Cross personnel will determine appropriate Charity Care Discount Percentage by analyzing patient financial information within the framework of Optimal Charity Care Sliding Scale (below).

[illegible] Poverty [illegible]	Discount
200%	**100%**
250%	**85%**
300%	**70%**
301% and greater	**N/A**

3. Calculation of Charity Care Benefits (if Patient is Eligible for Alternative Funding)

    a. Holy Cross personnel will forward full patient bill to appropriate funding source (Example: Private Funding) and adjust the patient balance based on reimbursement from said organization.

    b. Holy Cross personnel will then apply the appropriate Uninsured / Underinsured Discount to the remaining patient balance.

    c. Holy Cross personnel will determine appropriate Charity Care Discount Percentage by analyzing patient financial information within the framework of Optimal Charity Care Sliding Scale (as seen above). For example, if the patients' annualized household income is at 250% of the Regionally Adjusted Federal Poverty Guidelines they will receive a 75% discount on their bill, but patient would still be responsible for Remaining Balance.

Approved: ______________________
Vice President

Date: 7/2/12

HOLY CROSS HOSPITAL

Policy Title:	**Hospital Sponsored Financial Aid**	**Policy #: C.2**
Originating Department: Patient Financial Services		**Page 1 of 1**

Current Revision Date: 7/2/12	***Supersedes Date:*** **9/30/10**	***Original Effective Date: 9/2001***

Purpose: *Hospital Sponsored Financial Aid*

Holy Cross's policy is to provide those who are Indigent, as defined by Regionally Adjusted Federal Poverty Guidelines, with Charity Care or Partial Charity Care to relieve the financial burden associated with medically necessary treatment. Holy Cross intends, with this policy, to establish a policy and appropriate procedures for use, in circumstances in which free care, compliant with all applicable federal, state, and local laws, shall be extended to Holy Cross's Indigent patients, who may be Uninsured/Underinsured or have suffered a catastrophic injury.

Distribution/Scope: Patient financial Services and Patient Access

The following definitions are applicable to all sections of this Policy:

1. **Charity Care (or "Free Care"):** A 100% waiver of patient financial obligation resulting from medical services provided by Holy Cross. Patients who are classified as Indigent, whether they are Uninsured or Underinsured, and who have annualized household incomes not in excess of 200% of the Regionally Adjusted Federal Poverty Guidelines will be eligible to receive Charity Care.

2. **Partial Charity Care:** A percentage discount, based on the Optimal Charity Care Sliding Scale, applied to patient financial obligation resulting from medical services provided by Holy Cross. Patients' who are Indigent, whether they are Uninsured or Underinsured, and who have annualized household incomes in excess of 300%, of the Regionally Adjusted Federal Poverty Guidelines will be eligible to receive Partial Charity Care.

3. **Indigent Patient:** An individual who is unable to pay for medical services rendered when taking into consideration his / her household income and assets as well as their requirement for other necessities of life for themselves and their dependants. Assets would be defined, but not limited to:

   a. **Equity in a home**
   b. **Other significant personal property including real estate, automobiles, boats and other substantial personal property.**
   c. **Savings, retirement account(s), investments and other forms of assets that can be liquidated.**

4. **Uninsured Patient:** An individual who is uninsured, having no third-party coverage by a commercial third-party insurer; an ERISA plan; a Federal Health Care Program (including without limitation Medicare, Medicaid, SCHIP and CHAMPUS), Workers' Compensation, Medical Savings Accounts or other coverage for all or any part of his bill, including claims against third parties covered by insurance to which Holy Cross is subrogated, but only if payment is actually made by such insurance company.

5. **Underinsured Patient:** People with public or private insurance policies that do not cover all necessary health care services (adjusted for geographical region), resulting in out-of-pocket expenses that exceed their ability to pay

6. **Holy Cross** Charity Care Discounting Guidelines: The policies and procedures for determining the optimal Charity Care Discount bestowed upon Indigent patients, whether they are Uninsured or Underinsured.

CHARITY CARE POLICY

1. Holy Cross will provide access to necessary care for patients, regardless of ability to satisfy their financial obligation, in compliance with applicable federal and state laws. Charity Care shall be extended to patients in accordance with Holy Cross's mission and values, ensuring a demonstrative benefit to the community.

2. Both Uninsured and Underinsured patients will be considered eligible to receive Charity Care benefits, either Full or Partial, from Holy Cross. However, the applicant will be required to exhaust all other payment options as a condition of their approval. Payment sources include any and all forms of Federal, State, and Local medical assistance programs, grants, and other forms of financial aid. The patient's cooperation in accessing applicable & identifiable funding sources is required.

3. Holy Cross's patients who meet criteria based upon inability to pay for services will be screened and processed for assistance without respect to their residency, gender, ethnic origin or employment status. Annualized household income, both tangible and asset based, will be the primary factor in determining eligibility and the discounted amount for qualifying patients.

4. Annualized household income and family size must be verified through Holy Cross's Patient Financial Service Department obtaining and reviewing relevant patient documents. Such documents include, but are not limited to:
   a. Previous year's tax return plus last three month's pay stubs
   b. W-2 Withholding Statement
   c. Direct deposit payroll, pension or Social Security Income Statement
   d. Written or telephone verification, if obtaining hardcopy would be impossible
   e. Hospital access to data through applicable tools such as Trans Union

(Note: hospital may choose to obtain patient attestation and verify income through additional technology enablers.)

5. Holy Cross will document any and all Charity Care assistance, whether it is Full or Partial, in order to maintain information integrity and accessibility as well as to meet all internal and external compliance requirements.

Procedure

1. Notice of Charity Care Policy

    a. Holy Cross will post, at inpatient and outpatient admission areas and on its website, notice of its Charity Care policy. This will include taking steps to ensure that Charity Care literature (e.g. brochures, etc.) and Applications are readily accessible to patients at said locations.
    b. At the earliest feasible time, Holy Cross personnel will obtain necessary patient financial records and documentation regarding eligibility for any and all types of alternative funding to expedite processing of patient Charity Care Application. This time shall not exceed 90 days from date application was submitted.

2. Calculation of Charity Care Benefits (if Patient is Ineligible for Alternative Funding)

    a. Holy Cross personnel will apply the appropriate Uninsured / Underinsured discount to outstanding patient financial obligation.

    b. Holy Cross personnel will determine appropriate Charity Care Discount Percentage by analyzing patient financial information within the framework of Optimal Charity Care Sliding Scale (below).

[illegible]	Discount
200%	100%
250%	85%
300%	70%
301% and greater	N/A

3. Calculation of Charity Care Benefits (if Patient is Eligible for Alternative Funding)
    a. Holy Cross personnel will forward full patient bill to appropriate funding source (Example: Private Funding) and adjust the patient balance based on reimbursement from said organization.

    b. Holy Cross personnel will then apply the appropriate Uninsured / Underinsured Discount to the remaining patient balance.

    c. Holy Cross personnel will determine appropriate Charity Care Discount Percentage by analyzing patient financial information within the framework of Optimal Charity Care Sliding Scale (as seen above). For example, if the patients' annualized household income is at 250% of the Regionally Adjusted Federal Poverty Guidelines they will receive a 75% discount on their bill, but patient would still be responsible for Remaining Balance.

Approved: ______________________ **Date:** 7/2/12
Vice President

MOUNT SINAI HOSPITAL

FINANCIAL AID AND ADMITTING POLICIES

ATTACHMENT 19B

Policy No.:	SHS-FIN-002
Date Established:	
Date Reviewed/Updated:	March 2010
Section:	Finance

SINAI HEALTH SYSTEM POLICY AND PROCEDURE

SUBJECT: Financial Assistance Program (FAP)

PURPOSE:

To ensure that a guiding policy and systematic process exists to identify circumstances when a patient's financial status makes it impractical or impossible to pay for Medically Necessary services provided by any Sinai Health System (SHS) entity or affiliate.

This policy exists to identify and assist patients who have documented limited resources to pay for their healthcare. The policy exemplifies SHS's mission, vision and values, and is aligned with its tax-exempt, charitable status.

While regulations exist to ensure that Uninsured Patients receive financial assistance, these regulations do not pertain to physician groups. SHS recognizes that patients of Sinai Medical Group and Schwab Faculty Associate providers should also receive financial assistance through its Financial Assistance Program (FAP). It is the intent of this policy to simplify and coordinate the financial assistance policy and procedures throughout all SHS entities, and to ensure that financial assistance is provided for both hospital and physician services.

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

STATEMENT OF POLICY:

Sinai Health System has a long tradition of serving the poor, the needy, and all who require health care services. However, we must practice conscientious stewardship of resources in order to continue providing accessible and quality health care services to our community.

Our System will follow the Illinois Hospital Uninsured Patient Discount Act, the Fair Patient Billing Act, and all other applicable laws relating to billing and payment for health care services. Sinai will continue to play a leadership role in the community by helping to promote community-wide responses to patient needs, in partnership with government and private organizations.

In order to promote the health and well-being of the community served, individuals with limited financial resources who are unable to access public programs, such as Medicare, Medicaid, All Kids, the State Children's Health Insurance Program, Crime Victims Assistance, or any other program, shall be eligible for free or discounted health care services based on established criteria. Eligibility criteria will be based upon location of residence and the Federal Poverty Income Guidelines and will be updated periodically in conjunction with published updates by the United States Department of Health and Human Services. If a determination is made that the patient has the ability to pay all or a portion of a bill, such a determination does not prevent a reassessment of the person's ability to pay at a later date. The need for financial assistance is to be reevaluated at the following times:

- Family Income change
- Family size change
- When a patient presents for health care services, as appropriate or requested by patient
- When the last financial evaluation was completed more than three (3) months prior.

Individuals who reside in Sinai's Core Service Area will be eligible for financial assistance in excess of standards established by the Illinois Hospital Uninsured Patient Discount Act. It is Sinai's policy to provide free hospital care (100% discount) for patients that reside within Sinai's Core Service Area who are below 200% of the Federal Poverty Income Guidelines. Physician charges, through Sinai Medical Group and Schwab Faculty Associates, will be discounted to defined copayment amounts (see **Exhibit A: Sliding Fee Schedule (SFS) – Hospital & Physician**).

If a patient is eligible for Crime Victim assistance, the patient will not receive discounts until after Crime Victim Assistance has been awarded. If Crime Victim Assistance is awarded to a patient, Sinai will write off 100% of the account balances at all Sinai entities.

If Sinai has a formal, written ED Transfer Agreement with another hospital, any Uninsured Patient transferred to Sinai from the other hospital will be eligible for discounts as if they reside in Sinai's Core Service Area.

Signage, written communication and website notice of the Financial Assistance Program will be maintained in English and Spanish and made available in other languages or communication formats for patients who seek financial assistance. Each hospital bill, invoice, or other summary of charges to an uninsured patient shall include with it, or on it, a prominent statement that an Uninsured Patient who meets certain income requirements may qualify for an Uninsured Discount along with information regarding how the patient may apply under the FAP.

To be considered for financial assistance, the patient must cooperate with the organization to provide the information and documentation necessary to apply for other existing financial resources that may be available to pay for his or her health care. All accounts are to be evaluated for reimbursement sources, i.e., Medicare, Medicaid, Illinois funded Medical Assistance No Grant Programs (MANG) and commercial or Third Party insurances or programs, such as Crime Victim Assistance, prior to granting financial assistance under this policy.

Patients are responsible for completing required application forms, and cooperating fully with the information gathering and assessment process, in order to determine eligibility for financial assistance. Failure to provide valid proof of identity, Illinois Residency, dependents, Assets, Family Income or reimbursement source in a timely manner will result in inability to determine FAP eligibility.

Patients who are covered by healthcare insurance may request a discount on their healthcare services. Sinai will evaluate their financial need as if they are an Uninsured Patient. If the patient's financial responsibilities for a specific episode of care under a policy of health insurance exceed the payment obligations the patient would have as an Uninsured Patient, Sinai will define the patient as an Underinsured Patient for the specific episode of care, and provide a discount to a payment expectation consistent with that of an Uninsured Patient. A patient is not necessarily an Underinsured Patient for all episodes of care they receive. Therefore, Sinai will evaluate a patient's eligibility as an Underinsured Patient for each episode of care.

DEFINITIONS:

Affiliation Agreement: Written agreement between any Sinai entity and an external party that delineates cooperative practices aimed at fulfilling Sinai's Mission – to improve the health of the individuals and communities it serves.

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

Bad Debt Expense: Uncollectible accounts receivable that were expected to result in cash inflows (i.e. the patient did not meet the health system's Financial Assistance eligibility criteria). They are defined as the provision for actual or expected uncollectible charges resulting from the extension of credit.

Charity Care: Health care services for which the provider does not expect to receive payment from the patient or a third-party payer. Charity care is provided to a patient with demonstrated inability to pay. Charity care results from a provider's policy to provide health care services free or at a discount to individuals who meet the established criteria.

Core Service Area: The Core Service Area is defined as the primary (5) and secondary (10) zip code areas representing the surrounding communities served by Mount Sinai Hospital (**Exhibit B**). This represents approximately 80% of the patients served by Sinai, and approximately 14,982 adult inpatient admissions.

Cost to Charge Ratio: The ratio of a hospital's costs to its charges taken from its most recently filed Medicare cost report (CMS 2552-96 Worksheet C, Part I, PPS Inpatient Ratios).

Financial Assistance Program (FAP): The provision of health care services at a reduced charge to individuals who meet certain financial criteria.

Family Income: The sum of a family's annual earnings and cash benefits from all sources (including programs such as the Crime Victim Act) before taxes, less payments made for child support.

Family Members: all persons occupying the same residence who are identified as dependents for tax purposes to include children 18 years of age and under, full-time students age 21 and under, disabled children and elderly parents supported by the applicant.

Federal Poverty Income Guidelines: The poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority 42 U.S.C. 9902(2).

Federally Qualified Health Center ("FQHC"): shall mean Access Community Health Network, Lawndale Christian Health Center, and any other FQHC with which a formal affiliation agreement exists.

Health Care Services: Any Medically Necessary inpatient or outpatient hospital service, including pharmaceuticals or supplies provided by a Mount Sinai Hospital or Schwab Rehabilitation Hospital to a patient.

Illinois Resident: A person who lives in Illinois and who intends to remain living in Illinois indefinitely. Relocation to Illinois for the sole purpose of receiving health care benefits does not satisfy the residency requirement.

MANG Application: Application used by the State of Illinois to determine eligibility for Medical Assistance No Grant (Medicaid).

Maximum Collectible Amount: The amount that may be collected in a 12 month period for health care services provided by the hospital from a patient determined by that hospital to be an eligible Uninsured Patient is 25% of the patient's Family Income, contingent on the patient remaining eligible for Financial Assistance. The 12 month period to which the maximum amount applies shall begin on the first date an Uninsured Patient receives health care services that are determined to be eligible for the Uninsured Discount at SHS.

Medically Necessary: Any inpatient or outpatient hospital service, including pharmaceuticals or supplies provided by a hospital to a patient, covered under Title XVIII of the federal Social Security Act for beneficiaries with the same clinical presentation as the uninsured patient. A "medically necessary" service does not include any of the following: (1) Non-medical services such as social and vocational services. (2) Elective cosmetic surgery, but not plastic surgery designed to correct disfigurement caused by injury, illness, or congenital defect or deformity. Sinai maintains a list of services that do not meet the definition of Medical Necessary (**Exhibit C – Elective Procedures List**).

Uninsured Discount: The Illinois Hospital Uninsured Patient Discount Act sets the Uninsured Discount to be a hospital's charges multiplied by the uninsured discount factor, which is 1.0 less the product of a hospital's Cost to Charge Ratio multiplied by 1.35. Sinai's Uninsured Discount has been set to be greater than the standard established by the Illinois Hospital Uninsured Patient Discount Act. As of March 2010, the discount is 70% of charges, which is approximately the Hospital's Cost to Charge Ratio.

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

Underinsured Patient: An Illinois Resident who is a patient of a hospital and whose financial responsibilities under a policy of health insurance exceed the payment obligations the patient would have as an Uninsured Patient.

FINANCIAL ASSISTANCE GUIDELINES & ELIGIBILITY CRITERIA:
The necessity for medical treatment of any patient will be based on the clinical judgment of the provider without regard to financial status of the patient. All patients will be treated with respect and fairness regardless of their ability to pay.

With the exception of Underinsured Patients, any patient who is NOT covered by a policy of health insurance, and who is not a beneficiary under public or private health insurance, health benefit or other health coverage program, including high deductible health insurance plans, Crime Victim Assistance, worker's compensation, accident or other third party liability insurance, meets the criteria for assessment for financial assistance and will receive the discounts according to the guidelines below:

- Only Medically Necessary services will be eligible. All patients receiving emergent care through the Emergency Department are eligible in connection with such care.

- Any Uninsured Patient who is NOT an Illinois Resident will be offered a 30% discount of charges.

- An Illinois Resident who resides within SHS's Core Service Area, whose income is no greater than 600% of the FPL, will qualify for the FAP and will be eligible for free or discounted care up to 100% of charges or co-pay responsibility as determined by the Sliding Fee Schedule (SFS) – Hospital & Physician (**Exhibit A**) with the following exception.

- An Illinois Resident who resides outside of SHS's Core Service Area, whose income is no greater than 600% of the FAP will qualify for the Uninsured Discount (a 70% discount on billed charges) with the following exception:
    1) Patients of Federally Qualified Health Centers, with a written Affiliation Agreement with Sinai Health System, who reside outside the Core Service Area may be eligible for certain benefits beyond the Hospital Uninsured Discount Act, consistent with the Affiliation Agreement.

- Any Uninsured Patient transferred from a hospital with which Sinai has a formal, written ED Transfer Agreement will qualify for the FAP and will be eligible for free or discounted care up to 100% of charges or co-pay responsibility as determined by the Sliding Fee Schedule (SFS) – Hospital & Physician (**Exhibit A**) with the following exception.
    2) Eligibility for SFS is available to patients only after Crime Victims Assistance has been evaluated and awarded.

- If a patient has a card issued by the State of Illinois, for General Assistance, and resides within the Core Service Area, they will automatically qualify for Sliding Fee Schedule Category I discounts (**Exhibit A**) and receive 100% Free Care for Hospital services.

- If a patient has qualified for Illinois Crime Victim Assistance, all Sinai entities will write off unpaid balances according to FAP policy. Such discounts will only be made available after Crime Victim Assistance has been awarded.

- If a Grant program evaluates patient financial need in determining the patient's eligibility for grant assistance, Sinai may choose to accept the Grant's determination of financial need. Sinai will maintain a list of Grant programs for which Sinai will provide a discount of up to 100% on charges not covered by the Grant.

- Patients who are uninsured, report no income and/or report themselves to be homeless will be provided with all Medically Necessary care free of charge (with no co-pay) when documentation and/or written confirmation of these circumstances is received from the following:
  - Any social services worker with whom the patient has been working.
  - A letter from a homeless shelter, transitional house or other similar facility within the Core Service Area verifying that the uninsured patient resides.

- Sinai will not collect more than the Maximum Collectible Amount for hospital services. Further, except in cases where alternative funding sources exist (e.g., Crime Victims Act), Sinai Medical Group and Schwab Faculty Associates will reduce payment obligations under the Sliding Fee Schedule by two-thirds (66.67%).

PROCEDURE:

<u>Application Process</u>

Patients with need for financial assistance will be required to cooperate and provide truthful information in connection with the applications for assistance, and will also be assisted with applications for other available sources of funding for their care.

Automated FAP Application – Financial Counselors will utilize, when available, financial industry sources, such as credit history analytics, to determine a patient's current financial position for the purposes of determining financial need. Such third-party tools are an objective and efficient practice for verifying Family Income, family size and identifying opportunity for alternative forms of eligibility assistance (e.g., MANG), which helps to ensure eligible patients receive charity care rather than be classified as bad debt.

Manual FAP Application – If no data is found via an Automated FAP Application, or if a patient wants to dispute Automated FAP findings, patient may fill out the FAP Application and will be required to provide requisite information for MANG applications and/or Income Verification.

MANG Application – All inpatient accounts and outpatient recurring accounts (i.e. chemotherapy, radiation therapy, physical therapy, and renal dialysis) registered without any insurance are evaluated for State funded Medical Assistance No Grant Programs (MANG) by the MANG Processing Division staff.

Income Verification – Sinai must verify Family Income to evaluate eligibility. If Automated FAP Applications do not provide Family Income, applicants are required to provide any one of the following:

1) IRS tax returns for the most recent calendar year;
2) W-2 and 1099 forms for the most recent calendar year;
3) Last 3 current paystubs or any official documents from an employer if paid in cash;
4) One other reasonable form of income verification deemed acceptable by the hospital, such as pension or child support checks.

Identification – Sinai requires identification (ID) to protect the hospital and patient from potential identity theft and to comply with the Health Insurance Privacy and Portability Act (HIPPA) and Red Flag legislation. The following forms of ID are required:

1) Photo Identification;
2) Birth certificates for all dependent children. Sinai may utilize alternative sources, when available, to validate number of dependent children.

Proof of Illinois Residency – Sinai requires proof of residency so that the hospital can determine eligibility for public assistance or utilizing the guidelines codified by The Illinois Hospital Uninsured Patient Discount Act. Acceptable sources for this information include:

1) Any of the documents requested as part of income verification;
2) Illinois Voter registration card;
3) A lease agreement;
4) A vehicle registration card;
5) Mail addressed to the uninsured patient at an Illinois address from a governmental or other credible source;

Sinai may utilize alternative sources, when available, to validate residency.

Maximum Collectible Amount – Patients may inform SHS of that they have received health care services from SHS within the past 12 months, and may therefore be eligible for free care on subsequent service. Financial Counselors will then print out the payment history for health care services to be reviewed and may ask patient for proof of Assets if not available in the Automated FAP Application.

<u>Approval Determination</u>
Financial Counselors will review Automated FAP Applications and FAP Applications for completeness. If the documentation is incomplete the Financial Counselor will ask the patient to provide missing information and/or documentation before determining the patient's eligibility.

Once the Financial Counselor receives all required information the Financial Counselor will complete the FAP Eligibility Determination Form. If a patient has already received services, and is requesting an adjustment to the charges, the Financial Counselor will fill out an Adjustment Request Form. The Financial Counselor will bring both the FAP Eligibility Determination Form and the Adjustment Request Form to the Financial Counselor Supervisor for approval.

Financial Assistance applications require different levels of approval, based upon eligible charges, as follows:

Up to $5,000 – Financial Counselor
$5,001-$25,000 – Financial Counselor Supervisor

$25,001-$50,000 – Director of Patient Financial Services
Over $50,000 – Chief Financial Officer or designee

All approvals carry a one year eligibility period commencing on the date of eligibility. If services are still required after the year, the patient must re-apply for assistance. The need for financial assistance will be re-evaluated at the following times:

- Income change
- Family size change
- When a patient presents for health care services, as appropriate or requested by patient.
- When the last financial evaluation was completed more than one year prior.

A determination of eligibility/approval will be made within ten (10) business days of receipt of completed application and supporting documentation. A copy of either the Financial Assistance Approval or the Financial Assistance Denial Letter will be printed and provided to the patient. An FAP Identification Card will be given to each applicant upon approval detailing the patient's: name, address, eligibility period, Federal Poverty Income Guidelines and authorized signatures.

An internal committee, made up of a physician, MANG, Financial Counseling Manager, the Director of Patient Financial Services and or the Executive Director of Revenue Cycle will review and consider appeals to applications not approved for the FAP on an as needed basis.

Documentation

In Sinai's financial information systems, Financial Counselors will clearly and concisely document FAP activity, including, but not limited to date(s) application was given to the patient, when it was returned, eligibility determination, date authorized, approved by, and any other pertinent information discussed, agreed upon or to reference documentation provided. All applications will be logged and scanned into the financial systems and kept on file for seven years.

EXHIBITS:

Exhibit A:	Sliding Fee Schedule (SFS) – Hospital & Physician
Exhibit B:	Core Service Area – Mount Sinai Hospital
Exhibit C:	Elective Procedures List

Sliding Fee Schedule - Hospital Physician
Effective March 1, 2010

		Federal Poverty Guidelines								
	% of FPL	Category I < 100%	Category II 101%-150%	Category III 151%-200%	Category IV 201%-250%	Category V 251%-300%	Category VI 301%-350%	Category VII 351%-400%	Category VIII 401% - 500%	Category IX 501% - 600%
OUTPATIENT PROCEDURES	**ER**	**$30**	**$45**	**$60**	**$80**	**$110**	**$130**	**$150**	**$175**	**$200**
	Hospital	$0	$0	$0	$20	$50	$70	$90	$115	$140
	Physician	$30	$45	$60	$60	$60	$60	$60	$60	$60
	BASIC DIAGNOSTIC TESTING	**$30**	**$45**	**$60**	**$80**	**$150**	**$210**	**$220**	**$250**	**$300**
	Hospital				$20	$90	$140	$140	$150	$160
	Physician	$30	$45	$60	$60	$60	$70	$80	$100	$140
	HIGH-TECH DIAGNOSTIC TESTING	**$75**	**$100**	**$130**	**$200**	**$375**	**$450**	**$550**	**$625**	**$750**
	Hospital	$0	$0	$0	$40	$150	$200	$275	$325	$425
	Physician	$75	$100	$130	$160	$225	$250	$275	$300	$325
	PRIMARY CARE - Clinic Visits (Including Chiropractic and Behavioral Health)	**$10**	**$15**	**$15**	**$20**	**$20**	**$25**	**$30**	**$35**	**$40**
	Hospital	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Physician	$10	$15	$15	$20	$20	$25	$30	$35	$40
	SPECIALTY CARE Specialist Visits/ Therapy Visits	**$20**	**$30**	**$30**	**$40**	**$40**	**$50**	**$60**	**$105**	**$120**
	Hospital	$0	$0	$0	$10	$10	$20	$20	$30	$30
	Physician	$20	$30	$30	$30	$30	$30	$40	$75	$90
	Complex-Diagnostic / Surgery / Interventional / Procedures	**$150**	**$200**	**$250**	**variable**	**variable**	**variable**	**variable**	**variable**	**variable**
	Hospital	$0	$0	$0	2.5% of Total Charges	5% of Total Charges	10% of Total Charges	15% of Total Charges	20% of Total Charges	25% of Total Charges
	Physician	$150	$200	$250	$275	$275	$300	$300	$400	$500
	Deposit				$450	$600	$800	$1,000	$1,100	$1,200
INPATIENT/ ACUTE/ SUBACUTE CARE	**INPATIENT**	**$0**	**$0**	**$0**	**2.5% of Total Charges**	**5% of Total Charges**	**10% of Total Charges**	**15% of Total Charges**	**20% of Total Charges**	**25% of Total Charges**

ATTACHMENT 19B

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HOSPITAL POLICY AND PROCEDURE

SUBJECT: RESERVATIONS

POLICY

In order to provide for an orderly flow of patients into and within the Hospital, based primarily on medical need, Mount Sinai Hospital Medical Center has established criteria for admission priorities.

