ORIGINAL

13-020

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED
MAY 06 2013
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:	VHS-Westlake Hospital			
Street Address:	1225 Lake Street			
City and Zip Code:	Melrose Park, IL 60160			
County: Cook		Health Service Area	VII	Health Planning Area: A-06

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

Exact Legal Name:	VHS Westlake Hospital, Inc.
Address:	1225 Lake Street Melrose Park, IL 60160
Name of Registered Agent:	
Name of Chief Executive Officer:	William A. Brown, FACHE
CEO Address:	1225 Lake Street Melrose Park, IL 60160
Telephone Number:	708/938-7201

Type of Ownership of Applicant/Co-Applicant

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

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

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

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

Name:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	675North Court Suite 210 Palatine, IL 6067
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:	Honey Jacobs Skinner
Title:	Partner
Company Name:	Sidley & Austin
Address:	1 South Dearborn Chicago, IL 60603
Telephone Number:	312/853-7577
E-mail Address:	mskinner@sidley.com
Fax Number:	312/853-7036

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.

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City and Zip Code:	Melrose Park, IL 60160				
County: Cook		Health Service Area	VII	Health Planning Area:	A-06

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

Exact Legal Name:	Vanguard Health Systems, Inc.
Address:	20 Burton Hills Blvd. Suite 100 Nashville, TN 37215
Name of Registered Agent:	
Name of Chief Executive Officer:	Charles N. Martin, Jr.
CEO Address:	20 Burton Hills Blvd. Suite 100 Nashville, TN 37215
Telephone Number:	61/665-6000

Type of Ownership of Applicant/Co-Applicant

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

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- 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.

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E-mail Address:	mskinner@sidley.com
Fax Number:	312/853-7036

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:	William A. Brown, FACHE
Title:	Chief Executive Officer
Company Name:	VHS Westlake Hospital
Address:	1225 Lake Street Melrose Park, IL 60160
Telephone Number:	708/938-7201
E-mail Address:	wbrown@vhschicago.com
Fax Number:	708/938-7974

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: VHS Westlake Hospital, Inc.

Address of Site Owner: 1225 Lake Street Melrose Park, IL 60160

Street Address or Legal Description of Site: 1225 Lake Street Melrose Park, IL 60160

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: VHS Westlake Hospital, Inc.

Address: 1225 Lake Street Melrose Park, IL 60160

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

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

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

Organizational Relationships

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

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

Flood Plain Requirements

[Refer to application instructions.]

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

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

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

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

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

DESCRIPTION OF PROJECT

1. Project Classification

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

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

2. Narrative Description

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

The applicants propose the discontinuation of VHS Westlake Hospital's open heart surgery category of service, which will be consolidated into the similar service at VHS West Suburban Medical Center.

VHS Westlake Hospital is located at 1225 Lake Street in Melrose Park, Illinois, and VHS West Suburban Medical Center is located 11 minutes (MapQuest, adjusted) to the east, in Oak Park, Illinois.

By virtue of proposing the discontinuation of a category of service, this is a substantive project.

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 Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	$0	$0	$0
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	$0	$0	$0

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

Related Project Costs

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

Land acquisition is related to project ☐ Yes X No
Purchase Price: $_____
Fair Market Value: $_____

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 $ _____.

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): _____

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: VHS Westlake Hospital		**CITY: Melrose Park, Illinois**			
REPORTING PERIOD DATES:		**From: January 1, 2012**	**to: December 31, 2012**		
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	111	3,677	14,647	none	111
Obstetrics	24	1,079	2,207	none	24
Pediatrics	5	172	613	none	5
Intensive Care	12	466	2,461	none	12
Comprehensive Physical Rehabilitation	40	383	4,592	none	40
Acute/Chronic Mental Illness	33	850	10,327	none	33
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:	225	6,627	34,847	none	225

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

William A. Brown
SIGNATURE

WILLIAM A. BROWN
PRINTED NAME

CEO - VHS WESTLAKE HOSPITAL
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 29th day of April 2013

Kathleen M. Fox
Signature of Notary

Seal

Official Seal
Kathleen M Fox
Notary Public State of Illinois
My Commission Expires 07/30/2016

SIGNATURE

WILLIAM T. FOLEY
PRINTED NAME

SENIOR VP / ALEGIANCE HEALTH SYSTEMS
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 29th day of April 2013

Kathleen M. Fox
Signature of Notary

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Kathleen M Fox
Notary Public State of Illinois
My Commission Expires 07/30/2016

*Insert EXACT legal name of the applicant

CERTIFICATION

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

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SIGNATURE

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PRINTED NAME

CEO - VHS WESTLAKE HOSPITAL
PRINTED TITLE

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Signature of Notary

Seal

Official Seal
Kathleen M Fox
Notary Public State of Illinois
My Commission Expires 07/30/2016

SIGNATURE

WILLIAM T. FOLEY
PRINTED NAME

SENIOR VP, VANGUARD HEALTH SYSTEMS
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 29th day of April 2013

Kathleen M Fox
Signature of Notary

Seal

Official Seal
Kathleen M Fox
Notary Public State of Illinois
My Commission Expires 07/30/2016

*Insert EXACT legal name of the applicant

SECTION II. DISCONTINUATION

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

Criterion 1110.130 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

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

REASONS FOR DISCONTINUATION

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

IMPACT ON ACCESS

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

APPEND DOCUMENTATION AS ATTACHMENT-10, 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.
n/a		**TOTAL FUNDS AVAILABLE**

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

IX. 1120.130 - Financial Viability not applicable

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

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

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

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

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

2. Variance

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

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

X. 1120.140 - Economic Feasibility not applicable

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

A. Reasonableness of Financing Arrangements

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

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

2) That the total estimated project costs and related costs will be funded in total or in 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

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

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

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

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

C. **Reasonableness of Project and Related Costs**

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

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

* Include the percentage (%) of space for circulation

XI. Safety Net Impact Statement

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

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

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

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

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

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

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

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

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

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**2009**	**2010**	**2011**
Inpatient	269	179	65
Outpatient	2,871	498	397
Total	**3,140**	**577**	**462**
Charity (cost In dollars)			
Inpatient	$548,712	$680,024	$837.756
Outpatient	$307,093	$242,456	$210,899
Total	**$855,805**	**$922,480**	**$1,048,655**
MEDICAID			
Medicaid (# of patients)	**2009**	**2010**	**2011**
Inpatient	2,642	2,871	2,702
Outpatient	21,105	21,927	21,315
Total	23,747	24,798	24,017
Medicaid (revenue)			
Inpatient	$20,210,772	$14,231,149	$32,158,305
Outpatient	$2,178,863	$2,964,420	$1,072,445
Total	$22,389,635	$17,195,569	$33,230,750

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

XII. Charity Care Information

Charity Care information MUST be furnished for ALL projects.

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

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

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

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

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

CHARITY CARE			
	2009	**2010**	**2011**
Net Patient Revenue	**$96,100,142**	**$91,289,060**	**$89,999,234**
Amount of Charity Care (charges)	$3,443,273	$4,196,851	$4,392,345
Cost of Charity Care	$855,805	$922,480	$1,048,655

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

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.

File Number 6704-412-6

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

VHS WESTLAKE HOSPITAL, INC., INCORPORATED IN DELAWARE AND LICENSED TO TRANSACT BUSINESS IN THIS STATE ON MARCH 04, 2010, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 11TH *day of* APRIL *A.D.* 2013 .

Jesse White

Authentication #: 1310101903
Verify at www.cyberdriveillinois.com

SECRETARY OF STATE

ATTACHMENT 1

File Number 6402-314-4

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

VANGUARD HEALTH SYSTEMS, INC., INCORPORATED IN DELAWARE AND LICENSED TO TRANSACT BUSINESS IN THIS STATE ON FEBRUARY 02, 2005, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO TRANSACT BUSINESS 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* 23TH *day of* APRIL *A.D.* 2013 .

Jesse White

SECRETARY OF STATE

Authentication #: 1311301992

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

ATTACHMENT 1

VANGUARD | WESTLAKE HOSPITAL

WILLIAM A. BROWN, FACHE
Chief Executive Officer

April 26, 2013

Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, IL 62761

To Whom It May Concern:

I hereby attest that VHS Westlake Hospital, Inc. is the owner of the hospital' site, 1225 Lake Street, in Melrose Park, Illinois.

Sincerely,

William A. Brown

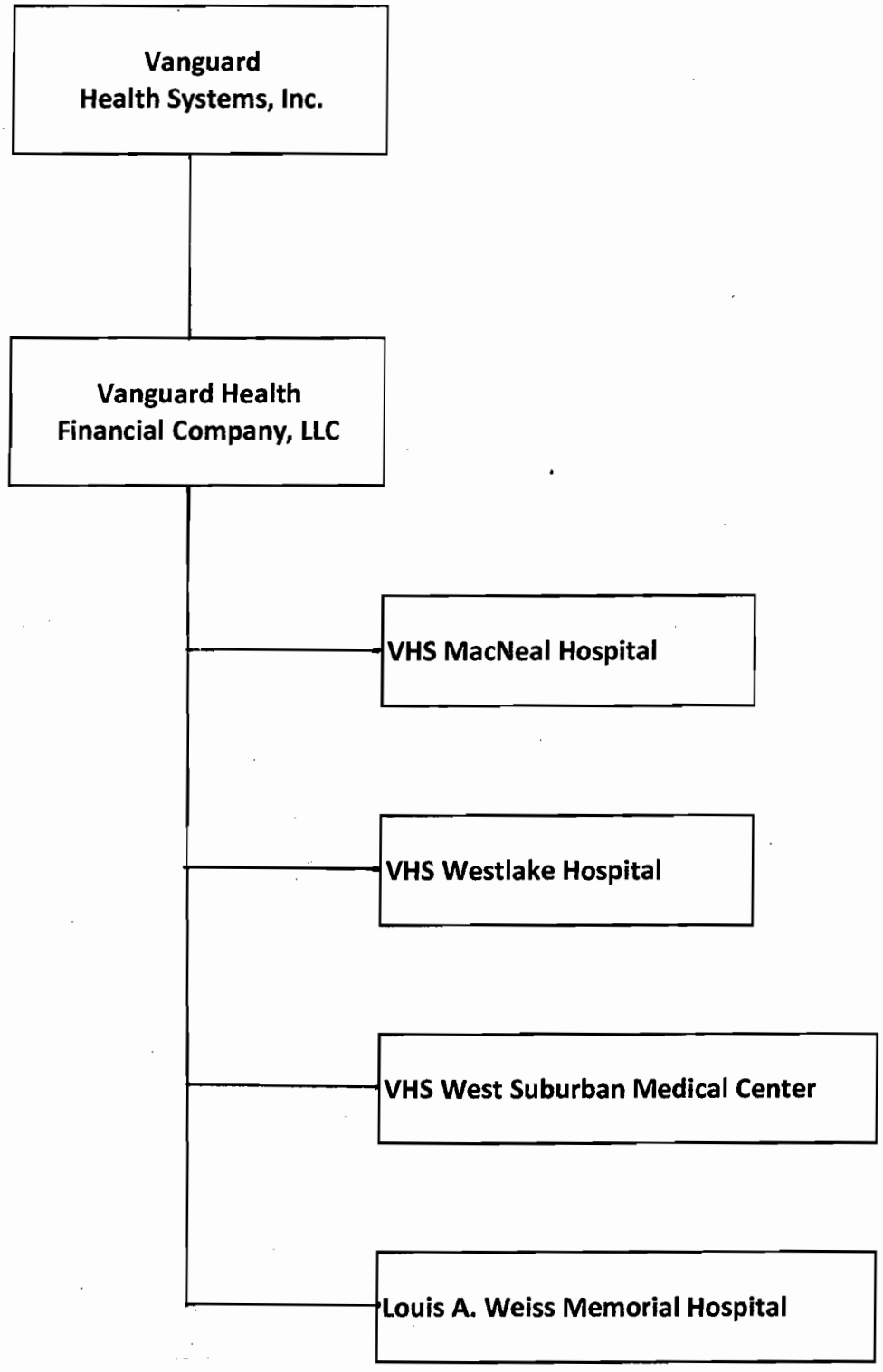
William A. Brown, FACHE
Chief Executive Officer

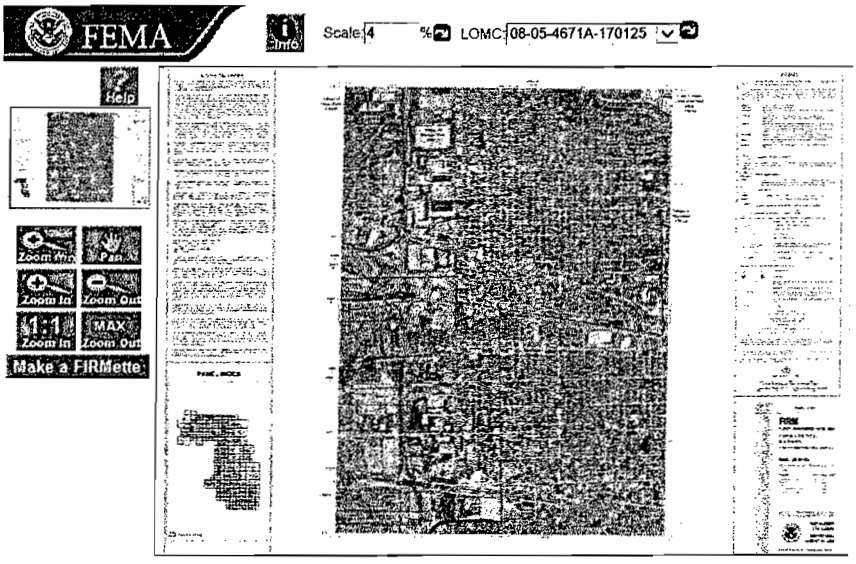
Kathleen M. Fox
April 29, 2013

Official Seal
Kathleen M Fox
Notary Public State of Illinois
My Commission Expires 07/30/2016

WAB/lll

ATTACHMENT 2


Vanguard
Health Systems, Inc.
Vanguard Health
Financial Company, LLC
VHS MacNeal Hospital
VHS Westlake Hospital
VHS West Suburban Medical Center
Louis A. Weiss Memorial Hospital



ATTACHMENT 5

DISCONTINUATION

Vanguard Health System ("Vanguard") was granted Certificate of Need Permits (#s 10-013 and 10-014) on June 9, 2010 to acquire Westlake Hospital in Melrose Park and West Suburban Medical Center in Oak Park. The acquisitions took place on August 1, 2010. When appearing before the Illinois Health Facilities and Services Review Board seeking approval for the change of ownership Certificate of Need applications, Vanguard pledged to not discontinue any categories of service at either of the two hospitals for a period of three years (as opposed to the typical two year period), and to conduct a thorough evaluation of the manner in which services were provided by these two nearby hospitals to the communities that they have historically been served. That evaluation process was initiated upon the change of ownership, and has been ongoing.

