

ORIGINAL

11-042

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

JUL 6 2011

Facility/Project Identification

HEALTH FACILITIES &
SERVICES REVIEW BOARD

Facility Name:	Provena Covenant Medical Center		
Street Address:	1400 West Park Avenue		
City and Zip Code:	Urbana, IL 61801		
County:	Champaign	Health Service Area	IV Health Planning Area: D-01

Applicant /Co-Applicant Identification

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

Exact Legal Name:	Provena Hospitals
Address:	19065 Hickory Creek Drive Mokena, IL 60448
Name of Registered Agent:	Mr. Guy Wiebking
Name of Chief Executive Officer:	Mr. Guy Wiebking
CEO Address:	19065 Hickory Creek Drive Mokena, IL 60448
Telephone Number:	708/478-6300

Type of Ownership of Applicant/Co-Applicant

<input checked="" type="checkbox"/>	Non-profit Corporation	<input type="checkbox"/>	Partnership	
<input type="checkbox"/>	For-profit Corporation	<input type="checkbox"/>	Governmental	
<input type="checkbox"/>	Limited Liability Company	<input type="checkbox"/>	Sole Proprietorship	<input type="checkbox"/> Other

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

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

Primary Contact

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

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

Additional Contact

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

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

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT**

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Provena Covenant Medical Center		
Street Address:	1400 West Park Avenue		
City and Zip Code:	Urbana, IL 61801		
County:	Champaign	Health Service Area	IV Health Planning Area: D-01

Applicant /Co-Applicant Identification

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

Exact Legal Name:	Provena Health
Address:	19065 Hickory Creek Drive Mokena, IL 60448
Name of Registered Agent:	Mr. Guy Wiebking
Name of Chief Executive Officer:	Mr. Guy Wiebking
CEO Address:	19065 Hickory Creek Drive Mokena, IL 60448
Telephone Number:	708/478-6300

Type of Ownership of Applicant/Co-Applicant

<input checked="" type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other

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E-mail Address:	Anne.Murphy@hkllaw.com
Fax Number:	312/578-6666

Additional Contact

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

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Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
Fax Number:	

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT**

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Provena Covenant Medical Center		
Street Address:	1400 West Park Avenue		
City and Zip Code:	Urbana, IL 61801		
County:	Champaign	Health Service Area	IV Health Planning Area: D-01

Applicant /Co-Applicant Identification

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

Exact Legal Name:	Resurrection Health Care Corporation
Address:	355 N. Ridge Avenue Chicago, IL 60202
Name of Registered Agent:	Ms. Sandra Bruce
Name of Chief Executive Officer:	Jeffrey Murphy
CEO Address:	355 N. Ridge Avenue Chicago, IL 60202
Telephone Number:	847/316-2352

Type of Ownership of Applicant/Co-Applicant

<input checked="" type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other

- o Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
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APPEND DOCUMENTATION AS ATTACHMENT-1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact

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

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

Additional Contact

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

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

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT**

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Provena Covenant Medical Center		
Street Address:	1400 West Park Avenue		
City and Zip Code:	Urbana, IL 61801		
County:	Champaign	Health Service Area	IV Health Planning Area: D-01

Applicant /Co-Applicant Identification

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

Exact Legal Name:	Cana Lakes Health Care		
Address:	7435 West Talcott Avenue		
Name of Registered Agent:	Ms. Sandra Bruce		
Name of Chief Executive Officer:	Ms. Sandra Bruce		
CEO Address:	7435 West Talcott Avenue Chicago, IL 60631		
Telephone Number:	773/792-5555		

Type of Ownership of Applicant/Co-Applicant

<input checked="" type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other

- o Corporations and limited liability companies must provide an Illinois certificate of good standing.
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APPEND DOCUMENTATION AS ATTACHMENT-1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact

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

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

Additional Contact

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

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

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:	Mike Brown
Title:	Regional President & CEO
Company Name:	Provena Covenant Medical Center
Address:	1400 West Park Avenue Urbana, IL 61801
Telephone Number:	217/337-2000
E-mail Address:	michael.brown@provena.org
Fax Number:	217/337-4541

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Provena Health
Address of Site Owner:	19065 Hickory Creek Drive Mokena, IL 60448
Street Address or Legal Description of Site:	1400 West Park Avenue Urbana, IL 61801
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:	Provena Hospitals	
Address:	19065 Hickory Creek Drive Mokena, IL 60448	
<input checked="" type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership	
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental	
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Other
<ul style="list-style-type: none">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.o 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:

- Substantive
 Non-substantive

Part 1120 Applicability or Classification: [Check one only.]

- Part 1120 Not Applicable
 Category A Project
 Category B Project
 DHS or DVA Project

2. Narrative Description

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

The proposed project is limited to a change of ownership of Provena Covenant Medical Center, a 210-bed community hospital located in Urbana, Illinois. The proposed change of ownership is a result of the impending merger of the Resurrection and Provena systems through a common "super parent" corporation that will become the parent entity of Resurrection Health Care Corporation (the current Resurrection system parent) and Provena Health (the current Provena system parent).

It is the expectation of the applicants that, for a minimum of two years following the change of ownership, all programs and services currently provided by Provena Covenant Medical Center will continue to be provided, and consistent with IHFSRB requirements, access to the hospital's services will not be diminished. The licensee will continue to be Provena Covenant Medical Center.

The proposed project, consistent with Section 1110.40.a, is classified as being "non-substantive" as a result of the scope of the project being limited to a change of ownership.

Please refer to the "Project Overview" for a summary of the transaction.

Project Costs and Sources of Funds Provena Covenant Medical Center

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

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			\$566,667
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Hospital			\$266,810,000
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS			\$267,376,667
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities			\$566,667
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Fair Market Value of Hospital			\$266,810,000
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS			\$267,376,667

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

Related Project Costs

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

Land acquisition is related to project Yes No
Purchase Price: \$ _____ not applicable
Fair Market Value: \$ _____ not applicable

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

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

Estimated start-up costs and operating deficit cost is \$ none.

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:

None or not applicable Preliminary
 Schematics Final Working

Anticipated project completion date (refer to Part 1130.140): September 30, 2011

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

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

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

State Agency Submittals

Are the following submittals up to date as applicable:

- Cancer Registry
 - APORS **please see documentation requested by State Agency staff on following pages**
 - All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
 - All reports regarding outstanding permits
- Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.**

Phone: 217-785-7126

FAX: 217-524-1770

From: Rose, Kevin [mailto:Edwin.Rose@provena.org]

Sent: Wednesday, February 16, 2011 12:42 PM

To: Fomoff, Jane

Subject: APORS Reporting - Provena St. Mary's Hospital and Provena Mercy Medical Center

Dear Jayne –

Thank you for working with me and staff at the local Provena ministries to assist us in improving our Adverse Pregnancy Outcome Reporting System (APORS) results. To summarize our conversation, the APORS reporting level at Provena St. Mary's Hospital is 77 and at Provena Mercy Medical Center is 75%. Given that each ministry's reporting level is only slightly below target and that each ministry is making a good faith effort to improve its reporting process such that they achieve target going forward, you will be recommending to Illinois Health Facilities and Services Review Board staff that review of any future certificate of need applications by Provena Health/Provena Hospitals be allowed to proceed, and that APORS reporting will not be a matter impacting project completeness.

Please respond back to confirm that you agree with this, and that I have accurately summarized our call. Thanks again – and I look forward to working with you and staff at the Provena ministries to ensure that we meet our targets in the future.

Sincerely,

Kevin

Kevin Rose

System Vice President, Strategic Planning & Business Development

Provena Health

19065 Hickory Creek Drive, Suite 300

From: Fornoff, Jane [mailto:Jane.Fornoff@Illinois.gov]
Sent: Thursday, February 17, 2011 1:28 PM
To: Rose, Kevin
Cc: Roate, George
Subject: RE: APORS Reporting - Provena St. Mary's Hospital and Provena Mercy Medical Center

Dear Kevin,

I am glad that you and the staff at Provena St. Mary's and Provena Mercy Medical Center are working to improve the timeliness of APORS (Adverse Pregnancy Outcome Reporting System). As I am sure you know, timely reporting is important because it helps assure that children achieve their full potential through the early case-management services provided to APORS cases.

As we discussed, since their current reporting timeliness is close to the compliance level, provided each ministry continues to make a good faith effort to improve its reporting process I will be recommending to Illinois Health Facilities and Services Review Board staff that review of any future certificate of need applications by Provena Health/Provena Hospitals be allowed to proceed, and that APORS reporting will not be a matter impacting project completeness.

Jane

Jane Fornoff, D.Phil.
Perinatal Epidemiologist
Illinois Department of Public Health
Adverse Pregnancy Outcomes Reporting System
535 W Jefferson St, Floor 3
Springfield, IL 62761

Cost Space Requirements

not applicable

Provide in the following format, the department/area **DGSF** or the building/area **BGSF** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		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**.

Provena					
FACILITY NAME: Covenant Medical Center		CITY: Urbana			
REPORTING PERIOD DATES: From: January 1, 2009 to: December 31, 2009					
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	110	5,325	21,962	None	110
Obstetrics	24	1,249	2,913	None	24
Pediatrics	6	74	140	None	6
Intensive Care	15	659	3,628	None	15
Comprehensive Physical Rehabilitation	25	396	4,362	None	25
Acute/Chronic Mental Illness	30	923	4,246	None	30
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify))					
TOTALS:	210	8,626	37,251	None	210

CERTIFICATION

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

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

This Application for Permit is filed on the behalf of Provena Hospitals * 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.

Guy Wiebking
SIGNATURE

Guy Wiebking
PRINTED NAME

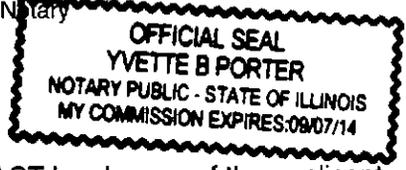
President and CEO
PRINTED TITLE

Anthony Filer
SIGNATURE

Anthony Filer
PRINTED NAME

Assistant Treasurer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 23rd day of March, 2011

Yvette B. Porter
Signature of Notary
Seal 

Notarization:
Subscribed and sworn to before me
this 23rd day of March, 2011

Yvette B. Porter
Signature of Notary
Seal 

*Insert EXACT legal name of the applicant

CERTIFICATION

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

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

Guy Wiebking
 SIGNATURE

Guy Wiebking
 PRINTED NAME

President and CEO
 PRINTED TITLE

Anthony Fier
 SIGNATURE

Anthony Fier
 PRINTED NAME

Assistant Treasurer
 PRINTED TITLE

Notarization:
 Subscribed and sworn to before me
 this 20th day of March 2011

Yvette B. Porter
 Signature of Notary
 Seal
 OFFICIAL SEAL
 YVETTE B PORTER
 NOTARY PUBLIC - STATE OF ILLINOIS
 MY COMMISSION EXPIRES:09/07/14

Notarization:
 Subscribed and sworn to before me
 this 20th day of March, 2011

Yvette B. Porter
 Signature of Notary
 Seal
 OFFICIAL SEAL
 YVETTE B PORTER
 NOTARY PUBLIC - STATE OF ILLINOIS
 MY COMMISSION EXPIRES:09/07/14

*Insert EXACT legal name of the applicant

CERTIFICATION

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

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

Sandra Bruce
SIGNATURE

Sandra Bruce
PRINTED NAME

President and CEO
PRINTED TITLE

Jeannie C. Frey
SIGNATURE

Jeannie C. Frey
PRINTED NAME

Secretary
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 22 day of March, 2011

Notarization:
Subscribed and sworn to before me
this 22 day of March

Florita de Jesus-Ortiz
Signature of Notary

Linda M. Noyola
Signature of Notary

Seal
OFFICIAL SEAL
FLORITA DE JESUS-ORTIZ
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES: 09/29/14

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

*Insert Notary Public Seal of Illinois Applicant

CERTIFICATION

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

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

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

Sandra Bruce
SIGNATURE

Sandra Bruce
PRINTED NAME

President
PRINTED TITLE

Jeannie C. Frey
SIGNATURE

Jeannie C. Frey
PRINTED NAME

Secretary
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 22 day of March, 2011

Notarization:
Subscribed and sworn to before me
this 22nd day of March

Florita de Jesus Ortiz
Signature of Notary

Linda M Noyola
Signature of Notary

Seal
OFFICIAL SEAL
FLORITA DE JESUS-ORTIZ
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 09/29/14
*Insert EXACT legal name of the applicant

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

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

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

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

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

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

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

PURPOSE OF PROJECT

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

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

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

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

ALTERNATIVES

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

Alternative options **must** include:

- A) Proposing a project of greater or lesser scope and cost;
 - B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;
 - C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and
 - D) Provide the reasons why the chosen alternative was selected.
- 2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short term (within one to three years after project completion) and long term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**
 - 3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

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

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

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

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

A. Criterion 1110.240(b), Impact Statement

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

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

B. Criterion 1110.240(c), Access

Read the criterion and provide the following:

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

C. Criterion 1110.240(d), Health Care System

Read the criterion and address the following:

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

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

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

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

VIII. - 1120.120 - Availability of Funds

Provena Covenant Medical Center

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

\$566,667	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to:
	1)	the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and
	2)	interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
_____	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including:
	1)	For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated;
	2)	For revenue bonds, proof of the feasibility of securing the specified amount and interest rate;
	3)	For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.;
	4)	For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment;
	5)	For any option to lease, a copy of the option, including all terms and conditions.
_____	e)	Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
_____	f)	Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
\$266,810,000	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project—FMV of hospital
\$267,376,667	TOTAL FUNDS AVAILABLE	

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

IX.

1120.130 - Financial Viability

**not applicable, funded through
Internal sources**

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

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

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

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

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

2. Variance

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

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

X. 1120.140 - Economic Feasibility

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

A. Reasonableness of Financing Arrangements

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

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

B. Conditions of Debt Financing **not applicable, no debt financing**

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

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

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

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

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

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

XI. Safety Net Impact Statement not applicable, non-substantive project

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

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

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

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.
2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.
3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

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

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

XII. Charity Care Information

Provena Covenant Medical Center

Charity Care information **MUST** be furnished for **ALL** projects.

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

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

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

CHARITY CARE			
	2007	2008	2009
Net Patient Revenue	\$149,983,420	\$149,754,361	\$165,234,681
Amount of Charity Care (charges)	\$11,121,913	\$16,014,112	\$19,587,053
Cost of Charity Care	\$3,485,275	\$4,994,875	\$4,601,303

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

Sources:

IDPH Annual Hospital Questionnaire for Net Patient Revenue and Cost of Charity Care
Internal Financial Statements for Amount of Charity Care (charges)



To all to whom these Presents Shall Come, Greeting:

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

PROVENA HOSPITALS, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 30, 1997, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

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

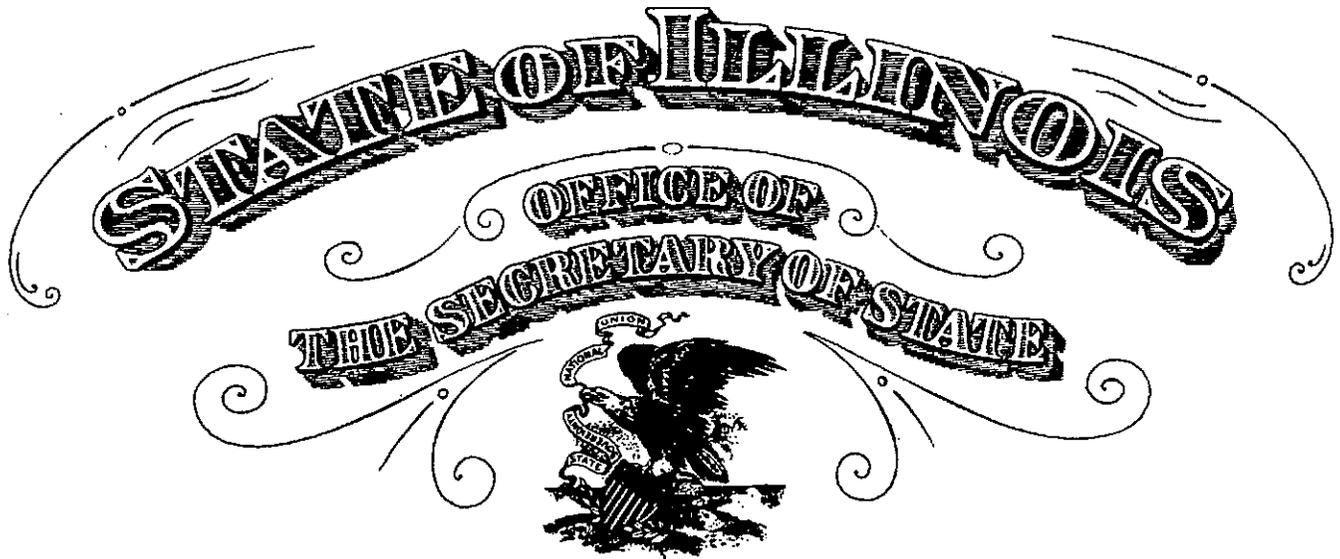


Authentication #: 1104200730

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

Jesse White

SECRETARY OF STATE
ATTACHMENT 1



To all to whom these Presents Shall Come, Greeting:

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

PROVENA HEALTH, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 10, 1985, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



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

Jesse White

Authentication #: 1104200726

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

SECRETARY OF STATE
ATTACHMENT 1



To all to whom these Presents Shall Come, Greeting:

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

RESURRECTION HEALTH CARE CORPORATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 27, 1949, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 17TH day of JANUARY A.D. 2011

Jesse White

SECRETARY OF STATE

Authentication #: 1101700286

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

ATTACHMENT 1



To all to whom these Presents Shall Come, Greeting:

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

CANA LAKES HEALTH CARE, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JANUARY 05, 1939, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 4TH day of MARCH A.D. 2011 .



Authentication #: 1106302140

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

Jesse White

SECRETARY OF STATE
ATTACHMENT I

Evidence of Site Control- Provena hospitals



PROPERTY

First-Party insurance that indemnifies the owner or users of property for its loss, or the loss of its income-producing ability, when the loss or damage is caused by a covered peril.

INSURER: FM Global

NAMED INSURED: Provena Health and any subsidiary, and Provena Health's interest in any partnership or joint venture in which Brush Engineered Material Inc. has management control or ownership as now constituted or hereafter is acquired, as the respective interest of each may appear; all hereafter referred to as the "Insured", including legal representatives.

POLICY NO.: FC999

POLICY PERIOD: June 1, 2010 – June 1, 2011 beginning and ending at 12:01 AM at the location of the property insured

**PERILS INSURED:
(LOSS OR DAMAGE INSURED)** "All Risk" of physical loss or damage including flood, earthquake, and Boiler & Machinery Insurance as more fully stated in the policy form. (see enclosed FM Quote)

PERILS EXCLUDED:

- Indirect or Remote Loss
- Interruption of business (except as provided under BI Coverage)
- Loss of Market
- Mysterious disappearance
- Law or Ordinance (except as provided under Demolition and Increased Cost of Construction and Decontamination Costs)
- Voluntary Parting of Property
- Nuclear Reaction / Radiation
- Hostile Warlike Action
- Terrorism (except as provided under Terrorism Coverage)
- Fraudulent or Dishonest Act or Acts
- Lack of Incoming Services (except as provided by Service Interruption)
- Defective Design / Faulty Material / Faulty Workmanship
- Wear and Tear
- Settling, Cracking, Shrinking, bulging of pavements, floors, foundations...
- Changes in temperature
- Insect, animal or vermin damage
- Rain, sleet or Snow damage to interior of buildings under construction
- Pollution
- Wind damage to Landscaping, lawns, trees, shrubs, etc. (all as more fully stated in the policy form)

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Excess Liability

**PROPERTY AND INTERESTS
INSURED:**

Property: All real and personal property owned, leased, acquired by, used by, intended for use by the Insured, including but not limited to:

- Property while in Transit
- Property of Others in the Insured's Care, Custody and Control including costs to defend allegations of liability for loss or damage to such property
- Improvements and Betterments
- Personal Property of Employees and Officers
- Property of Others that the Insured has agreed to insure
- Electronic Data Processing Equipment and Media
- Fine Arts
- Newly Acquired Property
- Miscellaneous Unnamed Locations – Personal Property
(all as more fully stated in the policy form)

COVERAGES/EXTENSIONS OF COVERAGE:

- Business Interruption, including Interdependency
- Extended Period of Liability
- Extra Expense
- Expediting Expense
- Consequential/Sequential Damage
- Accounts Receivable
- Leasehold Interest
- Rental Value and Rental Income
- Royalties, Licensing Fees, Technical Fees, Commissions
- Research and Development
- Fine Arts
- Contingent Business Interruption
- Contingent Extra Expense
- Service Interruption (Off Premises Power) – Property Damage and Time Element
- Civil or Military Authority
- Ingress/Egress
- Demolition and Increased Cost of Construction – Property Damage and Time Element
- Debris removal
- Land and Water Decontamination and Clean Up Expense
- Comprehensive Boiler & Machinery Insurance
- Automatic Coverage for Newly Acquired Properties
- Valuable Papers and Records
- Electronic Data Processing Media
- Protection and Preservation of Property (Sue and Labor)
(all as more fully stated in the attached policy form)

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SPECIAL CONDITIONS:

- Brands and Labels
 - Control of Damaged Merchandise
 - Pair and Set/Consequential Reduction in Value
 - Errors and Omissions
 - Loss Adjustment Expenses/Professional Fees
- (all as more fully stated in the policy form)

PROPERTY EXCLUDED:

- Watercraft, etc.
 - Land, etc., except land improvements (not at Mines)
 - Currency, Money, etc.
 - Animals, Growing Crops, Standing Timber, etc.
 - Water, etc.
 - Export and Import shipment, etc.
 - Waterborne Shipments via the Panama Canal
 - Waterborne Shipments to and from Alaska, Hawaii, Puerto Rico, Guam and Virgin Islands
 - Underground Mines, mine shafts and any property within such mine or shaft
- (all as more fully stated in the policy form)

VALUATION:

- Building and structures at the lesser of repair or replacement cost
 - Machinery, equipment, furniture, fixtures, and improvements and betterments at replacement cost new
 - Valuable Papers and Records and EDP Media at value blank plus cost of transcription
 - Finished Stock at Selling Price
 - Stock in Process at cost of materials, labor and overhead
 - Property of others at amount stipulated in lease, or Insured's contractual or legal liability
 - Fire damage resulting from Terrorism – Actual Cast Value
- (all as more fully stated in the policy form)

POLICY LIMITS:

\$500,000,000 Policy Limit per occurrence, except;
 Included Gross Earnings
 12 Months Gross Profits
 365 Days Ordinary Payroll
 or as noted below and in the policy form

SUBLIMITS:

\$100,000,000 Accounts Receivable
 Dependent Time Element
 \$20,000,000 • Per occurrence
 \$10,000,000 • Per location
 Included • For all suppliers direct and indirect and customers

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Excluded	• California, Alaska, Hawaii, Puerto Rico, New Madrid and Pacific Northwest High Hazard Zones for Earth Movement, Terrorism
Included	Control of Damaged Merchandise
\$10,000,000	• Goods held for resale Data, Media and Software and Computer Systems – Non Physical Damage combined
Yes	• Valuation includes Research Costs
Included	Defense Costs
Included	Debris Removal
\$100,000,000	Deferred Payments/Property Sold under Conditional Sales Agreements
\$100,000,000	Earth Movement per occurrence and in the aggregate in any one policy year
Excluded	• California, Alaska, Hawaii, Puerto Rico, New Madrid and Pacific Northwest High Hazard Zones for Earth Movement, Terrorism
\$100,000,000	Errors & Omissions (PD/BI/EE)
Excluded	• California, Alaska, Hawaii, Puerto Rico, New Madrid and Pacific Northwest High Hazard Zones for Earth Movement, Terrorism
90 Days	Extended Period of Indemnity
\$100,000,000	Extra Expense and Expediting Expense Combined
\$100,000,000	Fine Arts
	• but not to exceed 10,000 limit per item for Irreplaceable Fine Arts not on a schedule of file with the company
\$100,000,000	Flood per occurrence
Included	Increased Cost of Construction & Demolition, including resultant time element at the time of loss
\$5,000,000	Ingress/Egress – the lesser of limit shown or 30 day period
Excluded	• California, Alaska, Hawaii, Puerto Rico, New Madrid and Pacific Northwest High Hazard Zones for Earth Movement, Terrorism
30 Days	Interruption by Civil Authority – the lesser or limit shown or ___ day period.
Excl. Wind	Landscaping, including Trees, Shrubs and Plants
\$10,000,000	Leasehold Interest
\$10,000,000	Miscellaneous Unnamed Locations/ Personal Property
Excluded	• California, Alaska, Hawaii, Puerto Rico, New Madrid and Pacific Northwest High Hazard Zones for Earth Movement, Terrorism
\$100,000,000	Newly Acquired Property (Automatic Coverage – 90 day reporting)

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Excluded	• California, Alaska, Hawaii, Puerto Rico, New Madrid and Pacific Northwest High Hazard Zones for Earth Movement, Terrorism
\$10,000,000	Off Premise Storage for Property Under Construction
Excluded	• California, Alaska, Hawaii, Puerto Rico, New Madrid and Pacific Northwest High Hazard Zones for Earth Movement, Terrorism
Included	Rents
Included	Research and Development (TE)
\$100,000	Animals (PD)
\$25,000,000	Service Interruption- Property Damage and Time Element Combined
\$2,500,000	• Data, Voice and Video except accidental occurrence is excluded
Excluded	• California, Alaska, Hawaii, Puerto Rico, New Madrid and Pacific Northwest High Hazard Zones for Earth Movement, Terrorism
\$10,000,000	Soft Costs
Included	Tax Treatment of Profits
\$10,000,000	Transit, property in the due course of (excludes ocean cargo)
\$1,000,000	• Time Element
\$100,000,000	Valuable Papers
Repair or restore only	• but not to exceed 10,000 limit per item for Irreplaceable Valuable Papers and Records not on a schedule of file with the company
Included	Boiler and Machinery – per all terms and conditions of the policy form
\$500,000,000	Certified Terrorism - TRIPRA
\$5,000,000	Terrorism
\$1,000,000	• Miscellaneous Personal Property, Off Premises Storage for Property Under Construction, and Temporary Removal of Property
\$1,000,000	Flood
12 Month	Terrorism Time Element
	These limits shall not include the ACV portion of fire damage caused by Terrorism
	Or as further defined in the policy form

DEDUCTIBLES:

Per Occurrence
 \$50,000 Property Damage
 1 x DEQ Time element
 DEQ = Daily Equivalent
 Except as follows:

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\$100,000 min. 5% per location	Names Storm Wind (all affected locations are subject to this deductible)
\$100,000	Flood (surface water exposure) <ul style="list-style-type: none"> Provena Pineview Care Center 611 Allen Lane St. Charles, IL
\$25,000	Transit <ul style="list-style-type: none"> Property
48 hrs. waiting period and 48 hr. ded.	Data, Programs, and Software/Malicious Introduction of Machine Code
Min. \$100,000 48 hrs. waiting period and 48 hr. ded.	Computer Systems – Non Physical Damage
Min. 100,000 \$100,000	Dependent Time Element Location Per occurrence/location except; <ul style="list-style-type: none"> Per location for Earthquake Shock Per location for Flood Per location for Named Storm Wind* except; (*at all affected locations, are subject to this deductible)
\$100,000	
\$100,000	
\$100,000	
5% of Values*	
\$100,000 min/loc. 24 hrs. Policy deductible(s) per location	Service Interruption Waiting Period Terrorism – TRIPRA, and ACV portion of fire damage caused by Terrorism
\$100,000	Property Damage and Time Element deductible combined applies at the following locations: <ul style="list-style-type: none"> Covenant Medical Center 130-1412 West Park (excluding 1307 and 1405 West Park) Urbana, IL Provena United Samaritans Medical Center 812 North Logan Danville, IL St. Mary's Hospital (including bridge over West Court Street) 500 West Court Street Kankakee, IL Provena St. Joseph Medical Center Madison Street, Glenwood and Springfield 333 North Madison Joliet, IL

Proprietary Information: Data provided on this page is proprietary between Aon and Provena. This insurance document is furnished to you as a matter of information for your convenience. It only summarizes the listed policy(ies) and is not intended to reflect all the terms and conditions or exclusions of such policy(ies). Moreover, the information contained in this document reflects coverage as of the date of this summary as shown below of the policy(ies) and does not include subsequent changes. This document is not an insurance policy and does not amend, alter or extend the coverage afforded by the listed policy(ies). The insurance afforded by the listed policy(ies) is subject to all the terms, exclusions and conditions of such policy(ies).



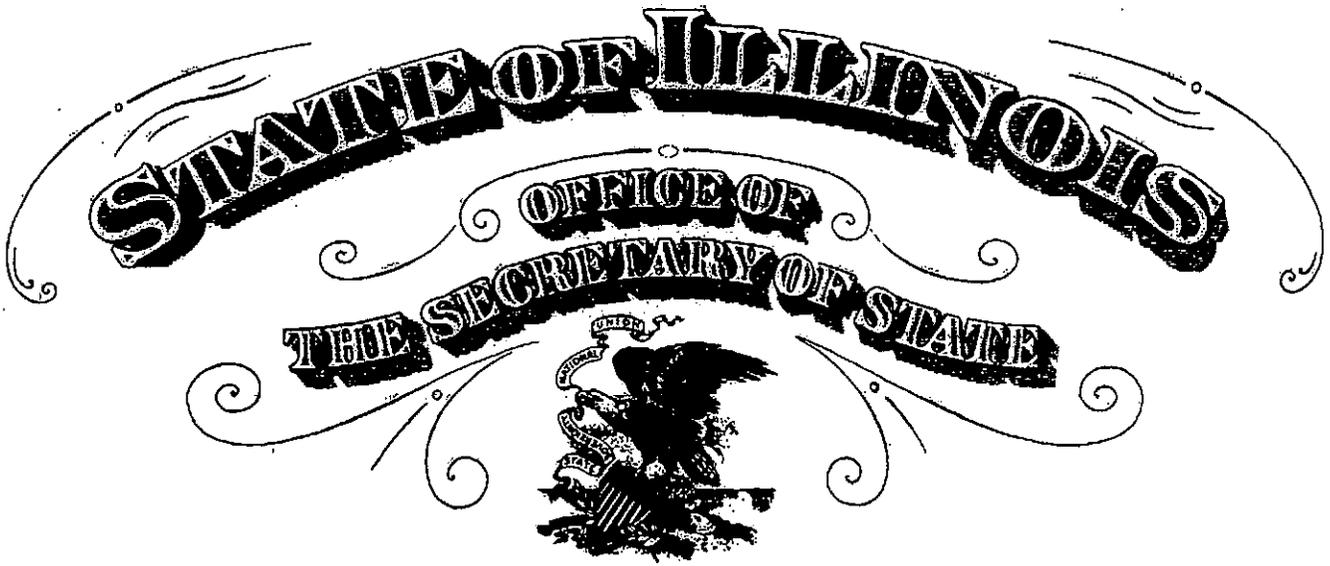
- St. Joseph Hospital
77 North Airline Street
Elgin, IL
- Provena Mercy Center
1325 North Highland Avenue
Aurora, IL

ANNUAL PREMIUM: \$1,029,000

CLAIMS REPORTING PROCEDURES: Doug Backes
FM Global
South Northwest Highway
Park Ridge, IL 60068
Phone: 847-430 7401
Fax: 847-430-7499

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To all to whom these Presents Shall Come, Greeting:

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

PROVENA HOSPITALS, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 30, 1997, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

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



Jesse White

Authentication #: 1104200730

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

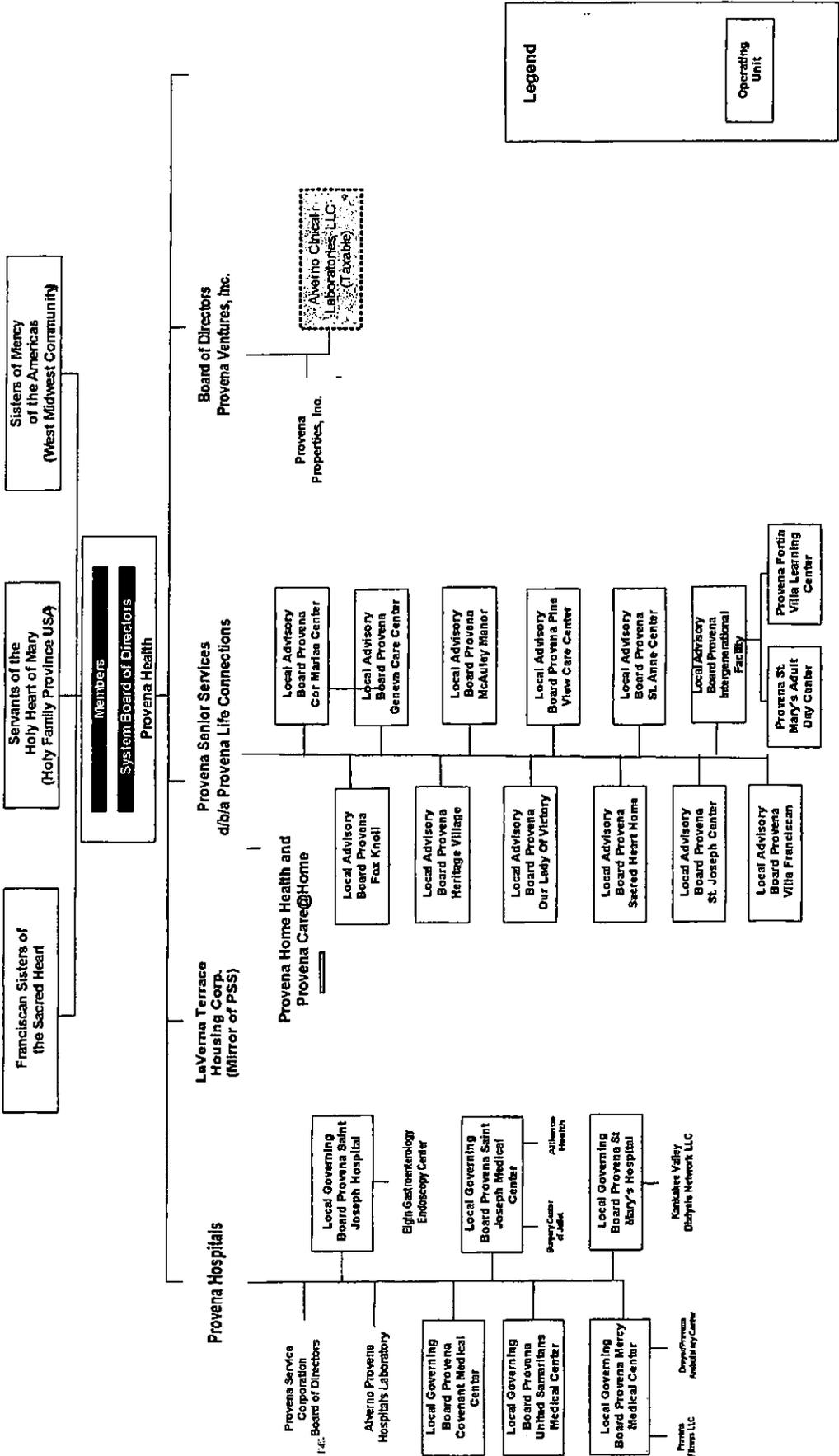
SECRETARY OF STATE

ATTACHMENT 3

CURRENT ORGANIZATIONAL CHARTS

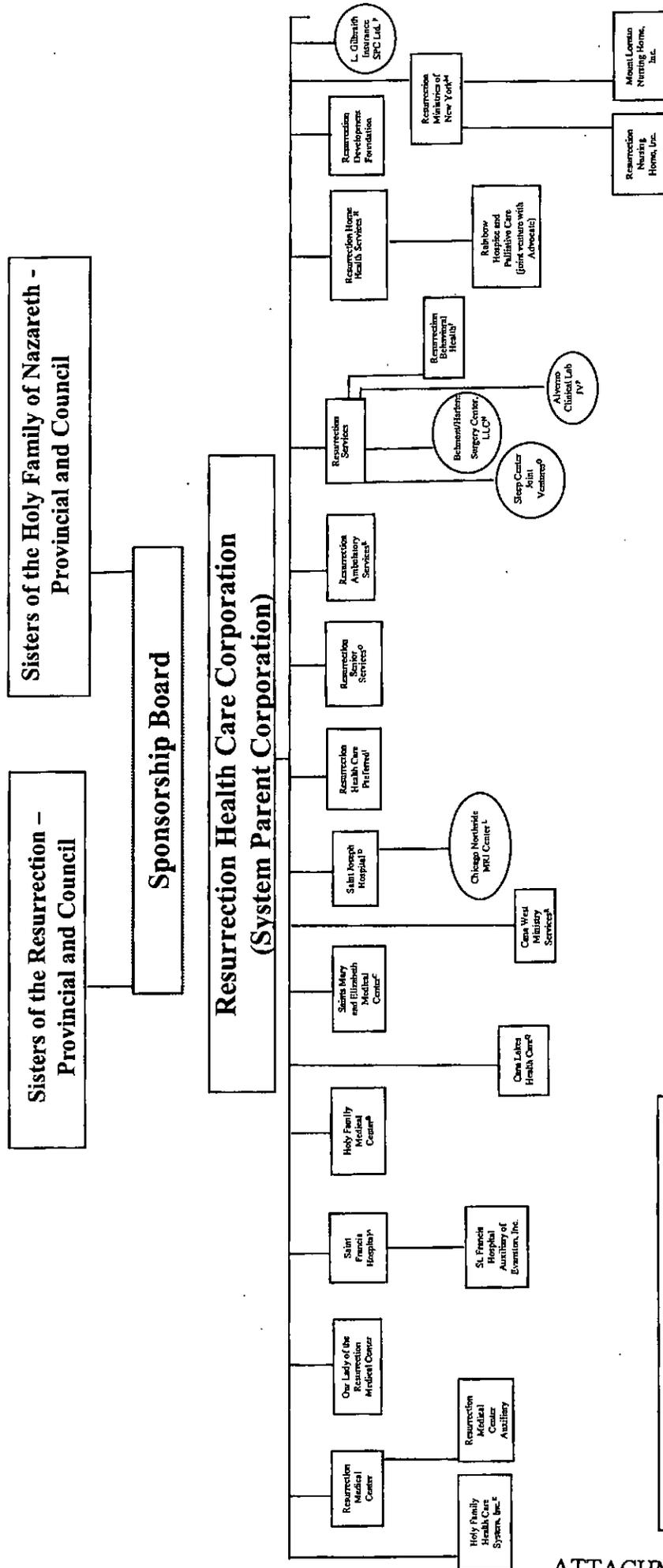
January 2011

Provena Health
Organizational Governance Structure



Resurrection Health Care Corporation Corporate Organizational and Governance Structure

October 21, 2010



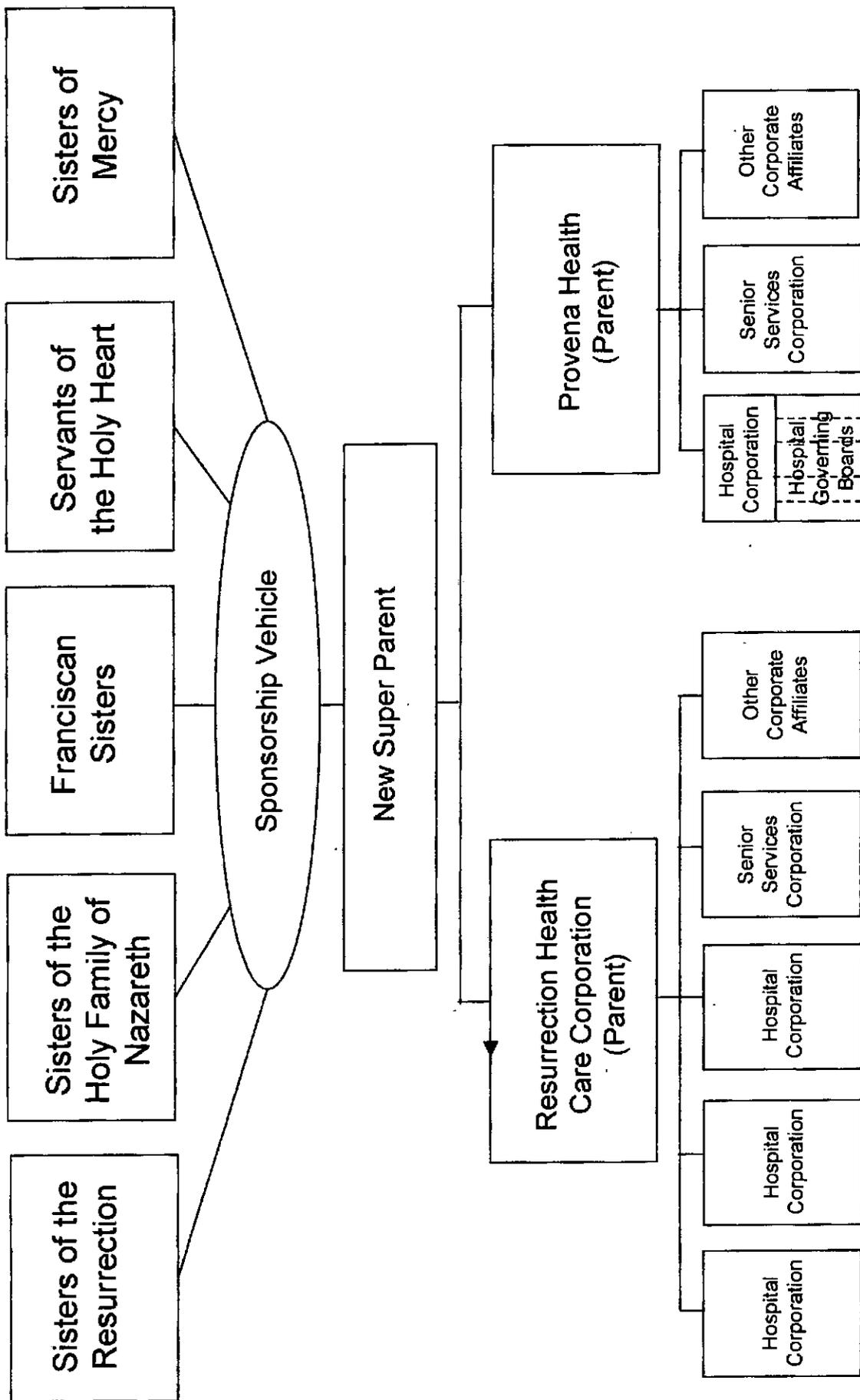
Key:
 Boxes denote not for profit corporations.
 Circles denote for profit corporations or other entities.
 Text of footnotes A through P are on the next page.

