

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD  
APPLICATION FOR PERMIT

DEC 20 2012

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

HEALTH FACILITIES &  
SERVICES REVIEW BOARD

Facility/Project Identification

Facility Name:	Trinity Rock Island – Heart Center and Emergency Department				
Street Address:	2701 17 <sup>th</sup> Street				
City and Zip Code:	Rock Island				61201
County:	Rock Island	Health Service Area	10	Health Planning Area:	C-05

Applicant /Co-Applicant Identification (See next page for additional applicants)

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

Exact Legal Name:	Trinity Medical Center				
Address:	2701 17 <sup>th</sup> Street, Rock Island, Illinois 61201				
Name of Registered Agent:	Steven J. Gross				
Name of Chief Executive Officer:	Rick Seidler				
CEO Address:	2701 17 <sup>th</sup> Street, Rock Island, Illinois 61201				
Telephone Number:	309-779-2200				

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.
- o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

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

Primary Contact

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

Name:	Jay Willsher
Title:	Chief Operating Officer
Company Name:	Trinity Medical Center
Address:	2701 17 <sup>th</sup> Street, Rock Island, Illinois 61201
Telephone Number:	309-779-5020
E-mail Address:	willshja@ihs.org
Fax Number:	309-779-2399

Additional Contact

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

Name:	Janet Scheuerman
Title:	Senior Consultant
Company Name:	PRISM Healthcare Consulting
Address:	1808 Woodmere Drive, Valparaiso, Indiana 46383
Telephone Number:	219-464-3969
E-mail Address:	prismjanet@aol.com
Fax Number:	219-464-0027

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

**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION****This Section must be completed for all projects.****Facility/Project Identification**

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City and Zip Code:	Rock Island				61201
County:	Rock Island	Health Service Area	10	Health Planning Area:	C-05

**Applicant /Co-Applicant Identification (See next page for additional applicants)****[Provide for each co-applicant [refer to Part 1130.220].**

Exact Legal Name:	Trinity Regional Health System				
Address:	2701 17 <sup>th</sup> Street, Rock Island, Illinois 61201				
Name of Registered Agent:	Tamara Byram				
Name of Chief Executive Officer:	Rick Seidler				
CEO Address:	2701 17 <sup>th</sup> Street, Rock Island, Illinois 61201				
Telephone Number:	309-779-2200				

**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
<ul style="list-style-type: none"> <li>o Corporations and limited liability companies must provide an <b>Illinois certificate of good standing</b>.</li> <li>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.</li> </ul>					
<p><b>APPEND DOCUMENTATION AS ATTACHMENT-1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b></p>					

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

Name:	Jay Willsher
Title:	Chief Operating Officer
Company Name:	Trinity Medical Center
Address:	2701 17 <sup>th</sup> Street, Rock Island, Illinois 61201
Telephone Number:	309-779-5020
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**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD  
APPLICATION FOR PERMIT**

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Street Address:	2701 17 <sup>th</sup> Street				
City and Zip Code:	Rock Island				61201
County:	Rock Island	Health Service Area	10	Health Planning Area:	C-05

**Applicant /Co-Applicant Identification (See next page for additional applicants)****[Provide for each co-applicant [refer to Part 1130.220].**

Exact Legal Name:	Iowa Health System				
Address:	1776 West Lakes Park, Suite 400, Des Moines, Iowa 50261				
Name of Registered Agent:	William B. Leaver, President/Chief Executive Officer				
Name of Chief Executive Officer:	William B. Leaver				
CEO Address:	1200 Pleasant Street, Des Moines, Iowa 50309				
Telephone Number:	515-241-6347				

**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
<ul style="list-style-type: none"> <li>o Corporations and limited liability companies must provide an <b>Illinois certificate of good standing</b>.</li> <li>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.</li> </ul>					
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[Person to receive all correspondence or inquiries during the review period]

Name:	Jay Willsher
Title:	Chief Operating Officer
Company Name:	Trinity Medical Center
Address:	2701 17 <sup>th</sup> Street, Rock Island, Illinois 61201
Telephone Number:	309-779-5020
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**Additional Contact**

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

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Title:	Senior Consultant
Company Name:	PRISM Healthcare Consulting
Address:	1808 Woodmere Drive, Valparaiso, Indiana 46383
Telephone Number:	219-464-3969
E-mail Address:	prismjanet@aol.com
Fax Number:	219-464-0027

**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:	Jay Willsher
Title:	Chief Operating Officer
Company Name:	Trinity Medical Center
Address:	2701 17 <sup>th</sup> Street, Rock Island, Illinois 61201
Telephone Number:	309-779-5020
E-mail Address:	willshja@ihs.org
Fax Number:	309-779-2399

**Site Ownership**

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Trinity Medical Center
Address of Site Owner:	2701 17 <sup>th</sup> Street, Rock Island, Illinois 61201
Street Address or Legal Description of Site:	2701 17 <sup>th</sup> Street, Rock Island, Illinois 61201
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 <u>ATTACHMENT-2</u> , 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:	Trinity Medical Center d/b/a Trinity Rock Island		
Address:	2701 17 <sup>th</sup> Street, Rock Island, Illinois 61201		
<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"> <li>o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.</li> <li>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.</li> <li>o <b>Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.</b></li> </ul>			
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](http://www.FEMA.gov) or [www.illinoisfloodmaps.org](http://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)]

<p>Part 1110 Classification:</p> <p><input checked="" type="checkbox"/> Substantive</p> <p><input type="checkbox"/> Non-substantive</p>	<p>Part 1120 Applicability or Classification: [Check one only.]</p> <p><input type="checkbox"/> Part 1120 Not Applicable</p> <p><input type="checkbox"/> Category A Project</p> <p><input checked="" type="checkbox"/> Category B Project</p> <p><input type="checkbox"/> DHS or DVA Project</p>
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**2. Narrative Description**

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

The applicants, Iowa Health System, Trinity Regional Health System, and Trinity Medical Center d/b/a/ Trinity Rock Island, are proposing to construct a new 3-level tower and modernize existing space on the Trinity Rock Island campus at 2701 17<sup>th</sup> Street, Rock Island, Illinois 61201.

The proposed project has two major components, both of which are necessary to enhance health care for the residents of Trinity Rock Island's multi-county service area. They include a new Heart Center and relocated and enlarged Emergency Department which will be in new construction.

The proposed Heart Center/Emergency Department tower will have the following functions in new construction:

Level 3	Cardiac Rehabilitation, Non Invasive Diagnostic Testing (NIDT), Community Education
Level 2 (ground level)	Level II Trauma Center/Emergency Department (including General Radiology and Computerized Tomography), Observation Unit
Level 1 (below ground)	Invasive Cardiology (Cardiac Cath) Labs, Phase II Prep/Recovery (CTU)

The tower will be connected to the existing hospital at Level 1.

The following functions will be modernized in vacated space between the new construction at Level 2 and the existing facility.

Level 2 (ground level)	Crisis Stabilization Unit and Behavioral Health Group Therapy Rooms
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Narrative Exhibit 1 is a site plan showing the location of the new construction and modernization. Narrative Exhibit 2 is a stacking diagram showing the location of the functions in new construction and modernization. Narrative Exhibit 3 shows the connector between the new tower and the existing facility.

The project has received strong community support; letters of support are included as Narrative, Exhibit 4.

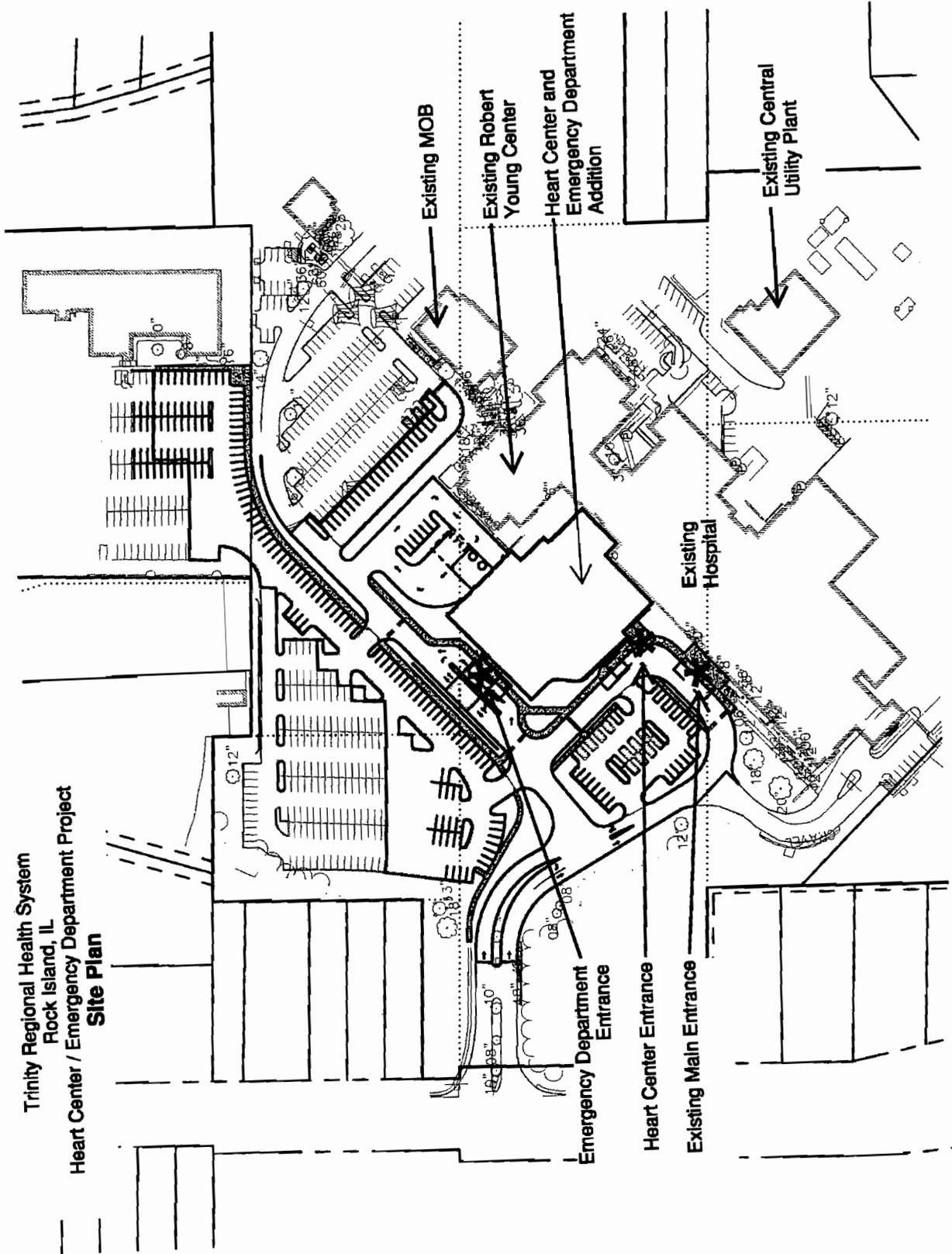
The proposed project is expected to be completed by July 31, 2016.

The project will include 184,245 GSF of square footage; of the total, 90,765 GSF will be in new construction, 8,065 GSF will be in modernization and there will be 85,415 GSF "as is". There will be 59,515 GSF of clinical space and 124,730 of non clinical space.

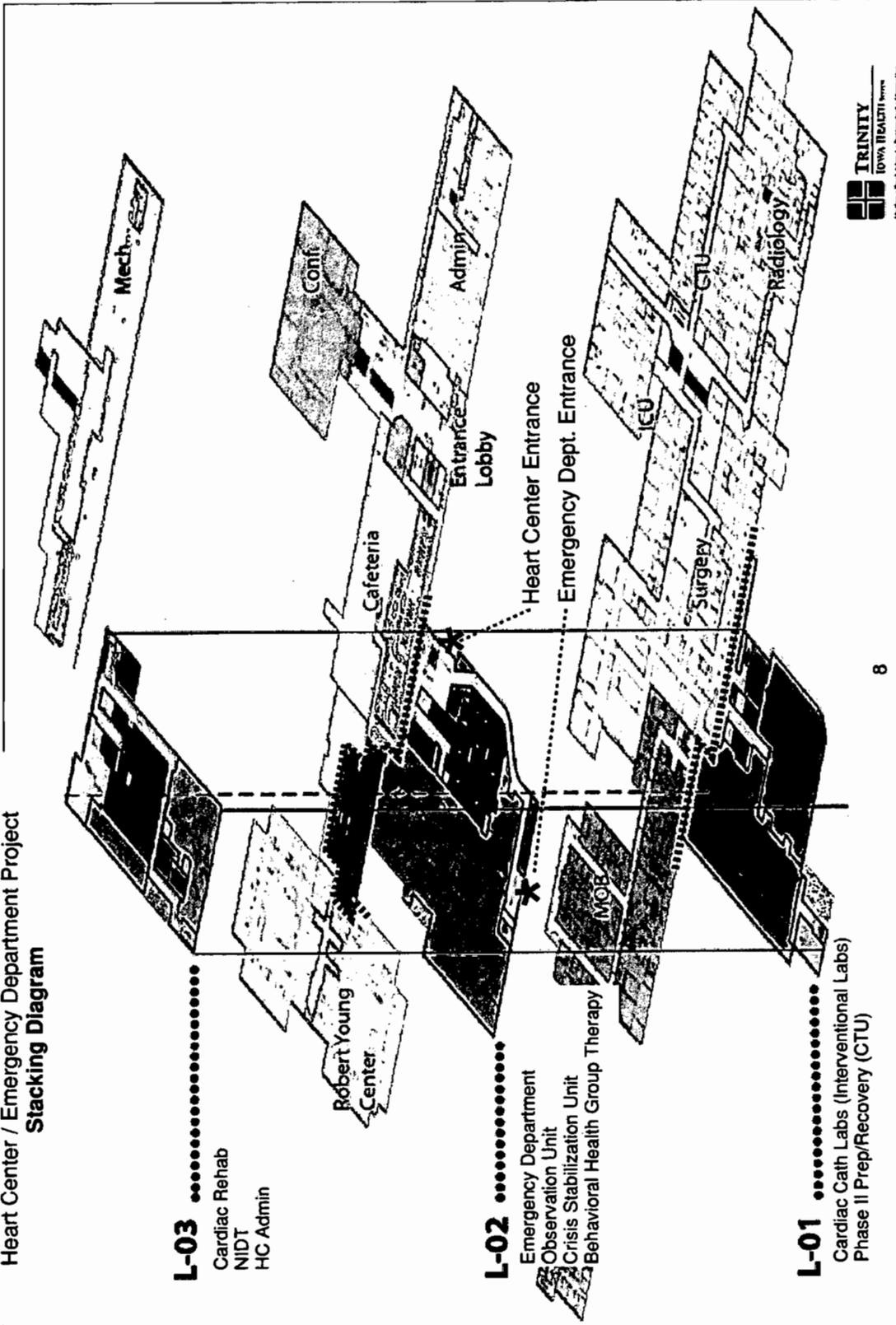
Total project cost is expected to be \$63,221,976. The project will be funded with cash and securities and pledges.

In accordance with the Illinois Administrative Code, Chapter II, Section 1110.40 (b), the project is classified as substantive because it is neither emergency nor non substantive; further total project cost exceeds the current HFSRB threshold.

Trinity Regional Health System  
 Rock Island, IL  
 Heart Center / Emergency Department Project  
 Site Plan



Trinity Regional Health System  
 Rock Island, IL  
 Heart Center / Emergency Department Project  
**Stacking Diagram**



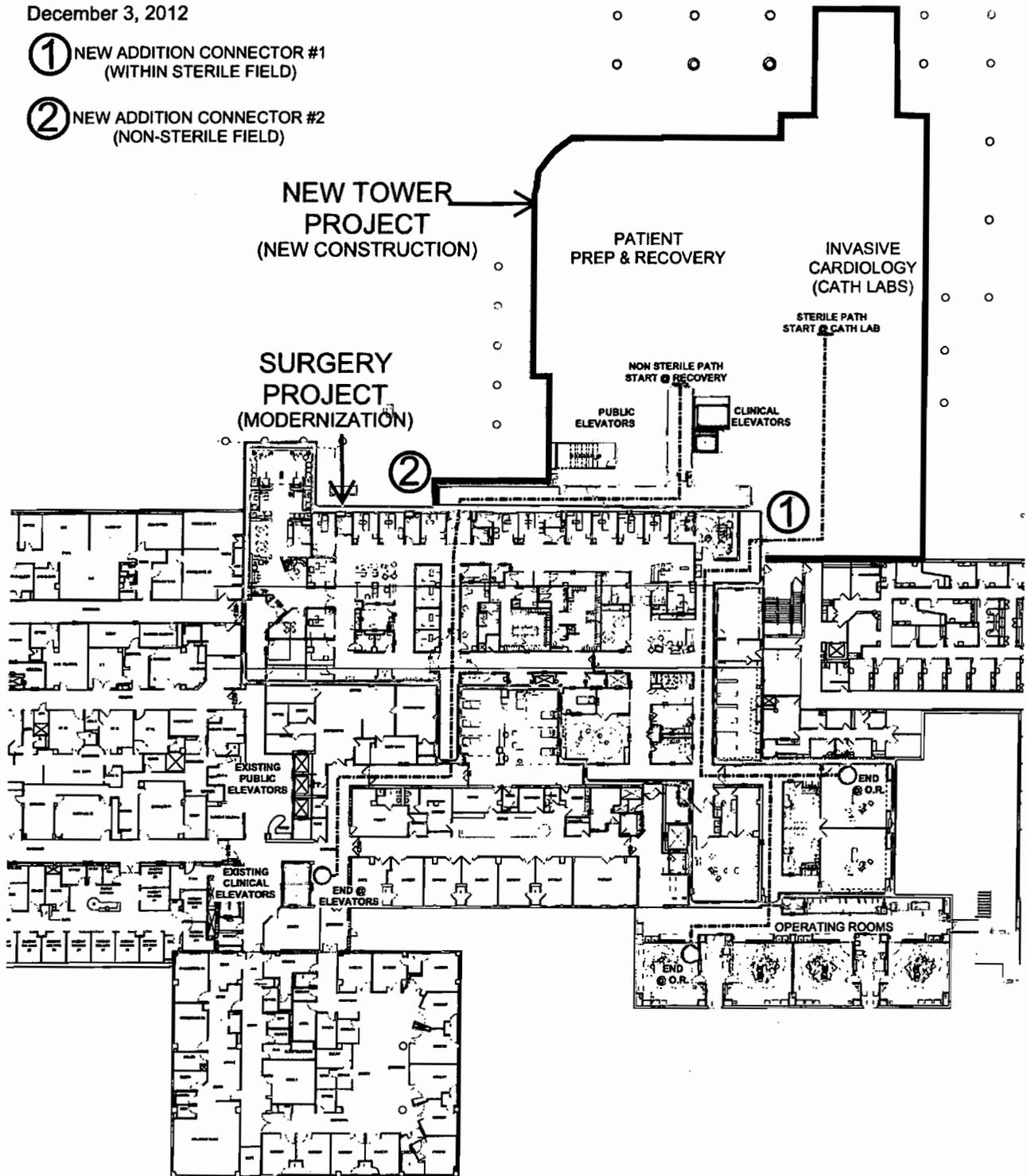
8

9

**TRINITY ROCK ISLAND HOSPITAL  
NEW TOWER PROJECT & SURGERY PROJECT CONNECTORS  
LOWER LEVEL PLAN**

December 3, 2012

- ① NEW ADDITION CONNECTOR #1  
(WITHIN STERILE FIELD)
- ② NEW ADDITION CONNECTOR #2  
(NON-STERILE FIELD)



## Letters of Support

### Public Officials

Cheri Bustos, Congresswoman-Elect, Congress of the United States

Mike Jacobs, State of Illinois, Senate

Patrick J. Verschoore, State of Illinois, House of Representatives

Jordan Litvik, Executive Director, Regions 3 & 4, Illinois Department of Human Services

Division of Mental Health

Donald P. Welvaert, Mayor, City of Moline

John Thodos, Mayor, City of East Moline

Dennis E. Pauley, Mayor, City of Rock Island

### Community Leaders

Alternatives for the Older Adult, Kathy Weiman, CEO

Casa Guanajuato, Quad Cities, Michael D. Wood, PhD, Executive Director

CGH Medical Center, Edward Anderson, President and CEO

Community Health Care, Inc. Tom Bowman, CEO

Family Resources, Cheryl Godwin, President/CEO

Hammond-Henry Hospital, Bradley Solberg, CEO

International Association of Bridge, Structural, Ornamental and Reinforcing Iron Workers,

Local Union No. 111, Mike Wilcher, Financial Secretary-Treasurer-Business Manager

John Deere, Mara L. Soverly, Director, Corporate Citizenship Center of Excellence, President,  
John Deere Foundation

KJWW Engineering Consultants, Paul D. Van Duyne, PE, President

Local 25 Plumbers & Pipefitters, W. Thomas McCune, Jr. Business Manager

Martin Luther King Community Center, Rev. Dwight L. Ford, M.Div.

Midland Information Resources, Gene M. Blanc, C & O and Chairman

Missman, Inc. Professional Engineers and Land Surveyors, Patrick D. Eikenberry, President/CEO

Operative Plasterers' and Cement Masons', Local 18 of Central Illinois, Monte D. Schell,  
Business Agent

Quad Cities Chamber of Commerce, Tara Barney, President and CEO

Quad Cities Cities First, William A. Martin President

Quad City Community Healthcare, James K. Thomson, CEO

Renew Moline, Janet Mathis, Executive Director

Rock Island Public Health Department, Theresa Berg, MS, Interim Public Health Administrator

Rock Island Renaissance, Brian Hallenbeck, President

Tri-City Building and Construction Trades Council

The Y, Dan R. Osterman, CEO

Physicians and Other Clinical Leaders

Cardiac Surgery Associates, S.C. Alyas P. Chaudhry, MD.

Cardiac Surgery Associates, Bryan K. Foy, MD

Cardiovascular Medicine, PC, Kristine K. Zeller Administrator

Cardiovascular Medicine, Sanjeev Puri, MD, FACC

Cardiovascular Medicine, PC, Sora Reddy, MD

Kevin W. Kurth, MD, Emergency Physician

Metropolitan Medical Laboratory, PLC, Paula Y. Arnell, MD Laboratory Director

Manasi Nadkarni, MD, Vice President of Medical Affairs, Trinity Muscatine

Eric Ritterhoff, MD

Other Friends of Trinity Rock Island

Pryce Boeye, Former Trinity Health System Board Member

Carol Hancock

Jim and Carol Horstman, Trinity Volunteer and Former Board Member

Tina Morris, Patient

Pat Van Court, Trinity Volunteer

Pat Walkup, President, Friends of Trinity Medical Center

**Congress of the United States**  
**Washington, DC 20515**

December 10, 2012

Mr. Jay Willsher, C.O.O.  
Trinity Regional Health System  
2701 – 17<sup>th</sup> Street  
Rock Island, Ill. 61201

Dear Mr. Willsher:

I write today to express my strong support for the proposed new heart center and emergency department project for Trinity Medical Center's Rock Island Campus.

It is my hope that the State of Illinois' Health Facilities Planning Commission will approve this important project to allow Trinity to expand its Emergency Department and to build a new heart center at Trinity in Rock Island.

Trinity's Rock Island campus has never undergone major facility improvements since it was built in 1972 and is in need of this upgrade. This \$60 million project, one of the largest capital investments in Rock Island County in many years, will benefit the community through improved service and at the same time create jobs in the area.

The project will improve patient care and privacy and reduce operational inefficiencies. The new heart center will accommodate all of Trinity's heart center services on one campus, which will improve patient satisfaction.

The new heart center and emergency department will have a positive effect on the surrounding community. Please help expedite this important project so Trinity can continue to be a leader in the health care services it provides. Thank you for your consideration of this request.

Sincerely,



Cheri Bustos,  
Congresswoman-Elect (IL-17)

PRINTED ON RECYCLED PAPER



STATE OF ILLINOIS  
SENATE

SENATOR  
MIKE JACOBS  
36TH DISTRICT

STATE CAPITOL  
SPRINGFIELD, ILLINOIS  
62706

December 6, 2012

I am honored to be able to offer my support for the Heart Center and Emergency Department expansion at Trinity's Rock Island Campus.

I am fully aware of how Trinity has worked to make a difference through compassionate care, exceptional physicians and staff and the comprehensive community benefit programs it provides us.

Your staff is dedicated to improving the health and well-being of the people throughout Rock Island by providing the highest quality health care possible. Programs your staff provides to the community such as HeartAware are invaluable to our community.

In addition, your collaborative approach to healthcare, which includes physicians, behavioral health providers and nursing facilities, provides an innovative care model that should be an example for other hospital systems around our state. Your utmost dedication to your patients helps to ensure quality care for all who utilize your services.

I know the Trinity Rock Island Medical Center has not undergone major facility improvements since it was built in 1972 and this expansion and renovation project will not only improve patient care and privacy, but also help to reduce operational inefficiencies. This new heart center will also help to improve patient services because of the consolidation of all of services onto one campus.

RECYCLED PAPER · SOYBEAN INKS

The new heart center and emergency department will have a very positive effect on the surrounding community and is one of the largest medical capital investments in Rock Island County in some time.

Thank you for your service to our community,



Mike Jacobs

36<sup>th</sup> Senate District

STATE OF ILLINOIS  
HOUSE OF REPRESENTATIVES



**CAPITOL OFFICE**  
259-S Stratton Building  
Springfield, Illinois 62706  
217-782-5970 Fax 217-558-1253

**DISTRICT OFFICE**  
County Office Building  
1504 3rd Ave.  
Rock Island, Illinois 61201  
309-558-3612 Fax 309-793-4764

**PATRICK J. VERSCHOORE**  
STATE REPRESENTATIVE  
72<sup>ND</sup> DISTRICT

**COMMITTEES**  
**CHAIRMAN**  
COUNTIES & TOWNSHIPS  
**VICE CHAIRMAN**  
AGRICULTURE & CONSERVATION  
**MEMBER**  
ENVIRONMENT & ENERGY  
FINANCIAL INSTITUTIONS  
HEALTH CARE LICENSES  
VETERANS' AFFAIRS

December 10, 2012

Mr. Jay Willsher, C.O.O.  
Trinity Regional Health System  
2701 17<sup>th</sup> Street  
Rock Island IL 61201

Dear Mr. Willsher:

I am pleased to provide a letter expressing my support for the proposed new heart center and emergency department project for Trinity Medical Center's Rock Island Campus.

No major facility improvements have been done on the Trinity Rock Island Medical Center since 1972 - a new heart center will improve patient care and privacy and will reduce operational inefficiencies. The new facility will accommodate all of Trinity's heart center services on one campus which will improve patient satisfaction. Our community will be positively enhanced by a new heart center and emergency department - a project which will be one of the largest recent capital investments in Rock Island County.

Trinity Medical Center is an asset to our community and provides a valuable service locally and to surrounding areas. I look forward to learning of approval being granted for a new heart center.

Sincerely,

  
Pat Verschoore  
State Representative  
72<sup>nd</sup> District

CC:Berlinda Tyler-Jamison

RECYCLED PAPER - SOYBEAN INKS



Pat Quinn, Governor

Illinois Department of Human Services

Michelle R. B. Saddler, Secretary

Greater Illinois - Central Region  
Andrew McFarland Mental Health Center

● Jordan Litvak, Network Manager  
● Karen Schweighart, Hospital Administrator

November 14, 2012

Ms. Courtney Avery  
Administrator  
Health Facilities and Services Review Board  
525 W. Jefferson St., 2nd Fl.  
Springfield, IL 62761

Dear Ms. Avery:

This letter comes to you in support of the Robert Young Center (RYC) in Rock Island/Moline, Illinois who is applying for a grant to develop a Crisis Stabilization Unit in order to add a critical component to their current continuum of care. We have worked closely with RYC both in their role as a state-funded provider of outpatient mental health services as well as in their role of managing an inpatient psychiatric program at Trinity Medical Center/Rock Island.

More specifically, we have had the pleasure of working with Robert Young Center as they have engaged in forward-thinking projects to meet the current and future needs of behavioral health individuals. Currently RYC is in the third and final year of a Title XX grant focused on Primary/Behavioral Health Integration. Their success in working with their local FQHC to form one treatment team serving shared clients and developing recovery-focused peer support groups for both mental health and medical issues has shown early success in raising client life-satisfaction scores and decreasing utilization of emergency room visits to address both behavioral and medical health concerns.

Most recently, the Division of Mental Health is working closely with RYC in the implementation of a state rebalancing plan to enhance community outpatient and inpatient assessment and service delivery to indigent individuals with severe mental illness to manage crisis episodes without resorting to state-operated hospital care. These services have included a service model of outreach and assessment that will lead to tele-assessment capability. The addition of a crisis stabilization unit to RYC's outpatient, partial hospital, inpatient behavioral health programs and integrated behavioral/primary health care services will allow this agency to provide the complete continuum of care in a most efficient and effective manner. It is therefore without reservation that we support Robert Young Center in their application for this grant.

Sincerely,

Jordan Litvak  
Executive Director, Regions 3 & 4  
Illinois Department of Human Services, Division of Mental Health



**Donald P. Welvaert**  
Mayor

619 - 16<sup>th</sup> Street  
Moline, Illinois 61265

Phone: (309) 524-2001  
Fax: (309) 524-2020  
Email:  
dwelvaert@moline.il.us

December 5, 2012

Mr. Jay Willsher, C.O.O.  
Trinity Regional Health System  
2701 - 17<sup>th</sup> Street  
Rock Island, Il. 61201

Congratulations, and thank you for your proposal to build a new Heart Center on the Trinity campus in Rock Island, in addition to expanding the emergency center. As a long time resident in the Illinois Quad Cities I can't recall any major construction that has occurred at the campus since it was constructed in the 1970's. Your efforts are appreciated.

Recent census data confirms that our demographic is indeed aging as we baby boomers reach retirement and begin to experience increased medical care needs; specifically heart care, diabetes and other illnesses associated with an aging population. The new heart center will have a very positive effect on not only Rock Island, but the entire Quad Cities region of over 375,000 people. The expansion and updating of the emergency room will increase patient privacy, care and wellness, by providing the updates in space and medical equipment needed to meet the needs of our communities in the Iowa - Illinois Quad Cities.

Trinity's Moline Campus has always been a leader in medical care and a great community partner. Together with the Trinity West medical complex in Rock Island, the City of Moline is afforded an excellent medical care opportunity for our businesses and citizens.

The City of Moline strongly supports Trinity's efforts to bring enhanced medical treatment opportunities to the Quad Cities.

Sincerely,

A handwritten signature in black ink, appearing to read "Donald P. Welvaert", written over a horizontal line.

Donald P. Welvaert  
Mayor  
City of Moline, Illinois

c: Berlinda Tyler-Jamison



CITY OF EAST MOLINE  
**OFFICE OF THE MAYOR**

December 5, 2012

Mr. Jay Willsher, C.O.O.  
Trinity Regional Health System  
2701 – 17<sup>th</sup> Street  
Rock Island, IL 61201

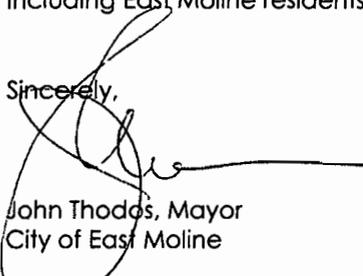
Dear Mr. Willsher:

I am writing to express my support for the new heart center and emergency department expansion at the Trinity Medical Center on the Rock Island campus. Having a new heart center will enable Trinity to have all their services on one campus, improving patient satisfaction, which is certainly a key goal for any entity. Advances in patient care and services are positives for not only Rock Island, but all of the Quad Cities community, giving area residents choices in their medical care.

From my understanding, the medical center has not undergone any major facility improvements since its inception in 1972. A project such as this one will most importantly improve patient care and in addition protect their privacy. Updates will reduce operational inefficiencies, thereby helping staff to give the highest level of care and work smarter, not harder.

As Mayor of East Moline, I endorse what will be one of the largest capital investments in Rock Island County creating top notch health care for the area, including East Moline residents.

Sincerely,



John Thodas, Mayor  
City of East Moline

Cc: Berlinda Tyler-Jamison

915 SIXTEENTH AVENUE • EAST MOLINE, ILLINOIS 61244



ROCK ISLAND  
ILLINOIS

Mayor Dennis E. Pauley

December 7<sup>th</sup>, 2012

Mr. Jay Willsher, C.O.O.  
Trinity Regional Health System  
2701 – 17<sup>th</sup> Street  
Rock Island, IL 61201

Dear Mr. Willsher:

As Mayor of the City of Rock Island, I write this letter show the City's support of your Heart Center and Emergency Department expansion at Trinity Regional Health System. The City of Rock Island has enjoyed a long and successful relationship with Trinity and know that this new heart center and emergency department will have a very positive impact on not only Rock Island, but also the surrounding community. Your planned expansion will be one of the largest capital investments in Rock Island County in some time.

We realize that the Trinity Rock Island Medical Center has never undergone major facility improvements since it was built in 1972 and that this project will not only improve patient care and privacy, it will also reduce operational inefficiencies. The new heart center would accommodate all of Trinity's heart center services on one campus, which will improve patient care and satisfaction.

I am pleased to offer our support to your project and look forward to continuing our successful partnership for many years to come.

Sincerely,

Dennis E. Pauley  
Mayor  
City of Rock Island

cc: Ms. Berlinda Tyler-Jamison

---

1528 Third Avenue, Rock Island, Illinois 61201-8678  
Phone: 309.732-2012 Fax: 309.732-2055  
Email: rimayor@rigov.org



# Alternatives for the Older Adult

1803 - 7th Street  
Moline, Illinois 61265  
(309) 277-0167 or 1-800-798-0988  
FAX (309) 277-0163

**BRANCH OFFICES**  
Galesburg, Illinois 61401  
Macomb, Illinois 61455  
Spring Valley, Illinois 61562  
Kewanee, Illinois 61443  
Bridges Senior Center  
Ottawa, Illinois 61350  
Sage Center, Moline, IL 61265

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Funded by  
IDOA, WIAAA, DHS and  
United Ways of the Quad Cities,  
Colona-Orion,  
Illinois Valley,  
Kewanee, Knox, Warren  
Eastern LaSalle County,  
and Community Funds  
of Geneseo and Walnut

December 11, 2012

Jay Willsher, C.O.O.  
Trinity Regional Health System  
2701 - 17<sup>th</sup> Street  
Rock Island, IL 61201

Dear Jay,

Please accept this letter of support for the proposed Trinity Heart/Emergency Department Project for the Rock Island, IL campus.

As a community organization serving the older adult population in northern and western Illinois, Alternatives for the Older Adult sees many advantages to improving patient care resources available to our shared community. As is well known, the older adult population uses a higher proportion of medical care, including emergency room care. With an increasing older adult population, the need for effective, efficient emergency room support will only continue to grow and current capacity constraints on Trinity will be further tested.

Alternatives has a unique role to coordinate services to assist older adults to maintain as much independence and quality of life possible. To do so, we work with more than 200 community providers to link the right resources with each senior.

Trinity has been a unique partner with us for more than 25 years. By allowing Alternatives to work side by side with Trinity for patients being discharged from hospital care, Trinity has been a leader in the development of hospital-to-home Transition Coordination.

Expanding their current facilities will further strengthen coordination of services between home, nursing home and hospital. It is difficult for older adults to handle long, confusing visits in the emergency room, particularly when their emergent condition is complicated by other chronic challenges. An improved facility will not only improve the immediate care, but will also support improved coordination of services to transition out of the hospital with streamlined communication and adequate space.

We support improved access to medical care and resources in our community via Trinity's planned facility and service expansion.