This application proposes the consolidation of the two hospitals' open heart surgery categories of service, to be centralized at VHS West Suburban Medical Center; and with that consolidation to be accomplished through the discontinuation of the category of service at VHS Westlake Hospital.

The reasons for the proposed discontinuation are consistent with the examples identified in Section 1110.130.b. The open heart surgery service is being discontinued/consolidated as a result of insufficient demand (1110.130.b)1) for the service at VHS Westlake Hospital, and because it is not economically feasible to operate duplicate programs in such close proximity to one another. In 2012, only ten open heart surgery procedures were performed at the VHS Westlake Hospital.

VHS Westlake Hospital and VHS West Suburban Medical Center, in many ways, currently operate as a two-campus hospital. There is significant overlap between the two hospitals' medical staffs, and staff, including nursing staff, routinely "float" between the two hospitals. As a result, from an operations perspective, it is anticipated that the consolidation of

the open heart surgery services will be seamless. In addition, because the hospitals are located only 11 minutes (MapQuest, adjusted) apart, patient accessibility will not be unreasonably compromised, nor will the discontinuation have an adverse effect upon access. As identified in the following table, there are twenty-eight (28) hospitals offering open heart surgery services within 45 minutes (MapQuest, adjusted) of VHS Westlake Hospital. Consistent with IHFSRB requirements evidence of the driving time to each hospital on the list is also provided.

Hospital	Location
Advocate Illinois Masonic Medical Center	Chicago
Northwestern Memorial Hospital	Chicago
Lurie Children's Hospital	Chicago
Resurrection Medical Center	Chicago
Saint Joseph Hospital	Chicago
Swedish Covenant Hospital	Chicago
John H. Stroger, Jr. Hospital	Chicago
Mount Sinai Hospital	Chicago
Rush University Medical Center	Chicago
St. Mary of Nazareth Hospital	Chicago
University of Illinois Medical Center	Chicago
Mercy Hospital and Medical Center	Chicago
University of Chicago Med. Center	Chicago
Adventist LaGrange Mem. Hospital	LaGrange
Advocate Christ Medical Center	Oak Lawn
Palos Commuity Hospital	Palos Heights
Adventist Hinsdale Hospital	Hinsdale
Advocate Good Samaritan Hospital	Downers Grove
Central DuPage Hospital	Winfield
Edward Hospital	Naperville
Elmhurst Memorial Hospital	Elmhurst
Gottlieb Memorial Hospital	Melrose Park
Loyola University Med. Center	Maywood
MacNeal Hospital	Berwyn
VHS West Suburban Med. Center	Oak Park
Alexian Brothers Med. Center	Elk Grove Village
Northwest Community Hosp.	Arlington Heights
Advocate Lutheran General Hosp.	Park Ridge

ATTACHMENT 10

Letters, requesting impact statements, consistent with Section 1110.130, were sent to each of the hospitals in the table above on April 1, 2013. A sample copy of the letter is attached. All responses will be forwarded to IHFSRB staff, or are included in this application.

The discontinuation of the two categories of service will occur within sixty (60) days of receipt of the CON Permit to do so.

The hospital currently has one operating room designated as a cardiovascular surgery room, which will be used for other types of surgery, including general and orthopedic surgery. The equipment associated with the open heart surgery services will either be distributed to other area hospitals operated by VHS, or disposed of.

The medical records of patients that have used the category of service to be discontinued will be maintained by VHS Westlake Hospital, for a minimum of ten (10) years. A copy of VHS' records retention policy is attached.

Vanguard Health Systems Chicago Market

HEALTH INFORMATION MANAGEMENT DEPARTMENT

Section: Record Management

Title: Retention, Storage and Destruction Policy

POLICY: All original medical records and health network records shall be preserved in accordance with the health enterprise policy based on the Illinois Hospital and HealthSystems Association recommendations in conjunction with the American Health Information Management Association and American Hospital Association and legal opinion. The retention time of medical record information is determined by law and regulation and by its use for patient care, legal, research, and/or educational purposes.

PURPOSE: To assure retention and preservation of all valued hospital and health network records. To establish record retention periods consistent with patient care needs. To comply with legal statutory and regulatory requirements pertaining to record retention. To serve medicolegal purposes, namely, to preserve patient and health network records for the probable statute of limitations periods for suits, and to generally adhere to recommended retention periods promulgated by respected medical associations, e.g. the Illinois Hospital and HealthSystems Association, so as to establish conformance with generally accepted practices.

COMPONENTS OF A MEDICAL RECORD:

Admission/discharge form
Anesthesia document
Authorization to Treat
Autopsy report
Consent for release of information
Consultation Reports
Dietary
Discharge Summary
Electronic Monitoring Strips
Graphic sheet
Labor/Delivery record
Medical History
Laboratory Reports
Medication Record
Newborn records
Nurses notes and flow sheets
Occupational therapy
Operative Record
Pastoral Care
Pathology Reports
Physician Orders
Physical examination
Physical Therapy
Progress Notes
Psychiatric history
Radiology Reports
Recovery Room Record
Social Service forms
Special consent forms
Special medical reports

OTHER DOCUMENTS:

When providers of health care collect raw data in the testing and assessment of the patient's health status, this information constitutes a medical document regardless of whether or not it is stored within or collated with the medical record. Raw data that is stored in the testing department shall be retained for the same time period as are the documents. All documents that pertain to a patient's diagnosis and treatment is considered a health document and shall be retained for the same time period as the medical document.

DOCUMENT RETENTION PERIODS:

MEDICAL RECORDS and HEALTH NETWORK RECORDS

Medical Records shall be retained for a minimum period of ten (10) years after the most recent patient care usage. Selected portions of the record shall be retained permanently.

DOCUMENT	RETENTION PERIOD	REMARKS
Accounting/Finance/Payroll		
Accounts Payable Ledgers and Schedules	7 years	
Accounts Receivables Ledgers and Schedules	7 years	
Annual Reports to Government	Permanent	
Audit Report of Accountants	Permanent	
Bank Reconciliation's	1 year	
Budget - worksheets	1 year	
Budget - final copy	3 years	
Capital Stock and Bond Records	Permanent	
Cash Receipts	1 year	
Cash Receipt Ledger	5 years	
Cash Reconciliations (daily)	1 year	
Cash Books	Permanent	
Charge Receipts	5 years	
Charge Tickets	2 years	
Chart of Account	Permanent	
Checks (canceled)	7 years	
Contracts and Leases/Expired	7 years	
Contracts and Leases/In Effect	Permanent	
Copyright Registrations	Permanent	
Correspondence - general	1-3 years	
Correspondence - legal/important	10 years/Permanent	

Axel & Associates, Inc.

MANAGEMENT CONSULTANTS

by Certified Mail

April 1, 2013

Mr. Bruce Crowther
Chief Executive Officer
Northwest Community Hospital
800 West Central Road
Arlington Heights, IL 60005

Dear Mr. Crowther:

VHS Westlake Hospital is preparing a Certificate of Need application to be filed with the Illinois Health Facilities and Services Review Board ("IHFSRB"), addressing the discontinuation of its obstetrics and open heart surgery categories of service. The hospital is located at 1225 Lake Street in Melrose Park, Illinois. The discontinuations are scheduled to occur following IHFSRB approval, anticipated to occur in August, 2013.

Over the past two years, the hospital has had 2,262 obstetrical admissions and 38 open heart surgery procedures.

As part of the discontinuation process, and consistent with the requirements of Section 1110.130.c), you are hereby asked to, within fifteen days, identify what impact, if any, the proposed discontinuation of the obstetrics and open heart surgery categories of service at VHS Westlake Hospital will have on your operations; whether your facility has the available capacity to accommodate a portion or all of VHS Westlake Hospital's open heart surgery and obstetrics caseload, and whether your facility operates with any restrictions or limitations that would preclude providing service to residents of VHS Westlake Hospital's market area.

Thank you for your prompt attention to this request.

Sincerely,

Jacob M. Axel
President

ATTACHMENT 10

675 North Court, Suite 210
Palatine, Illinois 60067

Phone (847) 776-7101
Fax (847) 776-7004

Notes

mapquest

Trip to:

Northwestern Memorial Hospital
541 N Fairbanks Ct

Chicago, IL 60611
(312) 755-0604
15.10 miles / 25 minutes

Westlake Hospital-ER
1225 W Lake St, Melrose Park, IL 60160
(708) 938-7190

1. Start out going **north** toward **Chicago Ave**. Map	**0.04 Mi**	*0.04 Mi Total*
2. Take the 1st **right** onto **Chicago Ave**. Map	**0.7 Mi**	*0.7 Mi Total*
3. Turn **right** onto **N 1st Ave / IL-171**. Map *N 1st Ave is just past N 2nd Ave* *If you reach Thatcher Ave you've gone about 0.4 miles too far*	**1.6 Mi**	*2.3 Mi Total*
4. Merge onto **I-290 E / IL-110 E / Eisenhower Expy E** via the ramp on the **left**. Map *If you are on S 1st Ave and reach Lexington St you've gone a little too far*	**9.6 Mi**	*11.9 Mi Total*
5. Merge onto **I-90 W / I-94 W / Kennedy Expy W** toward **Wisconsin**. Map	**1.5 Mi**	*13.4 Mi Total*
6. Take **EXIT 50B** toward **East Ohio St**. Map	**0.8 Mi**	*14.2 Mi Total*
7. Stay **straight** to go onto **W Ohio St**. Map	**0.9 Mi**	*15.1 Mi Total*
8. Turn **right** onto **N Fairbanks Ct**. Map *N Fairbanks Ct is 0.1 miles past N St Clair St* *Markethouse is on the corner* *If you reach N McClurg Ct you've gone about 0.1 miles too far*	**0.04 Mi**	*15.1 Mi Total*
9. **541 N FAIRBANKS CT** is on the **left**. Map *If you reach E Grand Ave you've gone a little too far*		

Northwestern Memorial Hospital
541 N Fairbanks Ct, Chicago, IL 60611
(312) 755-0604

Total Travel Estimate: **15.10 miles - about 25 minutes**

ATTACHMENT 10

30

Notes

mapquest

Trip to:

Resurrection Medical Center
7435 W Talcott Ave
Chicago, IL 60631
(773) 792-5032
9.17 miles / 22 minutes

Westlake Hospital-ER
1225 W Lake St, Melrose Park, IL 60160
(708) 938-7190

1. Start out going **north** toward **Chicago Ave**. Map	**0.04 Mi** *0.04 Mi Total*
2. Take the 1st **right** onto **Chicago Ave**. Map	**0.7 Mi** *0.7 Mi Total*
3. Turn **left** onto **N 1st Ave / IL-171**. Continue to follow **IL-171 N**. Map	**6.1 Mi** *6.9 Mi Total*
4. Merge onto **I-90 E / Kennedy Expy E**. Map	**1.2 Mi** *8.1 Mi Total*
5. Take **EXIT 81A** toward **IL-43 / Harlem Ave**. Map	**0.2 Mi** *8.3 Mi Total*
6. Stay **straight** to go onto **W Higgins Ave / IL-72 E**. Map	**0.2 Mi** *8.5 Mi Total*
7. Turn **left** onto **N Harlem Ave / IL-43**. Map	**0.3 Mi** *8.8 Mi Total*
8. Turn **left** onto **W Talcott Ave**. Map	**0.4 Mi** *9.2 Mi Total*
9. **7435 W TALCOTT AVE** is on the **left**. Map	

Resurrection Medical Center
Home Medical Equipment
7435 W Talcott Ave, Chicago, IL 60631
(773) 792-5032

Total Travel Estimate: **9.17 miles - about 22 minutes**

ATTACHMENT 10

Notes

mapquest

Trip to:

St Joseph Hospital-ER
2900 N Lake Shore Dr
Chicago, IL 60657
(773) 665-3086
17.33 miles / 33 minutes

Westlake Hospital-ER
1225 W Lake St, Melrose Park, IL 60160
(708) 938-7190

1. Start out going **north** toward **Chicago Ave**. Map	**0.04 Mi** *0.04 Mi Total*
2. Take the 1st **right** onto **Chicago Ave**. Map	**0.7 Mi** *0.7 Mi Total*
3. Turn **right** onto **N 1st Ave / IL-171**. Map	**1.6 Mi** *2.3 Mi Total*
4. Merge onto **I-290 E / IL-110 E / Eisenhower Expy E** via the ramp on the **left**. Map	**9.6 Mi** *11.9 Mi Total*
5. Merge onto **I-90 W / I-94 W / Kennedy Expy W** toward **Wisconsin**. Map	**0.8 Mi** *12.7 Mi Total*
6. Take the **West Randolph St** exit, **EXIT 51B**. Map	**0.1 Mi** *12.8 Mi Total*
7. Turn **left** onto **W Randolph St**. Map	**0.1 Mi** *13.0 Mi Total*
8. Turn **right** onto **N Halsted St**. Map	**1.9 Mi** *14.8 Mi Total*
9. **N Halsted St** becomes **N Halsted Sts**. Map	**0.05 Mi** *14.9 Mi Total*
10. **N Halsted Sts** becomes **N Halsted St**. Map	**1.4 Mi** *16.3 Mi Total*
11. Turn **right** onto **W Diversey Pky**. Map	**0.5 Mi** *16.8 Mi Total*
12. Turn **left** onto **N Sheridan Rd**. Map	**0.3 Mi** *17.1 Mi Total*
13. Turn **right** onto **W Wellington Ave**. Map	**0.1 Mi** *17.2 Mi Total*

ATTACHMENT 10

32

14. Turn **right** onto **N Lake Shore Dr W.** Map — **0.1 Mi**
17.3 Mi Total

15. **2900 N LAKE SHORE DR** is on the **right.** Map

St Joseph Hospital-ER
2900 N Lake Shore Dr, Chicago, IL 60657
(773) 665-3086

Total Travel Estimate: **17.33 miles - about 33 minutes**

ATTACHMENT 10

33

Notes

mapquest

Trip to:

ATM - Swedish Covenant Hospital
5140 N California Ave

Chicago, IL 60625
(800) 432-1000
14.78 miles / 33 minutes

Westlake Hospital-ER
1225 W Lake St, Melrose Park, IL 60160
(708) 938-7190

1. Start out going **north** toward **Chicago Ave**. Map	**0.04 Mi**	*0.04 Mi Total*
2. Take the 1st **right** onto **Chicago Ave**. Map	**0.7 Mi**	*0.7 Mi Total*
3. Turn **left** onto **N 1st Ave / IL-171**. Continue to follow **IL-171 N**. Map	**6.1 Mi**	*6.9 Mi Total*
4. Merge onto **I-90 E / Kennedy Expy E**. Map	**4.3 Mi**	*11.2 Mi Total*
5. Take the **Lawrence Ave** exit, **EXIT 84**. Map	**0.2 Mi**	*11.4 Mi Total*
6. Turn **slight left** onto **W Lawrence Ave**. Map	**3.0 Mi**	*14.4 Mi Total*
7. Turn **left** onto **N California Ave**. Map	**0.4 Mi**	*14.8 Mi Total*
8. **5140 N CALIFORNIA AVE** is on the **left**. Map		