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

- ^A Formerly named Saint Francis Hospital of Evanston (name change effective November 22, 2004)
- ^B Became part of the Resurrection system effective March 1, 2001, as part of the agreement of co-sponsorship between the Sisters of the Resurrection, Immaculate Conception Province and the Sisters of the Holy Family of Nazareth, Sacred Heart Province
- ^C Created from merger of Saint Elizabeth Hospital into Saint Mary of Nazareth Hospital Center, and name change of latter (surviving) corporation, both effective 12/1/03. Saint Mary of Nazareth Hospital Center (now part of Saints Mary and Elizabeth Medical Center) became part of Resurrection system under the co-sponsorship agreement referenced in Footnote B above
- ^D Saint Joseph Hospital, f/k/a Cana Services Corporation, f/k/a Westlake Health System
- ^E Formerly known as West Suburban Health Services, this 501(c)(3) corporation had been the parent corporation of West Suburban Medical Center prior to the hospital corporation becoming part of the Resurrection Health Care system. Effective January 1, 2010, Resurrection Ambulatory Services assumed the assets and liabilities of Resurrection Services' ambulatory care services division.
- ^F A Cayman Islands corporation registered to do business as an insurance company
- ^G Corporation formerly known as Westlake Nursing and Rehabilitation Center (also f/k/a Leyden Community Extended Care Center, Inc.)
- ^H Resurrection Home Health Services, f/k/a Health Connections, Inc., is the combined operations of Extended Health Services, Inc., Community Nursing Service West, Resurrection Home Care, and St. Francis Home Health Care (the assets of all of which were transferred to Health Connections, Inc. as of July 1, 1999).
- ^I Holy Family Health Preferred is a former d/b/a of Saints Mary and Elizabeth Health Preferred, and Saint Joseph Health Preferred. Operates under the d/b/a names of Resurrection Health Preferred, Saint Francis Health Preferred, and Holy Family Health Preferred
- ^J D/B/A name for Proviso Family Services, a/k/a ProCare Centers, a/k/a Employee Resource Centers
- ^K Former parent of Holy Family Medical Center; non-operating 501(c)(3) "shell" available for future use
- ^L An Illinois general partnership between Saint Joseph Hospital and Advocate Northside Health System, an Illinois not for profit corporation
- ^M Resurrection Health Care is the Corporate Member of RMNY, with extensive reserve powers, including appointment/removal of all Directors and approval of amendments to the Corporation's Articles and Bylaws. The Sponsoring Member of the Corporation is the Sisters of the Resurrection New York, Inc.
- ^N Resurrection Services owns over 50% of the membership interests of Belmont/Harlem, LLC, an Illinois limited liability company, which owns and operates an ambulatory surgery center
- ^O Resurrection Services owns a majority interest in the following Illinois limited liability companies which own and operate sleep disorder diagnostic centers: RES-Health Sleep Care Center of River Forest, LLC; RES-Health Sleep Care Center of Lincoln Park, LLC; RES-Health Sleep Care Center of Evanston, LLC; RES-Health Sleep Care Center of Chicago Northwest, LLC
- ^P Joint Venture for clinical lab services for 2 other Catholic health care systems, Provena and Sisters of Saint Francis Health Services, Inc., consisting of an Indiana limited liability company of which Resurrection Services is a 1/3 member, and a tax-exempt cooperative hospital service corporation, of which all Resurrection tax-exempt system hospitals collectively have a 1/3 interest
- ^Q Formerly named Westlake Community Hospital; all the assets of this corporation were sold to VHS Westlake Hospital Inc., effective August 1, 2010
- ^R Formerly named West Suburban Medical Center; all the assets of this corporation were sold to VHS West Suburban Medical Center, Inc., effective August 1, 2010

PROPOSED ORGANIZATIONAL CHART

Super Parent Structure



IDENTIFICATION OF PROJECT COSTS

Fair Market Value of Hospital

The insured value of the hospital was used to identify the Fair Market Value, consistent with a discussion of methodology with IHFSRB staff.

Consulting and Other Fees

The transaction-related costs anticipated to be incurred by Provena Health and Resurrection Health Care Corporation (approximately \$8,500,000) was equally apportioned among the thirteen hospitals, one ASTC and one ESRD facility for which CON applications need to be filed. The transaction-related costs include, but are not limited to: the due diligence process, the preparation of transaction-related documents, the CON application development process, CON review fees, and outside legal counsel, accounting and consulting fees.

7435 West Talcott Avenue
Chicago, Illinois 60631
773.792.5555



Sandra Bruce, FACHE
President & Chief Executive Officer

March 24, 2011

Illinois Health Facilities
and Services Review Board
525 West Jefferson
Springfield, IL 62761

To Whom It May Concern:

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

1. Over the past three years, there have been a total of five adverse actions involving a Resurrection hospital (each addressing Medicare Conditions of Participation). Two such actions relate to Our Lady of the Resurrection Medical Center (OLR), and three such actions relate to Saint Joseph Hospital (SJH). All five actions were initiated in 2009. Three of the five actions were fully resolved in 2009 to the satisfaction of CMS and IDPH, through plans of correction: (a) SJH was cited twice (in an initial and follow up survey) with certain deficiencies in conducting and documenting rounds on its psychiatry unit; and (b) OLR was cited with deficiencies in medical staff training and competencies in certain intubation procedures. The remaining two actions, each of which involves life safety code issues related to the age of the physical plant of OLR and SJH, are scheduled for plan of correction completion by March 31, 2011 and December 31, 2011 respectively.
2. Resurrection Health Care Corporation authorizes the State Board and State Agency access to information to verify documentation or information submitted in response to the requirements of Review Criterion 1110.230.b or to obtain any documentation or information which the State Board or State Agency finds pertinent to this application.

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

Sincerely,

A handwritten signature in cursive script that reads 'Sandra Bruce'.

Sandra Bruce, FACHE
President & CEO

SB/fdjo



March 23, 2011

Illinois Health Facilities
and Services Review Board
525 West Jefferson
Springfield, IL 62761

To Whom It May Concern:

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

3. Neither Provena Health ("Provena") nor any wholly-affiliated corporation that owns or operates a facility subject to the IHFSRB's jurisdiction has had any adverse actions (as defined in Section 1130.140) taken against any hospital or ESRD facility during the three (3) year period prior to the filing of this application, and
4. Provena Health authorizes the State Board and State Agency access to information to verify documentation or information submitted in response to the requirements of Review Criterion 1110.230.b or to obtain any documentation or information which the State Board or State Agency finds pertinent to this application.

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

Sincerely,

A handwritten signature in cursive script that reads "Meghan Kieffer".

Meghan Kieffer
System Senior Vice President/General Counsel



A handwritten signature in cursive script that reads "Yvette B. Porter".

FACILITIES LICENSED IN ILLINOIS

	Name	Location	IDPH Licensure #
Hospitals Owned by Resurrection Health Care Corporation:			
	Saint Mary of Nazareth Hospital	Chicago	2584
	Saint Elizabeth Hospital	Chicago	5314
	Resurrection Medical Center	Chicago	1974
	Saint Joseph Hospital	Chicago	5181
	Holy Family Medical Center	Des Plaines	1008
	St. Francis Hospital of Evanston	Evanston	2402
	Our Lady of Resurrection Medical Center	Chicago	1719
Hospitals Owned by Provena Health:			
	Covenant Medical Center	Urbana	4861
	United Samaritan Medical Center	Danville	4853
	Saint Joseph Medical Center	Joliet	4838
	Saint Joseph Hospital	Elgin	4887
	Provena Mercy Center	Aurora	4903
	Saint Mary's Hospital	Kankakee	4879
Ambulatory Surgical Treatment Centers Owned by Resurrection Health Care Corporation:			
	Belmont/Harlem Surgery Center, LLC*	Chicago	7003131
End Stage Renal Disease Facilities Owned by Provena Health:			
	Manteno Dialysis Center	Manteno	n/a
Long-Term Care Facilities Owned by Provena Health:			
	Provena Villa Franciscan	Joliet	2009220
	Provena St. Anne Center	Rockford	2004899
	Provena Pine View Care Center	St. Charles	2009222
	Provena Our Lady of Victory	Bourbonnais	2013080
	Provena Geneva Care Center	Geneva	1998975
	Provena McCauley Manor	Aurora	1992916
	Provena Cor Maniae Center	Rockford	1927199
	Provena St. Joseph Center	Freeport	0041871
	Provena Heritage Village	Kankakee	0042457
Long-Term Care Facilities Owned by Resurrection Health Care Corporation:			
	Holy Family Nursing and Rehabilitation Center	Des Plaines	0048652
	Maryhaven Nursing and Rehabilitation Center	Glenview	0044768
	Resurrection Life Center	Chicago	0044354
	Resurrection Nursing and Rehabilitation Ctr.	Park Ridge	0044362
	Saint Andrew Life Center	Niles	0044776
	Saint Benedict Nursing and Rehabilitation Ctr.	Niles	0044784
	Villa Scalabrini Nursing and Rehabilitation Ctr.	Northlake	0044792
	* Resurrection Health Care Corporation has a 51% ownership interest		
	** Provena Health has a 50% ownership interest		



State of Illinois 2009511
Department of Public Health

LICENSE / PERMIT / CERTIFICATION / REGISTRATION

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

DANON T. ARNOLD, M.D.
DIRECTOR

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

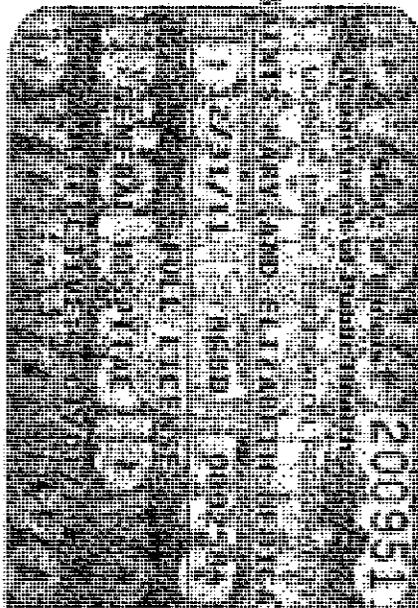
EXPIRATION DATE 12/31/11	CATEGORY RGMB	ID NUMBER 0002584
FULL LICENSE GENERAL HOSPITAL EFFECTIVE: 01/01/11		
BUSINESS ADDRESS		

SAINTS MARY AND ELIZABETH MEDICAL CENTE
D/B/A SAINI MARY OF NAZARETH HOSPITAL
2233 WEST DIVISION STREET
CHICAGO IL 60622

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 CONSPICUOUS PLACE

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 IDENTIFICATION



11/06/10
SAINTS MARY AND ELIZABETH MED
D/B/A SAINI MARY OF NAZARETH H
2233 WEST DIVISION STREET
CHICAGO IL 60622

FEE RECEIPT NO.



State of Illinois 2009544
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

BANON T. ARNOLD, M.D.
DIRECTOR

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

EXPIRATION DATE	CATEGORY	LP NUMBER
12/31/11	6680	0005314

FULL LICENSE
GENERAL HOSPITAL

EFFECTIVE- 10/01/11

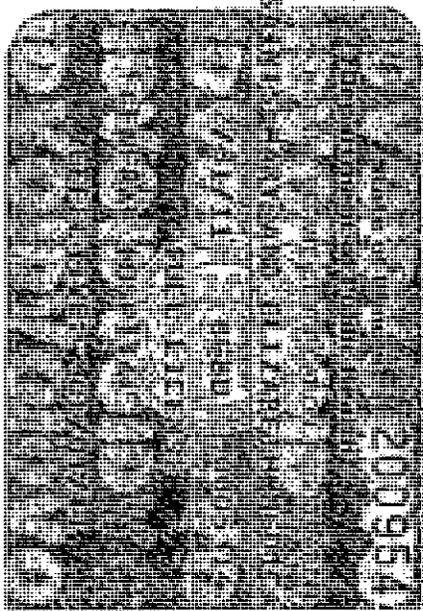
BUSINESS ADDRESS

SAINTS MARY AND ELIZABETH MEDICAL CENTE
D/B/A SAINT ELIZABETH HOSPITAL
1431 NORTH CLAREMONT AVENUE
CHICAGO, IL 60622

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11/06/10

SAINTS MARY AND ELIZABETH MED
D/B/A SAINT ELIZABETH HOSPITAL
1431 NORTH CLAREMONT AVENUE
CHICAGO IL 60622

FEE RECEIPT NO.



March 22, 2011

Margaret McDermott
Saints Mary and Elizabeth Medical Center
1431 N. Claremont
Chicago, IL 60622

Dear Ms. McDermott:

This letter is to certify that Saints Mary and Elizabeth Medical Center in Chicago, IL is currently accredited by the Healthcare Facilities Accreditation Program (HFAP) of the American Osteopathic Association (AOA).

The hospital was surveyed for re-accreditation by HFAP on November 15-17, 2010. They are currently in process and have not yet received their Accreditation Letter or Certificate.

You may use a copy of this letter with external organizations to demonstrate your accreditation status. Questions about the HFAP may be directed to my attention via phone at 312-202-8060.

Sincerely,

A handwritten signature in cursive script that reads "Troy Repuszka".

Troy Ann Repuszka, RN, BScN,
Deputy Director, HFAP



State of Illinois 2009495

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

DAMON T. ARNOLD, M.D.
DIRECTOR

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

EXPIRATION DATE 12/31/11	CATEGORY 068D	ID NUMBER 0001974
FULL LICENSE		
GENERAL HOSPITAL		
EFFECTIVE: 01/01/11		

BUSINESS ADDRESS

RESURRECTION MEDICAL CENTER
7435 WEST TALCOTT AVENUE

CHICAGO

IL 50631

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IDENTIFICATION

State of Illinois 2009495
Department of Public Health

RESURRECTION MEDICAL CENTER

EXPIRATION DATE 12/31/11	CATEGORY 688D	ID NUMBER 0001974
FULL LICENSE		
GENERAL HOSPITAL		
EFFECTIVE: 01/01/11		

EFFECTIVE: 01/01/11

11/06/10

RESURRECTION MEDICAL CENTER
7435 WEST TALCOTT AVENUE

CHICAGO

IL 50631

SEE RECEIPT NO.



March 22, 2011

Sandra Bruce, CEO
Resurrection Medical Center
7435 W. Talcott
Chicago, IL 60637

Dear Ms. Bruce:

This letter is to certify that Resurrection Medical Center in Chicago, IL is currently accredited by the Healthcare Facilities Accreditation Program (HFAP) of the American Osteopathic Association (AOA).

The hospital was surveyed for re-accreditation by HFAP on November 29-December 1, 2010. They are currently in process and have not yet received their Accreditation Letter or Certificate.

You may use a copy of this letter with external organizations to demonstrate your accreditation status. Questions about the HFAP may be directed to my attention via phone at 312-202-8060.

Sincerely,

A handwritten signature in cursive script that reads "Troy Repuszka".

Troy Ann Repuszka, RN, BScN,
Deputy Director, HFAP

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State of Illinois 2040005

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

SAINT JOSEPH HOSPITAL

EXPIRATION DATE	CATEGORY	ID NUMBER
07/02/12	9608	0005181

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 07/03/11

06/16/11

SAINT JOSEPH HOSPITAL
2900 NORTH LAKE SHORE DRIVE
CHICAGO IL 60657

FEE RECEIPT NO.



State of Illinois 2040005
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

GAMON J. ARNOLD, M.D.
DIRECTOR
Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRATION DATE	CATEGORY	ID NUMBER
07/02/12	9608	0005181

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 07/03/11

BUSINESS ADDRESS

SAINT JOSEPH HOSPITAL
2900 NORTH LAKE SHORE DRIVE
CHICAGO IL 60657

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February 11, 2011

Carol Schultz
Accreditation Coordinator
St. Joseph Hospital
2900 N. Lakeshore Drive
Chicago, IL 60657

Dear Ms. Schultz:

This letter is to certify that St. Joseph Hospital in Chicago, IL is currently accredited by the Healthcare Facilities Accreditation Program (HFAP) of the American Osteopathic Association (AOA).

The hospital was surveyed for re-accreditation by HFAP on October 11-13, 2010. They are currently in process and have not yet received their Accreditation Letter or Certificate.

You may use a copy of this letter with external organizations to demonstrate your accreditation status. Questions about the HFAP may be directed to my attention via phone at 312-202-8060.

Sincerely,

A handwritten signature in cursive script that reads "Troy Repuszka".

Troy Ann Repuszka, RN, BScN,
Deputy Director, HFAP

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State of Illinois 2035973

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

HOLY FAMILY MEDICAL CENTER
EXPIRATION DATE 06/30/12 CATEGORY B6ED ID. NUMBER 0001008

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 07/01/11

05/07/11

HOLY FAMILY MEDICAL CENTER
100 NORTH RIVER ROAD

DES PLAINES IL 60016 1278

FEE RECEIPT NO.

State of Illinois 2035973
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

DAMON T. ARNOLD, M.D.
DIRECTOR
Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRATION DATE 06/30/12 CATEGORY B6ED ID. NUMBER 0001008
FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 07/01/11

BUSINESS ADDRESS

HOLY FAMILY MEDICAL CENTER
100 NORTH RIVER ROAD

DES PLAINES IL 60016 1278
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AMERICAN OSTEOPATHIC ASSOCIATION

**BUREAU OF HEALTHCARE FACILITIES ACCREDITATION
HEALTHCARE FACILITIES ACCREDITATION PROGRAM**

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

January 7, 2011

John Baird
Chief Executive Officer
Holy Family Medical Center
100 North River Road
Des Plaines, IL 60016

Dear Mr Baird :

The American Osteopathic Association's Bureau of Healthcare Facilities Accreditation Executive Committee, at its meeting on January 4, 2011 reviewed the recertification survey report and found all Medicare conditions have been met. Your facility has been granted **Full Accreditation**, with resurvey within 3 years and AOA/HFAP **recommends continued deemed status**.

Holy Family Medical Center (All Sites as Listed)
100 North River Road
Des PLaines, IL 60016

Program: Acute Care Hospital
CCN # 140105
HFAP ID: 158128
Survey Dates: 08/23/2010 – 08/25/2010
Effective Date of Accreditation: 09/12/2010 - 09/12/2013

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

No further action is required.

Sincerely,

George A. Reuther
Secretary

GAR/pmh

C: Laura Weber, Health Insurance Specialist, CMS
Region V, CMS

ATTACHMENT 11



State of Illinois 2009508
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

DAMON T. ARNOLD, M.D.
DIRECTOR

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

EXPIRATION DATE 12/31/11	CATEGORY 6680	I.D. NUMBER 0002402
FULL LICENSE		
GENERAL HOSPITAL		
EFFECTIVE: 01/01/11		

BUSINESS ADDRESS

ST. FRANCIS HOSPITAL OF EVANSTON
355 RIDGE AVENUE
EVANSTON IL 60202

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State of Illinois 2009508
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

ST. FRANCIS HOSPITAL OF EVANSTON

EXPIRATION DATE 12/31/11	CATEGORY 6680	I.D. NUMBER 0002402
FULL LICENSE		
GENERAL HOSPITAL		
EFFECTIVE: 01/01/11		

GENERAL HOSPITAL
EFFECTIVE: 01/01/11

11/05/10
ST. FRANCIS HOSPITAL OF EVANSTON
355 RIDGE AVENUE
EVANSTON IL 60202

FEE RECEIPT NO.



AMERICAN OSTEOPATHIC ASSOCIATION

BUREAU OF HEALTHCARE FACILITIES ACCREDITATION
HEALTHCARE FACILITIES ACCREDITATION PROGRAM

142 E. Ontario Street, Chicago, IL 60611-2864 312 202 8268 | 800-621-1773 X 8268

January 24, 2011

Jeffrey Murphy
Chief Executive Officer
Saint Francis Hospital
355 Ridge Avenue
Evanston, IL 60202

Dear Mr Murphy :

The American Osteopathic Association's Bureau of Healthcare Facilities Accreditation Executive Committee, at its meeting on January 18, 2011 reviewed the recertification survey report and found all Medicare conditions have been met. Your facility has been granted **Full Accreditation**, with resurvey within 3 years and AOA/HFAP recommends **continued deemed status**.

Saint Francis Hospital (All Sites as Listed)
355 Ridge Avenue
Evanston, IL 60202

Program: Acute Care Hospital
CCN # 140080
HFAP ID: 118676
Survey Dates: 10/4/2010 – 10/6/2010
Effective Date of Accreditation: 10/26/2010 - 10/26/2013

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

No further action is required.

Sincerely,

George A. Reuther
Secretary

GAR/pmh

C: Laura Weber, Health Insurance Specialist, CMS
Region V, CMS



State of Illinois 2035984

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

DAMON T. ARNOLD, M.D.
DIRECTOR

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

Table with 3 columns: EXPIRATION DATE (06/30/12), CATEGORY (BGHD), I.D. NUMBER (0001719). License details: FULL LICENSE, GENERAL HOSPITAL, EFFECTIVE: 07/01/11.

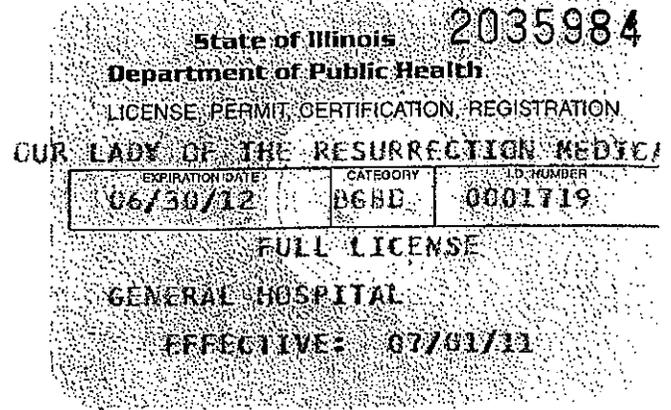
BUSINESS ADDRESS

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

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

DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION



05/07/11

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

FEE RECEIPT NO.



March 11, 2011

Betsy Pankau
Accreditation Coordinator
Our Lady of the Resurrection
5645 West Addison
Chicago, IL 60634

Dear Ms. Pankau:

This letter is to certify that Our Lady of the Resurrection Hospital in Chicago, IL is currently accredited by the Healthcare Facilities Accreditation Program (HFAP) of the American Osteopathic Association (AOA).

The hospital was surveyed for re-accreditation by HFAP on October 18-20, 2010. They are currently in process and have not yet received their Accreditation Letter or Certificate.

You may use a copy of this letter with external organizations to demonstrate your accreditation status. Questions about the HFAP may be directed to my attention via phone at 312-202-8060.

Sincerely,

A handwritten signature in cursive script that reads "Troy Repuszka".

Troy Ann Repuszka, RN, BScN,
Deputy Director, HFAP



State of Illinois 2009538
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

DAMON T. ARNOLD, M.D.
DIRECTOR

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

EXPIRATION DATE	CATEGORY	ID NUMBER
12/31/11	B680	0004861
FULL LICENSE		
GENERAL HOSPITAL		
EFFECTIVE: 01/01/11		

BUSINESS ADDRESS

**PROVENA HOSPITALS
 D/B/A COVENANT MEDICAL CENTER
 1400 WEST PARK AVENUE**

URBANA IL 61801

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Provena Covenant Medical Center

Urbana, IL

has been Accredited by



The Joint Commission

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

Hospital Accreditation Program

July 12, 2008

Accreditation is customarily valid for up to 39 months.

A handwritten signature in cursive script, reading "David L. Nahrwold".

David L. Nahrwold, M.D.
Chairman of the Board

4968
Organization ID #

A handwritten signature in cursive script, reading "Mark Chassin".

Mark Chassin, M.D.
President

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





State of Illinois 2009537
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.

DAVID T. ARNOLD, M.D.
DIRECTOR

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

EXPIRATION DATE	CATEGORY	TE NUMBER
12/31/11	BGBD	0004853

FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 01/01/11

BUSINESS ADDRESS

PROVENA HOSPITALS
D/B/A UNITED SAHARITAN MED CTR-LOGAN
812 NORTH LOGAN AVENUE

DANVILLE IL 61832

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Provena United Samaritans
Medical Center
Danville, IL
has been Accredited by



The Joint Commission

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

July 26, 2008

Accreditation is customarily valid for up to 39 months.

David L. Nahrwold

David L. Nahrwold, M.D.
Chairman of the Board

4928
Organization ID #

Mark Chassin

Mark Chassin, M.D.
President

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State of Illinois 2009536
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.

DARON T. ARNOLD, M.D.
DIRECTOR

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

EXPIRATION DATE 12/31/11	CATEGORY 86BD	LD NUMBER 0004838
FULL LICENSE GENERAL HOSPITAL EFFECTIVE: 01/01/11		

BUSINESS ADDRESS.

PROVENA HOSPITALS
D/B/A SAINT JOSEPH MEDICAL CENTER
333 NORTH MADISON STREET
JOLIET

IL 60435

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REMOVE THIS CARD TO CARRY AS AN
 IDENTIFICATION

2009536

State of Illinois
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION
PROVENA HOSPITALS

EXPIRATION DATE 12/31/11	CATEGORY 86BD	LD NUMBER 0004838
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FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 01/01/11

11/06/10

PROVENA HOSPITALS
D/B/A SAINT JOSEPH MEDICAL CENTER
333 NORTH MADISON STREET
JOLIET
IL 60435

FEE RECEIPT NO.



April 5, 2011

Jeffrey L. Brickman, M.B.A.
President and CEO
Provena Saint Joseph Medical Center
333 North Madison Street
Joliet, IL 60435

Joint Commission ID #: 7364
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of
Standards Compliance
Accreditation Activity Completed: 04/05/2011

Dear Mr. Brickman:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning January 29, 2011. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

Please visit [Quality Check®](#) on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

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



State of Illinois 2009540
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

DAMON T. ARNOLD, M.D.
DIRECTOR

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

EXPIRATION DATE 12/31/11	CATEGORY BGBD	ID NUMBER 0004887
FULL LICENSE		
GENERAL HOSPITAL		
EFFECTIVE: 01/01/11		
BUSINESS ADDRESS		

PROVENA HOSPITALS
D/B/A SAINT JOSEPH HOSPITAL
77 NORTH AIRLITE STREET
ELGIN

IL 60123

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REMOVE THIS CARD TO CARRY AS AN
 IDENTIFICATION

State of Illinois 2009540
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

PROVENA HOSPITALS

EXPIRATION DATE 12/31/11	CATEGORY BGBD	ID NUMBER 0004887
FULL LICENSE		
GENERAL HOSPITAL		
EFFECTIVE: 01/01/11		

11/06/10

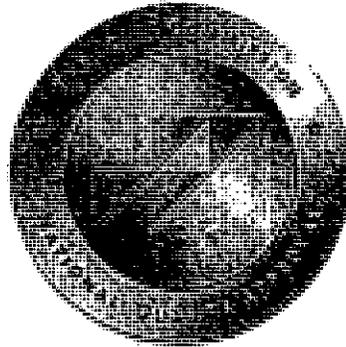
PROVENA HOSPITALS
D/B/A SAINT JOSEPH HOSPITAL
77 NORTH AIRLITE STREET
ELGIN
 IL 60120

FEE RECEIPT NO.

Provena Saint Joseph Hospital

Elgin, IL

has been Accredited by



The Joint Commission

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

May 10, 2008

Accreditation is customarily valid for up to 39 months.

David L. Nahrwold

David L. Nahrwold, M.D.
Chairman of the Board

7338
Organization ID #

Mark Chassin

Mark Chassin, M.D.
President

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





State of Illinois 2009541

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has completed with the Department of Public Health all requirements for the issuance of this license, permit, certification and registration and is hereby authorized to engage in the activity or activities herein.

DANNON T. ARMOUR, M.D.
DIRECTOR

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

12/31/11	06800	0004903
FULL LICENSE		
GENERAL HOSPITAL		
EFFECTIVE: 01/01/11		
BUSINESS ADDRESS		

PROVIDENNA MERCY CENTER
1325 NORTH HIGHLAND AVENUE
AURORA IL 60506

This form of certificate shall be removed, destroyed, replaced by issuance of the State of Illinois - 4911 *

Display This Part In A
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REMOVE THIS CARD TO OBTAIN AN
IDENTIFICATION

State of Illinois 2009541

Department of Public Health
LICENSE, PERMIT, CERTIFICATION, REGISTRATION

PROVIDENNA MERCY CENTER

12/31/11	06800	0004903
FULL LICENSE		
GENERAL HOSPITAL		
EFFECTIVE: 01/01/11		

PROVIDENNA MERCY CENTER
1325 NORTH HIGHLAND AVENUE
AURORA IL 60506

FEE RECEIPT NO.



June 17, 2011

George Einhorn, RN
Interim CEO
Provena Mercy Medical Center
1325 North Highland Avenue
Aurora, IL 60506

Joint Commission ID #: 7240
Program: Behavioral Health Care Accreditation
Accreditation Activity: 60-day Evidence of
Standards Compliance
Accreditation Activity Completed: 06/16/2011

Dear Mr. Einhorn:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Behavioral Health Care

This accreditation cycle is effective beginning March 05, 2011. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

Please visit [Quality Check®](#) on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

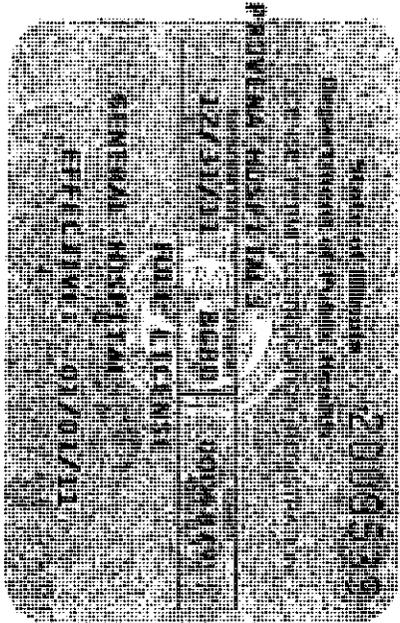
Sincerely,

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



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REMOVE THIS CARD TO CARRY AS AN
IDENTIFICATION



11/06/10
PROVENA HOSPITALS
D/B/A SAINT MARY'S HOSPITAL
500 WEST COURT STREET
KANKAKEE IL 60901

FEE RECEIPT NO.



May 27, 2011

Michael Arno, MBA, MHA
President and CEO, Provena St. Mary's
Hospital.
Provena St. Mary's Hospital
500 West Court Street
Kankakee, IL 60901

Joint Commission ID #: 7367
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of
Standards Compliance
Accreditation Activity Completed: 05/27/2011

Dear Mr. Arno:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning April 02, 2011. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

Please visit [Quality Check®](#) on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

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

DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

State of Illinois 2032822
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

LARON T. ARMOLD, M.D.
DIRECTOR

EXPIRATION DATE	CATEGORY	ID NUMBER
04/30/12	6889	7003131
FULL LICENSE		
AMBUL SURGICAL TREAT CNTR		
EFFECTIVE: 05/01/11		

BUSINESS ADDRESS

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

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State of Illinois 2032822
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

EXPIRATION DATE	CATEGORY	ID NUMBER
04/30/12	6889	7003131
FULL LICENSE		
AMBUL SURGICAL TREAT CNTR		
EFFECTIVE: 05/01/11		

04/30/12

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

FEE RECEIPT NO. 34561

elmont/Harlem Surgical Center, LLC

Chicago, IL

has been Accredited by



The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the
Ambulatory Health Care Accreditation Program

July 8, 2010

Accreditation is customarily valid for up to 39 months.

David L. Nahrwold
David L. Nahrwold, M.D.
Chairman of the Board

Organization ID #452703
Print/Reprint Date: 7/21/10

Mark Chassid
Mark Chassid, M.D.
President

ATTACHMENT #1
ATTACHMENT #1

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 11/14/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 99ES-63	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/15/2005
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MANTENO DIALYSIS CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 1 EAST DIVISION MANTENO, IL 60950
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

V 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 11384 A. Based on policy and procedure review, interview with hemodialysis staff members and review of patient records, Manteno Dialysis Centre located at 1 E. Division St., Manteno, IL has met the requirements at 42 CFR 405, Subpart U and is in compliance with the Conditions of Coverage for End Stage Renal Dialysis (ESRD) facilities in the State of IL, as of 11/15/05. No deficiencies were cited.</p> <p>11384</p>	V 000		
-------	--	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Juan Partelone RN</i>	TITLE CEO	(X6) DATE 11/14/05
---	---------------------	------------------------------

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

ATTACHMENT 11

PURPOSE OF THE PROJECT

The project addressed in this application is limited to a change of ownership as defined in the IHFSRB's rules, and does not propose any change to the services provided, including the number of beds provided at Provena Covenant Medical Center. The facility will continue operate as a general, acute care hospital. The hospital corporation will not change, and no change in the facility's IDPH license will be required.

The proposed change of ownership will result from the planned merger of the Provena and Resurrection systems, through the establishment of a not-for-profit, charitable "super parent" entity. This super parent will provide unified corporate oversight and system governance by serving as the corporate parent of Resurrection Health Care Corporation and Provena Health, each of which is the current parent entity of the Resurrection and Provena systems, respectively. The proposed merger—and the resultant deemed changes of ownership of the systems' facilities—will position Resurrection and Provena to strengthen access to Catholic health care, improve their long-term financial viability, enhance clinical capabilities, improve employee and medical staff satisfaction through a shared culture and integrated leadership, and position the unified system for innovation and adaptation under health care reform.

The table below identifies the hospital's inpatient origin for the 12-month period ending September 30, 2010; identifying each ZIP Code area that contributed a minimum of 1.0% of the hospital's admissions during that period.

ZIP Code	Community	Adm.	Cumulative	
			%	%
61821	Champaign	1,052	12.5%	12.5%
61802	Urbana	717	8.5%	21.0%
61820	Champaign	671	8.0%	29.0%
61866	Rantoul	601	7.1%	36.1%
61832	Danville	545	6.5%	42.6%
61801	Urbana	483	5.7%	48.3%
61822	Champaign	393	4.7%	53.0%
61853	Mahomet	271	3.2%	56.2%
61953	Tuscola	214	2.5%	58.7%
61874	Savoy	213	2.5%	61.3%
60957	Paxton	204	2.4%	63.7%
61873	Saint Joseph	164	1.9%	65.6%
61856	Monticello	125	1.5%	67.1%
61938	Mattoon	123	1.5%	68.6%
61880	Tolono	109	1.3%	69.9%
61956	Villa Grove	98	1.2%	71.0%
61834	Danville	88	1.0%	72.1%
other ZIP Code areas contributing <1%		<u>2,352</u>	<u>27.9%</u>	100.0%
		8,423	100.0%	

As can be noted from the table above, seventeen ZIP Code areas accounted for over 72% of the hospital's admissions. This analysis clearly demonstrates that Provena Covenant Medical Center provides services primarily to area residents.

The measurable goals resulting from the consolidating of the systems will be continually high patient satisfaction reports, strong utilization levels, and improved

access to capital to ensure that the hospital's physical plant is well maintained and that needed equipment can be acquired. These goals will each be measurable within two years.

ALTERNATIVES

Section 1110.230(c) requests that an applicant document that the proposed project is the most effective or least costly alternative for meeting the health care needs of the population to be served.

This project is limited to a change of ownership resulting from the proposed merger of the Provena and Resurrection systems. As described elsewhere in this application, this is being implemented through the formation of a "super parent" entity that will create unified system oversight. This super parent structure will create a change in control, and under IHFSRB rules, a change of ownership of thirteen (13) hospitals, one (1) ambulatory surgical treatment center (ASTC), and one (1) end stage renal disease (ESRD) facility.

In order to best respond to Section 1110.230(c) given the nature of the project, technical assistance direction was sought from State Agency staff on February 22, 2010. Through the technical assistance process, the applicants were advised by State Agency staff that it would be appropriate to explain why this proposed system merger was the only alternative considered.

As explained in the Project Overview, Resurrection and Provena are committed to advancing the shared mission of the existing health systems in a manner that improves long-term financial viability, clinical integration and administrative efficiencies. For these two not-for-profit Catholic health systems, the merger of the systems is uniquely well-suited to meeting these mission, service delivery, and efficiency goals.

In very different circumstances, health systems might give serious consideration to an asset sale/acquisition in exchange for cash considerations, or to a corporate reorganization in which one party acquires and controls the other. Here, however, Provena and Resurrection have determined, through a process of discernment that involved both existing systems and the five (5) religious sponsors, that the systems should come together in a merger of equals transaction through a super parent structure, which will align corporate oversight, provide unified governance equally to entities currently in both systems, and avert the need for asset sale/acquisition. The System Merger Agreement has been submitted with this application.

IMPACT STATEMENT

The proposed change of ownership will have a significant positive broad-based and health care delivery impact on the communities historically served by Provena Covenant Medical Center. Consistent with IHFSRB rules, this impact statement covers the two-year period following the proposed change of ownership.

Reason for the Transaction

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

Anticipated Changes to the Number of Beds or Services Currently Offered

No changes are anticipated either to the number of beds (210) or to the scope of services currently provided at Provena Covenant Medical Center.

The current and proposed bed complement, consistent with Provena Covenant Medical Center’s 2009 IDPH Hospital Profile are:

- 110 medical/surgical beds
- 6 pediatrics beds
- 15 intensive care beds
- 24 obstetrics/gynecology beds
- 30 acute mental illness
- 25 comprehensive rehabilitation beds.

Among the other clinical services currently offered and proposed to continue to be provided are: surgery (including cardiovascular surgery), nursery, clinical laboratory, pharmacy, diagnostic imaging, cardiac catheterization, GI lab, emergency department, outpatient clinics, and physical, occupational, and speech therapy.

Operating Entity

Upon the change of ownership, the operating entity/licensee will remain Provena Covenant Medical Center.

Additions or Reductions in Staff

No changes in clinical or non-system administrative staffing, aside from those routine changes typical of hospitals, are anticipated during the first two years following the proposed change of ownership. The applicants fully intend to offer all current hospital employees positions at compensation levels and employee benefits equivalent to their current position, compensation and benefits.

Cost/Benefit Analysis of the Transaction

1. Cost

The costs associated with the transaction are limited to those identified in Section I and discussed in ATTACHMENT 7, those being an apportionment of the transactional

costs, categorized as "Consulting and Other Fees". As required by the IHFSRB's rules, the value of the hospital is included in the project cost identified in Section I of this application document. However, that identified component of the "project cost" does not result in an expenditure by any applicant.

2. Benefit

The applicants believe that the community will benefit greatly from the change of ownership, primarily through the combined system's ability to operate more efficiently, improve clinical integration, and enhanced access to capital.

In 2009, the hospital admitted approximately 8,600 patients, provided approximately 235,800 outpatient visits, and treated over 35,000 patients in its emergency department.

It is the expectation of the applicants that, for a minimum of two years following the change of ownership, all programs and services currently provided by Provena Covenant Medical Center will continue to be provided, and consistent with IHFSRB requirements, access to the hospital's services will not be diminished. Assessments related to potential program expansion will commence shortly after the change of ownership/merger occurs.