Sincerely,



Kathy Weiman, CEO



Mission Statement: Alternatives for the Older Adult promotes the independence and quality of life of older adults and their families.  
Age Wise, Age Well



525 16<sup>th</sup> Street  
Moline, IL 61265

P: 309.736.7727  
F: 309.517.4051  
E: info@casaqc.org  
www.casaqc.org

December 10, 2012

Mr. Jay Willsher, C.O.O.  
Trinity Regional Health System  
2701 – 17th Street  
Rock Island, IL 61201

Dear Mr. Willsher,

On behalf of the board of directors, staff and our clients, it is my sincere pleasure to provide the highest level of support for the proposed new heart center and emergency department project for the Trinity Medical Center's Rock Island Campus.

Over the years, Trinity has been a steadfast advocate and provider of the highest quality health care for many of our clients and the community it serves. Above all, Trinity represents the willingness of everyone in our community to care for and about each other. Through times of prosperity and economic stress, the Trinity Medical Center has continued to grow carefully, steadily, and thoughtfully, while remaining true to its mission and longstanding tradition of providing high-quality, accessible healthcare close to home. The proposed project will benefit the Quad Cities and surrounding community by:

- improving patient care and privacy and will reduce operational inefficiencies;
- accommodating all of Trinity's heart center services on one campus which will improve patient satisfaction; and
- having a positive effect on the surrounding community and will be one of the largest capital investments in Rock Island County in some time.

In addition to these benefits, we are pleased to support this significant capital project as it is sure to better position the hospital in serving the changing demographic population across the Quad Cities. Specifically, the Hispanic population in the United States has more than doubled in size in the past 15 years and is now estimated to have reached 45 million. This same growth continues to be mirrored in the Quad Cities with a significant increase in our region's Hispanic population. This rapid expansion, combined with the increasing health concerns confronting Hispanic population, underlies the need for the highest quality of health care facilities available primed to serving the growing population.

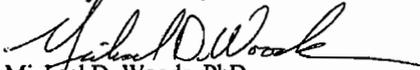
According to the American Heart Association, heart disease is the number one killer for all Americans and stroke is the fourth leading cause of death. Hispanics and Latinos, however, face even higher risks of cardiovascular diseases because of high blood pressure, obesity and diabetes. Furthermore, according to the U.S. Department of Health and Human Services:

- Among Mexican-American adults, 31.6% of men and 34.4% of women have cardiovascular disease;
- The risk of heart disease increases with physical inactivity. Compared with non-Latino white women, Latino women are less likely to engage in physical activity;
- Latino Americans are more likely to be obese and have diabetes - two related risk factors for cardiovascular diseases;
- Both Latinos and Latinas with diabetes have higher rates of heart disease death than those without diabetes;
- At least 65% of people with diabetes die from heart disease and stroke. Yet, only 1 in 4 Latinos with diabetes know they are at risk for heart disease;
- Compared with non-Latino white men and non-Latino black men, Mexican American men are more likely to have high cholesterol; and
- Awareness that heart disease is the leading cause of death was lowest for Latino women at 34% compared to 62% for white women, and 38% for black women.

In partnership with Trinity and other health care providers across western Illinois and eastern Iowa, since 1998, Casa has been committed to addressing inequities in quality of health care for the Hispanic population; building advocacy for high quality, culturally sensitive, and linguistically appropriate health care and prevention services; informing the public to make choices that favor better health outcomes; and empowering communities to fully participate in health planning, implementation, evaluation, and advocacy. As the leading voice on Latino issues across the Quad Cities, three major functions provide essential focus to the Casa's work: advocacy; education and outreach. These functions complement Casa's work in three key strategic areas: access to health care, health disparities and community health.

In light of these aforementioned critical health related matters facing the Hispanic population and staying true to our key strategic initiatives noted, we truly believe that the proposed expansion will better position the Trinity Medical Center in serving the needs of the Hispanic population and our community at large. For these reasons, I am pleased to provide the highest level of support and encouragement for the proposed plans being presented to expand and enhance the Trinity Medical Center's Rock Island Campus. Should I be of further assistance with this support and project, please call upon me at 309.736.7727 or [mwoods@casaqc.org](mailto:mwoods@casaqc.org).

Cordially submitted,



Michael D. Woods, PhD.  
Executive Director



10 December, 2012

Jay Willsher, C.O.O.  
Trinity Regional Health System  
2701 – 17<sup>th</sup> Street  
Rock Island, IL 61201

Dear Jay,

It is my pleasure to write a letter in support to the new heart center and emergency department project being proposed by Trinity Medical Center on its Rock Island, Ill. campus.

The new Heart Center and Emergency Department will have a positive impact on the surrounding community. As a health system that refers cases to tertiary facilities, these new facilities will offer our patients more choice in where to receive services.

In conclusion, we fully support the efforts of Trinity Medical Center as it seeks approval to upgrade their hospital designed to improve patient care and the overall work environment.

Sincerely,

  
Edward Andersen  
President & CEO  
CGH Medical Center

100 East LeFevre Road • Sterling, IL 61081 • 815.625.0400 • [www.cghmc.com](http://www.cghmc.com)

 **Community  
Health Care, Inc.**  
Opening Doors to Health Care

500 W. River Drive • Davenport, IA 52801-1014 • 563-336-3000 • (f) 563-336-3044

December 4, 2012

Jay Willsher, COO  
Trinity Regional Health System  
2701 17<sup>th</sup> Street  
Rock Island, IL 61201

Dear Jay,

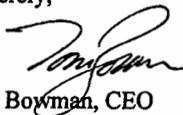
It is my pleasure to write a letter in support to the new Heart Center and Emergency Department project being proposed by Trinity Medical Center on its Rock Island, Illinois campus.

The Trinity Rock Island Hospital is verified by the Illinois Department of Public health as a Level II Trauma Center and is the largest hospital in the Illinois Quad-Cities. The Trinity Rock Island hospital was originally built in 1972, and since then has never undergone any major facility upgrades. This new facility will improve patient care and privacy by addressing capacity constraints in both its emergency department and heart center. This new facility will also improve patient care, by reducing infection prevention concerns and operational inefficiencies. By expanding our security office and relocating our Emergency Department closer to our Mental Health Center, patient and visitor safety also will be enhanced. The new heart center will accommodate all our Heart Center services to one campus location to include an improved cardiac rehabilitation department. This will improve patient outcomes and satisfaction by aiding in the recovery process with more space for individual education and group instruction.

The projected total cost of the Heart Center/ED project is \$60 million. The new Heart Center and Emergency Department will have many positive impacts on the surrounding community and will be one of the largest capital investments in Rock Island County in some time. By better accommodating the patients at this campus, our community members will be drawn to the closer and more convenient location rather than having to travel a further distance to another hospital. Improving the hospital as a whole, improves the community as a whole in terms of the physicians and staff who reside and work here, and for the patients who would benefit from these improvements to the hospital.

In conclusion, I fully support the efforts of Trinity Medical Center as it seeks approval to upgrade their hospital designed to improve patient care and overall work environment. Any improvement to the hospital, especially one of this magnitude, has extreme benefits to the economy, the community and the patients who reside in this community.

Sincerely,



Tom Bowman, CEO  
Community Health Care, Inc.

Accredited By



Joint Commission  
on Accreditation of Healthcare Organizations

December 10, 2012

Mr. Jay Willsher, C.O.O.  
Trinity Regional Health System  
2701 17<sup>th</sup> Street  
Rock Island, IL 61201

Dear Mr. Willsher,

Family Resources is pleased to support the proposed new heart center and emergency department project for Trinity Medical Center's Rock Island Campus. Family Resources is a private nonprofit multi-service organization serving the Quad Cities and Eastern Iowa. We have been providing comprehensive domestic violence and sexual assault services in the Quad Cities and Muscatine for approximately 30 years.

The new heart center and emergency department will have a very positive effect on the surrounding community and will be one of the largest capital investments in Rock Island County in some time.

The opportunity to expand upon the already great facilities at Trinity Medical Center's Rock Island Campus has been a long time coming. The Trinity Rock Island Medical Center has never undergone major facility improvements since it was built in 1972. This project will improve patient care and privacy and will reduce operational inefficiencies. The new heart center will also improve patient satisfaction through having all of Trinity's heart care services on one campus. Trinity, and more specifically the emergency services, is an important partner in the services we provide to victims of sexual assault and domestic violence. Our two organizations' staffs work closely, 24 hours a day/7 days a week, to respond to victims who present in your emergency room. An updated, safe, and pleasant surrounding is just one way we can help assist the victims to feel more comfortable.

Please join Family Resources in supporting the new heart center and emergency department for Trinity Rock Island.

Sincerely,

  
Cheryl Goodwin  
President/CEO  
Family Resources, Inc

Cc: Berlinda Tyler-Jamison

Cheryl Goodwin  
President/CEO

Jeri VanderVinn  
Chief Financial Officer

Christine Gradert  
Sr. Vice President

Mary  
Macumber-Schmidt  
Vice President

Phone  
563/326-6431

Fax  
563/326-2013

Website  
[www.famres.org](http://www.famres.org)

2800 Eastern Avenue  
Davenport, Iowa  
52803



Community Partner





December 10, 2012

Jay Willsher, Chief Operating Officer  
Trinity Regional Health System  
2701 17<sup>th</sup> Street  
Rock Island, IL 61201

Dear Jay:

On behalf of Hammond-Henry Hospital in Geneseo, Illinois, please accept this letter as our support of the proposed heart center and emergency department project for the Rock Island campus of Trinity Medical Center.

The referral pattern from Geneseo to Trinity Medical Center- Rock Island is the most common of all our referrals. The Level II Trauma Center designation by the state of Illinois is an important factor in that pattern. Also, the volume of cardiac care delivered in this location has increased incredibly over the years. This facility, which is now 40 years old, is certainly showing signs of such use. The care delivered in this setting is intense, and efficiencies are vital.

Trinity's plan for the proposed renovation of the facility is estimated to cost \$60 million. The new Heart Center and emergency department will be an important community investment in the resources of Rock Island and the surrounding area.

As a community hospital, we strive to keep patients within the community. We view Trinity as our partner in caring for these patients locally or in our case, as close as possible to home. Convenience and proximity to quality health care are important components of our missions.

In summary I support Trinity Health in its efforts to upgrade their facilities and in the approval process for such improvements to begin. We view the benefits of these enhancements in the best interest of our communities, in our economies and for the health of our patients.

Sincerely,

A handwritten signature in black ink that reads 'Bradley Solberg'.

Bradley Solberg, FACHE  
CEO



*International Association of Bridge, Structural, Ornamental  
and Reinforcing Iron Workers*

**Local Union No. 111**

8000 -29th Street West

Rock Island, Illinois 61201

309-756-6614 Fax: 309-756-6615

E-Mail: lu111@netexpress.net

Affiliated with AFL-CIO



December 12, 2012

Jay Willsher, C.O.O  
Trinity Regional Health System  
2701 17<sup>th</sup> Street  
Rock Island, IL 61201

RE: Trinity Regional Health System Heart Center and Emergency Department Expansion Project

Mr. Willsher:

I am writing to you today on behalf of Iron Workers Local 111. Our organization represents three hundred members and their families that utilize Trinity Health Systems.

As you are aware, the Rock Island Campus is forty years old. The new Heart Center and Emergency Department will allow Trinity Health System to consolidate to a single location thusly, providing the community with improved patient care. This would be accomplished while reducing Trinity's operational inefficiencies. Further, this project will create much needed jobs for Iron Workers during it's construction.

Iron Workers Local 111 strongly supports Trinity in getting the necessary support from the Illinois Health Facilities Board. I hope this letter helps you gain their support.

Sincerely,

Mike Wilcher  
Financial Secretary-Treasurer-Business Manager

jms



**JOHN DEERE**

Mara L. Sovey  
Director, Corporate Citizenship Center of  
Excellence  
President, John Deere Foundation  
One John Deere Place, Moline, IL 61265 USA

Jay Willsher, C.O.O.  
Trinity Regional Health System  
2701 – 17<sup>th</sup> Street  
Rock Island, IL 61201

Dear Jay,

It is my pleasure to write a letter of support for the new heart center and emergency department project being proposed by Trinity Medical Center on its Rock Island, Ill. campus. Trinity Medical Center is a dedicated corporate citizen to this community, responding not only to the needs of the patients its serves, but to the needs of the entire community.

As our population ages and grows, our demand for access to enhanced services in cardiology and emergency department services will grow with it. I applaud Trinity's efforts to stay ahead of this demand and modernize their facilities today to meet the growing demand today and well into the future.

Trinity Rock Island has never undergone any major facility upgrades. The new facility will improve patient care and privacy by addressing capacity constraints in both its emergency department and heart center. The new facility will also improve patient care, by reducing infection prevention concerns and operational inefficiencies. By expanding the security office and relocating the emergency department closer to the mental health center, patient and visitor safety also will be enhanced. The new heart center will accommodate all of Trinity's heart center services to one campus location to include an improved cardiac rehabilitation department. This will improve patient outcomes and satisfaction by aiding in the recovery process with more space for individual education and group instruction.

The new Heart Center and Emergency Department will have many positive impacts on the surrounding community and will be one of the largest capital investments in Rock Island County in some time.

The Quad Cities area is constantly competing to draw new businesses and new people to our community, and health care plays an important role in this decision-making process. Trinity's effort to modernize and expand its facilities within our community will further secure our area's place as a leader when it comes to healthcare for communities our size.

Trinity Medical Center is an asset to our community and I support efforts to modernize its campus.

Best wishes,

  
Mara L. Sovey

December 10, 2012

Jay Willsher, C.O.O.  
Trinity Regional Health System  
2701 17<sup>th</sup> Street  
Rock Island, IL 61201

Dear Jay,

As a business owner of a professional engineering firm in Rock Island (I also serve as Chair of the Quad Cities Chamber of Commerce), it is my great pleasure to write a letter in support of the new heart center and emergency department project being proposed by Trinity Medical Center on its Rock Island, Illinois campus.

The Trinity Rock Island hospital was originally built in 1972, and since then has never undergone any major facility upgrades. This new facility will improve patient care and privacy by addressing capacity constraints in both its emergency department and heart center. This new facility will also improve patient care, by reducing infection prevention concerns and operational inefficiencies. By expanding the security office and relocating the emergency department closer to the mental health center, patient and visitor safety will also be enhanced. I understand that the new heart center will accommodate all of their services to one campus location to include an improved cardiac rehabilitation department. This will improve patient outcomes and satisfaction by aiding in the recovery process with more space for individual education and group instruction.

The new Heart Center and Emergency Department will have many positive impacts on the surrounding community and will be one of the largest capital investments in Rock Island County in some time. The Rock Island community members will be drawn to the closer and more convenient location rather than having to travel a great distance to another hospital.

In conclusion, as President of KJWW Engineering Consultants, a professional engineering firm with corporate headquarters located in Rock Island, IL, I fully support the efforts of Trinity Medical Center as it seeks approval to upgrade their hospital which will improve patient care and the overall work environment. Any improvement to the hospital, especially one of this magnitude, has extreme benefits to the economy, the community and the patients who reside in this community, which would include our professional staff and would aid in our recruiting top notch engineers.

Sincerely,



Paul D. VanDuyne, PE  
President

PVD/sjm



Mr. Jay Willsher, C.O.O.  
Trinity Regional Health System  
2701-17<sup>th</sup> Street  
Rock Island, IL 61201

Re: Trinity Regional Health System Heart Center & Emergency Department Expansion Project

Dear Mr. Willsher:

I'm writing to you today on behalf of the Plumbers & Pipefitters Local 25. Our organization represents 1,400 members and we cover nearly 3000 belly buttons in our plans. Numerous families utilize Trinity Health Systems in various facilities within the region.

We strongly support Trinity in getting the necessary support from the Illinois Health Facilities Board and hope that this letter will help accomplish that goal.

The Rock Island Medical Campus was built in 1972 and has never had any major facility improvements. The new Heart Center and Emergency Department will allow Trinity to consolidate their Heart Services to a single location providing improved patient care and satisfaction while reducing operational inefficiencies.

Thank you for taking the time to read this letter and we look forward to your support.

Sincerely,

W. Thomas McCune Jr.  
Business Manager  
Local 25 Plumbers & Pipefitters

4600 - 46th Avenue, Rock Island, Illinois 61201 • (309) 788-4569 • Fax: (309) 788-3226





## MARTIN LUTHER KING CENTER

December 5, 2012

Mr. Jay Willsher, C.O.O.  
Trinity Regional Health System  
2701 – 17th Street  
Rock Island, IL 61201

Mr. Wilsher,

It is my pleasure to provide a letter in support of a new Heart and Emergency Department for Trinity Medical Center's Rock Island Campus. It is widely known that the current facility has been a vital resource for emergency care in Rock Island but is in dire need of revitalization. The Trinity Rock Island Medical Center was built in 1972 and has existed since that time without undergoing major facility improvements. While providing superb care to our community, the center is antiquated and hinders the Center's ability to improve patient care, reduce operational inefficiencies, and incorporate innovation, all of which requires necessary renovations.

The project will have many positive and measurable impacts. Consolidating all of Trinity's Heart Center services on one campus will provide convenience and productivity for the patients. Also, the new Heart Center and Emergency Department will have a very positive effect on the surrounding community and will be one of the largest capital investments in Rock Island County in recent history. Additionally, it will help to further distinguish Rock Island as an exceptional place to live work and play. Trinity Medical Center strives to provide the highest quality of services to vulnerable communities. Constituents of the King Center have long been the beneficiary of community spirit of Trinity from free health screenings, health fairs, to sponsorship of healthy eating programs. In turn, the community is invested in the care of this facility as our mission is to provide opportunity for a diverse population through a variety of programs and services; we strongly believe that meaningful life-impacting opportunities will be available to our community through the development of a new Heart and Emergency Department for Trinity Center's Rock Island Campus.

Please contact me if I can offer further support to bring this very important initiative to fruition.

Sincerely,



Rev. Dwight L. Ford, M.Div.

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Martin Luther King, Jr. Community Center  
630 Martin Luther King Drive, Rock Island, Illinois 61201-8678  
Phone.309.732-2999 Fax.309.732-2991 www.rigov.org





December 11, 2012

Mr. Jay Willsher, C.O.O.  
Trinity Regional Health System  
2701 - 17<sup>th</sup> Street  
Rock Island, IL 61201

Dear Mr. Willsher:

My involvement with the Trinity Regional Health System and Iowa Health System has given me a firsthand knowledge of the challenges facing hospitals and doctors in providing citizens access to the best medical care possible. I am pleased to write this letter of support for the new heart center and emergency department project proposed by Trinity Medical Center at the Rock Island, Illinois campus.

The Trinity Rock Island hospital was originally built in 1972, and to-date has not undergone any renovation or upgrade. The proposed project will modernize the antiquated parts of the hospital and will provide a much needed facility upgrade. Both the Emergency Department and Heart Center are vital community resources, and the health of our community depends on ensuring the approval of this project.

The Trinity Rock Island Hospital is certified by the Illinois Department of Public Health as a Level II Trauma Center and is the largest hospital in the Illinois Quad-Cities. This new facility will be designed to address areas of concern and will improve patient care and privacy by addressing capacity constraints in both its emergency department and heart center. By expanding our security office and relocating our emergency department closer to our mental health center, patient and visitor safety also will be enhanced. The new heart center will accommodate all of our heart center services to one campus location to include an improved cardiac rehabilitation department. This will improve patient outcomes and satisfaction by aiding in the recovery process with more space for individual education and group instruction and will provide up-to-date treatment and triage rooms, expanded support space for physicians, nurses, and other providers.

The projected cost of the Heart Center and Emergency Department project is \$60 million, and will have many positive impacts for our community; -- it will draw and keep people in our community, strengthening our cities and building economy. Our main goal is to deliver quality life-saving medical services, planning for community health care needs while respecting the privacy and dignity of patients and their families.

On behalf of Midland Information Resources, I am pleased to endorse the renovation of Trinity Rock Island and provide this letter of support.

Cordially yours,  
Midland Information Resources

  
Gene M. Blanc  
CEO & Chairman

GMB/dfs

Midland Information Resources • 5440 Corporate Park Drive • Davenport, IA 52807 • 800-232-3696 • www.midlandcorp.com



Jay Willsher, C.O.O.  
Trinity Regional Health System  
2701 – 17<sup>th</sup> Street  
Rock Island, IL 61201

Dear Mr. Willsher,

It is my pleasure to write a letter in support to the new heart center and emergency department project being proposed by Trinity Medical Center on its Rock Island, Ill. campus.

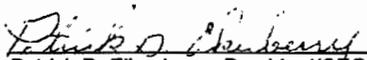
The Trinity Rock Island Hospital is verified by the Illinois Department of Public Health as a Level II Trauma Center and is the largest hospital in the Illinois Quad-Cities. I understand Trinity Rock Island hospital was originally built in 1972, and since then has never undergone any major facility upgrades.

As you may know, one of our employees went into cardiac arrest at the Rock Island Fitness Center. If it were not for Trinity staff's quick response and knowledge of the situation, Rich Parsons would not be with us today. This new facility will improve patient care and privacy by addressing capacity constraints in both its emergency department and heart center. The new facility will also improve patient care, by reducing infection prevention concerns and operational inefficiencies. By expanding our security office and relocating our emergency department closer to our mental health center, patient and visitor safety also will be enhanced. The new heart center will accommodate all of our heart center services to one campus location to include an improved cardiac rehabilitation department. This will improve patient outcomes and satisfaction by aiding in the recovery process with more space for individual education and group instruction.

The projected total cost of the Heart Center/ED project is \$60 million. We are confident the new Heart Center and Emergency Department will have many positive impacts on the surrounding community and will be one of the largest capital investments in Rock Island County in some time. By better accommodating the patients at this campus, our community members will be drawn to the closer and more convenient location rather than having to travel a further distance to another hospital. Improving the hospital as a whole, improves the community as a whole in terms of the physicians and staff who reside and work here, and for the patients who would benefit from these improvements to the hospital.

In conclusion, I fully support the efforts of Trinity Medical Center as it seeks approval to upgrade their hospital designed to improve patient care and the overall work environment. Any improvement to the hospital, especially one of this magnitude, has extreme benefits to the economy, the community and the patients who reside in this community.

Sincerely,

  
Patrick D. Eikenberry, President/CEO  
Missman, Inc.

1011 27<sup>th</sup> Avenue, P.O. Box 6040 • Rock Island, Illinois 61204-6040  
Phone: 309.788.7644 • Fax: 309.788.7691 • www.missman.com



AFFILIATED WITH  
AMERICAN FEDERATION OF LABOR AND  
CONGRESS OF  
INDUSTRIAL ORGANIZATIONS

BUILDING AND CONSTRUCTION  
TRADES DEPARTMENT

UNION LABEL AND SERVICE  
TRADES DEPARTMENT

## OPERATIVE PLASTERERS' AND CEMENT MASONS'

LOCAL 18 OF CENTRAL ILLINOIS  
7909-42<sup>nd</sup> West  
Rock Island IL 61201  
Ph. 309-787-8280 Fax 309-787-8276

December 12, 2012

Mr. Jay Willsher, C.O.O.  
Trinity Regional Health System  
2701-17<sup>th</sup> Street  
Rock Island, IL 61201

Re: Trinity Regional Health System Heart Center & Emergency Department  
Expansion Project

Dear Mr. Willsher:

I'm writing to you today on behalf of the Operative Plasterers & Cement Masons Local 18. Our organization represents 220 families that utilize Trinity Health Systems various facilities within the region.

The OPCMIA has partnered with Trinity and their Foundation for many years on various community activities to assist in providing health and wellness programs in our community. Many of these programs have improved the quality of life for our members and their families.

We strongly support Trinity in getting the necessary support from the Illinois Health Facilities Board and hope that this letter will help accomplish that goal.

The Rock Island Medical Campus was built in 1972 and has never had any major facility improvements. The new Heart Center and Emergency Department will allow Trinity to consolidate their Heart Services to a single location providing improved patient care and satisfaction while reducing operational inefficiencies.

Lastly, as our economy slowly recovers the economic impact of a project of this magnitude would provide hundreds of jobs for tradesmen and women in the community. These employment opportunities will have a significant economic impact on the entire region.

Sincerely,

Montie D. Schell  
Business Agent  
OPCMIA Local 18





December 11, 2012

Mr. Jay Willsher  
Chief Operation Officer  
Trinity Regional Health System  
2701 - 17<sup>th</sup> Street  
Rock Island, IL 61201

Dear Mr. Willsher:

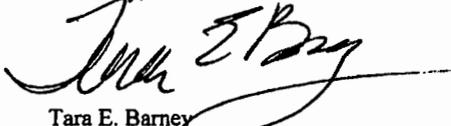
Quad Cities Chamber of Commerce is pleased to provide its support for the heart center and emergency department project being proposed by Trinity Medical Center for its Rock Island campus.

The Trinity Rock Island Hospital is the largest hospital in the Illinois Quad-Cities, but has never undergone any major facility upgrades. This new facility will improve patient care and privacy by addressing capacity constraints and operational inefficiencies in both its emergency department and heart center. Patient and visitor safety also will be enhanced. The new heart center will accommodate all of the heart center services on one campus location to include an improved cardiac rehabilitation department. This will improve patient outcomes and satisfaction by aiding in the recovery process with more space for individual education and group instruction.

The proposed \$60 million project will have many positive impacts on the surrounding community and will be one of the largest capital investments in Rock Island County in recent history. In addition to the economic benefits of the project, the community will also benefit from the improved services available at a close and convenient location. Improving the hospital improves the community.

The Chamber recognizes the importance of "quality of life" in the recruitment of new business. Improvements to the heart center and emergency department will benefit all of the citizens of the region.

Sincerely,



Tara E. Barney  
President and CEO

331 W. 3rd St., Suite 100, Davenport, IA 52801 • 563.326.1005

[www.QuadCitiesFirst.com](http://www.QuadCitiesFirst.com)



December 10, 2012

Mr. Jay Willsher  
Chief Operation Officer  
Trinity Regional Health System  
2701 - 17<sup>th</sup> Street  
Rock Island, IL 61201

Dear Mr. Willsher:

Quad Cities First is pleased to provide its support for the heart center and emergency department project being proposed by Trinity Medical Center for its Rock Island campus.

The Trinity Rock Island Hospital is the largest hospital in the Illinois Quad-Cities, but has never undergone any major facility upgrades. This new facility will improve patient care and privacy by addressing capacity constraints and operational inefficiencies in both its emergency department and heart center. Patient and visitor safety also will be enhanced. The new heart center will accommodate all of the heart center services on one campus location to include an improved cardiac rehabilitation department. This will improve patient outcomes and satisfaction by aiding in the recovery process with more space for individual education and group instruction.

The proposed \$60 million project will have many positive impacts on the surrounding community and will be one of the largest capital investments in Rock Island County in recent history. In addition to the economic benefits of the project, the community will also benefit from the improved services available at a close and convenient location. Improving the hospital improves the community.

As the business recruitment arm of the Quad Cities Chamber, Quad Cities First recognizes the importance of "quality of life" in the recruitment of new business. Improvements to the heart center and emergency department will benefit all of the citizens of the region.

Sincerely,

William A. Martin  
President

331 W. 3rd St., Suite 100, Davenport, IA 52801 • 563.326.1005

[www.QuadCitiesFirst.com](http://www.QuadCitiesFirst.com)



246 W. 3rd Suite 100 · Street Davenport Iowa 52801 · Phone 563.322.8995 · Fax 563.322.1071  
www.qcchealth.com

December 10, 2012

Jay Willsher, COO  
Trinity Regional Health System  
2701 17<sup>th</sup> Street  
Rock Island, IL 61201

Dear Jay,

As CEO of Quad City Community Healthcare(QCCH), I am writing to support Trinity in its request to renovate and upgrade the Heart Center and Emergency room.

As you know, QCCH is the locally-owned, managed and operated healthplan in the Quad Cities. We arrange for the insurance now for approximately 100 employers in the Quad Cities. It is critical to us that our contracted providers are able to provide up-to-date, efficient, quality care to the employees of our members.

We support this upgrade by Trinity, as we are convinced that the care will be improved to our members as well as the community at large. The major reasons for our support:

- Consolidation of the heart center into one location will provide a better continuity of care for heart patients by having the heart services not spread out
- Capacity in both the heart center and emergency room will be improved
- No major upgrade of these facilities has occurred for 40 years
- Space for patient privacy and education will be provided in the upgrade

These reasons all will result in higher quality of care and improved outcomes for patients in the Trinity Rock Island campus.

In the daily operation of our health plan we have worked with the Management of the hospital, which is one of the largest contracted providers in our network. We know the Management to be entirely dedicated to providing the highest quality of care, and cost efficient care, to its patients. Thus we are confident that the goals they are working towards with this renovation project will be achieved.

And thus I give my full support to the project.

Sincerely,

A handwritten signature in black ink, appearing to read "James K. Thomson".

James K. Thomson





December 5, 2012

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Mr. Jay Willsher, C.O.O.  
Trinity Regional Health System  
2701-17<sup>th</sup> Street  
Rock Island, IL 61201

Dear Mr. Willsher:

As the Executive Director of Renew Moline – a non-profit economic development organization located in Rock Island County, I whole-heartedly support Trinity Regional Health System's desire to expand its Rock Island Campus Medical Center to include a new heart center as well as enhancing the existing emergency department. I ask that the Illinois Health Facilities Planning Commission approve the organization's application for this project.

In addition to providing essential healthcare services, Trinity Regional Health System and its staff have long played an integral leadership role in the Quad Cities as is evidenced in their support and involvement in organizations such as Renew Moline. This project continues to show this regional commitment. Not only will it update a facility which has not had a major improvement since 1972, but, at an estimated cost of \$60 million, it will also be one of the most substantial private investments in Rock Island County in recent years.

The citizens of this region will all benefit from the improved patient care and privacy as well as reductions in operational redundancies that this expansion will provide. I wish you success in your application.

Sincerely,

Janet M. Mathis  
Executive Director

Cc: Berlinda Tyler-Jamison  
Greg Pagliuzza



**Public Health**  
Prevent. Promote. Protect.

**Rock Island County  
Health Department**

December 10, 2012

Mr. Jay Willsher, C.O.O.  
Trinity Regional Health System  
2701-17<sup>th</sup> Street  
Rock Island, IL 61201

Dear Mr. Willsher,

The Rock Island County Health Department would like to convey support for a new heart center and emergency room project at Trinity Medical Center's Rock Island Campus. The Health Department is both a neighbor to the Trinity - Rock Island Campus, and a community partner and friend of Trinity Health System.

Numerous community partners in our region recently engaged in an assessment and prioritization process which unanimously identified cardiovascular health and mental health as targets for improvement within our geographical area. Each of these priority areas will be addressed by the expansion and improvement of Trinity's heart center services and emergency department. Positive changes in operational efficiency and patient care will contribute to improved patient satisfaction and outcome, as physical and mental health are intertwined.

Public Health shares the same community with Trinity, and shares the common goal of a healthy, vital quality of life for our population. Trinity has proven itself to be a major force in creating positive impact regarding health behaviors and choices through meaningful planning and involvement in community initiatives. The planned expansion of the Rock Island Campus will enhance their ability to provide improved heart and emergency services, which benefits every segment of our population.

Sincerely,

Theresa Berg, M.S.  
Interim Public Health Administrator



- Development Association of Rock Island
- Rock Island Economic Growth Corporation
- The Downtown Rock Island Arts & Entertainment District

December 7, 2012

Mr. Jay Willsher, C.O.O.  
Trinity Regional Health System  
2701 – 17th Street  
Rock Island, Ill. 61201

Mr. Jay Willsher,

I am writing you in support of the proposed new heart center and emergency department project for Trinity Medical Center's Rock Island Campus. The new heart center and emergency department will have a very positive impact on the surrounding community and will be one of the largest capital investments in Rock Island County in some time.

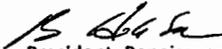
In addition, it would be a significant milestone for Trinity Rock Island because the Rock Island Medical Center has never undergone major facility improvements since it was built in 1972.

Trinity's Rock Island campus is a major employer for the city, and is a great supporter of the community and Renaissance Rock Island organizations. Trinity plays an active role in the Development Association of Rock Island (DARI) and is an active partner with Rock Island Economic Growth Corporation (GROWTH). We appreciate Trinity's support and commitment to Rock Island.

It would be great for the proposed new heart center and emergency department project to become a reality because it will improve patient care and privacy and will reduce operational inefficiencies. In addition, the new heart center will accommodate all of Trinity's heart center services on one campus, which will improve patient satisfaction.

Please feel free to contact me if you have any questions.

Sincerely,  
Brian Hollenback

  
President, Renaissance Rock Island  
100 19th Street, Suite 109  
Rock Island, IL 61201  
(309) 788-6311  
brian@teamrockisland.com

100 19th STREET, SUITE 109 • ROCK ISLAND, IL 61201 • PHONE (309) 788-6311 • FAX (309) 788-6323 • WWW.LIVERI.COM

# Tri-City Building and Construction Trades Council



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Carpenters No. 166  
Carpenters No. 772  
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Elevator Constructors No. 33  
Glaziers No. 581  
IBEW No. 34  
IBEW No. 145  
Ironworkers No. 111  
Ironworkers No. 112  
Ironworkers No. 577

Phone: 309-786-1115

Fax: 309-786-7292

4602 Forty Sixth Avenue  
ROCK ISLAND, ILLINOIS 61201

Laborers No. 309  
Laborers No. 538  
Laborers No. 852  
Laborers No. 1238  
Millwrights No. 1051  
Millwrights No. 2158  
Operating Engineers No. 150  
Operating Engineers No. 649  
Painters No. 502  
Painters No. 676  
Plasterers No. 18  
Plumbers & Pipefitters No. 25  
Roofers No. 32  
Sheet Metal Workers No. 91  
Sprinkler Fitters No. 669  
Teamsters No. 371

Mr. Jay Willsher, C.O.O.  
Trinity Regional Health System  
2701-17<sup>th</sup> Street  
Rock Island, IL 61201

Re: Trinity Regional Health System Heart Center & Emergency Department Expansion Project

Dear Mr. Willsher:

I'm writing to you today on behalf of the Tri-City Building & Construction Trades Council. Our organization is made up of 22 individual trade unions representing 8,500 families that utilize Trinity Health Systems various facilities within the region.

The Building Trades has partnered with Trinity and their Foundation for many years on various community activities to assist in providing health and wellness programs in our community.

We strongly support Trinity in getting the necessary support from the Illinois Health Facilities Board and hope that this letter will help accomplish that goal.

The Rock Island Medical Campus was built in 1972 and has never had any major facility improvements. The new Heart Center and Emergency Department will allow Trinity to consolidate their Heart Services to a single location providing improved patient care and satisfaction while reducing operational inefficiencies.

Lastly, as our economy slowly recovers the economic impact of a project of this magnitude would provide hundreds of jobs for tradesmen and women in the community. These employment opportunities will have a significant economic impact on the entire region.

Sincerely,

*RORY WASHBURN*  
Rory Washburn

Executive Director

Tri-City Building & Construction Trades Council

UNION YES





FOR YOUTH DEVELOPMENT®  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

December 5, 2012

Mr. Jay Willsher, C.O.O.  
Trinity Regional Health System  
2701 - 17<sup>th</sup> Street  
Rock Island, Ill. 61201

Dear Mr. Willsher:

It is my understanding that Trinity Regional Health Systems is seeking approval from the State of Illinois' Health Facilities Planning Commission to expand the emergency department and to build a new heart center at Trinity Medical Center's Rock Island campus. It is also my understanding that this is a \$60 million dollar project, one of the largest capital investments in Rock Island County in some time.

Mr. Willsher, Rock Island's Trinity Medical Center has not undergone any major facility improvements since it was built in 1972. I cannot think of any capital investment that would have a greater return on quality of life than an emergency room and heart center. Especially in today's environment, effective and efficient patient care is paramount.