ATM - Swedish Covenant Hospital
5140 N California Ave, Chicago, IL 60625
(800) 432-1000

Total Travel Estimate: **14.78 miles - about 33 minutes**

ATTACHMENT 10

Notes

mapquest

Trip to:

John H Stroger Jr Hospital-ER
1901 W Harrison St

Chicago, IL 60612
(312) 864-1300
10.64 miles / 17 minutes

Westlake Hospital-ER
1225 W Lake St, Melrose Park, IL 60160
(708) 938-7190

1. Start out going **north** toward **Chicago Ave**. Map	**0.04 Mi** *0.04 Mi Total*
2. Take the 1st **right** onto **Chicago Ave**. Map	**0.7 Mi** *0.7 Mi Total*
3. Turn **right** onto **N 1st Ave / IL-171**. Map	**1.6 Mi** *2.3 Mi Total*
4. Merge onto **I-290 E / IL-110 E / Eisenhower Expy E** via the ramp on the **left**. Map	**8.0 Mi** *10.3 Mi Total*
5. Take **EXIT 28A** toward **Damen Ave**. Map	**0.1 Mi** *10.5 Mi Total*
6. Stay **straight** to go onto **W Congress Pky**. Map	**0.03 Mi** *10.5 Mi Total*
7. Take the 1st **right** onto **S Damen Ave**. Map	**0.07 Mi** *10.6 Mi Total*
8. Take the 1st **left** onto **W Harrison St**. Map	**0.08 Mi** *10.6 Mi Total*
9. **1901 W HARRISON ST** is on the **right**. Map	

John H Stroger Jr Hospital-ER
1901 W Harrison St, Chicago, IL 60612
(312) 864-1300

Total Travel Estimate: **10.64 miles - about 17 minutes**

ATTACHMENT 10

35

Notes

mapquest

Trip to:

Mount Sinai Hospital
Ogden At California Ave
Chicago, IL 60608
(773) 542-2000
10.37 miles / 18 minutes

Westlake Hospital-ER
1225 W Lake St, Melrose Park, IL 60160
(708) 938-7190

1. Start out going **north** toward **Chicago Ave**. Map	**0.04 Mi**	*0.04 Mi Total*
2. Take the 1st **right** onto **Chicago Ave**. Map	**0.7 Mi**	*0.7 Mi Total*
3. Turn **right** onto **N 1st Ave / IL-171**. Map	**1.6 Mi**	*2.3 Mi Total*
4. Merge onto **I-290 E / IL-110 E / Eisenhower Expy E** via the ramp on the **left**. Map	**6.7 Mi**	*9.0 Mi Total*
5. Take the **Sacramento Blvd** exit, **EXIT 27A**. Map	**0.2 Mi**	*9.2 Mi Total*
6. Turn **right** onto **S Sacramento Blvd**. Map	**0.5 Mi**	*9.8 Mi Total*
7. Turn **left** onto **W Roosevelt Rd**. Map	**0.3 Mi**	*10.0 Mi Total*
8. Turn **right** onto **S California Ave**. Map	**0.4 Mi**	*10.4 Mi Total*
9. **OGDEN AT CALIFORNIA AVE**. Map		

Mount Sinai Hospital
Ogden At California Ave, Chicago, IL 60608
(773) 542-2000

Total Travel Estimate: **10.37 miles - about 18 minutes**

ATTACHMENT 10

36

Notes

mapquest

Trip to:

Rush University Medical Center
1653 W Congress Pkwy
Chicago, IL 60612
(312) 942-5000
10.92 miles / 18 minutes

Westlake Hospital-ER
1225 W Lake St, Melrose Park, IL 60160
(708) 938-7190

1. Start out going **north** toward **Chicago Ave**. Map	**0.04 Mi** *0.04 Mi Total*
2. Take the 1st **right** onto **Chicago Ave**. Map	**0.7 Mi** *0.7 Mi Total*
3. Turn **right** onto **N 1st Ave / IL-171**. Map	**1.6 Mi** *2.3 Mi Total*
4. Merge onto **I-290 E / IL-110 E / Eisenhower Expy E** via the ramp on the **left**. Map	**8.4 Mi** *10.7 Mi Total*
5. Take **EXIT 28B** toward **Paulina St / Ashland Ave**. Map	**0.2 Mi** *10.8 Mi Total*
6. Stay **straight** to go onto **W Congress Pky**. Map	**0.03 Mi** *10.9 Mi Total*
7. Take the 1st **right**. Map	**0.05 Mi** *10.9 Mi Total*
8. Turn **left**. Map	**0.01 Mi** *10.9 Mi Total*
9. **1653 W CONGRESS PKWY**. Map	

Rush University Medical Center
Patient Information
1653 W Congress Pkwy, Chicago, IL 60612
(312) 942-5000

Total Travel Estimate: **10.92 miles - about 18 minutes**

ATTACHMENT 10

Notes

mapquest

Trip to:

ATM - St Mary of Nazareth
2222 W Division St

Chicago, IL 60622
(800) 432-1000
12.14 miles / 23 minutes

Westlake Hospital-ER
1225 W Lake St, Melrose Park, IL 60160
(708) 938-7190

1. Start out going **north** toward **Chicago Ave**. Map	**0.04 Mi**	*0.04 Mi Total*
2. Take the 1st **right** onto **Chicago Ave**. Map	**0.7 Mi**	*0.7 Mi Total*
3. Turn **right** onto **N 1st Ave / IL-171**. Map	**1.6 Mi**	*2.3 Mi Total*
4. Merge onto **I-290 E / IL-110 E / Eisenhower Expy E** via the ramp on the **left**. Map	**7.3 Mi**	*9.6 Mi Total*
5. Take **EXIT 27C** toward **Western Ave**. Map	**0.2 Mi**	*9.8 Mi Total*
6. Keep **right** at the fork in the ramp. Map	**0.1 Mi**	*9.9 Mi Total*
7. Stay **straight** to go onto **W Congress Pky**. Map	**0.07 Mi**	*10.0 Mi Total*
8. Turn **left** onto **S Western Ave**. Map	**1.9 Mi**	*11.9 Mi Total*
9. Turn **right** onto **W Division St**. Map	**0.2 Mi**	*12.1 Mi Total*
10. **2222 W DIVISION ST** is on the **left**. Map		

ATM - St Mary of Nazareth
2222 W Division St, Chicago, IL 60622
(800) 432-1000

Total Travel Estimate: **12.14 miles - about 23 minutes**

ATTACHMENT 10

mapquest

Notes

Trip to:

University of Illinois Medical Center At Chicago Outpatient Centers
1801 W Taylor St
Chicago, IL 60612
(312) 996-3500
11.14 miles / 19 minutes

Westlake Hospital-ER
1225 W Lake St, Melrose Park, IL 60160
(708) 938-7190

1. Start out going **north** toward **Chicago Ave**. Map	**0.04 Mi**	*0.04 Mi Total*
2. Take the 1st **right** onto **Chicago Ave**. Map	**0.7 Mi**	*0.7 Mi Total*
3. Turn **right** onto **N 1st Ave / IL-171**. Map	**1.6 Mi**	*2.3 Mi Total*
4. Merge onto **I-290 E / IL-110 E / Eisenhower Expy E** via the ramp on the **left**. Map	**8.0 Mi**	*10.3 Mi Total*
5. Take **EXIT 28A** toward **Damen Ave**. Map	**0.1 Mi**	*10.5 Mi Total*
6. Stay **straight** to go onto **W Congress Pky**. Map	**0.03 Mi**	*10.5 Mi Total*
7. Take the 1st **right** onto **S Damen Ave**. Map	**0.4 Mi**	*10.9 Mi Total*
8. Turn **left** onto **W Taylor St**. Map	**0.3 Mi**	*11.1 Mi Total*
9. **1801 W TAYLOR ST** is on the **right**. Map		

University of Illinois Medical Center At Chicago Outpatient Centers
Cardio-Thoracic Surgery
1801 W Taylor St, Chicago, IL 60612
(312) 996-3500

Total Travel Estimate: **11.14 miles - about 19 minutes**

ATTACHMENT 10

39

Notes

mapquest

Trip to:

Mercy Hospital & Medical Center
2525 S Michigan Ave
Chicago, IL 60616
(312) 567-2141
15.87 miles / 25 minutes

Westlake Hospital-ER
1225 W Lake St, Melrose Park, IL 60160
(708) 938-7190

1. Start out going **north** toward **Chicago Ave**. Map	**0.04 Mi**	*0.04 Mi Total*
2. Take the 1st **right** onto **Chicago Ave**. Map	**0.7 Mi**	*0.7 Mi Total*
3. Turn **right** onto **N 1st Ave / IL-171**. Map	**1.6 Mi**	*2.3 Mi Total*
4. Merge onto **I-290 E / IL-110 E / Eisenhower Expy E** via the ramp on the **left**. Map	**9.6 Mi**	*11.9 Mi Total*
5. Merge onto **I-90 E / I-94 E / Dan Ryan Expy E** toward **Indiana**. Map	**1.4 Mi**	*13.2 Mi Total*
6. Merge onto **I-55 N / Stevenson Expy N** via **EXIT 53** toward **Lake Shore Dr**. Map	**1.9 Mi**	*15.1 Mi Total*
7. Take **EXIT 293D** toward **Martin L King Dr**. Map	**0.1 Mi**	*15.2 Mi Total*
8. Keep **right** at the fork in the ramp. Map	**0.04 Mi**	*15.3 Mi Total*
9. Turn **slight left** onto **E 25th St**. Map	**0.05 Mi**	*15.3 Mi Total*
10. Take the 1st **right** onto **S Dr Martin L King Jr Dr**. Map	**0.2 Mi**	*15.5 Mi Total*
11. Turn **right** onto **E 26th St**. Map	**0.3 Mi**	*15.8 Mi Total*
12. Turn **right** onto **S Michigan Ave**. Map	**0.09 Mi**	*15.9 Mi Total*
13. **2525 S MICHIGAN AVE** is on the **right**. Map		

ATTACHMENT 10

40

Mercy Hospital & Medical Center
Patient Information
2525 S Michigan Ave, Chicago, IL 60616
(312) 567-2141

Total Travel Estimate: **15.87 miles - about 25 minutes**

ATTACHMENT 10

41

Notes

Trip to:

Advocate II Masonic Medical Center
836 W Wellington Ave

Chicago, IL 60657

17.75 miles / 31 minutes

Westlake Hospital-ER
1225 W Lake St, Melrose Park, IL 60160

1. Start out going **north** toward **Chicago Ave**. Map	**0.04 Mi** *0.04 Mi Total*
2. Take the 1st **right** onto **Chicago Ave**. Map	**0.7 Mi**
3. Turn **right** onto **N 1st Ave / IL-171**. Map	**1.6 Mi** *2.3 Mi Total*
4. Merge onto **I-290 E / IL-110 E / Eisenhower Expy E** via the ramp on the **left**. Map	**9.6 Mi** *11.9 Mi Total*
5. Merge onto **I-90 W / I-94 W / Kennedy Expy W** toward **Wisconsin**. Map	**3.5 Mi** *15.4 Mi Total*
6. Take the **Armitage Ave** exit, **EXIT 48A**. Map	**0.2 Mi** *15.6 Mi Total*
	15.7 Mi Total
8. Take the 2nd **left** onto **N Ashland Ave**. Map	**1.0 Mi** *16.7 Mi Total*
	17.2 Mi Total
10. Turn **left** onto **N Racine Ave**. Map	**0.3 Mi** *17.4 Mi Total*
11. Turn **right** onto **W Wellington Ave**. Map	**0.3 Mi**
12. **836 W WELLINGTON AVE**. Map	

Advocate II Masonic Medical Center

(773) 975-1600

ATTACHMENT ~~10~~

Notes

mapquest

Trip to:

University of Chicago Med Ctr-ER
5841 S Maryland Ave
Chicago, IL 60637
(773) 702-6250
19.90 miles / 33 minutes

Westlake Hospital-ER
1225 W Lake St, Melrose Park, IL 60160
(708) 938-7190

1. Start out going **north** toward **Chicago Ave**. Map	**0.04 Mi**	*0.04 Mi Total*
2. Take the 1st **right** onto **Chicago Ave**. Map	**0.7 Mi**	*0.7 Mi Total*
3. Turn **right** onto **N 1st Ave / IL-171**. Map	**1.6 Mi**	*2.3 Mi Total*
4. Merge onto **I-290 E / IL-110 E / Eisenhower Expy E** via the ramp on the **left**. Map	**9.6 Mi**	*11.9 Mi Total*
5. Merge onto **I-90 E / I-94 E / Dan Ryan Expy E** toward **Indiana**. Map	**2.5 Mi**	*14.4 Mi Total*
6. Keep **left** to take **I-94 Express Ln E / Dan Ryan Express Ln E / I-90 Express Ln E** toward **Garfield Blvd**. Map	**2.2 Mi**	*16.6 Mi Total*
7. Take the **I-90-LOCAL / I-94-LOCAL** exit. Map	**0.3 Mi**	*16.9 Mi Total*
8. Merge onto **I-90 E / I-94 E / Dan Ryan Expy E**. Map	**0.8 Mi**	*17.7 Mi Total*
9. Take **EXIT 57** toward **Garfield Blvd**. Map	**0.2 Mi**	*18.0 Mi Total*
10. Stay **straight** to go onto **S Wells St**. Map	**0.09 Mi**	*18.1 Mi Total*
11. Take the 1st **left** onto **W Garfield Blvd / W 55th St**. Map	**0.9 Mi**	*19.0 Mi Total*
12. **W Garfield Blvd / W 55th St** becomes **Morgan Dr**. Map	**0.2 Mi**	*19.2 Mi Total*
13. Turn **slight left** onto **Rainey Dr**. Map	**0.2 Mi**	*19.3 Mi Total*

ATTACHMENT 10

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↑	14. **Rainey Dr** becomes **Payne Dr**. Map	**0.05 Mi** *19.4 Mi Total*
↱	15. Turn **right** onto **E Garfield Blvd / E 55th St**. Map	**0.06 Mi** *19.5 Mi Total*
↱	16. Turn **right** onto **S Cottage Grove Ave**. Map	**0.4 Mi** *19.8 Mi Total*
↰	17. Turn **left** onto **E 58th St**. Map	**0.06 Mi** *19.9 Mi Total*
↱	18. Take the 1st **right** onto **S Maryland Ave**. Map	**0.01 Mi** *19.9 Mi Total*
■	19. **5841 S MARYLAND AVE** is on the **left**. Map	