Each of the hospitals included in the system merger will provide both charity care and services to Medicaid recipients. According to IDPH data, during 2009 the admission

Provena hospitals ranged between 11.0% and 27.3%. The primary variable in these percentages is the geographic location of the individual hospitals. Over 20% of the patients admitted to five (5) of the thirteen (13) Resurrection and Provena hospitals in 2009 were Medicaid recipients.

Finally, with over 1,000 employees (FTEs), Provena Covenant Medical Center is a major area employer, and, as noted above, no changes in clinical or non-system administrative staffing, aside from those routine changes typical of hospitals, are anticipated during the first two years following the proposed change of ownership.

ACCESS

Access to the facilities addressed in the merger will not become more restrictive as a result of the merger; and letters affirming such from the Chief Executive Officers of Provena Health and Resurrection Health Care Corporation are attached.

Both Provena and Resurrection currently operate with system-wide charity care policies. Attached is the hospital's Patient and Visitor Non-Discrimination policy, and Provena's Provision of Financial Assistance policy, which applies across all of its hospitals. Provena and Resurrection intend to develop a new, consolidated charity care policy for the combined system hospitals, generally taking the best elements of each of the existing system policies. Provena and Resurrection representatives have offered to the Illinois Attorney General's office that this new charity care policy will be shared in draft form with the Attorney General's office, so that the Attorney general's office can provide input into the policy. That policy, as of the filing of this application, is being developed, and will be provided to State Agency staff when complete. Resurrection and Provena have committed to the State Agency to provide this policy to the State Agency prior to appearing before the State Board.

Provena Covenant Medical Center will, as is the case now, operate without any restrictive admissions policies, related to race, ethnic background, religion, payment

source, or any other factor. A copy of the hospital's policy addressing non-discrimination in its admissions practices is attached, and the policy will be retained following the system merger. The hospital will continue to admit Medicare and Medicaid recipients, as well as patients in need of charity care. In addition, no agreements with private third party payors currently in place at Provena Covenant Medical Center are anticipated to be discontinued as a result of the proposed change of ownership.



March 23, 2011

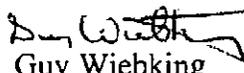
Illinois Health Facilities
and Services Review Board
Springfield, Illinois

To Whom It May Concern:

Please be advised that following the change of ownership of the hospitals and ESRD facility directly or indirectly owned or controlled by Provena Health, the admissions policies of those facilities will not become more restrictive.

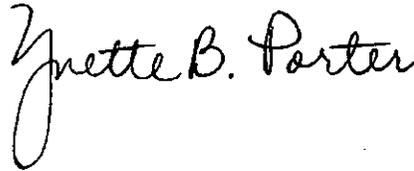
Provena and Resurrection, in consultation with the Illinois Attorney General's office, are currently revising the charity care policy to be used following the system merger. That revised policy will be provided to the State Agency upon completion.

Sincerely,


Guy Wiebking
President & CEO



Notarized:



7435 West Talcott Avenue
Chicago, Illinois 60631
773.792.5555



Sandra Bruce, FACHE
President & Chief Executive Officer

March 24, 2011

Illinois Health Facilities
and Services Review Board
Springfield, Illinois

To Whom It May Concern:

Please be advised that following the change of ownership of the hospitals and ASTC directly or indirectly owned or controlled by Resurrection Health Care Corporation, the admissions policies of those facilities will not become more restrictive.

Resurrection and Provena, in consultation with the Illinois Attorney General's office, are currently revising the charity care policy to be used following the system merger. That revised policy will be provided to the State Agency upon completion.

Sincerely,

A handwritten signature in cursive script that reads "Sandra Bruce".

Sandra Bruce, FACHE
President & CEO

Notarized:



CURRENT ADMISSIONS
and
CHARITY CARE POLICIES

PROCEDURE PROCESS

Section: Ethics, Rights and Responsibilities

Policy Number:

Subject: Patient and Visitor Nondiscrimination

Page: 1 of 1

Executive/Policy Owner: Ethics Committee

Approval Date: 9/17/10

Effective Date: 9/17/10

Last Review: 5/08

Revised Date: 9/17/10

Supersedes: 12/17/03

PURPOSE:

Provide guidance to all staff on PCMC's mission as a community service industry.

POLICY:

It is the policy and mission of Provena Covenant Medical Center to treat patients and visitors with the same respect and care regardless of that individual's:

- Race
- Color
- National origin
- Handicap
- Age
- Gender preference
- Life-style
- Religion
- Socio-economic status
- Payment Source.

In keeping with this policy clinical decisions for patient care are based solely on patient health care needs.

Approved by Ethics Committee: 9/17/10

SYSTEM POLICY

Section: Finance
Patient Financial Services

Policy Number: 5.1

Subject: Provision for Financial Assistance – Provena Hospitals

Page: 1 of 10

Executive Owner: System Senior VP, Chief Financial Officer

Approval Date: 05/01/06

Effective Date: 02/2011

Last Review Date: 1/17/11

Revised Date: 1/17/11

Supersedes: 8/4/10

POLICY

In order to promote the health and well-being of the community served, individuals who have no health insurance, with limited financial resources, and who are unable to access entitlement programs shall be eligible for free or discounted health care services based on established criteria for hospital charges. Eligibility criteria will be based upon the Federal Poverty guidelines, family size and medical expense. Provena Health is committed to:

- Communicating to patients so they can more fully and freely participate in providing the needed information without fear of losing basic assets and income;
- Assessing the patients' capacity to pay and reach payment arrangements that do not jeopardize the patients' health and basic living arrangements or undermine their capacity for self-sufficiency;
- Upholding and honoring patients' rights to appeal decisions and seek reconsideration, and to have a self-selected advocate to assist the patient throughout the process;
- Avoid seeking or demanding payment from or seizing exempt income or assets; and
- Providing options for payment arrangements, without requiring that the patient select higher cost options for repayment.

PURPOSE

Our Mission and Values call us to serve those in need and maintain fiscal viability. Provena Health has a long tradition of serving the poor, the needy, and all who require health care services. However, our Ministries alone cannot meet every community need. They can practice effective stewardship of resources in order to continue providing accessible and effective health care services. In keeping with effective stewardship, provision for financial assistance will be budgeted annually. Our Hospital Ministries will follow the Illinois Hospital Uninsured Patient Discount Act and the Illinois Fair Patient Billing Act.

PROVENA HEALTH**SYSTEM POLICY****Section:** Finance - PFS**Policy #:** 5.1**Subject:** Provision for Financial Assistance**Page:** 2 of 10

We also continue to play a leadership role in the community by helping to promote community-wide responses to patient needs, in partnership with government and private organizations.

This policy identifies circumstances when the ministry or related joint venture may provide care without charge or at a discount commensurate with the ability to pay, for a patient whose financial status makes it impractical or impossible to pay for medically necessary services. This policy applies only to hospital ministry charges and not independent physicians or independent company billings. The provision of free and discounted care through our Financial Assistance program is consistent, appropriate and essential to the execution of our mission, vision and values, and is consistent with our tax-exempt, charitable status.

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

SPECIAL INSTRUCTIONS/ DEFINITIONS**I. Definitions**

- A. Assets:** Provena Health may use assets in the determination of the 25% maximum collectible amount in 12-month period. Assets will not be used for initial financial assistance eligibility. Patient may be excluded if patient has substantial assets (defined as a value in excess of 600% Federal Poverty Level – attachment I) Certain assets will not be considered: the uninsured patient's primary residence; personal property exempt from judgment under Section 12-1001 of the Code of Civil Procedure; or any amounts held in a pension or retirement plan. Distributions and payments from pension or retirement plans may be included as income. Acceptable documentation of assets include: statements from financial institutions or some other third party verification of an asset's value. If no other third party exists the patient shall certify as to the estimated value of the asset.
- B. Charity Care:** Health care services that were never expected to result in cash. Charity care results from providing health care services free or at a discount to individuals who do not have the ability to pay based upon income and family size compared to established federal poverty guidelines.
- C. Financial Assistance Committee:** A group of people consisting of local ministry staff and leadership that meets monthly to review requests for financial assistance. The committee will consist of the Chief Executive Officer, Chief Financial Officer, VP Mission Services, Revenue Integrity Director (or designee), Risk Manager, Director of Case/Care Management, Patient Financial Counselor/Customer Service Representative/Collection Manager and the Director of Pastoral Care or a similar mix of individuals for ministries associated with Provena Health.

PROVENA HEALTH**SYSTEM POLICY****Section:** Finance - PFS**Policy #:** 5.1**Subject:** Provision for Financial Assistance**Page:** 3 of 10

D. Family: The patient, his/her spouse (including a legal common law spouse) and his/her legal dependents according to the Internal Revenue Service rules. Therefore, if the patient claims someone as a dependent on his/her income tax return, they may be considered a dependent for purposes of the provision of financial assistance.

E. Family Income: the sum of a family's annual earnings and cash benefits from all sources before taxes, less payment made for child support. Examples include but are not limited to: Gross wages, salaries, dividends, interest, Social Security benefits, workers compensation, training stipends, regular support from family members not living in the household, government pensions, private pensions, insurance and annuity payments, income from rents, royalties, estates and trusts.

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

G. Illinois resident: a person who currently lives in Illinois and who intends to remain living in Illinois indefinitely. Relocation to Illinois for the sole purpose of receiving health care benefits does not satisfy the residency requirement. Acceptable verification of Illinois residency shall include any one of the following:

1. Any of the documents listed in Paragraph (J);
2. A valid state-issued identification card;
3. A recent residential utility bill;
4. A lease agreement;
5. A vehicle registration card;
6. A voter registration card;
7. Mail addressed to the uninsured patient at an Illinois address from a government or other credible source;
8. A statement from a family member of the uninsured patient who resides at the same address and presents verification of residency; or
9. A letter from a homeless shelter, transitional house or other similar facility verifying that the uninsured patient resides at the facility.

All non-IL resident applications will be reviewed by the ministry Financial Assistance Committee. (See Financial Assistance Committee definition.)

H. Income Documentation: Acceptable family income documentation shall include **one (1)** of the following:

1. a copy of the most recent tax return;
2. a copy of the most recent W-2 form and 1099 forms;
3. copies of the 2 most recent pay stubs;
4. written income verification from an employer if paid in cash; or
5. one other reasonable form of third party income verification deemed acceptable to the hospital.

Section: Finance - PFS

Policy #: 5.1

Subject: Provision for Financial Assistance

Page: 4 of 10

- I. Catastrophic Discount:** a discount provided when the patient responsibility payments specific to medical care at Provena Health Hospitals, even after payment by third-party payers, exceed 25% of the patient's family annual gross income. Any patient responsibility in excess of the 25% will be written off to charity.
- J. Medically Necessary Service:** any inpatient or outpatient hospital service, including pharmaceuticals or supplies provided by a hospital to a patient, covered under Title XVIII of the federal Social Security Act for beneficiaries with the same clinical presentation as the uninsured patient. A "medically necessary" service does not include any of the following:
 1. Non-medical services such as social and vocational services.
 2. Elective cosmetic surgery, but not plastic surgery designed to correct disfigurement caused by injury, illness, or congenital defect or deformity.
 3. Services deemed not necessary by the patient's insurance provider.

II. Financial Assistance Guidelines and Eligibility Criteria (see Attachment #1)

A. Patient must be uninsured and meet the eligibility criteria noted below or meet the definition for the Catastrophic Discount.

Eligibility Criteria	
Percentage of Poverty Guidelines	Discount Percentage
Up to 200%	100%
201 - 300%	90%
301 - 400%	80%
401 - 500%	75%
501 - 600%	Approx. 72% (calculation based on IL Hospital uninsured discount Act)

- B. All patients will be treated with respect and fairness regardless of their ability to pay.
- C. The Eligibility Criteria discount percentage will be updated annually based on the calculation set forth by the Illinois Uninsured Patient Discount Act. The Federal Poverty Guideline calculations will also be updated annually in conjunction with the published updates by the United States Department of Health and Human Services.
- D. Individuals who are deemed eligible by the State of Illinois to receive assistance under the Violent Crime Victims Compensation Act or the Sexual Assault Victims Compensation Act shall be deemed eligible for financial assistance at a level to be determined on a case-by-case basis by the Financial Assistance Committee.
- E. A financial assistance application will not need to be repeated for dates of services incurred up to six (6) months after the date of application approval. Once financial assistance eligibility has been granted, all open accounts from 12 months before the date of approval are grandfathered in as financial assistance.
- F. A patient may apply for financial assistance at any time during the revenue cycle process.

Section: Finance - PFS**Policy #:** 5.1**Subject:** Provision for Financial Assistance**Page:** 5 of 10

- G. After the financial assistance adjustment has been computed, the remaining balances will be treated in accordance with Patient Financial Services policies regarding payment arrangements. If a patient is unable to meet the payment arrangement guidelines, the Revenue Cycle Representative (or designee) may review and recommend additional financial assistance to the ministry Financial Assistance Committee.

III. Presumptive Financial Assistance Eligibility

- A. Presumptive eligibility may be determined on the basis of individual life circumstances. In these situations, a patient is deemed to be eligible for a 100 percent reduction from charges (i.e. full write-off). A patient is presumed to be eligible and therefore does not need to complete a financial assistance application if they meet one of the following criteria:
1. Participation in state funded prescription programs.
 2. Participation in Women's Infants, and Children's Programs (WIC)
 3. Food stamp eligibility
 4. Subsidized school lunch program eligibility.
 5. Eligibility for other state or local assistance program that is unfunded.
 6. Low income/subsidized housing is provided as a valid address
 7. Patient is deceased with no known estate.
 8. Patient receiving free care from a community clinic and the community clinic refers the patient to the ministry for treatment or for a procedure.
 9. Patient states that he/she is homeless. The due diligence efforts are to be documented.
 10. Patient is mentally or physically incapacitated and has no one to act on his/her behalf.
 11. Patient is currently eligible for Medicaid, but was not eligible on a prior date of service, instead of making the patient duplicate the required paperwork; the ministry will rely on the financial assistance determination process from Medicaid.
 12. Patient receives a MANG denial due to asset availability.
- B. When a patient does not complete an application and there is adequate information to support the patient's inability to pay these cases will be submitted to the ministry's Financial Assistance Committee for approval. If approved, 100% write off to financial assistance will be granted for all open accounts from 12 months before the date of approval. Assistance will not be granted for future dates of service.

PROVENA HEALTH**SYSTEM POLICY****Section:** Finance - PFS**Policy #:** 5.1**Subject:** Provision for Financial Assistance**Page:** 6 of 10**PROCEDURE****I. Identification of Potentially Eligible Patients**

- A. Where possible, prior to the admission or pre-registration of the patient, the ministry will conduct a pre-admission/pre-registration interview with the patient, the guarantor, and/or his/her legal representative. If a pre-admission/pre-registration interview is not possible, this interview should be conducted upon admission or registration or as soon as possible thereafter. In case of an emergency admission, the ministry's evaluation of payment alternatives should not take place until the required medical screening has been provided. At the time of the initial patient interview, the following information should be gathered:
 - 1. Routine and comprehensive demographic data and employment information.
 - 2. Complete information regarding all existing third party coverage.
- B. Those patients who may qualify for financial assistance from a governmental program should be referred to the appropriate program, such as Medicaid, prior to consideration for financial assistance.
- C. Prior to an account being authorized for the filing of suit, a final review of the account will be conducted and approved by the Revenue Cycle Representative (or designee) to make sure that no application of financial assistance was ever received. Prior to a summons being filed, the Chief Financial Officer's (CFO) approval is required. Provena Health Ministries will not request nor support the use of body attachments from the court system for payment of an outstanding account; however, it is recognized that the court system may take this action in dependently.

II. Determination of Eligibility

- A. All patients identified as potential financial assistance recipients should be offered the opportunity to apply for financial assistance. If this evaluation is not conducted until after the patient leaves the ministry, or in the case of outpatients or emergency services, a Patient Financial Services representative will mail a financial assistance application to the patient for completion upon request. In addition, whenever possible, patient billing and collection communications will inform patients of the availability of financial assistance with appropriate contact information. When no representative of the patient is available, the ministry should take the required action to have a legal guardian/trustee appointed or to act on behalf of the patient.
- B. Patients are responsible for completing the required application forms and cooperating with the information gathering and assessment process, in order to determine eligibility for financial assistance. (See Special Instructions, III Presumptive Eligibility for exceptions).

Section: Finance - PFS**Policy #:** 5.1**Subject:** Provision for Financial Assistance**Page:** 7 of 10

- C. In the evaluation of an application for financial assistance, a patient's family size, income and medical expenses will be determining factors for eligibility and discount.
- D. The Catastrophic Discount will be available to patients who have medical expenses from a Provena Health Hospital that exceed 25% of the patient's family annual gross income, even after payment by third-party payers. Any patient responsibility in excess of the 25% will be written off to charity. Services that are determined not medically necessary by a third-party payer will not be eligible for this discount.
- E. The Financial Assistance Committee will consider patient accounts on a case-by-case basis that are exceptions to the eligibility criteria. The Committee has the authority to approve/reject any ministry specific exceptions to the Provision for Financial Assistance policy based on unusual or uncommon circumstances. This includes the review of all non-IL resident applications. All decisions, whether approved or rejected, must have the rationale clearly and formally documented by the committee and maintained in the account file.

III. Notification of Eligibility Determination

- A. Clear guidelines as to the length of time required to review the application and provide a decision to the patient should be provided at the time of application. A prompt turn-around and written decision, which provides a reason(s) for denial (if appropriate) will be provided, generally within 45 days of the ministry's Financial Assistance Committee's decision after reviewing a completed application. Patients will be notified in the denial letter that they may appeal this decision and will be provided contact information to do so.
- B. If a patient disagrees with the decision, the patient may request an appeal process in writing within 45 days of the denial. The ministry's Financial Assistance Committee will review the application. Decisions reached will normally be communicated to the patient within 45 days, and reflect the Committee's final and executive review.
- C. Collection activity will be suspended during the consideration of a completed financial assistance application or an application for any other healthcare bracket (i.e., Medicare, or Medicaid, etc.). A note will be entered into the patient's account to suspend collection activity until the financial assistance process is completed. If the account has been placed with a collection agency, the agency will be notified by telephone to suspend collection efforts until a determination is made. This notification will be documented in the account notes. The patient will also be notified verbally that the collection activity will be suspended during consideration. If a financial assistance determination allows for a percent reduction but leaves the patient with a self-pay balance, payment terms will be established on the basis of disposable income.

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- D. If a determination is made that the patient has the ability to pay all or a portion of a bill, such a determination does not prevent a reassessment of the person's ability to pay at a later date.
- E. Refunding Patient Payments – No refunds will be given for payments made prior to the financial assistance approval date.
- F. If the patient has a change in his/her financial status, the patient should promptly notify the Central Billing Office (CBO) or ministry designee. The patient may request and apply for financial assistance or a change in their payment plan terms.

IV. Patient Awareness of Policy

A. Signage

Signage will be visible in all ministries at points of registration in order to create awareness of the financial assistance program. At a minimum, signage will be posted in all patient intake areas, including, but not limited to, the emergency department, and the admission/patient registration area. All public information and/or forms regarding the provision of financial assistance will use languages that are appropriate for the ministry's service area in accordance with the state's Language Assistance Services Act. This policy will be translated to and made available in Spanish.

B. Hospital Bill

Each invoice or other summary of charges to an uninsured patient shall include with it, or on it, a prominent statement that an uninsured patient who meets certain income requirements may qualify for an uninsured discount and information regarding how an uninsured patient may apply for consideration under the hospital's financial assistance policy.

C. Policy

Every ministry, upon request, must provide any member of the public or state governmental entity a copy of its financial assistance policy. This policy will also be available on the Provena Health Website.

D. Application Form

Each ministry must make available the application used to determine a patient's eligibility for financial assistance.

Section: Finance - PFS**Policy #:** 5.1**Subject:** Provision for Financial Assistance**Page:** 9 of 10**V. Monitoring and Reporting**

1. A financial assistance log from which periodic reports can be developed shall be maintained aside from any other required financial statements.
2. Financial assistance logs will be maintained for a period of ten (10) years. At a minimum, the financial assistance logs are to include:
 - a. Account number
 - b. Date of Service
 - c. Application mailed (y / n)
 - d. Application returned and complete (y/n)
 - e. Total charges
 - f. Self-pay balances
 - g. Amount of financial assistance approved
 - h. Date financial assistance was approved/rejected
3. The financial assistance log will be printed monthly for review at the ministry Financial Assistance Committee meeting.
 - a. The financial assistance log must be signed and dated by the ministry CFO.
 - b. Financial Assistance meeting minutes must be signed by the ministry CFO.
4. The ministry's Collection Manager / Patient Financial Services Representative will approval financial assistance for amounts up to \$1,000. Amounts greater than \$1,000 but lower than \$5,000 will be approved by the ministry's Revenue Cycle Representative, those greater than \$5,000 will be approved by the ministry's CFO.
5. A record, paper or electronic, should be maintained reflecting authorization of financial assistance. These documents shall be kept for a period of ten (10) years.
6. The cost of financial assistance will be reported annually in the Community Benefit Report to the Community, IRS 990 schedule H and in compliance with the IL Community Benefit Act. Charity Care will be reported as the cost of care provided (not charges) using the documented criteria for the reporting requirement.

PROVENA HEALTH**SYSTEM POLICY****Section:** Finance - PFS**Policy #:** 5.1**Subject:** Provision for Financial Assistance**Page:** 10 of 10**ATTACHMENTS**

Eligibility Criteria for the Provena Health Financial Assistance Program – Attachment # 1
Hospital Financial Assistance Program Cover Letter and Application – Attachment # 2
Room and Board Statement – Attachment #3

REFERENCES

Section 12-1001 Code Civil Procedure
Title XVIII Federal Social Security Act
Illinois Uninsured Patient Discount Act
Illinois Fair Patient Billing Act
Violent Crime Victims Compensation Act
Sexual Crime Victims Compensation Act
Women's, Infant, Children Program (WIC)
IL Community Benefit Act
Internal Revenue Service (IRS) 990 Schedule
Ethical and Religious Directives, Part 1
Provena Health System Policy – Payment Arrangements

**ELIGIBILITY CRITERIA FOR THE
 PROVENA HEALTH FINANCIAL ASSISTANCE PROGRAM**

The table below is based upon 2009 Federal Poverty Guidelines.

Family Size	2009 Federal Poverty Guidelines	200%	600%
1	\$10,830	\$21,660	\$64,980
2	\$14,570	\$29,140	\$87,420
3	\$18,310	\$36,620	\$109,860
4	\$22,050	\$44,100	\$132,300
5	\$25,790	\$51,580	\$154,740
6	\$29,530	\$59,060	\$177,180
7	\$33,270	\$66,540	\$199,620
8	\$37,010	\$74,020	\$222,060
9	\$40,750	\$81,500	\$244,500
10	\$44,490	\$88,980	\$266,940

CALCULATION PROCESS

The matrix below is to be utilized for determining the level of assistance for patients who are uninsured.

1. Patients who are uninsured and at or below the 200% guideline will receive a full write-off of charges.
2. For uninsured patients who exceed the 200% guideline, but have income less than the 600% guideline, a sliding scale will be used to determine the percent reduction of charges that will apply. The matrix for deductions is below:

DISCOUNT MATRIX	
Percentage of Poverty Guidelines	Discount Percentage
Up to 200%	100%
201 - 300%	90%
301 - 400%	80%
401 - 500%	75%
501 - 600%	Approx. 72% (calculation based on IL Hospital uninsured discount Act)



HOSPITAL FINANCIAL ASSISTANCE APPLICATION COVER LETTER

Provena Health offers a variety of financial assistance programs to meet the needs of our patients. Our programs apply only to Provena hospital charges. Please be aware you will receive a separate bill from each independent practitioner, or groups of practitioners, for care, treatment, or services provided. The Provena Health Financial Assistance Program does not apply to these charges.

In addition to the Provena Health Financial Assistance Programs, you may also be eligible for public programs such as Medicaid, Medicare or AllKids. Applying for such programs may be required prior to applying for a Provena Health Financial Assistance Program. Provena will assist patients with state funded public programs and the enrollment process.

The Provena Health Financial Assistance Programs include:

Program	Available to	Description	How to Apply
Uninsured Financial Assistance	Uninsured Patients	Offers free care or discounted care based on family size and income according to the Federal Poverty Guidelines	Complete the Financial Assistance Program Application
Self-Pay Discount	Uninsured Patients	Offers an automatic 20% discount	No application necessary
Catastrophic Discount	Uninsured and Insured Patients	Limits the out-of-pocket costs when medical debts specific to medical care at Provena Health Hospitals exceed 25% of the patient's family gross income	Determine if your out-of-pocket expenses exceed 25% of family gross income. If so, complete the Financial Assistance Program Application
Payment Plan Program	Uninsured and Insured Patients	Assists patients with their financial obligations by establishing payment arrangements	Contact a Financial Counselor * or the Central Billing Office at 888-740-4111 if you have already received a statement

To help us determine if you are qualified to receive financial assistance, please complete, sign and return the enclosed application along with copies of the following applicable documents:

- Federal Income Tax Return - *preferred* (or)
2 most recent paycheck stubs or other proof of income
- Driver's License or State-issued ID

If applicable, please submit the following:

- Social Security Award Letter
- Room and Board Statement (if no income) available at www.provena.org/financialassistance
- Financial Award Letter(s) for any student loans or grants
- Unemployment Compensation Benefit Award Letter

Return completed form and supporting documents to:

Provena Health
Central Billing Office
1000 Remington Blvd., Suite 110
Bolingbrook, IL 60440

We will respond to you within 45 days of receiving the completed application and supporting documents. If you have any questions or need additional assistance, please contact us at 888-740-4111 or www.Provena.org/FinancialAssistance to obtain additional information on the Provena Health Financial Assistance Programs.



Program Applying For:

Uninsured Financial Assistance (Free/Discounted Care)

Catastrophic Discount

Hospital Financial Assistance Program Application

NOTE: This application is for Provena Health Hospital Charges only (does not include independent physician professional charges).

Please complete both sides of this form. Return the signed form with all required documents to the address below.
 Provena Health, Central Billing Office, 1000 Remington Blvd., Suite 110, Bolingbrook, IL 60440

Date of Application: _____ Date Application Mailed: _____

1. PATIENT INFORMATION: PLEASE PRINT ALL INFORMATION

Last Name	First Name	Middle Initial
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* If the patient is a minor or full-time student, please list parent(s)/guardian(s) as applicant and co-applicant

2. APPLICANT (PATIENT/PARENT) INFORMATION:

Relationship to Patient:

Self Spouse Parent Other

Marital Status:

Single Married Divorced Separated

Last Name	First Name	Middle Initial	Social Security Number	Date of Birth
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Street Address	City	State	Zip	Home Phone ()
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Current Employer	Street Address	Phone	Position	Years Employed
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Total Number of Dependents: (other than self and co-applicant)	Dependent Name	Date of Birth	Relationship

3. CO-APPLICANT (SPOUSE/PARENT) INFORMATION:

Relationship to Patient

Spouse Parent Other

Last Name	First Name	Middle Initial	Social Security Number	Date of Birth
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Street Address	City	State	Zip	Home Phone ()
----------------	------	-------	-----	----------------

Current Employer	Street Address	Phone	Position	Years Employed
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Total Number of Dependents: (other than self and co-applicant)	Dependent Name	Date of Birth	Relationship

4. INCOME INFORMATION:

List all contributing gross income. Include gross wages, salaries, dividends, interest, social security benefits, workers compensation, training stipends, regular support from family members not living in the household, government pensions, private pensions, insurance and annuity payments, income from rents, royalties, estates, trusts, and veteran stipends.

Monthly Income Sources	Applicant	Co-Applicant	Combined Monthly Income
Employment Income	\$	\$	\$
Social Security	\$	\$	\$
Disability	\$	\$	\$
Unemployment	\$	\$	\$
Spousal/Child Support	\$	\$	\$
Rental Property	\$	\$	\$
Investment Income	\$	\$	\$
Other:	\$	\$	\$
Other:	\$	\$	\$
Other:	\$	\$	\$
Other:	\$	\$	\$

Total Combined Monthly Income _____

ATTACHMENT 19B

Add all income above.

UNEMPLOYMENT: If you do not have monthly income, please complete the Room and Board Statement. Available at www.provena.org/financialassistance

5. ASSETS:

Do not include the patient's primary residence, personal property exempt from judgment under Section 12-1001 of Code of Civil Procedure, or any amounts held in a pension or retirement plan. Please list assets and approximate value. Acceptable documentation includes statements from financial institutions or some other third-party verifications of assets value.

Asset Name:	Approximate Value:
1.	\$
2.	\$
3.	\$

6. PROVENA HOSPITAL SERVICES:

Please indicate the Provena Hospitals that you have been seen at in the last twelve (12) months [calendar year if insured].

If additional space is needed for Account Numbers or Date of Service, please use section 7 below.	Account Number	Date(s) of Service	Patient Balances
<input type="checkbox"/> Provena Covenant Medical Center, Champaign			\$
<input type="checkbox"/> Provena Mercy Medical Center, Aurora			\$
<input type="checkbox"/> Provena Saint Joseph Hospital, Elgin			\$
<input type="checkbox"/> Provena Saint Joseph Medical Center, Joliet			\$
<input type="checkbox"/> Provena St. Mary's Hospital, Kankakee			\$
<input type="checkbox"/> Provena United Samaritans Medical Center, Danville			\$

7. ADDITIONAL INFORMATION/COMMENTS:

(This area is intentionally left blank for additional information or comments.)

8. SIGNATURE:

By signing below I certify that all information is valid and complete. I will immediately notify Provena Health if my financial circumstances change.

Applicant Signature	Date	Co-applicant Signature	Date

Please submit the following information with your application:

- Federal Income Tax Return - *preferred* (or) 2 most recent paycheck stubs or other proof of income
- Driver's License / State-issued ID (or proof of IL residence)

If applicable, please submit the following:

- Social Security Award Letter
- Room and Board Statement (if no income) – Attachment #3
- Financial Award Letter(s) for any student loans or grants
- Unemployment Compensation Benefit Award Letter

Return completed form and supporting documents to:

Provena Health
 Central Billing Office
 1000 Remington Blvd., Suite 110
 Bolingbrook, IL 60440

If you have any questions or need additional assistance, please contact us at 888-740-4111 or www.Provena.org/FinancialAssistance to obtain additional information on the Provena Health Financial Assistance Programs.

HEALTH CARE SYSTEM

The proposed change of ownership will not restrict the use of other area facilities, nor will it have an impact on other area providers. For purposes of this section, health care system refers to the combined Resurrection and Provena systems.

Impact of the Proposed Transaction on Other Area Providers

Following the change of ownership, Provena Covenant Medical Center will continue to operate with an “open” Medical Staff model, meaning that qualified physicians both can apply for admitting privileges at the hospital, and admit patients to the hospital on a voluntary basis—the physicians will not be required to admit only to Provena Covenant Medical Center. In addition, the hospital’s Emergency Department will maintain its current designated level, that being “comprehensive”. As a result, ambulance and paramedic transport patterns will not be altered because of the change of ownership. Last, because the admissions policies of the hospital will not be changed to become more restrictive (please see ATTACHMENT 19B), patients will not be “deflected” from Provena Covenant Medical Center to other area facilities as a result of the change of ownership.

Other Facilities Within the Acquiring Co-Applicants' Health Care System

Upon the completion of the merger, twelve other hospitals will be in the new Health Care System. All of those hospitals, with the exception of Holy Family Medical Center, which operates as a Long-Term Acute Care Hospital (LTACH), operate as general acute care hospitals. The table below identifies the distance and driving time (MapQuest, unadjusted) from Provena Covenant Medical Center to each of the other hospitals in the Health Care System.

Proximity of Provena Covenant Medical Center (1400 West Park Avenue Urbana)			Miles	Minutes
to:				
Saint Francis Hospital	355 Ridge Avenue	Evanston	154.8	171
Resurrection Medical Center	7435 W. Talcott Avenue	Chicago	151.2	161
Saint Mary of Nazareth Hospital and St. Elizabeth's Med. Ctr.	2233 W. Division Street	Chicago	141.7	151
Saint Joseph Hospital	2900 N. Lake Shore Drive	Chicago	143.6	156
Our Lady Resurrection Med. Ctr.	5645 West Addison St.	Chicago	147.5	161
Holy Family Medical Center	100 North River Road	Des Plaines	157.7	170
Provena United Samaritans Med. Ctr.	812 North Logan Street	Darville	32.6	37
Provena Mercy Medical Center	1325 N. Highland Avenue	Aurora	128	162
Provena Saint Joseph Hospital	77 North Airlite Street	Elgin	145.7	184
Provena Saint Joseph Medical Ctr.	333 North Madison Street	Joliet	120.5	134
Provena St. Mary's Hospital	500 West Court Street	Kankakee	79.7	84

Source: MapQuest, 02/22/2011

Consistent with a technical assistance conference held with IHFSRB Staff on February 14, 2011, historical utilization of the other facilities in the Health Care System is provided in the form of 2009 IDPH *Profiles* for those individual facilities, and those documents are attached.

Referral Agreements

Copies of Provena Covenant Medical Center’s current referral agreements related to IDPH “categories of service” not provided directly by the hospital are attached. It is the intent of the applicants to retain all of Provena Covenant Medical Center’s referral agreements, and each provider with which a referral agreement exists will be notified of the change of ownership. Each of the existing referral agreements will continue in their current form until those agreements are revised and/or supplemented, if and as necessary. That revision process is anticipated to take 6-12 months from the date of the change of ownership.

The table below identifies the driving time and distance between Provena Covenant Medical Center and each hospital with which PCMC maintains a referral agreement.

Referral Site	Service	Miles*	Minutes*
OSF St. Francis Medical Center 530 N.E. Glen Oak Ave. Peoria	perinatal	91.5	93
OSF St. Francis Medical Center 530 N.E. Glen Oak Ave. Peoria	general	91.5	93

*MapQuest (unadjusted) March 3, 2011

Duplication of Services

As certified in this application, the applicants fully intend to retain Provena Covenant Medical Center’s clinical programmatic complement for a minimum of two

years. An initial evaluation of the clinical services provided by Provena Covenant Medical Center would suggest that the hospital provides few, if any, clinical services not typically provided by general acute care hospitals. In addition, and as can be seen from the proximity data provided in the table above, the hospitals in the Health Care System do not have service areas that overlap.

Availability of Services to the Community

The proposed merger will, because of the strength of the newly-created system, allow for the development of important operations-based services that are not currently available. Examples of these new programs, which will benefit the community, and particularly the patient community are an electronic medical records (EMR) vehicle anticipated to be implemented system-wide, enhanced physician practice-hospital integration, more efficient equipment planning, replacement and procurement systems, and expanded material management programs; all of which will benefit the community through the resultant efficiencies in the delivery of patient care services.

In addition, Provena Covenant Medical Center is a primary provider of both hospital- and community-based health care programs in its community, and it is the intent of the applicants to provide a very similar community-based program complement, understanding that in the case of all hospitals, the complement of community programs is not static, and that from time-to-time programs are added or eliminated.

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	2	2	561	101	1886	131	2017	3.4	1.3
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	9	9	1066	993	1845	1092	2937	1.7	1.1
Gastroenterology	0	0	0	0	0	0	0	0	0	0.0	0.0
Neurology	0	0	0	0	318	44	1060	93	1153	3.3	2.1
OB/Gynecology	0	0	0	0	243	625	565	526	1091	2.3	0.8
Oral/Maxillofacial	0	0	0	0	6	28	18	76	94	3.0	2.7
Ophthalmology	0	0	0	0	52	916	98	801	899	1.9	0.9
Orthopedic	0	0	0	0	855	546	1539	731	2270	1.8	1.3
Otolaryngology	0	0	0	0	90	336	164	371	535	1.8	1.1
Plastic Surgery	0	0	0	0	13	60	22	83	105	1.7	1.4
Podiatry	0	0	0	0	53	74	70	125	195	1.3	1.7
Thoracic	0	0	0	0	179	16	435	24	459	2.4	1.5
Urology	0	0	1	1	350	815	605	584	1189	1.7	0.7
Totals	0	0	12	12	3786	4554	8307	4637	12944	2.2	1.0

SURGICAL RECOVERY STATIONS	Stage 1 Recovery Stations	12	Stage 2 Recovery Stations	20
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Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	5	5	1579	3774	970	2519	3489	0.6	0.7
Laser Eye Procedures	0	2	0	2	0	16	0	10	10	0.0	0.6
Pain Management	0	0	4	4	191	6576	143	4932	5075	0.7	0.8
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+Nondedicated labs):	4
Cath Labs used for Angiography procedures	0
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	1

Emergency/Trauma Care

Certified Trauma Center by EMS	<input type="checkbox"/>
Level of Trauma Service	Level 1 ---
	Level 2 ---
Operating Rooms Dedicated for Trauma Care	0
Number of Trauma Visits:	0
Patients Admitted from Trauma	0
Emergency Service Type:	Comprehensive
Number of Emergency Room Stations	21
Persons Treated by Emergency Services:	38,300
Patients Admitted from Emergency:	9,625
Total ED Visits (Emergency+Trauma):	38,300

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	3,366
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	1,987
Interventional Catheterizations (0-14):	0
Interventional Catheterizations (15+)	813
EP Catheterizations (15+)	566

Cardiac Surgery Data

Total Cardiac Surgery Cases:	215
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	215
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	147

Outpatient Service Data

Total Outpatient Visits	159,245
Outpatient Visits at the Hospital/ Campus:	159,245
Outpatient Visits Offsite/off campus	0

Diagnostic/Interventional Equipment

	Examinations		Radiation Equipment		Therapies/ Treatments
	Owned	Contract	Owned	Contract	
General Radiography/Fluoroscopy	9	0	33,176	30,020	Lithotripsy 0 0 0
Nuclear Medicine	5	0	3,504	5,520	Linear Accelerator 1 0 4,907
Mammography	2	0	19	19,164	Image Guided Rad Therapy 1 0 5108
Ultrasound	9	0	6,240	11,421	Intensity Modulated Rad Therap 0 0 0
Diagnostic Angiography	0	0	0	0	High Dose Brachytherapy 1 0 73
Interventional Angiography	0	0	0	0	Proton Beam Therapy 0 0 0
Positron Emission Tomography (PET)	1	0	8	724	Gamma Knife 0 0 0
Computerized Axial Tomography (CAT)	3	0	12,006	18,683	Cyber knife 0 0 0
Magnetic Resonance Imaging	2	0	2,390	5,544	

Ownership, Management and General Information

ADMINISTRATOR NAME: Jeff Murphy
ADMINSTRATOR PHONE 847-316-2353
OWNERSHIP: Saint Francis Hospital
OPERATOR: Saint Francis Hospital
MANAGEMENT: Not for Profit Corporation
CERTIFICATION: None
FACILITY DESIGNATION: General Hospital
ADDRESS 355 Ridge Avenue

Patients by Race

White 48.2%
 Black 23.5%
 American Indian 0.3%
 Asian 4.0%
 Hawaiian/ Pacific 0.0%
 Unknown: 24.1%

Patients by Ethnicity

Hispanic or Latino: 7.4%
 Not Hispanic or Latino: 75.9%
 Unknown: 16.7%
 IDPH Number: 2402
 HPA A-08
 HSA 7

CITY: Evanston

COUNTY: Suburban Cook County

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2009	Staff Bed Occupancy Rate %
Medical/Surgical	206	157	135	5,662	28,734	4,032	5.8	89.8	43.6	57.2
0-14 Years				0	0					
15-44 Years				889	3,318					
45-64 Years				1,741	8,300					
65-74 Years				1,151	6,190					
75 Years +				1,881	10,926					
Pediatric	12	12	6	283	636	211	3.0	2.3	19.3	19.3
Intensive Care	35	35	32	2,280	7,775	85	3.4	21.5	61.5	61.5
Direct Admission				1,678	5,840					
Transfers				602	1,935					
Obstetric/Gynecology	18	12	12	850	2,148	152	2.7	6.3	35.0	52.5
Maternity				714	1,862					
Clean Gynecology				136	286					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
<i>Dedicated Observation</i>	0					0				
Facility Utilization	271			8,473	39,293	4,480	5.2	119.9	44.3	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payer Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	48.1%	21.3%	0.0%	25.8%	3.3%	1.5%	8,473
	4072	1806	0	2186	282	127	
Outpatients	27.5%	20.1%	0.0%	20.3%	30.9%	1.2%	117,633
	32308	23699	0	23907	36315	1404	

Financial Year Reported:	7/1/2008 to 6/30/2009		Inpatient and Outpatient Net Revenue by Payer Source					Charity Care Expense	Total Charity Care Expense 3,344,304
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals			
Inpatient Revenue (\$)	47.8%	23.1%	0.0%	26.0%	3.1%	100.0%	1,883,268	Totals: Charity Care as % of Net Revenue	
	52,034,979	25,140,397	0	28,361,084	3,385,602	108,922,062			
Outpatient Revenue (\$)	17.6%	10.5%	0.0%	58.3%	13.6%	100.0%	1,461,036	2.0%	
	10,022,592	5,962,992	0	33,167,642	7,755,578	56,908,804			

Birthing Data

Number of Total Births: 721
 Number of Live Births: 710
 Birthing Rooms: 0
 Labor Rooms: 0
 Delivery Rooms: 0
 Labor-Delivery-Recovery Rooms: 0
 Labor-Delivery-Recovery-Postpartum Rooms: 18
 C-Section Rooms: 2
 CSections Performed: 175

Newborn Nursery Utilization

Level 1 Patient Days 1,729
 Level 2 Patient Days 660
 Level 2+ Patient Days 24
 Total Nursery Patientdays 2,413
Laboratory Studies
 Inpatient Studies 402,225
 Outpatient Studies 229,844
 Studies Performed Under Contract 7,672

Organ Transplantation

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

* Note: On 4/22/2009, Board approved the voluntary reduction of 104 beds within Medical Surgical, Pediatric, Ob-Gyn and ICU categories of service. The total bed count for the facility is 271 beds.