Physicians may be asked to categorize the medical needs of the patient as either emergency, urgent or elective.

1. The emergency status is used for patients who, in the opinion of the physician, require admission to the hospital immediately within twenty-four (24) hours, due to a condition where there is imminent danger of mortality or significant morbidity.

2. The urgent status is used for patients who, in the opinion of the physician, require prompt admission but where immediate admission is not necessary to avert a significant risk of mortality or morbidity. Except in very unusual circumstances or emergencies, a patient will assume admission within seventy-two (72) hours.

3. Elective status is used for scheduling routine elective admissions. The reservation should be made at least four (4) days prior to the day the patient is expected to be admitted. This will assist the Admitting Department in proper placement of the patient and to ensure that adequate financial arrangements are made.

The above priority categorization will be established for every admission. Utilization Management personnel may review each admission for appropriateness of the admission.

PROCEDURE

1. The following initial information is needed:

   a. The date of admission
   b. Correct full name of the patient
   c. Age and sex of the patient
   d. Admitting diagnosis
   e. Type of financial coverage
   f. Telephone number of the patient
   g. Attending Physician

APPROVAL: KAREN TEITELBAUM, EXECUTIVE VICE PRESIDENT AND CHIEF OPERATING OFFICER

Policy No. MSH-ADT-C-006
Date Established: August, 1978
Date Reviewed/Updated: September, 2012
Section: ADMISSION/DISCHARGE/TRANSFER

HOSPITAL POLICY AND PROCEDURE

SUBJECT: MEDICAL INTENSIVE CARE UNIT (MICU)

POLICY

The regulations and procedure for admission to Mount Sinai Hospital's Medical Intensive Care Unit (MICU) are as follows:

Organization

The Chief of the Division of Pulmonary and Critical Care Medicine is responsible for the overall operation of the unit.

Admission

1. Candidates for admission to the MICU include those medical cases requiring a high degree of nursing care and almost continuous medical and nursing supervision. Indications for admission to the unit include, but are not limited to, the following:

a. Patients in shock or potential shock because of blood loss, cardiovascular disease, etc.

b. Patients whose condition might reasonably be expected to lead to death or permanent disablement, unless treated and observed continuously. Examples: major gastrointestinal hemorrhage, where intensive care is indicated.

c. Patients whose condition produces severe impairment of vital functions such as: cardiovascular accidents, diabetic acidosis, severe hemorrhage, severe musculoskeletal impairment.

d. Patients with severe reactions or electrolyte imbalance, such as: prolonged blood clotting, intractable edema, renal malfunction, poisoning or severe drug reaction.

e. Patients with respiratory failure either impending or those needing intubation with or without mechanical ventilation.

f. Patients with endocrine emergencies such as severe diabetic ketoacidosis, or thyroid storm requiring close observation.

g. Patients with hypertension or hypotension needing invasive monitoring and use of vasoactive drugs.

h. Patients with acute cerebrovascular events associated with fever, lethargy, declining mental status, unstable blood pressure, unusual etiology, recent or recurrent TIA.

2. Not eligible for admission:

a. Patients judged by the patient's attending physician or MICU attending physician to be terminally ill, or at the end stage of a progressive degenerative disease.

b. Patients documented by EEG, cerebral blood flow studies, etc. to have brain death.

c. Burns.

3. If a patient has an irreversible disease, he can be moved out of the unit at the discretion of the MICU Director in order that the bed can be used for another who needs MICU.

4. Patient may be admitted to the Medical Intensive Care Unit either directly from the outside or by transfer from within the hospital.

a. Direct admission from the outside:

1) Only ICU to ICU (same level of care) will be admitted directly into the unit, all other patients must be admitted through the ED.

2) Admitting physician will call the MICU supervising resident requesting a bed and also consults the MICU attending.

3) If he/she approves of admission, they will then make arrangements with the Admitting Department for the admission and will also inform the attending physician of the admission.

b. Admissions from the ED will be approved by supervising MICU resident or fellow on-call.

c. Intra-hospital admissions:

1) The floor supervising resident requests the MICU supervising Resident or fellow to evaluate and transfer the patient to MICU. If there is a question of what decision should be made, the MICU attending physician will be contacted. This is also true if there are no available MICU beds.

If the MICU supervising resident or fellow approves of the transfer, the transfer will be made.

d. Bed Availability

If there are no available "medical" ICU beds, but beds from other services are available, the surgical or pediatric ICU attending will be contacted to work out arrangements.

When disagreement arises regarding admission or discharge from the unit, the physician in charge of the unit will be contacted and has the sole authority to decide an appropriate utilization of beds and resources. Internal transfers have priority over ED admissions.

APPROVAL: KAREN TEITELBAUM, EXECUTIVE VICE PRESIDENT AND CHIEF OPERATING OFFICER

Policy No.: MSH-ADT-C-017
Date Established: November, 1980
Date Reviewed/Updated: September, 2012
Section: ADMISSION/DISCHARGE/TRANSFER

HOSPITAL POLICY AND PROCEDURE

SUBJECT: **ADMISSION TO THE INPATIENT PSYCHIATRIC UNIT**

PURPOSE: To facilitate voluntary and involuntary psychiatric admissions in accordance with the Illinois Mental Health and Developmental Disabilities Code.

POLICY:

1. The Psychiatric Triage Worker (formerly known as Emergency Psychiatric Services Worker), attending psychiatrist or psychiatric resident on-call determines whether or not a patient meets the criteria for inpatient psychiatric hospitalization. These criteria are:

    a. Patient presents with signs of deterioration of his or her ability to function, compared to the patient's ability to function prior to the current onset of symptoms of the mental illness or disability for which treatment is presently sought; and/or

    b. Patient can be reasonably expected to inflict serious harm upon himself or herself or another in the near future which may include threatening behavior or conduct that places another individual at risk of harm; or

    c. Patient cannot be maintained within the community on an outpatient basis.

2. When eligibility is determined, the Psychiatric Triage Worker or the psychiatric resident on-call fills out the appropriate admission forms:

    a. For **VOLUNTARY** admissions, an *Application for Voluntary Admission* *(MH-2)* and a *Rights of Recipients (MHDD-1)* is filled out.

    b. For **INVOLUNTARY** admissions, a *Petition for Involuntary/Judicial Admission (MHDD5)* is filled out by anyone age 18 years or older with information about why the person needs admission against their will.
    Note: If a peace officer took the patient into custody, and/or transported the patient to Mount Sinai Hospital, the police officer who did so must complete the petition.

A *Certificate (MHDD-6)* is completed by a physician, qualified examiner or clinical psychologist who has personally examined the patient within the last 72 hours and has informed the patient that the patient does not have to talk to the examiner and that any statements the patient makes may be disclosed at a court hearing on the issue of whether he is subject to involuntary admission.

A *Rights of Recipients (MHDD-1)* is filled out by the Psychiatric Triage Worker or inpatient staff.

Copies of the *Petition* and *Rights of Recipients* are given to the patient within 12 hours of admission.

As soon as possible excluding Saturdays, Sundays, and holidays, but not more than 24 hours after the admission of an involuntary patient, the patient must be examined by a psychiatrist who may be a MSH psychiatrist but cannot be the physician who executed the first certificate. Prior to this examination the psychiatrist needs to inform the patient that the patient does not have to talk to the examiner and that any statements the patient makes may be disclosed at a court hearing on the issue of whether the patient is subject to involuntary admission.

Within 24 hours of the admission, excluding Saturdays, Sundays, and holidays, the petition and two certificates must be filed with the Circuit Court of Cook County.

c. Patients may be admitted for **24 Hour Observation** if they meet the following criteria:

   i. The presenting condition of the patient can reasonably be expected to be stabilized within 24 hours of admission to the Unit;

   ii. The patient signs an Application for Voluntary Admission (MH-2);

   iii. The patient has a discharge plan in place prior to admission to the Unit, including a prearranged follow up appointment.

d. The patient must be 18 year of age or older to be admitted to the inpatient psychiatric unit.

e. The legal guardian of a developmentally disabled person may sign the Voluntary Application as an interested person or may give verbal permission for admission on the telephone with a third party listening and confirming the conversation. To voluntarily admit a developmentally disabled person, the patient and the guardian must both agree to the admission.

PROCEDURAL STEPS:

1. The psychiatric resident on-call or the Psychiatric Triage Worker consults with the attending psychiatrist or the attending psychiatrist on-call to discuss the case and gets permission to admit the patient to the inpatient psychiatric unit. The time and name of the authorizing psychiatrist will be noted on the assessment.

2. The exception to #1 is that a patient aged 18-20 years is assessed by a S.A.S.S. staff member before the decision to admit to inpatient takes place.

3. The Psychiatric Triage Worker or resident on-call talks to the inpatient unit to review potential candidates for admission as well as to determine bed availability and eligibility on an individual basis, and notifies the admitting department of the impending admission.

4. The Psychiatric Triage Worker ascertains third party coverage and calls for authorization if indicated. MANG and Community Hospital Inpatient Psychiatric Services (CHIPS) determinations are made prior to admission. If a patient is ineligible for MANG, CHIPS funding is available, and the patient may be considered as a CHIPS admission. CHIPS funding generally is available for 6 patients per month.

5. The Psychiatric Triage Worker or psychiatric resident on-call ensures that the admission paperwork has been completed prior to the patient's arrival on the inpatient unit.

   a. For VOLUNTARY patients:
      i. The Application for Voluntary Admission must have a statement explaining why the person is not suitable for informal admission.
      ii. The designee of the patient is identified to be contacted in case of emergency, or the patient's refusal is documented.
      iii. Unless the physician is prepared to execute a certificate, a patient is never told that not signing the Voluntary Admission will result in involuntary admission.
      iv. A copy of the Voluntary Admission form is given to the patient and to any person the patient requests.

   b. For INVOLUNTARY patients:
      i. A completed Petition. Please review Standard 2.b.
      ii. A completed Certificate. Prior to examination of the patient for the purpose of certification, the psychiatrist or physician notifies the patient of the following in a clear, comprehensible manner, with an interpreter if needed:
         1. The purpose of the examination;
         2. That the patient does not have to talk to the examiner;
         3. That any statements made by the patient may be disclosed at a court hearing on the issue of whether the patient is subject to involuntary admission.

6. Once acceptance of the patient has been verified by the Unit, the Emergency Department nurse, or the nurse from the transferring (discharging) unit calls or faxes a report about the patient at least 30 minutes before the patient is transported to the Unit.

7. The patient is brought to the Unit by transport, accompanied by clinical staff if clinically indicated.

8. The admitting nurse ensures that the patient has been or is given a copy of the Voluntary form, or the Petition and the *Rights of Recipients*, and signs the back of the petition to indicate this has been done. Copies must be given to the patient within 12 hours of admission.

9. If a patient is admitted as an INVOLUNTARY patient, the admitting nurse notifies the Department of Psychiatry at extension 6658. A message can be left after business hours.

10. The accepting nurse on the inpatient unit communicates the patient's right to be discharged, as well as all other rights orally and in writing, by providing the patient with a copy of the *Right's of Recipients (MHDD-1)* and reviewing its contents. The admitting nurse signs the back of the original and files it in the chart.

11. The contact information for Guardianship and Advocacy Commission and Equip for Equality is available above the patient phones, in the Patient Handbook and on the back of the Rights of Recipients form.

12. If a VOLUNTARY patient is present on the Unit 30 days after admission, the attending psychiatrist must:

    a. Review the clinical record to assess the need for continued hospitalization;

    b. Ask the patient to affirm his desire to continue treatment; and

    c. Obtain a reaffirmation in the form of a new Application for Voluntary Admission

    d. The patient's refusal to sign a new Application for Voluntary Admission or the psychiatrist's failure to review the record and ask the patient to affirm the desire to continue treatment constitutes a notice of request for discharge.

APPROVAL:KAREN TEITELBAUM, EXECUTIVE VICE PRESIDENT AND CHIEF OPERATING OFFICER

Policy No.: MSH-ADT-C-014
Date Established: June, 1986
Date Reviewed/Updated: September, 2012
Section: ADMISSION/DISCHARGE/TRANSFER

HOSPITAL POLICY AND PROCEDURE

SUBJECT: OBSTETRIC/GYNECOLOGY SERVICE ASSIGNMENTS

POLICY

The following procedure will be in effect for hospital admissions of pregnant patients.

PROCEDURE

1. All pregnant patients must have one of the members of the department of Obstetrics and Gynecology as primary attending physician (except trauma).

2. Should a pregnant patient require extended medical or surgical treatment, the responsibility for obtaining the treatment will rest with the primary attending and his/her designated house staff.

3. It is understood that patients on the Obstetrics service are to be admitted to one of the care areas designated for obstetric services or other area determined by the attending physician if specialized services are needed.

4. For patients whose management plan includes termination of pregnancy and are under 20 weeks gestation, primary service designation will be Gynecology. For patients whose management plan includes termination of pregnancy and are 20 weeks or greater gestation, primary service will be Obstetrics. Regardless of gestational age it is at the discretion of the physician if a patient is to be evaluated and treated in Obstetrics.

APPROVAL: KAREN TEITELBAUM, EXECUTIVE VICE PRESIDENT AND CHIEF OPERATING OFFICER

Policy No.: MSH-ADT-C-024
Date Established: November, 1985
Date Reviewed/Updated: September, 2012
Section: ADMISSION/DISCHARGE/TRANSFER

HOSPITAL POLICY AND PROCEDURE

SUBJECT: OBSERVATION STATUS

PURPOSE

To make available safe and comprehensive services to patients whose medical conditions do not meet criteria for inpatient hospitalization but require monitoring and services for 24 hours or less.

ADMISSION PROCEDURE

Any attending physician on staff may admit patients as an observation status. There must be a timed and dated order for observation in the Physician Order section of the chart as well as an indication of this at the intended status of the patient in the Progress Notes. Patients may be admitted via Emergency Room or directly by reservation made with the Admitting Department.

All patients in an observation status will be identified by a Criteria For Observation Status

Observation should be considered if the patient is hemodynamically stable, does not meet acute care criteria, and any of the following apply:

1. Diagnosis, treatment, stabilization and discharge can reasonably be expected in less than 24 hours.

2. Treatment and/or procedures will require greater than 6 hours observation.

3. The clinical condition is changing and a discharge decision is expected within less than 24 hours.

4. It is unsafe for the patient to return home or caregiver is unavailable. Arrangements need to be made for a safe and appropriate discharge.

5. Complications following ambulatory surgery or procedure.

6. Symptoms are unresponsive to at least 4 hours of ER treatment.

7. Psychiatric crisis intervention/stabilization with observation every 15 minutes.

Specific criteria for severity of illness and intensity of service for observation status are contained in InterQual's "ISD Adult and Pediatric Acute Level of Care" manual.

DISCHARGE CRITERIA

Documentation of plans following the observation period must be complete, containing discharge arrangements/plans or rationale for transfer of patient to inpatient status by physician. Patients will be discharged upon written physician order.

PHYSICIAN

1. Resident physicians will make a determination of patient disposition in general by the eighteenth (18th) hour of the admission after consultation with the attending physician. A timed and dated note in the Progress Notes will document patient status and planned disposition. Any pertinent discharge plans should be noted at this time.

2. The physician will discuss discharge plans with the nurse caring for the patient, the patient and the patient's significant other persons.

3. If at any time during the stay, the patient meets criteria for admission, a new set of orders will be written by the attending/resident physician.

APPROVAL: KAREN TEITELBAUM, EXECUTIVE VICE PRESIDENT AND CHIEF OPERATING OFFICER

HEALTH CARE SYSTEM

The proposed change of ownership will not restrict the use of other area facilities, nor will it have an impact on other area providers.

Impact of the Proposed Transaction on Other Area Providers

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

Other Facilities Within the Health Care System

Sinai-Health System operates two IDPH-licensed health care facilities, Mount Sinai Hospital Medical Center and Schwab Rehabilitation Center, which share a campus, approximately 7.2 miles to the north of Holy Cross Hospital. Holy Cross Hospital is not affiliated with any other licensed health care facility.

Attached are the 2011 IDPH *Hospital Profiles* for each of the three hospitals identified above, as evidence of the utilization, bed complements, and services provided by each hospital.

Transfer Agreements

Copies of Holy Cross Hospital's current transfer agreements are attached. It is the intent of the applicants to retain all of Holy Cross Hospital's transfer agreements, and each provider with which a transfer agreement exists will be notified of the change of ownership. Each of the existing transfer agreements will continue in their current form until those agreements are revised and/or supplemented by Sinai Health System or Holy Cross Hospital. That revision process is anticipated to take 6-12 months from the date of the change of ownership.

Below are listed the facilities with which Holy Cross Hospital currently maintains transfer agreements, along with the facility's distance from Holy Cross Hospital:

Sinai Health System, Chicago (25 minutes/ 7.2 miles)

Rush University Medical Center, Chicago (25 min./8.1 miles)

Advocate Illinois Masonic Medical Center, Chicago (35 min./14.6 miles)

International Nursing & Rehabilitation, Chicago (9 min./2.9 miles)

Transfers from Holy Cross Hospital will typically be made at the discretion of the patient's physician, in consultation with the patient and family. There will not be a policy in place regarding any preference of transfers to health care system members over other facilities.

Duplication of Services

The proposed transaction will not result in the elimination of any "safety net services". There are however, both clinical and non-clinical redundancies that are being and will continue to be evaluated. As a result, the potential exists for the consolidation of services or changes to the manner in which services are provided; particularly non-clinical services such as receivables and payables management, human resources, and purchasing/procurement over the next twelve months. Potential changes in the manner in which these services are provided will likely result in a consolidation of a currently undetermined number of positions.

As of the filing of this application, no IDPH-designated "categories of service" have been earmarked for discontinuation. The applicants fully understand however, that should a decision be made to do so in the future, prior approval of the IHFSRB must be secured. The IDPH-designated "categories of services" provided by both HCH and Sinai Health System are: medical/surgical beds, ICU beds, obstetrics beds, comprehensive physical rehabilitation beds, and cardiac catheterization services.

In addition, while the potential exists to reduce the number of approved beds, no decision to do so has been made as of the filing of this application. Should the applicants elect to do so during the next two years, the IHFSRB will be informed of such.

Availability of Community Services

Holy Cross Hospital is a primary provider of both hospital- and community-based health care programs in its community, and it is Sinai Health System's intent to provide a very similar community-based program complement, understanding that in the case of all hospitals, the complement of community programs is not static, and that from time-to-time programs are added or eliminated. Due in major part to the broad scope of community programs and services currently provided, the applicants have not at this time identified additional programs to be offered, though it is fully anticipated that additional programs will be identified following the change of ownership, including the offering of programs currently offered through SHS.

The community will continue to be made aware of programs offered by the hospital through a variety of avenues, including hospital publications, local newspapers, public service announcements, information provided in physicians' offices, and information provided to patients by staff.

Below is a list of community programs currently offered by Holy Cross Hospital, and as of the writing of this document, it is not the intent of the applicants to eliminate any of these programs.

- Parish Nurse Program
- Inoculations
- Senior Outreach
- Flu and H1N1 shots
- Healthy Chicago Lawn
- Southwest Organizing Project
- Greater Southwest Development Corporation
- Latino Organization of the Southwest

- New Communities Project
- National Latino Education Institute
- IDPH H1N1 Advisory Board
- Southside Health Cooperative
- Medical Home Network
- HIV Early detection program
- Haz-Mat training
- CPR education
- Nutritional training
- Kidney disease check-ups
- Smoking cessation
- Rush Research Collaboration Women's Walking Program
- FQHC support (4 sited)
- WIC
- Family Case Management
- Season's Hospice
- Metropolitan Family Services
- Southwest PADS
- 5-4-3-2-1 (healthy foods and exercise)
- NLEI medical assistant training
- Alivio Medical center classes host
- Community Leadership Training (SWOP)
- IMAN leadership training

Ownership, Management and General Information

ADMINISTRATOR NAME:	Wayne Lerner
ADMINSTRATOR PHONE:	773-884-1602
OWNERSHIP:	Sisters of Saint Casimir
OPERATOR:	Sisters of Saint Casimir
MANAGEMENT:	Church-Related
CERTIFICATION:	
FACILITY DESIGNATION:	General Hospital
ADDRESS	2701 West 68th Street
CITY:	Chicago
COUNTY:	Suburban Cook (Chicago)

Patients by Race

White	27.6%
Black	70.7%
American Indian	0.0%
Asian	0.4%
Hawaiian/ Pacific	0.0%
Unknown:	1.2%

Patients by Ethnicity

Hispanic or Latino:	12.0%
Not Hispanic or Latino:	87.4%
Unknown:	0.6%

IDPH Number:	0992
HPA	A-03
HSA	6

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2011	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2011	Staff Bed Occupancy Rate %
Medical/Surgical	204	196	129	7,343	29,997	4,310	4.7	94.0	46.1	48.0
0-14 Years				*3*	*8*					
15-44 Years				*1,460*	*4,720*					
45-64 Years				*3,191*	*12,234*					
65-74 Years				*1,108*	*5,138*					
75 Years +				*1,581*	*7,897*					
Pediatric	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Intensive Care	20	20	20	1,748	5,235	0	3.0	14.3	71.7	71.7
Direct Admission				*1,340*	*4,277*					
Transfers				*408*	*958*					
Obstetric/Gynecology	16	15	9	433	1,040	0	2.4	2.8	17.8	19.0
Maternity				*433*	*1,040*					
Clean Gynecology				*0*	*0*					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Rehabilitation	34	20	20	470	5,015	0	10.7	13.7	40.4	68.7
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedcated Observation	*0*					*0*				
Facility Utilization	**274**			**9,586**	**41,287**	**4,310**	**4.8**	**124.9**	**45.592**	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	*Medicaid*	*Other Public*	*Private Insurance*	*Private Pay*	*Charity Care*	*Totals*
Inpatients	**45.5%**	**33.8%**	**0.3%**	**12.4%**	**2.1%**	**5.9%**	
	4358	3242	29	1189	201	567	9,586
Outpatients	**23.6%**	**34.1%**	**0.4%**	**28.4%**	**10.9%**	**2.6%**	
	18786	27070	285	22591	8641	2083	79,456

Financial Year Reported: 7/1/2010 *to* 6/30/2011

Inpatient and Outpatient Net Revenue by Payor Source

	Medicare	*Medicaid*	*Other Public*	*Private Insurance*	*Private Pay*	*Totals*	*Charity Care Expense*
Inpatient Revenue ($)	**60.2%**	**14.9%**	**0.1%**	**12.8%**	**12.1%**	**100.0%**	
	39,444,825	9,747,679	86,924	8,384,107	7,903,543	65,567,078	3,540,563
Outpatient Revenue ($)	**22.0%**	**9.9%**	**0.2%**	**35.9%**	**32.0%**	**100.0%**	
	5,777,418	2,586,668	49,510	9,398,800	8,397,150	26,209,546	4,074,876

Total Charity Care Expense
7,615,439

Total Charity Care as % of Net Revenue
8.3%

Birthing Data

Number of Total Births:	387
Number of Live Births:	383
Birthing Rooms:	7
Labor Rooms:	7
Delivery Rooms:	2
Labor-Delivery-Recovery Rooms:	7
Labor-Delivery-Recovery-Postpartum Rooms:	7
C-Section Rooms:	1
CSections Performed:	53

Newborn Nursery Utilization

Level 1 Patient Days	927
Level 2 Patient Days	163
Level 2+ Patient Days	1,090
Total Nursery Patientdays	**2,180**

Laboratory Studies

Inpatient Studies	249,557
Outpatient Studies	232,714
Studies Performed Under Contract	0

Organ Transplantation

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

ATTACHMENT 19C

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	0	0	165	70	429	179	608	2.6	2.6
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	6	6	346	193	792	431	1223	2.3	2.2
Gastroenterology	0	0	0	0	12	8	25	17	42	2.1	2.1
Neurology	0	0	0	0	0	0	0	0	0	0.0	0.0
OB/Gynecology	0	0	0	0	58	114	326	130	456	5.6	1.1
Oral/Maxillofacial	0	0	0	0	0	0	0	0	0	0.0	0.0
Ophthalmology	0	0	0	0	0	277	0	524	524	0.0	1.9
Orthopedic	0	0	0	0	186	225	569	472	1041	3.1	2.1
Otolaryngology	0	0	0	0	96	242	188	443	631	2.0	1.8
Plastic Surgery	0	0	0	0	0	0	0	0	0	0.0	0.0
Podiatry	0	0	0	0	45	19	104	40	144	2.3	2.1
Thoracic	0	0	0	0	0	0	0	0	0	0.0	0.0
Urology	0	0	1	1	244	247	592	602	1194	2.4	2.4
Totals	**0**	**0**	**7**	**7**	**1152**	**1395**	**3025**	**2838**	**5863**	**2.6**	**2.0**