Trinity has an exceptional heart program and a heavily used emergency room. The efficiencies created by combining Trinity's heart facilities into one facility are obvious. The other benefit will be increased patient satisfaction by improving privacy and reducing the stress of receiving a variety of heart services at multiple facilities. Based on personal experience, the emergency room facility should be improved/expanded to meet the excellence of the employees that staff the center.

The economic impact of the construction would be very helpful for the Quad City area in the short term and the sustained employment of Trinity personnel would benefit the area for the long term.

Two Rivers YMCA  
2040 53rd Street, Moline IL 61265  
P 309 797 3945 [www.tworiversymca.org](http://www.tworiversymca.org)

Trinity Regional Health Systems  
P. 2

During my long tenure with the Two Rivers YMCA I have had many positive interactions with Trinity Medical Center. They are an excellent partner, provide immeasurable community benefit and take their community responsibility seriously and deliberately. The Two Rivers YMCA is just one of many organizations that relies on Trinity to be impactful in the area of health and wellness.

I give my support of the new heart center and emergency room project for Trinity Medical Center's Rock Island Campus. The benefit to the community and to health and wellness in our area would be significant.

Be Well,



Dan R. Osterman  
Chief Executive Officer

CC. Berlinda Tyler-Jamison



CARDIAC SURGERY  
ASSOCIATES, S.C.

Rudolph A. Altergott, M.D., F.A.C.S.  
Mamdouh Bekhos, M.D., F.A.C.S.  
Alyas Chaudhry, M.D.  
Andrew R. Barksdale, M.D.  
Bradford P. Blakeman, M.D., F.A.C.S.  
Juan J. Bonilla, M.D., F.A.C.S.  
David M. Cheng, M.D., F.A.C.S.  
Elizabeth C. Colaiuta, M.D., F.A.C.S.  
Ronald M. Crossman, M.D.  
David J. Cziperle, M.D., F.A.C.S.  
Michael J. DaValle, M.D., F.A.C.S.  
Bryan K. Foy, M.D., F.A.C.S.  
Nicola A. Francalancia, M.D., F.A.C.S.  
Marc W. Gerdisch, M.D., F.A.C.S., F.A.C.C.

John F. Golan, M.D., F.A.C.S.  
James A. Gramm, M.D., F.A.C.S.  
John G. Grieco, M.D., F.A.C.S.  
Thomas J. Hinkamp, M.D., F.A.C.S.  
Fernando Lamounier, M.D., F.A.C.S., F.A.C.C.  
Bryan K. Lee, M.D., F.A.C.S.  
Frank J. Lutrin, M.D., F.A.C.S.  
Peter H. Marks, M.D., F.A.C.S.  
David R. Onsager, M.D.  
Maneesh Parikshak, M.D.  
Vitaly V. Piliuko, M.D., F.A.C.S., F.A.C.C.P.  
Jeffrey F. Schwartz, M.D., F.A.C.S.  
J. Michael Tucheck, D.O., F.A.C.S.  
James J. Walsh, M.D., F.A.C.S.

Jay Willsher, C.O.O.  
Trinity Regional Health System  
2701 - 17<sup>th</sup> Street  
Rock Island, IL 61201

December 12, 2012

Dear Mr. Willsher:

It is my pleasure to write to you in support of the proposed construction for the new Heart Center and Emergency Department at Trinity Medical Center - West Campus in Rock Island.

Cardiac Surgery Associates has been practicing at Trinity Medical Center for 8 years, and I have been a part of the group since 2009. Since we began, the open heart program continues to grow every year in both volume and complexity of cases. Because of the strong support from cardiac surgery, cardiology and administration, patients have been provided with quality care helping to make our hospital a Top 100 Hospital in 2011 and most recently one of America's 100 Best Hospitals for Cardiac Care and Coronary Intervention in 2012.

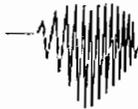
Yet despite overall accomplishments, I believe the proposed facility enhancements are greatly needed. The current lack of space, size and layout of our work environments have created an often unnecessary work flow that, with anticipated future growth, may hinder continued efficiency in patient care and safety. A new Heart Center and Emergency Department will significantly improve the patient experience and overall satisfaction. The proposed developments will not only significantly improve the program in our community, but also move us ahead of our current high standards making our program one of the best in the country

Our group is committed to Trinity Medical Center and the open heart program. In the long run we feel these enhancements will benefit our ability to treat our patients, but also our ability to recruit other physicians in the future who would find an updated facility to be more attractive from a practice standpoint. I fully support the efforts of Trinity Medical Center as it seeks approval to upgrade the Heart Center and Emergency Department as it will certainly benefit the patients and surrounding community.

Sincerely,

Alyas P. Chaudhry, M.D.

4480 Utica Ridge Road • Suite 2222 • Bettendorf, Iowa 52722 • (563)742-3111 • Fax (563)355-9905  
WWW.OPENHEART.NET

 **CARDIAC SURGERY  
ASSOCIATES, S.C.**

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Juan J. Bonilla, M.D., F.A.C.S.  
Keith D. Bowersox, M.D., P.H.D.  
Cris Carlos, M.D.  
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Thomas J. Hinkamp, M.D., F.A.C.S.  
Omid H. Javadi, M.D.  
Bryan K. Lee, M.D., F.A.C.S.  
Frank J. Lutrin, M.D., F.A.C.S.  
Peter H. Marks, M.D., F.A.C.S.  
Manesh Parikshak, M.D.  
William F. Polito, M.D.  
Jeffrey P. Schwartz, M.D., F.A.C.S.  
Jeffrey M. Silver, M.D.  
Vsoolvoid Tikhomirov, M.D.  
Lambros Tsonis, M.D.  
J. Michael Tucheck, D.O., F.A.C.S.  
James J. Walsh, M.D., F.A.C.S.

December 4, 2012

Jay Willsher, C.O.O.  
Trinity Regional Health System  
2701 - 17<sup>th</sup> Street  
Rock Island, Illinois 61201

Dear Mr. Willsher:

It is my privilege to support without reservation the CON application by Trinity West Medical Center for construction and enhancement to the emergency department and the heart center.

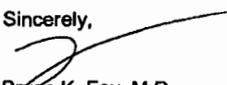
Our group, Cardiac Surgery Associates, has been practicing at Trinity now for six years. That open heart program has and continues to grow both in volume and in complexity of cases. This year again heart surgical volume will be increased over last year, which is notable given the overall environment for cardiology and heart surgery in the country. I think this is a testimonial to the overall strength of the program supported by cardiac surgery, cardiology, and administration.

The proposed facility enhancements will significantly improve patient experience and ability to handle the enhanced capacity which has been missed. It has been a bit of a chore the last year or two to try and process patients through the system given the constraints of the facility and the physical plant. I think these proposed developments will significantly improve that situation overall.

Our group is committed to Trinity and to the open heart program there for the long run and would certainly see these enhancements as benefiting our ability to treat our patients, but also our ability to recruit other physicians in the future who would find these enhancements to be quite attractive from a practice standpoint.

In addition to this letter, I would be happy to, as well, give public testimony in support of this much needed and long overdue program.

Sincerely,

  
Bryan K. Foy, M.D.  
BKF/cds

2650 Warrenville Road \* Suite 280 \* Downers Grove, IL 60515 \* 866-378-7900 / 630 324-7900 \*  
Fax 630 324-7946 \* Billing Fax 630-271-1813



**CLINIC LOCATIONS**

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Davenport, Iowa 52803  
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Fax 563.324.8562  
1.800.382.0707

350 John Deere Road  
Moline, Illinois 61265  
Telephone 309.743.6700  
Fax 309.764.2042  
1.877.788.4590

855 Illini Drive, Suite 402  
Silvis, Illinois 61282  
Telephone 309.743.6700  
Fax 309.278.0038  
1.877.788.4590

- Helbert Acosta, MD, FACC, FHRS
- Prakash R. Bontu, MD, FACC, FAHA
- Robert H. Brewer, MD
- Edmund P. Coyne, MD, FACP, FACC
- Eric J. Dippel, MD, FACC
- Blair W. Foreman, MD, FACC
- Michael J. Gimbel III, MD, FACC
- Nidal H. Harb, MD, FACP, FACC
- Kathleen J. Keyes, MD, FACC
- Mark W. Kovach, MD, FACC
- Faraz Manazir, MD
- Balakrishna Mundodi, MD, MRCP
- Rafat F. Padaria, MD, FACC
- Aswartha Pothula, MD, FACC
- Sanjeev Puri, MD, FACC, FSCAI
- Vijay R. Rajendran, MD, FACC, MRCP (UK)
- Bouyella Reddy, MD
- Sora Reddy, MD
- Jon A. Robken, MD, FCCP, FACC
- Nicolas W. Shammas, MD, FACC, FSCAI, FICA
- Peter J. Sharis, MD, FACC
- Kent J. Van Why, MD, FACC
- Harry R. Wallner, MD
- William J. Witcik, MD, FACP, FACC
- Rhonda Beneke, MSN, APN, ACNP-BC
- D. Diane Boelens, MS, APN, ACNP-BC
- Paula Bryant, MS, ARNP, FNP-BC
- Cyndi Burkholder, MS, ARNP, ACNP-BC
- Emily Coldiron, MSN, APN, FNP-BC
- Judi Deckert, MS, ARNP, FNP-BC
- Shawna Duske, MS, ARNP, ACNP-BC
- Wendy Escontrias, MS, ARNP, FNP-BC, CCDS
- Meredith Hodgson, MS, ARNP, ACNP-BC
- Jennifer Johnson, MSN, APN, FNP-BC
- Cassie King, MS, APN, ANP-BC
- Trisha McIntosh, MS, ARNP, ACNP-BC
- Shannon M. Mentzer, MSN, ARNP, FNP-BC
- Sonal Patel, MMS, PA-C
- Pamela ViPond, MS, ARNP, ACNP-BC

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December 7, 2012

Jay Willsher, C.O.O.  
Trinity Regional Health System  
2701 - 17<sup>th</sup> Street  
Rock Island, IL 61201

Dear Jay,

It is my pleasure to write a letter in support of the new heart center and emergency department project being proposed by Trinity Medical Center on its Rock Island, Ill. campus.

As the Practice Administrator of Cardiovascular Medicine, PC, a private cardiology practice serving Eastern Iowa and Western Illinois, we are committed to providing quality, value based care to the area. A new heart center and emergency department will address capacity constraints and improve patient care and privacy. The new heart center will accommodate all of our heart center services to one campus location to include an improved cardiac rehabilitation department. This will improve patient outcomes and satisfaction by aiding in the recovery process with more space for individual education and group instruction. The Trinity Rock Island hospital was originally built in 1972, and since then has never undergone any major facility upgrades. Further, this new facility will expand the security office and by relocating the emergency department closer to the mental health center, patient and visitor safety also will be enhanced.

The new Heart Center and Emergency Department will have many positive impacts on the health care provided in the Quad City Area. By better accommodating the patients at this campus, we will eliminate the need to leave the community for many services. Improving the hospital as a whole, improves the community as a whole and improves the opportunity to attract and retain quality physicians and staff.

In conclusion, I fully support the efforts of Trinity Medical Center as it seeks approval to upgrade their hospital designed to improve patient care and the overall work environment. Any improvement to the hospital, especially one of this magnitude, has extreme benefits to the economy, the community and the patients who reside in this community.

Sincerely,

Kristine K. Zeller, CMPE, MSHSA  
Administrator



December 7, 2012

**CLINIC LOCATIONS**

1236 East Rusholmie, Suite 300  
Davenport, Iowa 52803  
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Fax 563.324.8562  
1.800.382.0707

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855 Illinois Drive, Suite 402  
Silvis, Illinois 61282  
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Fax 309.792.7801  
1.877.788.4590

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- Mark W. Kovach, MD, FACC
- Faraz Madazir, MD
- Balakrishna Mundodi, MD, MRCP
- Rafat F. Padaria, MD, FACC
- Aswartha Pothula, MD, FACC
- Sanjeev Puri, MD, FACC, FSCAI
- Vijay R. Rejendran, MD, FACC, MRCP (UK)
- Bouyella Reddy, MD
- Sora Reddy, MD
- Jon A. Robken, MD, FCCP, FACC
- Nicolas W. Shamma, MD, FACC, FSCAI, FICA
- Peter J. Sharis, MD, FACC
- Kent J. Van Why, MD, FACC
- Harry R. Wallner, MD
- William J. Witck, MD, FACP, FACC
- Rhonda Beneke, MS, APN, ACNP-BC
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- Paula Bryant, MS, ARNP
- Cyndi Burkholder, MS, ARNP, ACNP-BC
- Emily Coldiron, MS, APN-FNP
- Judi Deckert, MS, ARNP
- Shawna Duske, MS, ARNP
- Wendy Escontrias, MS, ARNP, CCDS
- Tara Gengler, MS, APN-ACNP
- Trisha McIntosh, MS, ARNP
- Shannon M. Mentzer, MSN, ARNP, FNP-BC
- Sonal Patel, MMS, PA-C
- Tracy Rockey, MS, ARNP-BC

**OUTREACH CLINICS IN:**

- Aledo, Illinois
- Bettendorf, Iowa
- Burlington, Iowa
- Clinton, Iowa
- DeWitt, Iowa
- Dubuque, Iowa
- Geneseo, Illinois
- Maquoketa, Iowa
- Muscatine, Iowa
- Sterling/Rock Falls, Illinois

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JAY WILLISHER COO  
TRINITY REGIONAL HEALTH SYSTEMS  
2701 17 STREET  
ROCK ISLAND IL 61201

Dear Jay,

It gives me pleasure to write a letter of support for the new Heart Center and the Emergency Department at Trinity Medical Center on its Rock Island, Illinois campus.

I have worked in this hospital for the last ten years, and before that at St. Louis University Medical Center, and I have seen continued growth in the depth and breadth of services at Trinity Medical Center over the last decade. The complexity of procedures has also increased. The facilities for taking care of cardiac patients were built a couple of decades back as a stopgap measure in the basement of the hospital, and with increased growth of the department the facilities are at best extremely inadequate. The arcane facilities were meant for a small Heart Center, but now, as the Heart Center has grown in providing increased complexity of service and is the highest volume cardiac facility in the whole Iowa Health System, the current facilities pose not only a constraining effect on the further growth of the hospital, but at times limit our capacity to take care of very-sick patients, and at times fall short of national standards.

The new design of the facilities, as has been shown to us, really will help streamline the flow of emergent cardiac patients from the Emergency Department to the cardiac treatment unit and cardiac catheterization labs. The size of the cardiac cath labs is totally inadequate and a lot of times during procedures nurses and technicians have to rush from one room to the other to get our supplies and many a time that hampers the flow of work and we always dread the possibility of a bad outcome because of these factors. The new facilities will provide a streamlined work flow that will help improve the efficiency of work and help reduce cardiac costs in the future.

As part of the new facilities, there will be an observation area that will also help cut down readmission rate to the hospitals as emergent care of heart failure patients will be provided at these new facilities next to the Emergency Department. I feel Trinity has delayed this project for the last several years but finally this project has come to fruition and I congratulate Trinity administration for assembling a great team of architects and health facility planners along with their own administrators in planning this project, which will have a great impact not only in improving our cardiac care to the people of this area, but opening up of these facilities in the downtown Rock Island area will also help improve the economic image of the downtown Rock Island area.

Sincerely,

  
Sanjeev Puri, MD, FACC

SP/dlg

D: 12/7/2012  
T: 12/10/2012



**CLINIC LOCATIONS**

1236 East Rusholme, Suite 300  
Davenport, Iowa 52803  
Telephone 563.324.2992  
Fax 563.324.8562  
1.800.382.0707

350 John Deere Road  
Moline, Illinois 61265  
Telephone 309.743.6700  
Fax 309.764.2042  
1.877.788.4590

855 Illinois Drive, Suite 402  
Silvis, Illinois 61282  
Telephone 309.743.6700  
Fax 309.792.7601  
1.877.788.4590

- Helbert Acosta, MD, FACC, FHRS
- Prakash R. Bontu, MD, FACC, FAHA
- Robert H. Brewer, MD
- Edmund P. Coyne, MD, FACP, FACC
- Eric J. Dippel, MD, FACC
- Blair W. Foreman, MD, FACC
- Michael J. Gimbrel III, MD, FACC
- Michael C. Gitudi, MD, FACP, FACC, FHRS
- Nidal H. Harb, MD, FACP, FACC
- Kathleen J. Keyes, MD, FACC
- Mark W. Kovach, MD, FACC
- Faraz Manazir, MD
- Balakrishna Mundodi, MD, MRCP
- Rafat F. Padaria, MD, FACC
- Aswartha Pothula, MD, FACC
- Sanjeev Puri, MD, FACC, FSCAI
- Vijay R. Rajendran, MD, FACC, MRCP (UK)
- Bouyella Reddy, MD
- Sora Reddy, MD
- Jon A. Robken, MD, FCCP, FACC
- Nicolas W. Shammus, MD, FACC, FSCAI, FICA
- Peter J. Sharis, MD, FACC
- Kent J. Van Why, MD, FACC
- Harry R. Wallner, MD
- William J. Witcik, MD, FACP, FACC
- Rhonda Beneke, MS, APN, ACNP-BC
- D. Diane Boelens, MS, APN-ACNP
- Paula Bryant, MS, ARNP
- Cyndi Burkholder, MS, ARNP, ACNP-BC
- Emily Coldiron, MS, APN-FNP
- Judi Deckert, MS, ARNP
- Shawna Duske, MS, ARNP
- Wendy Escontrias, MS, ARNP, CCDS
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- Muscatine, Iowa
- Sterling/Rock Falls, Illinois

www.cvmedpc.com

December 7, 2012

Jay Willsher, C.O.O.  
Trinity Regional Health System  
2701 – 17<sup>th</sup> Street  
Rock Island, IL 61201

Dear Jay,

I write this letter in support on the new heart center and emergency department project being proposed by Trinity Medical Center on its Rock Island, Ill. campus.

I have worked in this hospital and community for over 16 years and I see the need for improvement to our Heart Center and Emergency Department. While we have made the best of the resources that we have, which is evident by the numerous notable recognitions for our hospital such as its Top 100 Hospital ranking in 2011 and its most recent achievement as one of America's 100 Best Hospitals for Cardiac Care and Coronary Intervention in 2013, it is my belief that a new center would help improve patient care and quality and enhance patient safety and security.

Our hospital cannot accommodate any further growth without significant work to the site infrastructure and central plant. The lack of space creates workarounds that build inefficiency in care delivery, pose quality and safety risks, and jeopardizes patient, physician and staff satisfaction. As a physician on site, I can attest to the fact that the limits have been reached at the current campus, it is only with expansion or upgrades that I believe we can continue to sustain and improve patient outcomes and meet the demands of our aging population. I am aware that emergency room patients have left without being seen due to long wait times. I have personally experienced capacity issues in our cardiac cath labs often delay cases that are urgent but not critical. I am confident that patient recovery also would be enhanced by relocating and expanding our cardiac rehabilitation department as it would provide an optimal environment for patient education and group instruction. By relocating the emergency department closer to our mental health center and upgrading our security facilities, patient and visitor safety would be improved.

With the amount of recognition our current center has received for the quality of care, I believe that this upgrade will only put us ahead of our current standards of care and continue to provide some of the best medical services in Illinois. By providing physicians with quality facilities for which to practice, it also aids in our ability to recruit physicians to Cardiovascular Medicine, P.C.

In conclusion, I fully support the efforts of Trinity Medical Center as the seek permission to upgrade their Rock Island hospital designed to improve patient care and the overall work environment. I believe that this project will improve the quality of care Trinity can provide its community with facilities that optimize the patient experience as well as outcomes.



**CLINIC LOCATIONS**

1236 East Rusholme, Suite 300  
Davenport, Iowa 52803  
Telephone 563.324.2892  
Fax 563.324.8562  
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350 John Deere Road  
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- Michael J. Gimbel III, MD, FACC
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- Kathleen J. Keyes, MD, FACC
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- Aswartha Pothula, MD, FACC
- Sanjeev Puri, MD, FACC, FSCAI
- Vijay R. Rajendran, MD, FACC, MRCP (UK)
- Bouyella Reddy, MD
- Sora Reddy, MD
- Jon A. Robken, MD, FCCP, FACC
- Nicolas W. Shammass, MD, FACC, FSCAI, FICA
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- Dubuque, Iowa
- Geneseo, Illinois
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- Muscatine, Iowa
- Sterling/Rock Falls, Illinois

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Sincerely,

Sora Reddy, MD



**TRINITY**  
IOWA HEALTH SYSTEM

Moline • Rock Island • Bettendorf • Muscatine

2701 17<sup>th</sup> Street  
Rock Island, IL 61201  
309-779-5000

December 12, 2012

Jay Willsher, C.O.O.  
Trinity Regional Health System  
2701 – 17<sup>th</sup> Street  
Rock Island, IL 61201

Dear Jay,

I am writing in support of the new Heart Center and Emergency Department/Observation Unit project being proposed by Trinity Medical Center on our Rock Island, IL campus.

I have worked at Trinity since 1995 as an Emergency Physician – part-time initially and then to full time in 2004, and now am proud to be part of the Trinity Team as your ED Medical Director.

I have practiced Emergency Medicine at the Rock Island Campus since it became the Trauma Center, and the need for improvements to our Emergency Department (ED) is glaringly evident to me. For many years, we have made the best of the resources that we have.

This physical plant was not designed as a Trauma Center, and with the closing of the East Campus many years ago, accommodations were made in an attempt to handle the inevitable surge in volume that occurred.

Adjoining hallways with clinic-sized rooms were added to the main ED. A room just barely larger than the current size standards for a single ED room has 2 beds. Patients are seen and treated in the hallways on stretchers and on chairs – and may never get to an ED room the entire ED stay. The triage intake space allows just one triage station so patients are triaged one at a time. This results in delays in getting patients to the care of a provider, which is why they came to the ED – to see a provider. Many rooms are out of the sight-line to the nurses' station. There is one nurses' station where all providers attempt to do their work.

The hospital cannot accommodate any further growth without significant work to the site infrastructure and central plant. The ED volume continues to steadily increase. The lack of space creates workarounds that build inefficiency in care delivery, pose quality and safety risks, and jeopardizes patient, physician and staff satisfaction. As a practicing Emergency Physician on site, I can attest to the fact that the limits have been reached in the current space.

I have no doubt that a new ED will help improve patient care and quality and enhance patient safety and security based on the following improvements a new physical plant will bring: All private rooms as opposed to several shared rooms. All rooms designed with Electronic Medical Record hardware and documentation considerations in mind. All general rooms will be identical in size and accoutrements – allowing staff to spend more time with the patient rather than searching through drawers and cabinets and other rooms for needed items. A room for bariatric patients; a state of the art Trauma/Major Resuscitation room with CT scanning right across the hall; X-ray capability in the ED so travel time is greatly reduced; A sub-waiting room with 8 patient staging stations for registration and test results waiting; Sub-waiting rooms right in the Department for family to step

out of the room as needed; Sufficient access to toilets (currently 2 in the department for approximately 34,000 visits.) Three specialized Medical/Psychiatric treatment rooms all grouped together with a security station allowing direct visual oversight and the safety of concealed yet easily accessible medical gases and equipment.

We will have simple things like room for a stretcher scale so that accurate patient weight can be determined for weight-based medication dosing, and storage in storage rooms rather than in patient rooms so that patients have more privacy. Specialty care carts will be based in alcoves right in the middle of the department for easy access rather than in patient rooms. Simple things - but all will help us meet our vision of "Best Outcome. Every Patient. Every Time."

It is only with expansion or upgrades that I believe we can continue to sustain and improve patient outcomes and meet the demands of our aging population and increased volumes of patients with emergency psychiatric needs. The relocation of the Emergency Department closer to our mental health center and integrating our security facilities will improve patient and visitor safety. Currently, the ED and Mental Health Centers are at opposite sides of the facility.

The addition of a Mental Health Crisis Stabilization Unit right next to the ED will allow Mental Health care to be delivered in an appropriate setting for those patients, not in a busy ED as it is now. Precious space in our current ED is often occupied for many hours by mental health patients after their medical screening examination is performed.

With the amount of recognition our current center has received for quality of care even with the current physical plant, it is my belief that an upgrade of this scope can only improve our current standards of care and continue to provide some of the best medical services in Illinois and the country. By providing physicians with quality facilities in which to practice, it also aids in our ability to recruit physicians to TRINITY.

As you know, we have just signed a new ED physician who was very enthused by the preliminary plans, and another candidate is interviewing tomorrow. The second candidate had done rotations in the ED here as a medical student, and also is excited to know this project is being proposed to replace the current ED. This project will provide an environment where she knows quality care could be delivered in an optimal patient-centered environment.

In conclusion, I fully support the efforts of Trinity Medical Center as we apply for the Certificate of Need to the State of Illinois to upgrade the Rock Island hospital ED and Heart Center. I believe this project will improve the quality of patient care and the overall work environment, and that Trinity can provide its community with facilities that optimize the patient experience as well as outcomes.

Sincerely,



Kevin W. Kurth, M.D.

P.Y. ARNELL, M.D.  
R.D. FRUS, M.D.  
J.K. BILLMAN Jr., M.D.  
W.W. HOOVER, M.D.



R.J. ANDERSON, M.D.  
L.A. BARNES, M.D.  
P.M. ARNELL, M.D.  
Y.J. LI, M.D., Ph.D.

December 10, 2012

Mr. Jay Willsher, COO  
Trinity Medical Center  
2701 17<sup>th</sup> Street  
Rock Island, IL 61201

Dear Mr. Willsher:

It is my pleasure to write this letter in support of the new Emergency Department (ED) and Heart Center Project proposed by Trinity Medical Center for its Rock Island Illinois Campus. Trinity Rock Island is the largest Emergency provider for over 75 miles in Illinois. The current overcrowded Emergency Department, certified as a Level II Trauma Center, results in long wait times. Additional ED space and facilities would better ensure patient privacy and safety by providing a dedicated mental health area. The current lack of space in the ED prohibits the creation of a STAT laboratory in this area. A STAT lab would better support the critically ill and injured patients by providing immediate laboratory results that could improve quality of care. In addition a STAT laboratory would improve the turnover of patients and decrease wait times for all patients.

The Heart Center portion of the project will support the increasing cardiac care demands for our aging population. With the expanded new cardiac care area there would be decreased wait times for non-critical patients. The proximity to the new ED will shorten transit times and improve care for heart patients who present acutely or who arrive by ambulance.

As a physician practicing at the Trinity Rock Island campus, I attest to the limitations of the current campus and the need for a new Emergency Department and an expanded Heart Center. I join our entire medical community in strong support of this project because of the positive impact it will have on the quality of care for our patients, their safety, and above all their outcomes.

Sincerely,

  
Paula Y. Arnell, MD  
Laboratory Director

---

1520 7th STREET MOLINE, ILLINOIS 61265 (309) 762-8555



**TRINITY REGIONAL  
HEALTH SYSTEM**  
IOWA HEALTH SYSTEM

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563-264-9100  
www.trinitymuscatine.com

Jay Willsher, C.O.O.  
Trinity Regional Health System  
2701 - 17<sup>th</sup> Street  
Rock Island, IL 61201

December 5, 2012

Dear Jay,

I am writing in support of the heart center and emergency department project proposed by Trinity Medical Center for the Rock Island, Illinois campus.

The need for improvement to the Heart Center and Emergency Department is unmistakable. We have made the best of our resources, which is marked by the abundant recognitions for our hospital. Even with these accomplishments, it's my opinion that a new center would help improve patient care and quality and heighten patient safety and security.

Without significant work to the site infrastructure and central plant, the hospital cannot accommodate any further growth. The lack of space creates workarounds that build inefficiency in care delivery, pose quality and safety risks, and jeopardizes patient, physician and staff satisfaction. As a physician, I can attest to the fact that the limits have been reached at the current campus. Only with expansion and upgrades can we continue to meet the demands of our population. Emergency room patients are leaving due to lengthy wait times. Relocating the emergency department closer to the mental health center and upgrading the security facilities would ensure improved patient and visitor safety. Capacity issues in the cardiac cath lab often delay urgent cases. Relocating and expanding the rehabilitation department would enhance patient recovery.

Enhancing these areas and services would likely aid in our recruiting efforts by providing physicians with quality facilities to practice in.

Trinity Medical Center has my whole hearted support as they seek permission to upgrade the Rock Island hospital. This project will improve the quality of care and optimize the patient experience as well as outcomes.

Sincerely,

Manasi Nadkami, MD  
Vice President, Medical Affairs  
Internal Medicine Physician  
Trinity Muscatine

Jay Willsher, C.O.O.  
Trinity Regional Health System  
2701 – 17<sup>th</sup> Street  
Rock Island, IL 61201

Dear Jay,

It is my pleasure to write a letter in support to the new heart center and emergency department project being proposed by Trinity Medical Center on its Rock Island, Ill. campus.

After working at this hospital for 40 years, it is evident of the need for an improvement to our Heart Center and Emergency Department. For many years, we have made the best of the resources that we have, which is evident by the numerous notable recognitions for our hospital such as its Top 100 Hospital ranking in 2011 and its most recent achievement as one of America's 100 Best Hospitals for Cardiac Care and Coronary Intervention in 2013. Despite these accomplishments, it is our belief that a new center would help improve patient care and quality and enhance patient safety and security.

The Trinity Rock Island Hospital is verified by the Illinois Department of Public Health as a Level II Trauma Center and is the largest hospital in the Illinois Quad-Cities. The Trinity Rock Island hospital was originally built in 1972, and since then has never undergone any major facility upgrades. This new facility will improve patient care and privacy by addressing capacity constraints in both its emergency department and heart center. This new facility will also improve patient care, by reducing infection prevention concerns and operational inefficiencies. By expanding our security office and relocating our emergency department closer to our mental health center, patient and visitor safety also will be enhanced. The new heart center will accommodate all of our heart center services to one campus location to include an improved cardiac rehabilitation department. This will improve patient outcomes and satisfaction by aiding in the recovery process with more space for individual education and group instruction.

The projected total cost of the Heart Center/ED project is \$60 million. The new Heart Center and Emergency Department will have many positive impacts on the surrounding community and will be one of the largest capital investments in Rock Island County in some time. By better accommodating the patients at this campus, our community members will be drawn to the closer and more convenient location rather than having to travel a further distance to another hospital. Improving the hospital as a whole, improves the community as a whole in terms of the physicians and staff who reside and work here, and for the patients who would benefit from these improvements to the hospital.

In conclusion, I fully support the efforts of Trinity Medical Center as it seeks approval to upgrade their hospital designed to improve patient care and the overall work environment. Any improvement to the hospital, especially one of this magnitude, has extreme benefits to the economy, the community and the patients who reside in the community.

Sincerely,   
Eric J. Ritterhoff MD

**PRYCE BOEYE**

31 Wildwood Drive  
Rock Island, IL 61201

December 12, 2012  
Jay Willsher  
Trinity Regional Health System  
2701- 17<sup>th</sup> Street  
Rock Island, IL 61201

Dear Jay,

A lifelong resident and business person of Rock Island and former Board Member of Trinity Health System, I am writing to you to endorse the proposed new heart center and emergency department project.

Trinity Rock Island was built in 1972 and was funded by the largest fund drive in the city history to that point. Unfortunately, since then the hospital has never undergone any major facility updates. The Rock Island Hospital is the largest hospital in the Illinois quad cities and is also designated as a level two trauma center which makes it imperative that we meet the needs of patient care. The new heart center will consolidate all of the heart services to one location, including the cardiac rehab department. The new facility will improve patient care by reducing infection prevention concerns and operational inefficiencies.

By relocating the emergency department closer to the mental health center, this will enhance patient and visitor safety. Finally, any improvement to the hospital of this magnitude will have a positive ripple effect which will benefit the patients, economy and the entire community. Thank you for your consideration.

Sincerely yours,

*Pryce Boeye*

Jay Willsher, C.O.O  
Trinity Regional Health System  
2701-17<sup>th</sup> Street  
Rock Island, IL 61201

Dear Jay,

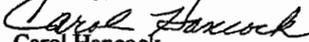
I am pleased to support the new heart center and emergency department project being proposed by Trinity Medical Center on its Rock Island, IL campus.

Trinity Medical Center's Rock Island hospital has never undergone any major facility upgrades since its original development in 1972. This new addition will improve patient care and privacy by addressing capacity constraints in both its emergency department and health center. The new facility will improve patient care, by reducing infection prevention concerns and operational inefficiencies. By expanding our security office and relocating our emergency department closer to our mental health center, patient and visitor safety also will be enhanced. The new heart center will accommodate all of our heart center services to one campus location to include an improved cardiac rehabilitation department. Improvement in patient outcomes and satisfaction is expected by aiding in the recovery process with more space available for individual education and group instruction.

The projected cost of the project is \$60 million. The new Heart Center and Emergency Department will have many positive impacts on the surrounding community and will be one of the largest capital investments in Rock Island County in some time. Trinity Medical Center, Rock Island offers award winning healthcare. Improving the environment in which this care is provided certainly will add to the benefits of choosing Trinity Rock Island for services. Improvements to the hospital will not only benefit patients, but will also improve the environment in which the staff and physicians practice.

In closing, I support the efforts of Trinity Medical Center in its quest for approval to upgrade their facility in Rock Island in order to improve patient care and the hospital environment. The improvements will positively impact the experience of both receiving and providing exceptional healthcare which in turn will benefit the community as a whole.

Sincerely,

  
Carol Hancock

Jay Willsher, C.O.O.  
Trinity Regional Health System  
2701 - 17<sup>th</sup> Street  
Rock Island, IL 61201

Dear Jay,

It is our pleasure to write a letter in support to the new heart center and emergency department project being proposed by Trinity Medical Center on its Rock Island, Ill. campus.

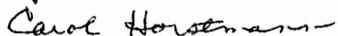
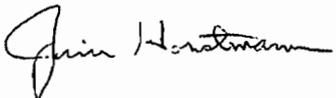
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The projected total cost of the Heart Center/ED project is over \$60 million. The new Heart Center and Emergency Department will have many positive impacts on the surrounding community and will be one of the largest capital investments in Rock Island County in some time. By better accommodating the patients at this campus, our community members will be drawn to the closer and more convenient location rather than having to travel a greater distance to another hospital. Improving the hospital as a whole, improves the community as a whole in terms of the physicians and staff who reside and work here, and for the patients like us who would benefit from these improvements to the hospital.

As Trinity Medical Center volunteer and past board member, we fully support the efforts of the hospital as it seeks approval to upgrade and improve patient care and the overall work environment. Any improvement to the hospital, especially one of this magnitude, has extreme benefits to the economy, the community and the patients who reside in this community.

Sincerely,

Jim and Carol Horstmann



December 12, 2012

Jay Willsher, Chief Administrator Officer  
Trinity Regional Health System  
2701 17<sup>th</sup> Street  
Rock Island, IL 62761

Dear Jay,

It is my pleasure to write a letter in support to the new heart center and emergency department project being proposed by Trinity Medical Center on its Rock Island, Ill. campus.

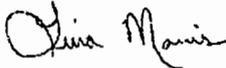
The Trinity Rock Island Hospital is verified by the Illinois Department of Public Health as a Level II Trauma Center and is the largest hospital in the Illinois Quad-Cities. The Trinity Rock Island hospital was originally built in 1972, and since then has never undergone any major facility upgrades. This new facility will improve patient care and privacy by addressing capacity constraints in both its emergency department and heart center. This new facility will also improve patient care, by reducing infection prevention concerns and operational inefficiencies. By expanding our security office and relocating our emergency department closer to our mental health center, patient and visitor safety also will be enhanced. The new heart center will accommodate all of our heart center services to one campus location to include an improved cardiac rehabilitation department. This will improve patient outcomes and satisfaction by aiding in the recovery process with more space for individual education and group instruction.