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	2	2	168	12	604	19	623	3.6	1.6
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	2	2	1096	801	2218	990	3208	2.0	1.2
Gastroenterology	0	0	2	2	0	0	0	0	0	0.0	0.0
Neurology	0	0	1	1	78	8	244	13	257	3.1	1.6
OB/Gynecology	0	0	1	1	188	277	514	342	856	2.7	1.2
Oral/Maxillofacial	0	0	0	0	0	0	0	0	0	0.0	0.0
Ophthalmology	0	0	2	2	22	744	24	584	608	1.1	0.8
Orthopedic	0	0	2	2	565	706	1379	1001	2380	2.4	1.4
Otolaryngology	0	0	0	0	58	161	90	219	309	1.6	1.4
Plastic Surgery	0	0	1	1	23	54	82	94	176	3.6	1.7
Podiatry	0	0	0	0	9	92	12	121	133	1.3	1.3
Thoracic	0	0	0	0	0	0	0	0	0	0.0	0.0
Urology	0	0	2	2	141	147	223	129	352	1.6	0.9
Totals	0	0	15	15	2348	3002	5390	3512	8902	2.3	1.2

SURGICAL RECOVERY STATIONS	Stage 1 Recovery Stations	11	Stage 2 Recovery Stations	28
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Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	3	3	808	1830	616	1427	2043	0.8	0.8
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	1	1	21	542	20	351	371	1.0	0.6
Cystoscopy	0	0	2	2	113	132	130	113	243	1.2	0.9
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+Nondedicated labs):	2
Cath Labs used for Angiography procedures	0
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Emergency/Trauma Care

Certified Trauma Center by EMS	<input checked="" type="checkbox"/>
Level of Trauma Service	Level 1 Adult
Operating Rooms Dedicated for Trauma Care	2
Number of Trauma Visits:	851
Patients Admitted from Trauma	491
Emergency Service Type:	Comprehensive
Number of Emergency Room Stations	20
Persons Treated by Emergency Services:	34,500
Patients Admitted from Emergency:	5,956
Total ED Visits (Emergency+Trauma):	35,351

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	836
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	524
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	312
EP Catheterizations (15+)	0

Cardiac Surgery Data

Total Cardiac Surgery Cases:	75
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	75
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	63

Outpatient Service Data

Total Outpatient Visits	117,633
Outpatient Visits at the Hospital/ Campus:	106,748
Outpatient Visits Offsite/off campus	10,885

Diagnostic/Interventional Equipment

Examinations

Radiation Equipment

Therapies/ Treatments

	Owned		Contract		Inpatient	Outpatient	Owned		Contract		Therapies/ Treatments
General Radiography/Fluoroscopy	4	0	13,559	29,471			Lithotripsy	0	0	0	
Nuclear Medicine	2	0	1,028	2,280			Linear Accelerator	1	0	119	
Mammography	3	0	0	10,623			Image Guided Rad Therapy	0	0	0	
Ultrasound	4	0	1,473	4,435			Intensity Modulated Rad Therap	1	0	74	
Diagnostic Angiography	0	0	0	0			High Dose Brachytherapy	0	0	0	
Interventional Angiography	0	0	0	0			Proton Beam Therapy	0	0	0	
Positron Emission Tomography (PET)	0	1	0	128			Gamma Knife	0	0	0	
Computerized Axial Tomography (CAT)	2	0	2,988	18,677			Cyber knife	0	0	0	
Magnetic Resonance Imaging	1	0	897	2,119							

Ownership, Management and General Information

ADMINISTRATOR NAME: Margaret McDermott
ADMINSTRATOR PHONE: 312-770-2115
OWNERSHIP: Saints Mary and Elizabeth Medical Center DBA Saint
OPERATOR: Saints Mary and Elizabeth Medical Center DBA Saint
MANAGEMENT: Not for Profit Corporation
CERTIFICATION: None
FACILITY DESIGNATION: General Hospital
ADDRESS: 2233 West Divison Street

Patients by Race

White 21.0%
 Black 25.7%
 American Indian 0.1%
 Asian 1.3%
 Hawaiian/ Pacific 0.0%
 Unknown: 52.0%

Patients by Ethnicity

Hispanic or Latino: 13.8%
 Not Hispanic or Latino: 85.9%
 Unknown: 0.3%
 IDPH Number: 2584
 HPA A-02
 HSA 6

CITY: Chicago

COUNTY: Suburban Cook (Chicago)

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2009	Staff Bed Occupancy Rate %
Medical/Surgical	186	186	152	10,373	48,081	3,623	5.0	141.7	76.2	76.2
0-14 Years				10	20					
15-44 Years				2,528	8,045					
45-64 Years				3,883	17,282					
65-74 Years				1,831	9,616					
75 Years +				2,121	13,118					
Pediatric	14	14	14	925	2,092	535	2.8	7.2	51.4	51.4
Intensive Care	32	32	30	2,010	7,979	5	4.0	21.9	68.4	68.4
Direct Admission				1,204	4,536					
Transfers				806	3,443					
Obstetric/Gynecology	20	20	20	2,199	5,113	235	2.4	14.7	73.3	73.3
Maternity				2,193	5,103					
Clean Gynecology				6	10					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	120	120	120	3,968	34,495	0	8.7	94.5	78.8	78.8
Rehabilitation	15	15	15	325	3,847	0	11.8	10.5	70.3	70.3
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
<i>Dedicated Observation</i>	0					0				
Facility Utilization	387			18,994	101,607	4,398	5.6	290.4	75.0	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	34.1%	42.9%	0.0%	18.8%	2.1%	2.1%	18,994
	6478	8142	8	3562	402	402	
Outpatients	20.6%	42.5%	0.1%	30.7%	3.3%	2.8%	160,335
	33067	68076	170	49228	5270	4524	

Financial Year Reported:	7/1/2008 to 6/30/2009		Inpatient and Outpatient Net Revenue by Payor Source					Charity Care Expense	Total Charity Care Expense 2,662,595
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals			
Inpatient Revenue (\$)	36.8%	34.8%	0.0%	18.9%	9.5%	100.0%	1,394,629	Totals: Charity Care as % of Net Revenue	
	64,870,370	61,419,970	0	33,285,730	16,816,201	176,392,271			
Outpatient Revenue (\$)	16.6%	32.9%	0.0%	31.8%	18.7%	100.0%	1,267,966	1.1%	
	11,265,066	22,276,179	0	21,509,882	12,633,284	67,684,411			

Birthing Data

Number of Total Births: 2,014
 Number of Live Births: 2,004
 Birthing Rooms: 0
 Labor Rooms: 0
 Delivery Rooms: 0
 Labor-Delivery-Recovery Rooms: 8
 Labor-Delivery-Recovery-Postpartum Rooms: 0
 C-Section Rooms: 2
 CSections Performed: 544

Newborn Nursery Utilization

Level 1 Patient Days: 3,691
 Level 2 Patient Days: 0
 Level 2+ Patient Days: 1,409
 Total Nursery Patientdays: 5,100

Organ Transplantation

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

Laboratory Studies

Inpatient Studies: 641,498
 Outpatient Studies: 251,694
 Studies Performed Under Contract: 3,466

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	1	1	843	87	2000	135	2135	2.4	1.6
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	6	6	963	704	1561	767	2328	1.6	1.1
Gastroenterology	0	0	0	0	5	15	7	9	16	1.4	0.6
Neurology	0	0	0	0	156	3	589	7	596	3.8	2.3
OB/Gynecology	0	0	0	0	519	499	744	403	1147	1.4	0.8
Oral/Maxillofacial	0	0	0	0	9	9	9	18	27	1.0	2.0
Ophthalmology	0	0	0	0	2	149	4	229	233	2.0	1.5
Orthopedic	0	0	0	0	325	162	637	217	854	2.0	1.3
Otolaryngology	0	0	0	0	70	99	66	109	175	0.9	1.1
Plastic Surgery	0	0	0	0	20	9	44	19	63	2.2	2.1
Podiatry	0	0	0	0	103	125	93	171	264	0.9	1.4
Thoracic	0	0	0	0	173	26	297	17	314	1.7	0.7
Urology	0	0	1	1	324	298	447	300	747	1.4	1.0
Totals	0	0	8	8	3612	2185	6498	2401	8899	1.9	1.1

SURGICAL RECOVERY STATIONS Stage 1 Recovery Stations 9 Stage 2 Recovery Stations 19

Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	3	3	1767	3958	628	1534	2162	0.4	0.4
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	0	0	0	0	0	0	0	0.0	0.0
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+Nondedicated labs):	2
Cath Labs used for Angiography procedures	0
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Emergency/Trauma Care

Certified Trauma Center by EMS	<input type="checkbox"/>
Level of Trauma Service	Level 1 Level 2
Operating Rooms Dedicated for Trauma Care	0
Number of Trauma Visits:	0
Patients Admitted from Trauma	0
Emergency Service Type:	Comprehensive
Number of Emergency Room Stations	31
Persons Treated by Emergency Services:	57,393
Patients Admitted from Emergency:	11,665
Total ED Visits (Emergency+Trauma):	57,393

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	1,438
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	852
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	268
EP Catheterizations (15+)	318

Cardiac Surgery Data

Total Cardiac Surgery Cases:	75
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	75
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	61

Outpatient Service Data

Total Outpatient Visits	160,335
Outpatient Visits at the Hospital/ Campus:	160,335
Outpatient Visits Offsite/off campus	0

Diagnostic/Interventional Equipment

	Examinations				Radiation Equipment			Therapies/ Treatments
	Owned	Contract	Inpatient	Outpatient	Owned	Contract		
General Radiography/Fluoroscopy	8	0	15,828	37,232	Lithotripsy	1	1	6
Nuclear Medicine	3	0	1,871	2,905	Linear Accelerator	1	0	124
Mammography	1	0	23	4,690	Image Guided Rad Therapy	0	0	0
Ultrasound	4	0	3,416	16,042	Intensity Modulated Rad Therap	0	0	0
Diagnostic Angiography	0	0	0	0	High Dose Brachytherapy	0	0	0
Interventional Angiography	0	0	0	0	Proton Beam Therapy	0	0	0
Positron Emission Tomography (PET)	0	0	0	0	Gamma Knife	0	0	0
Computerized Axial Tomography (CAT)	2	0	4,168	18,333	Cyber knife	0	0	0
Magnetic Resonance Imaging	1	0	1,315	2,749				

Ownership, Management and General Information

ADMINISTRATOR NAME: Roberta Luskin-Hawk
ADMINSTRATOR PHONE: 773-665-3972
OWNERSHIP: Saint Joseph Hospital
OPERATOR: Saint Joseph Hospital
MANAGEMENT: Not for Profit Corporation
CERTIFICATION: None
FACILITY DESIGNATION: General Hospital

Patients by Race

White 68.6%
 Black 18.6%
 American Indian 0.1%
 Asian 3.9%
 Hawaiian/ Pacific 0.5%
 Unknown: 8.2%

Patients by Ethnicity

Hispanic or Latino: 7.6%
 Not Hispanic or Latino: 84.2%
 Unknown: 8.2%
 IDPH Number: 2493
 HPA A-01
 HSA 6

ADDRESS: 2900 North Lake Shore Drive **CITY:** Chicago **COUNTY:** Suburban Cook (Chicago)

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2009	Staff Bed Occupancy Rate %
Medical/Surgical	219	186	186	7,862	36,064	2,485	4.9	105.6	48.2	56.8
0-14 Years				1	6					
15-44 Years				1,901	9,333					
45-64 Years				2,550	11,595					
65-74 Years				1,060	4,252					
75 Years +				2,350	10,878					
Pediatric	11	7	7	293	754	137	3.0	2.4	22.2	34.9
Intensive Care	23	21	21	1,587	6,734	65	4.3	18.6	81.0	88.7
Direct Admission				696	3,753					
Transfers				891	2,981					
Obstetric/Gynecology	23	23	23	1,925	4,453	103	2.4	12.5	54.3	54.3
Maternity				1,903	4,406					
Clean Gynecology				22	47					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	26	26	26	652	5,996	0	9.2	16.4	63.2	63.2
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	35	34	34	1,312	9,266	1	7.1	25.4	72.5	74.7
Rehabilitation	23	23	17	448	4,367	0	9.7	12.0	52.0	52.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
<i>Dedicated Observation</i>	0					0				
Facility Utilization	360			13,188	67,634	2,791	5.3	192.9	53.6	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	43.6%	16.2%	0.2%	37.7%	1.2%	1.1%	13,188
	5747	2142	22	4972	161	144	
Outpatients	25.2%	15.8%	0.1%	52.9%	5.1%	1.0%	188,191
	47383	29662	158	99559	9558	1871	

Financial Year Reported:	7/1/2008 to 6/30/2009		Inpatient and Outpatient Net Revenue by Payor Source					Charity Care Expense	Total Charity Care Expense
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals			
Inpatient Revenue (\$)	46.8%	13.9%	0.0%	36.8%	2.5%	100.0%	652,789	1,487,625	
	64,832,024	19,290,122	0	51,002,179	3,520,673	138,644,998			
Outpatient Revenue (\$)	16.1%	3.6%	0.0%	72.0%	8.2%	100.0%	834,836	Totals: Charity Care as % of Net Revenue	
	8,703,376	1,963,278	0	38,807,662	4,430,471	53,904,787		0.8%	

Birthing Data

Number of Total Births: 1,837
 Number of Live Births: 1,833
 Birthing Rooms: 0
 Labor Rooms: 0
 Delivery Rooms: 0
 Labor-Delivery-Recovery Rooms: 1
 Labor-Delivery-Recovery-Postpartum Rooms: 17
 C-Section Rooms: 2
 CSections Performed: 557

Newborn Nursery Utilization

Level 1 Patient Days: 2,892
 Level 2 Patient Days: 199
 Level 2+ Patient Days: 2,812
 Total Nursery Patientdays: 5,903
Laboratory Studies
 Inpatient Studies: 434,758
 Outpatient Studies: 111,988
 Studies Performed Under Contract: 4,512

Organ Transplantation

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

* Note: On 4/22/2009, Board approved the voluntary reduction of 42 beds within M/S, Ped and ICU categories of service. The total bed count for the facility is 360 beds. IMRT procedures are done on one of the Linear Accelerators.

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	1	1	265	136	765	254	1019	2.9	1.9
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	10	10	603	718	1656	1357	3013	2.7	1.9
Gastroenterology	0	0	0	0	22	1	25	1	26	1.1	1.0
Neurology	0	0	0	0	74	21	276	55	331	3.7	2.6
OB/Gynecology	0	0	0	0	280	450	856	729	1585	3.1	1.6
Oral/Maxillofacial	0	0	0	0	4	1	6	1	7	1.5	1.0
Ophthalmology	0	0	0	0	2	987	5	1241	1246	2.5	1.3
Orthopedic	0	0	0	0	362	837	920	1487	2407	2.5	1.8
Otolaryngology	0	0	0	0	66	776	92	998	1090	1.4	1.3
Plastic Surgery	0	0	0	0	39	331	267	1095	1362	6.8	3.3
Podiatry	0	0	0	0	30	241	51	445	496	1.7	1.8
Thoracic	0	0	0	0	40	11	135	20	155	3.4	1.8
Urology	0	0	1	1	133	339	212	473	685	1.6	1.4
Totals	0	0	12	12	1920	4849	5266	8156	13422	2.7	1.7

SURGICAL RECOVERY STATIONS	Stage 1 Recovery Stations	12	Stage 2 Recovery Stations	9
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Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	4	4	736	3738	879	4219	5098	1.2	1.1
Laser Eye Procedures	0	0	1	1	1	133	3	177	180	3.0	1.3
Pain Management	0	0	1	1	225	954	263	534	797	1.2	0.6
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+Nondedicated labs):	2
Cath Labs used for Angiography procedures	1
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Emergency/Trauma Care

Certified Trauma Center by EMS	<input type="checkbox"/>
Level of Trauma Service	Level 1 <input type="checkbox"/> Level 2 <input type="checkbox"/>
Operating Rooms Dedicated for Trauma Care	0
Number of Trauma Visits:	0
Patients Admitted from Trauma	0
Emergency Service Type:	Comprehensive
Number of Emergency Room Stations	14
Persons Treated by Emergency Services:	20,131
Patients Admitted from Emergency:	5,311
Total ED Visits (Emergency+Trauma):	20,131

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	882
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	582
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	285
EP Catheterizations (15+)	15

Cardiac Surgery Data

Total Cardiac Surgery Cases:	64
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	64
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	53

Outpatient Service Data

Total Outpatient Visits	188,191
Outpatient Visits at the Hospital/ Campus:	160,748
Outpatient Visits Offsite/off campus	27,443

Diagnostic/Interventional Equipment

	Examinations			
	Owned	Contract	Inpatient	Outpatient
General Radiography/Fluoroscopy	17	0	12,155	22,888
Nuclear Medicine	4	0	611	1,114
Mammography	3	0	0	8,837
Ultrasound	7	0	2,986	11,466
Diagnostic Angiography	0	0	0	0
Interventional Angiography	0	0	0	0
Positron Emission Tomography (PET)	0	1	0	391
Computerized Axial Tomography (CAT)	1	0	3,399	9,644
Magnetic Resonance Imaging	1	0	1,922	2,478

Radiation Equipment

	Radiation Equipment		Therapies/ Treatments
	Owned	Contract	
Lithotripsy	0	0	0
Linear Accelerator	1	0	167
Image Guided Rad Therapy	0	0	0
Intensity Modulated Rad Therap	1	0	9
High Dose Brachytherapy	1	0	16
Proton Beam Therapy	0	0	0
Gamma Knife	0	0	0
Cyber knife	0	0	0

Ownership, Management and General Information

ADMINISTRATOR NAME: Margaret McDermott
ADMINSTRATOR PHONE: 312-770-2115
OWNERSHIP: Saints Mary and Elizabeth Medical Center DBA St El
OPERATOR: Saints Mary and Elizabeth Medical Center DBA St El
MANAGEMENT: Not for Profit Corporation
CERTIFICATION: None
FACILITY DESIGNATION: General Hospital
ADDRESS: 1431 North Claremont

Patients by Race

White 19.3%
 Black 59.8%
 American Indian 0.0%
 Asian 0.4%
 Hawaiian/ Pacific 0.0%
 Unknown: 20.5%

Patients by Ethnicity

Hispanic or Latino: 4.0%
 Not Hispanic or Latino: 75.6%
 Unknown: 20.5%
 IDPH Number: 2360
 HPA A-02
 HSA 6

CITY: Chicago

COUNTY: Suburban Cook (Chicago)

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2009	Staff Bed Occupancy Rate %
Medical/Surgical	40	40	40	3,414	9,323	0	2.7	25.5	63.9	63.9
0-14 Years				0	0					
15-44 Years				1,479	3,898					
45-64 Years				1,866	5,225					
65-74 Years				67	194					
75 Years +				2	6					
Pediatric	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Intensive Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Direct Admission				0	0					
Transfers				0	0					
Obstetric/Gynecology	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Maternity				0	0					
Clean Gynecology				0	0					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	28	26	22	525	6,849	0	13.0	18.8	67.0	72.2
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	40	70	70	2,181	18,452	0	8.5	50.6	126.4	72.2
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
<i>Dedicated Observation</i>	0					0				
Facility Utilization	108			6,120	34,624	0	5.7	94.9	87.8	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	28.2%	65.2%	0.0%	6.0%	0.3%	0.3%	6,120
	1726	3989	0	367	18	20	
Outpatients	21.6%	40.9%	0.1%	32.6%	3.4%	1.4%	25,461
	5505	10402	34	8304	856	360	

Financial Year Reported:

	7/1/2008 to	6/30/2009	Inpatient and Outpatient Net Revenue by Payor Source					Charity Care Expense	Total Charity Care Expense 390,005
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals			
Inpatient Revenue (\$)	23.9%	70.1%	0.0%	5.5%	0.6%	100.0%	322,570	Totals: Charity Care as % of Net Revenue	
	9,280,892	27,203,305	0	2,126,999	216,467	38,827,663			
Outpatient Revenue (\$)	16.3%	43.1%	0.0%	36.1%	4.5%	100.0%	67,435	0.7%	
	3,057,316	8,058,125	0	6,755,379	838,631	18,709,451			

Birthing Data

Number of Total Births: 0
 Number of Live Births: 0
 Birthing Rooms: 0
 Labor Rooms: 0
 Delivery Rooms: 0
 Labor-Delivery-Recovery Rooms: 0
 Labor-Delivery-Recovery-Postpartum Rooms: 0
 C-Section Rooms: 0
 CSections Performed: 0

Newborn Nursery Utilization

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

Organ Transplantation

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

Laboratory Studies

Inpatient Studies: 83,706
 Outpatient Studies: 51,107
 Studies Performed Under Contract: 0

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	0	0	0	1	0	1	1	0.0	1.0
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	4	4	0	385	0	411	411	0.0	1.1
Gastroenterology	0	0	0	0	0	0	0	0	0	0.0	0.0
Neurology	0	0	0	0	0	0	0	0	0	0.0	0.0
OB/Gynecology	0	0	0	0	0	21	0	17	17	0.0	0.8
Oral/Maxillofacial	0	0	0	0	0	9	0	8	8	0.0	0.9
Ophthalmology	0	0	0	0	0	536	0	462	462	0.0	0.9
Orthopedic	0	0	0	0	0	274	0	372	372	0.0	1.4
Otolaryngology	0	0	0	0	0	94	0	102	102	0.0	1.1
Plastic Surgery	0	0	0	0	0	2	0	2	2	0.0	1.0
Podiatry	0	0	0	0	0	59	0	76	76	0.0	1.3
Thoracic	0	0	0	0	0	2	0	1	1	0.0	0.5
Urology	0	0	1	1	0	283	0	214	214	0.0	0.8
Totals	0	0	5	5	0	1666	0	1666	1666	0.0	1.0

SURGICAL RECOVERY STATIONS Stage 1 Recovery Stations 8 Stage 2 Recovery Stations 18

Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	2	2	0	12	0	3	3	0.0	0.3
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	0	0	0	0	0	0	0	0.0	0.0
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

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

Emergency/Trauma Care

Certified Trauma Center by EMS	<input type="checkbox"/>
Level of Trauma Service	Level 1 Level 2
	--- ---
Operating Rooms Dedicated for Trauma Care	0
Number of Trauma Visits:	0
Patients Admitted from Trauma	0
Emergency Service Type:	Comprehensive
Number of Emergency Room Stations	8
Persons Treated by Emergency Services:	4,286
Patients Admitted from Emergency:	341
Total ED Visits (Emergency+Trauma):	4,286

Cardiac Catheterization Utilization

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

Cardiac Surgery Data

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

Outpatient Service Data

Total Outpatient Visits	25,461
Outpatient Visits at the Hospital/ Campus:	25,461
Outpatient Visits Offsite/off campus	0

Diagnostic/Interventional Equipment

	Examinations			
	Owned	Contract	Inpatient	Outpatient
General Radiography/Fluoroscopy	7	0	860	8,260
Nuclear Medicine	0	0	0	0
Mammography	1	0	0	3,110
Ultrasound	2	0	109	274
Diagnostic Angiography	0	0	0	0
Interventional Angiography	0	0	0	0
Positron Emission Tomography (PET)	0	0	0	0
Computerized Axial Tomography (CAT)	1	0	112	552
Magnetic Resonance Imaging	0	0	0	0

Radiation Equipment

	Radiation Equipment		Therapies/ Treatments
	Owned	Contract	
Lithotripsy	1	1	34
Linear Accelerator	0	0	0
Image Guided Rad Therapy	0	0	0
Intensity Modulated Rad Therap	0	0	0
High Dose Brachytherapy	0	0	0
Proton Beam Therapy	0	0	0
Gamma Knife	0	0	0
Cyber knife	0	0	0

Ownership, Management and General Information

ADMINISTRATOR NAME: Ivette Estrada
ADMINSTRATOR PHONE: 773-282-3003
OWNERSHIP: Our Lady of the Resurrection Medical Center
OPERATOR: Our Lady of the Resurrection Medical Center
MANAGEMENT: Not for Profit Corporation
CERTIFICATION: None
FACILITY DESIGNATION: General Hospital
ADDRESS: 5645 West Addison Street

Patients by Race

White 76.2%
 Black 7.8%
 American Indian 0.1%
 Asian 1.8%
 Hawaiian/ Pacific 0.2%
 Unknown: 13.9%

Patients by Ethnicity

Hispanic or Latino: 9.8%
 Not Hispanic or Latino: 76.3%
 Unknown: 13.9%
 IDPH Number: 1719
 HPA A-01
 HSA 6

CITY: Chicago

COUNTY: Suburban Cook (Chicago)

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2009	Staff Bed Occupancy Rate %
Medical/Surgical	213	193	124	6,884	33,414	2,597	5.2	98.7	46.3	51.1
0-14 Years				27	57					
15-44 Years				884	3,152					
45-64 Years				1,978	9,385					
65-74 Years				1,255	6,409					
75 Years +				2,740	14,411					
Pediatric	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Intensive Care	20	20	20	1,600	6,393	36	4.0	17.6	88.1	88.1
Direct Admission				1,154	4,605					
Transfers				446	1,788					
Obstetric/Gynecology	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Maternity				0	0					
Clean Gynecology				0	0					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	66	56	49	1,372	13,966	0	10.2	38.3	58.0	68.3
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
<i>Dedicated Observation</i>	0					0				
Facility Utilization	299			9,410	53,773	2,633	6.0	154.5	51.7	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	62.7%	15.5%	0.0%	17.4%	2.8%	1.6%	9,410
	5898	1458	0	1642	263	149	
Outpatients	36.6%	27.8%	0.1%	26.3%	7.5%	1.8%	106,302
	38888	29528	95	27928	7995	1868	

Financial Year Reported:

	7/1/2008 to	6/30/2009	Inpatient and Outpatient Net Revenue by Payor Source				Charity Care Expense	Total Charity Care Expense
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals	1,613,275	
Inpatient Revenue (\$)	55.8%	5.8%	0.0%	17.8%	20.6%	100.0%	922,725	
	45,372,692	4,707,203	0	14,438,297	18,788,176	81,304,368		
Outpatient Revenue (\$)	19.2%	13.3%	0.0%	31.7%	35.7%	100.0%	1.2%	
	10,380,455	7,196,801	0	17,126,806	19,287,337	53,991,399	690,550	

Birthing Data

Number of Total Births: 1
 Number of Live Births: 1
 Birthing Rooms: 0
 Labor Rooms: 0
 Delivery Rooms: 0
 Labor-Delivery-Recovery Rooms: 0
 Labor-Delivery-Recovery-Postpartum Rooms: 0
 C-Section Rooms: 0
 CSections Performed: 0

Newborn Nursery Utilization

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

Organ Transplantation

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

Laboratory Studies

Inpatient Studies: 396,802
 Outpatient Studies: 297,369
 Studies Performed Under Contract: 10,827

* Note: According to Board action on 4/22/09, Board reduced 164 M/S beds overall voluntarily. New CON count for the facility is 299 beds

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	0	0	0	0	0	0	0	0.0	0.0
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	8	8	880	426	1399	424	1823	1.6	1.0
Gastroenterology	0	0	0	0	3	1	3	1	4	1.0	1.0
Neurology	0	0	0	0	162	12	492	19	511	3.0	1.6
OB/Gynecology	0	0	0	0	122	169	175	156	331	1.4	0.9
Oral/Maxillofacial	0	0	0	0	0	0	0	0	0	0.0	0.0
Ophthalmology	0	0	0	0	5	612	4	353	357	0.8	0.6
Orthopedic	0	0	0	0	364	360	603	442	1045	1.7	1.2
Otolaryngology	0	0	0	0	41	56	61	70	131	1.5	1.3
Plastic Surgery	0	0	0	0	8	23	21	30	51	2.6	1.3
Podiatry	0	0	0	0	0	0	0	0	0	0.0	0.0
Thoracic	0	0	0	0	28	0	83	0	83	3.0	0.0
Urology	0	0	1	1	170	169	267	196	463	1.6	1.2
Totals	0	0	9	9	1783	1828	3108	1691	4799	1.7	0.9

SURGICAL RECOVERY STATIONS Stage 1 Recovery Stations 8 Stage 2 Recovery Stations 19

Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
<i>Gastrointestinal</i>	1	1	0	2	1148	1403	1200	1501	2701	1.0	1.1
<i>Laser Eye Procedures</i>	0	0	0	0	0	0	0	0	0	0.0	0.0
<i>Pain Management</i>	0	1	0	1	0	1225	0	18375	18375	0.0	15.0
<i>Cystoscopy</i>	0	0	1	1	141	169	191	196	387	1.4	1.2
Multipurpose Non-Dedicated Rooms											
Minor/Local Procedur	0	1	0	1	0	89	0	59	59	0.0	0.7
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

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

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	625
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	479
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	146
EP Catheterizations (15+)	0

Emergency/Trauma Care

Certified Trauma Center by EMS	<input type="checkbox"/>
Level of Trauma Service	Level 1 Level 2
Operating Rooms Dedicated for Trauma Care	0
Number of Trauma Visits:	0
Patients Admitted from Trauma	0
Emergency Service Type:	Comprehensive
Number of Emergency Room Stations	18
Persons Treated by Emergency Services:	37,917
Patients Admitted from Emergency:	6,634
Total ED Visits (Emergency+Trauma):	37,917

Cardiac Surgery Data

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

Outpatient Service Data

Total Outpatient Visits	106,302
Outpatient Visits at the Hospital/ Campus:	106,302
Outpatient Visits Offsite/off campus	0

Diagnostic/Interventional Equipment

	Examinations				Radiation Equipment			Therapies/ Treatments
	Owned	Contract	Inpatient	Outpatient	Owned	Contract		
General Radiography/Fluoroscopy	7	0	13,247	29,193	Lithotripsy	0	0	0
Nuclear Medicine	2	0	1,666	2,499	Linear Accelerator	0	0	0
Mammography	2	0	8	4,544	Image Guided Rad Therapy	0	0	0
Ultrasound	4	0	3,487	6,636	Intensity Modulated Rad Therap	0	0	0
Diagnostic Angiography	0	0	0	0	High Dose Brachytherapy	0	0	0
Interventional Angiography	0	0	0	0	Proton Beam Therapy	0	0	0
Positron Emission Tomography (PET)	0	0	0	0	Gamma Knife	0	0	0
Computerized Axial Tomography (CAT)	2	0	4,225	15,489	Cyber knife	0	0	0
Magnetic Resonance Imaging	1	1	922	1,555				

Ownership, Management and General Information

ADMINISTRATOR NAME: John Baird
ADMINSTRATOR PHONE: 847-813-3161
OWNERSHIP: Holy Family Medical Center
OPERATOR: Holy Family Medical Center
MANAGEMENT: Not for Profit Corporation
CERTIFICATION: Long Term Acute Care Hospital (LTACH)
FACILITY DESIGNATION: General Hospital
ADDRESS: 100 North River Road

Patients by Race

White 71.2%
 Black 5.0%
 American Indian 0.0%
 Asian 2.5%
 Hawaiian/ Pacific 0.3%
 Unknown: 21.0%

Patients by Ethnicity

Hispanic or Latino: 1.3%
 Not Hispanic or Latino: 79.0%
 Unknown: 19.7%
 IDPH Number: 1008
 HPA A-07
 HSA 7

CITY: Des Plaines

COUNTY: Suburban Cook County

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2009	Staff Bed Occupancy Rate %
Medical/Surgical	59	110	100	1,524	32,196	0	21.1	88.2	#####	80.2
0-14 Years				0	0					
15-44 Years				507	3,009					
45-64 Years				546	9,236					
65-74 Years				179	7,529					
75 Years +				292	12,422					
Pediatric	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Intensive Care	0	8	6	160	1,937	0	12.1	5.3	0.0	66.3
Direct Admission				37	448					
Transfers				123	1,489					
Obstetric/Gynecology	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Maternity				0	0					
Clean Gynecology				0	0					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	129	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedicated Observation	0					0				
Facility Utilization	188			1,561	34,133	0	21.9	93.5	49.7	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payer Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	33.6%	14.0%	0.0%	48.9%	1.2%	2.3%	
	525	218	0	763	19	36	1,561
Outpatients	32.0%	24.6%	0.0%	38.5%	4.2%	0.6%	
	7164	5521	11	8624	950	135	22,405

Financial Year Reported:

	7/1/2008 to	6/30/2009	Inpatient and Outpatient Net Revenue by Payer Source					Charity Care Expense	Total Charity Care Expense
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals			
Inpatient Revenue (\$)	49.7%	15.0%	0.0%	30.0%	5.3%	100.0%		186,520	
	31,307,091	9,452,199	0	18,919,331	3,353,949	63,032,570	184,754	Totals: Charity Care as % of Net Revenue	
Outpatient Revenue (\$)	49.7%	15.0%	0.0%	30.0%	5.3%	100.0%		0.3%	
	5,291,206	1,597,515	0	3,197,553	566,851	10,653,125	1,766		

Birthing Data

Number of Total Births: 0
 Number of Live Births: 0
 Birthing Rooms: 0
 Labor Rooms: 0
 Delivery Rooms: 0
 Labor-Delivery-Recovery Rooms: 0
 Labor-Delivery-Recovery-Postpartum Rooms: 0
 C-Section Rooms: 0
 CSections Performed: 0

Newborn Nursery Utilization

Level 1 Patient Days: 0
 Level 2 Patient Days: 0
 Level 2+ Patient Days: 0
 Total Nursery Patientdays: 0
Laboratory Studies
 Inpatient Studies: 130,069
 Outpatient Studies: 43,454
 Studies Performed Under Contract: 44,795

Organ Transplantation

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

* Note: On 4/22/09, Board approved the reclassification of the beds under new category of service called Long Term Acute Care (LTAC) per PART 1100 rule. Facility opted to keep 59 beds in M/S and rest of the M/S beds clubbed with ICU were categorized as LTAC beds =129 beds. According to Board action on 4/22/09, Board reduced 50 LTAC beds voluntarily. New CON count for the facility is 188 beds (M/S=59, LTAC = 129). ACHM 04/22/09

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	0	0	3	6	3	8	11	1.0	1.3
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	1	1	66	74	87	60	147	1.3	0.8
Gastroenterology	0	0	0	0	82	77	52	75	127	0.6	1.0
Neurology	0	0	0	0	0	0	0	0	0	0.0	0.0
OB/Gynecology	0	0	0	0	1	35	1	24	25	1.0	0.7
Oral/Maxillofacial	0	0	0	0	0	2	0	1	1	0.0	0.5
Ophthalmology	0	0	1	1	0	794	0	573	573	0.0	0.7
Orthopedic	0	0	0	0	0	18	0	31	31	0.0	1.7
Otolaryngology	0	0	0	0	0	19	0	21	21	0.0	1.1
Plastic Surgery	0	0	0	0	0	186	0	460	460	0.0	2.5
Podiatry	0	0	0	0	0	223	0	497	497	0.0	2.2
Thoracic	0	0	0	0	3	0	3	0	3	1.0	0.0
Urology	0	0	0	0	12	13	10	11	21	0.8	0.8
Totals	0	0	2	2	167	1447	156	1761	1917	0.9	1.2

SURGICAL RECOVERY STATIONS	Stage 1 Recovery Stations	13	Stage 2 Recovery Stations	21
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Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	3	3	13	103	12	89	101	0.9	0.9
Laser Eye Procedures	0	0	1	1	0	145	0	37	37	0.0	0.3
Pain Management	0	0	0	0	0	0	0	0	0	0.0	0.0
Cystoscopy	0	0	1	1	7	0	9	0	9	1.3	0.0
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

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

Emergency/Trauma Care

Certified Trauma Center by EMS	<input type="checkbox"/>
Level of Trauma Service	Level 1 ---
	Level 2 ---
Operating Rooms Dedicated for Trauma Care	0
Number of Trauma Visits:	0
Patients Admitted from Trauma	0
Emergency Service Type:	Stand-By
Number of Emergency Room Stations	0
Persons Treated by Emergency Services:	0
Patients Admitted from Emergency:	0
Total ED Visits (Emergency+Trauma):	0

Cardiac Catheterization Utilization

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

Cardiac Surgery Data

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

Outpatient Service Data

Total Outpatient Visits	22,405
Outpatient Visits at the Hospital/ Campus:	22,405
Outpatient Visits Offsite/off campus	0

Diagnostic/Interventional Equipment

	Examinations				Radiation Equipment			Therapies/ Treatments
	Owned	Contract	Inpatient	Outpatient	Owned	Contract		
General Radiography/Fluoroscopy	8	0	6,055	4,191	Lithotripsy	0	0	0
Nuclear Medicine	2	0	50	410	Linear Accelerator	0	0	0
Mammography	3	0	0	4,250	Image Guided Rad Therapy	0	0	0
Ultrasound	5	0	769	2,692	Intensity Modulated Rad Therap	0	0	0
Diagnostic Angiography	0	0	0	0	High Dose Brachytherapy	0	0	0
Interventional Angiography	0	0	0	0	Proton Beam Therapy	0	0	0
Positron Emission Tomography (PET)	0	0	0	0	Gamma Knife	0	0	0
Computerized Axial Tomography (CAT)	1	0	1,554	1,125	Cyber knife	0	0	0
Magnetic Resonance Imaging	1	0	0	722				

Ownership, Management and General Information

ADMINISTRATOR NAME: Mike Brown
ADMINSTRATOR PHONE: 217-443-5201
OWNERSHIP: Provena Health
OPERATOR: Provena Health
MANAGEMENT: Church-Related
CERTIFICATION: None
FACILITY DESIGNATION: General Hospital
ADDRESS: 812 North Logan Street

Patients by Race

White
 Black
 American Indian
 Asian
 Hawaiian/ Pacific
 Unknown:

Patients by Ethnicity

80.1% Hispanic or Latino: 2.1%
 16.9% Not Hispanic or Latino: 97.3%
 0.1% Unknown: 0.5%
 IDPH Number: 4853
 HPA D-03
 HSA 4

CITY: Danville **COUNTY:** Vermilion County

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2009	Staff Bed Occupancy Rate %
Medical/Surgical	134	82	76	4,629	19,701	3,248	5.0	62.9	46.9	76.7
0-14 Years				0	0					
15-44 Years				708	2,035					
45-64 Years				1,318	5,251					
65-74 Years				830	3,906					
75 Years +				1,773	8,509					
Pediatric	9	8	8	168	329	94	2.5	1.2	12.9	14.5
Intensive Care	14	12	12	996	1,910	46	2.0	5.4	38.3	44.7
Direct Admission				642	1,231					
Transfers				354	679					
Obstetric/Gynecology	17	15	15	1,051	2,065	120	2.1	6.0	35.2	39.9
Maternity				916	1,738					
Clean Gynecology				135	327					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedicated Observation	0					0				
Facility Utilization	174			6,490	24,005	3,508	4.2	75.4	43.3	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	49.7%	24.2%	0.4%	22.1%	1.1%	2.6%	6,490
	3224	1570	24	1434	71	167	
Outpatients	19.3%	31.7%	0.9%	35.1%	8.4%	4.5%	87,354
	16876	27695	795	30690	7345	3953	

Financial Year Reported:	1/1/2009 to 12/31/2009		Inpatient and Outpatient Net Revenue by Payor Source					Charity Care Expense	Total Charity Care Expense
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals			
Inpatient Revenue (\$)	37.6%	20.5%	0.3%	36.8%	4.8%	100.0%	1,066,068	4,019,971	
	16,776,873	9,156,068	128,018	16,398,885	2,129,524	44,589,368		Totals: Charity Care as % of Net Revenue	
Outpatient Revenue (\$)	14.4%	11.7%	1.5%	59.1%	13.3%	100.0%	2,953,903	3.5%	
	10,036,415	8,123,116	1,056,472	41,059,236	9,246,308	69,521,547			

Birthing Data

Number of Total Births: 787
 Number of Live Births: 787
 Birthing Rooms: 0
 Labor Rooms: 0
 Delivery Rooms: 0
 Labor-Delivery-Recovery Rooms: 5
 Labor-Delivery-Recovery-Postpartum Rooms: 0
 C-Section Rooms: 1
 CSections Performed: 245

Newborn Nursery Utilization

Level 1 Patient Days: 1,217
 Level 2 Patient Days: 33
 Level 2+ Patient Days: 0
 Total Nursery Patientdays: 1,250
Laboratory Studies
 Inpatient Studies: 476,188
 Outpatient Studies: 538,649
 Studies Performed Under Contract: 69,358

Organ Transplantation

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

* Note: According to Board action on 4/22/09, Board reduced 36 beds (M/S= 24, Ped=9, OB=2, ICU=1) overall voluntarily. New CON count for the facility is 174 beds. Regarding Actual Cost of Services Provided to Charity Care Inpatients and Outpatients, Provena calculated using the 2009 IRS 990 Schedule H instructions to determine the cost to charge ratio. This methodology was used because the 2009 Medicare Cost Report was not available at the time the AHQ was due.