B **University of Chicago Med Ctr-ER**
5841 S Maryland Ave, Chicago, IL 60637
(773) 702-6250

Total Travel Estimate: **19.90 miles - about 33 minutes**

ATTACHMENT 10

44

Notes

mapquest

Trip to:

Adventist La Grange Memorial Hospital
5101 Willow Springs Rd
La Grange, IL 60525
(708) 245-9000
9.98 miles / 25 minutes

Westlake Hospital-ER
1225 W Lake St, Melrose Park, IL 60160
(708) 938-7190

1. Start out going **north** toward **Chicago Ave**. Map	**0.04 Mi**	*0.04 Mi Total*
2. Take the 1st **right** onto **Chicago Ave**. Map	**0.7 Mi**	*0.7 Mi Total*
3. Turn **right** onto **N 1st Ave / IL-171**. Map	**5.6 Mi**	*6.4 Mi Total*
4. Turn **right** onto **Plainfield Rd**. Map	**1.0 Mi**	*7.3 Mi Total*
5. Turn **slight right** onto **W 47th St / 47th St**. Continue to follow **W 47th St**. Map	**2.1 Mi**	*9.4 Mi Total*
6. Turn **left** onto **Willow Springs Rd / Gilbert Ave / S Gilbert Ave**. Continue to follow **Willow Springs Rd / Gilbert Ave**. Map	**0.5 Mi**	*10.0 Mi Total*
7. **5101 WILLOW SPRINGS RD** is on the **left**. Map		

Adventist La Grange Memorial Hospital
Emergency Services TDD
5101 Willow Springs Rd, La Grange, IL 60525
(708) 245-9000

Total Travel Estimate: **9.98 miles - about 25 minutes**

ATTACHMENT 10

45

Notes

mapquest

Trip to:
4440 W 95th St Advocate Christ
Oak Lawn, IL 60453-2600
17.83 miles / 39 minutes

Westlake Hospital-ER
1225 W Lake St, Melrose Park, IL 60160
(708) 938-7190

1. Start out going **north** toward **Chicago Ave**. Map	**0.04 Mi**	*0.04 Mi Total*
2. Take the 1st **right** onto **Chicago Ave**. Map	**0.7 Mi**	*0.7 Mi Total*
3. Turn **right** onto **N 1st Ave / IL-171**. Map	**1.6 Mi**	*2.3 Mi Total*
4. Merge onto **I-290 E / IL-110 E / Eisenhower Expy E** via the ramp on the **left**. Map	**4.4 Mi**	*6.7 Mi Total*
5. Take **EXIT 24B** toward **IL-50 / Cicero Ave**. Map	**0.2 Mi**	*6.9 Mi Total*
6. Turn **slight left** onto **W Lexington St**. Map	**0.06 Mi**	*6.9 Mi Total*
7. Take the 1st **right** onto **S Cicero Ave / IL-50 S**. Continue to follow **IL-50 S**. Map	**10.5 Mi**	*17.4 Mi Total*
8. Turn **left** onto **US-20 / US-12 / Ulysses S Grant Memorial Hwy / W 95th St**. Map	**0.4 Mi**	*17.8 Mi Total*
9. **4440 W 95TH ST** is on the **left**. Map		

4440 W 95th St, Oak Lawn, IL 60453-2600

Total Travel Estimate: **17.83 miles - about 39 minutes**

ATTACHMENT 10

Notes

mapquest

Trip to:

Palos Community Hospital
12251 S 80th Ave

Palos Heights, IL 60463
(708) 923-4000
20.47 miles / 36 minutes

Westlake Hospital-ER
1225 W Lake St, Melrose Park, IL 60160
(708) 938-7190

1. Start out going **north** toward **Chicago Ave**. Map	**0.04 Mi**	*0.04 Mi Total*
2. Take the 1st **right** onto **Chicago Ave**. Map	**0.7 Mi**	*0.7 Mi Total*
3. Turn **right** onto **N 1st Ave / IL-171**. Continue to follow **IL-171 S**. Map	**7.1 Mi**	*7.9 Mi Total*
4. Merge onto **I-55 S / Stevenson Expy S** toward **St Louis**. Map	**3.1 Mi**	*10.9 Mi Total*
5. Take the **US-12 / US-20 / US-45** exit, **EXIT 279A-B**, toward **La Grange Rd**. Map	**0.2 Mi**	*11.2 Mi Total*
6. Merge onto **US-45 S** via the ramp on the **left**. Map	**6.4 Mi**	*17.6 Mi Total*
7. Take the **Calumet Sag Rd / IL-83** ramp. Map	**0.2 Mi**	*17.7 Mi Total*
8. Turn **right** onto **W Cal Sag Rd / IL-83**. Map	**2.3 Mi**	*20.1 Mi Total*
9. Turn **right** onto **S 80th Ave**. Map	**0.4 Mi**	*20.5 Mi Total*
10. **12251 S 80TH AVE** is on the **left**. Map		

Palos Community Hospital
12251 S 80th Ave, Palos Heights, IL 60463
(708) 923-4000

Total Travel Estimate: **20.47 miles - about 36 minutes**

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Notes

mapquest

Trip to:

Adventist Hinsdale Hospital
120 N Oak St
Hinsdale, IL 60521
(630) 856-9000
10.10 miles / 21 minutes

Westlake Hospital-ER
1225 W Lake St, Melrose Park, IL 60160
(708) 938-7190

1. Start out going **north** toward **Chicago Ave**. Map	**0.04 Mi**	*0.04 Mi Total*
2. Take the 1st **left** onto **Chicago Ave**. Map	**0.3 Mi**	*0.3 Mi Total*
3. Turn **left** onto **N 17th Ave**. Map	**0.02 Mi**	*0.4 Mi Total*
4. Take the 1st **right** onto **W Lake St**. Map	**0.5 Mi**	*0.9 Mi Total*
5. Turn **left** onto **N 25th Ave**. Map	**1.6 Mi**	*2.5 Mi Total*
6. Turn **right** onto **Harrison St**. Map	**0.06 Mi**	*2.5 Mi Total*
7. Turn **slight left** to stay on **Harrison St**. Map	**0.2 Mi**	*2.8 Mi Total*
8. Merge onto **I-290 W / IL-110 W / Eisenhower Expy W** via the ramp on the **left**. Map	**1.9 Mi**	*4.7 Mi Total*
9. Keep **left** to take **I-88 W / IL-110 W / Ronald Reagan Memorial Tollway** via **EXIT 15A** toward **Aurora / I-294 S / Indiana** (Portions toll). Map	**0.5 Mi**	*5.1 Mi Total*
10. Merge onto **I-294 S** toward **Indiana** (Portions toll). Map	**3.6 Mi**	*8.7 Mi Total*
11. Take the **US-34 W / Ogden Ave** exit. Map	**0.4 Mi**	*9.1 Mi Total*
12. Turn **slight right** onto **E Ogden Ave / US-34**. Map	**0.1 Mi**	*9.2 Mi Total*
13. Turn **left** onto **N Oak St**. Map	**0.7 Mi**	*9.9 Mi Total*

ATTACHMENT 10

48

	14. Turn **right** onto **E Hickory St**. Map	**0.05 Mi** *10.0 Mi Total*
	15. Take the 1st **left** onto **N Oak St**. Map	**0.1 Mi** *10.1 Mi Total*
	16. **120 N OAK S**T is on the **right**. Map	

Adventist Hinsdale Hospital
Telephone Device for The Deaf
120 N Oak St, Hinsdale, IL 60521
(630) 856-9000

Total Travel Estimate: **10.10 miles - about 21 minutes**

ATTACHMENT 10

4/9

Notes

mapquest

Trip to:

Advocate Good Samaritan Hospital
4924 Forest Ave

Downers Grove, IL 60515
(630) 275-4085
13.82 miles / 26 minutes

Westlake Hospital-ER
1225 W Lake St, Melrose Park, IL 60160
(708) 938-7190

1. Start out going **north** toward **Chicago Ave**. Map	**0.04 Mi**	*0.04 Mi Total*
2. Take the 1st **left** onto **Chicago Ave**. Map	**0.3 Mi**	*0.3 Mi Total*
3. Turn **left** onto **N 17th Ave**. Map	**0.02 Mi**	*0.4 Mi Total*
4. Take the 1st **right** onto **W Lake St**. Map	**0.5 Mi**	*0.9 Mi Total*
5. Turn **left** onto **N 25th Ave**. Map	**1.6 Mi**	*2.5 Mi Total*
6. Turn **right** onto **Harrison St**. Map	**0.06 Mi**	*2.5 Mi Total*
7. Turn **slight left** to stay on **Harrison St**. Map	**0.2 Mi**	*2.8 Mi Total*
8. Merge onto **I-290 W / IL-110 W / Eisenhower Expy W** via the ramp on the **left**. Map	**1.9 Mi**	*4.7 Mi Total*
9. Keep **left** to take **I-88 W / IL-110 W / Ronald Reagan Memorial Tollway** via **EXIT 15A** toward **Aurora / I-294 S / Indiana** (Portions toll). Map	**1.9 Mi**	*6.6 Mi Total*
10. Keep **right** at the fork to continue on **I-88 W / IL-110 W / Ronald Reagan Memorial Tollway** (Portions toll). Map	**4.3 Mi**	*10.9 Mi Total*
11. Take the **Highland Ave** exit. Map	**0.2 Mi**	*11.1 Mi Total*
12. Keep **left** to take the ramp toward **Downers Grove / Midwestern College / Keller College**. Map	**0.04 Mi**	*11.2 Mi Total*
13. Turn **left** onto **Highland Ave**. Map	**1.3 Mi**	*12.4 Mi Total*

ATTACHMENT 10

50

↑	14. **Highland Ave** becomes **Main St**. Map	**1.3 Mi** *13.7 Mi Total*
↱	15. Turn **right** onto **Franklin St**. Map	**0.07 Mi** *13.7 Mi Total*
↰	16. Take the 1st **left** onto **Forest Ave**. Map	**0.08 Mi** *13.8 Mi Total*
■	17. **4924 FOREST AVE** is on the **right**. Map	

Advocate Good Samaritan Hospital
4924 Forest Ave, Downers Grove, IL 60515
(630) 275-4085

Total Travel Estimate: **13.82 miles - about 26 minutes**

ATTACHMENT 10

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Notes

mapquest

Trip to:

Central Dupage Hospital
25 N Winfield Rd

Winfield, IL 60190
(630) 933-2662
19.25 miles / 38 minutes

Westlake Hospital-ER
1225 W Lake St, Melrose Park, IL 60160
(708) 938-7190

1. Start out going **north** toward **Chicago Ave**. Map	**0.04 Mi**	*0.04 Mi Total*
2. Take the 1st **left** onto **Chicago Ave**. Map	**0.3 Mi**	*0.3 Mi Total*
3. Turn **left** onto **N 17th Ave**. Map	**0.02 Mi**	*0.4 Mi Total*
4. Take the 1st **right** onto **W Lake St**. Map	**0.5 Mi**	*0.9 Mi Total*
5. Turn **right** onto **N 25th Ave**. Map	**0.9 Mi**	*1.8 Mi Total*
6. Turn **left** onto **W North Ave / IL-64 W**. Continue to follow **IL-64 W**. Map	**14.7 Mi**	*16.5 Mi Total*
7. Turn **slight left**. Map	**0.08 Mi**	*16.6 Mi Total*
8. Turn **left** onto **County Farm Rd**. Map	**1.4 Mi**	*17.9 Mi Total*
9. Turn **right** onto **Geneva Rd**. Map	**0.3 Mi**	*18.2 Mi Total*
10. Turn **left** onto **Winfield Rd**. Map	**1.0 Mi**	*19.2 Mi Total*
11. **25 N WINFIELD RD**. Map		

Central Dupage Hospital
25 N Winfield Rd, Winfield, IL 60190
(630) 933-2662

Total Travel Estimate: **19.25 miles - about 38 minutes**

ATTACHMENT 10

5-2

Notes

mapquest

Trip to:

Edward Hospital
801 S Washington St
Naperville, IL 60540
(630) 527-3000
22.95 miles / 39 minutes

Westlake Hospital-ER
1225 W Lake St, Melrose Park, IL 60160
(708) 938-7190

1. Start out going **north** toward **Chicago Ave**. Map	**0.04 Mi**	*0.04 Mi Total*
2. Take the 1st **left** onto **Chicago Ave**. Map	**0.3 Mi**	*0.3 Mi Total*
3. Turn **left** onto **N 17th Ave**. Map	**0.02 Mi**	*0.4 Mi Total*
4. Take the **1st right** onto **W Lake St**. Map	**0.5 Mi**	*0.9 Mi Total*
5. Turn **left** onto **N 25th Ave**. Map	**1.6 Mi**	*2.5 Mi Total*
6. Turn **right** onto **Harrison St**. Map	**0.06 Mi**	*2.5 Mi Total*
7. Turn **slight left** to stay on **Harrison St**. Map	**0.2 Mi**	*2.8 Mi Total*
8. Merge onto **I-290 W / IL-110 W / Eisenhower Expy W** via the ramp on the **left**. Map	**1.9 Mi**	*4.7 Mi Total*
9. Keep **left** to take **I-88 W / IL-110 W / Ronald Reagan Memorial Tollway** via **EXIT 15A** toward **Aurora / I-294 S / Indiana** (Portions toll). Map	**1.9 Mi**	*6.6 Mi Total*
10. Keep **right** at the fork to continue on **I-88 W / IL-110 W / Ronald Reagan Memorial Tollway** (Portions toll). Map	**5.6 Mi**	*12.2 Mi Total*
11. Merge onto **I-355 S / Veterans Memorial Tollway** toward **Joliet** (Portions toll). Map	**4.5 Mi**	*16.7 Mi Total*
12. Take the **63rd St / Hobson Rd** exit. Map	**0.3 Mi**	*17.0 Mi Total*
13. Keep **right** to take the ramp toward **Woodridge / Naperville**. Map	**0.03 Mi**	*17.0 Mi Total*

ATTACHMENT 10

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	14. Merge onto **Hobson Rd**. Map	**4.7 Mi** *21.7 Mi Total*
	15. Turn **right** onto **S Washington St**. Map	**1.2 Mi** *23.0 Mi Total*
	16. **801 S WASHINGTON ST** is on the **left**. Map	

Edward Hospital
801 S Washington St, Naperville, IL 60540
(630) 527-3000

Total Travel Estimate: **22.95 miles - about 39 minutes**

ATTACHMENT 10

54

Notes

mapquest

Trip to:

Elmhurst Memorial Hospital
155 E. Brush Hill Road
Elmhurst, IL 60126
(331) 221-1000
6.78 miles / 15 minutes