The projected total cost of the Heart Center/ED project is \$60 million. The new Heart Center and Emergency Department will have many positive impacts on the surrounding community and will be one of the largest capital investments in Rock Island County in some time. By better accommodating the patients at this campus, our community members will be drawn to the closer and more convenient location rather than having to travel a further distance to another hospital. Improving the hospital as a whole, improves the community as a whole in terms of the physicians and staff who reside and work here, and for the patients who would benefit from these improvements to the hospital.

Nine years ago I presented in the Trinity Medical Center emergency department with warning signs of a heart attack. I had just turned 42 years old and was very afraid. I will be forever grateful to Dr. Paul Bolger and the ER staff for the attention I was given and for their actions which resulted in my life being saved. I hope by having a new heart center and emergency department that others in my community can survive as well.

In conclusion, I fully support the efforts of Trinity Medical Center as it seeks approval to upgrade their hospital designed to improve patient care and the overall work environment. Any improvement to the hospital, especially one of this magnitude, has extreme benefits to the economy, the community and the people who reside in this community.

Sincerely,



Tina Morris

2012-12-13 06:15 01366

309 765 3004 >>

P 1/1

Jay Willsher, C.O.O.  
Trinity Regional Health System  
2701 - 17<sup>th</sup> Street  
Rock Island, IL 61201

Dear Jay,

It is my pleasure to write a letter in support of the new heart center and emergency department project being proposed by Trinity Medical Center on its Rock Island, IL campus.

I have been a resident of this community for 36 years and Trinity Rock Island has never undergone any major facility upgrades in that time. I completely support the proposed project. I believe the new heart center and emergency room will have a positive impact on the surrounding community. It will improve patient care, maintain and acquire the best doctors and nurses, and provide privacy and safety to patients and visitors. It is my belief the best patient care can be given if services are centered at an inclusive cardiac and rehabilitation center.

On a personal note, I spent a great deal of time with my father, who had heart disease, at an excellent heart center in Mesa, and felt very comfortable and secure knowing he was receiving the best care possible. It is important to my family in Rock Island to have excellent health care in a facility with the best staff, care, and services.

Upon retiring from a teaching career, I began volunteering as a member of Friends of Trinity Medical Center Board. I have been involved with various fund raising projects to benefit the hospital and other components of Trinity Regional Health Systems. Friends of Trinity have committed a sum of money over the next two years for a cath lab in the heart center. Therefore I support the new project in many ways.

In conclusion, I fully support the efforts of Trinity Medical Center as it seeks approval to upgrade their hospital designed to improve patient care and the work environment. The improvement to the hospital has extreme benefits to the economy, the community, my family, and the patients who reside in this community.

Sincerely,  
*Pat Van Court*  
Pat Van Court

December 10, 2012

Jay Willsher, C.O.O.  
Trinity Regional Health System  
2701 - 17<sup>th</sup> Street  
Rock Island, IL 61201

Dear Jay,

This letter is written to indicate my full support of the proposed new Heart Center and Emergency Department at the Trinity Medical Center Rock Island, IL campus.

The Trinity Rock Island Hospital is verified by the Illinois Department of Public Health as a Level II Trauma Center and is the largest hospital in the Illinois Quad-Cities. However, many changes in medical treatment and patient care have occurred over the forty years since the hospital was originally built in 1970. As a result, the facility is in need of upgrades especially in both the heart center and emergency departments to address capacity constraints and improve patient care.

The proposed new Heart Center will reduce operational inefficiencies by accommodating all of the heart center services to one campus location. Improved patient outcomes and satisfaction will be addressed with more patient privacy, improved strategies to prevent infection, an improved cardiac rehabilitation department to aid the recovery process, and more space to provide individual education and group instruction. The plan to expand the security office and relocate the Emergency Department closer to the Mental Health Center will enhance both patient and visitor safety.

The projected total cost of the Heart Center/Emergency Department is \$60 million. This significant capital investment will reverberate throughout the community and Rock Island County regional area. Community members and highly trained staff will be drawn to this high quality facility and convenient location rather than traveling to other hospitals that are further away.

In conclusion, I wholeheartedly endorse Trinity Medical Center in its efforts to gain approval to upgrade the hospital to improve patient care and work efficiencies. Improvement to the hospital, especially of this magnitude, is certain to be beneficial to the patients and staff, the community and the economy, and to all who live and work in the whole regional area.

Sincerely,



Pat Walkup  
President,  
Friends of Trinity Medical Center

**Project Costs and Sources of Funds**

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

<b>Project Costs and Sources of Funds</b>			
<b>USE OF FUNDS</b>	<b>CLINICAL</b>	<b>NONCLINICAL</b>	<b>TOTAL</b>
Preplanning Costs	\$ 419,655	\$ 473,354	\$893,009
Site Survey and Soil Investigation	\$ 21,631	\$ 17,698	\$39,329
Site Preparation	\$1,000,122	\$1,452,827	\$2,452,949
Off Site Work	-	-	\$0
New Construction Contracts	\$17,975,300	\$14,445,357	\$32,420,657
Modernization Contracts	\$2,090,400	\$135,300	\$2,225,700
Contingencies	\$2,101,057	\$1,468,705	\$3,569,762
Architectural/Engineering Fees	\$1,592,590	\$1,336,664	\$2,929,254
Consulting and Other Fees	\$1,511,604	\$1,073,131	\$2,584,735
Movable or Other Equipment (not in construction contracts)	\$7,320,351	\$5,989,378	\$13,309,729
Bond Issuance Expense (project related)	-	-	\$0
Net Interest Expense During Construction (project related)	\$422,851	\$345,969	\$768,820
Fair Market Value of Leased Space or Equipment	-	-	\$0
Other Costs To Be Capitalized	\$1,115,417	\$912,614	\$2,028,030
Acquisition of Building or Other Property (excluding land)	-	-	\$0
<b>TOTAL USES OF FUNDS</b>	<b>\$35,570,978</b>	<b>\$27,650,998</b>	<b>\$ 63,221,976</b>
<b>SOURCE OF FUNDS</b>	<b>CLINICAL</b>	<b>NONCLINICAL</b>	<b>TOTAL</b>
Cash and Securities			\$53,221,976
Pledges			\$10,000,000
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
<b>TOTAL SOURCES OF FUNDS</b>	<b>\$ 35,570,978</b>	<b>\$27,650,998</b>	<b>\$ 63,221,976</b>
<b>NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>			

**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	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Purchase Price: \$	_____	
Fair Market Value: \$	_____	
The project involves the establishment of a new facility or a new category of service		
	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
If yes, provide the dollar amount of all <b>non-capitalized</b> operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.		
Estimated start-up costs and operating deficit cost is \$ <u>Not Applicable</u> .		

**Project Status and Completion Schedules**

Indicate the stage of the project's architectural drawings:	
<input type="checkbox"/> None or not applicable	<input type="checkbox"/> Preliminary
<input checked="" type="checkbox"/> Schematics	<input type="checkbox"/> Final Working
Anticipated project completion date (refer to Part 1130.140): <u>July 31, 2016</u>	
Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):	
<input type="checkbox"/> Purchase orders, leases or contracts pertaining to the project have been executed.	
<input type="checkbox"/> Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies	
<input checked="" type="checkbox"/> Project obligation will occur after permit issuance.	
<b>APPEND DOCUMENTATION AS ATTACHMENT-8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>	

**State Agency Submittals**

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

**Cost Space Requirements**

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
<b>REVIEWABLE</b>							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
<b>NON REVIEWABLE</b>							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
<b>TOTAL</b>							
<p><b>APPEND DOCUMENTATION AS ATTACHMENT-9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b></p>							

**Cost / Space Requirements**

Department	Cost <sup>2</sup>	Gross Square Feet (GSF)		Amount of Proposed Total GSF That Is:			
		Existing	Proposed <sup>3</sup>	New Construct.	Remodel.	As Is	Vacated
<b>Clinical</b>							
Cardiac Catheterization	\$ 5,557,375	3,460	7,090	7,090			3,460
Phase II Recovery (Cardiac Only)	\$ 4,909,746	3,310	7,850	7,850			3,310
Non Invasive Cardiology Testing (NIDT)	\$ 2,272,661	1,790	3,665	3,665			1,790
Cardiac Rehabilitation	\$ 2,122,857	1,425	4,455	4,455			1,425
Emergency Department	\$ 11,364,736	6,920	18,540	18,540			6,920
Diagnostic Imaging							
a. General Radiography	\$ 410,092	3,580	3,845	565		3,280	300
b. Computerized Tomography	\$ 555,258	1,365	1,730	765		965	400
Observation Unit	\$ 2,801,732	0	4,890	4,890			
Crisis Stabilization Unit	\$ 3,100,516	0	4,650		4,650		
Behavioral Health Group Therapy	\$ 1,645,865	2,800	2,800		2,800		
Vacated Space		7,450					7,450
<b>Total Clinical</b>	\$ 34,740,839	32,100	59,515	47,820	7,450	4,245	25,055
<b>Non Clinical</b>							
Registration / Intake	\$ 586,644		1,965	540		1,425	
Public Areas	\$ 3,865,846		19,920	6,995	615	12,310	
Physician Spaces	\$ 503,649		8,955	235		8,720	
Staff Spaces	\$ 2,222,430		15,745	3,810		11,935	
Administration	\$ 1,597,671		9,035	2,925		6,110	
Conference Rooms/ Educational Spaces	\$ 1,028,373		6,125	1,850		4,275	
Storage	\$ 1,744,163		11,305	4,005		7,300	
Security	\$ 375,575		1,300	315		985	185
Decontamination	\$ 243,706		365	365			85
Canopies	\$ 1,279,633		3,000	3,000			
Building Components <sup>1</sup>	\$ 13,595,112		44,000	15,890		28,110	
Ambulance Garage	\$ 1,438,335		3,015	3,015			1,935
<b>Total Non Clinical</b>	\$ 28,481,136		124,730	42,945	615	81,170	2,205
<b>Total Project</b>	\$ 63,221,976		<b>184,245</b>	<b>90,765</b>	<b>8,065</b>	<b>89,660</b>	<b>27,260</b>

<sup>1</sup> Includes CUP Upgrades, Mechanical, Information Systems, Data Rooms and Circulation, etc.

<sup>2</sup> Project Costs Total from Sources & Uses Exhibit

<sup>3</sup> Proposed Square Footage reports the sum of "New Construction" SF, "Remodeled" SF and "As Is" SF

**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**.

<b>FACILITY NAME: Trinity Rock Island</b>		<b>CITY: Rock Island</b>			
<b>REPORTING PERIOD DATES: From: December 31, 2010 to: December 31, 2011</b>					
<b>Category of Service</b>	<b>Authorized Beds</b>	<b>Admissions</b>	<b>Patient Days <sup>1</sup></b>	<b>Bed Changes</b>	<b>Proposed Beds</b>
Medical/Surgical	193	9,405	39,881	-	193
Obstetrics	-	-	-	-	-
Pediatrics	9	352	1,006	-	9
Intensive Care	20	1,383	4,915	-	20
Comprehensive Physical Rehabilitation	22	343	4,582	-	22
Acute/Chronic Mental Illness	54	2,393	14,175	-	54
Neonatal Intensive Care					
General Long Term Care	29	552	8,783	-	29
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify))					
<b>TOTALS:</b>	<b>327</b>	<b>14,428</b>	<b>73,342</b>	<b>-</b>	<b>327</b>

Source: *Hospital Profiles*, 2011

<sup>1</sup> Includes observation days

**CERTIFICATION**

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

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

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

  
 \_\_\_\_\_  
 SIGNATURE

Richard A. Seidler  
 \_\_\_\_\_  
 PRINTED NAME

President and CEO  
 \_\_\_\_\_  
 PRINTED TITLE

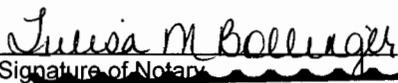
  
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 SIGNATURE

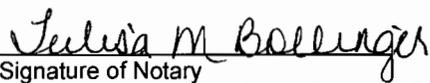
Gregory Pagliuzza  
 \_\_\_\_\_  
 PRINTED NAME

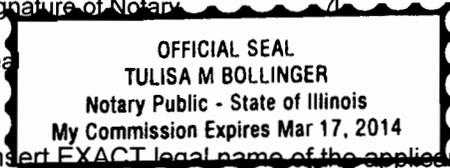
Chief Financial Officer  
 \_\_\_\_\_  
 PRINTED TITLE

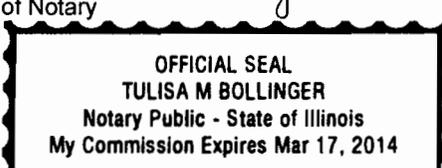
Notarization:  
 Subscribed and sworn to before me  
 this 12<sup>th</sup> day of December, 2012

Notarization:  
 Subscribed and sworn to before me  
 this 12<sup>th</sup> day of December, 2012

  
 \_\_\_\_\_  
 Signature of Notary

  
 \_\_\_\_\_  
 Signature of Notary

Seal 

Seal 

**CERTIFICATION**

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

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

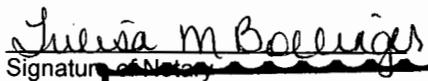
**This Application for Permit is filed on the behalf of Trinity Regional Health System \* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf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

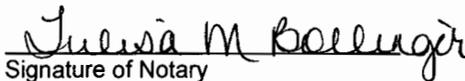
  
 SIGNATURE  
 Richard A. Seidler  
 PRINTED NAME  
 President and CEO  
 PRINTED TITLE

  
 SIGNATURE  
 Gregory Paqliuzza  
 PRINTED NAME  
 Chief Financial Officer  
 PRINTED TITLE

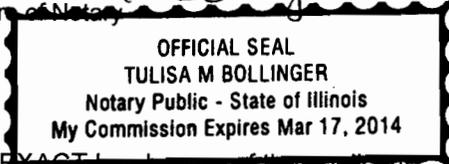
Notarization:  
Subscribed and sworn to before me  
this 12<sup>th</sup> day of December, 2012

Notarization:  
Subscribed and sworn to before me  
this 12<sup>th</sup> day of December, 2012

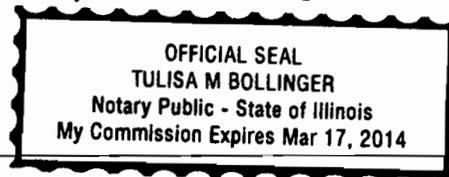
  
Signature of Notary

  
Signature of Notary

Seal



Seal



\*Insert EXACT legal name of the applicant

**CERTIFICATION**

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

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

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

William B. Leaver  
SIGNATURE

William B. Leaver  
PRINTED NAME

IHS President/CEO  
PRINTED TITLE

Dennis W. Drake  
SIGNATURE

Dennis W. Drake  
PRINTED NAME

IHS VP/General Counsel  
PRINTED TITLE

Notarization:  
Subscribed and sworn to before me  
this 13<sup>th</sup> day of December, 2012

Pamela K. Hoskins  
Signature of Notary

Seal  
**PAMELA K. HOSKINS**  
Commission Number 179554  
My Commission Expires  
May 24, 2013

Notarization:  
Subscribed and sworn to before me  
this 13<sup>th</sup> day of December, 2012

Tina M. Patten  
Signature of Notary

Seal  
**TINA M. PATTEN**  
Commission Number 183262  
My Commission Expires  
2/4/2014

\*Insert EXACT legal name of the applicant

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

<b>INDEX OF ATTACHMENTS</b>		
<b>ATTACHMENT NO.</b>		<b>PAGES</b>
1	Applicant/Co-applicant Identification including Certificate of Good Standing	71 – 74
2	Site Ownership	75 – 80
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	81 – 84
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	85 – 88
5	Flood Plain Requirements	89 – 90
6	Historic Preservation Act Requirements	91 – 92
7	Project and Sources of Funds Itemization	93 – 95
8	Obligation Document if required	96
9	Cost Space Requirements	97 – 98
10	Discontinuation	NA
11	Background of the Applicant	99 – 108
12	Purpose of the Project	109 – 120
13	Alternatives to the Project	121 – 145
14	Size of the Project	146 – 159
15	Project Service Utilization	160 – 161
16	Unfinished or Shell Space	162 – 163
17	Assurances for Unfinished/Shell Space	164
18	Master Design Project	NA
19	Mergers, Consolidations and Acquisitions	NA
	<b>Service Specific:</b>	
20	Medical Surgical Pediatrics, Obstetrics, ICU	NA
21	Comprehensive Physical Rehabilitation	NA
22	Acute Mental Illness	NA
23	Neonatal Intensive Care	NA
24	Open Heart Surgery	NA
25	Cardiac Catheterization	165 – 196
26	In-Center Hemodialysis	NA
27	Non-Hospital Based Ambulatory Surgery	NA
28	General Long Term Care	NA
29	Specialized Long Term Care	NA
30	Selected Organ Transplantation	NA
31	Kidney Transplantation	NA
32	Subacute Care Hospital Model	NA
33	Post Surgical Recovery Care Center	NA
34	Children's Community-Based Health Care Center	NA
35	Community-Based Residential Rehabilitation Center	NA
36	Long Term Acute Care Hospital	NA
37	Clinical Service Areas Other than Categories of Service (Emergency, Imaging)	197 – 244
38	Freestanding Emergency Center Medical Services	NA
	<b>Financial and Economic Feasibility:</b>	
39	Availability of Funds	245 – 252
40	Financial Waiver	253
41	Financial Viability	254
42	Economic Feasibility	255 – 258
43	Safety Net Impact Statement	259 – 269
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Appendix A	Site Ownership	281 – 292
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**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**

**This Section must be completed for all projects.  
Facility/Project Identification**

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

Exact Legal Name:	Trinity Medical Center
Address:	2701 17 <sup>th</sup> Street, Rock Island, Illinois 61201
Name of Registered Agent:	Steven J. Gross
Name of Chief Executive Officer:	Rick Seidler
CEO Address:	2701 17 <sup>th</sup> Street, Rock Island, Illinois 61201
Telephone Number:	309-779-2200

Exact Legal Name:	Trinity Regional Health System
Address:	2701 17 <sup>th</sup> Street, Rock Island, Illinois 61201
Name of Registered Agent:	Tamara Byram
Name of Chief Executive Officer:	Rick Seidler
CEO Address:	2701 17 <sup>th</sup> Street, Rock Island, Illinois 61201
Telephone Number:	309-779-2200

Exact Legal Name:	Iowa Health System
Address:	1776 West Lakes Park, Suite 400, Des Moines, Iowa 50261
Name of Registered Agent:	William B. Leaver, President/Chief Executive Officer
Name of Chief Executive Officer:	William B. Leaver
CEO Address:	1200 Pleasant Street, Des Moines, Iowa 50309
Telephone Number:	515-241-6347



**To all to whom these Presents Shall Come, Greeting:**

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

TRINITY MEDICAL CENTER, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 06, 1969, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



Authentication #: 1223702046  
Authenticate at: <http://www.cyberdriveillinois.com>

***In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 24TH day of AUGUST A.D. 2012***

*Jesse White*

SECRETARY OF STATE



**To all to whom these Presents Shall Come, Greeting:**

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

TRINITY REGIONAL HEALTH SYSTEM, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON DECEMBER 21, 1984, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



Authentication #: 1223702050

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

***In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 24TH day of AUGUST A.D. 2012 .***

*Jesse White*

SECRETARY OF STATE



**To all to whom these Presents Shall Come, Greeting:**

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

IOWA HEALTH SYSTEM, INCORPORATED IN IOWA AND LICENSED TO CONDUCT AFFAIRS IN THIS STATE ON JUNE 15, 2010, 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 A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO CONDUCT AFFAIRS IN THE STATE OF ILLINOIS.



Authentication #: 1223702054  
Authenticate at: <http://www.cyberdriveillinois.com>

**In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 24TH day of AUGUST A.D. 2012 .**

*Jesse White*

SECRETARY OF STATE

## SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

### Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Trinity Medical Center
Address of Site Owner:	2701 17 <sup>th</sup> Street, Rock Island, Illinois 61201
Street Address or Legal Description of Site:	2701 17 <sup>th</sup> Street, Rock Island, Illinois 61201
<b>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.</b>	
<b>APPEND DOCUMENTATION AS <u>ATTACHMENT-2</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>	

The appended documentation is proof of site ownership by Trinity Medical Center. Attachment 2, Exhibit 1 is the Commitment for Title Insurance issued by First American Title Insurance Company from April 2, 2008. Attachment 2, Exhibit 2 is the Rock Island County Abstract & Title Guaranty's invoice for the Trinity West Campus (Trinity Rock Island) dated April 14, 2008.

The full invoice document is included in Appendix A.

TO:  
Snyder, Park & Nelson, P.C.  
Attn: Dee A. Runnels  
1600 - 4th Avenue, Ste 200  
P O Box 3700  
Rock Island, IL 61204-3700  
Ph.: 309-786-8497  
Fx.: 309-786-0463



COMMITMENT FOR TITLE INSURANCE

ISSUED BY

*First American Title Insurance Company*

AGREEMENT TO ISSUE POLICY

We agree to issue a policy to you according to the terms of this Commitment. When we show the policy amount and your name as the proposed insured in Schedule A, this Commitment becomes effective as of the Commitment Date shown in Schedule A.

If the Requirements shown in this Commitment have not been met within six months after the Commitment Date, our obligation under this Commitment will end. Also, our obligation under this Commitment will end when the Policy is issued and then our obligation to you will be under the Policy.

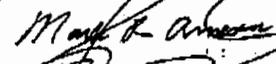
Our obligation under this Commitment is limited by the following:

- The Provisions in Schedule A.
- The Exceptions in Schedule B.
- The Conditions, Requirements and Standard Exceptions  
On the other side of this page.

The Commitment is not valid without Schedule A and Schedule B.



*First American Title Insurance Company*

BY  PRESIDENT  
ATTEST  SECRETARY  
BY  COUNTERSIGNED

! UNDERWRITER - FIRST AMERICAN TITLE INSURANCE COMPANY !  
! Issuing Agency: Rock Island County Abstract & Title Guaranty Company, 211 - 18<sup>th</sup> Street, Suite 300, Rock Island, Illinois 61201 Phone: 309-786-5476 !

## CONDITIONS

1. **DEFINITIONS**  
(a) "Mortgage" means mortgage, deed of trust or other security instrument. (b) "Public Record" means title records that give constructive notice of matters affecting the title according to the state law where the land is located.
2. **LATER DEFECTS**  
The Exceptions in Schedule B may be amended to show any defects, liens or encumbrances that appear from the first time in the public records or are created or attached between the Commitment Date and the date on which all of the Requirements (a) and (c) shown below are met. We shall have no liability to you because of this amendment.
3. **EXISTING DEFECTS**  
If any defects, liens or encumbrances existing at Commitment Date are not shown in Schedule B, we may amend schedule B to show them. If we do amend Schedule B to show these defects, liens or encumbrances, we shall be liable to you according to Paragraph 4 below unless you knew of this information and did not tell us about it in writing.
4. **LIMITATION OF OUR LIABILITY**  
Our only obligation is to issue to you the Policy referred to in this Commitment, when you have met its Requirements. If we have any liability to you for any loss you incur because of an error in this Commitment, our liability will be limited to you actual loss caused by your relying on this Commitment when you acted in good faith to:

comply with the Requirements shown below  
or  
eliminate with our written consent any Exceptions shown  
in Schedule B or the Standard Exceptions noted below.

We shall not be liable for more than the Policy Amount shown in Schedule A of this Commitment and our liability is subject to the terms of the Policy form to be issued to you.

5. **CLAIMS MUST BE BASED ON THIS COMMITMENT**  
Any claim, whether or not based on negligence, which you may have against us concerning the title to the land must be based on this Commitment and is subject to its terms.

## REQUIREMENTS

The following requirements must be met:

- (a) Pay the agreed amounts for the interest in the land and/or the mortgage to be insured.
- (b) Pay us the premiums, fees and charges for the policy.
- (c) Documents satisfactory to us creating the interest in the land and/or the mortgage to be insured must be signed, delivered and recorded.
- (d) You must tell us in writing the name of anyone not referred to in this Commitment who will get an interest in the land or who will make a loan on the land. We may then make additional requirements or exceptions.
- (e) Proper documentation to dispose of such exceptions as you wish deleted from Schedule B or the Standard Exceptions noted below.

## STANDARD EXCEPTIONS

The following Standard Exceptions will be shown on your policy:

- (1) Rights or claims of parties in possession not shown by the public records.
- (2) Easements, or claims of easements, not shown by the public records.
- (3) Encroachments, overlaps, boundary line disputes, or other matters which would be disclosed by an accurate survey or inspection of the premises.
- (4) Any Lien, or right to a lien, for services, labor, or material heretofore or hereafter furnished, imposed by law and not shown by the public records.
- (5) Taxes, or special assessments which are not shown as existing liens by the public records.

! UNDERWRITER - FIRST AMERICAN TITLE INSURANCE COMPANY !

! Issuing Agency: Rock Island County Abstract & Title Guaranty Company, 211 - 18<sup>th</sup> Street, Suite 300, Rock Island, Illinois 61201 Phone: 309-786-5476 !

SCHEDULE A

COMMITMENT NO. F88-110-L

1. Commitment Date: April 2, 2008 at 8:00 a.m.

2. Policy (or policies) to be issued:

(a) ALTA Owner's Policy  
Proposed Insured:

Policy Amount \$TDB

TBD

(b) ALTA Loan Policy  
Proposed Insured:

Policy Amount \$TDB

TBD

3. The estate or interest in the land described or referred to in this Commitment and covered herein is a fee simple and title thereto is at the effective date hereof vested in:

Trinity Medical Center

4. The land referred to in this Commitment is described as follows:

See Schedule A, No. 4 - continued, attached.

! UNDERWRITER - FIRST AMERICAN TITLE INSURANCE COMPANY !  
! Rating Agency: Best-Standard County Abstract & Title Guaranty Company, 711 - 11<sup>th</sup> Street, Suite 300, Rock Island, Illinois 61201 Phone: 309-786-5475 !

# Rock Island County Abstract & Title Guaranty Co.

Representative For  
Lawyers Title Insurance Corporation  
and  
First American Title Insurance Company  
Title Insurance - Abstracts - Escrow Service

211 - 18th Street, Suite 300  
Rock Island, Illinois 61201

email - wsharp@rcatitle.com

Phone (309) 786-6476  
Fax  
(309)  
786-8639  
Fax (309) 786-2698

P.O. Box 3308  
Rock Island, Illinois 61204-3308

Snyder, Park & Nelson, P.C.  
Attn: Dee A. Runnels  
1600 - 4th Avenue, Ste 200  
P O Box 3700  
Rock Island, IL 61204-3700  
Ph.: 309-786-8497  
Fx.: 309-786-0463

Date: April 14, 2008  
FED ID # 36-169-4210

## INVOICE

File No. F88-110-L

RE: TRINITY WEST CAMPUS

<u>Date</u>	<u>Services Description</u>	<u>Amount</u>
April 11, 2008	Owners & Lenders Title Insurance - Commitment Fee	\$250.00
	Additional Tract Searches (2 @ 100.00 each)	\$200.00
	Owner's Policy Premium (liability: \$TBD)	\$TBD

*Note: Billing does not include escrows, future updates, endorsement(s), additional policies, premiums, recording fees, document copies, document preparation, overnight deliveries, closing fees nor revenue stamps...as may be applicable.*

---

TOTAL \$450.00

Description: Commitment and Invoice to above VIA EMAIL

TO:  
Snyder, Park & Nelson, P.C.  
Attn: Dee A. Runnels  
1600 - 4th Avenue, Ste 200  
P O Box 3700  
Rock Island, IL 61204-3700  
Ph.: 309-786-8497  
Fx.: 309-786-0463



COMMITMENT FOR TITLE INSURANCE

ISSUED BY

*First American Title Insurance Company*

AGREEMENT TO ISSUE POLICY

We agree to issue a policy to you according to the terms of this Commitment. When we show the policy amount and your name as the proposed insured in Schedule A, this Commitment becomes effective as of the Commitment Date shown in Schedule A.

If the Requirements shown in this Commitment have not been met within six months after the Commitment Date, our obligation under this Commitment will end. Also, our obligation under this Commitment will end when the Policy is issued and then our obligation to you will be under the Policy.

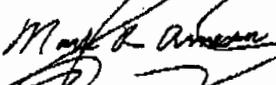
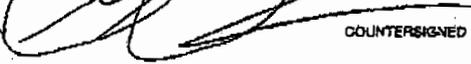
Our obligation under this Commitment is limited by the following:

- The Provisions in Schedule A.
- The Exceptions in Schedule B.
- The Conditions, Requirements and Standard Exceptions  
On the other side of this page.

The Commitment is not valid without Schedule A and Schedule B.



*First American Title Insurance Company*

BY  PRESIDENT  
ATTN:  SECRETARY  
BY  COUNTERSIGNED

! UNDERWRITER - FIRST AMERICAN TITLE INSURANCE COMPANY !

! Issuing Agency: Rock Island County Abstract & Title Guaranty Company, 311 - 16<sup>th</sup> Street, Suite 300, Rock Island, Illinois 61201 Phone: 309-786-5476 !

**Operating Identity/Licensee**

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

Exact Legal Name: Trinity Medical Center d/b/a Trinity Rock Island

Address: 2701 17<sup>th</sup> Street, Rock Island, Illinois 61201

- |  |  |                                |
|--|--|--------------------------------|
| <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.
- 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.**



**To all to whom these Presents Shall Come, Greeting:**

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

TRINITY MEDICAL CENTER, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 06, 1969, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

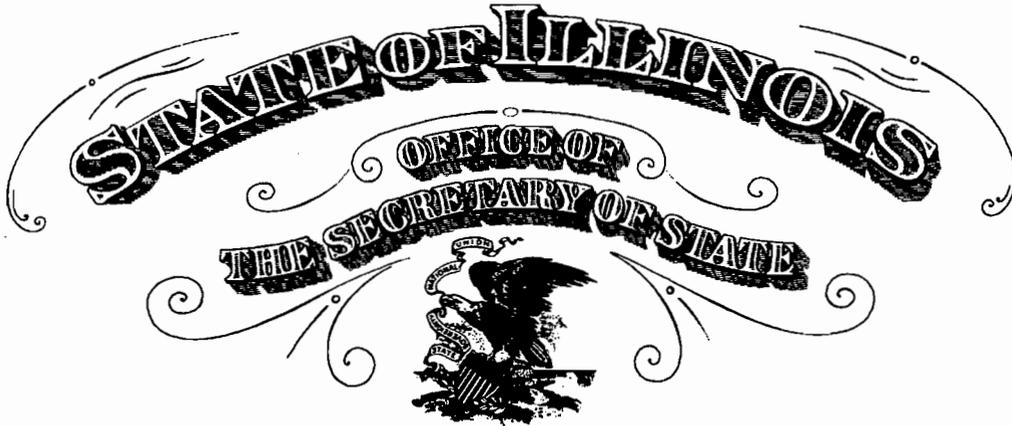


Authentication #: 1223702046  
Authenticate at: <http://www.cyberdriveillinois.com>

**In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 24TH day of AUGUST A.D. 2012 .**

*Jesse White*

SECRETARY OF STATE



**To all to whom these Presents Shall Come, Greeting:**

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

TRINITY REGIONAL HEALTH SYSTEM, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON DECEMBER 21, 1984, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



Authentication #: 1223702050

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

**In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 24TH day of AUGUST A.D. 2012 .**

*Jesse White*

SECRETARY OF STATE



**To all to whom these Presents Shall Come, Greeting:**

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

IOWA HEALTH SYSTEM, INCORPORATED IN IOWA AND LICENSED TO CONDUCT AFFAIRS IN THIS STATE ON JUNE 15, 2010, 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 A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO CONDUCT AFFAIRS IN THE STATE OF ILLINOIS.



Authentication #: 1223702054  
Authenticate at: <http://www.cyberdrivellinois.com>

***In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 24TH day of AUGUST A.D. 2012***

*Jesse White*

SECRETARY OF STATE

## SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

### 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.

This application has three co-applicants; they are Iowa Health System, Trinity Regional Health System, and Trinity Medical Center. Iowa Health System is the sole corporate member of Trinity Regional Health System, the sole corporate member of Trinity Medical Center and Robert Young Center for Community Mental Health.

Trinity Medical Center operates three hospitals, two of which are in Illinois – Trinity Moline and Trinity Rock Island. The third hospital, Trinity Bettendorf, is in Iowa.

See Attachment 4, Exhibits 1 and 2.

Trinity Rock Island is an assumed name (often known as “d/b/a/” for “doing business as”); Trinity Rock Island is an acute general hospital. The proposed project will be constructed on the Trinity Rock Island campus.

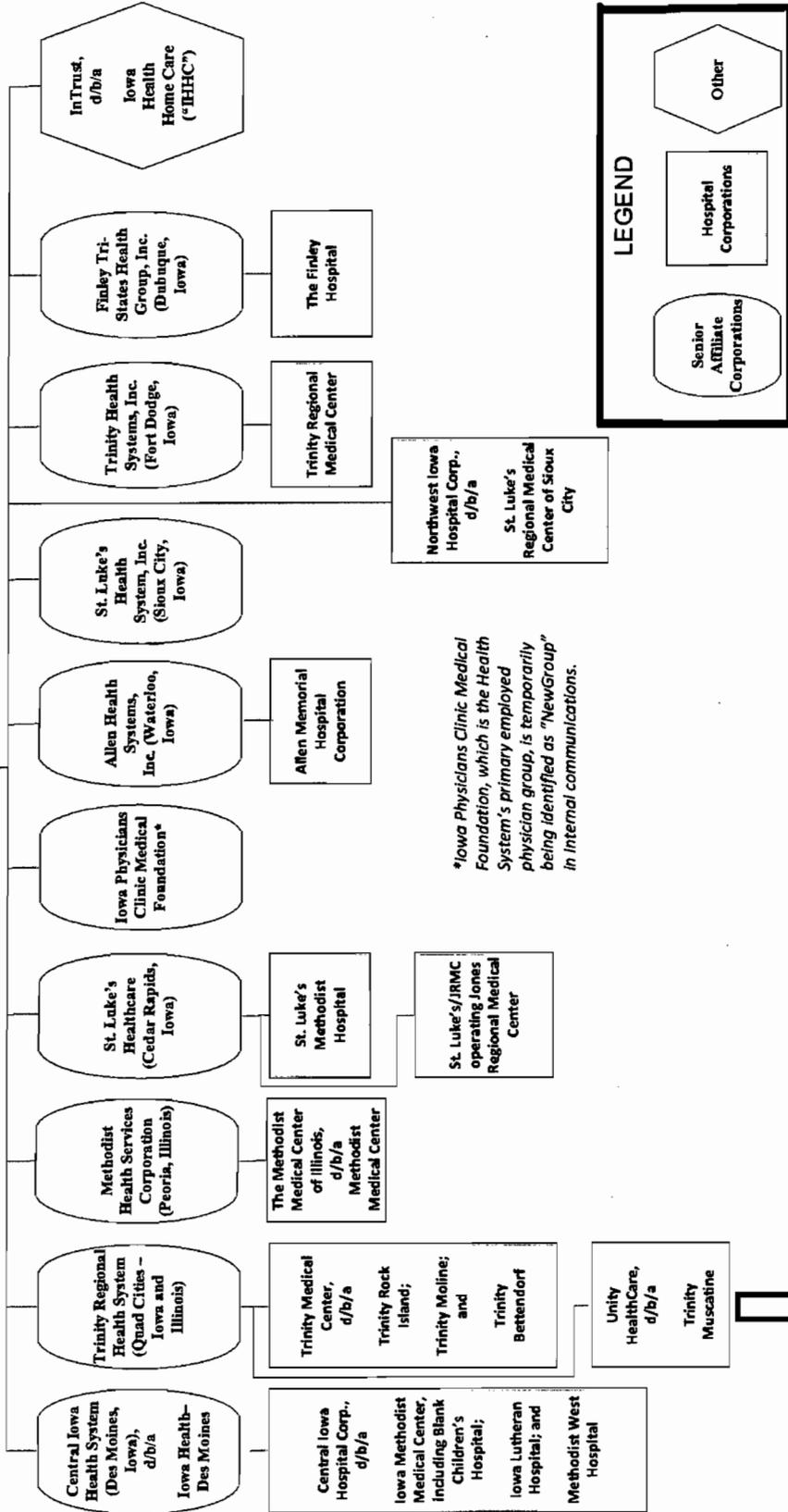
The Robert Young Center (RYC) was the first federally-funded Community Mental Health Center (CMHC) in Illinois as well as the first hospital-based CMHC in either Illinois or Iowa. It is extremely rare for a health system to include a community mental health center as part of its corporate configuration.