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	0	0	63	13	171	13	184	2.7	1.0
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	4	4	872	789	1817	875	2692	2.1	1.1
Gastroenterology	0	0	2	2	138	108	150	73	223	1.1	0.7
Neurology	0	0	0	0	0	0	0	0	0	0.0	0.0
OB/Gynecology	0	0	0	0	293	339	641	386	1027	2.2	1.1
Oral/Maxillofacial	0	0	0	0	0	0	0	0	0	0.0	0.0
Ophthalmology	0	0	0	0	0	0	0	0	0	0.0	0.0
Orthopedic	0	0	0	0	169	65	476	104	580	2.8	1.6
Otolaryngology	0	0	0	0	9	318	20	448	468	2.2	1.4
Plastic Surgery	0	0	0	0	1	1	1	1	2	1.0	1.0
Podiatry	0	0	0	0	1	17	1	25	26	1.0	1.5
Thoracic	0	0	0	0	0	0	0	0	0	0.0	0.0
Urology	0	0	0	0	25	6	42	6	48	1.7	1.0
Totals	0	0	6	6	1571	1656	3319	1931	5250	2.1	1.2

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

Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	2	2	363	1151	277	865	1142	0.8	0.8
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	0	0	0	0	0	0	0	0.0	0.0
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

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

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	56
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	56
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	0
EP Catheterizations (15+)	0

Emergency/Trauma Care

Certified Trauma Center by EMS	<input type="checkbox"/>
Level of Trauma Service	Level 1 Level 2
Operating Rooms Dedicated for Trauma Care	0
Number of Trauma Visits:	0
Patients Admitted from Trauma	0
Emergency Service Type:	Basic
Number of Emergency Room Stations	29
Persons Treated by Emergency Services:	37,712
Patients Admitted from Emergency:	4,225
Total ED Visits (Emergency+Trauma):	37,712

Cardiac Surgery Data

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

Outpatient Service Data

Total Outpatient Visits	217,114
Outpatient Visits at the Hospital/ Campus:	217,114
Outpatient Visits Offsite/off campus	0

Diagnostic/Interventional Equipment

Examinations

Radiation Equipment

Therapies/

	Owned		Contract		Inpatient	Outpatient	Owned		Contract		Treatments
General Radiography/Fluoroscopy	6	0	8,830	23,841			Lithotripsy	0	0	0	
Nuclear Medicine	2	0	402	1,803			Linear Accelerator	1	0	11,445	
Mammography	1	0	0	3,925			Image Guided Rad Therapy	0	0	0	
Ultrasound	2	0	922	6,877			Intensity Modulated Rad Therap	0	0	0	
Diagnostic Angiography	0	0	0	0			High Dose Brachytherapy	0	0	0	
Interventional Angiography	0	0	0	0			Proton Beam Therapy	0	0	0	
Positron Emission Tomography (PET)	0	1	0	132			Gamma Knife	0	0	0	
Computerized Axial Tomography (CAT)	2	0	3,222	11,462			Cyber knife	0	0	0	
Magnetic Resonance Imaging	2	0	454	3,565							

Ownership, Management and General Information

ADMINISTRATOR NAME: David A. Bertauski
ADMINSTRATOR PHONE 217-337-2141
OWNERSHIP: Provena Covenant Medical Center
OPERATOR: Provena Covenant Medical Center
MANAGEMENT: Church-Related
CERTIFICATION: None
FACILITY DESIGNATION: General Hospital
ADDRESS 1400 West Park Avenue

Patients by Race

White 82.4%
 Black 14.0%
 American Indian 0.1%
 Asian 1.2%
 Hawaiian/ Pacific 0.0%
 Unknown: 2.3%

Patients by Ethnicity

Hispanic or Latino: 1.1%
 Not Hispanic or Latino: 97.7%
 Unknown: 1.2%
 IDPH Number: 4861
 HPA D-01
 HSA 4

CITY: Urbana

COUNTY: Champaign County

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2009	Staff Bed Occupancy Rate %
Medical/Surgical	110	95	83	5,325	18,950	3,012	4.1	60.2	54.7	63.3
0-14 Years				0	0					
15-44 Years				653	1,806					
45-64 Years				1,724	6,148					
65-74 Years				1,027	3,703					
75 Years +				1,921	7,293					
Pediatric	6	4	3	74	140	0	1.9	0.4	6.4	9.6
Intensive Care	15	14	14	1,397	3,594	34	2.6	9.9	66.3	71.0
Direct Admission				659	1,695					
Transfers				738	1,899					
Obstetric/Gynecology	24	22	22	1,249	2,839	74	2.3	8.0	33.3	36.3
Maternity				988	2,223					
Clean Gynecology				261	616					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Wing Beds				0	0		0.0	0.0		
Acute Mental Illness	30	25	21	923	4,246	0	4.6	11.6	38.8	46.5
Rehabilitation	25	21	19	396	4,362	0	11.0	12.0	47.8	56.9
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Educated Observation	0					0				
Facility Utilization	210			8,626	34,131	3,120	4.3	102.1	48.6	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	45.8%	16.6%	1.9%	30.2%	2.8%	2.8%	
	3951	1429	164	2602	238	242	8,626
Outpatients	16.6%	45.8%	1.9%	30.4%	4.0%	1.3%	
	39058	107961	4488	71721	9524	3089	235,841

Financial Year Reported: 1/1/2009 to 12/31/2009

Inpatient and Outpatient Net Revenue by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals	Charity Care Expense	Total Charity Care Expense
Inpatient Revenue (\$)	43.0%	15.2%	0.4%	38.5%	3.0%	100.0%		4,601,304
	36,829,206	13,070,156	320,129	32,988,965	2,538,289	85,746,755	1,846,049	
Outpatient Revenue (\$)	11.9%	4.9%	2.6%	66.1%	14.4%	100.0%		
	9,423,391	3,928,867	2,085,649	52,568,920	11,481,099	79,487,926	2,755,255	2.8%

Birthing Data

Number of Total Births: 961
 Number of Live Births: 956
 Birthing Rooms: 0
 Labor Rooms: 0
 Delivery Rooms: 0
 Labor-Delivery-Recovery Rooms: 9
 Labor-Delivery-Recovery-Postpartum Rooms: 0
 Section Rooms: 2
 Sections Performed: 276

Newborn Nursery Utilization

Level 1 Patient Days: 1,592
 Level 2 Patient Days: 0
 Level 2+ Patient Days: 798
 Total Nursery Patientdays: 2,390
Laboratory Studies
 Inpatient Studies: 225,927
 Outpatient Studies: 271,900
 Studies Performed Under Contract: 58,884

Organ Transplantation

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

Note: According to Board action on 4/22/09, Board reduced 44 beds (M/S= 18, Ped=12, AMI=10, ICU=3, Rehab=1) overall voluntarily. New CON count for a facility is 210 beds. Actual Cost of Services Provided to Charity Care Inpatients and Outpatients was calculated using the 2009 IP-990 Schedule H instructions to determine the cost to charge ratio. This methodology was used by Provena because the 2009 Medicare Cost Report was not available at time AHQ was due.

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	0	0	178	473	495	614	1109	2.8	1.3
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	12	12	451	1199	1256	1557	2813	2.8	1.3
Gastroenterology	0	0	0	0	0	0	0	0	0	0.0	0.0
Neurology	0	0	0	0	20	54	56	70	126	2.8	1.3
OB/Gynecology	0	0	0	0	189	502	527	652	1179	2.8	1.3
Oral/Maxillofacial	0	0	0	0	11	30	31	38	69	2.8	1.3
Ophthalmology	0	0	0	0	194	514	540	666	1206	2.8	1.3
Orthopedic	0	0	0	0	413	1102	1153	1431	2584	2.8	1.3
Otolaryngology	0	0	0	0	276	734	767	953	1720	2.8	1.3
Plastic Surgery	0	0	0	0	3	7	9	10	19	3.0	1.4
Podiatry	0	0	0	0	129	342	360	443	803	2.8	1.3
Thoracic	0	0	0	0	17	46	47	59	106	2.8	1.3
Urology	0	0	0	0	237	630	660	818	1478	2.8	1.3
Totals	0	0	12	12	2118	5633	5901	7311	13212	2.8	1.3

SURGICAL RECOVERY STATIONS	Stage 1 Recovery Stations	15	Stage 2 Recovery Stations	0
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Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	2	2	522	3444	434	2870	3304	0.8	0.8
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	0	0	0	0	0	0	0	0.0	0.0
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+Nondedicated labs):	3
Cath Labs used for Angiography procedures	3
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Emergency/Trauma Care

Certified Trauma Center by EMS	<input type="checkbox"/>
Level of Trauma Service	Level 1 <input type="checkbox"/> Level 2 <input type="checkbox"/>
Operating Rooms Dedicated for Trauma Care	0
Number of Trauma Visits:	0
Patients Admitted from Trauma	0
Emergency Service Type:	Comprehensive
Number of Emergency Room Stations	22
Persons Treated by Emergency Services:	35,126
Patients Admitted from Emergency:	4,218
Total ED Visits (Emergency+Trauma):	35,126

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	1,931
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	1,341
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	563
EP Catheterizations (15+)	27

Cardiac Surgery Data

Total Cardiac Surgery Cases:	123
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	123
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	109

Outpatient Service Data

Total Outpatient Visits	235,841
Outpatient Visits at the Hospital/ Campus:	235,841
Outpatient Visits Offsite/off campus	0

Diagnostic/Interventional Equipment

	Examinations			
	Owned	Contract	Inpatient	Outpatient
General Radiography/Fluoroscopy	14	0	12,224	20,241
Nuclear Medicine	3	0	372	2,846
Mammography	1	0	0	2,379
Ultrasound	4	0	2,260	4,607
Diagnostic Angiography	1	0	1,087	429
Interventional Angiography	0	0	0	0
Positron Emission Tomography (PET)	0	1	0	82
Computerized Axial Tomography (CAT)	2	0	3,751	9,384
Magnetic Resonance Imaging	1	0	891	1,879

Radiation Equipment

	Radiation Equipment		Therapies/ Treatments
	Owned	Contract	
Lithotripsy	0	1	140
Linear Accelerator	1	0	3,100
Image Guided Rad Therapy	0	0	0
Intensity Modulated Rad Therap	0	0	0
High Dose Brachytherapy	0	0	0
Proton Beam Therapy	0	0	0
Gamma Knife	0	0	0
Cyber knife	0	0	0

Ownership, Management and General Information

ADMINISTRATOR NAME: James D. Witt
ADMINSTRATOR PHONE: 630-801-2616
OWNERSHIP: Provena Hospitals d/b/a Provena Mercy Medical Cent
OPERATOR: Provena Hospitals d/b/a Provena Mercy Medical Cent
MANAGEMENT: Church-Related
CERTIFICATION: None
FACILITY DESIGNATION: General Hospital
ADDRESS: 1325 North Highland Avenue

Patients by Race

White 62.8%
 Black 11.6%
 American Indian 0.0%
 Asian 0.6%
 Hawaiian/ Pacific 0.0%
 Unknown: 25.0%

Patients by Ethnicity

Hispanic or Latino: 22.7%
 Not Hispanic or Latino: 75.0%
 Unknown: 2.3%
 IDPH Number: 4903
 HPA A-12
 HSA 8

CITY: Aurora **COUNTY:** Kane County

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2009	Staff Bed Occupancy Rate %
Medical/Surgical	156	122	87	5,229	22,430	3,479	5.0	71.0	45.5	58.2
0-14 Years				0	0					
15-44 Years				972	3,368					
45-64 Years				1,634	7,079					
65-74 Years				900	4,051					
75 Years +				1,723	7,932					
Pediatric	16	16	11	443	867	370	2.8	3.4	21.2	21.2
Intensive Care	16	16	16	1,097	3,425	50	3.2	9.5	59.5	59.5
Direct Admission				768	2,286					
Transfers				329	1,139					
Obstetric/Gynecology	16	16	15	1,239	2,620	79	2.2	7.4	46.2	46.2
Maternity				1,145	2,419					
Clean Gynecology				94	201					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	95	72	64	2,718	16,682	0	6.1	45.7	48.1	63.5
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedicated Observation	0					0				
Facility Utilization	299			10,397	46,024	3,978	4.8	137.0	45.8	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payer Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	36.6%	27.3%	0.5%	30.2%	3.2%	2.1%	10,397
	3809	2838	55	3140	335	220	
Outpatients	15.9%	30.9%	0.6%	32.2%	17.8%	2.6%	93,254
	14809	28825	557	29986	16615	2462	

Financial Year Reported:	11/2009 to 12/31/2009		Inpatient and Outpatient Net Revenue by Payer Source					Charity Care Expense	Total Charity Care Expense 6,367,773
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals			
Inpatient Revenue (\$)	39.1%	33.6%	0.4%	24.9%	1.9%	100.0%	2,638,341	Totals: Charity Care as % of Net Revenue	
	30,667,645	26,391,096	350,575	19,532,576	1,501,912	78,443,804			
Outpatient Revenue (\$)	17.1%	23.7%	0.4%	54.8%	4.1%	100.0%	2,729,432	3.2%	
	15,493,796	21,553,255	323,234	49,733,701	3,677,093	90,781,079			

Birthing Data

Number of Total Births: 1,124
 Number of Live Births: 1,121
 Birthing Rooms: 0
 Labor Rooms: 0
 Delivery Rooms: 0
 Labor-Delivery-Recovery Rooms: 0
 Labor-Delivery-Recovery-Postpartum Rooms: 16
 C-Section Rooms: 2
 CSections Performed: 377

Newborn Nursery Utilization

Level 1 Patient Days: 1,746
 Level 2 Patient Days: 989
 Level 2+ Patient Days: 0
 Total Nursery Patientdays: 2,735
Laboratory Studies
 Inpatient Studies: 238,354
 Outpatient Studies: 122,789
 Studies Performed Under Contract: 28,893

Organ Transplantation

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

* Note: According to Board action on 4/22/09, Board reduced 16 beds (Ped=12, AMI=4) overall voluntarily. New CON count for the facility is 299 beds. Actual Cost of Services Provided to Charity Care Inpatients and Outpatients was calculated using the 2009 IRS 990 Schedule H instructions to determine the cost to charge ratio. This methodology was used because the 2009 Medicare Cost Report was not available at time of reporting.

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	2	0	0	2	377	74	1537	124	1661	4.1	1.7
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	10	10	668	678	1337	989	2326	2.0	1.5
Gastroenterology	0	0	0	0	0	0	0	0	0	0.0	0.0
Neurology	0	0	0	0	54	33	230	78	308	4.3	2.4
OB/Gynecology	0	0	0	0	138	210	308	240	548	2.2	1.1
Oral/Maxillofacial	0	0	0	0	3	2	9	4	13	3.0	2.0
Ophthalmology	0	0	0	0	1	15	3	15	18	3.0	1.0
Orthopedic	0	0	0	0	539	390	1320	699	2019	2.4	1.8
Otolaryngology	0	0	0	0	75	75	115	88	203	1.5	1.2
Plastic Surgery	0	0	0	0	11	5	32	7	39	2.9	1.4
Podiatry	0	0	0	0	29	32	38	54	92	1.3	1.7
Thoracic	0	0	0	0	0	0	0	0	0	0.0	0.0
Urology	0	0	0	0	84	117	194	157	351	2.3	1.3
Totals	2	0	10	12	1979	1631	5123	2455	7578	2.6	1.5

SURGICAL RECOVERY STATIONS

Stage 1 Recovery Stations

12

Stage 2 Recovery Stations

19

Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	2	2	801	1305	865	1310	2175	1.1	1.0
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	0	0	0	0	0	0	0	0.0	0.0
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+Nondedicated labs):	3
Cath Labs used for Angiography procedures	1
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	1,701
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	983
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	531
EP Catheterizations (15+)	187

Emergency/Trauma Care

Certified Trauma Center by EMS	<input checked="" type="checkbox"/>
Level of Trauma Service	Level 1 Adult
Operating Rooms Dedicated for Trauma Care	0
Number of Trauma Visits:	658
Patients Admitted from Trauma	334
Emergency Service Type:	Comprehensive
Number of Emergency Room Stations	26
Persons Treated by Emergency Services:	43,713
Patients Admitted from Emergency:	4,485
Total ED Visits (Emergency+Trauma):	44,371

Cardiac Surgery Data

Total Cardiac Surgery Cases:	185
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	185
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	185

Outpatient Service Data

Total Outpatient Visits	196,631
Outpatient Visits at the Hospital/ Campus:	196,631
Outpatient Visits Offsite/off campus	0

Diagnostic/Interventional Equipment

Examinations

Radiation Equipment

	Owned		Contract		Inpatient	Outpatient	Radiation Equipment			Therapies/ Treatments
	Owned	Contract	Inpatient	Outpatient			Owned	Contract		
General Radiography/Fluoroscopy	4	0	12,923	26,254			Lithotripsy	0	1	20
Nuclear Medicine	2	0	1,035	3,306			Linear Accelerator	0	0	0
Mammography	2	0	0	3,497			Image Guided Rad Therapy	0	0	0
Ultrasound	3	0	2,531	9,994			Intensity Modulated Rad Therap	0	0	0
Diagnostic Angiography	0	0	0	0			High Dose Brachytherapy	0	0	0
Interventional Angiography	0	0	0	0			Proton Beam Therapy	0	0	0
Positron Emission Tomography (PET)	0	0	0	0			Gamma Knife	0	0	0
Computerized Axial Tomography (CAT)	3	0	4,665	13,917			Cyber knife	0	0	0
Magnetic Resonance Imaging	2	0	658	2,465						

Ownership, Management and General Information

ADMINISTRATOR NAME: Stephen O. Scogna
ADMINSTRATOR PHONE: 847-695-3200 x5474
OWNERSHIP: Provena Hospitals d/b/a Provena Saint Joseph Hospi
OPERATOR: Provena Hospitals d/b/a Provena Saint Joseph Hospi
MANAGEMENT: Church-Related
CERTIFICATION: None
FACILITY DESIGNATION: General Hospital
ADDRESS: 77 North Airlite Street

Patients by Race

White 81.5%
 Black 5.6%
 American Indian 0.0%
 Asian 1.5%
 Hawaiian/ Pacific 0.0%
 Unknown: 11.5%

Patients by Ethnicity

Hispanic or Latino: 9.8%
 Not Hispanic or Latino: 89.3%
 Unknown: 0.8%
 IDPH Number: 4887
 HPA A-11
 HSA 8

CITY: Elgin

COUNTY: Kane County

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2009	Staff Bed Occupancy Rate %
Medical/Surgical	99	99	99	5,890	27,862	3,810	5.4	86.8	87.6	87.6
0-14 Years				34	75					
15-44 Years				941	3,341					
45-64 Years				1,774	7,903					
65-74 Years				1,098	5,495					
75 Years +				2,043	11,048					
Pediatric	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Intensive Care	15	15	15	1,123	4,210	0	3.7	11.5	76.9	76.9
Direct Admission				637	2,493					
Transfers				486	1,717					
Obstetric/Gynecology	0	15	6	232	508	66	2.5	1.6	0.0	10.5
Maternity				215	468					
Clean Gynecology				17	40					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	30	30	25	1,185	6,055	0	5.1	16.6	55.3	55.3
Rehabilitation	34	34	34	902	9,691	0	10.7	26.6	78.1	78.1
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Dedicated Observation	0					0				
Facility Utilization	178			8,846	48,326	3,876	5.9	143.0	80.3	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	52.9%	11.0%	0.7%	30.6%	2.4%	2.4%	8,846
	4679	975	63	2711	210	208	
Outpatients	25.7%	17.9%	0.4%	42.7%	11.5%	1.7%	94,884
	24364	17017	422	40545	10954	1582	

Financial Year Reported:

1/1/2009 to 12/31/2009

Inpatient and Outpatient Net Revenue by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals	Charity Care Expense	Total Charity Care Expense
Inpatient Revenue (\$)	52.0%	17.7%	0.3%	28.1%	1.9%	100.0%	1,675,691	3,749,548
	39,020,448	13,249,904	210,860	21,061,538	1,439,586	74,982,336		
Outpatient Revenue (\$)	22.5%	14.4%	0.4%	60.1%	2.6%	100.0%	2,073,857	2.3%
	20,044,749	12,794,644	327,225	53,398,003	2,348,798	88,913,419		

Birth Data

Number of Total Births: 222
 Number of Live Births: 222
 Birthing Rooms: 0
 Labor Rooms: 0
 Delivery Rooms: 0
 Labor-Delivery-Recovery Rooms: 7
 Labor-Delivery-Recovery-Postpartum Rooms: 0
 C-Section Rooms: 1
 CSections Performed: 47

Newborn Nursery Utilization

Level 1 Patient Days 368
 Level 2 Patient Days 239
 Level 2+ Patient Days 63
 Total Nursery Patientdays 670
Laboratory Studies
 Inpatient Studies 238,112
 Outpatient Studies 152,236
 Studies Performed Under Contract 80,753

Organ Transplantation

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

* Note: According to project #09-033, approved on 10/13/09, facility discontinued 15 bed OB category of service. The data shown is prior to ist discontinuation. Actual Cost of Services Provided to Charity Care Inpatients and Outpatients was calculated using the 2009 IRS 990 Schedule H instructions to determine the cost to charge ratio. This methodology was used because the 2009 Medicare Cost Report was not available and the 2008 was due.

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	0	0	207	32	830	74	904	4.0	2.3
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	10	10	1040	981	1919	1261	3180	1.8	1.3
Gastroenterology	0	0	0	0	713	1170	741	1169	1910	1.0	1.0
Neurology	0	0	0	0	98	10	312	19	331	3.2	1.9
OB/Gynecology	0	0	0	0	63	103	141	115	256	2.2	1.1
Oral/Maxillofacial	0	0	0	0	4	0	4	0	4	1.0	0.0
Ophthalmology	0	0	0	0	3	279	4	287	291	1.3	1.0
Orthopedic	0	0	0	0	565	588	1472	1001	2473	2.6	1.7
Otolaryngology	0	0	0	0	77	200	118	377	495	1.5	1.9
Plastic Surgery	0	0	0	0	19	41	73	84	157	3.8	2.0
Podiatry	0	0	0	0	4	31	9	49	58	2.3	1.6
Thoracic	0	0	0	0	0	0	0	0	0	0.0	0.0
Urology	0	0	0	0	189	502	278	510	788	1.5	1.0
Totals	0	0	10	10	2982	3937	5901	4946	10847	2.0	1.3

SURGICAL RECOVERY STATIONS	Stage 1 Recovery Stations	11	Stage 2 Recovery Stations	22
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Dedicated and Non-Dedicated Procedure Room Utilization

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

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+Nondedicated labs):	4
Cath Labs used for Angiography procedures	2
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Emergency/Trauma Care

Certified Trauma Center by EMS	<input checked="" type="checkbox"/>
Level of Trauma Service	Level 1 Adult
Operating Rooms Dedicated for Trauma Care	1
Number of Trauma Visits:	564
Patients Admitted from Trauma	424
Emergency Service Type:	Comprehensive
Number of Emergency Room Stations	20
Persons Treated by Emergency Services:	32,913
Patients Admitted from Emergency:	4,257
Total ED Visits (Emergency+Trauma):	33,477

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	1,373
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	732
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	481
EP Catheterizations (15+)	160

Cardiac Surgery Data

Total Cardiac Surgery Cases:	64
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	64
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	64

Outpatient Service Data

Total Outpatient Visits	204,613
Outpatient Visits at the Hospital/ Campus:	172,261
Outpatient Visits Offsite/off campus	32,352

Diagnostic/Interventional Equipment

	Examinations		Radiation Equipment		Therapies/ Treatments	
	Owned	Contract	Inpatient	Outpatient	Owned	Contract
General Radiography/Fluoroscopy	5	0	14,504	22,969	Lithotripsy	0
Nuclear Medicine	3	0	1,491	3,217	Linear Accelerator	2
Mammography	3	0	0	6,823	Image Guided Rad Therapy	0
Ultrasound	5	0	3,507	9,429	Intensity Modulated Rad Therap	1
Diagnostic Angiography	0	0	0	0	High Dose Brachytherapy	0
Interventional Angiography	0	0	0	0	Proton Beam Therapy	0
Positron Emission Tomography (PET)	0	1	0	182	Gamma Knife	0
Computerized Axial Tomography (CAT)	2	0	6,194	16,786	Cyber knife	0
Magnetic Resonance Imaging	1	0	1,449	2,538		0

Ownership, Management and General Information

ADMINISTRATOR NAME: Jeffrey L. Brickman
ADMINSTRATOR PHONE 815-725-7133
OWNERSHIP: Provena Health
OPERATOR: Provena Hospitals d/b/a Provena St. Joseph Medical
MANAGEMENT: Not for Profit Corporation
CERTIFICATION: None
FACILITY DESIGNATION: General Hospital
ADDRESS 333 North Madison Street

Patients by Race

White 77.3%
 Black 12.7%
 American Indian 0.0%
 Asian 0.8%
 Hawaiian/ Pacific 0.0%
 Unknown: 9.2%

Patients by Ethnicity

Hispanic or Latino: 8.2%
 Not Hispanic or Latino: 91.5%
 Unknown: 0.3%
 IDPH Number: 4838
 HPA A-13
 HSA 9

CITY: Joliet

COUNTY: Will County

Facility Utilization Data by Category of Service

Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2009	Staff Bed Occupancy Rate %
Medical/Surgical	319	282	271	15,783	67,402	9,063	4.8	209.5	65.7	74.3
0-14 Years				40	94					
15-44 Years				3,366	11,237					
45-64 Years				4,893	19,502					
65-74 Years				2,680	13,171					
75 Years +				4,804	23,398					
Pediatric	13	13	13	525	1,415	692	4.0	5.8	44.4	44.4
Intensive Care	52	52	51	4,413	11,848	22	2.7	32.5	62.5	62.5
Direct Admission				2,801	8,350					
Transfers				1,612	3,498					
Obstetric/Gynecology	33	33	33	2,406	6,039	275	2.6	17.3	52.4	52.4
Maternity				2,182	5,500					
Clean Gynecology				224	539					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	31	31	31	1,390	9,613	0	6.9	26.3	85.0	85.0
Rehabilitation	32	32	30	570	6,544	0	11.5	17.9	56.0	56.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
<i>Dedicated Observation</i>	0					0				
Facility Utilization	480			23,475	102,861	10,052	4.8	309.4	64.4	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payor Source

	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	46.0%	13.4%	0.9%	34.5%	3.2%	2.0%	23,475
	10793	3154	212	8099	751	466	
Outpatients	27.4%	16.9%	0.8%	48.5%	5.2%	1.3%	232,432
	63576	39251	1779	112829	12070	2927	

Financial Year Reported:	1/1/2009 to 12/31/2009		Inpatient and Outpatient Net Revenue by Payor Source						Charity Care Expense	Total Charity Care Expense 7,284,458
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Totals				
Inpatient Revenue (\$)	50.0%	11.1%	0.0%	25.3%	13.6%	100.0%				
	101,834,552	22,548,805	0	51,620,573	27,643,931	203,647,861	3,377,931		Totals: Charity Care as % of Net Revenue	
Outpatient Revenue (\$)	22.3%	6.0%	0.0%	51.9%	19.7%	100.0%				
	46,700,399	12,443,368	0	108,545,931	41,267,927	208,957,625	3,906,527		1.8%	

Birthing Data

Number of Total Births: 2,016
 Number of Live Births: 2,011
 Birthing Rooms: 0
 Labor Rooms: 0
 Delivery Rooms: 0
 Labor-Delivery-Recovery Rooms: 0
 Labor-Delivery-Recovery-Postpartum Rooms: 33
 C-Section Rooms: 2
 CSections Performed: 745

Newborn Nursery Utilization

Level 1 Patient Days 3,719
 Level 2 Patient Days 0
 Level 2+ Patient Days 1,943
 Total Nursery Patientdays 5,662

Organ Transplantation

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

Laboratory Studies

Inpatient Studies 766,465
 Outpatient Studies 603,298
 Studies Performed Under Contract 31,054

* Note: The 2 Linear Accelerators are capable of performing IGRT, IMRT and Brachytherapy treatments. Actual Cost of Services Provided to Charity Care Inpatients and Outpatients was calculated using the 2009 IRS 990 Schedule H instructions to determine the cost to charge ratio. This methodology was used because the 2009 Medicare Cost Report was not available at time the AHQ was due

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	2	2	237	0	1377	0	1377	5.8	0.0
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	8	8	1383	1564	2553	1989	4542	1.8	1.3
Gastroenterology	0	0	0	0	1962	3416	1405	2393	3798	0.7	0.7
Neurology	0	0	0	0	373	49	1548	124	1672	4.2	2.5
OB/Gynecology	0	0	0	0	346	686	775	763	1538	2.2	1.1
Oral/Maxillofacial	0	0	0	0	2	25	5	62	67	2.5	2.5
Ophthalmology	0	0	0	0	6	386	11	363	374	1.8	0.9
Orthopedic	0	0	0	0	900	854	1974	1294	3268	2.2	1.5
Otolaryngology	0	0	0	0	143	436	201	541	742	1.4	1.2
Plastic Surgery	0	0	0	0	16	101	29	195	224	1.8	1.9
Podiatry	0	0	0	0	19	118	30	246	276	1.6	2.1
Thoracic	0	0	0	0	421	197	1266	323	1589	3.0	1.6
Urology	0	0	0	0	213	232	743	1309	2052	3.5	5.6
Totals	0	0	10	10	6021	8064	11917	9602	21519	2.0	1.2

SURGICAL RECOVERY STATIONS	Stage 1 Recovery Stations	10	Stage 2 Recovery Stations	0
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Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	3	3	1962	3416	1405	2393	3798	0.7	0.7
Laser Eye Procedures	0	0	1	1	0	56	0	21	21	0.0	0.4
Pain Management	0	0	1	1	57	170	66	202	268	1.2	1.2
Cystoscopy	0	0	1	1	184	350	251	385	636	1.4	1.1
Multipurpose Non-Dedicated Rooms											
	0	0	1	1	0	2	0	1	1	0.0	0.5
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+Nondedicated labs):	4
Cath Labs used for Angiography procedures	0
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	1

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	2,714
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	1,329
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	995
EP Catheterizations (15+)	390

Emergency/Trauma Care

Certified Trauma Center by EMS	<input checked="" type="checkbox"/>
Level of Trauma Service	Level 1 Adult
Operating Rooms Dedicated for Trauma Care	1
Number of Trauma Visits:	904
Patients Admitted from Trauma	866
Emergency Service Type:	Comprehensive
Number of Emergency Room Stations	43
Persons Treated by Emergency Services:	69,565
Patients Admitted from Emergency:	12,450
Total ED Visits (Emergency+Trauma):	70,469

Cardiac Surgery Data

Total Cardiac Surgery Cases:	865
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	855
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	284

Outpatient Service Data

Total Outpatient Visits	506,576
Outpatient Visits at the Hospital/ Campus:	464,506
Outpatient Visits Offsite/off campus	42,070

Diagnostic/Interventional Equipment

	Examinations				Radiation Equipment			Therapies/ Treatments
	Owned	Contract	Inpatient	Outpatient	Owned	Contract		
General Radiography/Fluoroscopy	29	0	26,372	71,389	Lithotripsy	0	1	27
Clear Medicine	4	0	3,667	10,206	Linear Accelerator	2	0	70
Mammography	2	0	0	13,856	Image Guided Rad Therapy	2	0	40
Ultrasound	8	0	5,143	19,181	Intensity Modulated Rad Therap	2	0	36
Diagnostic Angiography	0	0	0	0	High Dose Brachytherapy	2	0	19
Interventional Angiography	0	0	0	0	Proton Beam Therapy	0	0	0
Positron Emission Tomography (PET)	0	1	0	0	Gamma Knife	0	0	0
Computerized Axial Tomography (CAT)	7	0	8,981	29,106	Cyber knife	0	0	0
Magnetic Resonance Imaging	4	0	4,170	8,779				

ATTACHMENT 19C

Ownership, Management and General Information		Patients by Race		Patients by Ethnicity	
ADMINISTRATOR NAME:	Michael Arno	White	78.3%	Hispanic or Latino:	3.1%
ADMINISTRATOR PHONE	(815) 937-2401	Black	20.7%	Not Hispanic or Latino:	96.6%
OWNERSHIP:	Provena Hospitals	American Indian	0.0%	Unknown:	0.3%
OPERATOR:	Provena Hospitals d/b/a Provena St.Marys Hospital	Asian	0.2%	IDPH Number:	4879
MANAGEMENT:	Church-Related	Hawaiian/ Pacific	0.0%	HPA	A-14
CERTIFICATION:	None	Unknown:	0.7%	HSA	9
FACILITY DESIGNATION:	General Hospital				
ADDRESS	500 West Court Street	CITY:	Kankakee	COUNTY:	Kankakee County

Facility Utilization Data by Category of Service										
Clinical Service	Authorized CON Beds 12/31/2009	Peak Beds Setup and Staffed	Peak Census	Admissions	Inpatient Days	Observation Days	Average Length of Stay	Average Daily Census	CON Occupancy 12/31/2009	Staff Bed Occupancy Rate %
Medical/Surgical	105	83	77	4,471	19,084	952	4.5	54.9	52.3	66.1
0-14 Years				5	19					
15-44 Years				817	2,600					
45-64 Years				1,789	6,969					
65-74 Years				694	3,272					
75 Years +				1,166	6,224					
Pediatric	14	13	10	542	1,711	445	4.0	5.9	42.2	45.4
Intensive Care	26	25	25	2,051	5,860	75	2.9	16.3	62.5	65.0
Direct Admission				1,417	3,233					
Transfers				634	2,627					
Obstetric/Gynecology	12	13	8	466	1,042	52	2.3	3.0	25.0	23.1
Maternity				420	936					
Clean Gynecology				46	106					
Neonatal	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long Term Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Swing Beds				0	0		0.0	0.0		
Acute Mental Illness	25	21	21	649	3,488	3	5.4	9.6	38.3	45.5
Rehabilitation	0	0	0	0	0	0	0.0	0.0	0.0	0.0
Long-Term Acute Care	0	0	0	0	0	0	0.0	0.0	0.0	0.0
<i>Dedicated Observation</i>	0					0				
Facility Utilization	182			7,545	31,185	1,527	4.3	89.6	49.2	

(Includes ICU Direct Admissions Only)

Inpatients and Outpatients Served by Payer Source							
	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Totals
Inpatients	46.0%	17.8%	1.2%	28.8%	4.2%	1.9%	7,545
	3474	1343	94	2171	320	143	
Outpatients	26.9%	15.1%	1.4%	40.9%	14.1%	1.5%	103,475
	27886	15592	1481	42310	14624	1582	

Financial Year Reported:	Inpatient and Outpatient Net Revenue by Payer Source							Charity Care Expense	Total Charity Care Expense
	1/1/2009 to	12/31/2009	Medicare	Medicaid	Other Public	Private Insurance	Private Pay		
Inpatient Revenue (\$)	32,691,073	9,028,207	105,333	18,527,435	1,932,268	62,284,316	1,856,922	2,657,530	
Outpatient Revenue (\$)	15,172,947	7,045,738	132,298	52,276,990	4,708,645	79,336,618	800,608	Totals: Charity Care as % of Net Revenue	
								1.9%	

Birthing Data		Newborn Nursery Utilization		Organ Transplantation	
Number of Total Births:	424	Level 1 Patient Days	781	Kidney:	0
Number of Live Births:	420	Level 2 Patient Days	242	Heart:	0
Birthing Rooms:	0	Level 2+ Patient Days	20	Lung:	0
Labor Rooms:	0	Total Nursery Patientdays	1,043	Heart/Lung:	0
Delivery Rooms:	0			Pancreas:	0
Labor-Delivery-Recovery Rooms:	1			Liver:	0
Labor-Delivery-Recovery-Postpartum Rooms:	4	Laboratory Studies		Total:	0
C-Section Rooms:	1	Inpatient Studies	167,326		
CSections Performed:	116	Outpatient Studies	204,947		
		Studies Performed Under Contract	0		

* Note: According to Board action on 4/22/09, Board reduced 4 ICU beds overall voluntarily. New CON count for the facility is 182 beds. Actual Cost of Services Provided to Charity Care Inpatients and Outpatients (Part II, Question 3 on page 14) was calculated using the 2009 IRS 990 Schedule H instructions to determine the cost to charge ratio. This methodology was used because the 2009 Medicare Cost Report was not available until after the 1/1/09 was due.