Westlake Hospital-ER
1225 W Lake St, Melrose Park, IL 60160
(708) 938-7190

1. Start out going **north** toward **Chicago Ave**. Map	**0.04 Mi** *0.04 Mi Total*
2. Take the 1st **left** onto **Chicago Ave**. Map	**0.3 Mi** *0.3 Mi Total*
3. Turn **left** onto **N 17th Ave**. Map	**0.02 Mi** *0.4 Mi Total*
4. Take the 1st **right** onto **W Lake St**. Map	**0.5 Mi** *0.9 Mi Total*
5. Turn **left** onto **N 25th Ave**. Map	**1.6 Mi** *2.5 Mi Total*
6. Turn **right** onto **Harrison St**. Map	**0.06 Mi** *2.5 Mi Total*
7. Turn **slight left** to stay on **Harrison St**. Map	**0.2 Mi** *2.8 Mi Total*
8. Merge onto **I-290 W / IL-110 W / Eisenhower Expy W** via the ramp on the **left**. Map	**1.9 Mi** *4.7 Mi Total*
9. Keep **left** to take **I-88 W / IL-110 W / Ronald Reagan Memorial Tollway** via **EXIT 15A** toward **Aurora / I-294 S / Indiana** (Portions toll). Map	**0.5 Mi** *5.1 Mi Total*
10. Merge onto **IL-38 W / Roosevelt Rd**. Map	**1.1 Mi** *6.3 Mi Total*
11. Take the **North York Road** exit. Map	**0.3 Mi** *6.5 Mi Total*
12. Turn **slight left** onto **E Brush Hill Rd**. Map	**0.2 Mi** *6.8 Mi Total*
13. **155 E. BRUSH HILL ROAD**. Map	

ATTACHMENT 10

55

Elmhurst Memorial Hospital
155 E. Brush Hill Road, Elmhurst, IL 60126
(331) 221-1000

Total Travel Estimate: **6.78 miles - about 15 minutes**

ATTACHMENT 10

52

Notes

mapquest

Trip to:

Gottlieb Memorial Hospital
701 W North Ave
Melrose Park, IL 60160
(708) 450-4510
2.28 miles / 6 minutes

Westlake Hospital-ER
1225 W Lake St, Melrose Park, IL 60160
(708) 938-7190

1. Start out going **north** toward **Chicago Ave**. Map	**0.04 Mi**	*0.04 Mi Total*
2. Take the 1st **right** onto **Chicago Ave**. Map	**0.7 Mi**	*0.7 Mi Total*
3. Turn **left** onto **N 1st Ave / IL-171**. Map	**1.0 Mi**	*1.8 Mi Total*
4. Turn **left** onto **W North Ave / IL-64 W**. Map	**0.4 Mi**	*2.1 Mi Total*
5. Take the 2nd **right**. Map	**0.2 Mi**	*2.3 Mi Total*
6. **701 W NORTH AVE**. Map		

Gottlieb Memorial Hospital
Hearing Center
701 W North Ave, Melrose Park, IL 60160
(708) 450-4510

Total Travel Estimate: **2.28 miles - about 6 minutes**

ATTACHMENT 10

Notes

mapquest

Trip to:
2160 S 1st Ave
Maywood, IL 60153-3328
2.95 miles / 8 minutes

Loyola

Westlake Hospital-ER
1225 W Lake St, Melrose Park, IL 60160
(708) 938-7190

1. Start out going **north** toward **Chicago Ave**. Map	**0.04 Mi**	*0.04 Mi Total*
2. Take the 1st **right** onto **Chicago Ave**. Map	**0.7 Mi**	*0.7 Mi Total*
3. Turn **right** onto **N 1st Ave / IL-171**. Map	**2.2 Mi**	*2.9 Mi Total*
4. **2160 S 1ST AVE** is on the **right**. Map		

2160 S 1st Ave, Maywood, IL 60153-3328

Total Travel Estimate: **2.95 miles - about 8 minutes**

ATTACHMENT 10

Notes

mapquest

Trip to:

Macneal Hospital
3249 Oak Park Ave
Berwyn, IL 60402
(708) 783-3158
7.26 miles / 18 minutes

Westlake Hospital-ER
1225 W Lake St, Melrose Park, IL 60160
(708) 938-7190

1. Start out going **north** toward **Chicago Ave**. Map	**0.04 Mi**	*0.04 Mi Total*
2. Take the 1st **right** onto **Chicago Ave**. Map	**0.7 Mi**	*0.7 Mi Total*
3. Turn **right** onto **N 1st Ave / IL-171**. Map	**1.6 Mi**	*2.3 Mi Total*
4. Merge onto **I-290 E / IL-110 E / Eisenhower Expy E** via the ramp on the **left**. Map	**1.3 Mi**	*3.6 Mi Total*
5. Take the **IL-43 / Harlem Ave** exit, **EXIT 21B**, on the **left**. Map	**0.2 Mi**	*3.8 Mi Total*
6. Turn **right** onto **Harlem Ave / S Harlem Ave / IL-43**. Continue to follow **Harlem Ave / IL-43**. Map	**2.1 Mi**	*5.9 Mi Total*
7. Turn **left** onto **26th St**. Map	**0.5 Mi**	*6.5 Mi Total*
8. Turn **right** onto **Oak Park Ave**. Map	**0.8 Mi**	*7.3 Mi Total*
9. **3249 OAK PARK AVE** is on the **left**. Map		

Macneal Hospital
Emergency Department
3249 Oak Park Ave, Berwyn, IL 60402
(708) 783-3158

Total Travel Estimate: **7.26 miles - about 18 minutes**

ATTACHMENT 10

Notes

mapquest

Trip to:

West Suburban Medical Center
3 Erie Ct
Oak Park, IL 60302
(708) 763-2327
4.21 miles / 13 minutes

Westlake Hospital-ER
1225 W Lake St, Melrose Park, IL 60160
(708) 938-7190

1.	Start out going **north** toward **Chicago Ave**. Map	**0.04 Mi** *0.04 Mi Total*
2.	Take the 1st **right** onto **Chicago Ave**. Map	**3.8 Mi** *3.8 Mi Total*
3.	Turn **right** onto **N Austin Blvd**. Map	**0.3 Mi** *4.1 Mi Total*
4.	Turn **right** onto **Ontario St**. Map	**0.08 Mi** *4.2 Mi Total*
5.	Turn **right** onto **Humphrey Ave N**. Map	**0.03 Mi** *4.2 Mi Total*
6.	**3 ERIE CT**. Map	

West Suburban Medical Center
3 Erie Ct, Oak Park, IL 60302
(708) 763-2327

Total Travel Estimate: **4.21 miles - about 13 minutes**

ATTACHMENT 10

40

Notes

mapquest

Trip to:

Alexian Brothers Medical Center
800 Biesterfield Rd

Elk Grove Village, IL 60007
(847) 981-3613
14.33 miles / 24 minutes

Westlake Hospital-ER
1225 W Lake St, Melrose Park, IL 60160
(708) 938-7190

1. Start out going **north** toward **Chicago Ave**. Map	**0.04 Mi**	*0.04 Mi Total*
2. Take the 1st **left** onto **Chicago Ave**. Map	**0.3 Mi**	*0.3 Mi Total*
3. Turn **left** onto **N 17th Ave**. Map	**0.02 Mi**	*0.4 Mi Total*
4. Take the 1st **right** onto **W Lake St**. Map	**3.3 Mi**	*3.7 Mi Total*
5. Stay **straight** to go onto **US-20 / W Lake St / Ulysses S Grant Memorial Hwy**. Map	**0.1 Mi**	*3.8 Mi Total*
6. Merge onto **I-290 W**. Map	**9.5 Mi**	*13.4 Mi Total*
7. Take the **Biesterfield Rd** exit, **EXIT 4**, toward **IL-53 S**. Map	**0.4 Mi**	*13.7 Mi Total*
8. Turn **right** onto **Biesterfield Rd**. Map	**0.5 Mi**	*14.2 Mi Total*
9. Make a **U-turn** onto **Biesterfield Rd**. Map	**0.1 Mi**	*14.3 Mi Total*
10. **800 BIESTERFIELD RD** is on the **right**. Map		

Alexian Brothers Medical Center
800 Biesterfield Rd, Elk Grove Village, IL 60007
(847) 981-3613

Total Travel Estimate: **14.33 miles - about 24 minutes**

ATTACHMENT 10

61

Notes

mapquest

Trip to:

Northwest Community Hospital
800 W Central Rd

Arlington Heights, IL 60005
(847) 618-4002
18.41 miles / 34 minutes

Westlake Hospital-ER
1225 W Lake St, Melrose Park, IL 60160
(708) 938-7190

1. Start out going **north** toward **Chicago Ave**. Map	**0.04 Mi**	*0.04 Mi Total*
2. Take the 1st **right** onto **Chicago Ave**. Map	**0.7 Mi**	*0.7 Mi Total*
3. Turn **left** onto **N 1st Ave / IL-171**. Map	**1.6 Mi**	*2.3 Mi Total*
4. Turn **slight left** onto **N Des Plaines River Rd**. Map	**2.9 Mi**	*5.2 Mi Total*
5. Turn **left** onto **Irving Park Rd / IL-19**. Map	**1.1 Mi**	*6.3 Mi Total*
6. Merge onto **I-294 N** toward **Wisconsin** (Portions toll). Map	**1.7 Mi**	*7.9 Mi Total*
7. Merge onto **I-90 W / Jane Addams Memorial Tollway** toward **Rockford** (Portions toll). Map	**7.6 Mi**	*15.6 Mi Total*
8. Take the **Arlington Hts Road** exit. Map	**0.4 Mi**	*15.9 Mi Total*
9. Keep **right** to take the ramp toward **Arlington Hts**. Map	**0.04 Mi**	*16.0 Mi Total*
10. Merge onto **S Arlington Heights Rd**. Map	**1.7 Mi**	*17.6 Mi Total*
11. Turn **left** onto **E Central Rd**. Map	**0.1 Mi**	*17.8 Mi Total*
12. Turn **slight right** onto **W Kirchhoff Rd**. Map	**0.4 Mi**	*18.2 Mi Total*
13. Turn **left**. Map	**0.03 Mi**	*18.2 Mi Total*

ATTACHMENT 10

62

14. Turn **right**. Map	**0.1 Mi** *18.4 Mi Total*
15. Turn **left**. Map	**0.04 Mi** *18.4 Mi Total*
16. **800 W CENTRAL RD**. Map	

Northwest Community Hospital
800 W Central Rd, Arlington Heights, IL 60005
(847) 618-4002

Total Travel Estimate: **18.41 miles - about 34 minutes**

ATTACHMENT 10

Notes

mapquest

Trip to:

Advocate Lutheran General Hospital
1775 Dempster St

Park Ridge, IL 60068
(847) 723-5437
13.32 miles / 27 minutes

Westlake Hospital-ER
1225 W Lake St, Melrose Park, IL 60160
(708) 938-7190

1. Start out going **north** toward **Chicago Ave**. Map	**0.04 Mi**	*0.04 Mi Total*
2. Take the 1st **right** onto **Chicago Ave**. Map	**0.7 Mi**	*0.7 Mi Total*
3. Turn **left** onto **N 1st Ave / IL-171**. Map	**1.6 Mi**	*2.3 Mi Total*
4. Turn **slight left** onto **N Des Plaines River Rd**. Map	**2.9 Mi**	*5.2 Mi Total*
5. Turn **left** onto **Irving Park Rd / IL-19**. Map	**1.1 Mi**	*6.3 Mi Total*
6. Merge onto **I-294 N** toward **Wisconsin** (Portions toll). Map	**5.7 Mi**	*12.0 Mi Total*
7. Merge onto **Dempster St / US-14 E**. Map	**1.1 Mi**	*13.1 Mi Total*
8. Turn **right** onto **Luther Ln**. Map	**0.1 Mi**	*13.2 Mi Total*
9. Turn **left**. Map	**0.07 Mi**	*13.3 Mi Total*
10. Take the 1st **left**. Map	**0.03 Mi**	*13.3 Mi Total*
11. **1775 DEMPSTER ST**. Map		

Advocate Lutheran General Hospital
Lutheran General Childrens Hospital
1775 Dempster St, Park Ridge, IL 60068
(847) 723-5437

Total Travel Estimate: **13.32 miles - about 27 minutes**

ATTACHMENT 10

64

Palos Community Hospital

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

Executive Offices

April 3, 2013

Mr. Jacob Axel
Axel & Associates, Inc.
675 North Court, Suite 210
Palatine, Illinois 60067

Dear Mr. Axel:

Due to the distances between facilities and the lack of overlap in our service areas, Palos Community Hospital anticipates no impact due to the closing of Obstetrical and Open Heart Surgery services at VHS Westlake Hospital.

Sincerely,

Timothy J. Brosnan
Vice President, Planning & Community Relations

TJB:gmk

ATTACHMENT 10

45

VANGUARD | MACNEAL HOSPITAL

MacNeal Hospital
3249 South Oak Park Avenue
Berwyn, Illinois 60402
Phone: 708-783-9100
www.macneal.com

April 4, 2013

Jacob M. Axel
Axel & Associates, Inc.
675 North Court
Suite 210
Palatine, Illinois 60067

Dear Mr. Axel:

I am writing in response to your letter of April 1, 2013 regarding VHS Westlake Hospital's intent to discontinue its obstetrics and open heart surgery categories of service at 1225 Lake Street in Melrose Park, Illinois.

MacNeal Hospital would not be adversely affected by the elimination of obstetrics and heart surgery services at Westlake Hospital. MacNeal does have available capacity to accommodate a portion of affected patients and we do not operate with any restrictions or limitations that would preclude us from providing service to residents of VHS Westlake Hospital's market share.

Sincerely,

J. Scott Steiner
Chief Executive Officer

SS/mo

ATTACHMENT 10

Elmhurst Memorial
Healthcare

April 11, 2013

Jacob M. Axel
President
Axel & Associates, Inc.
675 North Court, Suite 210
Palatine, IL 60067

Dear Jack:

We received your letter dated April 1, 2013, regarding a Certificate of Need application being filed by VHS Westlake Hospital to discontinue its obstetrics and open heart surgery categories of service. By this letter we wish to indicate that Elmhurst Memorial Hospital, located just over 6 miles from VHS Westlake Hospital, has the capacity and willingness to provide care to any and all patients in these categories of service previously served by VHS Westlake Hospital. We offer these services without restrictions or limitations.

We support VHS Westlake's plans to discontinue lower volume categories of service at its facility. We would be happy to work with the administrative staff and physicians as necessary to transition patients as appropriate to Elmhurst Memorial Hospital physicians and hospital care. Please let us know if further information is required.