The Robert Young Center offers an array of child and adult inpatient psychiatric services, residential rehabilitation services for substance abuse, mental health outpatient services for all ages, and community support services for the severe and persistent mentally ill (SPMI) consumers. RYC’s and Trinity Medical Center’s sole member is Trinity Regional Health System (TRHS), which has as its sole member the Iowa Health System (IHS), one of the largest systems in the U.S. The President of Robert Young Center also functions as the Vice President of Behavioral Health Services for Trinity Regional Health System, allowing for the direct oversight of Trinity Medical Center’s Inpatient Behavioral Health Units as well as Psychiatric Emergency Services at Trinity Medical Center.

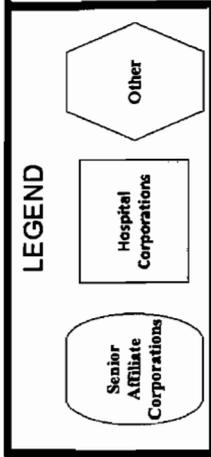
There are very few community mental health centers nationwide that have direct, full administrative and clinical responsibility for hospital emergency psychiatric services and inpatient psychiatric services..

This unique partnership has allowed for extensive, comprehensive and integrated services not found in most community-based mental health centers.

**IOWA HEALTH SYSTEM**



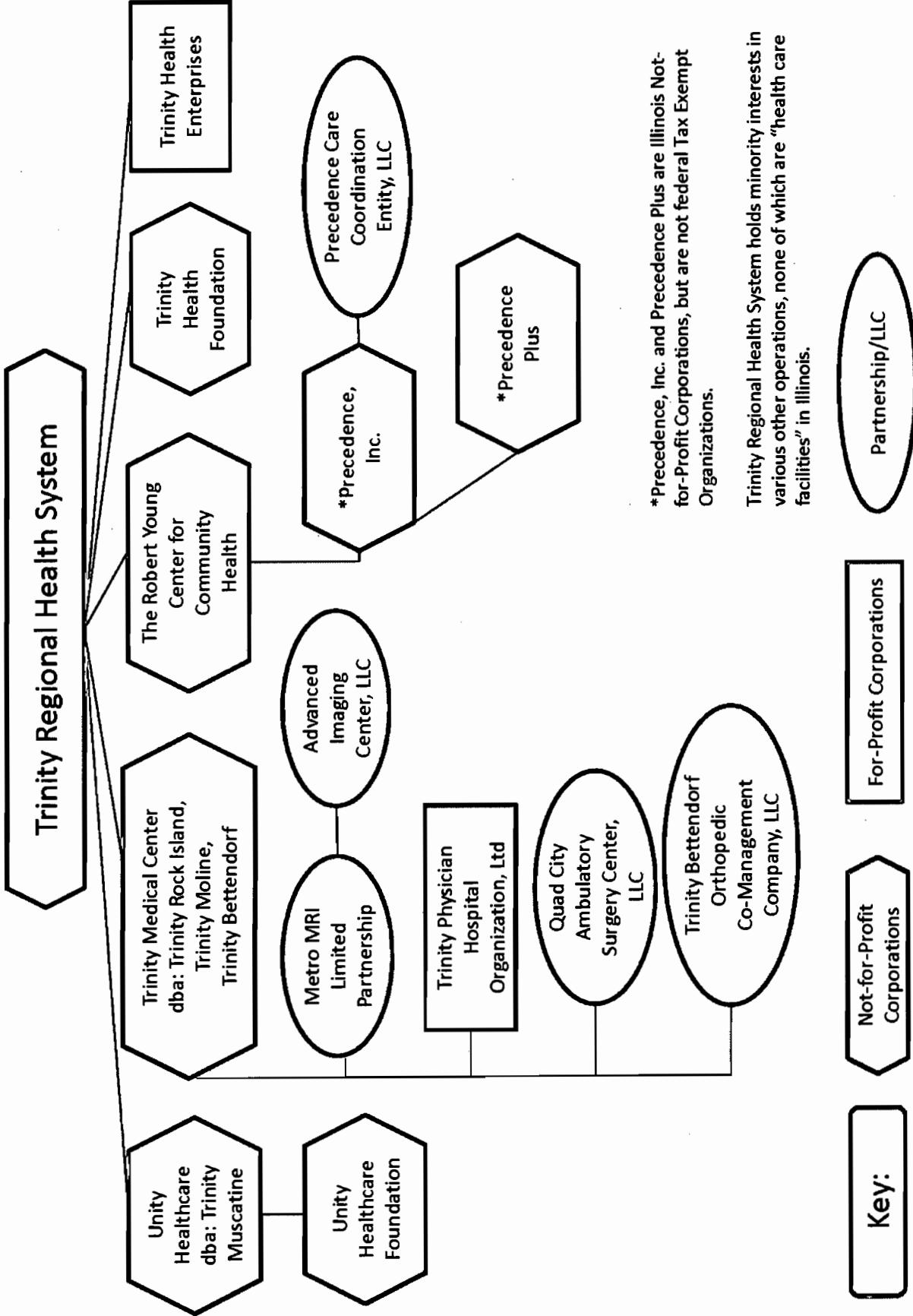
*\*Iowa Physicians Clinic Medical Foundation, which is the Health System's primary employed physician group, is temporarily being identified as "NewGroup" in internal communications.*



Iowa Health System, each Senior Affiliate, IHHC and each Hospital, except Trinity Regional Health System, Trinity Medical Center, Methodist Health Services Corporation, and The Methodist Medical Center of Illinois, are Iowa nonprofit corporations exempt from federal income taxation under Section 501(a) of the Internal Revenue Code of 1986, as amended (the "Code"), are organizations described in Section 501(c)(3) of the Code, and are not private foundations under Section 509(a) of the Code (a "Tax Exempt Organization"). Trinity Regional Health System, Trinity Medical Center, Methodist Health Services Corporation, and The Methodist Medical Center of Illinois are Illinois not-for-profit corporations and Tax Exempt Organizations.

Organizational structure reflects only the complete Trinity Regional Health System structure. The Chart does not reflect all Iowa Health System or non-Trinity Regional Health System Senior Affiliate controlled entities, including some entities that provide services in Illinois. None of the entities that provide services in Illinois are deemed to be "health care facilities" as that term is defined in the Planning Act.

**SEE ATTACHED FOR COMPLETE TRINITY REGIONAL HEALTH SYSTEM CORPORATE ORGANIZATIONAL CHART SHOWING ALL OPERATIONS**



\*Precedence, Inc. and Precedence Plus are Illinois Not-for-Profit Corporations, but are not federal Tax Exempt Organizations.

Trinity Regional Health System holds minority interests in various other operations, none of which are "health care facilities" in Illinois.

## SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

### 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](http://www.FEMA.gov) or [www.illinoisfloodmaps.org](http://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.

By the notarized signatures on the Certification pages of this application, the authorized representatives of Trinity Medical Center attest that the site shown on Attachment 5, Exhibit 1 as identified as the most recent FEMA Flood Insurance Rate Map complies with the Flood Plain Rule and the requirements stated under Illinois Executive Order #2006-5, "Construction Activities in the Special Flood Hazard Area." Trinity Medical Center is not located in a flood plain. The project complies with the requirements of Illinois Executive Order #2005-5.

**NOTES TO USERS**

1. This map is a reproduction of the original map and is not to be used as a substitute for the original map.

2. The map is a reproduction of the original map and is not to be used as a substitute for the original map.

3. The map is a reproduction of the original map and is not to be used as a substitute for the original map.

4. The map is a reproduction of the original map and is not to be used as a substitute for the original map.

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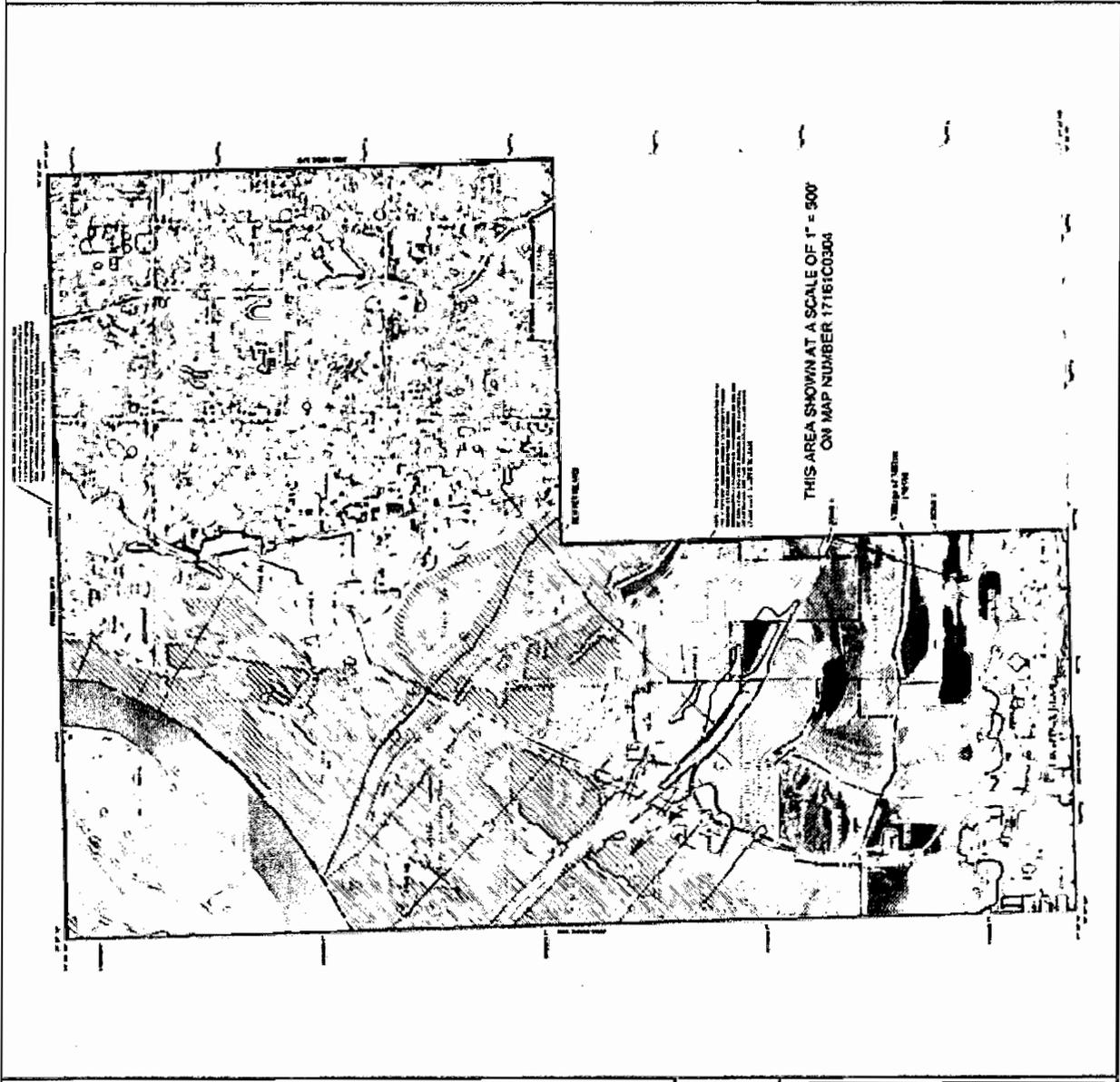
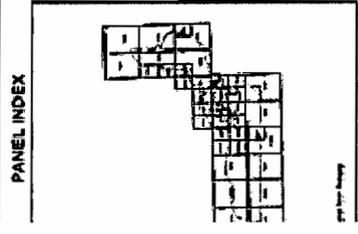
6. The map is a reproduction of the original map and is not to be used as a substitute for the original map.

7. The map is a reproduction of the original map and is not to be used as a substitute for the original map.

8. The map is a reproduction of the original map and is not to be used as a substitute for the original map.

9. The map is a reproduction of the original map and is not to be used as a substitute for the original map.

10. The map is a reproduction of the original map and is not to be used as a substitute for the original map.



**LEGEND**

1. FIRM FLOOD INSURANCE RATE MAPS (FIRM) - SPECIAL STUDY AREA

2. FIRM FLOOD INSURANCE RATE MAPS (FIRM) - SPECIAL STUDY AREA

3. FIRM FLOOD INSURANCE RATE MAPS (FIRM) - SPECIAL STUDY AREA

4. FIRM FLOOD INSURANCE RATE MAPS (FIRM) - SPECIAL STUDY AREA

5. FIRM FLOOD INSURANCE RATE MAPS (FIRM) - SPECIAL STUDY AREA

6. FIRM FLOOD INSURANCE RATE MAPS (FIRM) - SPECIAL STUDY AREA

7. FIRM FLOOD INSURANCE RATE MAPS (FIRM) - SPECIAL STUDY AREA

8. FIRM FLOOD INSURANCE RATE MAPS (FIRM) - SPECIAL STUDY AREA

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19. FIRM FLOOD INSURANCE RATE MAPS (FIRM) - SPECIAL STUDY AREA

20. FIRM FLOOD INSURANCE RATE MAPS (FIRM) - SPECIAL STUDY AREA

**FIRM**  
FLOOD INSURANCE RATE MAP  
SUNCK ISLAND C&H  
BILLINGS, MT  
SPECIAL STUDY AREA

**PANEL INDEX**

1. FIRM FLOOD INSURANCE RATE MAPS (FIRM) - SPECIAL STUDY AREA

2. FIRM FLOOD INSURANCE RATE MAPS (FIRM) - SPECIAL STUDY AREA

3. FIRM FLOOD INSURANCE RATE MAPS (FIRM) - SPECIAL STUDY AREA

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20. FIRM FLOOD INSURANCE RATE MAPS (FIRM) - SPECIAL STUDY AREA

**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**

**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.**

Attachment 6, Exhibit 1 is a letter from the Illinois Preservation Agency which confirms that no historic, architectural, or archaeological sites exist within the Trinity Rock Island project area.



**Illinois Historic  
Preservation Agency**

FAX (217) 782-8161

1 Old State Capitol Plaza • Springfield, Illinois 62701-1512 • [www.illinois-history.gov](http://www.illinois-history.gov)

Rock Island County  
Rock Island

New Construction of 3 Level Addition, Trinity Medical Center  
2701 17th St.  
IHPA Log #013083112

September 12, 2012

Janet Scheuerman  
PRISM Healthcare Consulting  
1808 Woodmere Drive  
Valparaiso, IN 46383

Dear Ms. Scheuerman:

This letter is to inform you that we have reviewed the information provided concerning the referenced project.

Our review of the records indicates that no historic, architectural or archaeological sites exist within the project area.

Please retain this letter in your files as evidence of compliance with Section 4 of the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420/1 et. seq.). This clearance remains in effect for two years from date of issuance. It does not pertain to any discovery during construction, nor is it a clearance for purposes of the Illinois Human Skeletal Remains Protection Act (20 ILCS 3440).

If you have any further questions, please contact me at 217/785-5027.

Sincerely,

Anne E. Haaker  
Deputy State Historic  
Preservation Officer

*A teletypewriter for the speech/hearing impaired is available at 217-524-7128. It is not a voice or fax line.*

80A Trinity Heart Center CON 7 31 2012 92  
12/19/2012 3:47 PM

ATTACHMENT 6  
Historic Resources Preservation Act  
Exhibit 1

## Project Costs and Sources of Funds

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

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs	\$ 419,655	\$ 473,354	\$893,009
Site Survey and Soil Investigation	\$ 21,631	\$ 17,698	\$39,329
Site Preparation	\$1,000,122	\$1,452,827	\$2,452,949
Off Site Work	-	-	\$0
New Construction Contracts	\$17,975,300	\$14,445,357	\$32,420,657
Modernization Contracts	\$2,090,400	\$135,300	\$2,225,700
Contingencies	\$2,101,057	\$1,468,705	\$3,569,762
Architectural/Engineering Fees	\$1,592,590	\$1,336,664	\$2,929,254
Consulting and Other Fees	\$1,511,604	\$1,073,131	\$2,584,735
Movable or Other Equipment (not in construction contracts)	\$7,320,351	\$5,989,378	\$13,309,729
Bond Issuance Expense (project related)	-	-	\$0
Net Interest Expense During Construction (project related)	\$422,851	\$345,969	\$768,820
Fair Market Value of Leased Space or Equipment	-	-	\$0
Other Costs To Be Capitalized	\$1,115,417	\$912,614	\$2,028,030
Acquisition of Building or Other Property (excluding land)	-	-	\$0
<b>TOTAL USES OF FUNDS</b>	<b>\$35,570,978</b>	<b>\$27,650,998</b>	<b>\$ 63,221,976</b>
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities			\$53,221,976
Pledges			\$10,000,000
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
<b>TOTAL SOURCES OF FUNDS</b>	<b>\$ 35,570,978</b>	<b>\$27,650,998</b>	<b>\$ 63,221,976</b>
<b>NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>			

<b>Attachment 7 - Itemization</b>		
<b>Cost Item</b>		<b>Total</b>
Preplanning Costs		
• Architectural/Operational Site and Facility Planning	\$ 565,809	
• Program Management Planning	\$ 301,000	
• Traffic/Parking Engineering Report	\$ 26,200	\$ 893,009
Site Survey and Soil Investigation		
• Soils Testing	\$ 20,329	
• Surveys	\$ 19,000	\$ 39,329
Site Preparation (Demolition, Dewatering, Shoring/Underpinning/Earthwork)		\$ 2,452,949
Off Site Work		\$0
New Construction Contracts		\$32,420,657
Modernization Contracts		\$ 2,225,700
Contingencies		\$ 3,569,762
Architectural/Engineering Fees		
• Architectural/Structural/MEPFP	\$2,366,421	
• Architectural Fee for Surgery Connector	\$ 34,000	
• Interiors/FF&E	\$ 102,583	
• Civil	\$ 211,750	
• Technology	\$ 66,000	
• Landscape Architecture	\$ 93,500	
• Wayfinding	\$ 55,000	\$ 2,929,254
Consulting and Other Fees	\$1,199,000	
• Program Management	\$ 200,000	
• Commissioning	\$ 59,900	
• CON Consultant	\$ 100,000	
• Municipal Fees/Approvals	\$ 358,000	
• Equipment Planning	\$ 250,000	
• Pre-Construction	\$ 125,000	
• QA Materials Testing	\$ 130,000	
• Activation/Transition Consultant	\$ 200,000	
• Surgery Connector Fees	\$ 62,835	\$ 2,584,735
Movable or Other Equipment (not in construction contracts)		
• Medical Equipment	\$9,885,729	
• Equipment for Surgery Connector	\$ 15,000	
• Communications/Security/TV/Cabling	\$2,000,000	
• Furniture	\$ 960,000	
• Furnishing	\$ 284,000	
• Artwork/Plants	\$ 165,000	\$13,309,729

<b>Attachment 7 - Itemization</b>		
<b>Cost Item</b>		<b>Total</b>
Bond Issuance Expense (project related)		\$ 0
Net Interest Expense During Construction (project related)		\$ 768,820
Fair Market Value of Leased Space or Equipment		\$ 0
Other Costs To Be Capitalized		
• Utility Costs During Construction	\$ 400,000	
• Site Tours/Public Relations	\$ 58,030	
• Owner's Cleaning	\$ 45,000	
• Mock-ups	\$ 85,000	
• Owner's Builder's Risk/Insurance	\$ 187,000	
• Utility Taps	\$ 55,000	
• Building Permit	\$ 250,000	
• Security Equipment	\$ 270,000	
• Signage	\$ 285,000	
• CON Fee	\$ 100,000	
• IDPH Fee	\$ 40,000	\$ 2,028,030
Acquisition of Building or Other Property (excluding land)		\$ 0
<b>TOTAL USES OF FUNDS</b>		<b>\$63,221,976</b>

**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**

**Project Status and Completion Schedules**

Indicate the stage of the project's architectural drawings:

- |   |  |
|---|--|
| <input type="checkbox"/> None or not applicable | <input type="checkbox"/> Preliminary   |
| <input checked="" type="checkbox"/> Schematics  | <input type="checkbox"/> Final Working |

Anticipated project completion date (refer to Part 1130.140): July 31, 2016

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.**

**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**

**Space Requirements**

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
<b>REVIEWABLE</b>							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
<b>NON REVIEWABLE</b>							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
<b>TOTAL</b>							

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

**Cost / Space Requirements**

Department	Cost <sup>2</sup>	Gross Square Feet (GSF)			Amount of Proposed Total GSF That Is:			
		Existing	Proposed <sup>3</sup>	New Construct.	Remodel.	As Is	Vacated	
<b>Clinical</b>								
Cardiac Catheterization	\$ 5,557,375	3,460	7,090	7,090				3,460
Phase II Recovery (Cardiac Only)	\$ 4,909,746	3,310	7,850	7,850				3,310
Non Invasive Cardiology Testing (NIDT)	\$ 2,272,661	1,790	3,665	3,665				1,790
Cardiac Rehabilitation	\$ 2,122,857	1,425	4,455	4,455				1,425
Emergency Department	\$ 11,364,736	6,920	18,540	18,540				6,920
Diagnostic Imaging								
a. General Radiography	\$ 410,092	3,580	3,845	565		3,280		300
b. Computerized Tomography	\$ 555,258	1,365	1,730	765		965		400
Observation Unit	\$ 2,801,732	0	4,890	4,890				
Crisis Stabilization Unit	\$ 3,100,516	0	4,650		4,650			
Behavioral Health Group Therapy	\$ 1,645,865	2,800	2,800		2,800			
Vacated Space		7,450						7,450
<b>Total Clinical</b>	\$ 34,740,839	32,100	59,515	47,820	7,450	4,245		25,055
<b>Non Clinical</b>								
Registration / Intake	\$ 586,644		1,965	540				1,425
Public Areas	\$ 3,865,846		19,920	6,995	615			12,310
Physician Spaces	\$ 503,649		8,955	235				8,720
Staff Spaces	\$ 2,222,430		15,745	3,810				11,935
Administration	\$ 1,597,671		9,035	2,925				6,110
Conference Rooms/ Educational Spaces	\$ 1,028,373		6,125	1,850				4,275
Storage	\$ 1,744,163		11,305	4,005				7,300
Security	\$ 375,575		1,300	315				985
Decontamination	\$ 243,706		365	365				85
Canopies	\$ 1,279,633		3,000	3,000				
Building Components <sup>1</sup>	\$ 13,595,112		44,000	15,890				28,110
Ambulance Garage	\$ 1,438,335		3,015	3,015				
<b>Total Non Clinical</b>	\$ 28,481,136		124,730	42,945	615			81,170
<b>Total Project</b>	\$ 63,221,976		<b>184,245</b>	<b>90,765</b>	<b>8,065</b>			<b>85,415</b>
								<b>27,260</b>

<sup>1</sup> Includes CUP Upgrades, Mechanical, Information Systems, Data Rooms and Circulation, etc.

<sup>2</sup> Project Costs Total from Sources & Uses Exhibit

<sup>3</sup> Proposed Square Footage reports the sum of "New Construction" SF, "Remodeled" SF and "As Is" SF

### 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.**

1. *A listing of all health care facilities owned or operated by the applicant, including licensing, and certification, if applicable.*

Iowa Health System is the sole corporate member of Trinity Regional Health System, the sole corporate member of Trinity Medical Center. Trinity Regional Health System is also a member of Quad City Ambulatory Surgery Center, L.L.C., which is an Illinois health care facility. Trinity Medical Center operates three hospitals, two of which are in Illinois – Trinity Moline and Trinity Rock Island.

Trinity Rock Island is an “assumed name” (often known as “d/b/a” for doing business as) for the hospital that is the subject of this CON application.

The proposed project will be constructed on the Trinity Rock Island Campus.

Licenses and Joint Commission Accreditation Letters for Illinois Facilities Owned and Operated by Iowa Health System in Illinois

The following is a listing of all health care facilities owned or operated by the applicants with applicable license numbers and Joint Commission accreditation numbers. Copies of these licenses and Joint Commission letters are included as Attachment 11, Exhibit 1.

Because the 2013 Illinois license had not yet been received for Trinity Moline by early December 2012, Trinity Medical Center contacted the State of Illinois Department of Public Health at 217-782-0852 (Kevin) to determine the reason for the delay. The caller was told that Trinity Moline was licensed but that the State had depleted its supply of the paper used to print license and that the 2013 license would be forwarded as soon as it was printed. As of the filing of this application, the new license has not been received. It will be forwarded to the State Agency as soon as it is received. The current application includes a copy of Trinity Moline's 2012 license.

Attachment 11, Table 1  
Current License and Joint Commission Identification Numbers

Name and Location of the Facility	Illinois License Identification Number	Joint Commission Identification Number
Trinity Medical Center Rock Island	0003244	Joint Commission ID #7421
Trinity Moline Moline, Illinois	0005140	Joint Commission ID #7421
Quad City Ambulatory Surgery Center, LLC Moline Illinois	7002520	AAAC ID #12794

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.*

Certified Listing of Adverse Action Against Any Facility Owned and Operated by the Applicants in Illinois

By the notarized signatures on the Certification pages of this application, the authorized representatives of Trinity Medical Center, Trinity Regional Health System and Iowa Health System attest that there have been no adverse actions during the 3 years prior to filing this application against any facility owned and/or operated Iowa Health System by any regulatory agency which would affect its ability to operate a licensed entity.

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*

Authorization Permitting HFSRB and IDPH to Access Necessary Documentation

By the notarized signatures on the Certification pages of this application, the authorized representatives of Trinity Medical Center, Trinity Regional Health System, and Iowa Health System hereby authorize the Health Facilities and Services Review Board and the Illinois Department of Public Health to access information in order to verify any documentation or information submitted in response to the requirements of this subsection, or to obtain any documentation or information which the State Board or Department of Public Health find pertinent to this subsection.

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.*

Exception for Filing Multiple Certificates of Need in One Year

Not applicable. This is the first certificate of need filed by Trinity Medical Center, Trinity Regional Health System, and Iowa Health System in 2013.

**State of Illinois 2087325**  
**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.

LA HAR HASBROUCK, MD, MPH  
 DIRECTOR

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

EXPIRATION DATE	CATEGORY	ID NUMBER
06/30/13	BGBD	0003244

**FULL LICENSE**  
**GENERAL HOSPITAL**  
**EFFECTIVE: 07/01/12**

BUSINESS ADDRESS

TRINITY ROCK ISLAND  
 2701 17TH STREET  
 ROCK ISLAND IL 61201

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

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION



**State of Illinois 2087325**  
**Department of Public Health**

**LICENSE, PERMIT, CERTIFICATION, REGISTRATION**

TRINITY ROCK ISLAND

EXPIRATION DATE	CATEGORY	ID NUMBER
06/30/13	BGBD	0003244

**FULL LICENSE**  
**GENERAL HOSPITAL**  
**EFFECTIVE: 07/01/12**

05/05/12  
 TRINITY ROCK ISLAND  
 2701 17TH STREET  
 ROCK ISLAND IL 61201

FEE RECEIPT NO.

# Trinity Medical Center

Rock Island, 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 13, 2012

Accreditation is customarily valid for up to 36 months.

Handwritten signature of Isabel V. Hoverman.

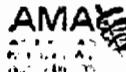
Isabel V. Hoverman, MD, MACP  
Chair, Board of Commissioners

Organization ID #: 7421  
Print/Reprint Date: 10/01/12

Handwritten signature of Mark R. Chassin.

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

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



This reproduction of the original accreditation certificate has been issued for use in regulatory/payer agency verification of accreditation by The Joint Commission. Please consult Quality Check on The Joint Commission's website to confirm the organization's current accreditation status and for a listing of the organization's locations of care.

**State of Illinois 2061091**  
**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 Statute and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

Special order the authority of  
 The State of Illinois  
 Department of Public Health

**DAWON T. ARNOLD, M.D.**  
 DIRECTOR

ISSUANCE DATE	CATEGORY	LICENSE NO.
11/28/12	8680	0005140

**FULL LICENSE**  
**GENERAL HOSPITAL**  
**EFFECTIVE: 11/29/11**

**BUSINESS ADDRESS:**

**TRINITY HOLLINE**  
**500 JOHN DEERE ROAD**  
**HOLLINE IL 61265**

The State of Illinois has a criminal background. Permitted by Authority of the State of Illinois - 487

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

**State of Illinois 2061091**  
**Department of Public Health**

**LICENSE, PERMIT, CERTIFICATION, REGISTRATION**

**TRINITY HOLLINE**

ISSUANCE DATE	CATEGORY	LICENSE NO.
11/28/12	8680	0005140

**FULL LICENSE**  
**GENERAL HOSPITAL**  
**EFFECTIVE: 11/29/11**

10/00/11

TRINITY HOLLINE  
 500 JOHN DEERE ROAD

HOLLINE IL 61265

FEE RECEIPT NO.

# Trinity Moline

Moline, 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 13, 2012

Accreditation is customarily valid for up to 36 months.

A handwritten signature in black ink, appearing to read "Lawrence M. Lowerman".

Lowerman, MD, MACP  
Chair of Commissioners

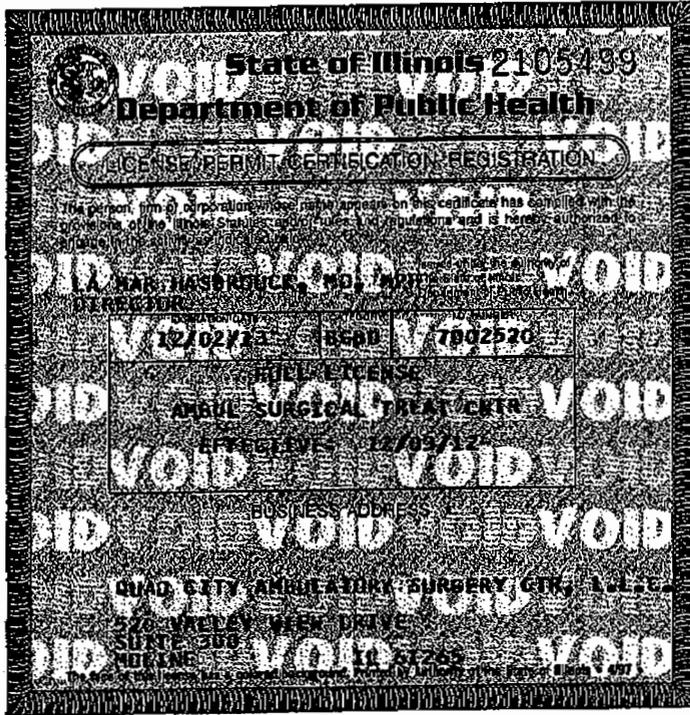
Organization ID #7421

Print/Reprint Date: 11/19/12

A handwritten signature in black ink, appearing to read "Mark R. Chassin".

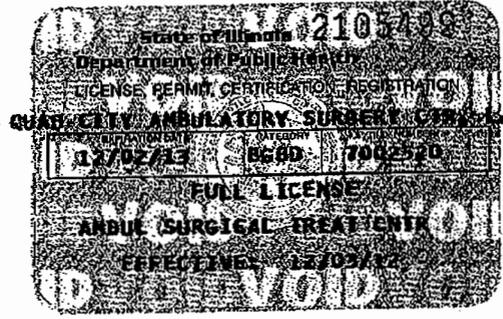
Mark R. Chassin, MD, FACP, MPP, MPH  
President

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



← DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION



09/29/12

QUAD CITY AMBULATORY SURGERY CTR, L.L.C.  
 520 VALLEY VIEW DRIVE  
 SUITE 300  
 MOLINE IL 61265

FEE RECEIPT NO. 15697



ACCREDITATION ASSOCIATION  
for AMBULATORY HEALTH CARE, INC.

October 22, 2012

Organization #: 12794  
 Organization: Quad City Ambulatory Surgery Center, LLC dba QCASC  
 Address: 520 Valley View Drive, Suite 300  
 City, State, Zip: Moline, IL 61265-6152  
 Decision Recipient: Mary Ann Sears, RN, MS  
 Survey Date: August 6-7, 2012 Type of Survey: Re-survey 1 year  
 Survey Chairperson: Joseph L. Posch, MBA, PhD  
 Accreditation Term Begins: August 24, 2012 Accreditation Term Expires: August 23, 2015 \*  
 Accreditation Renewal Code: 2d63084012794  
 Complimentary study participation code: 12794FREEIQI

Granting accreditation reflects confidence, based on evidence from this recent survey that you meet, and will continue to demonstrate throughout the accreditation term, the attributes of an accreditable organization, as reflected in the standards found in the *Accreditation Handbook for Ambulatory Health Care*. The dedication and effort necessary for an organization to be accredited is substantial and the compliance with those standards implies a commitment to continual self-evaluation and continuous improvement. If your organization was required to submit a plan for improvement, receipt of this letter denotes acceptance of the plan for improvement.

We hope the survey has been beneficial to your organization in identifying its strengths and opportunities to improve. AAAHC trusts that you will continue to find the accreditation experience meaningful, not only from the benefit of having carefully reviewed your own operation, but also from the recognition brought by your participation in this survey process.

Members of your organization should take time to review your Survey Report, which may arrive separately:

- Any standard marked "PC" (Partially Compliant) or "NC" (Non-Compliant) must be corrected promptly. Subsequent surveys by the AAAHC will seek evidence that deficiencies from this survey were addressed without delay.
- The Summary Table provides an overview of compliance for each chapter applicable to the organization.
- Statements in the "Consultative Comments" sections of the report represent the educational component of the survey. Such comments may provide helpful guidance for improvement.
- As a guide to the ongoing process of self-evaluation, periodic review of the Survey Report and the current year's *Handbook* will ensure the organization's ongoing compliance with the standards throughout the term of accreditation.

AAAHC policies and procedures and standards are revised on an annual basis, such revisions become effective March 1 each year. Accredited organizations are required to maintain their operations in compliance with the current AAAHC standards and policies. Therefore, the organization is encouraged to visit the AAAHC website, [www.aaahc.org](http://www.aaahc.org), for information pertaining to any revisions to AAAHC policies and procedures and standards.

In order to ensure continuation of accreditation, your organization should submit an application for survey approximately five months prior to your accreditation expiration. According to our *Accreditation Handbook*,

*Currently-accredited organizations must complete and submit the Application for Survey, supporting documentation, and application fee for their subsequent full accreditation survey (referred to as a re-accreditation survey). Please visit [www.aaahc.org](http://www.aaahc.org) to complete the Application for Survey and for further information. After review of an organization's completed Application for Survey and supporting documentation, the AAAHC will contact the organization to establish survey dates. To prevent a lapse in accreditation, an organization should ensure that all documentation is submitted to the AAAHC at least five (5) months prior to its accreditation expiration date. In states where accreditation is mandated by law, an organization should submit the completed Application for Survey and other required documentation a minimum of six (6) months prior to its accreditation expiration date.*

Improving Health Care Quality Through Accreditation

3250 Old Orchard Road, Suite 200  
Skokie, Illinois 60077

Tel: (847) 833 6060  
Fax: (847) 833 5028

[www.aaahc.org](http://www.aaahc.org)  
[info@aaahc.org](mailto:info@aaahc.org)

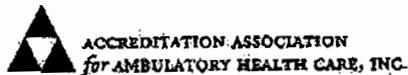
Organization #: 12794 Accreditation Expires: August 23, 2015  
Organization: Quad City Ambulatory Surgery Center, LLC dba QCASC  
October 22, 2012

Page 2

For submission of an application for survey, your organization will need the "accreditation renewal code" located underneath the accreditation expiration date.