SURGICAL RECOVERY STATIONS Stage 1 Recovery Stations 0 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	1	1	1171	1042	1171	1042	2213	1.0	1.0
Laser Eye Procedures	0	0	1	1	0	101	0	51	51	0.0	0.5
Pain Management	0	0	1	1	0	186	0	93	93	0.0	0.5
Cystoscopy	0	0	1	1	100	67	50	34	84	0.5	0.5
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	1
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Emergency/Trauma Care

Certified Trauma Center		No
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		33
Persons Treated by Emergency Services:		47,324
Patients Admitted from Emergency:		8,794
Total ED Visits (Emergency+Trauma):		**47,324**

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	**314**
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	284
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	30
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	**0**
Outpatient Visits at the Hospital/ Campus:	0
Outpatient Visits Offsite/off campus	0

Diagnostic/Interventional	Equipment Owned	Equipment Contract	Examinations Inpatient	Examinations Outpt	Examinations Contract
General Radiography/Fluoroscopy	12	0	14,913	24,916	0
Nuclear Medicine	2	0	2,142	1,120	0
Mammography	2	0	5	1,893	0
Ultrasound	3	0	4,149	7,383	0
Angiography	1	0			
Diagnostic Angiography			110	30	0
Interventional Angiography			20	0	0
Positron Emission Tomography (PET)	0	0	0	0	0
Computerized Axial Tomography (CAT)	2	0	6,260	11,225	0
Magnetic Resonance Imaging	1	0	962	940	0

Treatment 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: 2011 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development. ATTACHMENT 19C

Ownership, Management and General Information

ADMINISTRATOR NAME:	Alan H. Channing
ADMINSTRATOR PHONE:	773-257-6434
OWNERSHIP:	Sinai Health System
OPERATOR:	Mount Sinai Hospital Medical Center
MANAGEMENT:	Not for Profit Corporation (Not Church-R
CERTIFICATION:	
FACILITY DESIGNATION:	General Hospital
ADDRESS	California at 15th Avenue
CITY:	Chicago
COUNTY:	Suburban Cook (Chicago)

Patients by Race

White	33.6%
Black	60.8%
American Indian	0.0%
Asian	0.3%
Hawaiian/ Pacific	0.0%
Unknown:	5.2%

Patients by Ethnicity

Hispanic or Latino:	30.2%
Not Hispanic or Latino:	66.7%
Unknown:	3.1%

IDPH Number:	1644
HPA	A-02
HSA	6

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2011	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2011	Staff Bed Occupancy Rate %
Medical/Surgical	165	143	143	9,710	40,687	1,710	4.4	116.2	70.4	81.2
0-14 Years				*0*	*0*					
15-44 Years				*3,483*	*12,443*					
45-64 Years				*4,001*	*16,875*					
65-74 Years				*1,151*	*5,810*					
75 Years +				*1,075*	*5,559*					
Pediatric	31	29	29	1,840	4,226	258	2.4	12.3	39.6	42.4
Intensive Care	30	28	28	1,023	3,710	58	3.7	10.3	34.4	36.9
Direct Admission				*807*	*3,710*					
Transfers				*216*	*0*					
Obstetric/Gynecology	30	29	29	3,297	8,669	90	2.7	24.0	80.0	82.7
Maternity				*3,297*	*8,669*					
Clean Gynecology				*0*	*0*					
Neonatal	35	29	29	370	7,858	0	21.2	21.5	61.5	74.2
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	28	28	28	1,444	8,197	0	5.7	22.5	80.2	80.2
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedcated Observation	*0*					*0*				
Facility Utilization	**319**			**17,468**	**73,347**	**2,116**	**4.3**	**206.7**	**64.811**	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	*Medicaid*	*Other Public*	*Private Insurance*	*Private Pay*	*Charity Care*	*Totals*
Inpatients	**17.4%**	**45.9%**	**0.6%**	**23.2%**	**0.9%**	**12.0%**	
	3047	8021	104	4054	149	2093	**17,468**
Outpatients	**11.6%**	**39.9%**	**3.9%**	**24.4%**	**9.5%**	**10.8%**	
	28504	98231	9561	60076	23323	26596	246,291

Financial Year Reported: 7/1/2010 ***to*** 6/30/2011

Inpatient and Outpatient Net Revenue by Payor Source

	Medicare	*Medicaid*	*Other Public*	*Private Insurance*	*Private Pay*	*Totals*	*Charity Care Expense*
Inpatient Revenue ($)	**20.5%**	**61.0%**	**1.3%**	**11.9%**	**5.3%**	**100.0%**	
	45,591,347	135,631,868	2,836,151	26,389,494	11,827,235	222,276,095	11,987,607
Outpatient Revenue ($)	**13.9%**	**22.1%**	**7.1%**	**26.5%**	**30.4%**	**100.0%**	
	9,409,982	14,897,944	4,801,243	17,877,272	20,533,480	67,519,921	7,301,023

Total Charity Care Expense
19,288,630

Total Charity Care as % of Net Revenue
6.7%

Birthing Data

Number of Total Births:	2,950
Number of Live Births:	2,915
Birthing Rooms:	0
Labor Rooms:	0
Delivery Rooms:	0
Labor-Delivery-Recovery Rooms:	14
Labor-Delivery-Recovery-Postpartum Rooms:	0
C-Section Rooms:	2
CSections Performed:	846

Newborn Nursery Utilization

Level 1 Patient Days	5,770
Level 2 Patient Days	0
Level 2+ Patient Days	0
Total Nursery Patientdays	**5,770**

Laboratory Studies

Inpatient Studies	633,288
Outpatient Studies	1,005,198
Studies Performed Under Contract	113,296

Organ Transplantation

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

ATTACHMENT 19C

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms Inpatient	Operating Rooms Outpatient	Operating Rooms Combined	Operating Rooms Total	Surgical Cases Inpatient	Surgical Cases Outpatient	Surgical Hours Inpatient	Surgical Hours Outpatient	Surgical Hours Total Hours	Hours per Case Inpatient	Hours per Case Outpatient
Cardiovascular	0	0	0	0	139	115	616	348	964	4.4	3.0
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	8	8	1133	978	3213	1669	4882	2.8	1.7
Gastroenterology	0	0	0	0	176	84	254	125	379	1.4	1.5
Neurology	0	0	0	0	295	4	1714	13	1727	5.8	3.3
OB/Gynecology	0	0	0	0	245	527	774	818	1592	3.2	1.6
Oral/Maxillofacial	0	0	0	0	0	0	0	0	0	0.0	0.0
Ophthalmology	0	0	0	0	3	55	8	91	99	2.7	1.7
Orthopedic	0	0	1	1	478	261	1659	692	2351	3.5	2.7
Otolaryngology	0	0	0	0	73	316	157	432	589	2.2	1.4
Plastic Surgery	0	0	0	0	274	458	779	829	1608	2.8	1.8
Podiatry	0	0	0	0	59	156	146	301	447	2.5	1.9
Thoracic	0	0	0	0	29	1	105	1	106	3.6	1.0
Urology	0	0	1	1	115	605	440	753	1193	3.8	1.2
Totals	**0**	**0**	**10**	**10**	**3019**	**3560**	**9865**	**6072**	**15937**	**3.3**	**1.7**

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

Dedicated and Non-Dedicated Procedure Room Utilzation

Procedure Type	Procedure Rooms Inpatient	Procedure Rooms Outpatient	Procedure Rooms Combined	Procedure Rooms Total	Surgical Cases Inpatient	Surgical Cases Outpatient	Surgical Hours Inpatient	Surgical Hours Outpatient	Surgical Hours Total Hours	Hours per Case Inpatient	Hours per Case Outpatient
Gastrointestinal	0	0	2	2	459	1925	499	1995	2494	1.1	1.0
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	1	1	0	12	0	8	8	0.0	0.7
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

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

Emergency/Trauma Care

Certified Trauma Center		Yes
Level of Trauma Service	**Level 1**	**Level 2**
	Adult/Pediatric	Not Answered
Operating Rooms Dedicated for Trauma Care		1
Number of Trauma Visits:		5,898
Patients Admitted from Trauma		1,969
Emergency Service Type:		Comprehensive
Number of Emergency Room Stations		23
Persons Treated by Emergency Services:		50,486
Patients Admitted from Emergency:		12,665
Total ED Visits (Emergency+Trauma):		**56,384**

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	**1,035**
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	678
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	323
EP Catheterizations (15+)	34

Cardiac Surgery Data

Total Cardiac Surgery Cases:	**51**
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	51
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	21

Outpatient Service Data

Total Outpatient Visits	**246,291**
Outpatient Visits at the Hospital/ Campus:	167,479
Outpatient Visits Offsite/off campus	78,812

Diagnostic/Interventional	Equipment Owned	Equipment Contract	Examinations Inpatient	Examinations Outpt	Examinations Contract
General Radiography/Fluoroscopy	19	0	30,175	38,668	0
Nuclear Medicine	2	0	1,286	2,532	0
Mammography	2	0	32	12,137	0
Ultrasound	20	0	7,660	33,504	0
Angiography	2	0			
Diagnostic Angiography			0	0	0
Interventional Angiography			2612	1112	0
Positron Emission Tomography (PET)	0	0	0	0	0
Computerized Axial Tomography (CAT)	3	0	12,345	11,961	0
Magnetic Resonance Imaging	1	0	1,993	2,639	0

Treatment Equipment	Owned	Contract	Therapies/ Treatments
Lithotripsy	0	0	0
Linear Accelerator	1	0	9,011
Image Guided Rad Therapy	0	0	0
Intensity Modulated Rad Thrpy	0	0	918
High Dose Brachytherapy	1	0	10
Proton Beam Therapy	0	0	0
Gamma Knife	0	0	0
Cyber knife	0	0	0

Source: 2011 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development. ATTACHMENT 19C

Ownership, Management and General Information

ADMINISTRATOR NAME:	Alan H. Channing
ADMINSTRATOR PHONE:	773-257-6434
OWNERSHIP:	Sinai Health System
OPERATOR:	Schwab Rehabilitation Hospital
MANAGEMENT:	Not for Profit Corporation (Not Church-R
CERTIFICATION:	
FACILITY DESIGNATION:	Rehabilitation Hospital
ADDRESS	1401 South California Avenue **CITY:** Chicago **COUNTY:** Suburban Cook (Chicago)

Patients by Race

White	19.5%
Black	74.5%
American Indian	0.1%
Asian	1.1%
Hawaiian/ Pacific	0.0%
Unknown:	4.7%

Patients by Ethnicity

Hispanic or Latino:	12.1%
Not Hispanic or Latino:	83.5%
Unknown:	4.3%

IDPH Number:	2147
HPA	A-02
HSA	6

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2011	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2011	Staff Bed Occupancy Rate %
Medical/Surgical	0	0	0	0	0	0	0.0	0.0	0.0	0.0
0-14 Years				*0*	*0*					
15-44 Years				*0*	*0*					
45-64 Years				*0*	*0*					
65-74 Years				*0*	*0*					
75 Years +				*0*	*0*					
Pediatric	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Intensive Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Direct Admission				*0*	*0*					
Transfers				*0*	*0*					
Obstetric/Gynecology	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Maternity				*0*	*0*					
Clean Gynecology				*0*	*0*					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	21	20	20	318	4,089	0	12.9	11.2	53.3	56.0
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Rehabilitation	81	76	76	1,224	18,967	0	15.5	52.0	64.2	68.4
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedcated Observation	*0*					*0*				
Facility Utilization	**102**			**1,542**	**23,056**	**0**	**15.0**	**63.2**	**61.929**	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	*Medicaid*	*Other Public*	*Private Insurance*	*Private Pay*	*Charity Care*	*Totals*
Inpatients	**42.3%**	**39.0%**	**0.4%**	**16.6%**	**0.0%**	**1.6%**	
	653	602	6	256	0	25	1,542
Outpatients	**16.0%**	**54.1%**	**1.8%**	**21.5%**	**6.0%**	**0.7%**	
	6607	22363	732	8868	2476	271	41,317

Financial Year Reported: 7/1/2010 *to* 6/30/2011

Inpatient and Outpatient Net Revenue by Payor Source

	Medicare	*Medicaid*	*Other Public*	*Private Insurance*	*Private Pay*	*Totals*	*Charity Care Expense*
Inpatient Revenue ($)	**36.9%**	**55.1%**	**0.0%**	**6.5%**	**1.5%**	**100.0%**	
	13,074,413	19,554,256	0	2,291,142	538,606	35,458,417	673,434
Outpatient Revenue ($)	**28.8%**	**39.3%**	**0.3%**	**17.1%**	**14.6%**	**100.0%**	
	2,176,351	2,972,945	19,144	1,296,233	1,105,081	7,569,754	308,368

Total Charity Care Expense **981,802**

Total Charity Care as % of Net Revenue **2.3%**

Birthing Data

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

Newborn Nursery Utilization

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

Laboratory Studies

Inpatient Studies	36,086
Outpatient Studies	6
Studies Performed Under Contract	0

Organ Transplantation

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

ATTACHMENT 19C

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	0	0	0	0	0	0	0	0.0	0.0
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	0	0	0	0	0	0	0	0.0	0.0
Gastroenterology	0	0	0	0	0	0	0	0	0	0.0	0.0
Neurology	0	0	0	0	0	0	0	0	0	0.0	0.0
OB/Gynecology	0	0	0	0	0	0	0	0	0	0.0	0.0
Oral/Maxillofacial	0	0	0	0	0	0	0	0	0	0.0	0.0
Ophthalmology	0	0	0	0	0	0	0	0	0	0.0	0.0
Orthopedic	0	0	0	0	0	0	0	0	0	0.0	0.0
Otolaryngology	0	0	0	0	0	0	0	0	0	0.0	0.0
Plastic Surgery	0	0	0	0	0	0	0	0	0	0.0	0.0
Podiatry	0	0	0	0	0	0	0	0	0	0.0	0.0
Thoracic	0	0	0	0	0	0	0	0	0	0.0	0.0
Urology	0	0	0	0	0	0	0	0	0	0.0	0.0
Totals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0.0**	**0.0**

SURGICAL RECOVERY STATIONS Stage 1 Recovery Stations 0 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):	**0**
Cath Labs used for Angiography procedures	0
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Emergency/Trauma Care

Certified Trauma Center		No
Level of Trauma Service	**Level 1**	**Level 2**
	(Not Answered)	Not Answered
Operating Rooms Dedicated for Trauma Care		0
Number of Trauma Visits:		0
Patients Admitted from Trauma		0
Emergency Service Type:		Stand-By
Number of Emergency Room Stations		0
Persons Treated by Emergency Services:		0
Patients Admitted from Emergency:		0
Total ED Visits (Emergency+Trauma):		**0**

Cardiac Catheterization Utilization

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

Cardiac Surgery Data

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

Outpatient Service Data

Total Outpatient Visits	**41,317**
Outpatient Visits at the Hospital/ Campus:	41,317
Outpatient Visits Offsite/off campus	0

Diagnostic/Interventional	Equipment Owned	Equipment Contract	Examinations Inpatient	Examinations Outpt	Examinations Contract
General Radiography/Fluoroscopy	3	0	401	132	0
Nuclear Medicine	0	0	0	0	0
Mammography	0	0	0	0	0
Ultrasound	1	0	104	0	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)	0	0	0	0	0
Magnetic Resonance Imaging	0	0	0	0	0

Treatment 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: 2011 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development. ATTACHMENT 19C

INTER- HOSPITAL TRANSFER AGREEMENT

This Inter-Hospital Transfer Agreement is made as of March 1, 2004, by and between Holy Cross Hospital (HCH), and Advocate Illinois Masonic Medical Center (AIMMC).

WHEREAS, HCH wishes to provide emergency coronary angioplasty for patients who have presented to the Emergency Department and

WHEREAS, from time to time, such patients may require open heart surgery or other specialized cardiac intervention unavailable at HCH on an emergency basis ("Emergency Procedures"); and

WHEREAS, AIMMC provides such specialty care and desires to accept patients transferred by HCH for the emergency provision of such services.

NOW, THEREFORE, in consideration of the premises, the parties agree as follows:

1. AIMMC will accept all cardiac patients transferred by HCH to it for the performance of timely Emergency Procedures upon receipt of phone notification of such transfer by HCH.
2. HCH will be responsible for arranging any and all transportation incurred in connection with this transfer.
3. AIMMC will look solely to patients for payment for any services provided to the transferred patient and HCH is not responsible for any payment obligations related to the transferred patient.
4. There will be a timely interchange of medical and other information necessary and useful in the care of the patient. Copies of relevant medical records will be sent with the patient.
5. Neither party shall be liable for the negligent acts or omissions of the other in treatment of the patient.

HOLY CROSS HOSPITAL	ILLINOIS MASONIC MEDICAL CENTER
By: [signature]	By: [signature]

ATTACHMENT 19C

PATIENT TRANSFER AGREEMENT

This Patient Transfer Agreement ("Agreement") is made and effective as of the 1 day of July, 2009 ("Effective Date") between Rush University Medical Center, an Illinois not-for-profit corporation ("Rush"), and Holy Cross Hospital, an Illinois not-for-profit corporation ("Transferring Hospital"). Transferring Hospital and Rush may from time to time be referred to herein individually as a "Party" and collectively as the "Parties".

PREAMBLE

A. Transferring Hospital operates a general acute care hospital and ancillary facilities.

B. Transferring Hospital receives, from time to time, patients who are in need of specialized critical care services that are not available at the Transferring Hospital.

C. Rush is able to provide specialized critical care to this patient population.

D. The Parties wish to provide for the transfer of patients requiring specialized critical care from the Transferring Hospital to Rush under the following terms and conditions.

The Parties agree as follows:

TERMS

Section 1: Transfer of Patients

1.1. **Acceptance of Patients.** The need for transfer of a patient to Rush shall be determined by the patient's attending physician at Transferring Hospital. When the attending physician determines that transfer is medically appropriate, the Transferring Hospital shall contact Rush regarding the need for transfer. Rush shall notify the Transferring Hospital if it can accept the patient after Rush has determined (i) it has the appropriate space, equipment and personnel to provide care to the patient; (ii) a member of Rush's medical staff has agreed to accept responsibility for the care of the patient; (iii) customary admission requirements are met and State and Federal laws and regulations are met; and (iv) the Transferring Hospital has provided sufficient information to permit Rush to determine it can provide the necessary patient care. Notwithstanding the foregoing, Rush's decision to accept a patient in need of emergency care shall not be based upon the patient's ability or inability to pay for the services to be rendered by Rush. Notice of the transfer shall be given by the Transferring Hospital as far in advance as possible.

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1.2. **Appropriate Transfer.** It shall be Transferring Hospital's responsibility to arrange for appropriate and safe transportation and care of the patient during a transfer. The Transferring Hospital shall ensure that the transfer is an "appropriate transfer" under the Emergency Medical Treatment and Active Labor Act ("EMTALA"), as may be amended, and is carried out in accordance with all applicable laws and regulations. When deemed appropriate by Rush, it shall provide assistance in the transfer process and logistics through its Transfer Center.

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

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

1.5. **Billing and Collections.** All charges incurred with respect to any services performed by either Party for patients transferred pursuant to this Agreement shall be billed and collected by the Party providing such services directly from the patient, a thirty party payor, Medicare or Medicaid or any other sources normally billed by such Party. Neither Party shall assume any responsibility for the collection of any accounts receivable, other than those incurred as a result of rendering services directly to the patient; and neither institution shall be liable for any debts, obligations, or claims of a financial or legal nature incurred by the other institution.

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

1.7 **Return Transfer.** In the event the Rush attending physician determines the patient no longer requires the specialized care services offered by Rush, in accord with any relevant laws, regulations and Rush policies and upon consent of the patient, the patient shall be returned to the Transferring Hospital when deemed medically stable for transfer. Transferring Hospital agrees that upon request of Rush, it will accept the patient back for continued care within its functional capability in accordance with its own admission policies and procedures. The provisions of this Section 1.7 are intended to provide for continuity of care for the patient. Both Rush and Transferring Hospital acknowledge that the patient has the right to choose to be transferred from Rush to a hospital other than Transferring Hospital, subject to the willingness of such other Hospital to accept such transfer.

1.8 **Outcome of Care**. In accordance with the Health Insurance Portability and Accountability Act (HIPAA), Rush agrees to share quality data on all patients transferred to Rush by the Transferring Hospital and those transferred back to the Transferring Hospital pursuant to Section 1.7 of this Agreement so long as the sharing of such data involves the carrying out of treatment or pertains to a designated HIPAA exception.

Section 2: Medical Records

Transferring Hospital shall provide all information which may be necessary or useful in the care and treatment of the transferred patient or which may be relevant in determining whether Rush can provide adequate care of such patient. Such information shall be provided by the Transferring Hospital in advance, where possible, and in any event, at the time of the transfer. The Transferring Hospital shall send a copy of all patient medical records that are available at the time of transfer to Rush. Other records shall be sent as soon as practicable after the transfer. The patient's medical record shall include a physician's order transferring the patient and evidence that the patient was transferred promptly, safely and in accordance with all applicable laws and regulations.

Section 3: Term and Termination

3.1. **Term.** The term of this Agreement shall be five (5) years from the Effective Date, unless sooner terminated as provided herein.

3.2. **Termination.** This Agreement may be terminated by either Party upon thirty (30) days prior written notice. This Agreement may be terminated if either Party is in default of any material term of this Agreement and has failed to cure such default within ten (10) days of receipt of written notice from the other Party specifying such default. Either Party may terminate this Agreement effective immediately upon the happening of any of the following:

(i) Continuation of this Agreement would endanger patient care.

(ii) A general assignment by the other Party for the benefit of creditors.

(iii) The filing of a bankruptcy petition by or against the other Party or the appointment of a receiver for any of its property;

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

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

Section 4: Certification and Insurance

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

4.2. **<u>Insurance.</u>** Each Party shall maintain during the term of this Agreement, at its sole cost and expense, general and professional liability insurance in such amounts as are reasonable and customary in the industry to guard against those risks which are customarily insured against in connection with the operation of activities of comparable scope and size. Minimum coverage levels shall be $1,000,000 per occurrence and $3,000,000 annual aggregate. Evidence of such insurance shall be provided upon request. Each Party shall notify the other Party within thirty (30) days of any material change or cancellation in any policy of insurance required to be secured or maintained by such Party.

Section 5: <u>Liability</u>

It is understood and agreed that neither of the Parties to this Agreement shall be liable for any negligent or wrongful act chargeable to the other unless such liability is imposed by a court of competent jurisdiction. This Agreement shall not be construed as seeking to either enlarge or diminish any obligation or duty owed by one Party against the other or against third parties. In the event of a claim for any wrongful or negligent act, each Party shall bear the cost of its own defense.

Section 6: <u>Miscellaneous</u>

6.1. **<u>Non-Referral of Patients.</u>** Neither Party is obligated to refer or transfer patients to the other and neither Party will receive any payment for any patient referred or transferred to the other Party.

6.2. **<u>Relationship of the Parties.</u>** The Parties enter into this Agreement as independent parties. Neither Party shall have, nor represent itself to have, any authority to bind the other Party or to act on its behalf. This Agreement does not confer any right to use any name, trade name, trademark, or other designation of either Party to this Agreement (including contraction, abbreviation or simulation of any of the foregoing) in any way without the prior written consent of the other Party.

6.3. **<u>Notices.</u>** All notices and other communications under this Agreement shall be in writing and shall be deemed received when delivered personally or when deposited in the U.S. mail, postage prepaid, sent registered or certified mail, return receipt requested or sent via a nationally recognized and receipted overnight courier service, to the Parties at their respective principal office of record as set forth below or designated in writing from time to time. No notice of a change of address shall be effective until received by the other Party:

Notices to the Transferring Hospital:
Wayne Lerner
Chief Executive Officer
Holy Cross Hospital
Executive Office
2701 W. 68th Street
Chicago, IL 60629

with a copy to:
Andrew P. Tecson, Esq.
Chuhak & Tecson, P.C.
30 South Wacker Drive, Suite 2600
Chicago, Illinois 60606

Notices to the Rush:
Norma A. Melgoza
Assistant Vice President, Hospital Operations
Rush University Medical Center
1725 W. Harrison Street, Suite 129
Chicago, IL 60612

with a copy to:
Rush University Medical Center
Office of Legal Affairs
1700 West Van Buren Street, Suite 301
Chicago, Illinois 60612-3244
Attn: General Counsel

6.4. **Assignment.** Neither Party may assign its rights or delegate its obligations under this Agreement without the prior written consent of the other.

6.5. **Entire Agreement.** This Agreement contains the entire agreement of the Parties with respect to the subject matter and may not be amended or modified except in a writing signed by both Parties.

6.6. **Governing Law.** This Agreement shall be construed and all of the rights, powers and liabilities of the Parties hereunder shall be determined in accordance with the laws of the State of Illinois; provided, however, that the conflicts of law principles of the State of Illinois shall not apply to the extent that they would operate to apply the laws of another state.

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

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

6.9. **Severability.** If any provision of this Agreement, or the application thereof to any person or circumstance, shall be held to be invalid, illegal or unenforceable in any respect by any court or other entity having the authority to do so, the remainder of this Agreement, or the application of such affected provision to persons or circumstances other than those to which it is held invalid or unenforceable, shall be in no way affected, prejudiced or disturbed, and each provision of this Agreement shall be valid and shall be enforced to the fullest extent permitted by law.

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

6.11. **Waiver.** No failure by a Party to insist upon the strict performance of any covenant, agreement, term or condition of this Agreement, shall constitute a waiver of any such breach of such covenant, agreement, term or condition. Any Party may waive compliance by the other Party with any of the provisions of this Agreement if done so in writing. No waiver of any provision shall be construed as a waiver of any other provision or any subsequent waiver of the same provision.

6.12 **Non-Exclusivity:** This Agreement is non-exclusive.

6.13 **Compliance with Laws:** At all times, both Parties shall comply with all federal, state and local laws, rules and regulations including, but not limited to the Health Insurance Portability and Accountability Act of 1996.