Sincerely,

James F. Doyle
Acting President / CEO
Elmhurst Memorial Healthcare

ATTACHMENT 10

CADENCE HEALTH

April 8, 2013

Mr. Jacob Axel
Axel & Associates, Inc.
675 North Court, Suite 210
Palatine, Il 60067

Dear Jack:

This is in response to your letter of April 1, 2013 regarding proposed discontinuation of obstetrics and open heart surgery services at VHS Westlake Hospital.

Discontinuation of these categories of service at Westlake will have no impact on the operation of Central DuPage Hospital. Although we serve a market area very distant from that served by Westlake, Central DuPage Hospital has the capacity to accommodate any portion of Westlake's open heart or obstetrics caseload. We do not operate with any restrictions or limitations that would preclude providing services to residents of Westlake's service area.

Sincerely,

Brian J. Lemon
President
Central DuPage Hospital

25 N. Winfield Road
Winfield, Illinois 60190
630.933.1600
TTY for the hearing
impaired 630.933.4833
cdh.org

ATTACHMENT 10

VANGUARD | WEST SUBURBAN MEDICAL CENTER

April 4, 2013

Mr. Jacob M. Axel
President
Axel & Associates, Inc.
675 North Court, Suite 210
Palatine, Illinois 60067

Dear Mr. Axel:

This letter is in response to your notice of Westlake Hospital's intent to file a Certificate of Need (CON) application with the Illinois Health Facilities and Services Review Board (IHFSRB). West Suburban Medical Center is able and ready to accommodate the transition of all obstetrical admissions and open heart surgery procedures from Westlake Hospital.

As members of Vanguard Health Systems, Westlake Hospital and West Suburban Medical Center have worked closely together to provide accessible healthcare services to the communities we are privileged to serve. Our intent is to continue to do so, utilizing the healthcare resources available in the most effective and efficient manner.

West Suburban Medical Center unequivocally endorses Westlake's CON application and urges the IHFSRB's support as well.

Sincerely,

William A. Brown

William A. Brown, FACHE
Chief Executive Officer

LOYOLA
UNIVERSITY
HEALTH SYSTEM

Larry Goldberg
President & Chief Executive Officer
Tel: (708) 216-3215
Fax: (708) 216-6227
lgoldberg@lumc.edu

April 15, 2013

Mr. Jacob M. Axel
President
Axel & Associates, Inc.
675 North Court Suite 210
Palatine, Illinois

Re: VHS Westlake Hospital CON Application

Dear Mr. Axel,

We have received your letter dated April 1, 2013 concerning VHS Westlake Hospital's plans to file a Certificate of Need application to discontinue obstetrics and open heart surgery. The closure of these two categories of service and the anticipated increase in patients to our facility can be accommodated within our current capacity.

As part of the Loyola University Health System, the department of OB/GYN at Loyola University Medical Center operates within the guidelines given by the Catholic Bishops in their *Ethical and Religious Directives* which prohibit some specific procedures related to pregnancy termination and contraception.

Sincerely yours,

Larry M. Goldberg
President and CEO
Loyola University Health System

LOYOLA MEDICINE

Gottlieb Memorial Hospital

April 15, 2013

Mr. Jacob M. Axel
President
Axel & Associates, Inc.
675 North Court Suite 210
Palatine, Illinois

Re: VHS Westlake Hospital CON Application

Dear Mr. Axel,

We have received your letter dated April 1, 2013 concerning VHS Westlake Hospital's plans to file a Certificate of Need application to discontinue obstetrics and open heart surgery. The closure of these two categories of service and the anticipated increase in patients to our facility can be accommodated within our current capacity.

As part of the Loyola University Health System, the department of OB/GYN at Gottlieb Memorial Hospital operates within the guidelines given by the Catholic Bishops in their *Ethical and Religious Directives* which prohibit some specific procedures related to pregnancy termination and contraception.

Sincerely yours,

Ken Fishbain

Ken Fishbain
Chief Operating Officer

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

William Brown
VHS West Suburban
Medical Center
3 Erie Street
Oak Park, IL
60302

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☒ Agent ☐ Addressee

B. Received by (Printed Name) Maureen | C. Date of Delivery 4/02/13

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7012 0470 0001 9673 7925

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Paul Wheltron
Loyola University
Medical Center
2160 South first Ave.
Maywood, IL
60153

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Charles Bell ☐ Agent ☐ Addressee

B. Received by (Printed Name) Charles Bell | C. Date of Delivery

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7012 0470 0001 9673 7901

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mark Newton
Swedish Covenant
Hospital
5145 N. California Ave.
Chicago, IL 60625

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☒ Agent ☐ Addressee

B. Received by (Printed Name) Tom Farr | C. Date of Delivery 4/2

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7012 0470 0001 9673 7949

ATTACHMENT 10

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

72

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

John Morgan
Gothlieb Memorial Hospital
701 W. North Ave.
Melrose Park, IL
60160

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X M Lytle ☐ Agent ☐ Addressee

B. Received by (Printed Name) MLYTLE C. Date of Delivery 4/2/13

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7012 0470 0001 9673 7895

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Kenneth W. Lukhard
Advocate Christ Medical Center
4440 W. 95th St.
Oak Lawn, IL
60453

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

BRIDGEVIEW, IL 60455 APR 2 2013 USPS

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 0470 0003 2497 3332

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Rick Wright
Adventist La Grange Memorial Hospital
5101 S. Willow Springs Rd.
La Grange, IL 60525

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Julie OConnell ☐ Agent ☐ Addressee

B. Received by (Printed Name) Julie O'Connell C. Date of Delivery 4-2-13

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 0470 0003 2497 3349

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PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Alan Channing
Mount Sinai Hospital
California Ave. at
15th Street
Chicago, IL 60608

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

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

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 0470 0003 2499 2906

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Michael Vivoda
Central DuPage
Hospital
25 N. Winfield Rd.
Winfield, IL 60190

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

B. Received by (Printed Name) Dieter | C. Date of Delivery 4-3-13

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7012 0470 0001 9673 7864

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Anthony Armada
Advocate Lutheran
General Hospital
1775 Dempster St.
Park Ridge, IL
60068

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☒ Addressee

B. Received by (Printed Name) | C. Date of Delivery 4.2.13

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 0470 0003 2499 2968

ATTACHMENT 10

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

John Werrbach
Alexian Brothers
Medical Center
800 Biesterfield Rd.
Elk Grove Village, IL
60007

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) JS C. Date of Delivery 4-2-13

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7012 0470 0001 9673 7932

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

John Baird
Presence Resurrection
Medical Center
7435 W. Talcott Ave.
Chicago, IL 60631

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

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

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

APR 3 2013 USPS

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 0470 0003 2499 2937

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Bruce Crowther
Northwest Community
Hospital
800 W. Central Rd.
Arlington Heights, IL
60005

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) M. Rivera C. Date of Delivery 4/3/13

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 0470 0003 2499 2975

ATTACHMENT 10

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

W. Peter Daniels
Elmhurst Memorial Hospital
155 E. Brush Hill Rd.
Elmhurst, IL
60126

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) | C. Date of Delivery 4/3/13

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7012 0470 0001 9673 7888

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Pam Davis
Edward Hospital
801 S. Washington St.
Naperville, IL
60540

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☒ Agent ☐ Addressee

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

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7012 0470 0001 9673 7871

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Dr Roberta Luskin-Hawk
Presence Saint Joseph Hospital
2900 N. Lake Shore Dr.
Chicago, IL 60657

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) Richard Bamfo | C. Date of Delivery 4/4/13

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 0470 0003 2499 2920

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

ATTACHMENT 10

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

David L. Crane
Adventist Hinsdale Hospital
120 N. Oak St.
Hinsdale, IL 60521

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

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

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

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☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7012 0470 0001 9673 7840

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

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1. Article Addressed to:

CEO
VHS MacNeal Hospital
3249 Oak Park Ave.
Berwyn, IL 60402

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery 4/3/13

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

BERWYN
APR 03 2013

3. Service Type
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☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7012 0470 0001 9673 7918

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1. Article Addressed to:

Larry Goodman, MD
Rush University Hospital
1653 W. Congress Pkwy
Chicago, IL 60612

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery 4/2/13

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 0470 0003 2499 2876

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

ATTACHMENT 10

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

1. Article Addressed to:

John J. DaNardo
University of Illinois
Medical Center
1740 W. Taylor St.
Chicago, IL 60612

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) | C. Date of Delivery
4-8-13

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 0470 0003 2497 3295

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

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

1. Article Addressed to:

Susan Nordstrom Lopez
Advocate Illinois
Masonic Medical Center
836 W. Wellington Ave.
Chicago, IL 60657

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☑ Agent ☐ Addressee

B. Received by (Printed Name) | C. Date of Delivery
[signature] 4/4/13

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

APR 2013

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 0470 0003 2497 3363

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

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

1. Article Addressed to:

Dean M. Harrison
Northwestern Memorial
HealthCare
251 E. Huron St.
Chicago, IL 60611

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

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

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 0470 0003 2499 2011

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1. Article Addressed to:

Sister Margaret Wright
Palos Community Hospital
12251 S. 80th Ave.
Palos Heights, IL 60463

COMPLETE THIS SECTION ON DELIVERY

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

B. Received by (Printed Name) W.LLIAM COTTER
C. Date of Delivery

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 0470 0003 2497 3325

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1. Article Addressed to:

Everett M. Vokes, MD
University of Chicago Medical Center
5841 S. Maryland Ave.
Chicago, IL 60637

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X R. McEwen ☐ Agent ☐ Addressee

B. Received by (Printed Name)
C. Date of Delivery 4/2

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 0470 0003 2497 3226

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

1. Article Addressed to:

David S. Fox
Advocate Good Samaritan Hospital
3815 Highland Ave.
Downers Grove, IL 60515

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X M Cn ☐ Agent ☐ Addressee

B. Received by (Printed Name) M Rothberg
C. Date of Delivery 4-4-13

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7012 0470 0001 9673 7857

ATTACHMENT 10

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

1. Article Addressed to:

Sr. Sheila Lyne
Mercy Hospital and Medical Center
2525 S. Maryland Ave.
Chicago, IL 60616

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) [signature] C. Date of Delivery 4/3/13

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 0470 0003 2497 3240

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

1. Article Addressed to:

Presence St. Mary of Nazareth Hospital
2222 W. Division St.
Chicago, IL 60622

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

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

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

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

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 0470 0003 2499 2883

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

1. Article Addressed to:

Stroger Hospital of Cook County
1901 W. Harrison St.
Chicago, IL 60612

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery
APR 10 2013

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

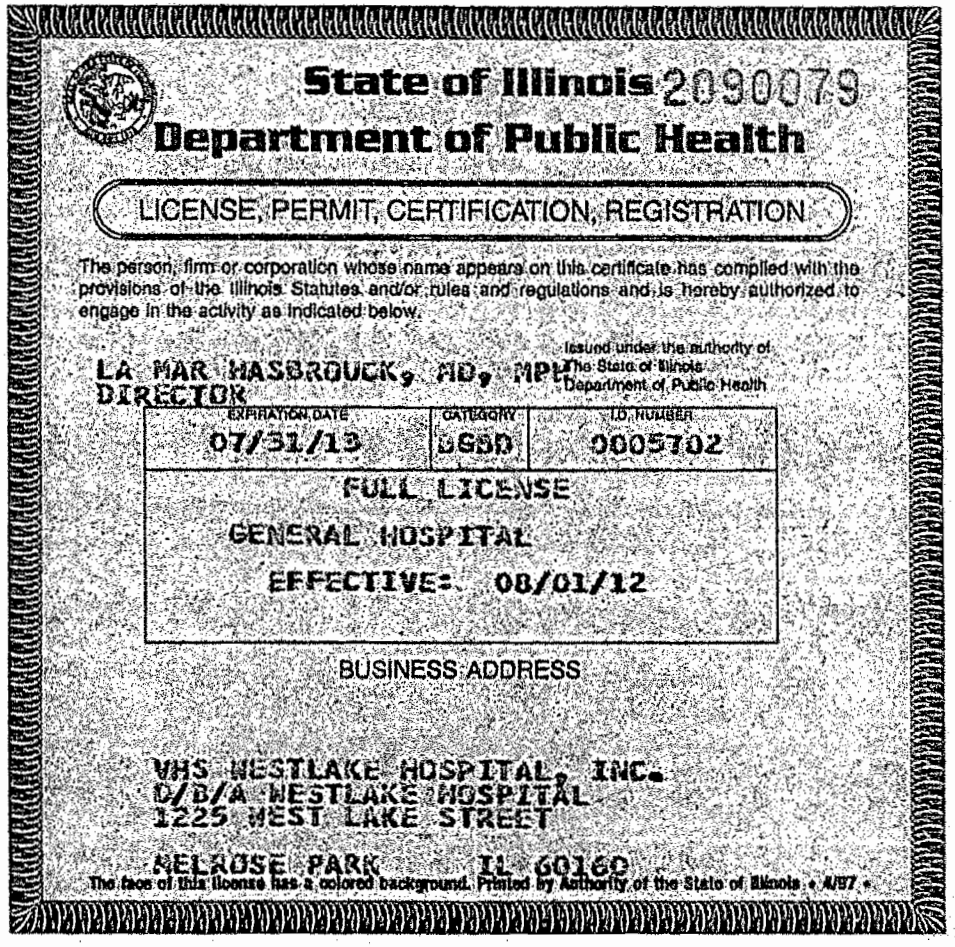
3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 0470 0003 2499 2913

ATTACHMENT 10

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540



State of Illinois 2090079
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

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

LA MAR HASBROUCK, MD, MPH
DIRECTOR

EXPIRATION DATE	CATEGORY	ID NUMBER
07/31/13	050D	0005702

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 08/01/12

BUSINESS ADDRESS

VHS WESTLAKE HOSPITAL, INC.
D/B/A WESTLAKE HOSPITAL
1225 WEST LAKE STREET

MELROSE PARK IL 60160

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

18

ATTACHMENT 11

SAFETY NET IMPACT STATEMENT

The proposed project, which is limited to the discontinuation of the open heart surgery category of service at VHS-Westlake Hospital, will not have an impact on any area hospital's provision of safety net services. Upon discontinuation, VHS Westlake Hospital's open heart surgery category of service will be consolidated into VHS West Suburban Medical Center's program.

Vanguard Health Systems, Inc., through each of its four metropolitan Chicago hospitals, is, and will continue to be a provider of safety net services to the communities that the individual hospitals serve, and copies of the charity care and financial assistance policies under which the four hospitals operate are attached. During 2011, the four hospitals provided in excess of $8.1 M (cost) of charity care.

ATTACHMENT 43

POLICIES & PROCEDURES

DEPARTMENT: Business Office	**POLICY DESCRIPTION:** Charity Care, Financial Assistance and Billing & Collection Policies for Uninsured Patients
PAGE: 1 of 10	**REVISED January 23, 2009**
APPROVED:	**RETIRED:**
EFFECTIVE DATE: January 23, 2009	**REFERENCE NUMBER:** 11-0801

SCOPE:
All Company-affiliated hospitals.