You will notice that you have a "complimentary study participation code" at the top of this letter. You may use this to register for one of the AAAHC Institute for Quality Improvement's studies. Please visit [www.aaahc.org/institute](http://www.aaahc.org/institute) for additional information or contact Michelle Chappell, at 847-324-7747 or [mchappell@aaahc.org](mailto:mchappell@aaahc.org).

If you have any questions or comments about any portion of the accreditation process, please contact the AAAHC Accreditation Services department at (847) 853-6060.



**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:

**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.**

1. *Document that the project will provide health services that improve the health care or well-being of the market population to be served.*

The purpose of the Heart Center/Emergency Department project is to improve access, continue to improve outcomes, and to reduce the cost of health care to the greater Rock Island community and beyond. The proposed project has two major components, both of which are necessary to improve the health care and well-being of residents of the area. These components will be achieved by constructing and modernizing space on the Trinity Rock Island (TRI, Hospital) campus.

The first component includes cardiac services. The project envisions developing a comprehensive range of cardiovascular diagnostic and therapeutic capabilities in close proximity to each other in the new construction. These services will be sized to accommodate the current and future needs of the service population, and especially the seniors. By consolidating these vital community services, access will be enhanced and coordination of care will be optimized. Improved access, including adequate capacity, will make these services more readily available to the community. Coordination

of care will help to improve outcomes. Together, improved access and coordination of care will improve the health care and well-being of the market area population.

Secondly, the project envisions replacing the existing Level II Trauma Center/Emergency Department (ED) in new construction. Today, the ED's 17 stations are operating in excess of the State Agency utilization targets; the departmental square footage is only 45 percent of the allowable State Guideline. Anticipated increased demand based on projected population growth and aging as well as the increased utilization projected as the result of the implementation of state and federal health reform initiatives are expected to further tax the ability of the ED to accommodate emergency patients in a timely way. By providing more capacity (and, hence, improved access) in the ED and by providing a 12-bed Observation Unit Trinity Rock Island will be able to improve outcomes and reduce the cost of delivering emergency services. Together, improved access/additional capacity and capabilities to reduce unnecessary admissions will improve the health care and well-being of the market area population.

The special needs of behavioral health (psychiatric and substance abuse) patients have been addressed in this project. The ED will have 3 safe rooms so that high risk behavioral health patients can do no harm to themselves, other emergency patients, or staff. In addition, a new Crisis Stabilization Unit is proposed as part of the project. This unit is an important component of the State's vision of rebalancing the delivery of behavior/mental health care. This unit will provide a unique area to begin treatment until behavioral health patients can be discharged to an inpatient or outpatient program. This improved access and provision of safe accommodations geared to the unique needs of behavioral health patients will improve the health care and well-being of the market area population.

2. Define the planning area or market, or other, per the applicant's definition.

Trinity Regional Health System defines a single service area for its four hospitals – Trinity Rock Island (TRI), Trinity Moline, and Trinity Bettendorf, and Trinity Muscatine. That service area includes Rock Island, Henry, Mercer, and Whiteside counties in Illinois and Scott, Muscatine, and Clinton counties in Iowa. Attachment 12, Exhibit 1, is a map of the entire TRHS service area.

The Trinity Rock Island serves the same multi-county service area as does the Trinity Rock Island System. All service area information reported below is based solely on TRI data.

Attachment 12, Table 1  
Patient Origin, 2011  
Trinity Rock Island and Robert Young Center

County, State	Trinity Rock Island Admissions		Robert Young Center Inpatients and Outpatients	
	Number	Percent	Number	Percent
Rock Island, Illinois	10,964	76.1	3,142	71.9
Henry, Illinois	1,030	7.1	288	6.6
Scott, Iowa	722	5.0	413	9.5
Whiteside, Illinois	233	1.6	93	2.1
Mercer, Illinois	690	4.8	149	3.4
Muscatine, Iowa	140	1.0	17	0.4
Clinton, Iowa	44	0.3		
All Other	588	4.1	268	6.1
Total	14,411	100.0	4,370	100.0

Source: Trinity Rock Island and Robert Young Center Records, 2011.

Note: Totals may not add due to rounding.

The service areas of Trinity Rock Island and Robert Young Center are similar, with a concentration of admissions and patients in Rock Island County, but also with a presence in Henry, Scott, Mercer, Whiteside and Muscatine counties.

Trinity Rock Island also receives 588 patients from beyond the Hospital's defined service area. These patients are often people traveling through the Quad Cities area or visiting local residents. Similarly, Robert Young Center draws patients from the service area counties as well as other counties in Illinois, Iowa, Wisconsin, and beyond. The reasons for the Robert Young Center's (RYC, Center) broad geographic reach are many. Among them are the following. First, RYC has the only adolescent acute mental illness beds in the Quad Cities area and the only substance abuse beds in Illinois within a 75-mile radius of the Center. Next, in response to the Singer State

Hospital's closure, RYC was awarded CHIPS funding to care for patients in 10 counties in northwest Illinois. In addition, RYC provides psychiatric services for area hospital emergency departments including the four Trinity Regional Health System campuses, Genesis Illini Hospital, Mercer County Hospital, and Hammond Henry Hospital. Finally, the Center provides point of service crisis services through mobile crisis and telepsychiatry.

The population of Rock Island County is projected to increase 2.2 percent between 2010 and 2025; however, population age 65 and over is expected to increase by 42.4 percent. Growth in all the service area counties, for the most part, follows these same population change trends, with modest growth overall, but with very strong growth in the 65 and over age group.

Attachment 12, Table 2  
Population Change in Trinity Rock Island Service Area Counties

	2000	2010	2015	2020	2025	Percent Change
<b>Rock Island County Illinois</b>						
0-14	29,295	28,005	28,581	29,208	28,752	+2.7
15-44	62,058	57,930	57,361	56,973	55,491	-4.2
45-64	35,683	41,383	40,165	37,768	35,947	-13.1
65 and over	22,601	24,333	27,189	30,992	34,656	+42.4
<b>Total</b>	<b>149,637</b>	<b>151,651</b>	<b>153,296</b>	<b>154,941</b>	<b>154,846</b>	<b>+2.1</b>
<b>Henry County, IL</b>						
0-14	10,469	10,122	10,424	10,369	10,315	+1.9
15-44	19,861	17,743	17,689	17,924	18,032	+1.6
45-64	12,420	14,516	14,190	13,778	13,245	-8.8
65 and over	8,357	8,326	9,222	10,347	11,629	+39.7
<b>Total</b>	<b>51,107</b>	<b>50,707</b>	<b>51,525</b>	<b>52,418</b>	<b>53,221</b>	<b>+7.1</b>
<b>Mercer County, IL</b>						
0-14	3,398	3,276	3,353	3,483	3,559	+8.6
15-44	6,565	6,299	6,308	6,295	6,332	+5.2
45-64	4,318	5,054	5,040	4,976	4,794	-5.1
65 and over	2,707	2,957	3,242	3,630	4,018	+35.9
<b>Total</b>	<b>16,988</b>	<b>17,586</b>	<b>17,943</b>	<b>18,384</b>	<b>18,703</b>	<b>+6.4</b>

Attachment 12, Table 2  
Population Change in Trinity Rock Island Service Area Counties  
(Continued)

	2000	2010	2015	2020	2025	Percent Change
<b>Whiteside County, IL</b>						
0-14	12,521	12,498	13,023	13,432	13,706	+9.7
15-44	24,063	22,549	22,750	23,242	23,724	+5.2
45-64	14,413	16,862	16,579	15,757	14,706	-12.8
65 and over	9,758	10,522	11,575	13,134	14,612	+38.9
<b>Total</b>	<b>60,755</b>	<b>62,431</b>	<b>63,927</b>	<b>65,565</b>	<b>66,748</b>	<b>+6.9</b>
<b>Scott County, Iowa</b>						
<b>Total</b>	<b>158,668</b>	<b>165,224</b>	<b>170,278</b>	<b>174,631</b>	<b>179,145</b>	<b>+8.4</b>
<b>Muscatine County Iowa</b>						
<b>Total</b>	<b>41,722</b>	<b>42,745</b>	<b>43,453</b>	<b>44,225</b>	<b>45,037</b>	<b>+5.4</b>
<b>Clinton County, IA</b>						
<b>Total</b>	<b>50,149</b>	<b>49,116</b>	<b>48,612</b>	<b>48,486</b>	<b>48,406</b>	<b>-1.4</b>

Source: <https://data.illinois.gov/Economics/DCEO-County-Population-Projections/h3bx-hbbh>;  
<http://data.iowadatecenter.org>;  
 Iowa Data projections done by Woods and Poole Economics Copyright 2009  
<http://data.iowadatecenter.org/datatables/CountyAll/co2010populationprojections20002040.pdf>

Note: Iowa population detail by age cohort not available from public sources.

This strong growth in the senior population portends greater demand for health care services, including cardiovascular and emergency services.

Attachment 12, Table 3  
Inpatient Utilization, 2006

Metric	Total Population	Age 65+
Discharges per 1,000 Population	116.9	253.4
Diseases of the Circulatory System (ICD-9 Code)	206.6 Discharges per 10,000 Population	1,020.0 Discharges per 10,000 Population
Rate of Cardiac catheterization	37.4 per 10,000 Population	142.0 per 10,000 Population
Operations of the Cardiovascular System	242.6 per 10,000 Population	981.8 per 10,000 Population

Source: DHHS Publication No. (PHS) 2011-1739, Series 12, No 168, December 20, 2010.

Based on this federal data, seniors are 5 times more likely to be discharged from a hospital with a diagnosis related to diseases of the circulatory system, 4 times more likely to have a cardiac catheterization and/or an operation related to the cardiovascular system than the total population.

Attachment 12, Table4  
Emergency Utilization, 2008

Metric	Total Population	Population Age 65+
Visits per 100 Population	41.4	51.7
Arrival by Ambulance	15.8 Percent	37.5 Percent
Immediate and Emergent (patient should be seen immediately or in 1-14 minutes)	1.1 Percent	1.9 Percent
Principal Reasons for Visit		Chest pain and related symptoms

Source: National Hospital Ambulatory Medical Survey: 2008 Emergency Department Summary Tables (no date)

Based on the above national data, seniors have more emergency department visits per 1,000 population than the total population, are more likely to arrive by ambulance and require immediate or urgent care, and their principal reasons for visiting the ED area are chest pain and related symptoms.

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.*

Trinity Rock Island has initiated a long-term campus redevelopment plan. The initial project addressed surgery, recovery, and surgical intensive care beds. The proposed project is the second project in the plan. The existing priority problems or issues that need to be addressed in this project include the care of cardiac, emergency, and behavioral health patients.

#### Issues Related to the Care of Patients with Heart Disease

TRI provides a comprehensive continuum of programs and services to meet the needs of patients with heart disease including community awareness and preventive services, non invasive and invasive diagnostic services, general and intensive care inpatient services, heart surgery, and rehabilitation. Today, most of these services are on the TRI campus; Phase II cardiac rehabilitation is on the Trinity Moline campus. Many, including community awareness and preventative services, diagnostic, invasive, and Phase II cardiac rehabilitation services, are undersized for current and future volume.

#### Issues Related to the Care of Emergency Patients

TRI is a Level II Trauma Center/Emergency Department (ED). The current department is undersized and operationally inefficient. Accommodations for high risk and often violent behavioral health patients in the ED are inadequate.

There is no Observation Unit. Observation units are a relatively new concept that focuses on providing accelerated diagnostic work-ups and stabilizing treatment in an effort to prevent unnecessary inpatient admissions and readmissions.

#### Issues Related to the Care of Behavioral Health Patients

Robert Young Center (RYC) is located on the TRI campus and has facilities in the Hospital. RYC and TRI have a unique organizational/operational relationship. Together they are major providers of behavior health services with a comprehensive range of programs including a 54-bed inpatient unit and a behavior health emergency service within TRI, as well as a wide array of outpatient services. Today, approximately 12 percent of the patients that present to the Hospital's ED are behavioral health patients (compared to the national average of 3.3 percent). This high volume of a high risk and often violent patient population needs special accommodations while they are in the ED for medical clearance and

afterwards as they await referral to an inpatient or outpatient program. Today, these accommodations are either inadequate or not available at all.

4. *Cite the sources of information provided as documentation.*

The following sources of information have been used in the preparation of this application:

- Iowa Health System, Trinity Regional Health System, and Trinity Medical Center d/b/a Trinity Rock Island clinical, administrative, and financial records
- Trinity Regional Health System 2009 – 2013 Strategic Plan, 2013 Plan Update
- Master Facility Plan
- Illinois Department of Public Health Licensing Code
- Illinois and local building, mechanical, electricity and accessibility codes
- Special studies performed by architects and engineers, construction managers, equipment planners and parking consultants
- National, State of Illinois, and State of Iowa demographic data
- U.S Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics
- HFSRB Rules and Standards
- Technical Assistance from State Staff
- Health care literature related to the likely implications of State and National Health Reform

5. *Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.*

Trinity Rock Island has space shortfalls and other deficits that detract from improving health care and the well-being of the market area population. This project has been designed to address these space shortfalls and deficits especially in two major areas of care – cardiac and trauma/emergency care. The proposed project envisions a three level tower to replace, relocate and expand cardiac and emergency services and to add an Observation Unit; it further envisions modernizing vacated space to develop a Crisis Stabilization Unit. The following will improve the issues identified in 3.

Identify the Existing Problems above.

### Resolution of Issues Related to the Care of Patients with Heart Disease

The currently dispersed programs and services related to the needs of patients with cardiac disease will be consolidated in the new Heart Center that is part of this project.

Cardiac rehabilitation services will be relocated from the Trinity Moline campus to the new Heart Center, and will be located on Level 3 along with the non invasive diagnostic testing services. In addition, all invasive (cardiac cath) services will also be consolidated in the new Heart Center. The invasive labs will be connected to the heart surgery rooms at project completion. As part of the redevelopment process, all of the areas – non invasive, invasive, and rehabilitation services will be appropriately enlarged to meet current and future need. Importantly, the number of invasive (cardiac cath) labs will be increased from the 3 over-utilized labs to 4 labs with new state-of-the-art equipment to accommodate this busy cardiac cath and electrophysiology service. In order to provide pre and post procedure accommodations for cath, EP, and other cardiac patients, 20 Phase II recovery areas will be provided adjacent to the labs.

### Resolution of Issues Related to the Care of Emergency Patients

As part of this project, the Level II Trauma Center/Emergency Department (ED) will be relocated to Level 2 of the new tower. The new ED will be enlarged from 17 to 23 stations to better meet current and future demand; the ED is designed to be operationally efficient and provide patient privacy. One general radiology room and one computerized tomography room that are currently in the Imaging Department will be replaced and relocated to the ED because of the high proportion of patients that require these services as part of their emergency visit. Further, 3 safe rooms will be developed in an area remote from the busiest part of the ED; these safe rooms will best meet the needs of behavioral health and other patients who might harm themselves, other patients or staff. Finally, a 12-bed Observation Unit will be developed adjacent to the ED. This new concept in the delivery of care is known to reduce both unnecessary admissions and the cost of health care.

### Resolution of Issues Related to the Special Needs of Behavior Health Patients

Three areas of the proposed project address issues related to the special needs of behavioral health patients. First, as noted above, 3 specially designed “safe rooms” will be located in the Emergency Department; they will be used for patients who might harm themselves or other patients, or staff. Next, the applicants will modernize vacant space adjacent to the ED to develop a Crisis Stabilization Unit. This unit is being developed as part of Governor Quinn’s Illinois plan for

rebalancing the delivery of mental health services. It will have 6 patient rooms and a “living” room for patients and their families. In this area, patients will undergo treatment while they await placement in either an inpatient or outpatient program, depending on their needs. Because the current 3 Behavioral Health Group Rooms will be displaced by the Crisis Stabilization Unit, they, too, will be replaced in modernized vacant space.

In conclusion the issues related to cardiac and emergency issues will be substantially resolved at the completion of the proposed project.

6. *Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals, as appropriate.*

#### Overriding Goal

Trinity Rock Island’s overriding goal is to increase access and improve outcomes while reducing cost for cardiac and emergency patients in Rock Island and beyond.

#### Objective 1

Consolidate and expand cardiac services to meet current and future community need. The Heart Center will be on Levels 1 and 3 of a proposed new tower linked to the main hospital at Level 1 to allow future linkage with surgery and the inpatient units. It will house 4 invasive (cardiac cath) labs, 20 Phase II Prep/Recovery stations, 6 non invasive testing rooms (echocardiography, stress testing, vascular testing and pulmonary function testing), and a new and expanded cardiac rehab area.

This objective will be fully implemented by January 31, 2016.

#### Objective 2

Replace and expand the Level II Trauma Center/Emergency Department (ED) on Level 2 of the proposed new tower to meet increasing community need for emergency services. The new unit will address the needs of medical as well as the high volume of behavior health patients. It will have both general radiology and computerized tomography capability in the department. The Hospital also proposes to develop a new 12-bed Observation Unit adjacent to the Emergency Department to reduce unnecessary admissions and cost of care.

This objective will be fully implemented by January 31, 2016.

### Objective 3

Expand and develop services for the behavioral health patients in the greater Rock Island service area. This will be accomplished by providing 3 special “safe rooms” in the Emergency Department and by developing a new Crisis Stabilization Unit as part of the Illinois plan to rebalance mental health care. Finally, this will be accomplished by replacing Behavior Health Group Therapy Rooms displaced by the Crisis Stabilization Unit.

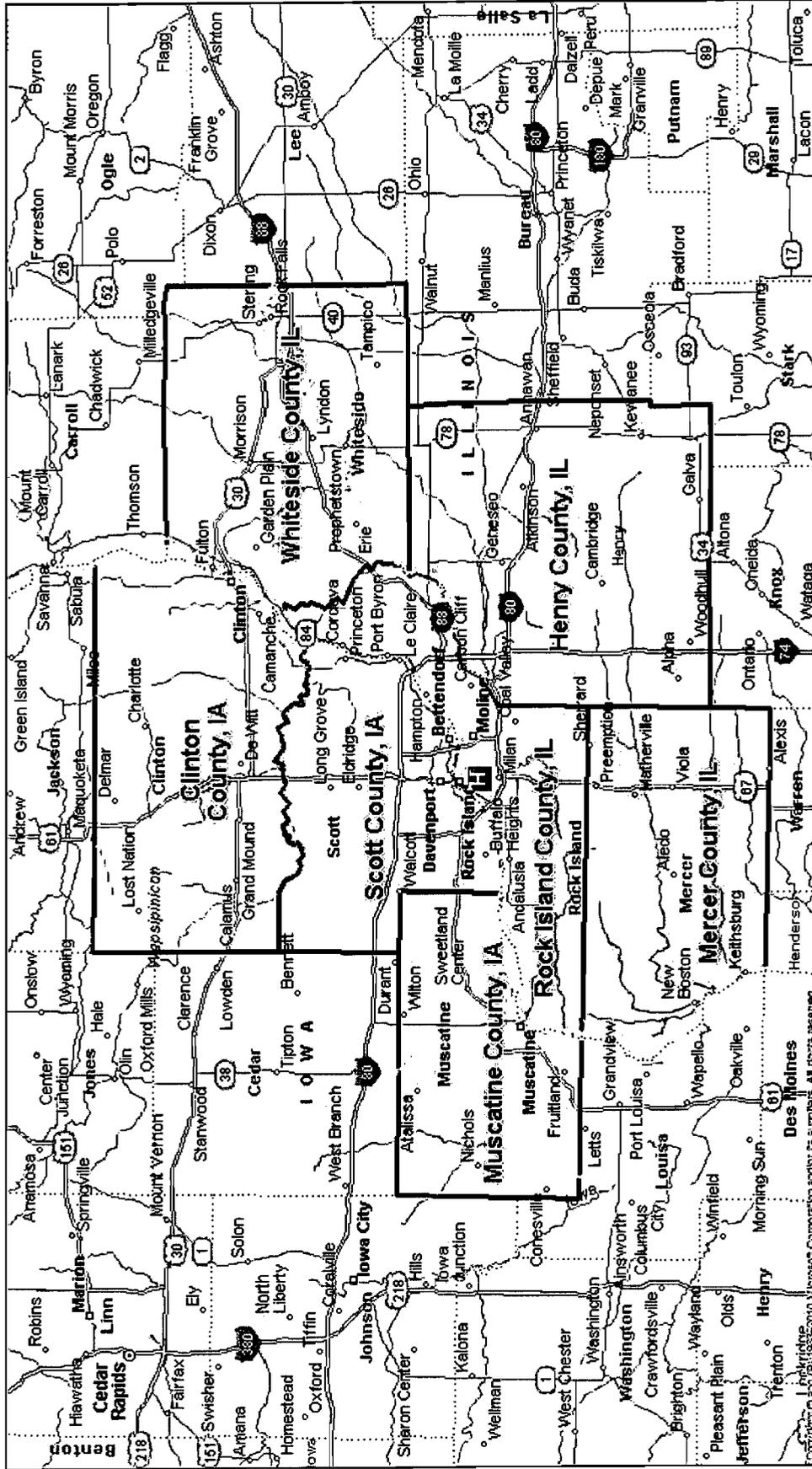
This objective will be fully implemented by January 31, 2016.

### Objective 4

Plan for the reuse of space vacated by the Heart Center/ Emergency Department project.

This objective is an outcome of vacating space as the result of this project, but the reuse of space is not part of this project. There is no implementation date for the reuse of existing space.

Trinity Rock Island  
Service Area



**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:

**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.**

Trinity Medical Center operates two campuses in Illinois – Trinity Moline is a provider-based facility with 38 beds (general medical surgical and obstetric), surgery and procedures areas, (primarily outpatient), basic emergency, limited diagnostic imaging, radiation therapy and cardiac rehabilitation. Trinity Rock Island (TRI, Hospital) is a 327-bed facility with a full range of services (except obstetrics) including medical surgical, pediatric, intensive care, long term care, acute mental illness, and rehabilitation beds. The Hospital also provides surgery, GI labs, cardiac catheterization and cardiac surgery and a comprehensive cadre of diagnostic and interventional imaging services as well as more than 275,000 outpatient visits each year both on and off campus.

In December 2010, Trinity Rock Island's application to construct and modernize surgery, recovery, pharmacy, central sterile processing, and the surgery HVAC was approved by the Health Facilities and Services Review Board. When construction of this project was underway, Trinity leadership undertook definitive planning for the next project for TRI campus. At that time, the priorities were the Heart Center, the Level II Trauma Center, and infrastructure. As the planning process progressed and the statewide mental health plan was being implemented, it became evident that the scope of the project needed to be expanded to include a Crisis Stabilization Unit for behavioral health patients.

The planning process considered a wide range of options, and ultimately focused on the development of one or more patient towers on the campus. The following alternatives were also considered.

1. and 2. Alternative Options and Documentation

**Alternative 1 – 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**

Trinity Rock Island considered pursuing joint ventures or other similar arrangements to meet all or a portion of the project's intended purposes.

The proposed project will be operated as part of the premises licensed under The Illinois Hospital Licensing Act. Consequently, joint ventures would necessarily involve a joint venture of the entire hospital; this is not a feasible option.

For this reason, the first alternative was rejected.

Because this alternative was not feasible, no cost was determined.

## **Alternative 2 – Developing alternative settings to meet all or a portion of the project’s intended purposes**

Trinity Regional Health System and Trinity Rock Island already offer services in alternative settings. Trinity Rock Island rejected Alternative 2, or developing additional alternative settings as an option to the proposed project.

The proposed project has two major clinical components;

- Replacement and expansion of the Heart Center including invasive cardiology (cardiac cath and electrophysiology), Phase II Prep/Recovery stations, non-invasive diagnostic testing, and cardiac rehabilitation.
- Replacement and expansion of Level II Trauma/Emergency Department, including development of a Crisis Stabilization Unit to enhance the continuum of care for behavioral health patients.

### Heart Center

One of the goals of this project is to, insofar as possible, consolidate all heart-related cardiovascular diagnostic and treatment services in one area – most will be part of this project; heart surgery will be in existing space immediately adjacent to the proposed new Heart Center and will be connected to it. By consolidating the services, patient access is more convenient and physicians are located in one place to readily confer on challenging cardiac cases.

The cardiac rehabilitation service is currently at Trinity Moline and will be relocated to space in the proposed project. An added benefit of consolidating cardiac rehabilitation on the Trinity Rock Island campus will be that the vacated space at Trinity-Moline that will help resolve space issues on that campus. Modernization of vacated space on the Moline campus is not part of this project.

A few heart-related non-invasive diagnostic tests will remain on the Trinity-Moline campus to support the services at that site. Hence, Trinity-Moline represents an alternative site for a limited number of heart-related diagnostic services. Additional alternative sites would not be feasible at this time.

## Level II Trauma / Emergency Department

Trinity-Rock Island is a Level II Trauma Center/Emergency Department. As part of the proposed project, emergency services will be replaced in new construction. With more than 35,000 visits in 2011, this emergency service relies on a full array of ancillary support services to diagnose and treat patients – imaging, laboratory, heart-related non-invasive and invasive services including surgery, to name a few. These services are only routinely available in a hospital.

Trinity Medical Center also provides basic emergency services in Moline; the Moline service reported 26,226 emergency visits in 2011. Hence, Trinity Medical Center already provides emergency services in an appropriate alternative setting. Additional alternative sites would not be feasible at this time.

Trinity Rock Island and the Robert Young Health Center provide a comprehensive continuum of behavior health services including emergency intervention. Together, these organizations are an important part of the State of Illinois' plan to rebalance the delivery of mental health services; Trinity Rock Island/Robert Young Center's role has expanded with the closure of Singer Mental Health Center at the end of October 2012. As part of this project, a Crisis Stabilization Unit will be developed in vacated space. In the proposed plan, behavioral health patients would be first medically cleared in the Emergency Department. They would then be immediately transferred to the new Crisis Stabilization Unit for behavioral evaluation and treatment before being discharged, admitted to a community mental health center, the Robert Young Center, or another qualified facility. Hence, the behavioral health patients that present at the Emergency Department require ancillary support services including laboratory and imaging for the medical clearance in the Emergency Department and security as well as behavioral health services that are part of the Robert Young Center. These services could not be duplicated in an alternative setting. Behavioral health services that can be provided in alternative settings are already provided in the Robert Young community health centers. Hence, the behavioral health continuum of care provided by Trinity Rock Island/Robert Young Center already includes appropriate behavioral health services in alternative settings. Additional alternative sites would not be feasible at this time.

As described above, the key elements of the proposed project are interrelated and must be located on the Trinity Rock Island campus – in support of each other and in support of other

services at the Hospital. To further decentralize these services would compromise timeliness and comprehensiveness of services to the community. Further, unnecessary and unwarranted decentralization of services to alternative sites would require additional staff and unnecessarily duplicate support services, equipment, supplies and records; further they could not optimize the use of specialty staff and costly clinical equipment.

For these reasons, the second alternative was rejected.

Because the development of alternative sites was not a feasible, no cost estimate was prepared.

### **Alternatives 3 and 4 Providing Projects of Greater and Lesser Scope**

After the alternatives of joint venturing and developing additional sites were rejected, the applicants realized that it would be necessary to develop space in new construction and to modernize existing space to support the key elements of the proposed project.

To ensure that the development of any new facilities would be consistent with the mission and values of the applicants, Trinity Rock Island's project team developed a set of principles to guide future capital development on the campus.

These guiding principles included the following.

1. **Improve Care and the Caregiving Experience**

Solidify Trinity's position as a leader in healthcare and a place where the community wants to come, physicians want to practice, and employees chose to work by delivering an unparalleled care experience provided by the finest healthcare professionals.

2. **Create a Secure Environment That Promotes Safety**

Create an environment that promotes patient, visitor, physician and staff safety and security compliant with regulatory requirements, balanced with the priorities of ensuring the respect, dignity and service expectations of the community Trinity supports.

### 3. Contribute to Community Health and Wellness

Improve the health and wellness of the community Trinity serves through the application of evidence-based care, timely access to medical services, superior care coordination, and community outreach.

### 4. Respect Stewardship of Resources

Be good stewards of resources through sustainable development, continuous process improvement, and operational efficiency enhancements that lower healthcare delivery costs and increase value to the community.

### 5. Protect Legacy for Future Needs

Design with strategic intent, anticipating tomorrow's needs to accommodate practice changes and remain at the forefront of value-based care delivery with a solution that is flexible and adaptable in the future.

### **Alternative 3 – Propose a Project of Greater Scope and Cost**

The third alternative envisioned constructing two towers, one would be a 3-level tower built at the front of the Trinity Rock Island hospital building and would be designated as the Heart Center. The lowest level would be for mechanical space and sterile supply; the second level would include 4 cardiac catheterization labs and a Phase II recovery area; the third level would house non-invasive diagnostic testing and cardiac rehab. This first tower would also have mechanical space at the fourth level and capability for future vertical expansion. The second tower would be located on the opposite side of the existing Hospital and would be a 2-level tower designated as the “Emergency Addition.” The lower level would be for additional mechanical space, and the second level would include the new Emergency Department. Alternative 3 had many attractive features. The cath labs and Phase II recovery as well as the Emergency Department would be at the same level as the existing surgery, imaging and laboratory – so that essential support services would be adjacent to these new towers. The plan also allowed for future expansion, thus protecting legacy for future needs.

However, Alternative 3 was rejected for several reasons.

- Two construction sites not only added to the overall construction costs but also caused construction congestion on two separate areas of the constrained urban Trinity Rock Island campus.

- The proposed two-site construction project detracted from patient flow and adjacencies – for example, the critical distance for behavioral health patients from the Emergency Department to the Robert Young Center was excessive.
- The project included costs for vertical expansion and mechanical costs; with a limited capital budget, the applicants looked for an alternative for which more capital could be invested in needed clinical areas.

In summary, this alternative was not consistent with the guiding principles because it did not respect stewardship of resources and legacy for future needs.

The Alternative 3 project included 64,000 bgsf of new construction and 6,000 bgsf of modernization at an estimated cost of \$70 million.

#### **Alternative 4 – Propose Alternatives of Lesser Scope**

##### **Alternative 4A Envisioned Modernizing only the Emergency Department**

Alternative 4A was rejected for the following reasons:

- While modernizing the Emergency Department would mitigate life safety concerns and the need to operate under waivers, it would not alleviate the operational inefficiencies, space constraints, and many of the other deficiencies in the current department. Expected increased demand for emergency services could not be met in the current Emergency Department space; community needs could not be met.
- Modernizing the Emergency Department without also investing in Heart Center’s capital needs would limit Trinity Rock Island’s ability to provide the needed diagnostic and therapeutic cardiac-related clinical services for Trinity Rock Island’s aging service area population.
- This option would not include the development of a Crisis Stabilization Unit for emergency, high risk behavioral health patients and would leave a void in the Illinois Governor’s plan for rebalancing the State’s mental health system of care.
- By only modernizing the Emergency Department, infrastructure improvements would not be made.

In summary, this alternative was rejected because it did not improve cardiac-related services, and behavioral health services.

The estimated modernization cost of Alternative 4A was \$2,246,500. Estimated project cost was \$3,333,062.

#### **Alternative 4B Envisioned Modernizing only the Health Center**

- Modernizing the Heart Center in its current location would not provide space to add the additional cath lab which is justified by current demand.
- The current heart-related services at Trinity Rock Island are dispersed on two campuses and detract from coordinated care delivery. Modernizing the current unit would not improve coordination of care; it would not provide space to relocate cardiac rehabilitation to the Trinity Rock Island campus.
- Modernizing only the Heart Center without also investing in the Emergency Department's capital needs would limit access to emergency services for both medical and behavior health patients.
- Modernizing only the Heart Center would not include developing a Crisis Stabilization Unit and detract from the Trinity Rock Island/Robert Young Health Center role in the Governor's plan for rebalancing the State's mental health system of care.
- By only modernizing the Heart Center, infrastructure improvements would not be made.

In summary, this alternative was rejected because it did not improve emergency services or behavioral health services.

The estimated construction cost of Alternative 4B was \$2,592,750. Total project cost was \$4,222,720.

## **Alternative 5 – Develop a Heart Center/Emergency Department Tower in New Construction and Modernize Space for the Crisis Stabilization Unit**

Alternative 5 envisions constructing an addition on the existing campus linked into the existing Hospital that would provide expanded space for the Heart Center, the Emergency Department and modernizing existing space for a Crisis Stabilization Unit.

Alternative 5 is the alternative of choice for the following reasons:

- This alternative provides a new Heart Center that is fully code and life safety compliant.
- The new Heart Center will include space to increase the number of invasive (cardiac cath) units from 3 to 4 and to relocate the cardiac rehabilitation unit from the Trinity Moline campus. These services will be able to better meet the needs of the aging community.
- Consolidating the existing invasive labs plus one additional lab, non-invasive diagnostic testing, and cardiac rehab (by relocating from the Trinity Moline campus) will enhance access and coordination of cardiovascular care for Trinity Rock Island's community.
- The design of the new addition will allow direct access to the heart surgery operating rooms from the cath labs in the event of an emergency situation as well as to intensive care and general medical surgical units.
- This alternative provides a new Emergency Department that is fully code and life safety compliant.
- Alternative 5 will include an expanded number of emergency treatment stations to better meet current as well as for projected need for trauma, medical and behavioral health emergencies. Patient wait times and the number of patients leaving without being seen will be reduced.
- As part of this alternative, there will be both general radiography and computerized tomography scanning available in the Emergency Department. These services will improve care to patients and preclude long travel distances to the Imaging Department.
- The proposed new Emergency Department will be adjacent to a 12-bed observation unit that will decrease unnecessary admissions and reduce cost, consistent with the goals of state and national health reform initiatives.

- The physical relationship of the new emergency department to the Robert Young Center will allow the development of a Crisis Stabilization Unit immediately adjacent to both and meet the expectations of the Governor's rebalancing plan for mental health services in the State.
- Although this alternative has no expansion capability, a site plan analysis determined that there is available site to develop a patient tower and parking in the future.

In summary, this alternative will improve care as well as patient and caregiver experiences, create a secure environment that promotes safety, contribute to community health and wellness, respect stewardship of resources and protect the legacy for the future.

The cost of Alternative 5 is \$63,221,976.

A summary of the alternatives is provided as Attachment 13, Exhibit 1.