6.14 **Exclusion:** Both Parties shall immediately notify the other Party in the event such Party becomes excluded from a government health care program.

Rush and the Transferring Hospital have executed this Agreement on the day and year first written above.

HOLY CROSS HOSPITAL	**RUSH UNIVERSITY MEDICAL CENTER**
By: [signature]	By: [signature]
Wayne Lerner, Chief Executive Officer	J. Robert Clapp, Jr. Senior Vice President of Hospital Affairs
Date: 7/6/09	Date: 7/15/09

ATTACHMENT 19C

HOLY CROSS HOSPITAL
CHICAGO, ILLINOIS

PATIENT TRANSFER AGREEMENT

This agreement is made and effective as of **December 1, 2008** between Holy Cross Hospital, a Non-profit corporation and **International Nursing & Rehabilitation**, a nursing home at **4815 S. Western Blvd., Chicago, IL**, both of which are organized and exist under the laws of the State of Illinois.

In the interests of good patient care and in securing the optimum use of the hospital and International Nursing & Rehabilitation, the parties agree as follows:

AUTONOMY

I. Each party shall have exclusive control of its management, assets and affairs. Neither party by virtue of this agreement assumes any liability for any debts or obligations of either a financial or legal nature incurred by the other party to this agreement.

TRANSFER OF PATIENTS

II. When a patients need for transfer from one of the above institutions to another has been determined by the patient's physician, the institution to which the transfer is to be made agrees to admit the patient as promptly as possible. Neither Holy Cross Hospital, nor any employee will be responsible for the patient after the patient is released from the hospital.

PRIORITY OR METHOD OF SELECTION OF PATIENTS

III. All patients admitted to the hospital must be under the medical care of a member of the hospital's medical staff.

The hospital agrees to admit the patient from International Nursing & Rehabilitation as promptly as possible, depending on urgency of need.

1. Patients declared as emergencies by their physician will be admitted without delay unless physical facilities absolutely do not permit it.
2. Patients categorized as urgent will be admitted as soon as possible.
3. Elective cases will be booked and admitted according to the routine procedure of the hospital.

International Nursing and Rehabilitation agrees:

1. To admit the patient from the hospital as promptly as possible provided general admissions requirements of the institution are met.
2. To give priority to readmission of patients transferred from **International Nursing and Rehabilitation** to the hospital.

TRANSFER INFORMATION

IV. Both parties agree to send with each patient, at the time of transfer, or in case of emergency, as promptly as possible thereafter, a summary of pertinent medical and other information utilizing the **PATIENT TRANSFER FORM** and/or other medical forms.

Each party agrees to notify the other party, as far in advance as possible, of an impending transfer.

TRANSFER OF PERSONAL EFFECTS

V. A patient personal effects and valuable will ordinarily be transferred with the patient from one institution to other, under the responsibility of the patient and/or family. Each institution assumes responsibility for items placed by patients into safekeeping, and these items are released only to the patients or close relatives and only upon signing a receipt.

FINANCIAL RELATIONASHIPS

VI. Neither party shall assume any responsibility for the collection of any accounts receivable, other than those incurred as a result of rendering services directly to the patient; and neither institution shall be liable for any debts, obligations, or claims of a financial or legal nature incurred by the other institution; and each institution assumes full responsibility for its own maintenance and operation.

TERMINATION OF AGREEMENT

VII. This agreement shall be terminated by either facility upon a ninety (90) day written notice. The agreement shall be automatically terminated should either facility fail to maintain its licensure of certification as a **nursing facility** to hospital under the laws of the State of Illinois.

ADVERTISING-PUBLICITY

VIII. Neither party shall use the name of the party in any promotional or advertising material unless review and approval of the intended use shall first be obtained from the party whose name is to be used.

NON-EXCLUSIVE CLAUSE

IX. Nothing in this agreement shall be constructed as limiting the right of either party to affiliate or contract with any other hospital, or nursing facility, on either a limited or general basis, while the agreement is in effect.

MODIFICATION OF AGREEMENT

X. This agreement shall be modified or amended from time by mutual agreement of the parties, and any such modification or amendment shall be attached to and become part of this agreement.

HOLY CROSS HOSPITAL	INTERNATIONAL NURSING
By: [illegible]	By: [illegible]
Date: 12/9/08	Date: 12/5/08

Holy Cross Hospital and Affiliate

Consolidated Financial Report
June 30, 2011

ATTACHMENT 39

Contents

McGladrey

Independent Auditor's Report on the Consolidated Financial Statements

To the Board of Trustees
Holy Cross Hospital
Chicago, Illinois

We have audited the accompanying consolidated balance sheets of Holy Cross Hospital and Affiliate (the Hospital) as of June 30, 2011 and 2010, and the related consolidated statements of operations and changes in net assets and of cash flows for the years then ended. These financial statements are the responsibility of the Hospital's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Holy Cross Hospital and Affiliate as of June 30, 2011 and 2010, and the results of their operations and changes in net assets and their cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

McGladrey & Pullen, LLP

Chicago, Illinois
November 22, 2011

Holy Cross Hospital and Affiliate

Consolidated Balance Sheets
June 30, 2011 and 2010

Assets	**2011**	2010
Current Assets		
Cash and cash equivalents	**$ 15,472,749**	$ 23,114,888
Assets whose use is limited, externally designated under debt agreements	**1,340,445**	515,280
Patient accounts receivable, less allowances of $8,901,000 in 2011 and $8,427,000 in 2010	**10,807,555**	12,324,545
Contribution receivable	**104,206**	225,279
Inventory	**1,625,775**	1,582,688
Prepaid expenses and other current assets	**597,837**	1,030,421
Total current assets	**29,948,567**	38,793,101
Assets Whose Use is Limited, net of current portion, externally designated under:		
Debt agreements	**-**	1,312,997
Self-insurance trust	**3,173,973**	-
Workmen's compensation contracts and other	**543,971**	1,029,332
	3,717,944	2,342,329
Property and Equipment, net	**37,098,824**	40,590,453
Other Assets	**100,000**	1,924
Deferred Bond Issuance Costs, net of amortization of $384,419 in 2010	**-**	113,981
Total assets	**$ 70,865,335**	$ 81,841,788

See Notes to Consolidated Financial Statements.

ATTACHMENT 39

Holy Cross Hospital and Affiliate

Consolidated Balance Sheets
June 30, 2011 and 2010

Liabilities and Net Assets	**2011**	2010
Current Liabilities		
Current portion of long-term debt	**$ 1,465,463**	$ 13,007,095
Accounts payable	**6,338,008**	6,797,454
Accrued expenses	**6,293,074**	7,236,385
Current portion of accrued pension and postretirement benefits	**266,000**	266,000
Due to third-party payors	**3,910,654**	3,195,298
Total current liabilities	**18,273,199**	30,502,232
Noncurrent Liabilities		
Long-term debt, less current portion	**47,590**	1,591,746
Accrued pension and postretirement benefits, net of current portion	**14,836,940**	28,434,598
Professional liability	**4,607,022**	3,632,000
Total noncurrent liabilities	**19,491,552**	33,658,344
Total liabilities	**37,764,751**	64,160,576
Commitments and Contingencies (Notes 9, 11 and 12)		
Net Assets		
Unrestricted	**32,437,122**	16,464,357
Temporarily restricted	**663,462**	1,216,855
Total net assets	**33,100,584**	17,681,212
Total liabilities and net assets	**$ 70,865,335**	$ 81,841,788

See Notes to Consolidated Financial Statements.

Holy Cross Hospital and Affiliate

Consolidated Statements of Operations and Changes In Net Assets
Years Ended June 30, 2011 and 2010

	2011	2010
Revenue:		
Net patient service revenue	$ 94,570,394	$ 95,305,459
Capitation revenue	4,351,072	4,879,222
Investment income	2,002	5,125
Other revenue	1,626,799	2,285,182
Medicaid stimulus revenue	6,394,752	-
Medicaid hospital assessment revenue	12,889,822	12,889,822
Net assets released from restrictions - used for operations	614,768	309,620
	120,449,609	115,674,430
Expenses:		
Salaries and employee benefits	55,556,349	52,492,687
Professional fees	9,323,589	9,491,900
Food, drugs and medical supplies	12,717,422	13,231,897
Supplies, utilities and other	19,998,660	20,178,330
Medicaid hospital assessment tax	5,509,292	5,509,291
Provision for uncollectible accounts	9,860,018	8,017,814
Depreciation and amortization	5,560,363	5,850,997
Interest	215,505	418,033
	118,741,198	115,190,949
Income from operations	1,708,411	483,481
Nonoperating income (expense):		
Investment income	173,606	162,002
Unrealized loss on investments	(26,027)	-
Total nonoperating income (expense)	147,579	162,002
Excess of revenue over expenses	$ 1,855,990	$ 645,483

(Continued)

Holy Cross Hospital and Affiliate

Consolidated Statements of Operations and Changes In Net Assets (Continued)
Years Ended June 30, 2011 and 2010

	2011	2010
Unrestricted net assets:		
Excess of revenue over expenses	**$ 1,855,990**	$ 645,483
Net assets released from restrictions - used for property and equipment	**417,260**	948,387
Pension-related changes other than net periodic pension cost	**13,699,515**	(4,906,199)
Increase (decrease) in unrestricted net assets	**15,972,765**	(3,312,329)
Temporarily restricted net assets:		
Contributions	**478,635**	1,331,650
Net assets released from restrictions	**(1,032,028)**	(1,258,007)
(Decrease) increase in temporarily restricted net assets	**(553,393)**	73,643
Increase (decrease) in net assets	**15,419,372**	(3,238,686)
Net assets:		
Beginning of year	**17,681,212**	20,919,898
End of year	**$ 33,100,584**	$ 17,681,212

See Notes to Consolidated Financial Statements.

Holy Cross Hospital and Affiliate

Consolidated Statements of Cash Flows
Years Ended June 30, 2011 and 2010

	2011	2010
Cash Flows from Operating Activities		
Increase (decrease) in net assets	**$ 15,419,372**	$ (3,238,686)
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Net change in unrealized losses on investments	**(26,027)**	-
Provision for uncollectible accounts	**9,860,018**	8,017,814
Loss on disposal	**24,647**	169,697
Depreciation	**5,444,458**	5,698,430
Amortization	**115,905**	152,567
Changes in operating assets and liabilities:		
Patient accounts receivable	**(8,343,028)**	(4,403,489)
Contribution receivable	**121,073**	723,108
Inventory, prepaid expenses and other assets	**289,497**	334,409
Due to third-party payors	**715,356**	(1,854,389)
Accounts payable and other liabilities	**(32,891)**	(101,635)
Accrued pension and postretirement benefits	**(13,597,658)**	4,443,635
Net cash provided by operating activities	**9,990,722**	9,941,461
Cash Flows from Investing Activities		
Purchases of property and equipment	**(2,370,742)**	(3,226,737)
Purchase of investments whose use is limited and other investments	**(3,367,538)**	(1,604,319)
Proceeds from sales of investments whose use is limited and other investments	**1,192,785**	514,921
Net cash used in investing activities	**(4,545,495)**	(4,316,135)
Cash Flows from Financing Activities		
Proceeds from contributions used for the purchase of capital assets	**417,260**	-
Payments on long-term debt	**(13,085,788)**	(1,862,654)
Payment of accounts payable for property and equipment	**(418,838)**	(738,920)
Net cash used in financing activities	**(13,087,366)**	(2,601,574)
Net (decrease) increase in cash and cash equivalents	**(7,642,139)**	3,023,752
Cash and cash equivalents:		
Beginning of year	**23,114,888**	20,773,632
End of year	**$ 15,472,749**	$ 23,797,384
Supplemental Disclosure of Cash Flow Information		
Cash paid for interest	**$ 197,993**	$ 423,435
Supplemental Schedule of Noncash Investing and Financing Activities		
Purchases of equipment in accounts payable	**$ 23,994**	$ 418,838

See Notes to Consolidated Financial Statements.

Note 1. Nature of Business and Summary of Significant Accounting Policies

Nature of business: The accompanying consolidated financial statements represent the accounts of Holy Cross Hospital (Hospital) and its wholly owned affiliate, Holy Cross Health Partners, Inc. (HCHP). The Hospital is an Illinois not-for-profit corporation. The Hospital provides inpatient, outpatient and emergency care services to residents of the Chicago Metropolitan area. The Hospital is the sole shareholder of HCHP, an Illinois for-profit corporation that was incorporated in 1998. HCHP's purpose is to administer and negotiate contracts on behalf of participating health care providers.

A summary of significant accounting policies follows:

Principles of consolidation: The consolidated financial statements include the Hospital and HCHP. All significant intercompany accounts and transactions have been eliminated in consolidation.

Use of estimates: The preparation of financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates. The use of estimates and assumptions in the preparation of the accompanying financial statements is primarily related to the determination of the net patient receivables and settlements with third-party payors and the accruals for pension and professional and general liability. Due to uncertainties inherent in the estimation and assumption process, it is at least reasonably possible that changes in these estimates and assumptions in the near-term would be material to the financial statements.

Basis of presentation: The Hospital may classify its net assets into three categories, which are unrestricted, temporarily restricted and permanently restricted.

Unrestricted net assets are reflective of revenues and expenses associated with the principal operating activities of the Hospital and are not subject to donor-imposed stipulations.

Temporarily restricted net assets are subject to donor-imposed stipulations that may or will be met either by actions of the Hospital and/or the passage of time. The Hospital has temporarily restricted net assets which are available for operations or improvements to the physical facility. When a donor restriction expires, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the statements of operations and changes in net assets as assets released from restriction.

Permanently restricted net assets are subject to donor-imposed stipulations that they be maintained permanently by the Hospital. The Hospital had no permanently restricted net assets at June 30, 2011 and 2010.

Donor-restricted gifts: Unconditional promises to give cash and other assets to the Hospital are reported at fair value at the date the promise is received. Conditional promises to give and indication of intentions to give are reported at fair value at the date the gift is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the statements of changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions in the accompanying financial statements.

Cash and cash equivalents: All investments that are not limited as to use with an original maturity of three months or less when purchased are reflected as cash and cash equivalents. The carrying value of cash equivalents approximates fair value.

Note 1. Nature of Business and Summary of Significant Accounting Policies (Continued)

Throughout the year, the Hospital may have amounts on deposit with financial institutions in excess of those insured by the FDIC. Management does not believe that this presents a more significant risk to the Hospital than other options available.

Patient accounts receivable, provision for uncollectible accounts and due to third party-payors: The collection of receivables from third-party payors and patients is the Hospital's primary source of cash for operations and is critical to its operating performance. The primary collection risks relate to uninsured patient accounts and patient accounts for which the primary insurance payor has paid, but patient responsibility amounts (deductibles and copayments) remain outstanding. Patient receivables, where a third-party payor is responsible for paying the amount, are carried at a net amount determined by the original charge for the service provided, less an estimate made for contractual adjustments or discounts provided to third-party payors.

Patient receivables due directly from the patients are carried at the original charge for the service provided less amounts covered by third-party payors, discounts for patients that are uninsured and an estimated allowance for doubtful receivables. Management estimates this allowance based on the aging of its accounts receivable and its historical collection experience for each payor type. Recoveries of receivables previously written off are recorded as a reduction of bad debt expense when received.

The past due status of receivables is determined on a case-by-case basis depending on the payor responsible. Interest is generally not charged on past due accounts.

Receivables or payables related to estimated settlements on various payor contracts, primarily Medicare, are reported as amounts due from or to third-party payors. Significant changes in payor mix, business office operations, economic conditions or trends in federal and state governmental health care coverage could affect the Hospital's collection of accounts receivable, cash flows and results of operations.

Inventory: Inventory is stated at cost, determined by the first-in, first-out method. Inventory consists mainly of supplies.

Deferred bond issuance costs: Bond issuance costs are deferred and amortized over the life of the related debt on a method that approximates the effective yield method. The bonds were paid off in 2011.

Assets whose use is limited: Investments in money market accounts are measured at fair value which approximates cost. Investments in certificates of deposit are carried at cost, which approximates fair value. Investments in debt and equity securities are recorded at fair value based on quoted market prices. The change in unrealized appreciation in fair value of investments is recognized as a change in net assets

Assets whose use is limited includes investments held by trustees under debt agreements, workmen's compensation contracts, and insurance policies.

Investments are regularly evaluated for impairment. The Hospital considers factors affecting the investee, factors affecting the industry the investee operates within, and general debt and equity market trends. The Hospital considers the length of time an investment's fair value has been below carrying value, the near-term prospects for recovery to carrying value, and the intent and ability to hold the investment until maturity or market recovery is realized. If and when a determination is made that a decline in fair value below the cost basis is other than temporary, the related investment is written down to its estimated fair value and included as a realized loss in excess of revenues over expenses.

Note 1. Nature of Business and Summary of Significant Accounting Policies (Continued)

Property and equipment: Property and equipment are stated at cost. Depreciation is provided over the estimated useful life of each asset and is computed on the straight-line method. Leased equipment under capital leases is amortized over the shorter of the lease term or estimated useful life unless it contains a bargain purchase option which the Hospital expects to exercise. Amortization expense on assets acquired under capital leases is included with depreciation expense on owned assets. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

Gifts of long-lived assets such as land, buildings, or equipment are reported as unrestricted support and are excluded from the excess of revenue over expenses unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

Accrued professional liability: The provision for accrued professional liability includes estimates of the ultimate costs for claims incurred but not reported. The provision is actuarially determined.

Net patient service revenue: The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

Capitation revenue: The Hospital has agreements with various Health Maintenance Organizations (HMOs) to provide medical services to subscribing participants. Under these agreements, the Hospital receives monthly capitation payments based on the number of each HMO's participants, regardless of services actually performed by the Hospital. In addition, the HMOs make fee-for-service payments to the Hospital for certain covered services based upon discounted fee schedules.

Results of operations: The statement of operations and changes in net assets includes excess of revenues over expenses. Changes in unrestricted net assets that are excluded from excess of revenues over expenses, consistent with industry practice, include net assets released from restrictions used for property and equipment, contributions of equipment, as well as pension-related changes other than the net periodic pension cost, investment income and unrealized gains and losses.

Fair value measurement: The Hospital adopted the provisions of the FASB's further guidance on improved disclosure about fair value measurements effective July 1, 2009. The adoption of this guidance did not have a material impact on the consolidated financial statements or results of operations of the Hospital.

Charity care and uninsured allowance: The Hospital provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than established rates. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue.

The Hospital provides a 64 percent discount from customary charges for uninsured patients. Charity care includes foregone charges for uninsured patients denied coverage by Public Aid.

Note 1. Nature of Business and Summary of Significant Accounting Policies (Continued)

Income taxes: The Hospital has received a determination letter from the Internal Revenue Service stating that it is exempt from the payment of federal income taxes under Section 501(c)(3) of the Internal Revenue Code. HCHP is subject to federal and state income taxes, which are not significant to the consolidated operations.

The Hospital files a Form 990 (Return of Organization Exempt from Income Tax) annually and HCHP files Federal and Illinois Forms 1120 (U.S. Corporation Income Tax Return) annually. When these returns are filed, it is highly certain that some positions taken would be sustained upon examination by the taxing authorities, while others are subject to uncertainty about the merits of the position taken or the amount of the position that would ultimately be sustained. UBIT is reported on Form 990T, as appropriate. The benefit of a tax position is recognized in the consolidated financial statements in the period during which, based on all available evidence, management believes that it is more likely than not that the position will be sustained upon examination, including the resolution of appeals or litigation processes, if any.

Tax positions are not offset or aggregated with other positions. Tax positions that meet the "more likely than not" recognition threshold are measured as the largest amount of tax benefit that is more than 50 percent likely to be realized on settlement with the applicable taxing authority. The portion of the benefits associated with tax positions taken that exceeds the amount measured as described above is reflected as a liability for unrecognized tax benefits in the accompanying consolidated balance sheets along with any associated interest and penalties that would be payable to the taxing authorities upon examination.

Forms 990 and 1120 filed by the Hospital and HCHP are subject to examination by the Internal Revenue Service (IRS) and the State of Illinois up to three years from the extended due date of each return. These returns filed by the Hospital and HCHP are no longer subject to examination for the years 2007 and prior.

Pending pronouncements: In August 2010, the FASB issued ASU 2010-23, *Health Care Entities (Topic 954) – Measuring Charity Care for Disclosure*. ASU 2010-23 required disclosure of charity care based on the health care provider's direct and indirect costs of providing charity care services, the method used to identify or estimate such costs of providing charity care services, the method used to identify or estimate such costs, and funds received to offset or subsidize charity services provided. The disclosures required by ASU 2010-23 are effective for fiscal years beginning after December 15, 2010, and must be applied retrospectively. The Hospital is assessing the impact of the implementation of ASU 2010-23 on the disclosures in its consolidated financial statements.

In August 2010, the FASB issued ASU 2010-24, *Health Care Entities (Topic 954) – Presentation of Insurance Claims and Related Insurance Recoveries*. ASU 2010-24 clarifies that a health care entity should not net insurance recoveries against a related claim liability. Additionally, ASU 2010-24 provides that the amount of the claims liability should be determined without consideration of insurance recoveries. The provisions of ASU 2010-24 are effective for fiscal years, and interim periods within those years, beginning after December 15, 2010. Entities must apply the provisions of ASU 2010-24 by recording a cumulative-effect adjustment to opening unrestricted net assets as of the beginning of the period of adoption. Retrospective application of the provisions of ASU 2010-24 is permitted. The Hospital is assessing the impact of the implementation of ASU 2010-24 on its consolidated financial statements.

Note 1. Nature of Business and Summary of Significant Accounting Policies (Continued)

In July 2011, the FASB issued ASU 2011-07, *Health Care Entities (Topic 954) – Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities.* ASU 2011-07 requires health care entities that recognize significant amounts of patient service revenue at the time the services are rendered even though they do not assess the patient's ability to pay, to change the presentation of their statement of operations by reclassifying the provision for bad debts associated with patient service revenue from an operating expense to a deduction from patient service revenue (net of contractual allowances and discounts). Additionally, ASU 2011-07 requires those health care entities to provide enhanced disclosure about their policies for recognizing revenue and assessing bad debts, disclosures of patient service revenue (net of contractual allowances and discounts) as well as qualitative and quantitative information about changes in the allowance for doubtful accounts.

For nonpublic entities such as the Hospital, the provisions of ASU 2011-07 are effective for the first annual period ending after December 15, 2012, and interim and annual periods thereafter, with early adoption permitted. The changes to the presentation of the provision for bad debts related to patient service revenue in the statement of operations should be applied retrospectively to all prior periods presented. The disclosures required by ASU 2011-07 should be provided for the period of adoption and subsequent reporting periods. The Hospital is assessing the impact of the implementation of ASU 2011-07 on its financial statements.

Reclassifications: Certain amounts in the 2010 financial statements have been reclassified to conform with the 2011 presentation with no effect on the net assets.

Subsequent events: Management has evaluated subsequent events for potential recognition or disclosure through November 22, 2011, the date the financial statements were available to be issued.

Note 2. Contractual Arrangements with Third-Party Payors

The Hospital has agreements with third-party payors which provide for reimbursement to the Hospital at amounts different from its established rates. Contractual adjustments under third-party reimbursement programs represent the difference between the Hospital's billings at list price and the amounts reimbursed by Medicare, Medicaid, Blue Cross, and certain other third-party payors; and any differences between estimated third-party reimbursement settlements for prior years and subsequent final settlements. Contractual adjustments under third-party reimbursement programs are accrued on an estimated basis in the period the related services are rendered and are adjusted in future periods as final settlements are determined. A summary of the basis of reimbursement with major third-party payors follows:

Medicare: The Hospital is paid for inpatient acute care and outpatient care services rendered to Medicare program beneficiaries under prospectively determined rates per discharge (Prospective Payment System). These rates vary according to a patient classification system that is based on clinical, diagnostic and other factors. The Hospital's classification of patients under the Prospective Payment System and the appropriateness of the patient's admissions are subject to validation reviews. The Hospital is reimbursed at tentative rates with final settlement determined after submission of annual reimbursement reports by the Hospital and audits by the Medicare fiscal intermediary.

Medicaid: The Hospital is reimbursed at prospectively determined rates for each Medicaid inpatient discharge. Outpatient services are reimbursed based on established fee screens. For inpatient acute care services, payment rates vary according to a patient classification system that is based on clinical, diagnostic and other factors. The prospectively determined rates are not subject to retroactive adjustment. The Hospital also receives incremental Medicaid reimbursement for specific programs and services at the discretion of the State of Illinois Medicaid Program. Medicaid reimbursement may be subject to periodic adjustment, as well as to changes in existing payment levels and rates, based on the amount of funding available to the Medicaid program.

Note 2. Contractual Arrangements with Third-Party Payors (Continued)

Due to the Hospital's relatively high Medicaid patient volume, the Hospital received additional reimbursement of approximately $4,679,000 in 2011 and $4,513,000 in 2010 in the form of Safety Net Adjustment Payments (SNAP), the majority of which is provided by the Illinois Medicaid program. The Hospital also received approximately $900,000 in 2011 and 2010 of additional reimbursement in the form of Critical Hospital Adjustment Payments (CHAP). The Hospital will continue to receive $900,000 in CHAP payments from the Illinois Medicaid program through 2013. Whether the program will be extended beyond 2013 is uncertain at this time. The Hospital also received additional payments from the Illinois Medicaid Disproportionate Share Hospital program (DSH) of approximately $2,242,000 and $1,881,000 at June 30, 2011 and 2010, respectively, to provide services that are vital to Medicaid patients. However, subsequent to June 30, 2009, the Illinois DSH status of the Hospital was contested by the Illinois Department of Health and Family Services (HFS) for fiscal year 2009. Accordingly, the Hospital had established a liability of approximately $2,000,000 in 2009, which was included in due to third-party payors. In 2010, the DSH status of the Hospital was reinstated by HFS retroactive to 2009 and the liability for 2009 of approximately $2,000,000 was reversed in 2010.