PURPOSE:
This Policy and Procedure is established to provide the operational guidelines for the Company's hospitals (each a "Hospital" and, collectively, the "Hospitals") to identify uninsured patients who are Financially Indigent or Medically Indigent that may qualify for charity care (free care) or financial assistance, to process patient applications for charity care or financial assistance and to bill and collect from uninsured patients, including those who qualify as Financially Indigent or Medically Indigent under this Policy.

POLICY:
1. Charity Care or Financial Assistance. The Company's Hospitals shall provide charity care (free care) or financial assistance to uninsured patients for their emergency, non-elective care who qualify for classification as Financially Indigent or Medically Indigent in accordance with the Charity Care Financial Assistance Process set forth below. The Company's Hospitals shall adopt a written policy in conformity with the Company's Policy and Procedure set forth herein. Charity Care (100% discounts) under this Policy shall be available for uninsured patients with incomes below 200% of the Federal Poverty Level (the "Financially Indigent"). 40 to 80% discounts shall be available for uninsured patients either (1) with income below 500% FPL or (2) with balances due for hospital services in excess of 50% of their annual income (the "Medially Indigent"). See attached Financial Assistance Eligibility Guidelines.

2. Billing and Collection Processes for Uninsured Patients. All uninsured patients receiving care at the Company's Hospitals will be treated with respect and in a professional manner before, during and after receiving care. Each of the Company's Hospitals should adopt a written policy in conformity with the Company's Policy and Procedure set forth herein for its billing and collection practices in respect of all uninsured patients, including those uninsured patients who qualify for classification as Financially Indigent or Medically Indigent under this Policy.

POLICIES &
PROCEDURES

DEPARTMENT: Business Office	**POLICY DESCRIPTION:** Charity Care, Financial Assistance and Billing & Collection Policies for Uninsured Patients
PAGE: 2 of 10	**REVISED January 23, 2009**
APPROVED:	**RETIRED:**
EFFECTIVE DATE: January 23, 2009	**REFERENCE NUMBER:** 11-0801

PROCEDURE:

A. CHARITY CARE AND FINANCIAL ASSISTANCE PROCESS

1. **Application.** Each Company Hospital will request that each patient applying for charity care financial assistance complete a Financial Assistance Application Form (Assistance Application). An example Financial Assistance Application Form is attached hereto. The Assistance Application allows for the collection of needed information to determine eligibility for financial assistance.

A. Calculation of Immediate Family Members. Each Hospital will request that patients requesting charity care verify the number of people in the patient's household.

1. *Adults*. In calculating the number of people in an adult patient's household, Hospital will include the patient, the patient's spouse and any dependents of the patient or the patient's spouse.

2. *Minors*. For persons under the age of 18. In calculating the number of people in a minor patient's household, Hospital will include the patient, the patient's mother, dependents of the patient's mother, the patient's father, and dependents of the patient's father.

B. Calculation of Income.

1. *Adults*. For adults, determine the sum of the total yearly gross income of the patient and the patient's spouse (the "Income"). Hospital may consider other financial assets of the patient and the patient's family (members of family are as defined in section "Calculation of Immediate Family Members") and the patient's or the patient's family's ability to pay.

2. *Minors*. If the patient is a minor, determine the Income from the patient, the patient's mother and the patient's father. Hospital may consider other financial assets of the patient and the patient's family (members of family are as defined in section "Calculation of Immediate Family Members") and the patient's or the patient's family's ability to pay.

DEPARTMENT: Business Office	**POLICY DESCRIPTION:** Charity Care, Financial Assistance and Billing & Collection Policies for Uninsured Patients
PAGE: 3 of 10	**REVISED January 23, 2009**
APPROVED:	**RETIRED:**
EFFECTIVE DATE: January 23, 2009	**REFERENCE NUMBER:** 11-0801

2. **Income Verification.** Hospital shall request that the patient verify the Income and provide the documentation requested as set forth in the Assistance Application. NOTE: Tax Returns and W-2's should be collected for year prior to date of admission.

A. Documentation Verifying Income. Income may be verified through any of the following mechanisms:

- Tax Returns (Hospital preferred income verification document)
- IRS Form W-2
- Wage and Earnings Statement
- Pay Check Remittance
- Social Security
- Worker's Compensation or Unemployment Compensation Determination Letters
- Qualification within the preceding 6 months for governmental assistance program (including food stamps, CDIC, Medicaid and AFDC)
- Telephone verification by the patient's employer of the patient's Income
- Bank statements, which indicate payroll deposits.

B. Documentation Unavailable. In cases where the patient is unable to provide documentation verifying Income, the Hospital may at it's sole discretion verify the patient's Income in either of the following two ways:

1. By having the patient sign the Assistance Application attesting to the veracity of the Income information provided or

2. Through the written attestation of the Hospital personnel completing the Assistance Application that the patient verbally verified Hospital's calculation of Income.

Note: In all instances where the patient is unable to provide the requested documentation to verify Income, Hospital will require that a satisfactory explanation of the reason the patient is unable to provide the requested documentation be noted on the Financial Assistance Assessment Form.

DEPARTMENT: Business Office	POLICY DESCRIPTION: Charity Care, Financial Assistance and Billing & Collection Policies for Uninsured Patients
PAGE: 4 of 10	REVISED January 23, 2009
APPROVED:	RETIRED:
EFFECTIVE DATE: January 23, 2009	REFERENCE NUMBER: 11-0801

C. Expired Patients. Expired patients may be deemed to have no Income for purposes of the Hospital's calculation of Income. Documentation of Income is not required for expired patients. Income verification is still required for any other family members (members of family are as defined in section "Calculation of Immediate Family Members").

D. Homeless Patients. Homeless patients may be deemed to have no Income for purposes of the Hospital's calculation of Income. Documentation of Income is not required for homeless patients. Income verification is still required for any other family members (members of family are as defined in section "Calculation of Immediate Family Members") only if other family information is available.

E. Incarcerated Patients. Incarcerated patients (incarceration verification should be attempted by Hospital personnel) may be deemed to have no Income for purposes of the Hospital's calculation of Income, *but only if their medical expenses are not covered by the governmental entity incarcerating them (ie the Federal Government, the State or a County is responsible for the care) since in such event they are not uninsured patients.* Income verification is still required for any other family members (members of family are as defined in section "Calculation of Immediate Family Members").

F. International Patients. International patients who are uninsured and whose visit to the Hospital was unscheduled will be deemed to have no Income for purposes of the Hospital's calculation of Income. Income verification is, moreover, still required for any other family members (members of family are as defined in section "Calculation of Immediate Family Members") only if other family are United States citizens.

G. Eligibility Cannot be Determined. If and when Hospital personnel cannot clearly determine eligibility, the Hospital personnel will use best judgment and submit a memorandum (such memorandum should be the first sheet in the documentation packet) listing reasons for judgment along with Financial Assistance documentation to appropriate supervisor. The Hospital Supervisor will then review the memorandum and documentation. If the Supervisor agrees to approve the eligibility, they will sign Eligibility Determination form and continue with normal Approval process. If the Supervisor does not approve eligibility of the patient under this Policy, the Supervisor should sign the submitted memorandum and return all documentation to Hospital personnel who will note account and

DEPARTMENT: Business Office	POLICY DESCRIPTION: Charity Care, Financial Assistance and Billing & Collection Policies for Uninsured Patients
PAGE: 5 of 10	REVISED January 23, 2009
APPROVED:	RETIRED:
EFFECTIVE DATE: January 23, 2009	REFERENCE NUMBER: 11-0801

send documentation to the Hospital's Business Office for filing. If Supervisor disagrees with hospital personnel's judgment, Supervisor should state reasons for new judgment and will return documentation to hospital personnel who will follow either denial process or approval process as determined by Supervisor.

H. Classification Pending Income Verification. During the Income Verification process, while Hospital is collecting the information necessary to determine a patient's Income, the patient may be treated as a self-pay patient in accordance with Hospital policies.

3. **Information Falsification.** Falsification of information may result in denial of the Assistance Application. If, after a patient is granted financial assistance as either Financially Indigent or Medically Indigent, and Hospital finds material provision(s) of the Assistance Application to be untrue, the financial assistance may be withdrawn.

4. **Request for Additional Information.** If adequate documents are not provided, Hospital will contact the patient and request additional information. If the patient does not comply with the request within 14 calendar days from the date of the request, such non-compliance will be considered an automatic denial for financial assistance. A note will be input into Hospital computer system and any and all paperwork that was completed will be filed according to the date of the denial note. No further actions will be taken by Hospital personnel. If requested documentation is later obtained, all filed documentation will be pulled and patient will be reconsidered for Financial Assistance.

5. **Automatic Classification as Financially Indigent.** The following is a listing of types of accounts where Financial Assistance is considered to be automatic and documentation of Income or a Financial Assistance application is not needed:

- Medicaid accounts-Exhausted Days/Benefits
- Medicaid spend down accounts
- Medicaid or Medicare Dental denials
- Medicare Replacement accounts with Medicaid as secondary-where Medicare Replacement plan left patient with responsibility

DEPARTMENT: Business Office	**POLICY DESCRIPTION:** Charity Care, Financial Assistance and Billing & Collection Policies for Uninsured Patients
PAGE: 6 of 10	**REVISED January 23, 2009**
APPROVED:	**RETIRED:**
EFFECTIVE DATE: January 23, 2009	**REFERENCE NUMBER:** 11-0801

6. **Classification as Financially Indigent.** Financially Indigent means an uninsured person who is accepted for care with no obligation (charity care) or with a discounted obligation to pay for the services rendered, based on the Hospital Eligibility Criteria.

A. Classification. The Hospital may classify as Financially Indigent all uninsured patients whose income, as determined in accordance with the Assistance Application, is less than or equal to 200% of the poverty guidelines updated annually in the Federal Register by the U.S. Department of Health and Human Services (Federal Poverty Guidelines).

B. Acceptance. If Hospital accepts the patient as Financially Indigent, the patient may be granted charity care or financial assistance discounts in accordance with the attached Financial Assistance Eligibility Guidelines.

7. **Classification as Medically Indigent.** Medically Indigent means *an uninsured patient* who does not qualify as Financially Indigent under this policy because the patient's Income exceeds 500% of Federal Poverty Guidelines, but whose medical or hospital bills exceed a specified percentage of the person's Income, and who is unable to pay the remaining bill.

A. Initial Assessment. To be considered for classification as a Medically Indigent patient, the amount owed by the patient on all outstanding accounts after all payments by the patient must exceed 10% of the patient's Income and the patient must be unable to pay the remaining bill. If the patient does not meet the Initial Assessment criteria, the patient may not be classified as Medically Indigent.

B. Acceptance. The Hospital may also accept a patient as Medically Indigent when they meet the acceptance criteria set forth below.

(1) The patient's bill is greater than 50% of the patient's Income, calculated in accordance with the Hospital's income verification procedures, and the patient's Income is greater than 500% of the Federal Poverty Guidelines. The Hospital will determine the amount of financial assistance granted to these patient's in accordance with the attached Financial Assistance Eligibility Guidelines.

DEPARTMENT: Business Office	POLICY DESCRIPTION: Charity Care, Financial Assistance and Billing & Collection Policies for Uninsured Patients
PAGE: 7 of 10	REVISED January 23, 2009
APPROVED:	RETIRED:
EFFECTIVE DATE: January 23, 2009	REFERENCE NUMBER: 11-0801

(2) NOTE: TO QUALIFY AS MEDICALLY INDIGENT, THE PATIENT MUST BE UNINSURED.

8. **Approval Procedures.** Hospital will complete a Financial Assistance Eligibility Determination Form for each patient granted status as Financially Indigent or Medically Indigent. The approval signature process is as following:

$1 - $2,000	Director
$2,001 - $10,000	Director and CFO
$10,001 and above	Director, CFO and CEO

A. The accounts will be filed according to the date the Financial Assistance adjustment was entered onto the account.

B. The Eligibility Determination Form allows for the documentation of the administrative review and approval process utilized by the Hospital to grant financial assistance. Any change in the Eligibility Determination Form must be approved by the Director of Patient Financial Services. **NOTE: If application is approved, approval is automatic for all admissions for calendar year on balances that can be considered for Financial Assistance.**

9. **Denial for Financial Assistance.** If the Hospital determines that the patient is not Financially Indigent or Medically Independent under this policy, it shall notify the patient of this denial in writing. A suggested denial of coverage letter is attached to this policy.

10. **Document Retention Procedures.** Hospital will maintain documentation sufficient to identify for each patient qualified as Financially Indigent or Medically Indigent, the patient's Income, the method used to verify the patient's Income, the amount owed by the patient, and the person who approved granting the patient status as Financially Indigent or Medically Indigent. All documentation will be forwarded and filed within the Hospital's Business Office for audit purposes. Financial Assistance applications and all documentation will be retained within the Hospital's Business Office for 1 calendar year. After which, the documents will be boxed and marked as: Charity Docs, JANUARY YYYY-DECEMBER YYYY and forwarded to the Hospital Warehouse,

DEPARTMENT: Business Office	POLICY DESCRIPTION: Charity Care, Financial Assistance and Billing & Collection Policies for Uninsured Patients
PAGE: 8 of 10	REVISED January 23, 2009
APPROVED:	RETIRED:
EFFECTIVE DATE: January 23, 2009	REFERENCE NUMBER: 11-0801

where it will then be retained for an additional 6 years before shredding.

11. **Reservation of Rights.** It is the policy of the Company and its Hospitals to reserve the right to limit or deny financial assistance at the sole discretion of each of its Hospitals.

12. **Non-covered Services.** Elective and non-emergency services are not covered by this policy.

B. <u>BILLING AND COLLECTION PRACTICES FOR ALL UNINSURED PATIENTS, INCLUDING THOSE WHO QUALIFY AS FINANICALLY INDIGENT OR MEDICALLY INDIGENT UNDER THIS POLICY</u>

1. **Fair and Respectful Treatment.** Uninsured patients will be treated fairly and with respect during and after treatment, regardless of their ability to pay.

2. **Trained Financial Counselors.** All uninsured patients at the Company's hospitals will be provided with financial counseling, including assistance applying for state and federal health care programs such as Medicare and Medicaid. If not eligible for governmental assistance, uninsured patients will be informed of and assisted in applying for charity care and financial assistance under the hospital's charity care and financial assistance policy. Financial counselors will attempt to meet with all uninsured patients prior to discharge from the Company's hospital. Hospitals should ensure that appropriate staff members are knowledgeable about the existence of the hospital's financial assistance policies. Training should be provided to staff members (i.e., billing office, financial department, etc.) who directly interact with patients regarding their hospital bills.