Summary of Alternatives

Description	Construction Cost	Project Cost	Rationale
Alternative 1 – Pursue Joint Ventures	No cost determined	No cost determined	<p>This alternative was rejected because:</p> <ul style="list-style-type: none"> <li>The proposed project will be operated as part of the premises licensed under The Illinois Hospital Licensing Act. Consequently, joint ventures would necessarily involve a joint venture with the entire hospital; this is not a feasible option.</li> </ul>
Alternative 2 – Develop Alternative Settings	No cost determined	No cost determined	<p>This alternative was rejected because:</p> <ul style="list-style-type: none"> <li>The key elements of the project are interrelated and must be located on the Trinity Rock Island campus.</li> <li>To decentralize these services would compromise timeliness and comprehensiveness of services to the community.</li> <li>Unnecessary and unwarranted decentralization of services to alternative settings would require additional staff and unnecessarily duplicating support services, equipment, supplies and records.</li> <li>This alternative would not optimize the use of specialty staff and costly clinical equipment.</li> </ul>
Alternative 3 – Promote a Project of Greater Scope and Cost	\$43 million	\$70 million	<p>This alternative was rejected because:</p> <ul style="list-style-type: none"> <li>This alternative required two construction sites; this added to overall construction costs.</li> <li>This two construction site alternative would also cause congestion on two separate areas of the very constrained urban Trinity Rock Island Campus</li> <li>A two-site construction project detracted from patient flow and adjacencies.</li> <li>This alternative included costs for vertical expansion and large mechanical costs; the applicants looked for an alternative that allowed more capital to be invested in needed clinical areas.</li> <li>Alternative 3 was not consistent with the guiding principles because it did not respect stewardship of resources.</li> </ul>

Summary of Alternatives

Description	Construction Cost	Project Cost	Rationale
<p>Alternative 4 – Propose Alternatives of Lesser Scope</p> <p>Alternative 4A Modernize the Emergency Department Only</p>	<p>\$2.2 million</p>	<p>\$3.3 million</p>	<p>This alternative was rejected because:</p> <ul style="list-style-type: none"> <li>• Alternative 4A would preclude Trinity Rock Island’s ability to provide cardiac services needed by the community</li> <li>• This alternative would not alleviate operational efficiencies.</li> <li>• This option would preclude the development of a Crisis Stabilization Unit</li> <li>• Alternative 4A would not provide the space to add a needed fourth invasive lab.</li> <li>• This alternative would continue to have key cardiac-related services on two campuses and this would detract from continuity and coordination of care.</li> </ul> <p>This alternative was rejected because:</p> <ul style="list-style-type: none"> <li>• By only modernizing the Heart Center, the needed expansion of the Emergency Department would not occur, thereby limiting access by both medical and behavioral health patients</li> <li>• This option would preclude developing the Crisis Stabilization which is an important element in the Governor’s plan for rebalancing the State’s mental health system.</li> </ul>
<p>Alternative 4B Modernize only the Heart Center</p>	<p>\$2.5 million</p>	<p>\$4.2 million</p>	
<p>Alternative 5 – Provide the Alternative of Choice: Develop a Heart Center/Emergency Department in New Construction and Modernize Space for the Crisis Stabilization Unit</p>	<p>\$38.2 million</p>	<p>\$63.2 million</p>	<p>This is the alternative of choice because:</p> <ul style="list-style-type: none"> <li>• It provides a Heart Center that is fully code and life safety compliant.</li> <li>• A new Heart Center with all key elements could be developed, thereby enhancing access and coordination of care.</li> <li>• Alternative 5 provides an opportunity to develop a direct link between the Heart Center and heart surgery to better respond to emergencies in the cath labs as well as to inpatient units.</li> <li>• This alternative provides space to add a needed fourth interventional lab and to safely move cardiac patients to surgery and inpatient units.</li> </ul>

Summary of Alternatives			
Description	Construction Cost	Project Cost	Rationale
Alternative 5 – (Continued)			<ul style="list-style-type: none"> <li>• With this alternative, the cardiac rehabilitation unit now located at Trinity Moline can be moved to the Trinity Rock Island campus to enhance the continuum and quality of care.</li> <li>• It provides a new Emergency Department that is fully code and life safety compliant.</li> <li>• A larger project permits increasing the capacity of the Emergency Department from 17 to 23 stations to better meet current and projected community need for emergency services.</li> <li>• It also provides space to have general radiology and computerized tomography units in the Emergency Department.</li> <li>• This option provides space to develop an Observation Unit adjacent to the Emergency Department. This Observation Unit will decrease unnecessary admissions and reduce cost, consistent with the goals of state and national health reform initiatives.</li> <li>• Alternative 5 will allow the development of a Crisis Stabilization Unit that will meet the expectations of the Governor's rebalancing plan for mental health services in the State.</li> <li>• Although this alternative has no expansion capability, a site plan analysis determined that there is available site to develop a patient tower and necessary parking in the future.</li> </ul>

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

### **Heart Center**

For almost a decade, Trinity Rock Island (TRI, Hospital) has been working closely with physicians to improve quality of cardiovascular care.

In 2004, the Hospital established a partnership with cardiac surgeons committed to excellence in the practice of cardiac, thoracic, and peripheral vascular surgery. This group covers 20 hospitals. They are committed to the use of standard protocols – they do everything the same way, every time; the use of these protocols translates into better patient care and excellent outcomes.

The Hospital and the physicians utilize the Thomson-Reuters Cardiovascular Hospitals National Benchmarks Report as a performance measurement tool. The Hospital outperformed the benchmark group (winners of the study) and the peer group regarding average length of stay; the average length of stay for TRI's coronary artery by-pass surgery (CABG) was 23 percent better than the benchmark group and 31 percent better than the peer group. A shorter length of stay translates into lower overall costs. In addition, for CABG surgery, the Hospital performed better than either the benchmark or the peer group on the risk adjusted mortality-complications index, internal mammary artery use, and cost per case. Since the costs of treating heart disease are expected to triple over the next 3 decades, lower cost is an important outcome of these quality initiatives.

In November 2011, Trinity Rock Island also partnered with a cardiology group by forming a management services agreement. The objective of this agreement is to increase collaboration with the physicians to improve quality, efficiency and effectiveness of cardiovascular services. Among the benefits of this agreement over the past year are increasing trust and improving working relationships, which in turn create a culture of process improvement, and improving oversight in the invasive lab processes. Quantifiable benefits include reduction in supply costs and inventory carrying costs.

This physician-hospital partnership identified areas of improvement pertaining to quality, efficiency and new program development.

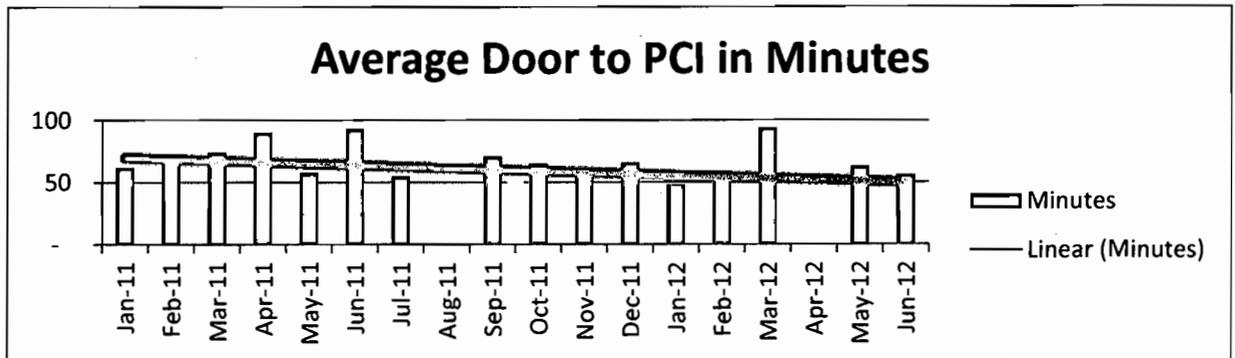
Quality of Service

1. 100 percent of echocardiograms read in one calendar day

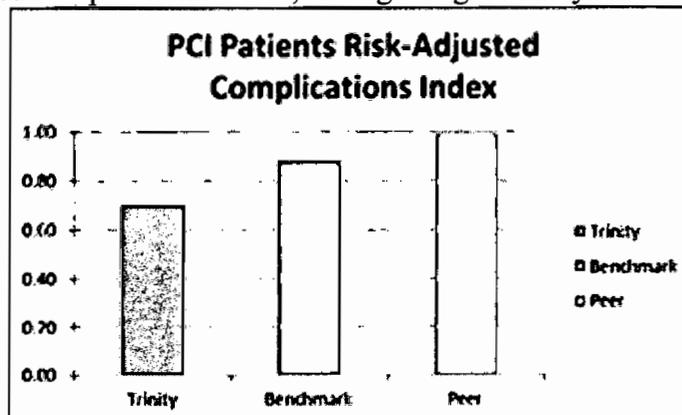
Best practice in reading echocardiograms is for the results to be ready within 24 hours of the study. Prior to the management agreement, from 80 to 90 percent of the echo exams were read within one calendar day. Through education, collaboration, and process improvement, Trinity Rock Island is now from 99 to 100 percent compliant with echocardiograms being read within one calendar day. Improved turn around times on echocardiograms reduces delay in patient care and enhances outcomes.

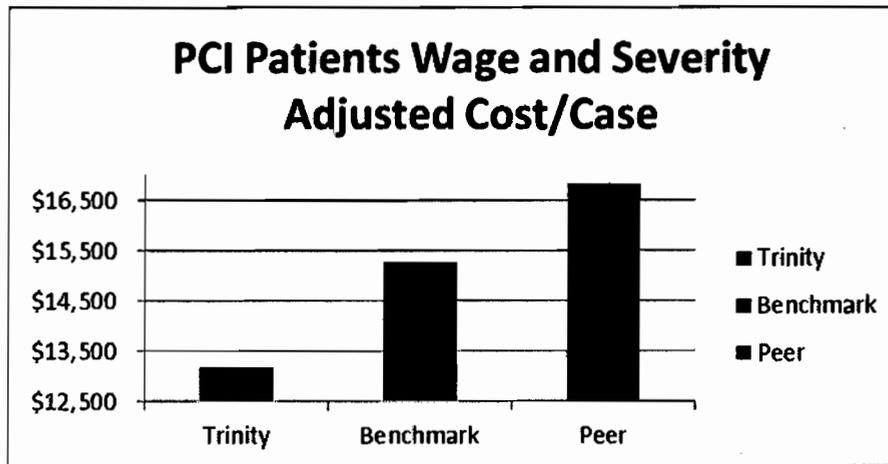
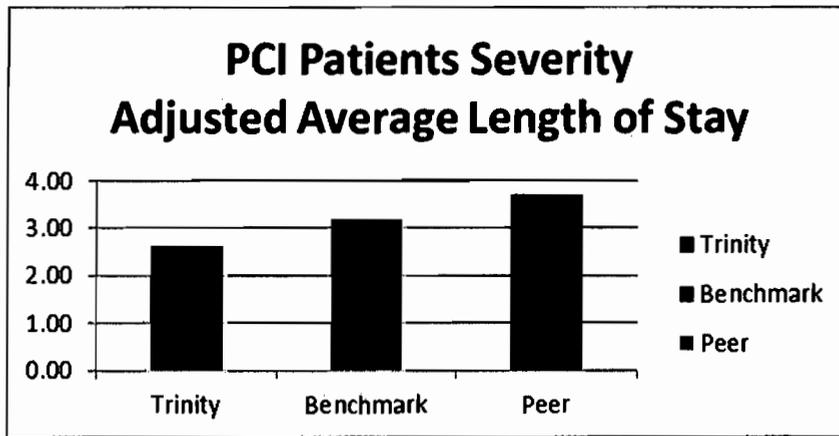
2. Percutaneous Coronary Intervention – Percent Less than 90 Minutes

Percutaneous coronary intervention (PCI), commonly known as coronary angioplasty, is a non-surgical procedure used to treat coronary arteries narrowed due to the build-up of plaque. Between January 2011 and June 2012, Trinity Rock Island met an internal goal of providing PCI in less than 90 minutes in 16 out of 18 months with reportable data. Average Door-to-PCI time has been decreased to less than 60 minutes.



When compared to the Reuters 2011 Top 50 Cardiovascular Hospitals, Trinity Rock Island ranks better than the benchmark group and significantly better than peers in the severity-adjusted complications index, average length of stay and cost per case.





Trinity Rock Island compares better to national standards related to the complexity of the patient's condition, the lower cost of care, and the lesser time the Trinity Rock Island team is able to open the affected artery when the patient is having a heart attack.

### 3. Statins Prescribed on Discharge for Acute Myocardial Infarction (AMI) Patients

An additional outcome of the management agreement was a significant improvement in the percentage of AMI patients discharged with a prescription for statins. There are studies that CMS is following that show a patient being on a statin when discharged from the hospital leads to better patient outcomes. Trinity Rock Island has been able to meet the CORE measures set by CMS.

#### 4. Acute Myocardial Infraction Complications, Mortality Rate and Cost/Case

According to Thomson-Reuters Top 50 Cardiovascular Hospitals report, Trinity is equal to the benchmark group for the rate of AMI complications and 14 percent lower than the peer group. In addition the 30-day mortality rate for AMI patients is 5.5 percent less than the benchmark group and 11.6 percent lower than the peer group.

For AMI patients, the average length of stay and the cost/case are 23 percent and 1.6 percent better than the benchmark.

As shown in these metrics, the management agreement has enabled TRI staff to work cohesively with the cardiologists in solving operational inefficiencies. These measures demonstrate that outcomes have been improved and costs reduced in a short period of time.

#### Operational Efficiency

Research has shown that cath lab cost per case can be significantly reduced by focusing on improving overall utilization rate, creating a more predictable scheduling process, maximizing turnover efficiency, and ensuring appropriate staffing.

The metric chosen to measure improved operational efficiency is on-time starts.

The first case for on-time start is to have targeted levels of patients and physicians ready for procedures scheduled at the beginning of each day. On-time starts are currently defined as those cases with a “stick time” within fifteen minutes of the scheduled time. Meeting the target for this metric means lower costs due to less overtime for staff as well as increasing patient, physician, and staff satisfaction by being able to work efficiently and effectively.

Measuring cath lab on-time starts includes analyzing why first-case starts are delayed. Besides monitoring start time, the TRI staff is focusing on limiting cancellations and creating a more predictable scheduling process by tracking physician case times, using block scheduling, and ensuring appropriate staffing based on daily volumes.

#### New Program Development

As leaders in healthcare, TRI recognizes that organizations will be increasingly required to take on financial risk and be held accountable, clinically and economically, for what happens across the continuum of care, whether or not they own the full continuum. A collaborative, non-punitive approach to continuous quality improvement creates the

necessary foundation for data sharing and constructive case reviews. The cardiologists and leaders of Trinity identified three areas of development to focus on for the next 12 months that will improve patient quality and care along the continuum. These programs are:

1. Congestive Heart Failure (CHF) Program Development

The Congestive Heart Failure Program is designed to reduce readmissions for patients with this disease by requiring the clinical staff to make the patient appointment prior to discharge for a follow up with the cardiologist. CHF is the most common cardiovascular discharge diagnosis and a condition with one of the highest rates of preventable readmissions; almost 1 in 4 CHF patients return to the hospital within 30 days. CMS considers the overwhelming majority of these readmissions to be preventable.

Comprehensive discharge planning is imperative to equip patients and their families to manage CHF care after a hospital stay. A patient's health status can quickly deteriorate due to gaps in care between acute and post-acute care providers. The first month of monitoring this metric was August 2012 and 76 percent of patients discharged with CHF left TRI with an appointment already made for follow up with their physician. In addition, the discharge instructions included personalized care records that addressed activity level, diet, medications, follow-up appointments, weight monitoring and symptoms requiring follow-up care.

For heart failure patient population, TRI compares well to the Thomson-Reuters benchmark group for heart failure complications, equal to benchmark and 14 percent better than peers. The average length of stay is 15 percent lower than the benchmark group and 20 percent lower than the peer group.

The implementation of this program is expected to improve patient outcomes and reduce unnecessary readmissions and cost.

## 2. Appropriate Stenting Program Development

The objective of the program is to follow criteria defined by the American College of Cardiology for appropriate stenting. The Hospital's cardiologists led the way by developing a check list with strict criteria defining the patient's acuity to meet the criteria that assures Trinity Rock Island physicians are stenting patients appropriately. (See Attachment 13, Exhibit 2) Trinity Rock Island is currently the only facility in the region following this practice.

## 3. Cardiac Rehab Program Development

Studies show statistically significant improvement in health and wellness at 3 and 12 months among patients with a diagnosis of heart failure who exercised compared to those who received vigorous medical management only. The goal of this metric is to develop and monitor protocols to ensure a uniform standard for appropriate clinical indications for follow-up cardiac rehabilitation care. The clinical indicators will focus on medical necessity and be backed by evidence-based medicine as defined by the American College of Cardiology and the American Association of Cardiovascular and Pulmonary Rehabilitation.

Cardiac rehab can lead to reduced readmissions not only with cardiovascular disease patients but also related causes as patients' overall health outcomes improve.

### Community Outreach

Trinity Rock Island's commitment to the community goes beyond the walls of the Hospital. TRI offers multiple online screenings and assessments to community members as part of a continued effort to increase awareness of severe health conditions. The assessments are free and take just a few minutes to complete; they include heart, diabetes, weight, sleep, various cancer conditions, vascular, stroke, spine and joint. TRI has had the most activity around the HeartAware assessments. Studies have shown that 90 percent of first time heart attacks can be prevented. The best way to reduce risk is awareness. The HeartAware assessment reached 3,392 members of our community and 1,151 were deemed at risk and accepted the offer to receive a free cholesterol screening and consultation.

### Healthgrades Awards

Trinity Rock Island's success in improving outcome of care for cardiovascular patients has been recognized by Healthgrades, a leader in helping consumers make informed choices when choosing health care providers. On October 24, 2012, Rock Island was recognized by Healthgrades with the following awards:

- 5 Star Recipient for Overall Cardiac Services
- 5 Star Recipient for Cardiology Services
- 5 Star Recipient for Treatment of Heart Attack (4 years in a row 2010-2013)
- 5 Star Recipient for Heart Failure, and
- 5 Star Recipient for Coronary Interventional Procedures (4 years in a row 2010-2013).

### **Emergency Services**

In August 2011, Trinity Rock Island was re-designated for 2 years as a Level II Trauma Center for Region 2 of the State of Illinois. This re-designation recognizes the contribution that TRI has made to the Illinois trauma system over the last several years. Trinity Rock Island was also re-designated for 4 years as an Emergency Department Approved for Pediatrics (EDAP) in the same month.

In July 2011, Trinity Rock Island was named a Primary Stroke Center by The Joint Commission. The Joint Commission's Certificate of Distinction for Primary Stroke Centers recognizes hospitals that make an exceptional effort to foster better outcomes for stroke care. Achievement of certification signifies that the services that the Hospital provides have the critical elements to achieve long-term success in improving outcomes. It is the best signal to the community that the quality of care provided at the Hospital is effectively managed to meet the unique and special needs of stroke patients.

### Quality of Service

#### 1. Left Without Being Seen Rate per 100 Patient Visits

Best practice in any emergency department is to complete a medical screening examination on every patient who presents. In 2011, the proportion of patients who were leaving the Hospital prior to seeing a qualified care provider had risen to a high of 2.6 percent. In an effort to decrease the number of patients leaving, a new patient flow model of care was initiated in January of 2012 which separates the lower acuity patients from

those who require more time and resources. This separation of “not so sick” from “very sick” resulted in a decrease of the overall “Left Without Being Seen” rate to less than 1 percent.

When a patient leaves the Emergency Department without being seen, it means that he did not receive a medical screening exam by trained Emergency Department staff. Consequently, an emergency patient who may need medical attention (for example, someone with chest pain), may come to the triage area, register, and then leave because he sees many other waiting patients. He goes home and has an event or his condition worsens. Had he received medical attention, the event or worsening condition may have been prevented or at least it could have been addressed when it was in a more treatable stage. Thus the patient could have avoided more complex and costly intervention or treatment in the future.

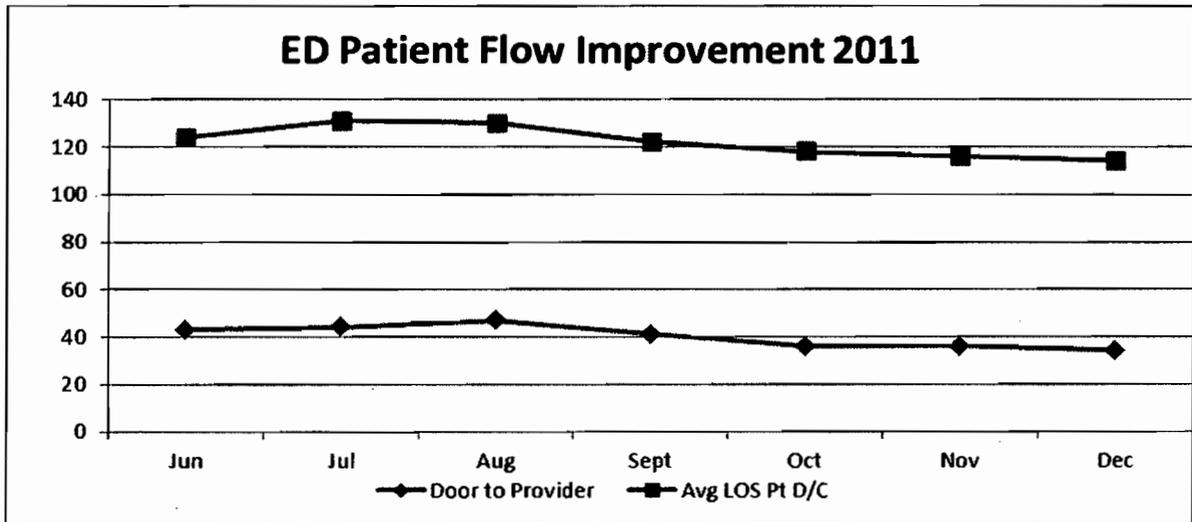
### Operational Efficiency

Among the largest contributors to decreased patient flow through Trinity Rock Island’s Emergency Department was related to extended triage times, ED occupancy, and volume surges by the day of the week. Although the statistically significant factors influencing patient throughput at the Hospital involved problems with inflow, an increase in ED occupancy was causing a substantial outflow obstruction that necessitated increased capacity both within the ED and the Hospital.

The metric chosen to measure the operational efficiency was door to provider times.

#### 1. Door-to-Provider Times

Using a goal of having a qualified provider see all ED patients within 30 minutes of arrival defined the need to decrease the overall time each patient spent in triage. By working to meet the target for this metric, staff identified the need to “direct bed” patients or place them immediately in an Emergency Department station upon arrival, when emergency stations were available. Skipping the traditional lengthy process of triage and allowing physician’s quicker access to all patients showed a decrease in the number of patients who left without being seen, a decrease in average length of stay for patients who were discharged, and improved overall patient satisfaction.



### New Program Development

Emergency medicine is recognized as an essential public service.

At Trinity Rock Island, patients seeking emergency care are treated by board certified emergency physicians who believe quality emergency care is a fundamental right and that unobstructed access should be available to all patients who perceive the need for emergency services. The Emergency Department physicians and leaders at the Hospital have identified several areas of development to focus on in the next year that will improve patient quality of care along the continuum. These programs are:

#### 1. Telepsychiatry Consultations

Trinity Rock Island physicians believe that telepsychiatry can make a significant impact on the delivery of mental health services, particularly to individuals with limited or no access to regional centers. Crisis consultations provided via telepsychiatry have been shown to be comparably effective to those delivered in person. Patient access is improved and satisfaction is high with telepsychiatric services being done in a timely fashion. Other benefits include reduction of stigma associated with patients having to be transferred to a psychiatric hospital and retention of staff who can easily serve underserved rural areas. By allowing area emergency departments to medically clear patients prior to a telepsychiatric evaluation will reduce unnecessary transports to the ED that cause overcrowding.

## 2. Electronic Medical Records

Trinity Rock Island's Emergency Department is the front door of the Hospital. More than 50 percent of TRI admissions come through the ED. Having an electronic medical record (EMR) that starts upon first contact with the patient and continues as the patient moves from one department to another has shown to promote patient safety and transparency of care. Beginning in August of 2012, Trinity's Emergency Department implemented an electronic medical record and moved away from the then-traditional paper records. The patient's past medical history, allergies, medications, treatments and procedures are now available to all care providers once the patient arrives in the ED. Having one source of information for each patient eliminates redundancy of gathering data, and reduces errors in capturing baseline information.

## 3. Case Manager in the ED

As Trinity Rock Island continues to address the ever-changing goals, mandates, and regulations for reimbursement, cost reductions, quality, and satisfaction of care, the Hospital recognizes the need to implement case management functions in the ED. Case management has a long history with roots in social service and it is a strategy that will help both payer and provider organizations to operate more efficiently and effectively in caring for emergency patients. Beginning in 2013, TRI plans to have a Case Manager available in the Rock Island ED 24 hours a day and 7 days a week.

### Emergency Medical Services System Program Development

Trinity Rock Island is a designated Resource Hospital within Illinois Region II Emergency Medical Services (EMS) and continues to provide education and training for pre-hospital care providers. As rural ambulances struggle to maintain their voluntary services, TRI has been instrumental in offering ongoing education that allows new volunteers to supplement workforces who are challenged with education costs and availability to attend courses outside their immediate response boundaries. The Hospital's EMS Medical Director has worked to update the EMS standing medical orders that are used by over 30 ambulances in the system. These updated protocols include protocols for post resuscitation induced hypothermia, use of the Cincinnati Prehospital Stroke Scale to initiate Stroke Alerts, and performance of 12-lead EKGs in the field. Having the EMS providers coordinate care that complements what is being done in the ED has resulted in better patient outcomes.

### Community Outreach

TRI's commitment to the community is best characterized by its commitment to care for victims of sexual assault. Since 2005 the Hospital has been able to offer sexual assault trained nurses to respond 24 hours a day, 7 days a week to care for any patient who presents with a complaint of alleged sexual assault. TRI recognizes the need to have trained staff available to provide services for these victims. The Hospital's nurses work in collaboration with local law enforcement, the State's Attorney's office, and the Children's Advocacy Center, leading to a higher reporting and conviction rate for sexual assault in Rock Island County. Today most national, state, and institutional protocols recommend that evidentiary exams be completed within 72 hours after a sexual assault. Having nurses trained and committed to do this work in even less time is a great asset to our community, patients, and entities involved prosecuting these cases.

### Recognition for Quality Improvement

Trinity Rock Island's initiatives to improve quality of care and outcomes were recently recognized by Press Ganey, consultants in clinical and business outcomes improvement. In January 2012, the Hospital received their Journey to High Performance award. This award certified that Trinity Rock Island had achieved an improvement of 3.6 Mean Score Points for Emergency Department Overall Satisfaction on the January 1, 2012 report.



**SECTION IV - PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE**

**Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space**

READ THE REVIEW CRITERION and provide the following information:

**SIZE OF PROJECT:**

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative.**
2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following::
  - a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;
  - b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;
  - c. The project involves the conversion of existing space that results in excess square footage.

**Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.**

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?

**APPEND DOCUMENTATION AS ATTACHMENT-14, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

1. *Document the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative.***

Trinity Rock Island (TRI) has carefully planned and designed the proposed Heart Center/Emergency Department project. User groups for each of the departments/areas in the project worked with the team of national and local architectural and engineering firms over more than 8 months. During this time, the groups established guiding principles for the project. The guiding principles are:

1. Improve Care and Caregiving Experience

Solidify Trinity's position as a leader in healthcare and a place where the community wants to come, physicians want to practice and employees choose to work by delivering an unparalleled care experience, provided by the finest health care professionals.

2. Create a Secure Environment that Promotes Safety

Create an environment that promotes patient, visitor, physician and staff safety and security compliant with regulatory requirements, balances with the priorities of ensuring the respect, dignity and service expectations of the community Trinity supports.

3. Contribute to Community Health and Wellness

Improve the health and wellness of the community. Trinity serves through the application of evidence based care, timely access to medical services, superior care coordination, and community outreach.

4. Respect Stewardship of Resources

Be good stewards of resources through sustainable facility development, continuous process improvement, and operational efficiency enhancements that lower healthcare delivery costs and increase value to the community.

5. Protect Legacy for Future Needs

Design with strategic intent, anticipating tomorrow's needs to accommodate practice changes and remain at the forefront of value-based delivery with a solution that is flexible and adaptable in the future.

These Guiding Principles were used as the touchstone for decision making throughout the facility development process.

The facility development team developed flow diagrams. They also developed key room counts based on projected utilization. Preliminary functional programs were developed and refined. Departmental layouts were reviewed and revised to ensure operational efficiency. Mock rooms were built so that the team could fully understand the implications of the proposed size of key rooms and equipment layouts. Throughout the process, estimated costs were tested against the project's approved budget and modifications were made. As modifications were being made, the team's priority was to maintain the integrity of the clinical areas.

Based on the comprehensive, iterative process, Trinity Rock Island was able to develop a project in which the departmental gross square footage is less than the State Guideline for every department/ area for which there is a guideline.

2. *If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy.*

NA No department/area in this project exceeds the BGSF/DGSF standards in Appendix B.

Attachment 14, Table 1 includes all of the information in the table outlined above.

Attachment 14, Table 2 is a listing of non-clinical square footage by category, by floor.

Attachment 14, Exhibit 1 includes the floor-by-floor drawings of each of the levels of the proposed tower as well as the modernized space in the existing building.

Attachment 14, Exhibit 2 includes impediments letters from the architect and the construction manager.

Comparison of Project Square Footage to State Guidelines

Department/ Service	Number of Key Rooms	Proposed DGSF	Proposed DGSF per Room	State Guideline/ Allowable	Difference per Key Room	Met Standard?
Cardiac Catheterization	4 labs	7,090	1,773	1,800	(27) per room	Yes
Phase II Cardiac Prep/Recovery	20 stations	7,850	393	400	(7)	Yes
Non Invasive Cardiology/ NIDT	6 units (2 echo, 1 stress, 2 vascular and 1 PFT)	3,665	611	NA	NA	NA
Cardiac Rehabilitation	1 room/ 26 therapy stations, 6 weight stations, and 1 mat table	4,455	4,455	NA	NA	NA
Emergency Department	23 stations incl. 1 trauma room	18,540	806	900	(94)	Yes
General Radiology	4 units 3 existing in the Imaging Department and 1 replacement located in the Emergency Department	3,845	961	1,300	(339)	Yes
Computerized Tomography	2 units 1 existing in the Imaging Department and 1 replacement to the Emergency Department	1,730	865	1,800	(935)	Yes
Observation Unit	12 rooms	4,890	408	NA	NA	NA
Crisis Stabilization Unit	6 rooms	4,650	775	NA	NA	NA
Behavioral Health Group Therapy Rooms	3 rooms	2,800	933	NA	NA	NA

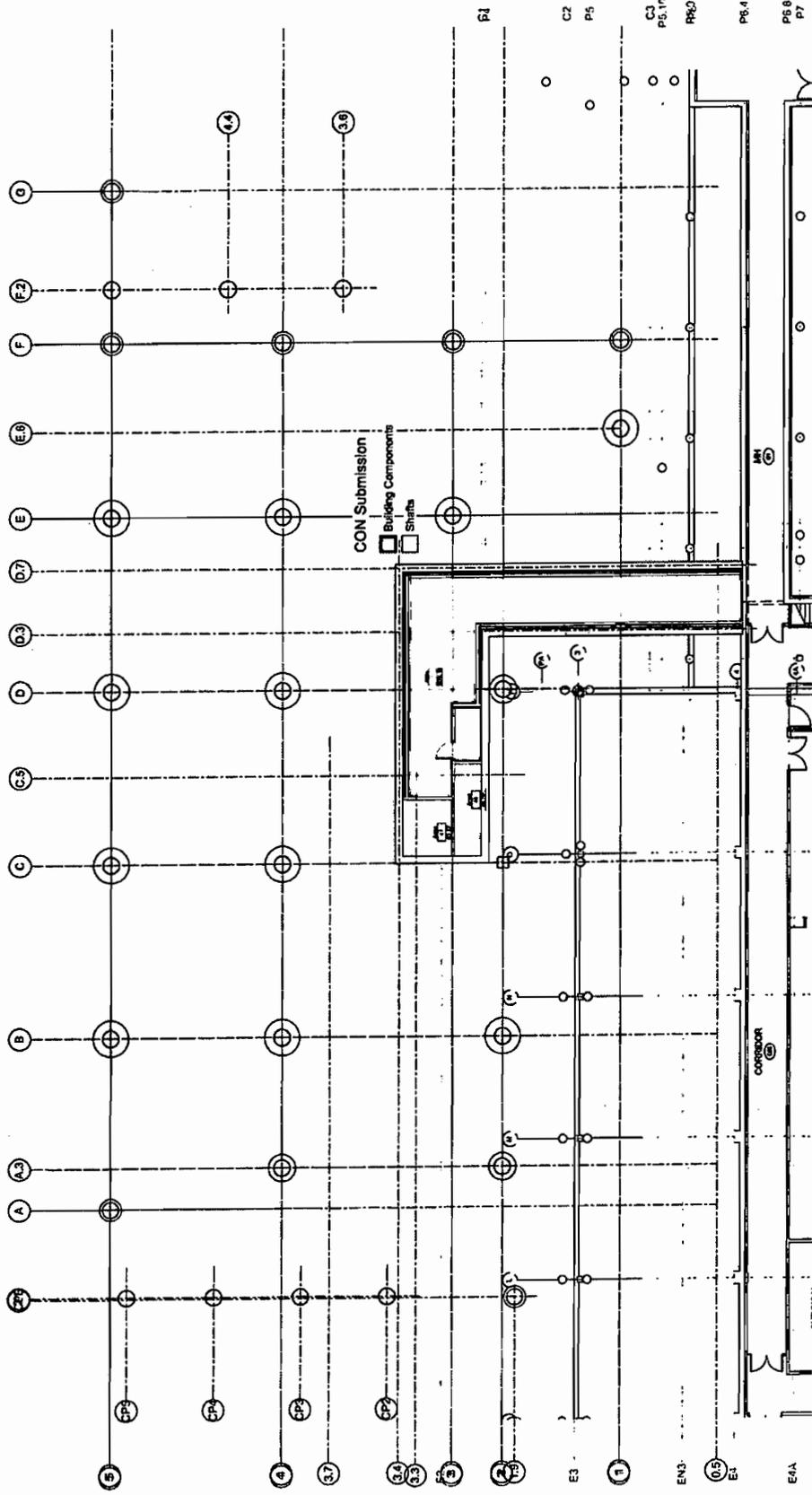
Source: Cannon Design

<b>Non-Clinical</b>		
<b>Registration/Intake</b>	Level 01	41 GSF
	Level 02	455 GSF
	Level 03	43 GSF
		538 GSF
<b>Public Areas</b>	Level 01	41 GSF
	Level 02	455 GSF
	Level 03	43 GSF
		538 GSF
<b>Public Areas – Renovation</b>	Level 02	614 GSF
		614 GSF
<b>Resource Center/Outreach</b>	Level 02	1,190 GSF
		1,190 GSF
<b>Physician Spaces</b>	Level 01	232 GSF
		232 GSF
<b>Staff Space</b>	Level 01	1,580 GSF
	Level 02	1,926 GSF
	Level 03	618 GSF
		4,124 GSF
<b>Administration</b>	Level 03	2,079 GSF
	Level 01	205 GSF
		2,283 GSF

Conference Rooms/Education Spaces	Level 03	1,852 GSF
		1,852 GSF
Storage	Level 01	3,891 GSF
		3,891 GSF
Security	Level 02	314 GSF
		314 GSF
Decontamination	Level 02	364 GSF
		364 GSF
Canopies	Level 02	4,494 GSF
		4,494 GSF
Building Components	Ground Level	1,375 GSF
	Level 01	4,826 GSF
	Level 02	3,054 GSF
	Level 03	4,891 GSF
	Level 04	1,236 GSF
		15,380 GSF

Note: Totals may not add due to rounding

Floor – by – Floor Drawings.