In December 2008, the Federal Centers for Medicare & Medicaid Services (CMS) approved State of Illinois (State) legislation for a Medicaid Hospital Assessment Program (Program) relating to the period July 1, 2008 to June 30, 2014. Under these Programs, the Hospital received additional Medicaid reimbursement from the State and paid the related assessment taxes. Total reimbursement revenue recognized by the Hospital for fiscal years 2011 and 2010 was $12,889,822 for both years. Total assessment tax incurred by the Hospital for fiscal years 2011 and 2010 related to this program was approximately $5,509,300. The Hospital will continue to receive a net reimbursement of approximately $7,381,000 from this Program through 2014. Whether the Program will be extended beyond 2014 is uncertain at this time. In 2011, the Hospital received $6,394,752 in Medicaid stimulus payments and is expected to receive $2,700,180 in 2012 from this program.

Blue Cross: The Hospital also participates as a provider of health care services under a reimbursement agreement with Blue Cross. The provisions of this agreement stipulate that services will be reimbursed at a tentative reimbursement rate and that final reimbursement for these services is determined after the submission of an annual cost report by the Hospital and a review by Blue Cross.

Managed Care Organizations: The Hospital has also entered into reimbursement agreements with certain commercial insurance carriers, health maintenance organizations and preferred provider organizations. The basis for payment under these agreements includes discounts from established charges and prospectively determined per diem rates.

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The Hospital believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation, as well as significant regulatory action including fines, penalties and exclusion from the Medicare and Medicaid programs. Net patient service revenue was increased by approximately $1,317,000 and $911,000 for the years ended June 30, 2011 and 2010, respectively, due to the removal of allowances previously estimated that are no longer necessary as a result of accrual adjustments and final settlements.

Note 3. Community Commitment

Community commitment includes charity care for patient care services rendered to the community at a reduced or no fee due to the inability of the patient to pay for services. Community commitment also includes the difference between the estimated cost of services provided to Medicaid patients and the reimbursement from this governmental program. The estimated amount of community commitment provided for the years ended June 30, 2011 and 2010 is as follows:

	2011	2010
Charity care (foregone charges)	$ 14,150,162	$ 16,158,075
Uninsured discount	12,570,677	12,697,791
Unreimbursed cost (estimated cost, less reimbursement)	10,986,485	10,926,264

In addition, the Hospital is involved in many community benefit activities. These activities are conducted free of charge or below the cost of providing them.

Note 4. Concentrations of Credit Risk

The Hospital grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of net receivables from patients and third-party payors at June 30, 2011 and 2010 is as follows:

	2011	2010
Concentration of risk		
Medicare	20 %	21 %
Medicaid	32	31
Managed care	20	15
Self pay	21	25
Other	7	8
	100 %	100 %

Gross revenue from the Medicare program accounted for approximately 43 percent and 45 percent, respectively, for the years ended June 30, 2011 and 2010. Revenue from the Medicaid program accounted for approximately 30 percent and 25 percent of the Hospital's gross patient revenue for the years ended June 30, 2011 and 2010, respectively.

Note 5. Assets Whose Use is Limited

The composition of assets limited as to use is as follows as of June 30:

	2011	2010
Money market and other funds	$ 506,965	$ -
Certificates of deposit	1,884,416	2,342,329
Marketable equity securities	932,983	-
Fixed income securities	1,734,025	-
	$ 5,058,389	$ 2,342,329

Note 5. Assets Whose Use is Limited (Continued)

Total investment return for the years ended June 30, 2011 and 2010 is summarized as follows:

	2011	2010
Dividend and interest income	$ 175,608	$ 167,127
Reported as:		
Investment income--operations	$ 2,002	$ 5,125
Investment income--nonoperating	173,606	162,002
	$ 175,608	$ 167,127
Unrealized loss on investments	$ (26,027)	$ -

Note 6. Property and Equipment

Property and equipment consist of the following at June 30, 2011 and 2010:

	2011	2010
Land and improvements	$ 2,868,224	$ 2,868,224
Buildings	52,957,624	52,238,435
Equipment	75,738,165	75,618,065
Construction in progress	293,629	475,083
	131,857,642	131,199,807
Less accumulated depreciation and amortization	(94,758,818)	(90,609,354)
	$ 37,098,824	$ 40,590,453

The amounts above include assets under capital leases that are capitalized using interest rates appropriate at the inception of each lease. Equipment under capital leases is as follows at June 30, 2011 and 2010:

	2011	2010
Equipment	$ 8,365,588	$ 8,517,411
Less accumulated amortization	(7,158,602)	(6,712,612)
	$ 1,206,986	$ 1,804,799

Note 7. Pledged Assets, Note Payable and Long-Term Debt

Long-term debt is comprised of the following at June 30, 2011 and 2010:

	2011	2010
Illinois Finance Authority adjustable rate Demand Revenue Refunding Bonds, Series 2007, interest payable monthly at the daily, weekly,adustable or fixed rate as defined by the remarketing agent. These Bonds were paid in full on December 1, 2010.	$ -	$ 12,625,000
Bank note, monthly payments of $6,228 of principal and interest at 3.08%, due and paid in full on July 1, 2011.	1,209,565	1,245,905
Capitalized leases, varying amounts, secured by related equipment	303,488	727,936
	1,513,053	14,598,841
Less current maturities	(1,465,463)	(13,007,095)
	$ 47,590	$ 1,591,746

The maturities of long-term debt and future payments under capital leases are as follows:

Year ended June 30,	Bank Note	Capital Leases	Total
2012	$ 1,209,565	$ 266,009	$ 1,475,574
2013	-	48,138	48,138
	1,209,565	314,147	1,523,712
Less interest payments	-	(10,659)	(10,659)
	$ 1,209,565	$ 303,488	$ 1,513,053

Pursuant to the refinancing of the bank note in 2010, certain funds are required to be held on deposit at a commercial lender. At June 30, 2011 and June 30, 2010, such lender held funds in amounts of $1,340,445 and $1,312,997, respectively.

Note 8. Employee Benefit Programs

The Hospital has a noncontributory defined benefit pension plan and a noncontributory postretirement health plan. Effective June 30, 2005, the defined benefit pension plan's credited service was frozen, and the definition of pay was changed to exclude pay after 2014. Effective December 31, 2010, the definition of pay was changed to exclude pay after December 31, 2010 (fully freezing the accrual of benefits at that point).

Obligations and funded status were as follows at June 30:

	2011		2010	
	Pension Benefits	Other Benefits	Pension Benefits	Other Benefits
Change in benefit obligation				
Benefit obligation, beginning of year	$ 77,884,965	$ 2,287,087	$ 70,298,819	$ 2,010,562
Service cost	-	-	-	-
Interest cost	4,154,892	117,407	4,263,160	117,333
Change due to plan amendment	(2,477,383)	-	-	-
Actuarial (gains) losses	(3,455,870)	(232,217)	6,051,370	347,214
Benefits paid	(2,779,360)	(47,280)	(2,728,384)	(188,022)
Benefit obligation, end of year	73,327,244	2,124,997	77,884,965	2,287,087
Change in plan assets				
Fair value of plan assets, beginning of year	51,471,454	-	48,052,418	-
Actual return on plan assets	11,657,207	-	6,147,420	-
Employer contributions	-	47,280	-	188,022
Benefits paid	(2,779,360)	(47,280)	(2,728,384)	(188,022)
Fair value of plan assets, end of year	60,349,301	-	51,471,454	-
Funded status of the plan	$ (12,977,943)	$ (2,124,997)	$ (26,413,511)	$ (2,287,087)

Amounts recognized in the consolidated balance sheets consist of:

	2011		2010	
	Pension Benefits	Other Benefits	Pension Benefits	Other Benefits
Liabilities				
Current liabilities	$ -	$ (266,000)	$ -	$ (266,000)
Noncurrent liabilities	(12,977,943)	(1,858,997)	(26,413,511)	(2,021,087)
Total recognized as a liability	$ (12,977,943)	$ (2,124,997)	$ (26,413,511)	$ (2,287,087)
Unrestricted net assets				
Net actuarial (gains) losses	$ 9,608,311	$ (629,271)	$ 20,631,915	$ (426,692)
Net prior service cost (credit)	(2,309,056)	(230,236)	204,042	(270,001)
Total recognized in unrestricted net assets	$ 7,299,255	$ (859,507)	$ 20,835,957	$ (696,693)

Note 8. Employee Benefit Programs (Continued)

The accumulated benefit obligation for both benefit plans was $75,452,241 and $77,351,910 at June 30, 2011 and 2010, respectively.

The components of net periodic pension (benefit) cost and other amounts recognized in unrestricted net assets for the years ended June 30, 2011 and 2010 are as follows:

	2011		2010	
	Pension Benefits	Other Benefits	Pension Benefits	Other Benefits
Components of net periodic pension (benefit) cost:				
Service cost	$ -	$ -	$ -	$ -
Interest cost	4,154,892	117,407	4,263,160	117,333
Expected return on plan assets	(4,448,937)	-	(4,556,456)	-
Amortization of unrecognized prior service costs (credits)	35,715	(39,765)	35,715	(39,765)
Amortization of unrecognized net losses	359,464	(29,638)	-	(94,530)
	101,134	48,004	(257,581)	(16,962)
Other changes in plan assets and benefit obligations recognized in unrestricted net assets:				
Net actuarial loss (gain) arising during the period	(10,664,140)	(232,217)	4,460,406	347,214
Amortization of prior service (cost) credit	252,123	39,765	(35,715)	39,765
Amortization of actuarial gain	359,464	29,638	-	94,530
	(10,052,553)	(162,814)	4,424,691	481,509
Total recognized in net periodic benefit cost and unrestricted net assets	$ (9,951,419)	$ (114,810)	$ 4,167,110	$ 464,547

The estimated net actuarial losses and prior service credit for the defined benefit pension plan that will be amortized from unrestricted net assets into net periodic benefit cost over the next fiscal year is $192,696 and $252,123, respectively. The estimated net gain and prior service credit for the defined benefit post retirement plan that will be amortized from unrestricted net assets into net periodic benefit cost over the next fiscal year is $76,472 and $39,765, respectively.

Note 8. Employee Benefit Programs (Continued)

Information relative to the assumptions used to determine the benefit obligations and net periodic benefit cost as of and for the years ended June 30 are as follows:

	2011		2010	
	Pension Benefits	Other Benefits	Pension Benefits	Other Benefits
Assumptions used to determine the benefit obligations at June 30:				
Discount rate	5.65%	5.65%	5.45%	5.45%
Rate of compensation increase	N/A	4.00%	4.00%	4.00%
Medical inflation rate- year 1	N/A	7.50%	N/A	8.00%
Medical inflation rate- ultimate	N/A	5.00%	N/A	5.00%
Assumptions used to determine the net periodic benefit cost for the year ended June 30:				
Discount rate	5.45%	5.45%	6.20%	6.20%
Expected return on plan assets	7.50%	N/A	7.50%	N/A
Rate of compensation increase	4.00%	4.00%	4.00%	4.00%
Medical inflation rate- year 1	N/A	8.00%	N/A	8.00%
Medical inflation rate- ultimate	N/A	5.00%	N/A	5.00%
Year that the rate reaches the ultimate trend rate	N/A	2016	N/A	2015

The assumed health care cost trend rate has a significant effect on the amounts reported. A one-percentage-point change in the assumed health care cost trend rate would have the following effects:

	One Percentage Point Increase	One Percentage Point Decrease
Effect on total of service and interest cost components	$ 4,129	$ (3,744)
Effect on postretirement benefit obligation	72,465	(65,985)

The asset allocation of investment categories for the defined benefit plan at June 30, 2011 and 2010 was as follows:

	2011	2010
Equity securities	70%	65%
Debt securities	30%	35%
Total	100%	100%

The overall expected long-term rate of return on assets is based upon the weighted average expected long-term return of a target asset allocation of 60 percent – 70 percent equity securities and 30 percent – 40 percent debt securities. Debt securities are expected to have a long-term rate of return based on current interest levels. Equity securities are expected to have a long-term rate of return based on historical equity premiums over returns on debt securities.

There is no required contribution for the pension plan for the years ended June 30, 2011 and 2010. A contribution of $266,000 is expected for other benefits for the year ended June 30, 2012. No plan assets are expected to be returned to the Hospital over the next fiscal year.

Note 8. Employee Benefit Programs (Continued)

Estimated future benefit payments for the years ending June 30 are as follows (in thousands):

	Pension Benefits	Other Benefits
Years ending June 30,		
2012	$ 3,327	$ 266
2013	3,525	236
2014	3,724	237
2015	3,884	226
2016	4,051	216
2017 - 2021	23,817	903

The Hospital's overall investment strategy is to preserve, protect, and grow the plan assets, as well as to maintain sufficient liquid reserves to meet plan obligations by maintaining a wide diversification of asset types, fund strategies, and fund managers. The target allocations for plan assets are 60-70 percent equity securities and 30-40 percent debt securities. Equity securities primarily include investments in large-cap and mid-cap companies primarily in the United States and abroad. Debt securities include corporate bonds of companies from diversified industries and U.S Treasuries. Other types of investments include investments in real estate and commodity linked funds that follow several different strategies.

The fair value of the Hospital's pension plan assets at June 30, 2011, by asset category are as follows:

	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Cash	$ 1,679,039	$ -	$ -	$ 1,679,039
Equity securities index funds:				
Emerging Europe region	-	5,739,281	-	5,739,281
International region	-	10,509,301	-	10,509,301
U.S. large-cap	-	15,356,912	-	15,356,912
U.S. mid-cap	-	2,895,701	-	2,895,701
U.S. small cap	-	2,862,196	-	2,862,196
Fixed income securities fund: U.S. government and government agency obligations	2,801,104	-	-	2,801,104
Fixed income securities: Corporate bonds	4,520,533	8,621,917	-	13,142,450
Real estate index fund	676,681	-	-	676,681
Commodity linked funds	4,686,636	-	-	4,686,636
	$ 14,363,993	$ 45,985,308	$ -	$ 60,349,301

Note 8. Employee Benefit Programs (Continued)

The fair value of the Hospital's pension plan assets at June 30, 2010, by asset category are as follows:

	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Cash	$ 2,492,056	$ -	$ -	$ 2,492,056
Equity securities index funds:				
Emerging Europe region	-	4,790,271	-	4,790,271
International region	-	8,040,289	-	8,040,289
U.S. large-cap	-	12,104,207	-	12,104,207
U.S. mid-cap	-	2,075,982	-	2,075,982
U.S. small cap	-	2,078,345	-	2,078,345
Fixed income securities fund: U.S. government and government agency obligations	2,229,219	-	-	2,229,219
Fixed income securities: Corporate bonds	4,213,848	8,306,604	-	12,520,452
Real estate index fund	525,608	-	-	525,608
Commodity linked funds	4,615,025	-	-	4,615,025
	$ 14,075,756	$ 37,395,698	$ -	$ 51,471,454

Effective July 1, 2005, the Hospital established a 401(k) defined contribution retirement plan which is available to all employees after one month of service who work at least 1,040 hours per year and are at least 18 years old. The Hospital currently matches 100 percent of the participant's contribution up to a maximum of 1 percent of the participant's annual compensation, subject to the annual limit as required by the Internal Revenue Code. The Hospital's expense related to this plan for the years ended June 30, 2011 and 2010 was approximately $249,000 and $309,000, respectively.

Note 9. Self-Insurance Program

Since June 1, 1979, the Hospital's primary professional and general liability coverage has been provided through the Chicago Hospital Risk Pooling Program (CHRPP) with 15 other participating hospitals. CHRPP is a self-insured trust that provides coverage, after a nominal deductible, through the use of a fund specific to each participating hospital and two pooled funds, which include all CHRPP participating hospitals. Excess insurance coverage is purchased from a commercial insurance company. Required reserves and contributions by participating hospitals are determined annually by an independent actuary based on claim experience, investment performance and assumed self-insured retentions. The required contributions are subject to future retrospective adjustments. Effective January 1, 2003, CHRPP changed its coverage from occurrence basis to claims-made and the Hospital has established a tail liability related to this change in coverage. Additionally, effective January 1, 2011, the CHRPP program ceased offering coverage for new claims, and is now in run-off mode until all active claims are resolved. As a result, the Hospital is providing medical malpractice coverage through a self-insured trust for calendar year 2011. The Hospital is self-funded for the first $4,000,000 per claim with a $12,000,000 annual aggregate limit. Excess insurance coverage is $10,000,000 for the primary layer, and an additional $10,000,000 secondary level has been purchased with a $20,000,000 aggregate limit per year.

Note 9. Self-Insurance Program (Continued)

Accrued professional and general liability claim losses have been discounted at 4.5 and 5.5 percent for the years ended June 30, 2011 and 2010, respectively and are based on a confidence level of 60%. If accrued professional liability losses had not been discounted, the estimated liability would be approximately $1,293,000 and $1,364,000 higher than the amounts reported in the consolidated balance sheets as of June 30, 2011 and 2010, respectively. The portion of the accrual for estimated professional and general liability claims expected to be paid within one year of the balance sheet dates is not readily determinable, and therefore, the entire accrual balance is classified as a noncurrent liability.

Self-insured professional and general liability expense of approximately $3,524,000 in 2011 and $4,740,000 in 2010 has been included in supplies, utilities and other in the accompanying consolidated statements of operations and changes in net assets. In 2011 and 2010 the Hospital received a premium refund from CHRPP of approximately $193,000 and $542,000, respectively, resulting in a decrease in the self-insurance professional and general liability expense for 2011 and 2010. For the purposes of the incurred but not reported (IBNR) calculation the Hospital assumed potential losses at the level of $3,000,000 for the years ended June 30, 2011 and 2010.

The Hospital has recorded a reserve for incurred but not reported claims at June 30, 2011 and 2010 of $4,607,000 and $3,632,000, respectively, related to its estimated tail liability.

Note 10. Functional Expenses

The Hospital provides general health care services to residents within its geographic location. Expenses related to these services for the years ended June 30, 2011 and 2010 are as follows:

	2011	2010
Health care services	$ 112,914,144	$ 109,545,172
General and administrative	5,770,317	5,575,028
Fundraising	56,737	70,749
	$ 118,741,198	$ 115,190,949

Certain costs have been allocated among health care services and general and administrative.

Note 11. Operating Leases

The Hospital leases certain facilities and equipment under operating leases that expire at various dates through November 2016. The aggregate minimum annual rental commitments under noncancellable operating leases are $52,895 through the year ending June 30, 2016.

Rent expenses incurred on all operating leases totaled approximately $99,000 for both years ended June 30, 2011 and 2010.

Note 12. Commitment and Contingencies

Medicaid Reimbursement: The Hospital's net patient service revenue for the years ended June 30, 2011 and 2010 includes approximately $14,216,000 and $7,300,000, respectively, of high volume adjustments and other add-on and one-time payments from the Illinois Medicaid program. However, subsequent to year-end 2009, the Illinois DSH status of the Hospital was contested by HFS for fiscal year 2009. Accordingly, the Hospital had established a $2,000,000 liability and reduced net patient service revenue by the same amount for fiscal 2009. In 2010, the DSH status of the Hospital was reinstated by HFS retroactive to 2009 and the liability for 2009 of approximately $2,000,000 was reversed and net patient service revenue was increased in 2010.

The amount of additional reimbursement from the Illinois Medicaid program which will be made to hospitals in the future is uncertain, and future legislative changes to reimbursements provided to hospitals could have a material adverse effect on the Hospital's operating results. The Hospital's operations for the years ended June 30, 2011 and 2010, benefited from the Medicaid Hospital Assessment Program (Program) net reimbursement of approximately $7,381,000. The Program expires June 30, 2014 and there is no assurance that it will be continued after its expiration.

CMS RAC Program: Congress passed the Medicare Modernization Act in 2003, which among other things established a demonstration of The Medicare Recovery Audit Contractor (RAC) program. The RAC's identified and corrected a significant amount of improper overpayments to providers. In 2006, Congress passed the Tax Relief and Health Care Act of 2006, which authorized the expansion of the RAC program to all 50 states. CMS rolled out this program in Illinois during the fiscal year ended June 30, 2010. At June 30, 2011 and 2010, the Hospital recorded a liability for estimated amounts that will be repaid under the RAC program based on the Hospital's RAC program experience to date.

Illinois Hospital Uninsured Patient Discount Act: On May 30, 2008, the Illinois legislature passed a bill titled the "Hospital Uninsured Patient Discount Act" (Act). This Act requires hospitals to provide certain mandated discounts from charges to the uninsured in Illinois. Charges are to be discounted to 135 percent of cost. Furthermore, a hospital may not collect more than 25 percent of an uninsured family's gross income in any one year.

Litigation: The Hospital is involved in litigation arising in the normal course of business. In consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the Hospital's financial position or results of operations.

Regulatory Investigation and Contingencies: The U.S. Department of Justice, other federal agencies and the Illinois Department of Public Aid routinely conduct regulatory investigations and compliance audits of health care providers. The Hospital is subject to these regulatory efforts. The Hospital is in the process of settling a self-reported Stark violation related to the period July 1, 2004 through April 30, 2011, related primarily to technical violations of personal services contracts and physician leases. As of June 30, 2011, the Hospital has recorded a reserve related to this voluntary self-disclosure. The range of exposure is unclear, but the Hospital has established a liability based on its best estimate with legal counsel. Management believes that the Hospital is in compliance with fraud and abuse statutes, as well as other applicable government laws and regulations. While no regulatory inquiries have been made that is expected to have a material effect on the Hospital's financial position or results from operations, compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or asserted at this time.

Note 12. Commitment and Contingencies (Continued)

The FASB issued guidance on Accounting for Conditional Asset Retirement Obligations, which clarifies when an entity is required to recognize a liability for a conditional asset retirement obligation. The Hospital has a legal obligation to remove hazardous material from its facilities in the event the facilities are renovated or replaced. Such hazardous materials include asbestos. Since inception of Holy Cross Hospital and throughout its history, management has renovated, replaced, or newly constructed the majority of the physical plant facilities, resulting in only a small portion of the facilities with any remaining hazardous material. Management believes that there is an indeterminate settlement date for the asset retirement obligations because the range of time over which the Hospital may settle the obligation is unknown. However, management does not believe that the estimate of the liability related to these asset retirement activities is a material amount at June 30, 2011 and 2010.

Note 13. Fair Value Disclosures

Fair Value Disclosures

Fair value of financial instruments – The following methods and assumptions were used by the Corporation to estimate the fair value of financial instruments:

The carrying values of cash and cash equivalents, accounts receivable, other receivables, accounts payable, accrued liabilities and estimated third-party payor settlements are reasonable estimates of their fair value due to the short-term nature of these financial instruments.

The fair value of investments in debt and equity securities, which are the amounts reported on the balance sheet, is based on quoted market prices, if available, or estimated using quoted market prices for similar securities. The fair value of investments in certificates of deposit approximates the cost due to the short term nature of the accounts.

The fair value of the long-term debt is estimated based on the quoted market prices for the same or similar issues or on current rates offered to market participants for debt of the same remaining maturities. The fair value of the long-term debt approximates the carrying value.

Fair Value Measurements – Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. In determining fair value, the Hospital uses various methods including market, income and cost approaches. Based on these approaches, the Hospital often utilizes certain assumptions that market participants would use in pricing the asset or liability, including assumptions about risk and or the risks inherent in the inputs to the valuation technique. These inputs can be readily observable, market corroborated, or generally unobservable inputs. The Hospital utilizes valuation techniques that maximize the use of observable inputs and minimize the use of unobservable inputs. Based on the observability of the inputs used in the valuation techniques the Hospital is required to provide the following information according to the fair value hierarchy. The fair value hierarchy ranks the quality and reliability of the information used to determine fair values. Assets and liabilities carried at fair value are classified and disclosed in one of the following three categories:

<u>Level 1</u>: Quoted prices for identical instruments in active markets.

<u>Level 2</u>: Valuations for assets and liabilities traded in less active dealer or broker markets. Valuations are obtained from third party pricing services for identical or similar assets or liabilities.

<u>Level 3</u>: Valuations for assets and liabilities that are derived from other valuation methodologies, including option pricing models, discounted cash flow models and similar techniques, and not based on market exchange, dealer, or broker traded transactions. Level 3 valuations incorporate certain assumptions and projections in determining the fair value assigned to such assets or liabilities.

Note 13. Fair Value Disclosures (Continued)

For the fiscal year ended June 30, 2011, the application of valuation techniques applied to similar assets and liabilities has been consistent. The following is a description of the valuation methodologies used for instruments measured at fair value:

Investment Securities

The fair value of investment securities is the market value based on quoted market prices, when available, or market prices provided by recognized broker dealers. If listed prices or quotes are not available, fair value is based upon externally developed models that use unobservable inputs due to the limited market activity of the instrument.

Fair Value on a Recurring Basis

The table below presents the balances of assets and liabilities measured at fair value on a recurring basis, as of June 30, 2011. There were no such assets or liabilities as of June 30, 2010.

	Level 1	Level 2	Level 3	Total
Money market funds	$ 84,155	$ -	$ -	$ 84,155
Fixed income securities fund:				
U.S. and government obligations	192,073	-	-	192,073
Fixed income securities: corporate bonds	1,541,952	-	-	1,541,952
Marketable equity securities:				
Emerging Europe Region	-	122,925	-	122,925
International Region	-	185,363	-	185,363
United States	-	624,695	-	624,695
Real estate index fund	155,656	-	-	155,656
Commodity linked funds	267,154	-	-	267,154
	$ 2,240,990	$ 932,983	$ -	$ 3,173,973

McGladrey

Independent Auditor's Report on the Supplementary Information

To the Board of Trustees
Holy Cross Hospital
Chicago, Illinois

Our audits were made for the purpose of forming an opinion on the basic consolidated financial statements taken as a whole. The consolidating information is presented for purposes of additional analysis of the basic consolidated financial statements rather than to present the financial position and results of operations of the individual organizations. The consolidating information has been subjected to the auditing procedures applied in the audits of the basic consolidated financial statements and, in our opinion, is fairly stated in all material respects in relation to the basic consolidated financial statements taken as a whole.