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	0	0	0	0	0	0	0	0.0	0.0
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	7	7	450	640	839	989	1828	1.9	1.5
Gastroenterology	0	0	0	0	166	69	201	83	284	1.2	1.2
Neurology	0	0	0	0	51	747	121	909	1030	2.4	1.2
OB/Gynecology	0	0	0	0	197	248	391	416	807	2.0	1.7
Oral/Maxillofacial	0	0	0	0	12	9	24	17	41	2.0	1.9
Ophthalmology	0	0	0	0	3	385	8	422	430	2.7	1.1
Orthopedic	0	0	0	0	394	607	1047	1223	2270	2.7	2.0
Otolaryngology	0	0	0	0	10	285	15	360	375	1.5	1.3
Plastic Surgery	0	0	0	0	1	33	4	66	70	4.0	2.0
Podiatry	0	0	0	0	11	76	18	154	172	1.6	2.0
Thoracic	0	0	0	0	24	14	60	17	77	2.5	1.2
Urology	0	0	1	1	197	659	301	872	1173	1.5	1.3
Totals	0	0	8	8	1516	3772	3029	5528	8557	2.0	1.5

SURGICAL RECOVERY STATIONS	Stage 1 Recovery Stations	0	Stage 2 Recovery Stations	0
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Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	5	5	360	1289	382	1565	1947	1.1	1.2
Laser Eye Procedures	0	0	1	1	0	22	0	17	17	0.0	0.8
Pain Management	0	0	0	0	0	0	0	0	0	0.0	0.0
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+Nondedicated labs):	2
Cath Labs used for Angiography procedures	2
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Emergency/Trauma Care

Certified Trauma Center by EMS	<input checked="" type="checkbox"/>
Level of Trauma Service	Level 1 Adult
Operating Rooms Dedicated for Trauma Care	Level 2 ---
Number of Trauma Visits:	1
Patients Admitted from Trauma	291
Emergency Service Type:	Comprehensive
Number of Emergency Room Stations	22
Persons Treated by Emergency Services:	31,174
Patients Admitted from Emergency:	5,913
Total ED Visits (Emergency+Trauma):	31,465

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	658
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	522
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	113
EP Catheterizations (15+)	23

Cardiac Surgery Data

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

Outpatient Service Data

Total Outpatient Visits	218,663
Outpatient Visits at the Hospital/ Campus:	187,202
Outpatient Visits Offsite/off campus	31,461

Diagnostic/Interventional Equipment

	Examinations			
	Owned	Contract	Inpatient	Outpatient
General Radiography/Fluoroscopy	7	0	7,780	30,258
Nuclear Medicine	2	0	1,405	1,861
Mammography	4	0	0	4,584
Ultrasound	4	0	2,102	6,361
Diagnostic Angiography	0	0	0	0
Interventional Angiography	0	0	0	0
Positron Emission Tomography (PET)	0	1	0	0
Computerized Axial Tomography (CAT)	2	0	2,494	15,811
Magnetic Resonance Imaging	2	0	609	255

Radiation Equipment

	Radiation Equipment		Therapies/ Treatments
	Owned	Contract	
Lithotripsy	0	1	156
Linear Accelerator	0	0	0
Image Guided Rad Therapy	0	0	0
Intensity Modulated Rad Therap	0	0	0
High Dose Brachytherapy	0	0	0
Proton Beam Therapy	0	0	0
Gamma Knife	0	0	0
Cyber knife	0	0	0

NUMBER OF PATIENTS BY AGE GROUP

AGE	MALE	FEMALE	TOTAL
0-14	15	12	27
15-44	159	185	344
45-64	308	322	630
65-74	266	388	654
75+ Yea	192	420	612
TOTAL	940	1,327	2,267

NUMBER OF PATIENTS BY PRIMARY PAYMENT SOURCE

PAYMENT SOURCE	MALE	FEMALE	TOTAL
Medicaid	25	26	51
Medicare	414	851	1,265
Other Public Insurance	0	0	0
Private Pay	10	16	26
Charity Care	3	1	4
TOTAL	940	1,327	2,267

NET REVENUE BY PAYOR SOURCE for Fiscal Year

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense	Charity Care Expense as % of Total Net Revenue
18.7%	0.5%	0.0%	58.6%	22.2%	100.0%		0%
870,580	21,951	0	2,730,613	1,035,739	4,658,883	16,139	

OPERATING ROOM UTILIZATION FOR THE REPORTING YEAR

SURGERY AREA	TOTAL SURGERIES	SURGERY		TOTAL SURGERY (HOURS)	AVERAGE CASE TIME (HOURS)
		TIME (HOURS)	PREP and CLEAN-UP TIME (HOURS)		
Cardiovascular	0	0.00	0.00	0.00	0.00
Dermatology	0	0.00	0.00	0.00	0.00
Gastroenterology	266	133.00	88.00	221.00	0.83
General	16	12.00	7.00	19.00	1.19
Laser Eye	0	0.00	0.00	0.00	0.00
Neurological	0	0.00	0.00	0.00	0.00
OB/Gynecology	0	0.00	0.00	0.00	0.00
Ophthalmology	1304	652.00	325.00	977.00	0.75
Oral/Maxillofacial	0	0.00	0.00	0.00	0.00
Orthopedic	287	287.00	119.00	406.00	1.41
Otolaryngology	37	22.00	12.00	34.00	0.92
Pain Management	148	74.00	24.00	98.00	0.66
Plastic	0	0.00	0.00	0.00	0.00
Podiatry	164	164.00	68.00	232.00	1.41
Thoracic	0	0.00	0.00	0.00	0.00
Urology	45	30.00	22.00	52.00	1.16
TOTAL	2267	1,374.00	665.00	2039.00	0.90

PROCEDURE ROOM UTILIZATION FOR THE REPORTING YEAR

SURGERY AREA	PROCEDURE ROOMS	TOTAL SURGERIES	SURGERY		TOTAL SURGERY (HOURS)	AVERAGE CASE TIME (HOURS)
			TIME (HOURS)	PREP and CLEAN-UP TIME (HOURS)		
Cardiac Catheteriza	0	0	0	0	0	0.00
Gastro-Intestinal	0	0	0	0	0	0.00
Laser Eye	0	0	0	0	0	0.00
Pain Management	0	0	0	0	0	0.00
TOTALS	0	0	0	0	0	0.00

Reference Numbers	Facility Id	7003131	Number of Operating Rooms	4	
Health Service Area	006	Planning Service Area	030	Procedure Rooms	0
BELMONT/HARLEM SURGERY CENTER, LLC			Exam Rooms	0	
3101 NORTH HARLEM AVENUE			Number of Recovery Stations Stage 1	5	
CHICAGO, IL 60634			Number of Recovery Stations Stage 2	8	

Administrator
 FAITH MCHALE

Date
 Completed
 4/26/2010

Registered Agent
 NANCY ARMATAS

Property Owner
 RESURRECTION SERVICES

Legal Owner

Type of Ownership
 Limited Liability Company (RA required)

HOSPITAL TRANSFER RELATIONSHIPS

HOSPITAL NAME	NUMBER OF PATIENTS
RESURRECTION MEDICAL CENTER, CHICAGO	2
OUR LADY OF RESURRECTION, CHICAGO	0
	0
	0
	0

STAFFING PATTERNS

PERSONNEL	FULL-TIME EQUIVALENTS
Administrator	0.00
Physicians	0.00
Nurse Anesthetists	0.00
Dir. of Nurses	1.00
Reg. Nurses	2.00
Certified Aides	1.00
Other Hlth. Profs.	2.00
Other Non-Hlth. Profs	3.00
TOTAL	9.00

DAYS AND HOURS OF OPERATION

Monday	10
Tuesday	10
Wednesday	10
Thursday	10
Friday	10
Saturday	0
Sunday	0

FACILITY NOTES

HISTORICAL UTILIZATION OF
MANTENO DIALYSIS CENTER

Provena Health maintains a 50% ownership interest in Manteno Dialysis Center, 15-station ESRD facility located in Manteno, Illinois. According to data provided by The Renal Network, Manteno Dialysis Center operated at 41.11% of capacity during the reporting quarter ending September 30, 2009.

PROVENA COR MARIAE CENTER

3330 MARIA LINDEN DRIVE
ROCKFORD, IL. 61114
Reference Numbers Facility ID 6005771
Health Service Area 001 Planning Service Area 201

Administrator
Teresa Wester-Peters

Contact Person and Telephone

Sandra Fuller
815-877-7416

Registered Agent Information

Teresa Wester-Peters
3330 Maria Linden Drive
Rockford, IL 61114

FACILITY OWNERSHIP

NON-PROF CORPORATION

CONTINUING CARE COMMUNITY

No

LIFE CARE FACILITY

No

ADMISSION RESTRICTIONS

Aggressive/Anti-Social 0
Chronic Alcoholism 0
Developmentally Disabled 0
Drug Addiction 0
Medicaid Recipient 0
Medicare Recipient 0
Mental Illness 0
Non-Ambulatory 0
Non-Mobile 0
Public Aid Recipient 0
Under 65 Years Old 0
Unable to Self-Medicate 0
Ventilator Dependent 1
Infectious Disease w/ Isolation 0
Other Restrictions 0
No Restrictions 0

Note: Reported restrictions denoted by '1'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS
Neoplasms 0
Endocrine/Metabolic 0
Blood Disorders 0
*Nervous System Non Alzheimer 0
Alzheimer Disease 0
Mental Illness 0
Developmental Disability 0
Circulatory System 28
Respiratory System 23
Digestive System 10
Genitourinary System Disorders 14
Skin Disorders 4
Musculo-skeletal Disorders 14
Injuries and Poisonings 10
Other Medical Conditions 12
Non-Medical Conditions 7

TOTALS 122

Total Residents Diagnosed as Mentally Ill 14

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

ADMISSIONS AND DISCHARGES - 2009

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS		BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	ADMISSIONS AND DISCHARGES - 2009	
		SET-UP	USED					Residents on 1/1/2009	
Nursing Care	73	73	69	73	69	4	73	16	113
Skilled Under 22	0	0	0	0	0	0	0	0	484
Intermediate DD	0	0	0	0	0	0	0	0	475
Sheltered Care	61	61	53	61	53	8	0	0	122
TOTAL BEDS	134	134	122	134	122	12	73	16	Identified Offenders 0

FACILITY UTILIZATION - 2009

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL	Licensed Beds	Peak Beds Set Up
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.							
Nursing Care	10344	38.8%	4319	74.0%	0	0	8821	167	23651	88.8%	88.8%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	1570	17775	0	19345	86.9%	86.9%
TOTALS	10344	38.8%	4319	74.0%	0	1570	26596	167	42996	87.9%	87.9%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009

AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	0	0	0	0	0	0	0	0	0	0	0
60 to 64	1	1	0	0	0	0	0	1	1	2	3
65 to 74	2	2	0	0	0	0	2	3	4	5	9
75 to 84	3	12	0	0	0	0	5	8	8	20	28
85+	10	38	0	0	0	0	10	24	20	62	82
TOTALS	16	53	0	0	0	0	17	36	33	89	122

PROVENA COR MARIAE CENTER

3330 MARIA LINDEN DRIVE
ROCKFORD, IL. 61114

Reference Numbers Facility ID 6005771

Health Service Area 001 Planning Service Area 201

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Other					Private Pay	Charity Care	TOTALS
	Medicare	Medicaid	Public Insurance					
Nursing Care	36	12	3	3	15	0	69	
Skilled Under 22	0	0	0	0	0	0	0	
ICF/DD		0	0	0	0	0	0	
Sheltered Care			0	0	53	0	53	
TOTALS	36	12	3	3	68	0	122	

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	343	207
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	144	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	1	1
Amer. Indian	0	0	0	0	0
Black	4	0	0	0	4
Hawaiian/Pac. Isl.	0	0	0	0	0
White	65	0	0	52	117
Race Unknown	0	0	0	0	0
Total	69	0	0	53	122

ETHNICITY	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Hispanic	0	0	0	1	1
Non-Hispanic	69	0	0	52	121
Ethnicity Unknown	0	0	0	0	0
Total	69	0	0	53	122

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	2.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	9.54
LPN's	13.78
Certified Aides	41.78
Other Health Staff	0.00
Non-Health Staff	58.70
Totals	126.80

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
36.0%	5.9%	0.0%	5.5%	52.6%	100.0%		0.3%
3,213,321	522,027	0	494,247	4,684,406	8,914,001	25,072	

*Charity Expense does not include expenses which may be considered a community benefit.

PROVENA GENEVA CARE CENTER

1101 EAST STATE STREET
 GENEVA, IL. 60134
Reference Numbers Facility ID 6003503
 Health Service Area 008 Planning Service Area 089

Administrator
 Dawn Renee Furman

Contact Person and Telephone
 DAWN. R. FURMAN
 630-232-7544

Registered Agent Information Date Completed 5/12/2010

FACILITY OWNERSHIP
 NON-PROF CORPORATION
CONTINUING CARE COMMUNITY No
LIFE CARE FACILITY No

ADMISSION RESTRICTIONS

Aggressive/Anti-Social	0
Chronic Alcoholism	1
Developmentally Disabled	1
Drug Addiction	1
Medicaid Recipient	0
Medicare Recipient	0
Mental Illness	0
Non-Ambulatory	0
Non-Mobile	0
Public Aid Recipient	0
Under 65 Years Old	0
Unable to Self-Medicare	0
Ventilator Dependent	1
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	0

Note: Reported restrictions denoted by 'I'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	
Neoplasms	0
Endocrine/Metabolic	1
Blood Disorders	0
*Nervous System Non Alzheimer	5
Alzheimer Disease	24
Mental Illness	11
Developmental Disability	1
Circulatory System	10
Respiratory System	10
Digestive System	3
Genitourinary System Disorders	1
Skin Disorders	0
Musculo-skeletal Disorders	2
Injuries and Poisonings	1
Other Medical Conditions	12
Non-Medical Conditions	0
TOTALS	81

Total Residents Diagnosed as Mentally Ill 15

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

ADMISSIONS AND DISCHARGES - 2009

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	ADMISSIONS AND DISCHARGES - 2009	
									Residents on 1/1/2009	
Nursing Care	107	106	106	106	81	26	63	69	89	190
Skilled Under 22	0	0	0	0	0	0		0		198
Intermediate DD	0	0	0	0	0	0		0		81
Sheltered Care	0	0	0	0	0	0				0
TOTAL BEDS	107	106	106	106	81	26	63	69		

Identified Offenders 0

FACILITY UTILIZATION - 2009

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL	Licensed Beds Occ. Pct.	Peak Beds Set Up Occ. Pct.
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.							
Nursing Care	6481	28.2%	19671	78.1%	0	311	5973	0	32436	83.1%	83.8%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	0	0	0	0.0%	0.0%
TOTALS	6481	28.2%	19671	78.1%	0	311	5973	0	32436	83.1%	83.8%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009

AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	1	0	0	0	0	0	0	0	1	0	1
60 to 64	1	0	0	0	0	0	0	0	1	0	1
65 to 74	4	4	0	0	0	0	0	0	4	4	8
75 to 84	6	19	0	0	0	0	0	0	6	19	25
85+	6	40	0	0	0	0	0	0	6	40	46
TOTALS	18	63	0	0	0	0	0	0	18	63	81

PROVENA GENEVA CARE CENTER

1101 EAST STATE STREET
GENEVA, IL. 60134

Reference Numbers Facility ID 6003503

Health Service Area 008 Planning Service Area 089

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Other						TOTALS
	Medicare	Medicaid	Public Insurance	Private Pay	Charity Care		
Nursing Care	15	47	0	1	18	0	81
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD		0	0	0	0	0	0
Sheltered Care			0	0	0	0	0
TOTALS	15	47	0	1	18	0	81

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	274	224
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	0	0	0	0	0
Hawaiian/Pac. Isl.	0	0	0	0	0
White	81	0	0	0	81
Race Unknown	0	0	0	0	0
Total	81	0	0	0	81

ETHNICITY	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Hispanic	0	0	0	0	0
Non-Hispanic	81	0	0	0	81
Ethnicity Unknown	0	0	0	0	0
Total	81	0	0	0	81

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.50
Director of Nursing	1.00
Registered Nurses	7.50
LPN's	12.00
Certified Aides	41.00
Other Health Staff	7.00
Non-Health Staff	24.00
Totals	94.00

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
32.7%	38.5%	0.0%	1.5%	27.2%	100.0%		0.0%
2,055,000	2,417,269	0	95,656	1,709,374	6,277,299	0	

*Charity Expense does not include expenses which may be considered a community benefit.

PROVENA HERITAGE VILLAGE		ADMISSION RESTRICTIONS		RESIDENTS BY PRIMARY DIAGNOSIS	
901 NORTH ENTRANCE		Aggressive/Anti-Social	1	DIAGNOSIS	
KANKAKEE, IL. 60901		Chronic Alcoholism	1	Neoplasms	0
Reference Numbers	Facility ID 6004246	Developmentally Disabled	0	Endocrine/Metabolic	0
Health Service Area 009	Planning Service Area 091	Drug Addiction	1	Blood Disorders	0
Administrator		Medicaid Recipient	1	*Nervous System Non Alzheimer	0
Carol McIntyre		Medicare Recipient	0	Alzheimer Disease	19
Contact Person and Telephone		Mental Illness	1	Mental Illness	0
CAROL D MCINTYRE		Non-Ambulatory	0	Developmental Disability	1
815-939-4506		Non-Mobile	0	Circulatory System	31
Registered Agent Information	Date Completed 4/9/2010	Public Aid Recipient	0	Respiratory System	10
		Under 65 Years Old	0	Digestive System	5
		Unable to Self-Medicate	0	Genitourinary System Disorders	0
		Ventilator Dependent	1	Skin Disorders	0
		Infectious Disease w/ Isolation	0	Musculo-skeletal Disorders	0
		Other Restrictions	0	Injuries and Poisonings	0
		No Restrictions	0	Other Medical Conditions	8
FACILITY OWNERSHIP		<i>Note: Reported restrictions denoted by 'I'</i>		Non-Medical Conditions	0
NON-PROF CORPORATION				TOTALS	74
CONTINUING CARE COMMUNITY	No				
LIFE CARE FACILITY	No				
				Total Residents Diagnosed as Mentally Ill	0

LEVEL OF CARE	LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS							ADMISSIONS AND DISCHARGES - 2009		
	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	Residents on 1/1/2009	
Nursing Care	51	51	51	51	42	9	51	0	72	Total Admissions 2009
Skilled Under 22	0	0	0	0	0	0	0	0	225	Total Discharges 2009
Intermediate DD	0	0	0	0	0	0	0	0	74	Residents on 12/31/2009
Sheltered Care	79	36	36	36	32	47			0	Identified Offenders
TOTAL BEDS	130	87	87	87	74	56	51	0		

FACILITY UTILIZATION - 2009											
BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE											
LEVEL OF CARE	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL	Licensed Beds	Peak Beds Set Up
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.	Pat. days	Pat. days	Pat. days	Pat. days	Pat. days	Occ. Pct.	Occ. Pct.
Nursing Care	8657	46.5%	0	0.0%	0	547	9197	0	18401	98.9%	98.9%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	5840	365	6205	21.5%	47.2%
TOTALS	8657	46.5%	0	0.0%	0	547	15037	365	24606	51.9%	77.5%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009												
AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	TOTAL	
Under 18	0	0	0	0	0	0	0	0	0	0	0	
18 to 44	0	0	0	0	0	0	0	0	0	0	0	
45 to 59	1	0	0	0	0	0	0	0	1	0	1	
60 to 64	0	0	0	0	0	0	0	0	0	0	0	
65 to 74	0	4	0	0	0	0	0	0	0	4	4	
75 to 84	5	10	0	0	0	0	0	4	5	14	19	
85+	3	19	0	0	0	0	4	24	7	43	50	
TOTALS	9	33	0	0	0	0	4	28	13	61	74	

PROVENA HERITAGE VILLAGE

901 NORTH ENTRANCE

KANKAKEE, IL. 60901

Reference Numbers Facility ID 6004246

Health Service Area 009 Planning Service Area 091

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other		Private Pay	Charity Care	TOTALS
			Public	Insurance			
Nursing Care	24	0	0	10	8	0	42
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD		0	0	0	0	0	0
Sheltered Care			0	0	31	1	32
TOTALS	24	0	0	10	39	1	74

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	206	177
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	113	102

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	1	0	0	0	1
Hawaiian/Pac. Isl.	0	0	0	0	0
White	41	0	0	32	73
Race Unknown	0	0	0	0	0
Total	42	0	0	32	74

ETHNICITY	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Hispanic	0	0	0	0	0
Non-Hispanic	42	0	0	32	74
Ethnicity Unknown	0	0	0	0	0
Total	42	0	0	32	74

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	7.00
LPN's	11.00
Certified Aides	41.00
Other Health Staff	4.00
Non-Health Staff	48.00
Totals	113.00

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
47.3%	0.0%	0.0%	3.7%	49.0%	100.0%		0.2%
2,600,153	0	0	200,575	2,691,589	5,492,317	9,000	

*Charity Expense does not include expenses which may be considered a community benefit.

PROVENA MCAULEY MANOR

400 W. SULLIVAN ROAD
 AURORA, IL. 60506
 Reference Numbers Facility ID 6005912
 Health Service Area 008 Planning Service Area 089

Administrator
 Jennifer Roach

Contact Person and Telephone
 Bill Erue
 630-859-3700

Registered Agent Information
 Megan Kieffer
 19065 Hickory Creek Drive Suite 300
 Mokena, IL 60448

FACILITY OWNERSHIP
 NON-PROF CORPORATION

CONTINUING CARE COMMUNITY No
LIFE CARE FACILITY No

ADMISSION RESTRICTIONS

Aggressive/Anti-Social	0
Chronic Alcoholism	0
Developmentally Disabled	0
Drug Addiction	0
Medicaid Recipient	0
Medicare Recipient	0
Mental Illness	1
Non-Ambulatory	0
Non-Mobile	0
Public Aid Recipient	0
Under 65 Years Old	0
Unable to Self-Medicate	0
Ventilator Dependent	1
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	0

Note: Reported restrictions denoted by '1'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	
Neoplasms	3
Endocrine/Metabolic	0
Blood Disorders	0
*Nervous System Non Alzheimer	5
Alzheimer Disease	3
Mental Illness	1
Developmental Disability	0
Circulatory System	17
Respiratory System	3
Digestive System	6
Genitourinary System Disorders	0
Skin Disorders	1
Musculo-skeletal Disorders	15
Injuries and Poisonings	4
Other Medical Conditions	5
Non-Medical Conditions	0
TOTALS	63
Total Residents Diagnosed as Mentally Ill	
	1

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

ADMISSIONS AND DISCHARGES - 2009

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	ADMISSIONS AND DISCHARGES - 2009	
									Residents on 1/1/2009	
Nursing Care	87	87	74	87	63	24	87	9	Total Admissions 2009	517
Skilled Under 22	0	0	0	0	0	0		0	Total Discharges 2009	516
Intermediate DD	0	0	0	0	0	0		0	Residents on 12/31/2009	63
Sheltered Care	0	0	0	0	0	0			Identified Offenders	0
TOTAL BEDS	87	87	74	87	63	24	87	9		

FACILITY UTILIZATION - 2009

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL	Licensed Beds Occ. Pct.	Peak Beds Set Up Occ. Pct.
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.							
Nursing Care	10591	33.4%	1312	39.9%	0	695	10073	192	22863	72.0%	72.0%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	0	0	0	0.0%	0.0%
TOTALS	10591	33.4%	1312	39.9%	0	695	10073	192	22863	72.0%	72.0%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009

AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	1	0	0	0	0	0	0	0	1	0	1
45 to 59	0	1	0	0	0	0	0	0	0	1	1
60 to 64	2	0	0	0	0	0	0	0	2	0	2
65 to 74	5	1	0	0	0	0	0	0	5	1	6
75 to 84	5	10	0	0	0	0	0	0	5	10	15
85+	6	32	0	0	0	0	0	0	6	32	38
TOTALS	19	44	0	0	0	0	0	0	19	44	63

PROVENA MCAULEY MANOR

400 W. SULLIVAN ROAD
AURORA, IL. 60506

Reference Numbers Facility ID 6005912
Health Service Area 008 Planning Service Area 089

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Other					Charity Care	TOTALS
	Medicare	Medicaid	Public Insurance	Private Pay	Insurance		
Nursing Care	24	4	0	4	31	0	63
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD		0	0	0	0	0	0
Sheltered Care			0	0	0	0	0
TOTALS	24	4	0	4	31	0	63

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	228	207
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	1	0	0	0	1
Hawaiian/Pac. Isl.	0	0	0	0	0
White	60	0	0	0	60
Race Unknown	2	0	0	0	2
Total	63	0	0	0	63

ETHNICITY	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Hispanic	2	0	0	0	2
Non-Hispanic	61	0	0	0	61
Ethnicity Unknown	0	0	0	0	0
Total	63	0	0	0	63

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	7.00
LPN's	3.00
Certified Aides	22.00
Other Health Staff	6.00
Non-Health Staff	32.00
Totals	72.00

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
48.8%	2.4%	0.0%	3.0%	45.8%	100.0%		0.1%
3,259,177	161,944	0	201,199	3,056,364	6,678,684	7,530	

*Charity Expense does not include expenses which may be considered a community benefit.

PROVENA OUR LADY OF VICTORY

20 BRIARCLIFF LANE
BOURBONNAIS, IL. 60914
Reference Numbers Facility ID 6007009
Health Service Area 009 Planning Service Area 091

Administrator
Robin Gifford

Contact Person and Telephone

ROBIN GIFFORD
815-937-2022

Registered Agent Information

Date Completed
5/6/2010

FACILITY OWNERSHIP

NON-PROF CORPORATION

CONTINUING CARE COMMUNITY

No

LIFE CARE FACILITY

No

ADMISSION RESTRICTIONS

Aggressive/Anti-Social	0
Chronic Alcoholism	0
Developmentally Disabled	0
Drug Addiction	0
Medicaid Recipient	0
Medicare Recipient	0
Mental Illness	0
Non-Ambulatory	0
Non-Mobile	0
Public Aid Recipient	0
Under 65 Years Old	0
Unable to Self-Medicate	0
Ventilator Dependent	1
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	0

Note: Reported restrictions denoted by '1'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	
Neoplasms	2
Endocrine/Metabolic	5
Blood Disorders	2
*Nervous System Non Alzheimer	5
Alzheimer Disease	1
Mental Illness	1
Developmental Disability	0
Circulatory System	25
Respiratory System	17
Digestive System	2
Genitourinary System Disorders	8
Skin Disorders	2
Musculo-skeletal Disorders	9
Injuries and Poisonings	5
Other Medical Conditions	10
Non-Medical Conditions	0
TOTALS	94
Total Residents Diagnosed as Mentally Ill	1

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

ADMISSIONS AND DISCHARGES - 2009

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS		BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	ADMISSIONS AND DISCHARGES - 2009	
		SET-UP	USED					Residents on 1/1/2009	
Nursing Care	107	107	107	94	13	55	90	Residents on 1/1/2009	95
Skilled Under 22	0	0	0	0	0	0	0	Total Admissions 2009	205
Intermediate DD	0	0	0	0	0	0	0	Total Discharges 2009	206
Sheltered Care	0	0	0	0	0	0	0	Residents on 12/31/2009	94
TOTAL BEDS	107	107	107	94	13	55	90	Identified Offenders	0

FACILITY UTILIZATION - 2009

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL	Licensed Beds Occ. Pct.	Peak Beds Set Up Occ. Pct.
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.							
Nursing Care	7906	39.4%	23104	70.3%	0	480	2785	0	34275	87.8%	87.8%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	0	0	0	0.0%	0.0%
TOTALS	7906	39.4%	23104	70.3%	0	480	2785	0	34275	87.8%	87.8%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009

AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	1	0	0	0	0	0	0	0	1	1
45 to 59	0	0	0	0	0	0	0	0	0	0	0
60 to 64	2	2	0	0	0	0	0	0	2	2	4
65 to 74	4	10	0	0	0	0	0	0	4	10	14
75 to 84	10	20	0	0	0	0	0	0	10	20	30
85+	4	41	0	0	0	0	0	0	4	41	45
TOTALS	20	74	0	0	0	0	0	0	20	74	94

PROVENA OUR LADY OF VICTORY

20 BRIARCLIFF LANE

BOURBONNAIS, IL. 60914

Reference Numbers Facility ID 6007009

Health Service Area 009 Planning Service Area 091

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other		Private Pay	Charity Care	TOTALS
			Public	Insurance			
Nursing Care	21	64	0	0	9	0	94
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD		0	0	0	0	0	0
Sheltered Care			0	0	0	0	0
TOTALS	21	64	0	0	9	0	94

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	177	173
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	8	0	0	0	8
Hawaiian/Pac. Isl.	0	0	0	0	0
White	86	0	0	0	86
Race Unknown	0	0	0	0	0
Total	94	0	0	0	94

ETHNICITY	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Hispanic	0	0	0	0	0
Non-Hispanic	94	0	0	0	94
Ethnicity Unknown	0	0	0	0	0
Total	94	0	0	0	94

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	10.00
LPN's	16.00
Certified Aides	27.00
Other Health Staff	0.00
Non-Health Staff	37.00
Totals	92.00

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
38.1%	46.8%	0.0%	2.6%	12.5%	100.0%		0.0%
2,380,646	2,919,597	0	162,995	777,678	6,240,916	0	

*Charity Expense does not include expenses which may be considered a community benefit.

PROVENA PINE VIEW CARE CENTER

611 ALLEN LANE
ST. CHARLES, IL. 60174
Reference Numbers Facility ID 6007439
Health Service Area 008 Planning Service Area 089

Administrator
MELISSA ADAMS

Contact Person and Telephone
HOLLY ORLAND
630-377-2211

Registered Agent Information

Date Completed
5/7/2010

FACILITY OWNERSHIP

NON-PROF CORPORATION

CONTINUING CARE COMMUNITY

No

LIFE CARE FACILITY

No

ADMISSION RESTRICTIONS

Aggressive/Anti-Social 0
Chronic Alcoholism 0
Developmentally Disabled 0
Drug Addiction 1
Medicaid Recipient 0
Medicare Recipient 0
Mental Illness 1
Non-Ambulatory 0
Non-Mobile 0
Public Aid Recipient 0
Under 65 Years Old 0
Unable to Self-Medicate 0
Ventilator Dependent 1
Infectious Disease w/ Isolation 0
Other Restrictions 0
No Restrictions 0

Note: Reported restrictions denoted by 'I'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS
Neoplasms 4
Endocrine/Metabolic 0
Blood Disorders 0
*Nervous System Non Alzheimer 5
Alzheimer Disease 1
Mental Illness 3
Developmental Disability 0
Circulatory System 12
Respiratory System 11
Digestive System 3
Genitourinary System Disorders 5
Skin Disorders 4
Musculo-skeletal Disorders 11
Injuries and Poisonings 4
Other Medical Conditions 36
Non-Medical Conditions 4
TOTALS 103

Total Residents Diagnosed as Mentally Ill 24

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

ADMISSIONS AND DISCHARGES - 2009

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	ADMISSIONS AND DISCHARGES - 2009	
									Residents on 1/1/2009	
Nursing Care	120	110	110	110	103	17	120	60	88	270
Skilled Under 22	0	0	0	0	0	0	0	0		255
Intermediate DD	0	0	0	0	0	0	0	0		103
Sheltered Care	0	0	0	0	0	0	0	0		0
TOTAL BEDS	120	110	110	110	103	17	120	60		Identified Offenders 0

FACILITY UTILIZATION - 2009

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL	Licensed Beds Occ. Pct.	Peak Beds Set Up Occ. Pct.
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.							
Nursing Care	8895	20.3%	17874	81.6%	0	607	7533	0	34909	79.7%	86.9%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	0	0	0	0.0%	0.0%
TOTALS	8895	20.3%	17874	81.6%	0	607	7533	0	34909	79.7%	86.9%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009

AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	1	1	0	0	0	0	0	0	1	1	2
60 to 64	3	2	0	0	0	0	0	0	3	2	5
65 to 74	2	5	0	0	0	0	0	0	2	5	7
75 to 84	8	13	0	0	0	0	0	0	8	13	21
85+	12	56	0	0	0	0	0	0	12	56	68
TOTALS	26	77	0	0	0	0	0	0	26	77	103

PROVENA PINE VIEW CARE CENTER

611 ALLEN LANE
ST. CHARLES, IL. 60174

Reference Numbers Facility ID 6007439

Health Service Area 008 Planning Service Area 089

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Other				Private	Charity	TOTALS
	Medicare	Medicaid	Public	Insurance	Pay	Care	
Nursing Care	25	50	0	1	27	0	103
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD		0	0	0	0	0	0
Sheltered Care			0	0	0	0	0
TOTALS	25	50	0	1	27	0	103

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	327	227
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	0	0	0	0	0
Hawaiian/Pac. Isl.	0	0	0	0	0
White	103	0	0	0	103
Race Unknown	0	0	0	0	0
Total	103	0	0	0	103
ETHNICITY	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Hispanic	0	0	0	0	0
Non-Hispanic	103	0	0	0	103
Ethnicity Unknown	0	0	0	0	0
Total	103	0	0	0	103

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	20.00
LPN's	5.00
Certified Aides	38.00
Other Health Staff	0.00
Non-Health Staff	41.00
Totals	106.00

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
38.1%	30.5%	0.0%	2.6%	28.8%	100.0%		0.0%
2,855,512	2,289,829	0	193,073	2,163,888	7,502,302	0	

*Charity Expense does not include expenses which may be considered a community benefit.

PROVENA ST. ANN CENTER		ADMISSION RESTRICTIONS		RESIDENTS BY PRIMARY DIAGNOSIS	
4405 HIGHCREST ROAD		Aggressive/Anti-Social 1		DIAGNOSIS	
ROCKFORD, IL. 61107		Chronic Alcoholism 1		Neoplasms 4	
Reference Numbers	Facility ID 6008817	Developmentally Disabled 1		Endocrine/Metabolic 4	
Health Service Area 001	Planning Service Area 201	Drug Addiction 1		Blood Disorders 0	
Administrator		Medicaid Recipient 0		*Nervous System Non Alzheimer 7	
Janelle Chadwick		Medicare Recipient 0		Alzheimer Disease 0	
Contact Person and Telephone		Mental Illness 1		Mental Illness 0	
JANELLE CHADWICK		Non-Ambulatory 0		Developmental Disability 0	
815-229-1999		Non-Mobile 0		Circulatory System 33	
	Date Completed	Public Aid Recipient 0		Respiratory System 8	
Registered Agent Information	4/28/2010	Under 65 Years Old 0		Digestive System 5	
Meghan Kieffer		Unable to Self-Medicate 0		Genitourinary System Disorders 13	
19608 Hickory Creek Drive Suite 300		Ventilator Dependent 1		Skin Disorders 4	
Mokena, IL 60448		Infectious Disease w/ Isolation 0		Musculo-skeletal Disorders 26	
FACILITY OWNERSHIP		Other Restrictions 0		Injuries and Poisonings 34	
NON-PROF CORPORATION		No Restrictions 0		Other Medical Conditions 5	
CONTINUING CARE COMMUNITY	No	<i>Note: Reported restrictions denoted by 'I'</i>		Non-Medical Conditions 0	
LIFE CARE FACILITY	No			TOTALS 143	
				Total Residents Diagnosed as Mentally Ill 0	

LEVEL OF CARE	LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS							ADMISSIONS AND DISCHARGES - 2009		
	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	Residents on 1/1/2009	
Nursing Care	179	179	163	179	143	36	119	60	153	724
Skilled Under 22	0	0	0	0	0	0		0		734
Intermediate DD	0	0	0	0	0	0		0		143
Sheltered Care	0	0	0	0	0	0		0		
TOTAL BEDS	179	179	163	179	143	36	119	60		Identified Offenders 0

LEVEL OF CARE	FACILITY UTILIZATION - 2009									Licensed Beds Occ. Pct.	Peak Beds Set Up Occ. Pct.	
	Medicare			Medicaid		Other Public	Private Insurance	Private Pay	Charity Care			TOTAL
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.	Pat. days	Pat. days	Pat. days	Pat. days	Pat. days			
Nursing Care	15823	36.4%	19188	87.6%	0	3254	16973	0	55238	84.5%	84.5%	
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%	
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%	
Sheltered Care					0	0	0	0	0	0.0%	0.0%	
TOTALS	15823	36.4%	19188	87.6%	0	3254	16973	0	55238	84.5%	84.5%	

AGE GROUPS	RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009										
	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	TOTAL
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	1	1	0	0	0	0	0	0	1	1	2
60 to 64	0	2	0	0	0	0	0	0	0	2	2
65 to 74	5	8	0	0	0	0	0	0	5	8	13
75 to 84	8	27	0	0	0	0	0	0	8	27	35
85+	23	68	0	0	0	0	0	0	23	68	91
TOTALS	37	106	0	0	0	0	0	0	37	106	143

PROVENA ST. ANN CENTER

4405 HIGHCREST ROAD
ROCKFORD, IL. 61107

Reference Numbers Facility ID 6008817

Health Service Area 001 Planning Service Area 201

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Other					Private Pay	Charity Care	TOTALS
	Medicare	Medicaid	Public	Insurance				
Nursing Care	44	52	0	8	39	0	143	
Skilled Under 22	0	0	0	0	0	0	0	
ICF/DD		0	0	0	0	0	0	
Sheltered Care			0	0	0	0	0	
TOTALS	44	52	0	8	39	0	143	

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	231	195
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	7	0	0	0	7
Hawaiian/Pac. Isl.	0	0	0	0	0
White	136	0	0	0	136
Race Unknown	0	0	0	0	0
Total	143	0	0	0	143

ETHNICITY	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Hispanic	1	0	0	0	1
Non-Hispanic	142	0	0	0	142
Ethnicity Unknown	0	0	0	0	0
Total	143	0	0	0	143

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	21.00
LPN's	35.00
Certified Aides	100.00
Other Health Staff	5.00
Non-Health Staff	54.00
Totals	217.00

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
39.0%	18.5%	0.0%	8.5%	34.0%	100.0%		0.0%
4,961,570	2,358,343	0	1,081,399	4,329,706	12,731,018	0	

*Charity Expense does not include expenses which may be considered a community benefit.

PROVENA ST. JOSEPH CENTER

659 EAST JEFFERSON STREET
FREEPORT, IL. 61032

Reference Numbers Facility ID 6008973

Health Service Area 001 Planning Service Area 177

Administrator

Michelle Lindeman

Contact Person and Telephone

Michelle Lindeman

815-232-6181

Registered Agent Information

Date
Completed
5/4/2010

ADMISSION RESTRICTIONS

Aggressive/Anti-Social	0
Chronic Alcoholism	0
Developmentally Disabled	0
Drug Addiction	0
Medicaid Recipient	0
Medicare Recipient	0
Mental Illness	1
Non-Ambulatory	0
Non-Mobile	0
Public Aid Recipient	0
Under 65 Years Old	0
Unable to Self-Medicate	0
Ventilator Dependent	1
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	0

Note: Reported restrictions denoted by '1'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	
Neoplasms	2
Endocrine/Metabolic	5
Blood Disorders	1
*Nervous System Non Alzheimer	11
Alzheimer Disease	3
Mental Illness	6
Developmental Disability	2
Circulatory System	41
Respiratory System	5
Digestive System	7
Genitourinary System Disorders	3
Skin Disorders	0
Musculo-skeletal Disorders	9
Injuries and Poisonings	2
Other Medical Conditions	5
Non-Medical Conditions	0
TOTALS	102

Total Residents Diagnosed as Mentally Ill 9

FACILITY OWNERSHIP

NON-PROF CORPORATION

CONTINUING CARE COMMUNITY

No

LIFE CARE FACILITY

No

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

ADMISSIONS AND DISCHARGES - 2009

LEVEL OF CARE	LICENSED BEDS	PEAK	PEAK	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	ADMISSIONS AND DISCHARGES - 2009	
		BEDS SET-UP	BEDS USED					Residents on 1/1/2009	
Nursing Care	120	111	111	108	102	18	120	94	103
Skilled Under 22	0	0	0	0	0	0		0	193
Intermediate DD	0	0	0	0	0	0		0	194
Sheltered Care	0	0	0	0	0	0			102
TOTAL BEDS	120	111	111	108	102	18	120	94	Identified Offenders 0

FACILITY UTILIZATION - 2009

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL Pat. days	Licensed Beds	Peak Beds Set Up
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.	Pat. days	Pat. days	Pat. days	Pat. days		Occ. Pct.	Occ. Pct.
Nursing Care	4263	9.7%	23066	67.2%	0	1291	10535	0	39155	89.4%	96.6%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	0	0	0	0.0%	0.0%
TOTALS	4263	9.7%	23066	67.2%	0	1291	10535	0	39155	89.4%	96.6%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009

AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	0	0	0	0	0	0	0	0	0	0	0
60 to 64	0	0	0	0	0	0	0	0	0	0	0
65 to 74	1	8	0	0	0	0	0	0	1	8	9
75 to 84	9	23	0	0	0	0	0	0	9	23	32
85+	9	52	0	0	0	0	0	0	9	52	61
TOTALS	19	83	0	0	0	0	0	0	19	83	102

PROVENA ST. JOSEPH CENTER

659 EAST JEFFERSON STREET

FREEPORT, IL. 61032

Reference Numbers Facility ID 6008973

Health Service Area 001 Planning Service Area 177

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare		Other		Private	Charity	TOTALS
	Medicare	Medicaid	Public	Insurance	Pay	Care	
Nursing Care	12	59	0	2	29	0	102
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD		0	0	0	0	0	0
Sheltered Care			0	0	0	0	0
TOTALS	12	59	0	2	29	0	102

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	195	163
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	3	0	0	0	3
Hawaiian/Pac. Isl.	0	0	0	0	0
White	98	0	0	0	98
Race Unknown	1	0	0	0	1
Total	102	0	0	0	102

ETHNICITY	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Hispanic	0	0	0	0	0
Non-Hispanic	101	0	0	0	101
Ethnicity Unknown	1	0	0	0	1
Total	102	0	0	0	102

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	8.00
LPN's	15.00
Certified Aides	44.00
Other Health Staff	6.00
Non-Health Staff	47.00
Totals	122.00

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
18.4%	40.8%	0.0%	6.3%	34.5%	100.0%		0.1%
1,196,547	2,652,594	0	411,964	2,245,919	6,507,024	4,872	

*Charity Expense does not include expenses which may be considered a community benefit.