3. **Additional Invoice Statements or Enclosures.** When sending a bill to uninsured patients, the Hospital should include (a) a statement on the bill or in an enclosure to the bill that indicates that if the patient meets certain income requirements, the patient may be eligible for a government-sponsored program or for financial assistance from the Hospital under its charity care or financial assistance policy; and (b) a statement on the bill or in an enclosure to the bill that provides the patient a telephone number of a hospital employee or office from whom or which the patient may obtain information about such financial assistance policy for patients and how to apply for such assistance. The following statement on the bill or in an enclosure to the bill complies with the above requirements of this Section B.3.:

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"Please note, based on your household income, you may be eligible for Medicaid *[Note: please refer to MediCal for California patients and Arizona's AHCCCS program for Arizona patients]* or financial assistance from the Hospital. For further information, please contact our customer service department at (XXX) XXX-XXXX."

4. **Notices.** Each of the Company's hospitals should post notices regarding the availability of financial assistance to uninsured patients. These notices should be posted in visible locations throughout the hospital such as admitting/registration, billing office and emergency department. The notices also should include a contact telephone number that a patient or family member can call for more information. The following specific language complies the above notice requirements of this Section B.4.: "For help with your Hospital bill or Financial Assistance, please call or ask to see our Financial Counselor or call (XXX) XXX-XXXX (M-F 8:30 am to 4:30 pm)."

5. **Liens on Primary Residences.** The Company's hospitals shall not, in dealing with patients who quality as Financially Indigent or Medically Indigent under this Policy, place or foreclose liens on primary residences as a means of collecting unpaid hospital bills. However, as to those patients who qualify as Medically Indigent but have income in excess of 500% of the Federal Poverty Guidelines, the Company may place liens on primary residences as a means of collecting discounted hospital bills, but the Company's hospitals may not pursue foreclosure actions in respect of such liens.

6. **Garnishments.** The Company's hospitals shall only use garnishments on Medically Indigent Patients where clearly legal under state law and only where it has evidence that the Medically Indigent Patient has sufficient income or assets to pay his discounted bill.

7. **Collection Actions Against Uninsured Patients.** Each of the Company's hospitals should have written policies outlining when and under whose authority an unpaid balance of any uninsured patient is advanced to collection, and hospitals should use their best efforts to ensure that patient accounts for all uninsured patients are processed fairly and consistently.

8. **Interest Free, Extended Payment Plans**. All uninsured patients shall be offered extended payment plans by the Company's hospitals to assist the patients in settling

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past due outstanding hospital bills. The Company's hospitals will not charge uninsured patients any interest under such extended payment plans.

9. **Body Attachments.** The Company's hospitals shall not use body attachment to require that its uninsured patients or responsible party appear in court.

10. **Collection Agencies Follow Hospital Collection Policies.** The Company's hospitals should define the standards and scope of practices to be used by their outside (non-hospital) collection agencies, and should obtain written agreements from such agencies that they will adhere to such standards and scope of practices. These standards and practices should not be inconsistent with the Company's collection practices for its hospitals set forth in this Policy.

C. **RESERVATION OF RIGHTS AGAINST THIRD PARTIES.**

Nothing in this Policy shall preclude the Company's hospitals from pursuing reimbursement from third party payors, third party liability settlements or tortfeasors or other legally responsible third parties.

REFERENCES

HHS, Office of Inspector General, Guidance dated February 2, 2004, entitled " Hospital Discounts Offered to Patients Who Cannot Afford To Pay Their Hospital Bills".

Letter dated February 19, 2004, from Tommy G. Thompson, HHS Secretary, to Richard J. Davidson, President, American Hospital Association, including Questions and Answers attached thereto entitled "Questions On Charges For The Uninsured".

Federal Poverty Guidelines published by US Department of Health and Human Services from time to time. (Most recent publication at effective date of this Policy is *Federal Register*, (74 FR 4199-4201) January 23, 2009.

FINANCIAL ASSISTANCE ELIGIBILITY GUIDELINES

Based on Federal Poverty Guidelines Effective January 23, 2009

Schedule A (shaded)
Financially Indigent

Schedule B (unshaded)
Medically Indigent

Number In Household	100%	200%	300%	400%	500%
1	10,830	21,660	32,490	43,320	54,150
2	14,570	29,140	43,710	58,280	72,850
3	18,310	36,620	54,930	73,240	91,550
4	22,050	44,100	66,150	88,200	110,250
5	25,790	51,580	77,370	103,160	128,950
6	29,530	59,060	88,590	118,120	147,650
7	33,270	66,540	99,810	133,080	166,350
8	37,010	74,020	111,030	148,040	185,050
Discount		100%	80%	60%	40%
Financially Indigent Classification					

Schedule C
Catastrophic Eligibility as Medically Indigent -

Only applicable if patients income exceeds 500% of Federal Poverty Guidelines

Balance Due	Discount
Balance Due is equal to or greater than 90% patients annual income	80%
Balance Due is equal to or greater than 70% and less than 90% patients annual income	60%
Balance Due is equal to or greater than 50% and less than 70% patients annual income	40%

ATTACHMENT 43

[HOSPITAL LETTERHEAD]

«GUARANTOR»
«ADDRESS»
«CITY», «State» «zip»

[DATE]

Re: «PATIENT»
Admission: «ACCOUNT»
Balance Due: $«TOTAL_CHARGES»

Dear «GUARANTOR»,

Thank you for choosing _____ Hospital the [system] [Hospital] of choice in _____. We appreciate you taking the time to complete and return the Application for Assistance. _____ Hospital uses this information to determine your eligibility for a reduce fee under the _____ Hospital Financial Assistance program.

In reviewing your Application for Assistance, we are happy to inform you that you have been approved for a «DISCOUNT»% discount your new balance has been reduced to $«REMAINING_BAL». Our determination was based upon your income, household size and Federal Poverty Guidelines.

If you have any questions about our decision, please call the Hospital's [Customer Service] at (___)-_____.

Sincerely,

[Customer Service Representative]

FINANCIAL ASSISTANCE ELIGIBILITY DETERMINATION
OFFICE USE ONLY

Patient Name: _____

Account Number(s): _____ Total Yearly Income: $_____ Total Charges:$_____

Balance Due: $_____ Income Verification Code: _____ Number in Household: _____ Financial Class:_____

1. **Is Total Yearly Income equal to or less than 200% of the Federal Poverty Guidelines?** (See Financial Assistance Eligibility Guidelines - Schedule A) **Circle One**

   YES Approved for 100% financial assistance as Financially Indigent.

   NO Does not qualify for assistance as Financially Indigent. Continue to Step 2.

2. **Is this balance due greater than 10% of Total Yearly Income? Circle One**

   YES Continue to Step 3.

   NO Patient does not qualify for Financial Assistance.

3. **Is Total Yearly Income equal to or less than 500% of the Federal Poverty Guidelines?** See Financial Assistance Eligibility Guidelines - Schedule B. **Circle One**

   YES Total Yearly Income is greater than _____% and less than _____ % of the Federal Poverty Guidelines. Patient qualifies for _____% discount as Medically Indigent pursuant to Financial Assistance Eligibility Guidelines - Schedule B .

   NO: Continue to Step 4.

4. **Is this balance due greater than 50% of Total Yearly Income? Circle One**

   YES Balance due is _____% of the total yearly income. Eligible for_____% discount as Medically Indigent pursuant to Financial Assistance Eligibility Guidelines - Schedule C. Continue to Step 5.

   NO: Patient does not qualify for Financial Assistance.

5. $_____ *Balance Due Before Discount* Multiply by _____% = $_____ *Discount Amount* $_____ *Remaining Balance Due After Discount*

Employee Name (Print)_____

Employee Signature_____ Approved By _____

Date_____ Approved By _____

$1 - $2,000	Director	Approved By_____
$2,001 - $10,000	Director and CFO	
$10,001 & above	Director, CFO and CEO	

Income Verification Codes

1	IRS Form W-2, Wage and Earnings Statement	7	Written attestation of patient
2	Pay Check Remittance	8	Verbal attestation of patient
3	Tax Returns	9	Patient deceased, no estate
4	Social Security, Work Comp or Unempl Comp letter	10	Government Program
5	Telephone verification by employer	11	Other
6	Bank Statements		

ATTACHMENT 43

FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

Instructions:

As part of its commitment to serve the community, _____ Hospital elects to provide financial assistance to individuals who are financially indigent or medically indigent and satisfy certain requirements.

To determine if a person qualifies for financial assistance, we need to obtain certain financial information. Your cooperation will allow us to give all due consideration to your request for financial assistance.

Please provide the information requested and mail to the following address:

_____ Hospital
_____
_____
_____

Income Verification:

IN ORDER TO CONSIDER YOUR REQUEST FOR FINANCIAL ASSISTANCE, VERIFICATION OF INCOME IS REQUIRED. PLEASE PROVIDE A COPY OF THE FOLLOWING DOCUMENTS:

- Governmental Assistance, Social Security, Workers Compensation, or Unemployment Compensation Determination Letter
- Income Tax Return for previous year

PLEASE ALSO INCLUDE ONE OR MORE OF THE FOLLOWING:

- IRS Form W-2, Wage and Earnings Statement for all household earnings
- Last 2 pay check stubs for all household earnings
- Bank Statement that contains income information

In the event income verification is unavailable, please contact our office for further instructions. Applications without verification are considered incomplete and **WILL NOT BE PROCESSED**. Please return the application and verification of income within 7 days to the above address.

Notification of Determination:

We will notify you of your eligibility following receipt and review of all necessary information. The notification will be mailed to the mailing address you have provided on the Financial Assistance Application.

Physician Services:

The physicians providing services at this Hospital are not employees of _____ Hospital. You will receive separate bills from your private physician and from other physicians whose services you required (pathologist, radiologist, surgeon, etc.). The Financial Assistance Application does not apply to any amounts due by you for physician services. For questions regarding their bills, or to make payment arrangements for physician services, please contact the individual physician's office.

For assistance in completing this application, please contact _____ Hospital [Customer Service] at (___) _____ or Toll Free: 1-_____, Monday through Friday between the hours of 8:00 a.m. and 5:00 p.m.

GRNTOR #: _____

HOSP CODE: _____

PATIENT INFORMATION/INFORMACION DEL PACIENTE

Patient Name/Nombre del Paciente	Account Balance/Balancia de Cuenta	Patient Number/Numero del Paciente	Date of Birth/Fetch del Nacimiento
Admission Date/Fecha De Entrada	Discharge Date/Fecha De Despedida	Social Security No/Num de Seguro Social	Marital Status/Estado Civil
Home Address/Direccion De Residencia			
City/Ciudad		State/Estado	Zip
Name of Medical Provider/Nombre Del Proveedor De Sercisios Medicos		Beginning Coverage Date/Fecha del Comienzo	
Name of Doctor/Nombre Del Medico			
Employer Name/Nombre		Occupation/Ocupacion	Telephone/Telefono

GUARANTOR INFORMATION/PERSONA RESPONSABLE

Name/Nombre		Social Security No/Num de Seguro Social	Age/Edad
Realationship to Applicant Relacion con el Paciente	Address/Direccion		Telephone/Telefono
City/Ciudad		State/Estado	Zip
Employer/Empleador		Employer Phone/Number De Empleador	Occupation/Ocupacion
Address/Direccion			
City/Ciudad		State/Estado	ZIP:

ATTACHMENT 3

I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge. I agree to tell the provider of service within ten (10) days if there are any changes in my (or the persons on whose behalf I am acting) income, property, expenses or in the persons household or any change of address. I understand that I may be asked to prove my statements and my eligibility statements will be subject to verification by contact with my employer, bank credit verification and property searches. I understand the county is required by law to keep any information I provide confidential. I further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse the county from the proceeds of litigation or settlement resulting from such an act.	Declaro bajo pena de perjuria que las respuestas que he dado son verdaderas y correctas al mejor de mi conocimiento. Acuerdo decirle al abastecedor del servicio en el plazo de diez dias si hay algunos cambios en mi (o personas en el favor que yo este actuando) renta, propiedad, gastos o en la casa de las personas o cualquier cambio de direccion. Entiendo que puedo ser pedido probar mis declaraciones de la elegibilidad estaran conforme a la verificacion al lado de contacto con mi patron, verification del credito de banco y busquedas de propiedad. Entiendo que el condado es requerido por ley de protejer cualquier informacion que yo proporcione confidencial. Tambien convengo, en la consideracion de recibir servicios del cuidado medico como resultado de un accidente o lesion, de tener que reembolsarle al condado de los ingresos de la demanda o cualquier resultado de tal acto.

Signature/Firma _____ Date/Fecha _____

For Hospital Use Only/Uso Solamente Para el Hospital

Facility/Facilidad: _____ **Accepted/Aceptar:** _____ **Denied/Negacion:** _____

COMMENTS/COMETARIOS:

_____

_____

_____

_____

_____

Signature Approval _____ **Date** _____

FINANCIAL INFORMATION/INFORMACION FINANCIAL

Total Monthly Income/Ingresos Mensuales	No. of Dependents Cuantos Dependientes	Residence(Own/Rent) Casa Propia o Renta	Car (Model/Year)/Carro (Modelo/Ano)

RESOURCES/RECURSOS

Name of Bank/Nombre del Banco	Checking Account/Cueta de Cheques	Savings Account/Cuentas de Ahorros
	$	$

MONTHLY EXPENSES/GASTOS MENSUALES

Rent/Mortgage/ Payment Payment/Renta o Pago Hipotecario	Water Bill/Pago de Agua	Gas Bill/Pago de Gas	Phone Bill/Cuenta De Telefono
$	$	$	$
Electric Bill/Pago de Electricidad	Car Payment/Pago de Carro	Insurance Premium/Pago de Prima	Other Bills/Otro Gastos
$	$	$	$

HOUSEHOLD COMPOSITION/INFORMACION DE LA CASA

Name/Nombre	Relationship/Relacion con el Paciente	Date of Birth/Fecha de Nacimiento	Social Security No. Num de Seguro Social

If unable to provide requested documents, please explain below/

Por favor de dar una explicacion si no es posible proveer los documentos.

COMMENTS/COMETARIOS:

ATTACHMENT 43

AFFIDAVIT/DECLARACION JURADA

[Hospital Logo]

Date:

Re:
Admission #
Balance Due:

Dear ,

Thank you for choosing _____ Hospital. We appreciate you taking the time to complete and return the Application for Assistance. _____ Hospital uses this information to determine your eligibility for a reduced fee under the _____ Hospitals Charity Care Financial Assistance program.

In reviewing your Application for Financial Assistance, we have determined that you are not eligible for charity care or financial assistance under our policy. Our determination was based upon your income, household size and Federal Poverty Guidelines.

If you have any questions about our decision, please call Customer Service at (XXX)___-____.

Sincerely,

Customer Service Representative

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

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