McGladrey & Pullen, LLP

Chicago, Illinois
November 22, 2011

Holy Cross Hospital and Affiliate

Consolidating Balance Sheet
June 30, 2011

	Holy Cross Hospital	Holy Cross Health Partners	Eliminations	Consolidated
Assets				
Current Assets				
Cash and cash equivalents	$ 14,312,709	$ 1,160,040	$ -	$ 15,472,749
Assets whose use is limited, externally designated under debt agreements	1,340,445	-	-	1,340,445
Patient accounts receivable, less allowances	10,807,555	-	-	10,807,555
Contribution receivable	104,206	-	-	104,206
Inventory	1,625,775	-	-	1,625,775
Due from affiliates	839,881	-	(839,881)	-
Prepaid expenses and other current assets	531,108	66,729	-	597,837
Total current assets	29,561,679	1,226,769	(839,881)	29,948,567
Assets Whose Use is Limited, net of current portion, externally designated under:				
Self-insurance trust	3,173,973	-	-	3,173,973
Workmen's compensation contracts and other	543,971	-	-	543,971
	3,717,944	-	-	3,717,944
Property and Equipment, net	37,098,824	-	-	37,098,824
Other Assets	100,000	-	-	100,000
Total assets	$ 70,478,447	$ 1,226,769	$ (839,881)	$ 70,865,335

Holy Cross Hospital and Affiliate

Consolidating Balance Sheet
June 30, 2011

	Holy Cross Hospital	Holy Cross Health Partners	Eliminations	Consolidated
Liabilities and Net Assets (Deficit)				
Current Liabilities				
Current portion of long-term debt	$ 1,465,463	$ -	$ -	$ 1,465,463
Accounts payable	5,458,236	879,772	-	6,338,008
Due to affiliate	-	839,881	(839,881)	-
Accrued expenses	5,964,909	328,165	-	6,293,074
Current portion of accrued pension and postretirement benefits	266,000	-	-	266,000
Due to third-party payors	3,910,654	-	-	3,910,654
Total current liabilities	17,065,262	2,047,818	(839,881)	18,273,199
Noncurrent Liabilities				
Long-term debt, less current portion	47,590	-	-	47,590
Accrued pension and postretirement benefits, net of current portion	14,836,940	-	-	14,836,940
Professional liability	4,607,022	-	-	4,607,022
Total noncurrent liabilities	19,491,552	-	-	19,491,552
Total liabilities	36,556,814	2,047,818	(839,881)	37,764,751
Net Assets (Deficit)				
Unrestricted	33,258,171	(821,049)	-	32,437,122
Temporarily restricted	663,462	-	-	663,462
Total net assets (deficit)	33,921,633	(821,049)	-	33,100,584
Total liabilities and net assets (deficit)	$ 70,478,447	$ 1,226,769	$ (839,881)	$ 70,865,335

Holy Cross Hospital and Affiliate

Consolidating Balance Sheet
June 30, 2010

	Holy Cross Hospital	Holy Cross Health Partners	Eliminations	Consolidated
Assets				
Current Assets				
Cash and cash equivalents	$ 22,184,780	$ 930,108	$ -	$ 23,114,888
Assets whose use is limited, externally designated under bond agreements	515,280	-	-	515,280
Patient accounts receivable, less allowances	12,324,545	-	-	12,324,545
Contribution receivable	225,279	-	-	225,279
Inventory	1,582,688	-	-	1,582,688
Due from affiliate	560,001	-	(560,001)	-
Prepaid expenses and other current assets	906,913	123,508	-	1,030,421
Total current assets	38,299,486	1,053,616	(560,001)	38,793,101
Assets Whose Use is Limited, net of current portion, externally designated under:				
Debt agreements	1,312,997	-	-	1,312,997
Workmen's compensation contracts and other	1,029,332	-	-	1,029,332
	2,342,329	-	-	2,342,329
Property and Equipment, net	40,590,453	-	-	40,590,453
Other Assets	1,924	-	-	1,924
Deferred Bond Issuance Costs, net	113,981	-	-	113,981
Total assets	$ 81,348,173	$ 1,053,616	$ (560,001)	$ 81,841,788

Holy Cross Hospital and Affiliate

Consolidating Balance Sheet
June 30, 2010

	Holy Cross Hospital	Holy Cross Health Partners	Eliminations	Consolidated
Liabilities and Net Assets (Deficit)				
Current Liabilities				
Current portion of long-term debt	$ 13,007,095	$ -	$ -	$ 13,007,095
Accounts payable	5,793,700	1,003,754	-	6,797,454
Due to affiliate	-	560,001	(560,001)	-
Accrued expenses	6,925,475	310,910	-	7,236,385
Current portion of accrued pension and postretirement benefits	266,000	-	-	266,000
Due to third-party payors	3,195,298	-	-	3,195,298
Total current liabilities	29,187,568	1,874,665	(560,001)	30,502,232
Noncurrent Liabilities				
Long-term debt, less current portion	1,591,746	-	-	1,591,746
Accrued pension and postretirement benefits, net of current portion	28,434,598	-	-	28,434,598
Professional liability	3,632,000	-	-	3,632,000
Total noncurrent liabilities	33,658,344	-	-	33,658,344
Total liabilities	62,845,912	1,874,665	(560,001)	64,160,576
Net Assets (Deficit)				
Unrestricted	17,285,406	(821,049)	-	16,464,357
Temporarily restricted	1,216,855	-	-	1,216,855
Total net assets (deficit)	18,502,261	(821,049)	-	17,681,212
Total liabilities and net assets (deficit)	$ 81,348,173	$ 1,053,616	$ (560,001)	$ 81,841,788

Holy Cross Hospital and Affiliate

Consolidating Schedule of Operations
Year Ended June 30, 2011

	Holy Cross Hospital	Holy Cross Health Partners	Eliminations	Consolidated
Revenue:				
Net patient service revenue	$ 94,570,394	$ -	$ -	$ 94,570,394
Capitation revenue	778,380	3,572,692	-	4,351,072
Investment income	2,002	-	-	2,002
Other revenue	1,926,799	-	(300,000)	1,626,799
Medicaid stimulus revenue	6,394,752	-	-	6,394,752
Medicaid hospital assessment revenue	12,889,822	-	-	12,889,822
Net assets released from restrictions - used for operations	614,768	-	-	614,768
	117,176,917	3,572,692	(300,000)	120,449,609
Expenses:				
Salaries and employee benefits	55,556,349	-	-	55,556,349
Professional fees	7,141,463	2,182,126	-	9,323,589
Food, drugs and medical supplies	12,717,422	-	-	12,717,422
Supplies, utilities and other	18,902,668	1,395,992	(300,000)	19,998,660
Medicaid hospital assessment tax	5,509,292	-	-	5,509,292
Provision for uncollectible accounts	9,860,018	-	-	9,860,018
Depreciation and amortization	5,560,363	-	-	5,560,363
Interest	215,505	-	-	215,505
	115,463,080	3,578,118	(300,000)	118,741,198
Income (loss) from operations	1,713,837	(5,426)	-	1,708,411
Nonoperating income (expense):				
Investment income	168,180	5,426	-	173,606
Unrealized loss on investments	(26,027)	-	-	(26,027)
Total nonoperating income (expense), net	142,153	5,426	-	147,579
Excess of revenue over expenses	$ 1,855,990	$ -	$ -	$ 1,855,990

Holy Cross Hospital and Affiliate

Consolidating Schedule of Operations
Year Ended June 30, 2010

	Holy Cross Hospital	Holy Cross Health Partners	Eliminations	Consolidated
Revenue:				
Net patient service revenue	$ 95,305,459	$ -	$ -	$ 95,305,459
Capitation revenue	966,228	3,912,994	-	4,879,222
Investment income	5,125	-	-	5,125
Other revenue	2,585,182	-	(300,000)	2,285,182
Medicaid hospital assessment revenue	12,889,822	-	-	12,889,822
Net assets released from restrictions - used for operations	309,620	-	-	309,620
	112,061,436	3,912,994	(300,000)	115,674,430
Expenses:				
Salaries and employee benefits	52,492,687	-	-	52,492,687
Professional fees	7,012,171	2,479,729	-	9,491,900
Food, drugs and medical supplies	13,231,897	-	-	13,231,897
Supplies, utilities and other	19,038,415	1,439,915	(300,000)	20,178,330
Medicaid hospital assessment tax	5,509,291	-	-	5,509,291
Provision for uncollectible accounts	8,017,814	-	-	8,017,814
Depreciation and amortization	5,850,997	-	-	5,850,997
Interest	418,033	-	-	418,033
	111,571,305	3,919,644	(300,000)	115,190,949
Income (loss) from operations	490,131	(6,650)	-	483,481
Nonoperating income:				
Investment income	155,352	6,650	-	162,002
Total nonoperating income, net	155,352	6,650	-	162,002
Excess of revenue over expenses	$ 645,483	$ -	$ -	$ 645,483

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Sinai Health System and Affiliates

Consolidated Financial Report
June 30, 2011

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McGladrey

Independent Auditor's Report

To the Board of Directors
Sinai Health System
Chicago, Illinois

We have audited the accompanying consolidated balance sheets of Sinai Health System and Affiliates (the Corporation) as of June 30, 2011 and 2010, and the related consolidated statements of operations and changes in net assets and of cash flows for the years then ended. These financial statements are the responsibility of the Corporation's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Sinai Health System and Affiliates as of June 30, 2011 and 2010, and the results of their operations and changes in net assets, and their cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

McGladrey & Pullen, LLP

Chicago, Illinois
December 12, 2011

Sinai Health System and Affiliates

Consolidated Balance Sheets
June 30, 2011 and 2010
(Dollars in Thousands)

	2011	2010
Assets		
Current Assets		
Cash and cash equivalents	$ 10,758	$ 9,154
Assets limited as to use		
Externally designated investments	4,197	4,019
Internally designated investments under self-insurance program	3	250
Patient accounts receivable, less allowances of $36,306 in 2011 and $45,885 in 2010	53,076	49,416
Notes receivable, current portion	8,525	13,457
Other accounts receivable	7,069	8,827
Prepaid expenses, inventories, and other	6,336	8,116
Total current assets	89,964	93,239
Assets Limited as to Use, net of amounts required to meet current liabilities		
Internally designated investments for capital program	15,640	9,116
Externally designated investments under debt agreements	14,057	13,210
Total assets limited as to use	29,697	22,326
Other Assets		
Deferred bond issuance costs, less amortization of $658 in 2011 and $543 in 2010	2,322	2,438
Notes receivable, long-term portion	9,494	5,471
Other investments	169	2,905
Other	9,365	6,717
Total other assets	21,350	17,531
Property and Equipment, net	114,881	112,584
Total assets	$ 255,892	$ 245,680

See Notes to Consolidated Financial Statements.

Sinai Health System and Affiliates

Consolidated Balance Sheets (continued)
June 30, 2011 and 2010
(Dollars in Thousands)

	2011	2010
Liabilities and Net Assets		
Current Liabilities		
Accounts payable and accrued expenses	$ **49,034**	$ 36,702
Accrued salaries and employee benefits	**21,941**	22,503
Amounts due to third-party payors	**4,880**	6,203
Self-insurance claims payable	**2,003**	3,316
Notes payable	**2,889**	5,648
Current maturities of long-term debt	**4,159**	4,316
Other current liabilities	**7,804**	9,465
Total current liabilities	**92,710**	88,153
Noncurrent Liabilities		
Long-term debt, less current maturities	**100,011**	100,622
Self-insurance claims payable, less current portion	**46,134**	44,479
Other	**4,414**	4,050
Total liabilities	**243,269**	237,304
Commitments and Contingencies (Notes 10, 14 and 16)		
Net Assets		
Noncontrolling interest in subsidiary	**123**	22
Unrestricted	**4,051**	3,500
Temporarily restricted	**8,449**	4,779
Permanently restricted	**-**	75
	12,623	8,376
Total liabilities and net assets	$ **255,892**	$ 245,680

Sinai Health System and Affiliates

Consolidated Statements of Operations and Changes in Net Assets
Years Ended June 30, 2011 and 2010
(Dollars in Thousands)

	2011	2010
Unrestricted revenue and other support:		
Net patient service revenue	$ 376,003	$ 373,716
Other revenue	13,870	15,722
Investment income	653	532
Contributions from the Jewish Federation of Metropolitan Chicago	685	854
Grant revenue	17,195	14,230
Net assets released from restrictions	686	827
Total unrestricted revenue and other support	409,092	405,881
Expenses:		
Salaries and wages	209,064	203,387
Supplies and purchased services	77,795	70,178
Depreciation and amortization	12,736	12,796
Provision for bad debts	50,623	57,860
Insurance	9,323	11,860
Interest	5,587	5,788
Provider tax	17,081	17,081
Other	26,254	25,946
Total expenses	408,463	404,896
Income from operations	629	985
Nonoperating (losses) gains:		
Contributions	35	33
Investment income	2,038	1,125
Net change in unrealized gains and losses on investments	(221)	290
Contributions to other organizations	(2,000)	(1,851)
Other	21	22
Net income attributable to noncontrolling interest	(104)	(34)
Total nonoperating (losses) gains	(231)	(415)
Revenue in excess of expenses	$ 398	$ 570

See Notes to Consolidated Financial Statements.

Sinai Health System and Affiliates

Consolidated Statements of Operations and Changes in Net Assets (Continued)
Years Ended June 30, 2011 and 2010
(Dollars in Thousands)

	2011	2010
Unrestricted net assets:		
Revenue in excess of expenses	$ 398	$ 570
Other increases in unrestricted net assets	188	327
Net assets released from restriction used for capital purposes	66	156
Increase in unrestricted net assets	652	1,053
Temporarily restricted net assets:		
Contributions	4,573	2,468
Net assets released from restriction used in operations	(611)	(827)
Net assets released from restriction used for capital purposes	(66)	(156)
Other changes in temporarily restricted net assets	(226)	-
Increase in temporarily restricted net assets	3,670	1,485
Permanently restricted net assets:		
Net assets released from restriction used in operations	(75)	-
Decrease in permanently restricted net assets	(75)	-
Increase in net assets	4,247	2,538
Net assets, beginning of year	8,376	5,838
Net assets, end of year	$ 12,623	$ 8,376

Sinai Health System and Affiliates

Consolidated Statements of Cash Flows
Years Ended June 30, 2011 and 2010
(Dollars in Thousands)

	2011	2010
Cash Flows from Operating Activities		
Increase in net assets	$ 4,247	$ 2,538
Change attributable to noncontrolling interest	(101)	(22)
Increase in net assets after change attributable to noncontrolling interest	4,146	2,516
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	12,852	12,920
Provision for self-insurance in excess of (less than) amounts paid	342	(862)
Restricted contributions	(4,573)	(2,468)
Provision for bad debts	50,623	57,860
Changes in operating assets and liabilities:		
Patient accounts receivable, net	(54,283)	(59,195)
Investments	(4,566)	(1,457)
Amounts due to third-party payors, net	(1,323)	1,798
Prepaid expenses, inventories, and other current assets	3,538	(1,279)
Accounts payable, accrued expenses, and other current liabilities	10,109	5,726
Other noncurrent assets and liabilities	(2,183)	(1,406)
Net cash provided by operating activities	14,682	14,153
Cash Flows from Investing Activities		
Purchases of buildings and equipment	(15,033)	(13,264)
Increase (decrease) in notes receivable	909	(1,748)
Net cash used in investing activities	(14,124)	(15,012)
Cash Flows from Financing Activities		
(Repayments) proceeds of notes payable and long-term debt	(3,527)	300
Proceeds from restricted contributions	4,573	2,468
Net cash provided by financing activities	1,046	2,768
Increase in cash and cash equivalents	1,604	1,909
Cash and cash equivalents:		
Beginning of year	9,154	7,245
End of year	$ 10,758	$ 9,154
Supplemental Disclosure of Cash Flow Information		
Cash payments for interest	$ 5,656	$ 5,857

See Notes to Consolidated Financial Statements.

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Note 1. Organization and Summary of Significant Accounting Policies

Organization and basis of consolidation: The consolidated financial statements include the accounts and transactions of Sinai Health System (the Corporation) and its affiliates. The Corporation is the sole corporate member of its affiliates. All significant intercompany transactions and balances have been eliminated in consolidation. The Corporation and its affiliates provide comprehensive health care services to residents of the Chicago metropolitan area.

Affiliates of the Corporation include:

- Mount Sinai Hospital Medical Center of Chicago and Subsidiaries (Mount Sinai) – Mount Sinai is a licensed 431-bed teaching, research, and tertiary-care facility that offers medical, surgical, behavioral health, therapeutic, and diagnostic services to meet the needs of the community and patients of the southwest side of Chicago. Subsidiaries of Mount Sinai include Sinai Community Pharmacy and Sinai Touhy Pharmacy which are wholly owned, and Hawthorne Works Medical Imaging, LLC which is a joint venture in which Mount Sinai has a controlling 51 percent ownership interest.
- Schwab Rehabilitation Hospital & Care Network (Schwab) – Schwab is a licensed 125-bed rehabilitation hospital that offers comprehensive inpatient and outpatient rehabilitation services for adults and children.
- Mount Sinai Community Foundation (SCF) – SCF is a physician group with over 200 physician specialists in more than 36 specialties, such as cardiology, gastroenterology, neurology, oncology, endocrinology, urology, and neurosurgery. SCF's physicians practice at clinics throughout the communities the Corporation serves, as well as at Schwab Rehabilitation Hospital and Mount Sinai.
- Sinai Community Institute (SCI) – SCI is an organization that develops community-based health and social service programs designed to help families within the community improve their health and well-being through education, employment, wellness and nutrition.

A summary of significant accounting policies is as follows:

Use of estimates: The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. These estimates and assumptions also affect the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates. Significant estimates in the accompanying consolidated financial statements include contractual allowance reserves, allowances for uncollectible accounts and charity care, depreciation and amortization, amounts due to third-party payors, and self insurance claims payable.

Cash and cash equivalents: Cash and cash equivalents include highly liquid short-term investments with maturities of three months or less at the date of acquisition. The carrying value of cash equivalents approximates fair value. Throughout the year, the Corporation may have amounts on deposit with financial institutions in excess of those insured by the FDIC. The Corporation has not experienced any losses in such accounts and believes it is not exposed to any significant credit risk.

Patient accounts receivable: Patient accounts receivable are stated at net realizable value. The Corporation maintains allowances for uncollectible accounts for estimated losses resulting from a payor's inability to make payment on accounts. The Corporation estimates the allowance for uncollectible accounts based upon management's assessment of historical and expected net collections considering historical business and economic conditions, trends in health care coverage, and other collection indicators. Management assesses the adequacy of the allowance for uncollectible accounts based upon historical write-off experience. After satisfaction of amounts due from insurance, the Corporation follows established guidelines for placing certain past-due balances with collection agencies, subject to the terms of certain restrictions on collection efforts as determined by the Corporation.

Note 1. Organization and Summary of Significant Accounting Policies (Continued)

Inventories: Inventories are stated at the lower of cost, on the first-in, first-out method, or market.

Assets limited as to use and investments: Assets limited as to use consist of investments set aside by the Board of Directors for future capital improvements and for endowment funds, over which the Board of Directors retains control and may, at its discretion, subsequently use for other purposes. Additionally, assets limited as to use include investments held by trustees under debt agreements, self-insurance and employee benefit trust arrangements.

Investments are carried at fair value and all investments in debt securities are reported at fair value based on quoted market prices. The Corporation has designated its investment portfolio as trading, with unrealized gains and losses and investment income, which includes realized gains and losses, included in revenue in excess of expenses unless the income or loss is restricted by donor intent.

Property and equipment: Property and equipment are stated at cost and depreciated over the estimated useful lives of the assets ranging from 3 to 40 years using the straight-line method. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Such amortization is included in depreciation expense in the accompanying consolidated financial statements. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the costs of acquiring those assets. No interest was capitalized during the years ended June 30, 2011 and 2010.

Asset impairment: The Corporation considers whether indicators of impairment are present and performs the necessary tests to determine if the carrying value of an asset is appropriate. Impairment write-downs are recognized in operating income at the time the impairment is identified. No impairments were identified during the years ended June 30, 2011 and 2010.

Deferred bond issuance costs: Bond issuance costs are deferred and amortized over the life of the related debt, using a method which approximates the effective interest method.

Self-insurance liabilities: The Corporation's accruals for self-insurance represent the present value of the estimated liability for asserted and unasserted professional malpractice and patient general liability claims. The provision is actuarially determined.

Fair value measurement: The Corporation adopted the provisions of the FASB's guidance related to the nonfinancial assets and nonfinancial liabilities effective July 1, 2009. The adoption of this guidance did not have a material impact on the consolidated financial statements or results of operations of the Corporation.

Noncontrolling interest: Effective July 1, 2010, the Corporation adopted the new measurement and presentation requirements for noncontrolling interests in the consolidated financial statements. As a result of this adoption, the Corporation reclassified its minority interest in joint ventures to noncontrolling interests, included in net assets for the years ended June 30, 2011 and 2010.

Noncontrolling interest represents the portion of net assets in the subsidiaries not attributable, directly or indirectly, to Mount Sinai. The profit or loss derived from the performance of the subsidiary is allocated to the excess of revenue over expenses attributable to the noncontrolling interest in the consolidated statements of operations and changes in net assets.

Note 1. Organization and Summary of Significant Accounting Policies (Continued)

Net assets: Resources are classified for reporting purposes into three net asset categories as unrestricted, temporarily restricted, and permanently restricted according to the absence or existence of donor-imposed restrictions. Temporarily restricted net assets are those assets, including contributions and accumulated investment returns, whose use has been limited by donors for a specific purpose or time period. Permanently restricted net assets are those for which donors require the principal of the gifts to be maintained in perpetuity and provide a permanent source of income.

Net patient service revenue: The Corporation has agreements with various third-party payors that provide for payments to the Corporation at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, discounted charges, per diem rates, and fee schedules. Net patient service revenue is reported at the estimated net amounts received or due from patients, third-party payors, and others for services rendered. These amounts include estimated adjustments under certain reimbursement agreements with third-party payors, which are subject to audit by the applicable administering agency. These adjustments are accrued on an estimated basis and are adjusted in future periods as final settlements are determined.

Contributions: Contributions are reported as either temporarily or permanently restricted net assets if the contributions are received with donor stipulations. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the accompanying consolidated statements of operations and changes in net assets as net assets released from restriction.

Unconditional promises to give cash or other assets are reported as pledges receivable and contributions at fair value at the date the promise is received, within the appropriate net asset class. At June 30, 2011 and 2010, pledges receivable were discounted at 3.0 percent. There was no allowance for uncollectible pledges at June 30, 2011 or 2010.

Grant revenue: Grants are recognized as revenue when earned. Expense driven grants are recognized as revenue when the qualifying expenses have been incurred and all other grant requirements have been met.

Charity care: The Corporation provides care to all patients regardless of their ability to pay. Charity care provided by the Corporation is included with no realizable value in net patient service revenue by recording the revenue at gross charges and then a charity care write-off is recorded which offsets the recorded revenue. The amount of charges forgone for charity based on established rates was $80,833 and $70,606 during the years ended June 30, 2011 and 2010, respectively.

Operating indicator: The Corporation's income from operations includes all unrestricted revenue, including investment income on trustee-held investments, other support, and expenses for the reporting period. Nonoperating income includes nonoperating gains and losses, contributions, investment income on board-designated and other investments, contributions to related parties, and other nonoperating activities, which management views as outside of normal patient care related activities.

Revenue in excess of expenses: The consolidated statements of operations and changes in net assets include revenue in excess of expenses. Changes in unrestricted net assets, which are excluded from revenue in excess of expenses consistent with industry practice, include contributions of long-lived assets, including assets acquired using contributions, which by donor restriction were to be used for the purpose of acquiring such assets.

Reclassifications: Certain amounts in the 2010 consolidated financial statements have been reclassified to conform with the 2011 presentation with no effect on net assets.

Note 1. Organization and Summary of Significant Accounting Policies (Continued)

Income taxes: The Corporation, Mount Sinai, Schwab, SCF, and SCI are tax-exempt organizations under Internal Revenue Code Section 501(c)(3) and each as required files a Form 990 (Return of Organization Exempt from Income Tax) annually.

The Corporation adopted FASB issued guidance for uncertainty in income taxes. This guidance prescribes a recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken or expected to be taken in a tax return. Examples of tax positions common to health systems include such matters as the following: the tax-exempt status of each entity, the nature, characterization and taxability of joint venture income and various positions relative to potential sources of unrelated business taxable income (UBIT). UBIT is reported on Form 990T, as appropriate. The benefit of a tax position is recognized in the consolidated financial statements in the period during which, based on all available evidence, management believes that it is more likely than not that the position will be sustained upon examination, including the resolution of appeals or litigation processes, if any.

Tax positions are not offset or aggregated with other positions. Tax positions that meet the "more likely than not" recognition threshold are measured as the largest amount of tax benefit that is more than 50 percent likely to be realized on settlement with the applicable taxing authority. The portion of the benefits associated with tax positions taken that exceeds the amount measured as described above is reflected as a liability for unrecognized tax benefits in the consolidated balance sheet along with any associated interest and penalties that would be payable to the taxing authorities upon examination. As of June 30, 2011 and 2010, there were no unrecognized tax benefits identified and recorded.

Forms 990 filed by the Corporation, Mount Sinai, Schwab, SCF, and SCI are subject to examination by the Internal Revenue Service (IRS) for up to three years from the extended due date of each return. Forms 990 filed by the Corporation, Mount Sinai, Schwab, SCF, and SCI are no longer subject to examination for the years 2007 and prior.