PROVENA VILLA FRANCISCAN		ADMISSION RESTRICTIONS		RESIDENTS BY PRIMARY DIAGNOSIS		
210 NORTH SPRINGFIELD AVENUE		Aggressive/Anti-Social	0	DIAGNOSIS		
JOLIET, IL. 60435		Chronic Alcoholism	0	Neoplasms	0	
Reference Numbers	Facility ID 6012678	Developmentally Disabled	0	Endocrine/Metabolic	2	
Health Service Area 009	Planning Service Area 197	Drug Addiction	0	Blood Disorders	1	
Administrator		Medicaid Recipient	0	*Nervous System Non Alzheimer	2	
Ann Dodge		Medicare Recipient	0	Alzheimer Disease	0	
Contact Person and Telephone		Mental Illness	0	Mental Illness	3	
ANN DODGE		Non-Ambulatory	0	Developmental Disability	0	
815-725-3400		Non-Mobile	0	Circulatory System	4	
Registered Agent Information	Date Completed 4/28/2010	Public Aid Recipient	0	Respiratory System	5	
		Under 65 Years Old	0	Digestive System	2	
		Unable to Self-Medicare	0	Genitourinary System Disorders	9	
		Ventilator Dependent	0	Skin Disorders	2	
		Infectious Disease w/ Isolation	0	Musculo-skeletal Disorders	90	
		Other Restrictions	0	Injuries and Poisonings	2	
		No Restrictions	1	Other Medical Conditions	36	
FACILITY OWNERSHIP		<i>Note: Reported restrictions denoted by '1'</i>			Non-Medical Conditions	0
NON-PROF CORPORATION				TOTALS	158	
CONTINUING CARE COMMUNITY	No			Total Residents Diagnosed as Mentally Ill	102	
LIFE CARE FACILITY	No					

LEVEL OF CARE	LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS								ADMISSIONS AND DISCHARGES - 2009	
	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	Residents on 1/1/2009	
Nursing Care	176	176	173	176	158	18	176	82	Total Admissions 2009	517
Skilled Under 22	0	0	0	0	0	0		0	Total Discharges 2009	525
Intermediate DD	0	0	0	0	0	0		0	Residents on 12/31/2009	158
Sheltered Care	0	0	0	0	0	0		0	Identified Offenders	0
TOTAL BEDS	176	176	173	176	158	18	176	82		

FACILITY UTILIZATION - 2009											
BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE											
LEVEL OF CARE	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL Pat. days	Licensed Beds	Peak Beds Set Up
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.	Pat. days	Pat. days	Pat. days	Pat. days		Occ. Pct.	Occ. Pct.
Nursing Care	24894	38.8%	16739	55.9%	0	989	16317	0	58939	91.7%	91.7%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	0	0	0	0.0%	0.0%
TOTALS	24894	38.8%	16739	55.9%	0	989	16317	0	58939	91.7%	91.7%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009											
AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	TOTAL
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	3	0	0	0	0	0	0	0	3	0	3
60 to 64	2	0	0	0	0	0	0	0	2	0	2
65 to 74	7	8	0	0	0	0	0	0	7	8	15
75 to 84	25	38	0	0	0	0	0	0	25	38	63
85+	9	66	0	0	0	0	0	0	9	66	75
TOTALS	46	112	0	0	0	0	0	0	46	112	158

PROVENA VILLA FRANCISCAN

210 NORTH SPRINGFIELD AVENUE

JOLIET, IL. 60435

Reference Numbers Facility ID 6012678

Health Service Area 009 Planning Service Area 197

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Other				Private	Charity	TOTALS
	Medicare	Medicaid	Public	Insurance	Pay	Care	
Nursing Care	77	43	0	1	37	0	158
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD		0	0	0	0	0	0
Sheltered Care			0	0	0	0	0
TOTALS	77	43	0	1	37	0	158

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	280	250
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	9	0	0	0	9
Hawaiian/Pac. Isl.	0	0	0	0	0
White	149	0	0	0	149
Race Unknown	0	0	0	0	0
Total	158	0	0	0	158

ETHNICITY	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Hispanic	7	0	0	0	7
Non-Hispanic	151	0	0	0	151
Ethnicity Unknown	0	0	0	0	0
Total	158	0	0	0	158

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	2.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	23.42
LPN's	14.40
Certified Aides	65.80
Other Health Staff	14.00
Non-Health Staff	137.38
Totals	258.00

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
51.8%	15.4%	0.0%	0.9%	31.9%	100.0%		0.0%
7,277,014	2,169,644	0	119,626	4,478,378	14,044,662	0	

*Charity Expense does not include expenses which may be considered a community benefit.

ST. BENEDICT NURSING & REHAB

6930 WEST TOUHY AVENUE

NILES, IL. 60714

Reference Numbers Facility ID 6008874

Health Service Area 007 Planning Service Area 702

Administrator

Peter Goschy

Contact Person and Telephone

BRENDA DAVIS

847-813-3712

Registered Agent Information

Sandra Bruce

7435 West Talcott

Chicago, IL 60631

FACILITY OWNERSHIP

NON-PROF CORPORATION

CONTINUING CARE COMMUNITY

LIFE CARE FACILITY

No

No

ADMISSION RESTRICTIONS

Aggressive/Anti-Social	1
Chronic Alcoholism	1
Developmentally Disabled	1
Drug Addiction	1
Medicaid Recipient	0
Medicare Recipient	0
Mental Illness	1
Non-Ambulatory	0
Non-Mobile	0
Public Aid Recipient	0
Under 65 Years Old	0
Unable to Self-Medicate	0
Ventilator Dependent	1
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	0

Note: Reported restrictions denoted by 'I'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	
Neoplasms	3
Endocrine/Metabolic	5
Blood Disorders	0
*Nervous System Non Alzheimer	8
Alzheimer Disease	0
Mental Illness	0
Developmental Disability	0
Circulatory System	26
Respiratory System	28
Digestive System	10
Genitourinary System Disorders	4
Skin Disorders	0
Musculo-skeletal Disorders	0
Injuries and Poisonings	0
Other Medical Conditions	12
Non-Medical Conditions	0
TOTALS	96

Total Residents Diagnosed as Mentally Ill 0

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

ADMISSIONS AND DISCHARGES - 2009

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	ADMISSIONS AND DISCHARGES - 2009	
									Residents on 1/1/2009	
Nursing Care	99	99	99	99	96	3	99	99	Residents on 1/1/2009	96
Skilled Under 22	0	0	0	0	0	0	0	0	Total Admissions 2009	150
Intermediate DD	0	0	0	0	0	0	0	0	Total Discharges 2009	150
Sheltered Care	0	0	0	0	0	0	0	0	Residents on 12/31/2009	96
TOTAL BEDS	99	99	99	99	96	3	99	99	Identified Offenders	0

FACILITY UTILIZATION - 2009

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL	Licensed Beds Occ. Pct.	Peak Beds Set Up Occ. Pct.
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.							
Nursing Care	7889	21.8%	5350	14.8%	0	0	21399	0	34638	95.9%	95.9%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	0	0	0	0.0%	0.0%
TOTALS	7889	21.8%	5350	14.8%	0	0	21399	0	34638	95.9%	95.9%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009

AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	0	0	0	0	0	0	0	0	0	0	0
60 to 64	0	0	0	0	0	0	0	0	0	0	0
65 to 74	2	1	0	0	0	0	0	0	2	1	3
75 to 84	9	18	0	0	0	0	0	0	9	18	27
85+	10	56	0	0	0	0	0	0	10	56	66
TOTALS	21	75	0	0	0	0	0	0	21	75	96

ST. BENEDICT NURSING & REHAB

6930 WEST TOUHY AVENUE

NILES, IL. 60714

Reference Numbers Facility ID 6008874

Health Service Area 007 Planning Service Area 702

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Other					Private Pay	Charity Care	TOTALS
	Medicare	Medicaid	Public	Insurance				
Nursing Care	22	16	0	0	58	0	96	
Skilled Under 22	0	0	0	0	0	0	0	
ICF/DD		0	0	0	0	0	0	
Sheltered Care			0	0	0	0	0	
TOTALS	22	16	0	0	58	0	96	

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	261	233
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	0	0	0	0	0
Hawaiian/Pac. Isl.	0	0	0	0	0
White	96	0	0	0	96
Race Unknown	0	0	0	0	0
Total	96	0	0	0	96

ETHNICITY	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Hispanic	0	0	0	0	0
Non-Hispanic	96	0	0	0	96
Ethnicity Unknown	0	0	0	0	0
Total	96	0	0	0	96

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	8.68
LPN's	5.52
Certified Aides	40.61
Other Health Staff	43.00
Non-Health Staff	11.00
Totals	110.81

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
39.8%	7.4%	0.0%	0.0%	52.7%	100.0%		0.0%
3,792,372	707,936	0	0	5,021,073	9,521,381	0	

*Charity Expense does not include expenses which may be considered a community benefit.

RESURRECTION LIFE CENTER

7370 WEST TALCOTT
 CHICAGO, IL. 60631
Reference Numbers Facility ID 6014575
 Health Service Area 006 Planning Service Area 601

Administrator
 Nancy Razo

Contact Person and Telephone
 BRENDA DAVIS
 847-813-3712

Registered Agent Information
 Sandra Bruce
 7435 West Talcott
 Chicago, IL 60631

FACILITY OWNERSHIP
 NON-PROF CORPORATION

CONTINUING CARE COMMUNITY No
LIFE CARE FACILITY No

ADMISSION RESTRICTIONS

Aggressive/Anti-Social	0
Chronic Alcoholism	0
Developmentally Disabled	1
Drug Addiction	1
Medicaid Recipient	0
Medicare Recipient	0
Mental Illness	1
Non-Ambulatory	0
Non-Mobile	0
Public Aid Recipient	0
Under 65 Years Old	0
Unable to Self-Medicate	0
Ventilator Dependent	1
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	0

Note: Reported restrictions denoted by '1'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	
Neoplasms	4
Endocrine/Metabolic	10
Blood Disorders	0
*Nervous System Non Alzheimer	14
Alzheimer Disease	9
Mental Illness	16
Developmental Disability	0
Circulatory System	22
Respiratory System	10
Digestive System	4
Genitourinary System Disorders	3
Skin Disorders	4
Musculo-skeletal Disorders	23
Injuries and Poisonings	0
Other Medical Conditions	42
Non-Medical Conditions	0
TOTALS	161
Total Residents Diagnosed as Mentally Ill 16	

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

ADMISSIONS AND DISCHARGES - 2009

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	ADMISSIONS AND DISCHARGES - 2009	
									Residents on 1/1/2009	
Nursing Care	147	147	146	147	146	1	112	112	161	161
Skilled Under 22	0	0	0	0	0	0	0	0	264	264
Intermediate DD	0	0	0	0	0	0	0	0	264	264
Sheltered Care	15	15	15	15	15	0	0	0	161	161
TOTAL BEDS	162	162	161	162	161	1	112	112	Identified Offenders	0

FACILITY UTILIZATION - 2009

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL	Licensed Beds	Peak Beds
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.		Pat. days	Pat. days	Pat. days		Pat. days	Occ. Pct.
Nursing Care	8445	20.7%	24529	60.0%	0	0	19603	0	52577	98.0%	98.0%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	5475	0	5475	100.0%	100.0%
TOTALS	8445	20.7%	24529	60.0%	0	0	25078	0	58052	98.2%	98.2%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009

AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	0	0	0	0	0	0	0	0	0	0	0
60 to 64	0	0	0	0	0	0	0	0	0	0	0
65 to 74	1	0	0	0	0	0	2	0	3	0	3
75 to 84	4	31	0	0	0	0	1	3	5	34	39
85+	16	94	0	0	0	0	0	9	16	103	119
TOTALS	21	125	0	0	0	0	3	12	24	137	161

RESURRECTION LIFE CENTER7370 WEST TALCOTT
CHICAGO, IL 60631

Reference Numbers Facility ID 6014575

Health Service Area 006 Planning Service Area 601

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Other					Private Pay	Charity Care	TOTALS
	Medicare	Medicaid	Public	Insurance				
Nursing Care	20	79	0	0	47	0	146	
Skilled Under 22	0	0	0	0	0	0	0	
ICF/DD		0	0	0	0	0	0	
Sheltered Care			0	0	15	0	15	
TOTALS	20	79	0	0	62	0	161	

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	261	0
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	166	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	2	0	0	0	2
Hawaiian/Pac. Isl.	0	0	0	0	0
White	144	0	0	15	159
Race Unknown	0	0	0	0	0
Total	146	0	0	15	161

ETHNICITY	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Hispanic	1	0	0	0	1
Non-Hispanic	145	0	0	15	160
Ethnicity Unknown	0	0	0	0	0
Total	146	0	0	15	161

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	21.02
LPN's	7.00
Certified Aides	51.71
Other Health Staff	11.77
Non-Health Staff	30.40
Totals	123.90

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
29.0%	22.2%	0.0%	0.0%	48.8%	100.0%		0.0%
3,599,478	2,752,857	0	0	6,046,287	12,398,622	0	

*Charity Expense does not include expenses which may be considered a community benefit.

FACILITY NOTES

Bed Change 7/15/2009 Added 10 nursing care beds and discontinued 10 sheltered care beds. Facility now has 147 nursing care and 15 sheltered care beds.

RESURRECTION NSG & REHAB CTR

1001 NORTH GREENWOOD AVENUE

PARK RIDGE, IL. 60068

Reference Numbers Facility ID 6007892

Health Service Area 007 Planning Service Area 702

Administrator

James Farlee

Contact Person and Telephone

BRENDA DAVIS

847-813-3712

Registered Agent Information

Sandra Bruce

7435 West Talcott

Chicago, IL 60631

FACILITY OWNERSHIP

NON-PROF CORPORATION

CONTINUING CARE COMMUNITY

No

LIFE CARE FACILITY

No

ADMISSION RESTRICTIONS

Aggressive/Anti-Social	1
Chronic Alcoholism	1
Developmentally Disabled	1
Drug Addiction	1
Medicaid Recipient	0
Medicare Recipient	0
Mental Illness	1
Non-Ambulatory	0
Non-Mobile	0
Public Aid Recipient	0
Under 65 Years Old	0
Unable to Self-Medicat	0
Ventilator Dependent	1
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	0

Note: Reported restrictions denoted by '1'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	
Neoplasms	31
Endocrine/Metabolic	0
Blood Disorders	0
*Nervous System Non Alzheimer	58
Alzheimer Disease	26
Mental Illness	0
Developmental Disability	0
Circulatory System	69
Respiratory System	41
Digestive System	0
Genitourinary System Disorders	12
Skin Disorders	0
Musculo-skeletal Disorders	25
Injuries and Poisonings	0
Other Medical Conditions	0
Non-Medical Conditions	0
TOTALS	262

Total Residents Diagnosed as Mentally Ill 0

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

ADMISSIONS AND DISCHARGES - 2009

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS		BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	ADMISSIONS AND DISCHARGES - 2009	
		SET-UP	USED					Residents on 1/1/2009	243
Nursing Care	298	285	262	262	36	298	298	Total Admissions 2009	603
Skilled Under 22	0	0	0	0	0	0	0	Total Discharges 2009	584
Intermediate DD	0	0	0	0	0	0	0	Residents on 12/31/2009	262
Sheltered Care	0	0	0	0	0	0	0	Identified Offenders	1
TOTAL BEDS	298	285	262	262	36	298	298		

FACILITY UTILIZATION - 2009

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare		Medicaid		Other Public	Private Insurance		Private Pay		Charity Care	TOTAL	Licensed Beds Occ. Pct.	Peak Beds Set Up Occ. Pct.
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.		Pat. days	Pat. days	Pat. days	Pat. days				
Nursing Care	20742	19.1%	41546	38.2%	0	2026	21347	1068	86729	79.7%	83.4%		
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%		
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%		
Sheltered Care					0	0	0	0	0	0.0%	0.0%		
TOTALS	20742	19.1%	41546	38.2%	0	2026	21347	1068	86729	79.7%	83.4%		

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009

AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	5	3	0	0	0	0	0	0	5	3	8
60 to 64	5	9	0	0	0	0	0	0	5	9	14
65 to 74	16	21	0	0	0	0	0	0	16	21	37
75 to 84	20	49	0	0	0	0	0	0	20	49	69
85+	22	112	0	0	0	0	0	0	22	112	134
TOTALS	68	194	0	0	0	0	0	0	68	194	262

RESURRECTION NSG & REHAB CTR

1001 NORTH GREENWOOD AVENUE

PARK RIDGE, IL. 60068

Reference Numbers Facility ID 6007892

Health Service Area 007 Planning Service Area 702

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Other				Private	Charity	TOTALS
	Medicare	Medicaid	Public	Insurance	Pay	Care	
Nursing Care	52	136	0	8	62	4	262
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD		0	0	0	0	0	0
Sheltered Care			0	0	0	0	0
TOTALS	52	136	0	8	62	4	262

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	261	220
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Asian	4	0	0	0	4
Amer. Indian	0	0	0	0	0
Black	4	0	0	0	4
Hawaiian/Pac. Isl.	0	0	0	0	0
White	254	0	0	0	254
Race Unknown	0	0	0	0	0
Total	262	0	0	0	262

ETHNICITY	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Hispanic	2	0	0	0	2
Non-Hispanic	260	0	0	0	260
Ethnicity Unknown	0	0	0	0	0
Total	262	0	0	0	262

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	59.50
LPN's	3.00
Certified Aides	92.00
Other Health Staff	10.00
Non-Health Staff	89.00
Totals	255.50

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
48.2%	25.9%	0.0%	0.0%	25.9%	100.0%		0.1%
9,977,713	5,363,092	0	0	5,373,527	20,714,332	26,938	

*Charity Expense does not include expenses which may be considered a community benefit.

MARYHAVEN NSG. & REHAB. CTR.

1700 EAST LAKE AVENUE
 GLENVIEW, IL. 60025
 Reference Numbers Facility ID 6005854
 Health Service Area 007 Planning Service Area 702

Administrator
 Sara Szumski

Contact Person and Telephone
 BRENDA DAVIS
 847-813-3712

Registered Agent Information
 Sandra Bruce
 7435 West Talcott
 Chicago, IL 60631

FACILITY OWNERSHIP
 NON-PROF CORPORATION

CONTINUING CARE COMMUNITY No
 LIFE CARE FACILITY No

ADMISSION RESTRICTIONS

Aggressive/Anti-Social	0
Chronic Alcoholism	0
Developmentally Disabled	1
Drug Addiction	1
Medicaid Recipient	0
Medicare Recipient	0
Mental Illness	0
Non-Ambulatory	0
Non-Mobile	0
Public Aid Recipient	0
Under 65 Years Old	0
Unable to Self-Medicate	0
Ventilator Dependent	1
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	0

Note: Reported restrictions denoted by '1'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	
Neoplasms	3
Endocrine/Metabolic	4
Blood Disorders	0
*Nervous System Non Alzheimer	5
Alzheimer Disease	38
Mental Illness	0
Developmental Disability	1
Circulatory System	22
Respiratory System	3
Digestive System	1
Genitourinary System Disorders	1
Skin Disorders	0
Musculo-skeletal Disorders	33
Injuries and Poisonings	0
Other Medical Conditions	4
Non-Medical Conditions	0
TOTALS	115
Total Residents Diagnosed as Mentally Ill 6	

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

ADMISSIONS AND DISCHARGES - 2009

LEVEL OF CARE	LICENSED BEDS	PEAK		BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	ADMISSIONS AND DISCHARGES - 2009	
		BEDS SET-UP	BEDS USED					Residents on 1/1/2009	Total Admissions 2009
Nursing Care	135	135	122	135	115	20	135	135	110
Skilled Under 22	0	0	0	0	0	0	0	0	157
Intermediate DD	0	0	0	0	0	0	0	0	152
Sheltered Care	0	0	0	0	0	0	0	0	115
TOTAL BEDS	135	135	122	135	115	20	135	135	Identified Offenders 0

FACILITY UTILIZATION - 2009

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL	Licensed Beds	Peak Beds
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.						Pat. days	Pat. days
Nursing Care	5974	12.1%	21182	43.0%	0	0	15550	0	42706	86.7%	86.7%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	0	0	0	0.0%	0.0%
TOTALS	5974	12.1%	21182	43.0%	0	0	15550	0	42706	86.7%	86.7%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009

AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	TOTAL
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	0	2	0	0	0	0	0	0	0	2	2
60 to 64	1	3	0	0	0	0	0	0	1	3	4
65 to 74	3	3	0	0	0	0	0	0	3	3	6
75 to 84	8	20	0	0	0	0	0	0	8	20	28
85+	15	60	0	0	0	0	0	0	15	60	75
TOTALS	27	88	0	0	0	0	0	0	27	88	115

MARYHAVEN NSG. & REHAB. CTR.

1700 EAST LAKE AVENUE

GLENVIEW, IL. 60025

Reference Numbers Facility ID 6005854

Health Service Area 007 Planning Service Area 702

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare		Other		Private	Charity	TOTALS
	Medicare	Medicaid	Public	Insurance	Pay	Care	
Nursing Care	9	45	0	1	60	0	115
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD		0	0	0	0	0	0
Sheltered Care			0	0	0	0	0
TOTALS	9	45	0	1	60	0	115

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	224	201
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	1	0	0	0	1
Hawaiian/Pac. Isl.	0	0	0	0	0
White	114	0	0	0	114
Race Unknown	0	0	0	0	0
Total	115	0	0	0	115

ETHNICITY	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Hispanic	0	0	0	0	0
Non-Hispanic	115	0	0	0	115
Ethnicity Unknown	0	0	0	0	0
Total	115	0	0	0	115

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	17.21
LPN's	5.11
Certified Aides	38.34
Other Health Staff	3.73
Non-Health Staff	39.86
Totals	106.25

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
33.8%	29.7%	0.0%	0.0%	36.5%	100.0%		0.0%
3,019,283	2,645,099	0	0	3,256,278	8,920,660	0	

*Charity Expense does not include expenses which may be considered a community benefit.

HOLY FAMILY NURSING & REHABILITA CENTER

2380 DEMPSTER STREET
 DES PLAINES, IL. 60016
 Reference Numbers Facility ID 6004543
 Health Service Area 007 Planning Service Area 702

Administrator
 Tony Madl

Contact Person and Telephone
 BRENDA DAVIS
 847-813-3712

Registered Agent Information
 Sandra Bruce
 7435 West Talcott Avenue
 Chicago, IL 60631

FACILITY OWNERSHIP
 NON-PROF CORPORATION

CONTINUING CARE COMMUNITY No
LIFE CARE FACILITY No

ADMISSION RESTRICTIONS

Aggressive/Anti-Social	1
Chronic Alcoholism	0
Developmentally Disabled	0
Drug Addiction	1
Medicaid Recipient	0
Medicare Recipient	0
Mental Illness	1
Non-Ambulatory	0
Non-Mobile	0
Public Aid Recipient	0
Under 65 Years Old	0
Unable to Self-Medicate	0
Ventilator Dependent	0
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	0

Note: Reported restrictions denoted by '1'

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	
Neoplasms	0
Endocrine/Metabolic	11
Blood Disorders	4
*Nervous System Non Alzheimer	17
Alzheimer Disease	3
Mental Illness	10
Developmental Disability	0
Circulatory System	26
Respiratory System	24
Digestive System	1
Genitourinary System Disorders	5
Skin Disorders	8
Musculo-skeletal Disorders	14
Injuries and Poisonings	13
Other Medical Conditions	24
Non-Medical Conditions	0
TOTALS	160

Total Residents Diagnosed as Mentally Ill 10

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

ADMISSIONS AND DISCHARGES - 2009

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS		BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	ADMISSIONS AND DISCHARGES - 2009	
		SET-UP	USED					Residents on 1/1/2009	
Nursing Care	251	231	170	231	160	91	149	247	153
Skilled Under 22	0	0	0	0	0	0	0	0	580
Intermediate DD	0	0	0	0	0	0	0	0	573
Sheltered Care	0	0	0	0	0	0	0	0	160
TOTAL BEDS	251	231	170	231	160	91	149	247	Identified Offenders 0

FACILITY UTILIZATION - 2009

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL	Licensed Beds	Peak Beds Set Up
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.							
Nursing Care	8617	15.8%	34052	37.8%	0	0	10734	1382	54785	59.8%	65.0%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	0	0	0	0.0%	0.0%
TOTALS	8617	15.8%	34052	37.8%	0	0	10734	1382	54785	59.8%	65.0%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009

AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	2	2	0	0	0	0	0	0	2	2	4
45 to 59	9	8	0	0	0	0	0	0	9	8	17
60 to 64	5	7	0	0	0	0	0	0	5	7	12
65 to 74	9	13	0	0	0	0	0	0	9	13	22
75 to 84	5	31	0	0	0	0	0	0	5	31	36
85+	7	62	0	0	0	0	0	0	7	62	69
TOTALS	37	123	0	0	0	0	0	0	37	123	160

HOLY FAMILY NURSING & REHABILITA CENTER

2380 DEMPSTER STREET
DES PLAINES, IL. 60016

Reference Numbers Facility ID 6004543
Health Service Area 007 Planning Service Area 702

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Other					Private Pay	Charity Care	TOTALS
	Medicare	Medicaid	Public Insurance					
Nursing Care	27	99	0	6	22	6	160	
Skilled Under 22	0	0	0	0	0	0	0	
ICF/DD		0	0	0	0	0	0	
Sheltered Care			0	0	0	0	0	
TOTALS	27	99	0	6	22	6	160	

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	261	220
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Asian	5	0	0	0	5
Amer. Indian	0	0	0	0	0
Black	5	0	0	0	5
Hawaiian/Pac. Isl.	0	0	0	0	0
White	150	0	0	0	150
Race Unknown	0	0	0	0	0
Total	160	0	0	0	160

ETHNICITY	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Hispanic	11	0	0	0	11
Non-Hispanic	149	0	0	0	149
Ethnicity Unknown	0	0	0	0	0
Total	160	0	0	0	160

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	28.40
LPN's	3.20
Certified Aides	51.02
Other Health Staff	14.60
Non-Health Staff	48.50
Totals	147.72

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
34.7%	41.4%	0.0%	0.0%	23.9%	100.0%		1.7%
3,796,733	4,533,430	0	0	2,623,018	10,953,181	181,416	

*Charity Expense does not include expenses which may be considered a community benefit.

VILLA SCALABRINI NSG & REHAB		ADMISSION RESTRICTIONS		RESIDENTS BY PRIMARY DIAGNOSIS	
480 NORTH WOLF ROAD NORTHLAKE, IL. 60164		Aggressive/Anti-Social	0	DIAGNOSIS	
Reference Numbers Facility ID 6009591		Chronic Alcoholism	1	Neoplasms	6
Health Service Area 007 Planning Service Area 704		Developmentally Disabled	1	Endocrine/Metabolic	26
Administrator		Drug Addiction	1	Blood Disorders	10
Jim Kouzious		Medicaid Recipient	0	*Nervous System Non Alzheimer	28
Contact Person and Telephone		Medicare Recipient	0	Alzheimer Disease	28
BRENDA DAVIS		Mental Illness	1	Mental Illness	0
847-813-3712		Non-Ambulatory	0	Developmental Disability	3
Registered Agent Information		Non-Mobile	0	Circulatory System	43
Sandra Bruce		Public Aid Recipient	0	Respiratory System	18
7435 West Talcott		Under 65 Years Old	0	Digestive System	5
Chicago, IL 60631		Unable to Self-Medicate	0	Genitourinary System Disorders	7
FACILITY OWNERSHIP		Ventilator Dependent	0	Skin Disorders	2
NON-PROF CORPORATION		Infectious Disease w/ Isolation	0	Musculo-skeletal Disorders	48
CONTINUING CARE COMMUNITY		Other Restrictions	0	Injuries and Poisonings	0
LIFE CARE FACILITY		No Restrictions	0	Other Medical Conditions	0
		<i>Note: Reported restrictions denoted by 'I'</i>		Non-Medical Conditions	0
				TOTALS	224
				Total Residents Diagnosed as Mentally Ill	14

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

ADMISSIONS AND DISCHARGES - 2009

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS SET-UP	PEAK BEDS USED	BEDS SET-UP	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	ADMISSIONS AND DISCHARGES - 2009	
									Residents on 1/1/2009	Total Admissions 2009
Nursing Care	246	253	230	253	224	22	171	202	Total Discharges 2009	420
Skilled Under 22	0	0	0	0	0	0	0	0	Residents on 12/31/2009	224
Intermediate DD	0	0	0	0	0	0	0	0	Identified Offenders	0
Sheltered Care	7	0	0	0	0	7	0	0		
TOTAL BEDS	253	253	230	253	224	29	171	202		

FACILITY UTILIZATION - 2009

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare		Medicaid		Other Public	Private Insurance	Private Pay	Charity Care	TOTAL	Licensed Beds Occ. Pct.	Peak Beds Set Up Occ. Pct.
	Pat. days	Occ. Pct.	Pat. days	Occ. Pct.							
Nursing Care	17447	28.0%	45709	62.0%	0	1287	18792	433	83648	93.2%	90.6%
Skilled Under 22			0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD			0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care					0	0	0	0	0	0.0%	0.0%
TOTALS	17447	28.0%	45709	62.0%	0	1267	18792	433	83648	90.6%	90.6%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009

AGE GROUPS	NURSING CARE		SKL UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	1	1	0	0	0	0	0	0	1	1	2
45 to 59	4	2	0	0	0	0	0	0	4	2	6
60 to 64	2	0	0	0	0	0	0	0	2	0	2
65 to 74	5	13	0	0	0	0	0	0	5	13	18
75 to 84	14	50	0	0	0	0	0	0	14	50	64
85+	25	107	0	0	0	0	0	0	25	107	132
TOTALS	51	173	0	0	0	0	0	0	51	173	224

VILLA SCALABRINI NSG & REHAB

480 NORTH WOLF ROAD

NORTHLAKE, IL. 60164

Reference Numbers Facility ID 6009591

Health Service Area 007 Planning Service Area 704

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare		Other		Private	Charity	TOTALS
	Medicare	Medicaid	Public	Insurance	Pay	Care	
Nursing Care	44	126	0	6	47	1	224
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD		0	0	0	0	0	0
Sheltered Care			0	0	0	0	0
TOTALS	44	126	0	6	47	1	224

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	252	212
Skilled Under 22	0	0
Intermediate DD	0	0
Shelter	0	0

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	18	0	0	0	18
Hawaiian/Pac. Isl.	0	0	0	0	0
White	197	0	0	0	197
Race Unknown	9	0	0	0	9
Total	224	0	0	0	224

ETHNICITY	Nursing	SkUnd22	ICF/DD	Shelter	Totals
Hispanic	16	0	0	0	16
Non-Hispanic	208	0	0	0	208
Ethnicity Unknown	0	0	0	0	0
Total	224	0	0	0	224

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	34.61
LPN's	7.05
Certified Aides	75.20
Other Health Staff	13.30
Non-Health Staff	64.89
Totals	197.05

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	TOTALS	Charity Care Expense*	Charity Care Expense as % of Total Net Revenue
41.3%	31.6%	0.0%	0.0%	27.2%	100.0%		0.5%
7,596,699	5,807,508	0	0	4,996,309	18,400,516	89,396	

*Charity Expense does not include expenses which may be considered a community benefit.

TRANSFER AGREEMENT
between
OSF HEALTHCARE SYSTEM,
OSF Saint Francis Medical Center
and
PROVENA COVENANT MEDICAL CENTER

THIS TRANSFER AGREEMENT ("Agreement") is made and executed on the last date written below, by and between OSF HEALTHCARE SYSTEM, an Illinois not-for-profit corporation, having its Corporate Office in Peoria, Illinois, owner and operator of OSF SAINT FRANCIS MEDICAL CENTER, located and doing business in Peoria, Illinois (such System and Hospital are collectively referred to as "Receiving Hospital") and PROVENA HOSPITALS d/b/a PROVENA COVENANT MEDICAL CENTER, located and doing business in Urbana, Illinois (hereinafter referred to as "Transferring Facility").

R E C I T A L S:

A. The Transferring Facility and the Receiving Hospital desire, by means of this Agreement, to assist physicians in the treatment of patients.

B. The parties hereto specifically wish to facilitate: (a) the timely transfer of patients and the medical records and other information necessary or useful for the care and treatment of patients transferred; (b) the determination as to whether such patients can be adequately cared for other than by either of the parties hereto; (c) the continuity of care and treatment appropriate to the needs of the transferred patient; and (d) the utilization of knowledge and other resources of both healthcare entities in a coordinated and cooperative manner to improve the professional healthcare of patients.

NOW, THEREFORE, in consideration of the mutual covenants contained herein, and in reliance upon the recitals, set forth above and incorporated by reference herein, the parties hereto agree as follows:

I. DUTIES AND RESPONSIBILITIES.

- 1.1 Joint Responsibilities. In accordance with the policies and procedures of the Transferring Facility and upon the recommendation of the patient's attending physician that such a transfer is medically appropriate, such patient shall be transferred from the Transferring Facility to the Receiving Hospital as long as the Receiving Hospital has bed availability, staff availability, is able to provide the services requested by the Transferring Facility, including on-call specialty physician availability, and pursuant to any other necessary criteria established by the Receiving Hospital. In such cases, the Receiving Hospital and the Transferring Facility agree to exercise best efforts to provide for prompt admission of the patient. If applicable, the parties shall comply with all EMTALA requirements with respect to such transfers. Receiving Hospital and Transferring Facility shall meet periodically to review the transfer process, of policies and

procedures in order to improve the process, including efficiency, clinical care and patient safety.

- 1.2 Receiving Hospital. The Receiving Hospital shall accept patients in need of transfer from the Transferring Facility pursuant to the criteria set forth in Section 1.1. Further, Receiving Hospital shall designate a person to coordinate with Transferring Facility in order to establish acceptable and efficient transfer guidelines.
- 1.3 Transferring Facility. Transferring Facility shall request transfers of patients to Receiving Hospital pursuant to the criteria set forth in Section 1.1. Further, Transferring Facility shall:
 - a. Have responsibility for obtaining the patient's informed consent for the potential transfer to Receiving Hospital, if the patient is competent. If the patient is not competent, the consent of the legal guardian, agent with power of attorney for health care, or surrogate decision maker of the patient shall be obtained.
 - b. Notify Receiving Hospital as far in advance as possible of the impending transfer.
 - c. Transfer to Receiving Hospital the personal effects, including money and valuables, and information related thereto. Personal effects will be listed and sent with appropriate documentation at the time of the patient transfer.
 - d. Affect the transfer to Receiving Hospital through qualified personnel and appropriate transfer equipment and transportation, including the use of necessary and medically appropriate life support measures. Receiving Hospital's responsibility for the patient's care shall begin when the patient arrives at the Receiving Hospital. Notwithstanding anything to the contrary set forth above, in the event the patient is transferred by Receiving Hospital's Life Flight program, Receiving Hospital's responsibility shall begin when the patient leaves Transferring Hospital's Emergency Department.
 - e. Transfer, and supplement as necessary, all relevant medical records, or in the case of an emergency, as promptly as possible, transfer an abstract of the pertinent medical and other records necessary in order to continue the patient's treatment without interruption and to provide identifying and other information, including contact information for referring physician, name of physician(s) at Receiving Hospital contacted with regard to the

patient (and to whom the patient is to be transferred), medical, social, nursing and other care plans. Such information shall also include, without limitation and if available, current medical and lab findings, history of the illness or injury, diagnoses, advanced medical directives, rehabilitation potential, brief summary of the course of treatment at the Transferring Facility, medications administered, known allergies, nursing, dietary information, ambulation status and pertinent administrative, third party billing and social information.

- 1.4 Non Discrimination. The parties hereto acknowledge that nothing in this Agreement shall be construed to permit discrimination by either party in the transfer process set forth herein based on race, color, national origin, handicap, religion, age, sex or any other characteristic protected by Illinois state laws, Title VI of the Civil Rights Act of 1964, as amended or any other applicable state or federal laws. Further, Section 504 of the Rehabilitation Act of 1973 and the American Disabilities Act require that no otherwise qualified individual with an handicap shall, solely by reason of the handicap, be excluded from participation in, or denied the benefits of, or be subjected to discrimination in a facility certified under the Medicare or Medicaid programs.
- 1.5 Name Use. Neither party shall use the name of the other party in any promotional or advertising material unless the other party has reviewed and approved in writing in advance such promotional or advertising material.
- 1.6 Standards. Receiving Hospital shall ensure that its staff provide care to patients in a manner that will ensure that all duties are performed and services provided in accordance with any standard, ruling or regulation of The Joint Commission, the Department of Health and Human Services or any other federal, state or local government agency, corporate entity or individual exercising authority with respect to or affecting Receiving Hospital. Receiving Hospital shall ensure that its professionals shall perform their duties hereunder in conformance with all requirements of the federal and state constitutions and all applicable federal and state statutes and regulations.
- 1.7 Exclusion/Debarment. Both parties certify that they have not been debarred, suspended, or excluded from participation in any state or federal healthcare program, including, but not limited to, Medicaid, Medicare and Tricare. In addition, each party agrees that it will notify the other party immediately if it subsequently becomes debarred, suspended or excluded

or proposed for debarment, suspension or exclusion from participation in any state or federal healthcare program.

- 1.8 Confidentiality. Receiving Hospital agrees to maintain confidentiality. Receiving Hospital acknowledges that certain material, which will come into its possession or knowledge in connection with this Agreement, may include confidential information, disclosure of which to third parties may be damaging to Transferring Facility. Receiving Hospital agrees to hold all such material in confidence, to use it only in connection with performance under this Agreement and to release it only to those persons requiring access thereto for such performance or as may otherwise be required by law and to comply with the Health Insurance Portability and Accountability Act.
- 1.9 Access to Books and Records. Both parties will maintain records relating to their responsibilities under this Agreement for a period of one (1) year from the date of services. During normal working hours and upon prior written and reasonable notice, each party will allow the other party reasonable access to such records for audit purposes and also the right to make photocopies of such records (at requesting party's expense), subject to all applicable state and federal laws and regulations governing the confidentiality of such records.
- 1.10 Non-Exclusivity. This Agreement does not establish an exclusive arrangement between the parties, and both the Transferring Facility and the Receiving Hospital may enter into similar agreements with other hospitals. In addition, Transferring Facility's patients are not restricted in any way in their choice of emergency care providers.
- 1.11 Regulatory Compliance. The parties hereto agree that nothing contained in this Agreement shall require either party to refer patients to the other party for emergency care services or to purchase goods and services. Neither party will knowingly and intentionally conduct its behavior in such a manner as to violate the prohibition against fraud and abuse in connection with Medicare and Medicaid programs.

II. FINANCIAL ARRANGEMENTS.

- 2.1 Billing and Collection. The patient is primarily responsible for payment for care provided by Transferring Facility or Receiving Hospital. Each party shall bill and collect for services rendered by each party pursuant to all state and federal guidelines and those set by third party payors. Neither the Transferring Facility nor the Receiving Hospital shall have any liability to the other for billing, collection or other financial matters

relating to the transfer or transferred patient. Since this Agreement is not intended to induce referrals, there should be no compensation or anything of value, directly or indirectly, paid between the parties.

- 2.2 Insurance. Each party shall, at its expense, maintain through insurance policies, self-insurance or any combination thereof, such policies of comprehensive general liability and professional liability insurance with coverage limits of at least One Million Dollars (\$1,000,000.00) per occurrence and Three Million Dollars (\$3,000,000.00) annual aggregate to insure such party and its Board, officers, employees and agents acting within the scope of their duties and employment against any claim for damages arising by reason of injuries to property or personal injuries or death occasioned directly or indirectly in connection with services provided by such party and activities performed by such party in connection with this Agreement. Either party shall notify the other party thirty (30) days prior to the termination or modification of such policies.

III. TERM AND TERMINATION.

- 3.1 Term. The promises and obligations contained herein shall commence as of June 1, 2010, for a term of three (3) years therefrom and shall expire on May 31, 2013, subject, however, to termination under Section 3.2 herein.
- 3.2 Termination. This Agreement may be sooner terminated on the first to occur of the following:
- a. Written agreement by both parties to terminate this Agreement.
 - b. In the event of breach of any of the terms or conditions of this Agreement by either party and the failure of the breaching party to correct such breach within ten (10) business days after written notice of such breach by either party, such other party may terminate this Agreement immediately with written notice of such termination to the breaching party.
 - c. In the event either party to this Agreement shall, with or without cause, at any time give to the other at least thirty (30) days advanced written notice, this Agreement shall terminate on the future date specified in such notice.
 - d. Debarment, suspension or exclusion, as set forth in Section 1.7.
- 3.3 Effects of Termination. Upon termination of this Agreement, as hereinabove provided, no party shall have any further obligations hereunder, except for obligations accruing prior to the date of termination.

IV. MISCELLANEOUS.

- 4.1 This Agreement constitutes the entire agreement between the parties and contains all of the terms and conditions between the parties with respect to the subject matter hereunder. Receiving Hospital and Transferring Facility shall be entitled to no benefits or services other than those specified herein. This Agreement supersedes any and all other agreements, either written or oral, between the parties with respect to the subject matter hereof.
- 4.2 This Agreement shall be construed and interpreted in accordance with the laws of Illinois. It may only be amended, modified or terminated by an instrument signed by the parties. This Agreement shall inure to the benefit of and be binding upon the parties, their successors, legal representatives and assigns, and neither this Agreement nor any right or interest of Receiving Hospital or Transferring Facility arising herein shall be voluntarily or involuntarily sold, transferred or assigned without written consent of the other party, and any attempt at assignment is void.
- 4.3 The parties are independent contractors under this Agreement. Nothing in this Agreement is intended nor shall be construed to create an employer/employee relationship or a joint venture relationship between the parties, or to allow any party to exercise control or direction over the manner or method by which any of the parties perform services herein. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as, or be construed to be, a waiver of any subsequent breach of the same or other provisions hereof. Notices required herein shall be considered effective when delivered in person, or when sent by United States certified mail, postage prepaid, return receipt requested and addressed to:

Receiving Hospital:

Keith Steffen
President & CEO
Saint Francis Medical Center
530 N.E. Glen Oak Avenue
Peoria, Illinois 61637

Transferring Facility:

David Bertauski
President & CEO
Provena Covenant Medical Center
1400 W. Park Street
Urbana, IL 61801

or to other such address, and to the attention of such other person(s) or officer(s) as a party may designate by written notice.