Subsequent events: The Corporation has evaluated subsequent events for potential recognition and/or disclosures through December 12, 2011, the date the consolidated financial statements were issued.

Recent accounting pronouncements: In September 2009, the FASB issued Accounting Standards Update 2009-12, Fair Value Measurements and Disclosures (Topic 820) - Investments in Certain Entities That Calculate Net Asset Value per Share (or Its Equivalent), which, among other things, provides new guidance on valuing and classifying these investments within the fair value hierarchy. As a practical expedient, the Corporation may now measure these investments on the basis of the net asset value per share of the investment (or its equivalent) if it is calculated in a manner consistent within the fair value measurement standards of Accounting Standards Codification (ASC) 820, Fair Value Measurements and Disclosures. The adoption of this guidance effective June 30, 2010, did not have a material impact on the Corporation's consolidated financial statements.

Note 2. Financial Condition

The Corporation generated income from operations totaling $629 and $985 for the years ended June 30, 2011 and 2010, respectively. The financial viability of the Corporation is largely dependent on the financial viability of its affiliates, Mount Sinai and Schwab. For the years ended June 30, 2011 and 2010, Mount Sinai's loss from operations totaled $1,845 and $1,431, respectively. For the years ended June 30, 2011 and 2010, Schwab's income from operations totaled $2,474 and $2,416, respectively.

In both fiscal 2011 and 2010, the Corporation's income from operations was impacted by enhanced net patient service revenue. For the years ended June 30, 2011 and 2010, Mount Sinai and Schwab, combined, received additional State of Illinois Department of Public Aid (IDPA) revenue of $40,431. These increases in revenue were partially offset by $17,081 in hospital provider tax assessments for both fiscal 2011 and 2010, and by increases in uncompensated care. This program was renewed and extended for one more year through June 30, 2014. See Note 5 for further information.

The Corporation continues to be pressured by rising costs attributable to clinical labor (including physician, nursing, and certain ancillary staff), new technology, and higher uncompensated care. Additionally, the Corporation and its major affiliate, Mount Sinai, continue to be highly dependent on reimbursement from IDPA. Any future decline in reimbursement, continued significant cost increases, or continued growth in uncompensated care may require management and the Board of Directors to further realign or reduce services to the community.

Note 3. Asset Retirement Obligations

In accordance with FASB issued guidance on, *Accounting for Conditional Asset Retirement Obligations*, the Corporation records all known asset retirement obligations for which the liability's fair value can be reasonably estimated, including certain asbestos removal costs. At June 30, 2011 and 2010, the Corporation had remaining asset retirement obligations of $2,941 and $2,782, respectively, which are recorded as other long-term liabilities in the consolidated balance sheets. The liability was estimated using an inflation rate of 3.44 percent and a discount rate of 6 percent. The asset retirement obligation will continue to accrete until 2016 at which time the Corporation expects to remediate the situation. The liability in 2016 will be approximately $3,433.

Note 4. Contractual Arrangements with Third-Party Payors

The Corporation provides care to certain patients under payment arrangements with Medicare, Medicaid, Blue Cross, and various managed care programs. At Mount Sinai, the Medicare program pays for inpatient, capital costs, and outpatient services at predetermined rates. Medical education costs are reimbursed at interim rates with annual settlements based on reimbursable costs. At Schwab, the Medicare program reimburses both inpatient and outpatient services, including capital costs, at predetermined rates. Medical education costs are reimbursed at interim rates with annual settlements based on reimbursable costs. The Medicaid program pays the Corporation for covered services at predetermined rates. Services provided to inpatients covered by the Blue Cross program are paid at interim rates with monthly settlements based upon predetermined rates. Reported costs and services provided under the reimbursement arrangements with Medicare, Medicaid, and Blue Cross are subject to audit or review by the administering agencies. Changes in the Medicare and Medicaid programs and reduction in funding levels could have an adverse effect on the Corporation.

Note 4. Contractual Agreements with Third-Party Payors (Continued)

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The Corporation believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action, including fines, penalties, and exclusion from the Medicare and Medicaid programs.

The Corporation also has contractual arrangements with various Health Maintenance and Preferred Provider Organizations, the terms of which call for the Corporation to be paid for covered services at negotiated rates.

Provisions have been made in the consolidated financial statements for contractual adjustments, representing the difference between the Corporation's standard charges for services and estimated payments received from payors. Net patient service revenue received under the Medicare and Medicaid reimbursement arrangements with Mount Sinai and Schwab amounted to approximately $244,528 and $232,159 (excluding the hospital tax assessment program revenue discussed in Note 5) in the years ended June 30, 2011 and 2010, respectively. Revenue received under HMO/PPO arrangements amounted to approximately $45,515 and $49,846 in the years ended June 30, 2011 and 2010, respectively. Net patient service revenue increased by $224 in 2011 and $1,302 in 2010, respectively, as a result of third-party settlements and changes in estimates related to prior years.

The Corporation grants credit without collateral to its patients, most of whom are local residents and are insured under third-party arrangements. Medicaid accounts receivable account for 56 percent and 53 percent of the Corporation's net accounts receivable at June 30, 2011 and 2010, respectively. Medicare accounts receivable account for 15 percent of the Corporation's net accounts receivable at June 30, 2011 and 2010.

Note 5. Illinois Provider Tax Assessment Program

The Corporation is part of the State of Illinois hospital tax assessment program which is administered by the Illinois Department of Public Aid. The laws and regulations authorizing this Program have been revised and extended for the period July 1, 2008 to June 30, 2014. There is no assurance of the continuation of this program after June 30, 2014. Under this renewed program, the Corporation is to receive annually approximately $40,431 from the State and pay annually a provider tax assessment approximating $17,081. For the years ended June 30, 2011 and 2010, the Corporation has recorded $40,431, in assessment revenue (reported as net patient service revenue) and $17,081, in provider tax expense (reported in other operating expenses). In the past, the State of Illinois has significantly delayed certain payments related to this program as well as collection of the related assessment tax. The payment methodology has switched from annual to monthly payments, and as of June 30, 2011, the State of Illinois has been current in payments and collections related to this program. Although future payments cannot be assured, management believes that the assessment program's obligations will be fulfilled in the next year.

Note 6. Assets Limited as to Use and Investments

Assets limited as to use and investments consist of the following at June 30:

	Fair Value 2011	Fair Value 2010
Investment agreements	$ 6,816	$ 6,819
Cash equivalents - money market funds and mutual funds	1,177	1,231
United States Treasury securities	12,783	9,986
Federation pooled funds	11,191	9,562
Mutual funds invested in equity securities	1,814	1,754
Equities	285	148
	$ 34,066	$ 29,500

Total investment return for the years ended June 30 is as follows:

	2011	2010
Interest and dividend income	$ 2,691	$ 1,657
Net change in unrealized gains and losses on investments	(221)	290
	$ 2,470	$ 1,947
Reported as:		
Operating revenue	$ 653	$ 532
Nonoperating gains	1,817	1,415
	$ 2,470	$ 1,947

Note 7. Property and Equipment

Property and equipment consist of the following at June 30:

	2011	2010
Land and land improvements	$ 6,325	$ 5,576
Building and improvements	180,112	176,733
Equipment	108,010	96,929
Construction in progress	1,785	2,390
	296,232	281,628
Less accumulated depreciation and amortization	(181,351)	(169,044)
	$ 114,881	$ 112,584

Note 8. Long-Term Debt

Long-term debt consists of the following at June 30:

	2011	2010
Illinois Finance Authority Revenue Bonds, Series 2006, 4.80%, fixed rate, these were paid in full in May 2011	$ -	$ 970
Illinois Health Facilities Authority FHA Insured Mortgage Revenue Refunding Bonds, Series 2003, 1.37% to 5.15%, payable in semiannual installments with maturities through 2037	86,840	88,495
Northern Trust Company, term loan, variable rate (0.628% at June 30, 2011) maturing July 2011 subsequently renewed to August 2012	5,684	5,684
Illinois Development Finance Authority Revenue Bonds Series 1997, variable rate (0.20% and 0.36% at June 30, 2011 and 2010, respectively) maturing March 1, 2022	5,000	5,000
Capital lease obligations	6,430	4,572
Other	216	217
	104,170	104,938
Less current maturities	(4,159)	(4,316)
	$ 100,011	$ 100,622

In April 2006, the Illinois Finance Authority issued $7,300 in Illinois Finance Revenue Bonds (Mount Sinai Hospital Medical Center of Chicago), Series 2006. The bonds were issued under the Illinois Finance Authority Act and under and pursuant to a Master Financing Agreement between Mount Sinai Hospital Medical Center of Chicago and GE Capital Public Finance, Inc. They were issued for the purpose of making a loan to Mount Sinai to finance and refinance the costs of acquiring and equipping certain of the health facilities of Mount Sinai. These bonds were paid in full in May 2011.

In December 2003, the Illinois Health Facilities Authority, on behalf of the Corporation, issued $97,505 in Illinois Health Facilities Authority Federal Housing Authority (FHA) Insured Mortgage Revenue Refunding Bonds, Series 2003 (Series 2003 Bonds). The proceeds from the sale of the Series 2003 Bonds were used to pay certain expenses incurred in connection with the issuance of the Series 2003 Bonds, to refund the outstanding principal amount of other bonds, and to add the debt service reserve fund for the benefit of the Series 2003 Bond closing.

Under the terms of a master trust indenture, the Corporation, Mount Sinai, and Schwab form the Obligated Group, $6,640 and $6,650 are held on deposit with a trustee for bond redemption and interest payments at June 30, 2011 and 2010, respectively. Additionally, hospitals insured by the U.S. Department of Housing and Urban Development (HUD) under Section 242 of the National Housing Act are required to fund a Mortgage Reserve Fund. Mount Sinai and Schwab make quarterly deposits to the fund. At June 30, 2011 and 2010, the fund had a balance of $7,417 and $6,560, respectively.

Substantially all of the assets of the Corporation secure the outstanding bonds. The terms of the agreements require quarterly financial reporting measures, as well as audited financial statements to be received by a certain number of days after year-end.

Note 8. Long-Term Debt (Continued)

The agreement requires that an insurance certificate be obtained evidencing that the liability insurance is fully funded. As of June 30, 2011, this insurance certificate was not obtained as the liability insurance is not fully funded. The Corporation worked with HUD and the bond trustees to address the self-insurance trust deficiency and instituted a corrective action plan. The Corporation was not in compliance with this requirement but has obtained notification from the bond trustees that the cure period has been extended indefinitely and that no event of default has occurred so long as the cure period is in effect.

In July 2008, Mount Sinai and SCF's outstanding portion of the Series 2002 bonds were placed in a term loan with the Northern Trust Company in a principal amount of $5,915. This note was reduced to $5,684 in 2010. Under the terms of the agreement, interest is payable monthly, at a rate based on a 30-day LIBOR (0.628 percent at June 30, 2011) plus 100 basis points. The loan matures on August 12, 2012, unless extended. The loan is guaranteed by the Jewish Federation of Metropolitan Chicago (Federation). There are no funds held on deposit with a trustee for the years ended June 30, 2011 and 2010.

During 1997, SCI issued $5,000 in bonds through the Illinois Development Finance Authority. The bonds are guaranteed by the Federation.

Future maturities of long-term debt are as follows:

Year ending June 30:	
2012	$ 4,159
2013	9,356
2014	3,228
2015	2,558
2016	2,179
Thereafter	82,690
	$ 104,170

At June 2011 and 2010, the Corporation had outstanding irrevocable letters of credit, other than the letters of credit related to the Series 1997 and Series 2002 debt disclosed above, totaling $3,434 and $3,004, respectively. No amounts were outstanding under the letters of credit at June 30, 2011 and 2010.

Capital lease obligations relate to certain equipment which Mount Sinai leases under various lease agreements that expire through 2015. The net carrying value of this equipment was $2,060 and $4,433 at June 30, 2011 and 2010, respectively. The Corporation has capital lease obligations outstanding of $6,430 and $4,572 at June 30, 2011 and 2010, respectively.

Future minimum payments under capital lease obligations with initial or remaining terms of one year or more consist of the following at June 30, 2011:

2012	$ 2,701
2013	2,030
2014	1,429
2015	622
2016	140
Total future minimum lease payments	6,922
Less amount representing interest	(492)
Present value of future minimum lease payments	$ 6,430

Note 9. Notes Payable

Mount Sinai has a revolving credit agreement, which allows it to borrow principal amounts up to $4,000, effective until February 28, 2012. Interest on amounts borrowed is at adjusted LIBOR rates (1.67 percent at June 30, 2011); adjusted LIBOR rate is annual LIBOR divided by reserve percentage (reserves to be maintained by member banks of the Federal Reserve System for Eurocurrency liabilities). Mount Sinai had $2,200 and $4,000 outstanding under the credit agreement at June 30, 2011 and 2010, respectively.

During November 2002, Mount Sinai secured a note payable with the Federation that bears interest at the U.S. Treasury rate plus 1 percent. At June 30, 2011 and 2010, $364 and $1,023 was outstanding under this agreement, respectively. The note matures in January 2012.

During May 2001, SCF issued a promissory note to a bank totaling $3,025. The note bears interest at adjusted LIBOR rates. SCF's net patient accounts receivable are pledged as collateral under the note. SCF had outstanding balances under the note of $325 and $625 at June 30, 2011 and 2010, respectively. The note matures in February 2012.

Note 10. Insurance

Effective June 1, 1976, Mount Sinai, and effective July 1, 1985, Schwab, became self-insured for professional malpractice and patient general liability claims and for the costs of claims administration and defense. Effective November 1, 2003, the Corporation does not maintain a commercial excess insurance policy. The Corporation has retained all risk for claims occurring subsequent to this date. The liability for self-insured risks is based on a report of consulting actuaries that is updated annually to reflect the Corporation's actual experience. Obligations for self-insured liabilities were approximately $41,300 and $40,400 as of June 30, 2011 and 2010, respectively. The provision is actuarially determined. The undiscounted amount of these claims was $48,377 and $48,502 at June 30, 2011 and 2010, respectively. The interest rate used to discount these claims was 5.25 and 5.75 percent at June 30, 2011 and 2010, respectively. The claims that are expected to be paid within 12 months are classified as current liabilities in the accompanying consolidated financial statements. Claims expected to be paid after 12 months are classified as noncurrent.

SCF has purchased professional malpractice insurance for employed physicians on a claims-made basis with annual limits of $1,000 per occurrence and $3,000 in the aggregate, per physician. The policy term extends through June 30, 2012.

SCF management is not aware of any factors that would cause insurance expense to vary materially from the amounts provided. Should the claims-made policy not be renewed or replaced with equivalent insurance, claims based on occurrences during the policy's term, but reported subsequently, may not be insured. Estimated provisions for incurred but not reported claim expenses have been provided for based on SCF's historical claims experience and amounted to approximately $6,800 at June 30, 2011 and 2010. The undiscounted amount of these claims was $7,803 and $7,961 at June 30, 2011 and 2010, respectively. The interest rate used to discount these claims was 5.25 and 5.75 percent at June 30, 2011 and 2010, respectively.

Note 11. Employee Benefit Plans

The Corporation participates in a multi-employer defined-contribution plan covering substantially all full-time employees who have completed one year of service. Matching contributions are based on each participant's contribution. Contributions are based on each participant's salary level. Retirement benefits are funded as accrued through Metropolitan Life Insurance Company (MetLife). A retirement plan for union employees of Mount Sinai Hospital covered by a collective bargaining agreement negotiated with Local 73 SEIUO-HC is also in place.

Schwab has two defined-contribution (money purchase) plans covering substantially all of its full-time employees who have at least two years of continuous service. Contributions are based on each participant's, income level. Insurance annuity contracts are purchased for individuals who retire. Schwab funds the plans costs as accrued.

The Corporation recorded expense of $1,892 and $1,677 for the years ended June 30, 2011 and 2010, respectively, related to these plans.

In addition, SCF has a nonqualified deferred compensation plan as the primary vehicle for a physician retirement savings plan. Participation in the plan is voluntary and is open to all eligible physicians. Plan investments are held by a trustee and are the property of SCF until the funds are withdrawn by a participant. The consolidated balance sheets include plan investments of $990 and $806 at June 30, 2011 and 2010, respectively, reflected as other noncurrent assets. The corresponding obligations of $990 and $806 are reflected as other noncurrent liabilities at June 30, 2011 and 2010, respectively. The plan is funded by the participants.

Note 12. Notes Receivable and Transactions With Other Organizations

Access Community Health Network (Access) is a private community health center organization formerly affiliated with the Corporation. Access and the Corporation collaborate to provide health care services and improve the health of citizens living in the metropolitan Chicago area serviced by the Corporation and Access.

During the years ended June 30, 2011 and 2010, the Corporation provided certain services totaling $7,984 and $8,463, respectively, to Access. Additionally, the Corporation provided contributions to Access totaling $1,700 for the years ended June 30, 2011 and 2010, respectively, primarily for uncompensated care and capital grants. In addition, the Corporation charges Access interest on the amounts due to the Corporation and all amounts owed to the Corporation are documented and supported by underlying contractual agreements. The annual interest rate was 5 percent for the years ended June 30, 2011 and 2010, respectively. Interest income was $1,047 and $1,002 for the years ended June 30, 2011 and 2010, respectively. Amounts due from Access are reported as notes receivable current and long term in the accompanying consolidated balance sheets, and mature at various times, ranging from due upon demand to June 30, 2016.

There were contributions to other organizations of $300 and $151, for the years ended June 30, 2011 and 2010, respectively.

Note 13. Temporarily and Permanently Restricted Net Assets

The Corporation's endowment consists of an endowment development program with donated funds which was established to support Mount Sinai. As required by accounting principles generally accepted in the United States of America, net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions. The endowment includes permanently and temporarily donor-restricted principal. Income earned on the principal is unrestricted and can be used for general operating expenses and maintenance of Mount Sinai.

On June 30, 2009, the governor of the State of Illinois signed into law the Uniform Prudent Management of Institutional Funds Act (UPMIFA). UPMIFA differs from laws previously in place in a few key areas. It eliminates the historic dollar value rule with respect to endowment fund spending, it updates the prudence standard for the management and investment of charitable funds, and it amends the provisions governing the release and modification of restrictions on charitable funds.

Interpretation of Relevant Law – The Board of Directors of the Corporation has interpreted the Illinois UPMIFA as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, the Corporation classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. In accordance with UPMIFA, the Corporation considers the following factors in making a determination to appropriate or accumulate earnings on donor-restricted endowment funds:

1) The duration and preservation of the fund;
2) The purpose of the Corporation and the donor-restricted endowment fund;
3) General economic conditions;
4) The possible effect of inflation and deflation;
5) The expected total return from income and the appreciation of investments;
6) Other resources of the Corporation, and;
7) The investment policies of the Corporation.

The Organization's endowment net asset composition by type of fund is as follows for the year ended June 30, 2011 and 2010:

	2011				2010			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted	$ -	$ -	$ -	$ -	$ -	$ -	$ 75	$ 75
Board-designated	1,967	-	-	1,967	1,586	-	-	1,586
Total funds	$ 1,967	$ -	$ -	$ 1,967	$ 1,586	$ -	$ 75	$ 1,661

Note 13. Temporarily and Permanently Restricted Net Assets (Continued)

The changes in endowment net assets of the Corporation were as follows for the years ended June 30, 2011 and 2010:

	2011				2010			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets, beginning of year	$ 1,586	$ -	$ 75	$ 1,661	$ 1,433	$ -	$ 75	$ 1,508
Other changes:								
Reclassification	75	-	(75)	-	47	-	-	47
Investment return:								
Investment loss	306	-	-	306	106	-	-	106
Endowment net assets, end of year	$ 1,967	$ -	$ -	$ 1,967	$ 1,586	$ -	$ 75	$ 1,661

Funds with Deficiencies – From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor or Illinois UPMIFA requires the Corporation to retain as a fund of perpetual duration. There were no deficiencies in the endowment fund as of June 30, 2011 and 2010.

Return Objectives and Risk Parameters – The Corporation has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Endowment assets include those assets of donor-restricted funds that the Corporation must hold in perpetuity or for a donor-specified period(s). Under this policy, as approved by the Board of Directors, the endowment assets are invested in a manner intended to achieve an annualized long-term average return of nominal percent. Actual returns in any given year may vary from this amount.

Strategies Employed for Achieving Objectives – To satisfy its long-term rate-of-return objectives, the Corporation relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends).

Spending Policy and How the Investment Objectives Relate to Spending Policy – The Corporation does not have a spending policy relating to its endowment; however, there are policies and procedures in place to ensure that expenditures are used to properly support hospital operations.

Note 13. Temporarily and Permanently Restricted Net Assets (Continued)

Temporarily restricted net assets are available for the following purposes at June 30:

	2011	2010
Scholarships	$ 220	$ 163
Research	26	26
Health care services	5,933	2,088
Purchase of property and equipment	2,270	2,502
	$ 8,449	$ 4,779

Permanently restricted net assets at June 30 are summarized below, the income from which is expendable to support:

	2011	2010
Health care services	$ -	$ 75

In 2011, a prior year gift in the amount of $75, previously recorded as permanently restricted, was reclassified as unrestricted by the donor. Accordingly, the asset has been released in the statement of operations.

Net assets were released from donor restrictions by incurring expenditures for the following purposes during the years ended June 30:

	2011	2010
Purchase of property and equipment	$ 66	$ 156
Health care services	686	827
Total net assets released from restriction	$ 752	$ 983

Note 14. Leases

Future minimum payments under noncancelable operating leases with terms of one year or more are as follows:

Year ending June 30:	
2012	$ 941
2013	941
2014	221
2015	221
2016	221
Total	$ 2,545

Rental expense under operating leases amounted to $1,223 and $1,500 for the years ended June 30, 2011 and 2010, respectively.

Note 15. Functional Expenses

The Corporation provides general health care services to residents within its geographic location. Expenses related to this, general and administrative, and fundraising functions are as follows for the years ended June 30:

	2011	2010
Health care services	$ 391,400	$ 388,413
General and administrative	16,432	15,833
Fundraising	631	650
	$ 408,463	$ 404,896

Certain costs have been allocated between health care services and general and administrative costs.

Note 16. Commitments and Contingencies

Litigation – In addition to professional liability claims, the Corporation is involved in litigation arising in the ordinary course of business. In the opinion of management, after consultation with legal counsel, these matters are expected to be resolved without material adverse effect on the Corporation's consolidated financial position, results of operations and cash flows.

Regulatory Environment Including Fraud and Abuse Matters – The health care industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government activity continues with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the Corporation is in compliance with fraud and abuse, as well as other applicable government laws and regulations. While no regulatory inquiries that are expected to have a material adverse effect on the Corporation have been made, compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

Illinois Hospital Uninsured Patient Discount Act – The provisions of the Hospital Uninsured Patient Discount Act (the Act) became effective April 1, 2009. The Act requires Illinois hospitals to provide certain mandated discounts from charges to the uninsured in Illinois. Charges are to be discounted to no more than 135 percent of cost. Furthermore, a hospital may not collect more than 25 percent of an uninsured family's gross income in any one year.

CMS Recovery Audit Contractor Program – Congress passed the Medicare Modernization Act in 2003, which among other things established a three-year demonstration of The Medicare Recovery Audit Contractor (RAC) program. The RAC's identified and corrected a significant amount of improper overpayments to providers. In 2006, Congress passed the Tax Relief and Health Care Act of 2006 which authorized the expansion of the RAC program to all 50 states by 2010. CMS rolled out this program nationally, in Illinois during the fiscal year ended June 30, 2010. At June 30, 2011, the Corporation recorded a liability for estimated amounts that will be repaid under the RAC program based on the Corporation's RAC program experience to date.

Note 16. Commitments and Contingencies (Continued)

Medicare and Medicaid Reimbursement: The Governor of Illinois recently signed into law the budget for the State's fiscal year ending June 30, 2012, which reduces Medicaid appropriations to hospitals in the upcoming year. These reductions are expected to delay Medicaid payments into the State's fiscal year 2013 and the potential to cut spending in the upcoming year. For non-expedited hospitals, payments based on claims will be held for the first 160 days of the State fiscal year, whereas, for expedited hospitals such as Mount Sinai and Schwab, payments will be based on a twelve day cycle beginning in August based on their claims. In addition to delayed Medicaid payments, deep cuts to both the Medicare and Medicaid programs are under consideration by the U.S. Congress as it looks to cut federal spending. Such cuts in Medicaid and Medicare reimbursement, if enacted, could have a significant adverse effect on the Corporation's consolidated financial statements.

Patient Protection and Affordable Care and Reconciliation Act: On March 23, 2010, President Barack Obama signed into law the most sweeping health care reform legislation since the advent of Medicare. The law promises to expand insurance coverage to an additional 32 million Americans, reduce the growth of Medicare expenditures, dramatically reform insurance markets, and continue the march toward value-based payment. The Reconciliation Act amends various provisions of the Patient Protection and Affordable Care Act and adds some new provisions that were not included originally.

Construction in Progress – Construction in progress as of June 30, 2011, consists primarily of costs related to the expansion of the third floor of the Sinai Community Institute Building for the movement of the clinics out of the Kling Building. The estimated cost to complete the project is approximately $3,500 at June 30, 2011.

Note 17. Fair Value Disclosures

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. In determining fair value, the Corporation uses various methods including market, income and cost approaches. Based on these approaches, the Corporation often utilizes certain assumptions that market participants would use in pricing the asset or liability, including assumptions about risk and or the risks inherent in the inputs to the valuation technique. These inputs can be readily observable, market corroborated, or generally unobservable inputs. The Corporation utilizes valuation techniques that maximize the use of observable inputs and minimize the use of unobservable inputs. Based on the observability of the inputs used in the valuation techniques the Corporation is required to provide the following information according to the fair value hierarchy. The fair value hierarchy ranks the quality and reliability of the information used to determine fair values. Financial assets and liabilities carried at fair value will be classified and disclosed in one of the following three categories:

Level 1: Quoted prices for identical instruments in active markets.