- 4.4 It is understood and agreed that neither party to this Agreement shall be legally liable for any negligent nor wrongful act, either by commission or omission, chargeable to the other, unless such liability is imposed by law

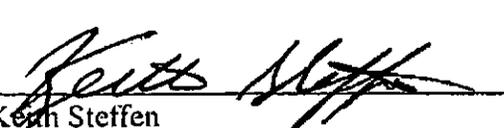
and that this Agreement shall not be construed as seeking to either enlarge or diminish any obligations or duty owed by one party against the other or against a third party. The invalidity or unenforceability of any particular provision of this Agreement shall not affect the other provisions hereof, and this Agreement shall be construed in all respects as if such invalid or unenforceable provision were omitted. The section titles and other headings contained in this Agreement are for reference only and shall not affect in any way the meaning or interpretation of this Agreement.

- 4.5 This Agreement is a result of negotiations between the parties, none of whom have acted under any duress or compulsion, whether legal, economic or otherwise. Accordingly, the parties hereby waive the application of any rule of law that otherwise would be applicable in connection with the construction of this Agreement that ambiguous or conflicting terms or provisions should be construed against the party who (or whose attorney) prepared the executed Agreement or any earlier draft of the same.

IN WITNESS WHEREOF, the parties have hereto executed this Agreement in multiple originals as of the last date written below.

RECEIVING HOSPITAL:

OSF HEALTHCARE SYSTEM,
an Illinois not-for-profit
corporation, owner and operator of
OSF Saint Francis Medical Center

By: 
Keith Steffen
President & CEO

Dated: 4/7/10

BBBB 3/29/10

TRANSFERRING FACILITY:

Provena Covenant Medical Center

By: 
David Bertauski
President & CEO

Dated: 4/12/10

**NORTH CENTRAL PERINATAL REGION
AFFILIATION AGREEMENT
between
OSF SAINT FRANCIS MEDICAL CENTER
and
PROVENA COVENANT MEDICAL CENTER**

This Affiliation Agreement ("AGREEMENT") entered into as of the 1st day of December, 2005, by and between OSF HEALTHCARE SYSTEM, an Illinois not-for-profit corporation, owner, and operator of OSF SAINT FRANCIS MEDICAL CENTER, located and doing business in Peoria, Illinois, sometimes referred to hereinafter as "HOSPITAL" (such System and HOSPITAL shall be referred to hereinafter collectively as "PERINATAL CENTER") and Provena Covenant Medical Center, an Illinois corporation, located and doing business in Urbana, Illinois (hereinafter referred to as "Level II with extended capabilities Center").

RECITALS

- A. Member institutions of the North Central Perinatal Region ("REGION") believe that the goals of the perinatal services of the member institutions are to make optimal preconception, maternal-fetal, neonatal, infant and family care available to the families in the REGION through a regional network.
- B. PERINATAL CENTER, which has been designated by the State of Illinois as a Level III Perinatal Center pursuant to the Illinois Department of Public Health Rules and Regulations, desires to provide perinatal service to LEVEL II with extended capabilities center.
- C. LEVEL II with extended capabilities center desires to receive perinatal services from PERINATAL CENTER.

NOW THEREFORE, in consideration of the mutual promises and covenants contained herein, PERINATAL CENTER and LEVEL II with extended capabilities center hereby agree to the following terms and conditions:

I. PREREQUISITES

- 1.1 This AGREEMENT conforms to the Prevention of Developmental Disability Act, Ill. REV. Stat. Ch. 111 ½, Sec. 2101 et. seq., the Abused and Neglected Child Reporting Act, Ill. Rev. Stat., Ch. 23, Sec. 2051 et. seq. and Illinois Department of Public Health rules and regulations:

**TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER I: MATERNAL AND CHILD HEALTH**

**Part 640
Regionalized Perinatal Care
Section 640.70**

- 1.2 Provena Covenant Medical Center will function as a Level II with extended capabilities Perinatal Service Unit per Subpart O of the Maternity and Newborn Services Regulations, State of Illinois, and the Regionalized Perinatal Health Care Code of Illinois.
- 1.3 The Perinatal Program will be administered by the OSF Saint Francis Perinatal Center through the Chairpersons of Obstetrics/Gynecology and Pediatrics at the Level II with extended capabilities Center.

II. COMMUNICATION SERVICES

- 2.1 The Director of Maternal/Fetal Medicine of the PERINATAL CENTER or Level III Center shall oversee:
- a. The maintenance of 24-hour obstetric hotlines for consultation/referral and transfer/transport of obstetric patients.
 - b. The prompt sending of patient management and outcome information from the PERINATAL CENTER primary physician, who cared for the patient, to the referring AFFILIATE and the physician at his/her office.
 - c. The prompt sending of patient management and outcome information from the PERINATAL CENTER primary physician who cared for the patient to the AFFILIATE'S patient chart.
- 2.2 The Director of Neonatology of the PERINATAL CENTER or Level III Center shall oversee:
- a. The maintenance of 24-hour neonatal hotlines for consultation/referral and transfer/transport of neonatal patients.
 - b. The prompt sending of patient management and outcome information from the PERINATAL CENTER neonatologists who cared for the patient to the referring physician at his/her office.
 - c. The prompt sending of patient management and outcome information from the PERINATAL CENTER.
- 2.3 While the PERINATAL CENTER primary physician will endeavor to keep the referring physician from the AFFILIATE informed concerning the continuing progress of transferred/transported patients, the referring physician is encouraged to call the PERINATAL CENTER and/or LEVEL III CENTER to check on interim developments.

III. REFERRALS

- 3.1 The PERINATAL CENTER or Level III Center will accept all medically eligible obstetrical/neonatal patients. When beds are unavailable it will be the responsibility of the PERINATAL CENTER or Level III Center to locate and make arrangement for the transfer of patients to a hospital designated by the State of Illinois as a Level III Perinatal Unit. If the appropriate mode of transportation for transfer is ground, the LEVEL II with extended capabilities Center may provide transportation of the patient to the PERINATAL CENTER or Level III Center. If the PERINATAL CENTER transports the patient, when the transporting staff for the PERINATAL CENTER arrives at the LEVEL II with extended capabilities CENTER, PERINATAL CENTER shall be responsible for the care of the patients, providing that they have sufficient time to be briefed and initiate care and the LEVEL II with extended capabilities center and referring physician relinquish patient care management.

3.2 MATERNAL REFERRALS

- a. Physicians will consult and/or transfer to the PERINATAL CENTER or Level III Center obstetrical patients who require the services of the PERINATAL CENTER, including but not limited to, patients outlined in the perinatal rules and regulations (see Appendix A for patients to be included for consultation or transfer).

Outpatient consultations for maternal high-risk conditions will be performed in either the Maternal-Fetal Medicine Clinics, Level III Center or the PERINATAL CENTER. It will be the responsibility of the primary care physician to consult the Maternal/Fetal Medicine Specialist in accordance with the guidelines set forth in the high-risk conditions listed in the Perinatal Healthcare Code. The Maternal-Fetal Medicine Specialists at the PERINATAL CENTER and Level III Center are also available for telephone consults.

Provena Covenant Medical Center will have responsibility, through a peer review process, for assuring Maternal-Fetal Medicine consultations are obtained appropriately, as stipulated in the perinatal rules and regulations, for hospitalized maternal/fetal patients.

- b. Requests for transport of high-risk mothers may be initiated by any physician or his designee at the LEVEL II with extended capabilities center. The Director of Maternal/Fetal Medicine or his designee, after consultation with the referring physician at the LEVEL II with extended capabilities center, will decide whether to have patient remain at the LEVEL II with extended capabilities center, or be transferred immediately. Additionally, the best possible transport mechanisms from available alternatives and the staff needed for transport will be determined.
- c. The following information shall accompany the patient being transferred:

Admission form	Laboratory Values
Admission History/Physical	Prenatal Records
Physician Progress Notes	Outpatient Testing Dates –Summary
Nurses Notes	Discharge Summary
Medical History	

- d. Twenty four hotlines for immediate consultation, referral, and transport of Maternal-Fetal patients:

1-309-655-2027 1-309-655-2367 1-309-655-2000

3.3 NEONATAL REFERRALS

- a. Physicians will consult and/or transfer to the PERINATAL CENTER or Level III Center neonatal patients who require the services of the PERINATAL CENTER or Level III Center including but not limited to, patients outlined in the perinatal rules and regulations (see Appendix B for patients to be included for consultation or transfer).
- b. Decisions regarding transport personnel and mode of transport remain with the neonatologist on call.

- c. Twenty-four hour neonatal hotlines for immediate consultation, referral, and transport of neonatal patients are available.

1-309-655-2106

1-309-655-2107

1-309-655-2000

- d. Information to accompany the patient at the time of transfer should include the following.

Admission form

Physician's Progress Notes

Laboratory Values

Admission History/Physical

Nurses Notes

Transfer Summary

IV. EDUCATIONAL SERVICES

- 4.1 The PERINATAL CENTER agrees that a professional outreach education program is essential to the goal of improved pregnancy outcomes. The PERINATAL CENTER will collaborate with the LEVEL II with extended capabilities center and other LEVEL III CENTERS to meet the regional outreach education needs.
- 4.2 In an effort to enhance present educational objectives, the LEVEL II with extended capabilities CENTER and the PERINATAL CENTER will collaborate on the content of outreach education programs emphasizing improved accessibility of the educational programs throughout the Region.

V. FOLLOW-UP AND REPORTING SERVICES

- 5.1 The PERINATAL CENTER and LEVEL II with extended capabilities center shall work together to institute an enhancement for the current Illinois Department of Public Health Perinatal Report of Activities. This will be instituted in order to identify need for perinatal services in the REGION. The information obtained will be reported to the PERINATAL CENTER on a monthly basis.
- 5.2 The LEVEL II with extended capabilities center shall designate a person to coordinate the community nursing follow-up referral process as required by the Illinois Department of Public Health rules with the designated local agency.
- 5.3 The LEVEL II with extended capabilities center and the PERINATAL CENTER agree to periodically review the methodology of evaluation and reporting for the service units as mandated by the Division of Family Health of the Illinois Department of Human Services and Public Health.

VI. JOINT MORTALITY AND MORBIDITY REVIEWS

The PERINATAL CENTER will conduct quarterly reviews of perinatal activities with the LEVEL II with extended capabilities center.

- 6.1 The success of this joint venture in the delivery of intensive perinatal care is expected to be ensured by the continuous cooperation of the St. Francis Perinatal Center and Provena Covenant Medical Center. Periodic review of the activities of the perinatal services and appropriate recommendations for adjustments in the delivery of perinatal care will be the responsibility of the OSF Saint Francis Perinatal Review Committee.

- 6.2 Case reviews will determine:
 - a. The appropriateness of the diagnosis.
 - b. The appropriateness of the treatment rendered. This will include whether the treatment was adequate for the condition, and whether the treatment was withheld due to the severity of the handicap or potential neuro-developmental disability.
 - c. The appropriateness of information, counseling, and referral for the family.
- 6.3 If it is determined that a decision to withhold care was made because of the severity of the fetus/neonate's handicap or potential neuro-developmental disability this case will be reviewed by the Care Decision's Committee of the PERINATAL CENTER.
- 6.4 It is the responsibility of the LEVEL II with extended capabilities Chairpersons of Obstetrics and Pediatrics to determine cases in which care may have contributed to the morbidity/mortality of the patient and refer these for discussion to the Case Review Meeting.
- 6.5 Joint Mortality and Morbidity conferences for Level I and Level II hospitals that are affiliated with the PERINATAL CENTER will be provided twice annually.
- 6.6 Data from the Morbidity/Mortality Reviews will be collected and utilized as a framework for Network Continuous Quality Improvement Activities. It is also the responsibility of the LEVEL II with extended capabilities Center to participate in Network and State Wide Quality Improvement Activities.

VII. REVIEW OF PERINATAL DEATH AND HANDICAPPING CONDITIONS

- 7.1 All perinatal deaths and infants included in the Adverse Pregnancy Outcome Reporting System will be reviewed by the LEVEL II with extended capabilities CENTER.
 - a. These reviews will be held at least every two months.
 - b. The LEVEL II with extended capabilities center will determine the make-up of its own review committee and the format of the review meetings.
 - c. General minutes of the review meetings will be forwarded to the Perinatal Center.
 - d. It is the responsibility of the LEVEL II with extended capabilities CENTER Chairpersons of Obstetrics and Pediatrics to conduct these meetings and determine the appropriateness of care.

VIII. IDENTIFICATION OF CHILDREN WITH HANDICAPPING CONDITIONS

- 8.1 The primary care physician will be responsible for the identification of high risk obstetrical patients and fetus/newborns with actual or potential handicaps or developmental disabilities. This includes determination of the need for referral for more intensive or specialized care than what is locally available.
- 8.2 The LEVEL III CENTER Ethics Committee may be consulted regarding ethical questions. The Care Decisions Committee at the PERINATAL CENTER will accept consultations from the LEVEL II with extended capabilities CENTER.
- 8.3 The provision of information, counseling and referral services shall occur within twenty-four (24) hours of identification of a life-threatening handicapping condition and prior to discharge in non-life threatening conditions, and shall be the responsibility of the primary care physician. Documentation of this transfer of information shall be maintained within the permanent medical record of the patient.

IX. TERM AND TERMINATION

- 9.1 Term. The promises and obligations herein contained shall commence as of December 1, 2005 for an initial term of one (1) year periods therefrom and shall be automatically renewed under like terms for one (1) year periods thereafter, unless either party gives to the other party written notice of intent not to renew this AGREEMENT at least ninety (90) days prior to the expiration of its initial term or the then-existing renewal period subject, however, to termination under Section 9.2.
- 9.2 Termination. This AGREEMENT may be sooner terminated on the first to occur of the following:
 - a. Written agreement by both parties to terminate this AGREEMENT.
 - b. Written direction by the Illinois Department of Public Health or Human Services to terminate this AGREEMENT.
 - c. In the event either party of this AGREEMENT shall, with or without cause, at anytime give to the other at least one hundred twenty (120) days advance written notice and upon approval by the Illinois Department of Public Health or Human Services to terminate, this AGREEMENT, shall terminate on the future date specified in such notice.
 - d. In the event of the material breach of any of the terms or conditions of this AGREEMENT by either party and the failure of the breaching party to correct such breach within (10) business days after written notice of such breach by either party, such other party may terminate the AGREEMENT within sixty (60) days by delivering to the breaching party written notice of termination and the effective date thereof.

- e. If either party is prevented from performing its obligations under this AGREEMENT by strikes or other labor disputes, official or unofficial; fire; war; flood; or any other reason beyond the party's reasonable control, each party's rights and obligations hereunder shall cease without further notice.

X. MISCELLANEOUS

- 10.1 Assignments. This AGREEMENT and all rights and benefits hereunder are personal to LEVEL II with extended capabilities CENTER and OSFHS and neither this AGREEMENT nor any right or interest of LEVEL II with extended capabilities CENTER or OSFHS herein, or arising hereunder, shall be voluntarily or involuntarily sold, transferred, or assigned without written consent by the other party, and any attempt at assignment is void. However, OSFHS shall have the right to assign this AGREEMENT to an affiliate or subsidiary corporation.
- 10.2 Independent Contractor. It is expressly acknowledged by the parties that they are independent contractors and that nothing in this AGREEMENT is intended nor shall be construed to create an employer/employee relationship or a joint venture relationship between the parties.
- 10.3 Changes or Modifications. No change or modification of this AGREEMENT shall be valid unless the same shall be in writing signed by OSFHS and by the LEVEL II with extended capabilities CENTER. No waiver of any provision of the AGREEMENT shall be valid unless in writing and signed by the person or party against whom charged.
- 10.4 Entire Agreement. This AGREEMENT constitutes the entire AGREEMENT between the parties and contains all of the agreements between the parties with respect to the subject administrative and professional services at PRACTICE and at LEVEL II with extended capabilities CENTER. LEVEL II with extended capabilities CENTER and OSFHS shall be entitled to no benefits other than those specified here. LEVEL II with extended capabilities center and OSFHS acknowledge that in entering into and executing the AGREEMENT, they have relied solely upon the representations and agreements contained in this AGREEMENT. This AGREEMENT supersedes any and all other agreements either written or oral, between the parties with respect to the subject matter herein.
- 10.5 Notices. Notices required herein shall be considered effective when delivered in person or sent by United States Certified Mail, postage prepaid, return receipt requested and addressed to:

OSFHS
Keith Steffen
Administrator
Saint Francis Medical Center
530 N. E. Glen Oak Avenue
Peoria, Illinois 61637

LEVEL II CENTER
David Bertauski,
CEO
Provena Covenant Medical Center
1400 W. Park St.
Urbana, IL 61801

- 10.6 Governing Law. This AGREEMENT has been executed and delivered in, and shall be interpreted, construed, and enforced pursuant to and in accordance with the laws of Illinois.
- 10.7 Severability. The invalidity or unenforceability of any particular provision of this AGREEMENT shall not effect the other provisions hereof, and this AGREEMENT shall be construed in all respects as if such invalid or unenforceable provision were omitted.
- 10.8 Waiver of Breach. The waiver by either party or a breach or violation of any provision of the AGREEMENT shall not operate as, or be construed to be, a waiver of any subsequent breach of the same or other provision hereof
- 10.9 Headings. The section titles and other headings contained in this AGREEMENT are for reference only and shall not affect in any way the meaning or interpretation of this AGREEMENT.
- 10.10 Indemnification.
A. Level II with extended capabilities Center agrees to indemnify and hold harmless Perinatal Center from and against any and all liabilities, losses, damages, claims, or causes of action, including any expenses connected therewith (including reasonable attorney's fees), which directly or indirectly arise out of the negligent or willful acts or omissions of Level III Center or its employees, agents or representatives pursuant to this Agreement.
B. Perinatal Center agrees to indemnify and hold harmless Level II with extended capabilities Center from and against any and all liabilities, losses, damages, claims, or causes of action, including any expenses connected therewith (including reasonable attorney's fees), which directly or indirectly arise out of the negligent or willful acts or omissions of Perinatal Center or its employees, agents, or representatives pursuant to this Agreement.
- 10.11 Compliance. Perinatal Center acknowledges and shall uphold Level II with extended capabilities Center's commitment to compliance with all federal and state laws and regulations. Each party certifies to the other that it has not been excluded from participation in Medicare, Medicaid, or any other federal or state funded health care program. Both parties agree to maintain the confidentiality of all patient information encountered under the terms of this Agreement (including, but not limited to, medical records, electronic data, radiology films, laboratory blocks and slides and billing information) in accordance with applicable state and federal laws, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Standards of Privacy of Individually Identifiable Health Information promulgated by the federal Department of Health and Human Services pursuant to its authority under HIPAA.

IN WITNESS WHEREOF, the parties hereto have executed the AGREEMENT in multiple originals on the last date written below.

OSFHS:

OSF HEALTHCARE SYSTEM
An Illinois not-for-profit
Corporation, owner and operator
of Saint Francis Medical Center

By: *Kirk Stephen*
Title: CEO
Dated: 2/16/06

AFFILIATE:

Provena Covenant Medical Center

By: *Del Betti*
Title: CEO
Dated: 12/12/15

APPENDIX A
Level II with extended capabilities Center

MATERNAL:

For the following maternal conditions, consultation with a maternal-fetal medicine subspecialist, with subsequent management and delivery at the appropriate facility, as determined by mutual collaboration is recommended.

1. Current obstetric history suggestive of potential difficulties such as:
 - a. intrauterine growth restriction
 - b. prior neonatal death
 - c. two or more previous preterm deliveries less than 34 weeks gestation
 - d. single previous preterm deliveries less than 30 weeks gestation
 - e. birth of neonate with serious complications resulting in a handicapping condition
 - f. recurrent spontaneous abortion or fetal demise
 - g. family history of genetic disease

2. Active chronic medical problems with known increase in perinatal mortality, such as:
 - a. cardiovascular disease Class I and Class II
 - b. autoimmune disease
 - c. reactive airway disease requiring treatment with systemic corticosteroids
 - d. seizure disorder
 - e. controlled hypothyroidism on replacement therapy
 - f. hypertension controlled on a single medication
 - g. idiopathic thrombocytopenia purpura
 - h. thromboembolic disease
 - i. malignant disease (especially when active)
 - j. renal disease with functional impairment
 - k. human immunodeficiency viral infection (consultation may be with maternal-fetal medicine or infectious disease subspecialist)

3. Selected obstetric complications that present prior to 34 weeks gestation, such as:
 - a. suspected intrauterine growth restriction
 - b. polyhydramnios
 - c. oligohydramnios
 - d. pre-eclampsia/pregnancy induced hypertension
 - e. congenital viral disease
 - f. maternal surgical conditions
 - g. suspected fetal abnormality or anomaly
 - h. isoimmunization with antibody titers greater than 1:8
 - i. antiphospholipid syndrome

4. Abnormalities of the reproductive tract known to be associated with an increase in preterm delivery, such as:
 - a. uterine anomalies
 - b. diethylstilbesterol exposure

5. Insulin dependent diabetes Class A2 and B or greater (White's criteria)

For the following maternal conditions, referral to a maternal-fetal medicine subspecialist for evaluation shall occur. Subsequent patient management and site of delivery shall be determined by mutual collaboration between the patient's physician and the maternal-fetal medicine subspecialist.

1. Selected chronic medical conditions with a known increase in perinatal mortality, such as:
 - a. cardiovascular disease with functional impairment (Class III or greater)
 - b. respiratory failure requiring mechanical ventilation
 - c. acute coagulopathy
 - d. intractable seizures
 - e. coma
 - f. sepsis
 - g. solid organ transplantation
 - h. active autoimmune disease requiring corticosteroid treatment
 - i. unstable reactive airway disease
 - j. renal disease requiring renal dialysis or with a serum creatinine concentration greater than 1.5 mg%
 - k. active hyperthyroidism
 - l. hypertension that is unstable or requires more than one medication to control
 - m. severe hemoglobinopathy
2. Selected obstetric complications that present prior to 30 weeks gestation, such as:
 - a. multiple gestation with more than two fetuses
 - b. twin gestation complicated by demise, discordancy, or maldevelopment of one fetus or by fetal-fetal transfusion
 - c. premature labor unresponsive to first-line tocolytics
 - d. premature rupture of membranes
 - e. medical and obstetrical complications of pregnancy possibly requiring induction of labor or non-emergent caesarean section for maternal or fetal indications, such as severe pre-eclampsia
3. Isoimmunization with possible need for intrauterine transfusion
4. Insulin-dependent diabetes mellitus Classes C, D, R, F, or H (White's criteria)
5. Suspected congenital anomaly or abnormality requiring an invasive fetal procedure, neonatal surgery or postnatal medical intervention to preserve life, such as:
 - a. fetal hydrops
 - b. pleural effusion
 - c. ascites
 - d. persistent fetal arrhythmia
 - e. major organ system malformation-malfunction
 - f. genetic condition

APPENDIX B
LEVEL II with extended capabilities Center

NEONATAL:

For the following neonatal conditions, Perinatal Center consultation is recommended. Transfer to a Level III or Perinatal Center will occur when mutually agreed upon by the Level II with extended capabilities neonatologist and a neonatologist at the Perinatal Center.

1. Premature birth with gestation less than 30 weeks gestation.
2. Infants with a birth weight less than 1251 grams.
3. Infants with significant congenital heart disease associated with cyanosis, congestive heart failure, or impaired peripheral blood flow.
4. Infants with major congenital malformations requiring immediate comprehensive evaluation or neonatal surgery.
5. Infants requiring neonatal surgery with general anesthesia.
6. Infants with sepsis, unresponsive to therapy, associated with persistent shock or other organ system failure.
7. Infants with uncontrolled seizures
8. Infants with stupor, coma, hypoxic- ischemic encephalopathy Stage II or greater.
9. Infants requiring double-volume exchange transfusion
10. Infants with metabolic derangement persisting after initial correction therapy.
11. Infants identified as having handicapping conditions that threaten life for which transfer can improve outcome.
12. Provena Covenant Medical Center agrees to provide a physician or advanced practice nurse, experienced in the management of mechanically ventilated infants, in the hospital during the entire time that an infant receives mechanical ventilation. In addition, a licensed respiratory care practitioner with documented competence and experience in the care of mechanically ventilated infants must also be available to the nursery during the entire time the infant receives mechanical ventilation. If these services are not available the infant will be transferred to a Level III Center for care.

Audited Financial Statements as evidence of the availability of funds are provided in the Certificate of Need application addressing the change of ownership of Resurrection Medical Center



March 22, 2011

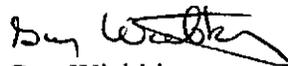
Illinois Health Facilities
and Services Review Board
Springfield, Illinois

RE: FUNDING OF PROJECT

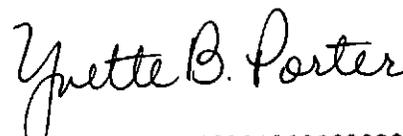
To Whom It May Concern:

I hereby attest that all of the real costs associated with the changes of ownership of the facilities directly or indirectly owned and/or controlled by either Resurrection Health Care Corporation or Provena Health will be funded in total with cash or equivalents.

Sincerely,


Guy Wiebking
President and CEO

Notarized:





ATTACHMENT 42A

7435 West Talcott Avenue
Chicago, Illinois 60631
773.792.5555



Sandra Bruce, FACHE
President & Chief Executive Officer

March 22, 2011

Illinois Health Facilities
and Services Review Board
Springfield, Illinois

RE: FUNDING OF PROJECT

To Whom It May Concern:

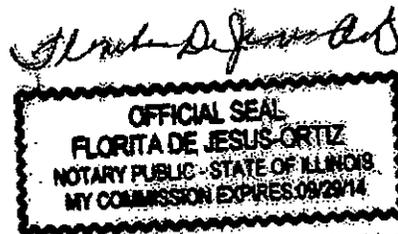
I hereby attest that all of the real costs associated with the changes of ownership of the facilities directly or indirectly owned and/or controlled by Resurrection Health Care Corporation will be funded in total with cash or equivalents.

Sincerely,

A handwritten signature in cursive script that reads "Sandra Bruce".

Sandra Bruce, FACHE
President & Chief Executive Officer

Notarized:



OPERATING and CAPITAL COSTS
per ADJUSTED PATIENT DAY

Provena Covenant Medical Center
2012 Projection

ADJUSTED PATIENT DAYS:

\$	<u>86,330,000</u>	
\$	2,764	31,236

OPERATING COSTS

salaries & benefits	\$ 63,043,000
supplies	<u>\$ 22,375,000</u>
TOTAL	\$ 85,418,000

Operating cost/adjusted patient day:	\$ 2,734.61
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CAPITAL COSTS

depreciation, amortization and interest	\$ 11,785,000
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Capital cost/adjusted patient day:	\$ 377.29
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Project Overview

Resurrection Health Care Corporation ("Resurrection") and Provena Health ("Provena") propose a merging of the two systems that will better position the combined system's hospitals, long-term care facilities, outpatient centers and other programs and facilities to continue to serve the patients and communities that have traditionally looked to those facilities and programs for care. As explained below and throughout the application, this system merger is intended to preserve access to Catholic health care; improve financial viability; improve patient, employee, and medical staff satisfaction through a shared culture and integrated leadership; and position the combined system for innovation and adaptation under health care reform.

This Project Overview supplements the Narrative Description provided in Section I.3. of the individual Certificate of Need applications filed to address the change of ownership of each of the thirteen (13) hospitals, one (1) ambulatory surgical treatment center (ASTC) and one (1) end stage renal dialysis (ESRD) facility currently owned or controlled by either Provena or Resurrection; and highlights the overall features of the proposed system merger.

Provena's hospitals are located primarily in the communities to the west of Chicago and in central Illinois, and Resurrection's hospitals are located in Chicago and communities to the north of Chicago. None of either system's hospital service areas overlap with those of any hospitals in the other system. Therefore, the proposed merger will not result in duplicative clinical services in any geographic area.

The proposed transaction would affect thirteen (13) hospitals, twenty-eight (28) long-term care facilities, one (1) ASTC, one (1) ESRD facility, an expanding health science university, six (6) home health agencies, and approximately fifty-eight (58) other freestanding outpatient sites. Resurrection is the sole member of seven (7) of the hospitals and Provena is the sole member of six (6) of the hospitals. The ASTC is a joint venture in which Resurrection has "control" pursuant to the IHFSRB definition, and the ESRD is a joint venture in which Provena has such "control".

About Provena Health

Provena Health is a health care system that was established in 1997 through the merging of the health care services of the Franciscan Sisters of the Sacred Heart, the Sisters of Mercy of the Americas—Chicago Regional Community (now West Midwest Community), and the Servants of the Holy Heart of Mary. These three congregations of religious women are now the sponsors of Provena Health. The primary reason for the formation of Provena Health was to strengthen the Catholic health ministry in Illinois, which at the time of formation was a major goal of the late Joseph Cardinal Bernardin, Archbishop of Chicago.

Today, Provena Health operates six acute care hospitals, twelve long-term care facilities, four senior residential facilities and a variety of freestanding outpatient facilities and programs.

About The Resurrection Health Care System

The Resurrection Health Care System grew from a single hospital, now known as Resurrection Medical Center, established by the Sisters of the Resurrection in northwest Chicago in the early 1950s. A second hospital, Our Lady of the Resurrection, was added in 1988. During the period from late 1997 through 2001, six more hospitals joined the Resurrection system. During the same period, eight Chicago area licensed long-term care facilities, three retirement communities, a home care agency, an ambulatory surgery center, and numerous freestanding outpatient facilities became part of Resurrection Health Care System. The Resurrection system is co-sponsored by two congregations of Catholic religious women, the Sisters of the Resurrection and the Sisters of the Holy Family of Nazareth.

In 2010, following a thorough discernment process, and in response to an immediate need to address financial concerns, Resurrection Health Care Corporation divested itself of two hospitals; Westlake Hospital and West Suburban Medical Center (IHFSRB Permits 10-013 and 10-014) to ensure that the two hospitals would be able to continue to serve their communities.

Decision to Merge and Goals of the Merger

In late 2010, Provena and Resurrection leadership began discussions to explore the potential benefits of a system merger. In addition to their clear mission compatibility, the two systems share many similar priorities related to clinical integration, administrative efficiencies and strategic vision. While their respective facilities are geographically proximate, their markets do not overlap, providing opportunities to strengthen all facilities through operational efficiencies and enhanced clinical collaborations.

This system merger decision was made in the larger context of a rapidly changing health care delivery environment. Across the nation, hospitals and other health care providers are addressing health care reform through various forms of integration and consolidation. These actions are thought necessary to achieve improved quality of care, efficiency of service delivery, and patient, medical staff, and employee satisfaction—all critical components of future success.

For Catholic-sponsored health care providers, including Resurrection and Provena, these adaptations to health care reform must be consistent with the mission and values inherent in the religious sponsorship of health care providers. This particular merger would afford Provena and Resurrection the opportunity to achieve essential systemic enhancements in a mission-compatible manner.

The Provena and Resurrection systems have, since 2008, been equal partners in Alverno Clinical Laboratories, LLC, which provides clinical pathology services to each of Resurrection's and Provena's thirteen hospitals, as well as a variety of other facilities.

Structure of the Transaction and Commitments

Through the proposed transaction, the Resurrection and Provena systems will merge through a common, not-for-profit, charitable "super parent" corporation that will become the parent entity of Resurrection Health Care Corporation (the current Resurrection system parent) and Provena Health (the current Provena system parent). Both of the current parent entities will continue to exist and operate, and will continue to serve as the direct parents of their respective subsidiary entities. It is the applicants' expectation that, for a minimum of two years, no Resurrection or Provena hospital or hospitals will be eliminated or restructured in the course of the system merger, and no health care facilities will require new or modified health facilities licenses as a result of the system merger. A chart depicting this proposed merged structure is attached as Exhibit A. The executed System Merger Agreement submitted with this application, provides detail regarding the means by which the super parent will exercise unified corporate oversight for the combined system.

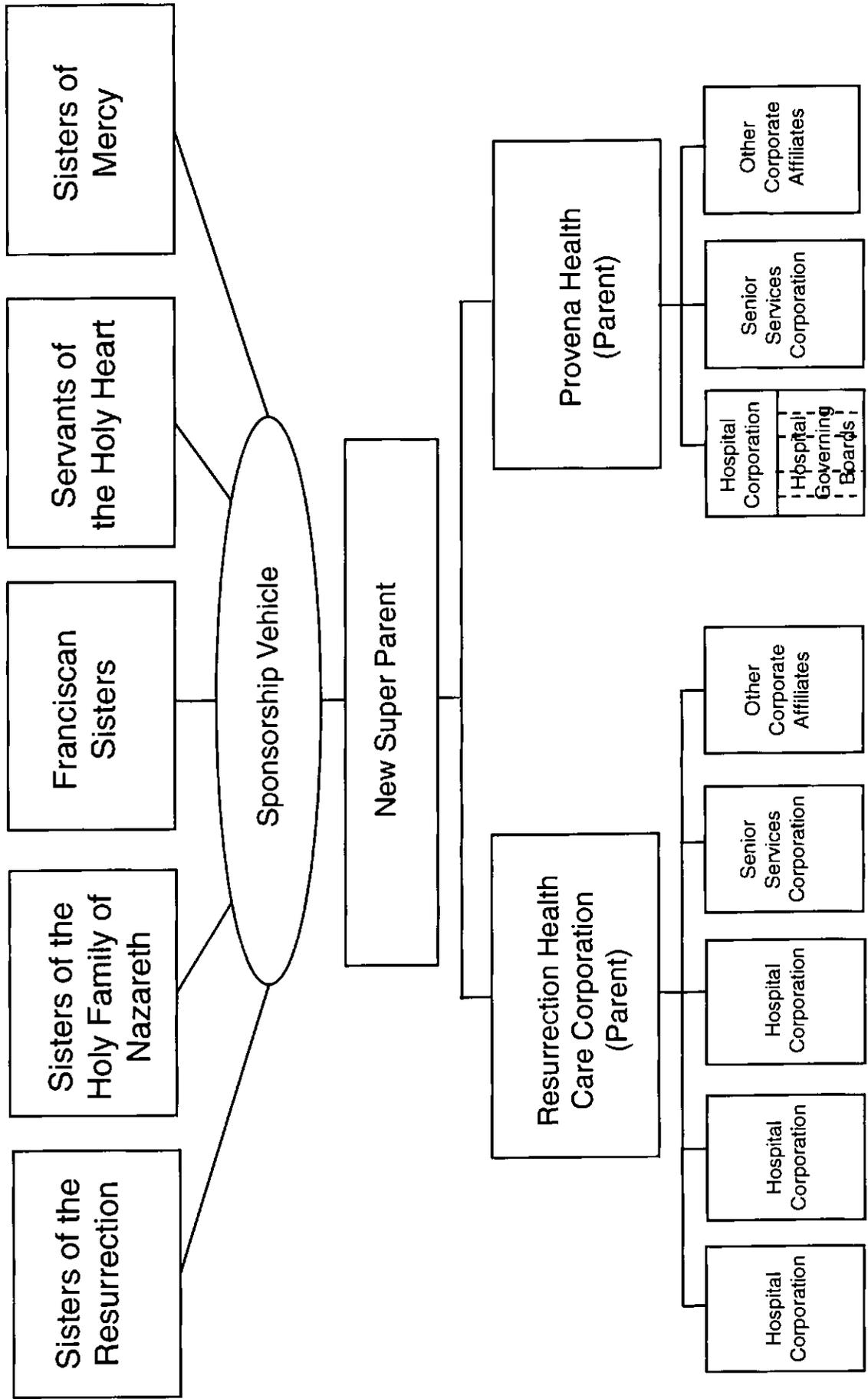
A co-applicant in each Certificate of Need application is Cana Lakes Health Care, which is an existing Illinois not-for-profit corporation. The Cana Lakes corporation will be reconstituted to serve as the super parent entity, through amendment of its corporate documents to reflect unified governance and corporate oversight. The Bylaws of the Super Parent will detail the composition of the Board of Directors; reserve powers of the five (5) religious sponsors; and other governance matters typically addressed in such documents. These Bylaws will be substantially in the form of an exhibit to the System Merger Agreement.

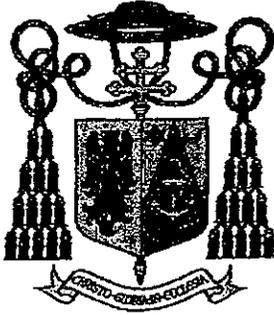
The licensees of the individual hospitals, long-term care facilities and the ASTC will not change. All of Resurrection's clinical programs and all of Provena's clinical programs will be included in the new structure.

The health care facilities and services will continue to operate as Catholic facilities, consistent with the care principles of the Ethical and Religious Directives for Catholic Health Care Services. It is the expectation of the applicants that all major clinical programs will be maintained for a minimum of two years, and each hospital will operate with non-discrimination and charity care policies that are no more restrictive than those currently in place.

The proposed transaction, while meeting the IHFSRB's definition of a "change of ownership" as the result of a new "super parent" entity, is a system merger through a straight forward corporate reorganization, without any payment to Resurrection by Provena, or to Provena by Resurrection. The only true costs associated with the transaction are those costs associated with the transaction itself. The merger is being entered into following thorough due diligence processes completed by both Provena and Resurrection, as well as independent analyses commissioned by Resurrection and by Provena.

Super Parent Structure





ARCHDIOCESE OF CHICAGO

OFFICE OF THE ARCHBISHOP

March 17, 2011

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

Dear Ms. Avery,

Resurrection Health Care Corporation and Provena Health have proposed a merging of the two systems that will better position the combined system's hospitals, long-term care facilities, outpatient centers and other programs and facilities to continue to serve the patients and communities that have traditionally looked to them for care. This system merger is intended to improve the financial viability of both entities as well as enhance patient, employee and medical staff satisfaction. Through a shared culture and integrated leadership, this merger would also position the combined system for innovation and adaptation under health care reform.

The proposed merger will position Resurrection and Provena to strengthen and improve access to Catholic health care in Illinois. This has long been an area of great interest and concern for me, and I am grateful for the willingness of two of our state's premier Catholic providers to collaborate in order to meet the current challenges in health care. As they do now, the combined systems will operate without any restrictive admissions policies related to race, ethnic background, religion, payment source, or any other factor. The new system will continue to admit Medicare and Medicaid recipients and to care for those patients in need of charity care.

This proposed merger has my full support and I can assure you that both Resurrection Health Care and Provena Health are working together collegially and in the best interests of their communities to strengthen and improve access to high quality, highly accountable Catholic health care in the State of Illinois.

Sincerely yours,

Francis Cardinal George, O.M.I.
Archbishop of Chicago



March 28, 2011

Ms. Courtney Avery, Administrator
Illinois Health Facilities and
Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, IL 62761

RE: Merger of Provena Health and Resurrection Health Care Corporation

Dear Ms. Avery:

We represent the five communities of women religious who seek the approval of the Illinois Health Facilities and Services Review Board to form a new Catholic health system to serve the citizens of Illinois through a merger of Provena Health and Resurrection Health Care Corporation.

As individual health systems, Provena Health and Resurrection Health Care have long provided compassionate healing to those in need. In keeping with the true spirit of the Sisters who came before us, ours have been ministries deeply focused on quality care for all, regardless of one's ability to pay.

Now, as we anticipate Health Reform and the sweeping changes that will transform the delivery of care as we have come to know it, we are keenly aware that the key to sustaining and growing our person-centered Mission lies in the strength of enduring partnerships we forge today.

By coming together, our two health systems would create the single largest Catholic healthcare network in the State, spanning 12 hospitals, 28 long-term care and senior residential facilities, more than 50 primary and specialty care clinics and six home health agencies, all serving adjacent, non-conflicting markets. A combined Provena Health and Resurrection Health Care would also represent one of the State's largest health systems, with locations throughout Chicago, the suburbs of Des Plaines, Evanston, Aurora, Elgin, Joliet and Kankakee, and Rockford, Urbana, Danville, and Avilla, Indiana, providing services for patients and residents across the continuum through nearly 100 sites of care.

Rooted in the tradition of Catholic healthcare, the new system would be distinguished by an ability to deliver quality care across the continuum from a broad and complementary base of leading edge locations and physician networks. From a foundation steeped in a shared heritage and set of values, the new system would give rise to an enormous potential to truly improve the wellbeing of generations of Illinoisans to come.

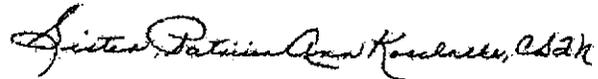
With a dedicated and talented combined team of nearly 5,000 physicians, supported by over 22,000 employees, the new system will play an important role in the economic vitality of the communities in which we serve. Above all, our partnership will remain true to the hallmarks of our Catholic identity: promoting and protecting the dignity of every individual from conception to death, caring for the poor and vulnerable and properly stewarding our precious people and financial resources.

A combined Provena Health and Resurrection Health Care will strengthen and expand access to an exceptional tradition of quality care and service millions of Illinois residents have come to know and depend upon for more than a century. On behalf of the women religious whose communities are sponsoring the proposal before you, we request your approval.

Gratefully,



Sister Mary Elizabeth Imler, OSF
Chairperson
Provena Health Member Body



Sister Patricia Ann Koschalke, CSFN
Chairperson
Resurrection Health Care Sponsorship Board