Level 2: Valuations for assets and liabilities traded in less active dealer or broker markets. Valuations are obtained from third party pricing services for identical or similar assets or liabilities.

Level 3: Valuations for assets and liabilities that are derived from other valuation methodologies, including option pricing models, discounted cash flow models and similar techniques, and not based on market exchange, dealer, or broker traded transactions. Level 3 valuations incorporate certain assumptions and projections in determining the fair value assigned to such assets or liabilities.

Note 17. Fair Value Disclosures (Continued)

For the fiscal year ended June 30, 2011, the application of valuation techniques applied to similar assets and liabilities has been consistent. The following is a description of the valuation methodologies used for instruments measured at fair value:

Fair Value on a Recurring Basis – The tables below present the balances of assets and liabilities measured at fair value on a recurring basis, as of June 30, 2011 and 2010.

	June 30, 2011			
	Level 1	Level 2	Level 3	Total
Investment agreements	$ 6,816	$ -	$ -	$ 6,816
Cash equivalents - money market funds				
and mutual funds	1,177	-	-	1,177
United States Treasury securities	12,783	-	-	12,783
Federation pooled funds		-	11,191	11,191
Mutual funds invested in equity securities	1,814	-	-	1,814
Equities	285	-	-	285
	$ 22,875	$ -	$ 11,191	$ 34,066

	June 30, 2010			
	Level 1	Level 2	Level 3	Total
Investment agreements	$ 6,820	$ -	$ -	$ 6,820
Cash equivalents - money market funds				
mutual funds	1,232	-	-	1,232
United States Treasury securities	9,984	-	-	9,984
Federation pooled funds	-	-	9,562	9,562
Mutual funds invested in equity securities	78	-	-	78
Equities	1,824	-	-	1,824
	$ 19,938	$ -	$ 9,562	$ 29,500

Investment agreements consist primarily of guaranteed investment contracts.

Investments – The fair value of investments is the market value based on quoted market prices, when available, or market prices provided by recognized broker-dealers. If listed prices or quotes are not available, fair value is based upon externally developed models that use unobservable inputs due to the limited market activity of the instrument.

The Corporation invests in a pooled fund maintained by the Federation. The Federation's pooled fund is comprised of various types of investments including: mutual funds, equity and debt securities, alternative investments and other investment vehicles. The Corporation owns only a portion of the Federation's pooled fund; the Corporation does not own or have any interest in the underlying investments. As an outside investor in the portfolio, the Corporation has the ability to withdraw funds from its account on the first day of any calendar quarter. Withdrawal requests are required to be submitted to Federation in writing at least five days prior to quarter-end and withdrawals representing 25 percent or more of an investor's assets are paid in two installments.

Note 17. Fair Value Disclosures (Continued)

Alternative investments and other investment vehicles are valued at fair value based on the applicable percentage ownership of the investment funds' net assets as of year-end, as determined by the Federation. In determining fair value, the Federation utilizes valuations and other information provided by fund managers or the general partners of investment partnerships. The underlying investment funds value securities and other financial instruments substantially on a mark-to-market or fair value basis of accounting. The estimated fair values of certain investments of the underlying investment funds are determined by the investment manager or sponsor of the respective fund. The fair value of the Federation's alternative investments generally represents the amount expected to be received if the Federation were to liquidate its alternative investments, excluding any redemption charges that may apply.

Accordingly, the estimated fair values of the alternative investments may differ significantly from the values that would have been used had a ready market existed for these investments.

The Corporation currently invests a significant amount of funds in the pooled funds of the Federation. In the event the Federation does not fulfill its obligations, the Corporation may be exposed to risk. This risk of default depends on the creditworthiness of the counterparty to these transactions. The Federation attempts to minimize this credit risk by monitoring the creditworthiness of its counterparties.

The following table presents a reconciliation of activity for the Level 3 financial instruments:

	2011 Federation	2010 Federation
Balance, July 1	$ 9,562	$ 8,740
Total net losses included in:		
Revenue in excess of expenses	2,077	1,238
Sale of investment securities	(448)	(416)
Balance, June 30	$ 11,191	$ 9,562

Gains and losses above relate to assets still held at June 30, 2011 and 2010, and are recorded on the consolidated statement of operations and changes in net assets for the years ended June 30, 2011 and 2010, as follows:

	2011	2010
Investment income-operating	$ 75	$ (133)
Net change in unrealized gains and losses on investments	2,002	1,371
	$ 2,077	$ 1,238

The Corporation, as an investor in the Federation pooled funds, enters into transactions with a variety of securities and derivative financial instruments, including exchange-traded future and options contracts. These derivative financial instruments may have market and/or credit risk in excess of the amounts recorded in the consolidated balance sheets.

Note 17. Fair Value Disclosures (Continued)

As of June 30, 2011 and 2010, the pooled funds of the Federation were invested as follows:

	2011 Percentage of Total Pooled Fund	2010 Percentage of Total Pooled Fund
Federation Hierarchy Level 1		
Money market funds	2 %	2 %
Mutual funds and other investment vehicles		
Domestic equity - large capitalization	13	11
Domestic equity - small capitalization	7	8
International equity	17	16
Fixed income - domestic	8	8
Fixed income - international	5	5
Total Percentage Federation Hierarchy Level 1	52 %	50 %
Federation Hierarchy Level 2		
State of Israel bonds	1 %	1 %
Total Percentage Federation Hierarchy Level 2	1 %	1 %
Federation Hierarchy Level 3		
Alternative investments		
Absolute return hedge funds	19 %	21 %
Real asset funds (real estate, energy and natural resources)	15	14
Private equity and fund-of-funds	13	14
Total Percentage Federation Hierarchy Level 3	47 %	49 %

Fair Value of Financial Instruments – The following methods and assumptions were used by the Corporation to estimate the fair value of other financial instruments not detailed above.

The carrying values of cash and cash equivalents, patient accounts receivable, other accounts receivable, accounts payable and accrued expenses, and amounts due to third-party payors are reasonable estimates of their fair value due to the short-term nature of these financial instruments.

The fair value of the long-term debt is estimated based on the quoted market prices for the same or similar issues or on current rates offered to market participants for debt of the same remaining maturities. The approximate fair value of outstanding debt and notes payable at June 30, 2011 and 2010, was $107,000 and $109,000, respectively.

Note 18. Pending Adoption of New Accounting Principles

In August 2010, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2010-23, *Health Care Entities (Topic 954) - Measuring Charity Care for Disclosure.* ASU 2010-23 requires disclosure of charity care based on the health care provider's direct and indirect costs of providing charity care services, the method used to identify or estimate such costs, and funds received to offset or subsidize charity services provided. The disclosures required by ASU 2010-23 are effective for fiscal years beginning after December 15, 2010, and must be applied retrospectively. The Corporation is assessing the impact of the implementation of ASU 2010-23 on the disclosures in its financial statements.

In August 2010, the FASB issued ASU 2010-24, *Health Care Entities (Topic 954) - Presentation of Insurance Claims and Related Insurance Recoveries.* ASU 2010-24 clarifies that a health care entity should not net insurance recoveries against a related claim liability. Additionally, ASU 2010-24 provides that the amount of the claims liability should be determined without consideration of insurance recoveries. The provisions of ASU 2010-24 are effective for fiscal years, and interim periods within those years, beginning after December 15, 2010. Entities must apply the provisions of ASU 2010-24 by recording a cumulative-effect adjustment to opening retained earnings (or unrestricted net assets) as of the beginning of the period of adoption. Retrospective application of the provisions ASU 2010-24 is permitted. The Corporation is assessing the impact of the implementation of ASU 2010-24 on its financial statements.

In July 2011, the FASB issued ASU 2011-07, *Health Care Entities (Topic 954) – Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities.* ASU 2011-07 requires health care entities that recognize significant amounts of patient service revenue at the time the services are rendered even though they do not assess the patient's ability to pay, to change the presentation of their statement of operations by reclassifying the provision for bad debts associated with patient service revenue from an operating expense to a deduction from patient service revenue (net of contractual allowances and discounts). Additionally, ASU 2011-07 requires those health care entities to provide enhanced disclosure about their policies for recognizing revenue and assessing bad debts, disclosures of patient service revenue (net of contractual allowances and discounts) as well as qualitative and quantitative information about changes in the allowance for doubtful accounts.

For entities such as the Corporation, the provisions of ASU 2011-07 are effective for the first annual period beginning after December 15, 2011, and interim and annual periods thereafter, with early adoption permitted. The changes to the presentation of the provision for bad debts related to patient service revenue in the statement of operations should be applied retrospectively to all prior periods presented. The disclosures required by ASU 2011-07 should be provided for the period of adoption and subsequent reporting periods. The Corporation is assessing the impact of the implementation of ASU 2011-07 on its financial statements.

In September 2011, the FASB issued ASU 2011-09, *Compensation – Retirement Benefits – Multiemployer Plans (Subtopic 715-80): Disclosures about an Employer's Participation in a Multiemployer Plan*. ASU 2011-09 addresses concerns about the lack of transparency in an employer's financial statements about its participation in a multiemployer pension plan. This ASU requires employers to provide additional separate disclosures about their participation in multiemployer pension plans and multiemployer benefit plans. The amendments do not change the current recognition and measurement guidance for an employer's participation in a multiemployer plan, which requires that an employer recognize as pension or other postretirement benefit cost its required contribution to the plan for the period and recognize a liability for any unpaid contribution. Also, the amendments do not change the requirement that an employer apply the provisions for contingencies in FASB Accounting Standards Codification Topic 450, *Contingencies*, if an obligation due to withdrawal from a multiemployer plan is either probable or reasonably possible.

The enhanced disclosures are required in fiscal years ending after December 15, 2011. The Corporation is assessing the impact of ASU 2011-09 on its financial statements.

McGladrey & Pullen, LLP
Certified Public Accountants

McGladrey

Independent Auditor's Report on the Supplementary Information

To the Board of Directors
Sinai Health System
Chicago, Illinois

Our audits were made for the purpose of forming an opinion on the basic consolidated financial statements for the years ended June 30, 2011 and 2010 taken as a whole. The consolidating and other supplementary information is presented for purposes of additional analysis of the basic consolidated financial statements rather than to present the financial position and results of operations of the individual companies. The consolidating and other supplementary information for the years ended June 30, 2011 and 2010, except for that portion marked "unaudited," on which we express no opinion, has been subjected to the auditing procedures applied in the audits of the basic 2011 and 2010 consolidated financial statements and, in our opinion, is fairly stated in all material respects in relation to the basic 2011 and 2010 consolidated financial statements taken as a whole.

McGladrey & Pullen, LLP

Chicago, Illinois
December 12, 2011

Sinai Health System and Affiliates

Details of Consolidated Balance Sheet
June 30, 2011
(Dollars in Thousands)

	Sinai Health System	Mount Sinai Hospital Medical Center and Subsidiaries	Schwab Rehabilitation Hospital	Sinai Community Foundation	Sinai Community Institute	Eliminations	Consolidated
Assets							
Current Assets							
Cash and cash equivalents	$ 347	$ 8,827	$ 894	$ 439	$ 251	$ -	$ 10,758
Assets limited as to use							
Externally designated investments	-	3,448	749	-	-	-	4,197
Internally designated investments under			-				
self-insurance program	-	3	-	-	-	-	3
Patient accounts receivable, less allowances	-	33,378	5,133	14,565	-	-	53,076
Due from affiliates	-	-	51,048	-	-	(51,048)	-
Notes receivable, current portion	3,949	3,314	416	770	76	-	8,525
Other accounts receivable	514	3,862	210	1,151	1,332	-	7,069
Prepaid expenses, inventories, and other	46	5,373	778	23	116	-	6,336
Total current assets	4,856	58,205	59,228	16,948	1,775	(51,048)	89,964
Assets Limited as to Use, net of amounts required to meet current liabilities							
Internally designated investments for capital program	-	11,955	3,685	-	-	-	15,640
Externally designated investments under debt agreements	-	11,345	2,712	-	-	-	14,057
Total assets limited as to use	-	23,300	6,397	-	-	-	29,697
Other Assets							
Deferred bond issuance costs, less amortization	-	1,672	619	-	31	-	2,322
Notes receivable, long-term portion	-	3,868	-	5,626	-	-	9,494
Other investments	-	-	169	-	-	-	169
Other	5,271	1,876	(88)	2,306	-	-	9,365
Total other assets	5,271	7,416	700	7,932	31	-	21,350
Property and Equipment, net	7,807	80,885	18,782	2,011	5,396	-	114,881
Total assets	$ 17,934	$ 169,806	$ 85,107	$ 26,891	$ 7,202	$ (51,048)	$ 255,892

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Sinai Health System and Affiliates

Details of Consolidated Balance Sheet (Continued)
June 30, 2011
(Dollars in Thousands)

	Sinai Health System	Mount Sinai Hospital Medical Center and Subsidiaries	Schwab Rehabilitation Hospital	Sinai Community Foundation	Sinai Community Institute	Eliminations	Consolidated
Liabilities and Net Assets (Deficit)							
Current Liabilities							
Accounts payable and accrued expenses	$ 1,114	$ 43,926	$ 1,663	$ 2,033	$ 298	$ -	$ 49,034
Accrued salaries and employee benefits	1,143	12,160	3,483	4,736	419	-	21,941
Amounts due to third-party payors	-	3,090	1,434	356	-	-	4,880
Due to affiliates	5,257	2,344	-	184,367	12,933	(204,901)	-
Self-insurance claims payable	-	1,327	442	234	-	-	2,003
Notes payable	-	2,564	-	325	-	-	2,889
Current maturities of long-term debt	426	2,996	426	311	-	-	4,159
Other current liabilities	1,249	4,282	132	1,726	415	-	7,804
Total current liabilities	9,189	72,689	7,580	194,088	14,065	(204,901)	92,710
Noncurrent Liabilities							
Long-term debt, less current maturities	414	72,651	20,572	1,374	5,000	-	100,011
Self-insurance claims payable, less current portion	-	36,825	2,751	6,558	-	-	46,134
Due to affiliates	-	132	-	-	-	(132)	-
Other	386	2,459	579	990	-	-	4,414
Total liabilities	9,989	184,756	31,482	203,010	19,065	(205,033)	243,269
Net Assets (Deficit)							
Noncontrolling interest in subsidiary	-	123	-	-	-	-	123
Unrestricted	427	(15,588)	53,257	(176,167)	(11,863)	153,985	4,051
Temporarily restricted	7,518	515	368	48	-	-	8,449
	7,945	(14,950)	53,625	(176,119)	(11,863)	153,985	12,623
Total liabilities and net assets (deficit)	$ 17,934	$ 169,806	$ 85,107	$ 26,891	$ 7,202	$ (51,048)	$ 255,892

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Sinai Health System and Affiliates

Details of Consolidated Schedule of Operations
Year Ended June 30, 2011
(Dollars in Thousands)

	Sinai Health System	Mount Sinai Hospital Medical Center and Subsidiaries	Schwab Rehabilitation Hospital	Sinai Community Foundation	Sinai Community Institute	Eliminations	Consolidated
Unrestricted revenue and other support:							
Net patient service revenue	$ -	$ 291,902	$ 43,028	$ 41,073	$ -	$ -	$ 376,003
Other revenue	25,238	9,311	756	19,199	1,041	(41,675)	13,870
Investment income	-	477	150	26	-	-	653
Contributions from the Jewish Federation of Metropolitan Chicago	-	685	-	-	-	-	685
Grant revenue	2,804	5,607	382	343	8,059	-	17,195
Net assets released from restrictions	185	391	83	14	13	-	686
Total unrestricted revenue and other support	28,227	308,373	44,399	60,655	9,113	(41,675)	409,092
Expenses:							
Salaries and wages	14,145	121,998	24,843	58,960	4,635	(15,517)	209,064
Supplies and purchased services	6,967	75,867	7,898	4,080	4,096	(21,113)	77,795
Depreciation and amortization	1,882	8,982	1,242	412	218	-	12,736
Provision for bad debts	-	58,727	1,640	11,626	133	(21,503)	50,623
Insurance	-	5,264	(390)	4,437	12	-	9,323
Interest	46	5,130	1,197	19	50	(855)	5,587
Provider tax	-	13,938	3,143	-	-	-	17,081
Other	5,190	20,312	2,352	2,406	1,039	(5,045)	26,254
Total expenses	28,230	310,218	41,925	81,940	10,183	(64,033)	408,463
Income (loss) from operations	(3)	(1,845)	2,474	(21,285)	(1,070)	22,358	629
Nonoperating (losses) gains:							
Contributions	4	30	-	-	1	-	35
Investment income	-	1,377	465	196	-	-	2,038
Net change in unrealized gains and (losses) on investments	-	(194)	(27)	-	-	-	- (221)
Contributions to other organizations		(2,000)	-	-	-	-	(2,000)
Affiliate interest income	-	-	855	-	-	(855)	-
Other	-	21	-	-	-	-	21
Net income attributable to noncontrolling interest	-	(104)	-	-	-	-	(104)
Total nonoperating (losses) gain	4	(870)	1,293	196	1	(855)	(231)
Revenue in excess of (less than) expenses	$ 1	$ (2,715)	$ 3,767	$ (21,089)	$ (1,069)	$ 21,503	398

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Sinai Health System and Affiliates

Details of Consolidated Balance Sheet
June 30, 2010
(Dollars in Thousands)

	Sinai Health System	Mount Sinai Hospital Medical Center and Subsidiaries	Schwab Rehabilitation Hospital	Sinai Community Foundation	Sinai Community Institute	Eliminations	Consolidated
Assets							
Current Assets							
Cash and cash equivalents	$ 349	$ 6,477	$ 1,195	$ 1,010	$ 123	$ -	$ 9,154
Assets limited as to use							
Externally designated investments		3,271	748	-	-	-	4,019
Internally designated investments under self-insurance program	-	217	33	-	-	-	250
Patient accounts receivable, less allowances for uncollectible accounts	-	33,354	5,609	10,453	-	-	49,416
Due from affiliates	-	-	47,758	-	-	(47,758)	-
Notes receivable, current portion	4,738	1,833	416	6,394	76	-	13,457
Other accounts receivable	765	4,645	261	1,436	1,720	-	8,827
Prepaid expenses, inventories, and other		6,977	928	176	35	-	8,116
Total current assets	5,852	56,774	56,948	19,469	1,954	(47,758)	93,239
Assets Limited as to Use, net of amounts required to meet current liabilities							
Internally designated investments for capital program	-	8,839	277	-	-	-	9,116
Externally designated investments under debt agreements	-	10,512	2,698	-	-	-	13,210
Total assets limited as to use	-	19,351	2,975	-	-	-	22,326
Other Assets							
Deferred bond issuance costs, less amortization	-	1,760	644	-	34	-	2,438
Notes receivable, long-term portion	-	5,471	-	-	-	-	5,471
Other investments	-	-	2,905	-	-	-	2,905
Other	2,486	1,888	129	2,183	31	-	6,717
Total other assets	2,486	9,119	3,678	2,183	65	-	17,531
Property and Equipment, net	7,107	78,483	19,622	2,177	5,195	-	112,584
Total assets	$ 15,445	$ 163,727	$ 83,223	$ 23,829	$ 7,214	$ (47,758)	$ 245,680

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Sinai Health System and Affiliates

Details of Consolidated Balance Sheet (Continued)
June 30, 2010
(Dollars in Thousands)

	Sinai Health System	Mount Sinai Hospital Medical Center and Subsidiaries	Schwab Rehabilitation Hospital	Sinai Community Foundation	Sinai Community Institute	Eliminations	Consolidated
Liabilities and Net Assets (Deficit)							
Current Liabilities							
Accounts payable and accrued expenses	$ 882	$ 31,825	$ 1,381	$ 2,503	$ 111	$ -	$ 36,702
Accrued salaries and employee benefits	1,079	13,451	3,212	4,380	381	-	22,503
Amounts due to third-party payors	-	4,011	2,192	-	-	-	6,203
Due to affiliates	7,567	1,384	-	159,893	12,359	(181,203)	-
Self-insurance claims payable	-	2,717	393	206	-	-	3,316
Notes payable	-	5,023	-	625	-	-	5,648
Current maturities of long-term debt	426	3,168	413	309	-	-	4,316
Other current liabilities	881	5,892	691	1,854	147	-	9,465
Total current liabilities	10,835	67,471	8,282	169,770	12,998	(181,203)	88,153
Noncurrent Liabilities							
Long-term debt, less current maturities	440	72,497	20,998	1,687	5,000	-	100,622
Self-insurance claims payable,							-
less current portion	-	34,455	3,437	6,587	-		44,479
Due to affiliates	-	224	-	-	-	(224)	-
Other	284	2,409	552	805	-	-	4,050
Total liabilities	11,559	177,056	33,269	178,849	17,998	(181,427)	237,304
Net Assets (Deficit)							
Noncontrolling interest in subsidiary	-	22	-	-	-	-	22
Unrestricted	427	(14,215)	49,491	(155,078)	(10,794)	133,669	3,500
Temporarily restricted	3,459	789	463	58	10	-	4,779
Permanently restricted	-	75	-	-	-	-	75
	3,886	(13,329)	49,954	(155,020)	(10,784)	133,669	8,376
Total liabilities and net assets (deficit)	$ 15,445	$ 163,727	$ 83,223	$ 23,829	$ 7,214	$ (47,758)	$ 245,680

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Sinai Health System and Affiliates

Details of Consolidated Schedule of Operations
Year Ended June 30, 2010
(Dollars in Thousands)

	Sinai Health System	Mount Sinai Hospital Medical Center and Subsidiaries	Schwab Rehabilitation Hospital	Sinai Community Foundation	Sinai Community Institute	Eliminations	Consolidated
Unrestricted revenue and other support:							
Net patient service revenue	$ -	$ 295,607	$ 41,718	$ 36,391	$ -	$ -	$ 373,716
Other revenue	20,943	9,241	1,646	19,573	785	(36,466)	15,722
Investment income	-	384	136	12	-	-	532
Contributions from the Jewish Federation of Metropolitan Chicago	-	854	-	-	-	-	854
Grant revenue	3,224	5,894	308	-	4,804	-	14,230
Net assets released from restrictions	10	656	93	68	-	-	827
Total unrestricted revenue and other support	24,177	312,636	43,901	56,044	5,589	(36,466)	405,881
Expenses:							
Salaries and wages	14,052	120,352	23,983	55,870	4,300	(15,170)	203,387
Supplies and purchased services	3,061	70,262	7,781	3,577	1,284	(15,787)	70,178
Depreciation and amortization	2,114	8,868	1,283	293	238	-	12,796
Provision for bad debts	-	68,193	1,570	9,764	220	(21,887)	57,860
Insurance	-	6,457	362	5,028	13	-	11,860
Interest	54	5,232	1,225	75	57	(855)	5,788
Provider tax	-	13,938	3,143	-	-	-	17,081
Other	4,827	20,765	2,138	2,159	711	(4,654)	25,946
Total expenses	24,108	314,067	41,485	76,766	6,823	(58,353)	404,896
Income (loss) from operations	69	(1,431)	2,416	(20,722)	(1,234)	21,887	985
Nonoperating gains (losses):							
Contributions	-	33	(3)	-	3	-	33
Investment income	-	747	256	122	-	-	1,125
Net change in unrealized gains and losses on investments	-	254	36	-	-	-	290
Contributions to related party	-	(1,851)	-	-	-	-	(1,851)
Affiliate interest income	-	-	-	-	-	-	-
Other	-	22	-	-	-	-	22
Net income attributable to noncontrolling interest	-	(34)	-	-	-	-	(34)
	-	(829)	289	122	3	-	(415)
Revenue in excess of (less than) expenses	$ 69	$ (2,260)	$ 2,705	$ (20,600)	$ (1,231)	$ 21,887	570

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Sinai Health System and Affiliates

Schedule of Charity Care and Community Benefits (Continued)
Years Ended June 30, 2011 and 2010
(Dollars in Thousands) - Unaudited

	2011 Total Community Benefit	% of Total Expenses	2010 Total Community Benefit	% of Total Expenses
Benefits for the poor, at cost				
Traditional charity care	$ 20,560	5.0 %	$ 18,270	4.5 %
Community services:				
Community health services	1,843	0.5	1,545	0.4
Health professions education	2,207	0.5	2,216	0.5
Subsidized health services	21,154	5.2	19,730	4.9
Research	107	0.0	104	0.0
Grants and donations	2,000	0.5	1,851	0.5
Community benefit operations	31	0.0	24	0.0
Total community services for the poor	27,342	6.7	25,470	6.3
Total benefits for the poor	47,902	11.7	43,740	10.8
Benefits for the broader community, at cost				
Community services:				
Community health services	2,432	0.6	2,237	0.6
Health professions education	2,913	0.7	3,209	0.8
Subsidized health services	469	0.1	-	0.0
Research	141	0.0	151	0.0
Community benefit operations	41	0.0	35	0.0
Total benefits for the broader community	5,996	1.4	5,632	1.4
Total community benefits	53,898	13.1	49,372	12.2
Bad debt expense	38,997	9.5	48,096	11.9
Total community benefits including bad debt expense	$ 92,895	22.6 %	$ 97,468	24.1 %

OPERATING and CAPITAL COSTS
per ADJUSTED PATIENT DAY

Sinai Health System - 2011				
Adjusted Patient Day Calculation:				
	outpt revenue		$ 75,089,675	
	inpt pt rev per pt day		$ 2,990	**25,113**
Operating Costs per Adjusted Patient Day:				
Salaries & Benefits:	$ 209,064,000			
Supplies	$ 77,795,000			
	$ 286,859,000			$ 11,423
Capital Costs per Adjusted Patient Day:				
Interest:	$ 5,587,000			
Depreciation & Amort.:	$ 12,736,000			
	$ 18,323,000			$ 730

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