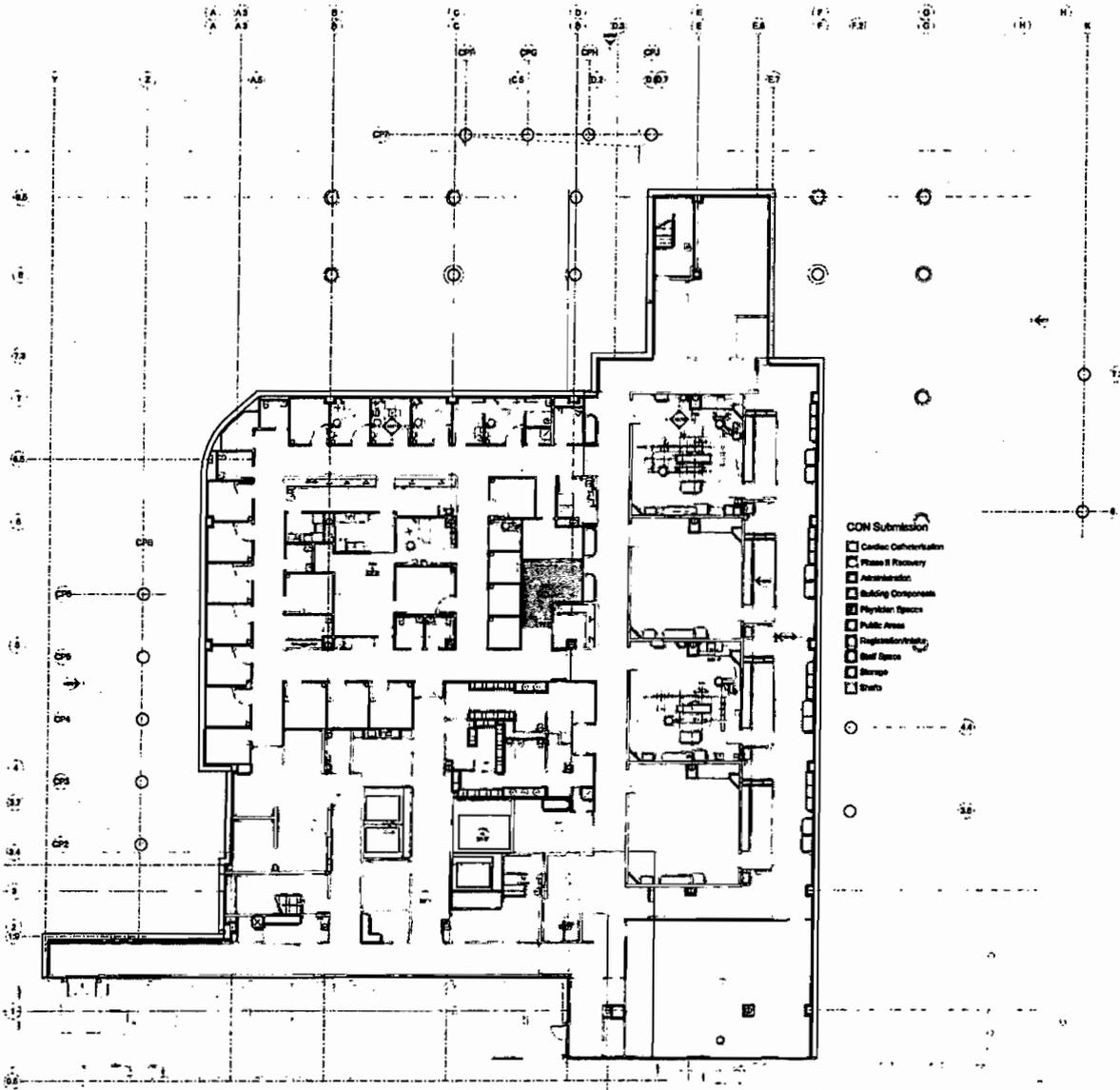
EL EM EN EN1 E0 EP PA PB CA PBB PC CB PD PE PF

1 GROUND LEVEL

**TRINITY REGIONAL HEALTH SYSTEM  
HEART CENTER / EMERGENCY  
DEPARTMENT**

**GROUND FLOOR CON SF**

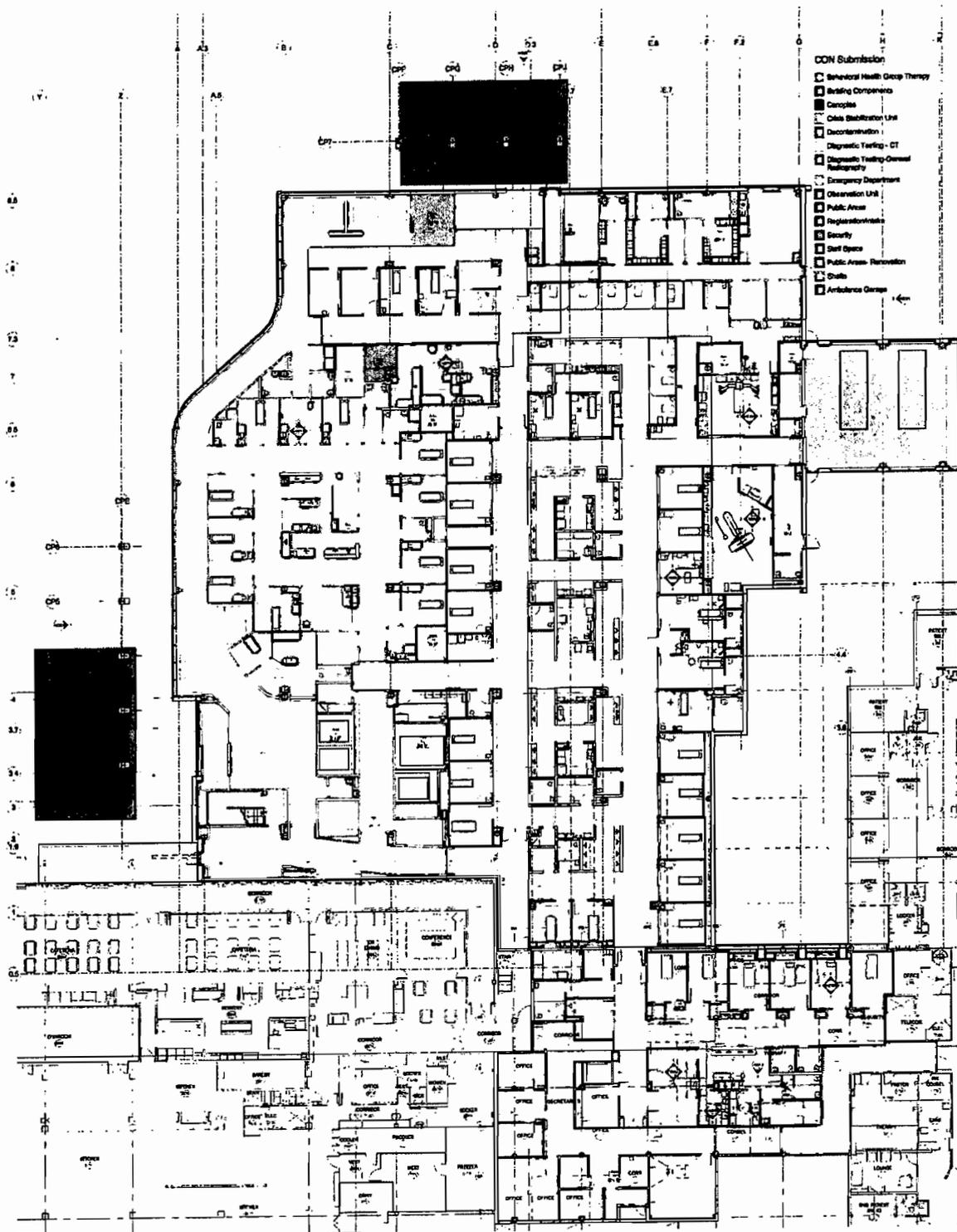
CANNON DESIGN | gda  
SCALE: 1/8" = 1'-0"  
12/12/2012



TRINITY REGIONAL HEALTH SYSTEM  
 HEART CENTER / EMERGENCY  
 DEPARTMENT

LEVEL 01 CON SF

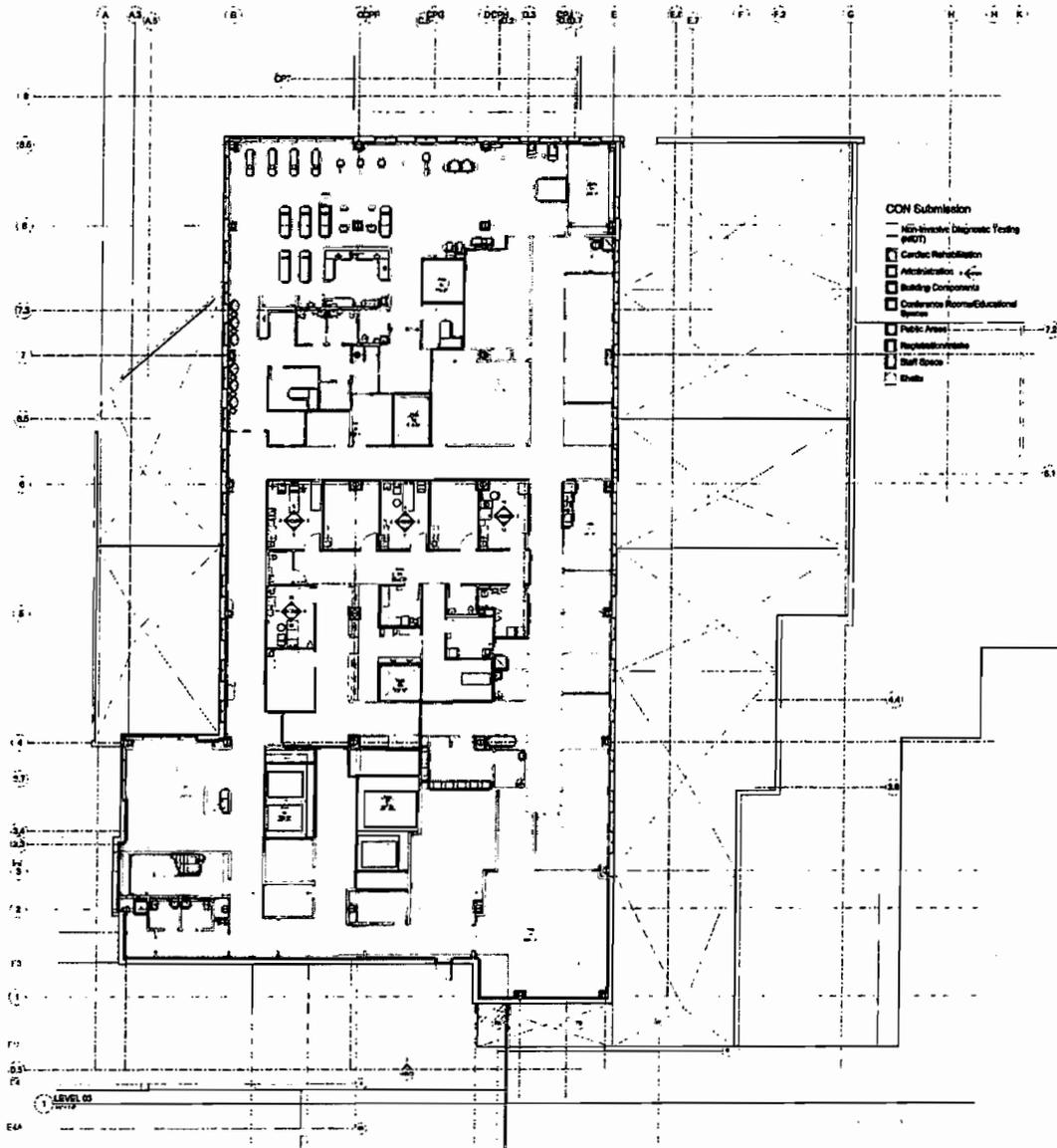
CANNON DESIGN | gda  
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 12/15/2012



TRINITY REGIONAL HEALTH SYSTEM  
 HEART CENTER / EMERGENCY  
 DEPARTMENT

LEVEL 02 CON SF

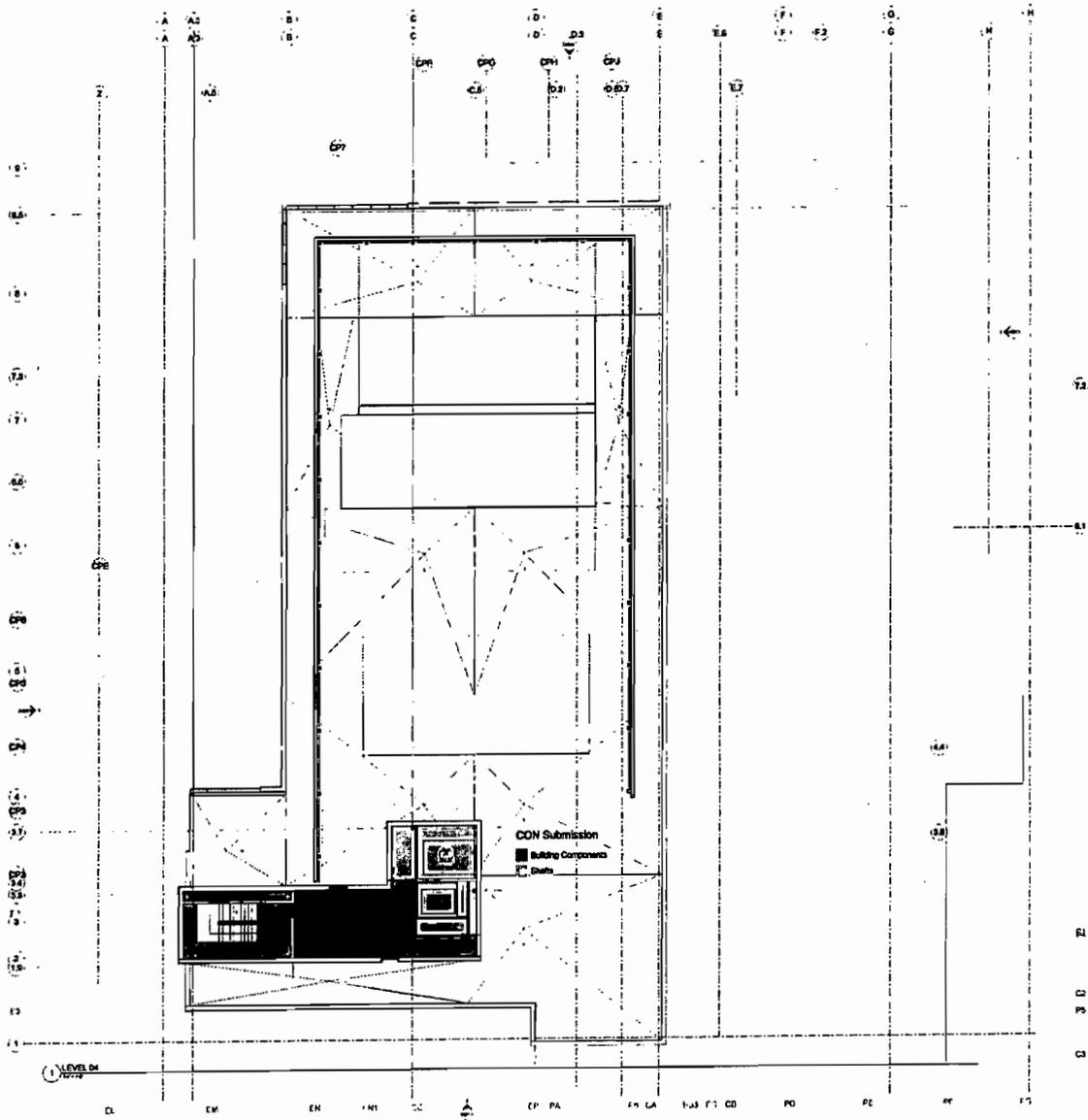
CANNON DESIGN gda  
 SCALE: 1/8" = 1'-0"  
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**TRINITY REGIONAL HEALTH SYSTEM  
HEART CENTER / EMERGENCY  
DEPARTMENT**

**LEVEL 03 CON SF**

**CANNON DESIGN | gda**  
SCALE: 1/8" = 1'-0"  
12/19/2012



**TRINITY REGIONAL HEALTH SYSTEM  
HEART CENTER / EMERGENCY  
DEPARTMENT**

**LEVEL 04 CON SF**

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12/12/2012

# CANNONDESIGN

December 14, 2012

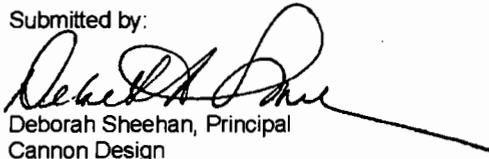
Health Facilities and Services Review Board  
525 West Jefferson Street, Second Floor  
Springfield, IL 62761  
Re: Trinity Health New Tower Expansion

The following is a list of impediments that have impacted the cost of the New Tower:

Chicago  
Baltimore  
Boston  
Buffalo  
Calgary  
Houston  
Los Angeles  
Mumbai  
New York  
Phoenix  
St. Louis  
San Francisco  
Shanghai  
Toronto  
Vancouver  
Victoria  
Washington DC

1. The additional capacity requires substantial upgrade to the existing Central Utility Plant (CUP) inclusive of upgrade of existing generator size within the current plant and service routing from the plant located on the South of the campus.
2. Working adjacent to the main hospital entry requires temporary measures to protect the public and create alternative means of safe entry and egress to maintain hospital operations during construction.
3. The two connectors to Surgery are provided due to the travel distance and number of turns required through the existing hospital and the valuable added minutes in an emergency. The connector designed minimizes the travel time for patients to access critical services.
4. The new Energy Efficient Envelope requirements of ASHRAE 90.1 and IECC, 2009, requires a higher performing fenestration, the addition of insulation material in the exterior walls, below grade walls and below slab on grade floors.
5. Regrading of the site to maximize surface parking and grade transition to the new building requires substantial cut and fill earthwork.
6. As a result of this project, the municipal code officials are requiring the upgrade of the storm water detention system on the Hospital campus resulting in creation of a sub surface storm water detention solution due to limitations of surface area on the Hospital campus.
7. Insufficient soil bearing capacity located in the project area has predicated the design of deep pier foundations systems.
8. Sheet piling is required due to construction in close proximity to the existing hospital structures in order to maximize clinical adjacencies to diagnostic service.

Submitted by:

  
Deborah Sheehan, Principal  
Cannon Design

225 North Michigan Avenue  
Suite 1100  
Chicago, Illinois  
60601  
T: 312.332.9600  
F: 312.332.9601  
www.cannondesign.com



December 14, 2012

**RE: Trinity Regional Health Systems  
Heart Center / ED Expansion**

To Whom It May Concern:

Regarding the subject project, there are several factors that affect the cost of construction. The following is a list of those factors:

- Building excavation and construction is adjacent to occupied spaces that will be left in operation throughout construction. Exterior envelope modifications to existing and breakthrough areas require an elevated level of protection, cleanup, and infection control efforts. Work plans are expected to implement premiums for off-hours shifts to minimize disturbances.
- Renovation on the 2<sup>nd</sup> floor occurs over an existing unit that will remain active. During the process of demolition and rough-in, this will require additional infection control efforts, protection and cleanup, and may require off-hours premium work shifts, especially related to plumbing work.
- This project includes demolition of an adjacent existing entry canopy and construction of new replacement, not otherwise associated with the Emergency Department itself, but required due to its adjacency.
- The replacement canopy construction dictates a re-route and/or temporary entrance be established to protect staff and customer traffic.
- Several of the mechanical, electrical and plumbing systems are routed through the existing occupied facility, and each requires heightened infection control and interim life safety management efforts to protect occupants. These include:
  - Primary electrical service, steam, and chilled water routed from the power plant located on the other side of the facility
  - Medical gas mains through the existing basement
  - Domestic plumbing mains through the existing basement
  - Fire Protection mains extended through existing space on each floor
- Existing site utilities require interim handling. Pipe runs and manholes must be demolished to make room for the building excavation, but cannot be re-established permanently until the new structure and piping are installed. Waste and storm water services for the existing building will temporary re-route during construction.
- Due to site parking constraints, the project must include remote parking facility and added transportation costs for tradesmen every day.

Sincerely,

**RUSSELL-PEPPER L.L.C.**

A handwritten signature in black ink, appearing to read "Rich Schuster", is written over a light blue horizontal line.

Rich Schuster  
Senior Vice President

**SECTION IV - PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE**

**Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space**

READ THE REVIEW CRITERION and provide the following information:

**PROJECT SERVICES UTILIZATION:**

**This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.**

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B. **A narrative of the rationale that supports the projections must be provided.**

**A table must be provided in the following format with Attachment 15.**

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MET STANDARD?
YEAR 1					
YEAR 2					

**APPEND DOCUMENTATION AS ATTACHMENT-15, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

Attachment 15, Exhibit 1, provides documentation that the services that are part of the Heart Center/Emergency Department project proposed by Trinity Rock Island meet or exceed the utilization standards specified in 1110 Appendix B.

See Attachments 25 and 37 for a narrative of the rationale that supports the projections.

Summary of Utilization

Summary of Utilization Department/Service	Historical Utilization		Projected Utilization –2018	State Standard	Number of Key Rooms		Met Standard?
	2010	2011			Current	Proposed	
Cardiac Catheterization (Invasive) Labs	4,271 Visits 8,043 Hours	4,354 Visits 8,238 Hours	6,180 Visit Hours NA	1,500 Hours Per Room NA	3 Labs	4 Labs	Yes
Phase II Prep/Recovery	NA	NA	NA	NA	11 Stations	20 Stations	NA
Non Invasive Diagnostic Testing (NIDT) <sup>1</sup>	7,086	7,065	8,089	NA	6 Modalities	6 Modalities	NA
Cardiac Rehabilitation	9,372	8,276	12,821	NA	13 Therapy Stations	26 Therapy Stations	NA
Emergency Department	33,181	35,676	45,032	2,000 Visits per Station	17	23	Yes
General Radiology	24,827	25,673	NA Current Volume Supports Projected Units	8,000 Procedures per Room	4	4	Yes
Computerized Tomography	15,643	13,057	NA Current Volume Supports Projected Units	7,000 Procedures per Room	2	2	Yes
Observation Unit	NA	NA	2,533	NA	NA	6 Rooms	NA
Crisis Stabilization Unit	NA	NA	39,184 Days	NA	NA	6 Rooms	NA
Behavioral Health/Group Therapy	NA	NA	Varies	NA	NA	3 Rooms	NA

<sup>1</sup> NIDT volume includes EKGs.

**SECTION IV - PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE**

**Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space**

READ THE REVIEW CRITERION and provide the following information:

**UNFINISHED OR SHELL SPACE:**

Provide the following information:

1. Total gross square footage of the proposed shell space;
2. The anticipated use of the shell space, specifying the proposed GSF tot be allocated to each department, area or function;
3. Evidence that the shell space is being constructed due to
  - a. Requirements of governmental or certification agencies; or
  - b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.
4. Provide:
  - a. Historical utilization for the area for the latest five-year period for which data are available; and
  - b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

**APPEND DOCUMENTATION AS ATTACHMENT-16, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

1. The Total Gross Square Footage of the Proposed Shell Space and Vacated Space

There will be no shell space as part of Trinity Rock Island's project. The applicants are responding to this criterion to describe the location and amount of vacated space in the project. There will be 17,605 total GSF of vacated space at the completion of the project. Of the total space, 16,180 GSF will be on the Trinity Rock Island campus and 1,425 GSF will be on the Trinity Moline campus.

Attachment 16, Table 1  
Vacated Space at the Completion of the New Tower

Area/ Department	Current Location	DGSF Being Vacated
Emergency Department	Second Floor – West	6,920 SF
Cath Labs	Second Floor – Central	3,460 SF
Non Invasive Cardiology	Second Floor – Central	1,790 SF
Cardiac Rehab	Moline Campus Second Floor	1,425 SF
General Radiography	Second Floor – Central	300 SF
Computerized Tomography	Second Floor – Central	400 SF
Phase II Recovery (Cardiac Only)	Second Floor – Central	3,310 SF
Total		17,605 SF

Source: Trinity Rock Island Records

At the present time, there are no definitive plans for the reuse of the vacated space on either the Rock Island or the Moline campus.

Trinity Medical Center takes pride in involving physicians, users and other stakeholders including the community in long-term strategic decisions. The final strategic decisions relating to the reuse of the vacated space will begin with an assessment of future community healthcare needs that will flow into a formal space planning process involving administration, physicians, users and other stakeholders.

Several reuses of the space have been mentioned. For example,

- The vacated cardiac cath labs may be reused for the expansion of the Endoscopy Suite; Trinity Rock Island has experienced a sudden increase in endoscopic procedures over the last 12 months.
- Several key clinical departments including laboratory and pharmacy have been “landlocked” on the Trinity Rock Island campus and may need to be expanded.
- The vacated cardiac rehab space on the Trinity Moline campus may be used for physician offices or administrative space.

The final decisions related to the reuse of space will occur through a formal space planning process when IHS priorities are set and capital funds become available.

**SECTION IV - PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE**

**Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space**

READ THE REVIEW CRITERION and provide the following information:

**ASSURANCES:**

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.
2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and
3. The anticipated date when the shell space will be completed and placed into operation.

**APPEND DOCUMENTATION AS ATTACHMENT-17, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

NA There is no shell space in this project.

## **F. Criterion 1110.1330 - Cardiac Catheterization**

**This section is applicable to all projects proposing to establish or modernize a cardiac catheterization category of service or to replace existing cardiac catheterization equipment.**

### **1. Criterion 1110.1330(a), Peer Review**

Read the criterion and submit a detailed explanation of your peer review program.

### **2. Criterion 1110.1330(b), Establishment or Expansion of Cardiac Catheterization Service**

Read the criterion and, if applicable, submit the following information:

- a. A map (8 1/2" x 11") showing the location of the other hospitals providing cardiac catheterization service within the planning area.
- b. The number of cardiac catheterizations performed for the last 12 months at each of the hospitals shown on the map.
- c. Provide the number of patients transferred directly from the applicant's hospital to another facility for cardiac catheterization services in each of the last three years.

### **3. Criterion 1110.1330(c), Unnecessary Duplication of Services**

Not Applicable. Trinity Medical Center has an established cardiac catheterization lab.

Read the criterion and, if applicable, submit the following information.

- a. Copies of the letter sent to all facilities within 90 minutes travel time which currently provide cardiac catheterization. This letter must contain a description of the proposed project and a request that the other facility quantify the impact of the proposal on its program.
- b. Copies of the responses received from the facilities to which the letter was sent.

### **4. Criterion 1110.1330(d), Modernization of Existing Cardiac Catheterization Laboratories**

Read the criterion and, if applicable, submit the number of cardiac catheterization procedures performed for the latest 12 months.

### **5. Criterion 1110.1330(e), Support Services**

Read the criterion and indicate on a service by service basis which of the listed services are available on a 24 hour basis and explain how any services not available on a 24 hour basis will be available when needed.

### **6. Criterion 1110.1330(f), Laboratory Location**

Read the criterion and, if applicable, submit line drawings showing the location of the proposed laboratories. If the laboratories are not in close proximity explain why.

### **7. Criterion 1110.1330(g), Staffing**

Read the criterion and submit a list of names and qualifications of those who will fill the positions detailed in this criterion. Also provide staffing schedules to show the coverage required by this criterion.

### **8. Criterion 1110.1330(h), Continuity of Care**

Read the criterion and submit a copy of the fully executed written referral agreement(s).

**9. Criterion 1110.1330(i), Multi-institutional Variance**

Not Applicable. Trinity Medical Center is not seeking a multi-institutional variance.

Read the criterion and, if applicable, submit the following information:

- a. A copy of a fully executed affiliation agreement between the two facilities involved.
- b. Names and positions of the shared staff at the two facilities.
- c. The volume of open heart surgeries performed for the latest 12-month period at the existing operating program.
- d. A cost comparison between the proposed project and expansion at the existing operating program.
- e. The number of cardiac catheterization procedures performed in the last 12 months at the operating program.
- f. The number of catheterization laboratories at the operating program.
- g. The projected cardiac catheterization volume at the proposed facility annually for the next 2 years.
- h. The basis for the above projection.

APPEND DOCUMENTATION AS ATTACHMENT-25 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

### **Introduction**

There are two Trinity Regional Health System hospitals in Illinois –Trinity Rock Island (TRI, Hospital) and Trinity Moline. The majority of invasive and non invasive cardiac services are located at Trinity Rock Island; however Phase II cardiac rehabilitation and a few non invasive units needed for the care of its patients are located at Trinity Moline. Trinity Rock Island is proposing to consolidate all invasive and non invasive cardiac services currently provided at Trinity Rock Island along with Phase II cardiac rehab from Trinity Moline in a new Heart Center to be located on the TRI campus.

### Professional Staff

Trinity Regional Health System has a specialized team of physicians, nurses, and other health professionals that consistently deliver cardiovascular services with excellent outcomes – substantially better than the national averages. TRHS has 28 board certified cardiologists and 9 heart surgeons who are double certified in cardiovascular and thoracic surgery. These physicians serve the Rock Island community.

TRI's heart program has received national recognition for clinical excellence. The ability to achieve clinical excellence is the result of a positive working relationship between the Hospital staff and the cardiologists and cardiovascular surgeons. See Attachment 13. 3) Empirical Evidence.

### Services

The greater Rock Island community and beyond benefit from the following broad range of cardiac – related services available at Trinity Rock Island

#### Detection and Prevention Programs

- Trinity Heart Aware is an on-line evaluation service used by the community to assess risk for heart disease, stroke or vascular disease. TRI provides each participant with a confidential report to help them:
- Assess their own cardiovascular health status
- Identify medical and lifestyle conditions that may lead to the development of cardiovascular disease
- Understand specific cardiovascular health and risks by providing free continuing education about health and risk factors, and
- Take action to reduce the potential of risk.
- “My Nurse” is a free health information service available 24/7. A registered nurse can answer community callers’ heart-related questions, evaluate symptoms, and offer guidance on whether the problem can be treated at home, or should be seen by a physician in his office, or whether immediate treatment should be sought.
- “Eat Smart for Your Health: the Cardiac Diet” is available to the community. This attractive and easy to read brochure addresses the principles of a good cardiac diet with emphasis on reducing cholesterol, fat, and salt. It provides healthy cooking tips and assistance in understanding nutrition labels on food purchases.

## Level II Trauma/Emergency Department Services

The Level II Trauma Center/Emergency Department at the Hospital provides immediate care in conjunction with patients' physicians. Currently 10 percent of TRI's emergency patients present with a cardiac diagnosis; approximately 14 percent of these patients or about 500 patients a year are transferred directly to the cardiac cath lab.

## Cardiac Intensive, Medical Surgical Intensive Care, and General Medical Surgical Inpatient Care

### Non Invasive Diagnostic Testing (NIDT)

NIDT includes electrocardiography, vascular ultrasound, echocardiography, stress testing, transesophageal testing, Holter monitoring, and pulmonary function testing.

### Diagnostic and Interventional Cardiac Cath/Electrophysiology/Peripheral Angiography Labs

A comprehensive range of invasive procedures are performed in the existing 3 cath labs. Recently, the Hospital implemented the use of cryogenic cooling agents to speed cardiac ablations and reduce scar tissue. This is an important advance in performing ablations, one of the many electrophysiology procedures performed at TRI.

### Heart Surgery

Heart surgery procedures performed at TRI include coronary artery bypass grafts (CABGs), valve replacement, aneurysm repair, ascending aortic arch repair, maze procedures. The surgeons at TRI also perform vascular surgery.

### Phases I, II, and III Cardiac Rehabilitation

Phase I cardiac rehabilitation begins while the patient is in the Hospital. Phase II cardiac rehabilitation is a 3-month hospital-based outpatient exercise and education program that is currently provided at Trinity Moline. Phase III cardiac rehabilitation is provided in conjunction with Augustana Fitness Center.

### Nutritional Counseling

### Congestive Health Failure Clinic

### Home Health, and

### Cardiac Research.

One of the purposes of the proposed project is to meet the community needs for cardiac-related services by providing updated, additional technology and space in a new tower that will enhance patient outcomes, continuity of care, multidisciplinary care, as well as patient comfort and convenience.

1. Criterion 1110.1330 (a), Peer Review

*Read the criterion and submit a detailed explanation of your peer review program.*

Cardiovascular Peer Review Program

The Trinity Rock Island Cardiology Division has its own quality review process.

The cardiac catheterization lab currently participates in the American College of Cardiology (ACC) Registries which allow comparison to national benchmarks. This data is reviewed quarterly at the Cardiovascular Quality Committee to identify potential quality issues.

Medical Staff Peer Review Program

Trinity Medical Center's (Medical Center) Peer Review Committee functions on behalf of all three of the Medical Center's providers. It is comprised of 13 active members of the medical staff and also includes non-voting representation from risk management, senior nursing, as well as the Chief Medical Officer. Meetings are scheduled monthly. Peer review cases are identified by physicians and nurses, patients and families, risk management, administration, cath lab personnel, the Medical Executive Committee, as well as the case management and quality improvement staffs.

Case criteria may include but are not limited to:

- Deaths within 24 hours of procedure/admission
- Extended hospital stays (3 times ALOS for the patient's DRG)
- Readmission within 24 hours for same or related condition
- Root cause analysis/Sentinel event with physician issues, and
- Recommendation following risk management review.

Each case is given to a member of the Peer Review Committee to review. The physician reviews the case and makes a recommendation to either close the case or forward for a full committee review. A quorum of 50 percent of the members must be present at any meeting of the full committee in order to conduct business. Findings, along with recommendations, are forwarded to the Medical Executive Committee.

When a case is referred to the full Medical Executive Committee, they review the information and consider the severity ranking. They meet as a group, discuss the issue, and then define a very process-oriented, action plan based on the facts surrounding the case. The action will take

one of two paths based on severity. Most often, the resulting action (if not a serious case) has an educational plan set in motion with either education required for the individual physician or entire medical staff. Sometimes, a Focused Professional Practice Evaluation might be recommended. Typically, the action taken on low severity issues is not meant to be punitive. In higher severity instances that require punitive action (restricted, suspended or loss of privileges, etc.) an administrative review process (as defined by the Medical Center's by-laws) is set into motion. The by-laws define how this process proceeds and details the process for review and appeal at this level.

2. Criterion 1110.1330(b), Establishment or Expansion of Cardiac Catheterization Service

*Read the criterion and, if applicable, submit the following information:*

- a. *A map (8 1/2" x 11") showing the location of the other hospitals providing cardiac catheterization service within the planning area.*
- b. *The number of cardiac catheterizations performed for the last 12 months at each of the hospitals shown on the map.*
- c. *Provide the number of patients transferred directly from the applicant's hospital to another facility for cardiac catheterization services in each of the last three years.*

2.a) Attachment 25, Exhibit 1 is a map of HSA 10 which includes Rock Island, Mercer, and Henry counties. Two hospitals in HSA 10 provide cardiac catheterization services – they are Trinity Rock Island (TRI) and Genesis Medical Center – Illini Campus. Both hospitals are located in Rock Island County. As shown on the map, Genesis – Illini Campus is located 11 miles northeast of Trinity Rock Island.

2.b) Trinity Rock Island has an established cardiac catheterization service with three labs. Attachment 25, Table 1 shows the number of cardiac catheterizations performed at TRI and Genesis Medical Center – Illini Campus in 2011.

Attachment 25, Table 1  
Utilization of Cath Labs in HSA 10, 2011

Provider	Number of Catheterizations			
	Diagnostic 15+	Interventional 15+	EP 15+	Total
Trinity Medical Center – Rock Island	1,982	1,336	564	3,882
Genesis Medical Center - Illini Campus	635	268	105	1,008

Source: *Hospital Profiles, 2011*

Each of the hospitals that provide cardiac catheterization services in HSA 10 performed more than 1,000 procedures in 2011. Trinity Rock Island performed almost 4 times as many procedures as the other provider.

2.c) Trinity Rock Island's cardiac catheterization service provides adult diagnostic and interventional catheterization, electrophysiology, peripheral angiography, and other services typically performed in a cath lab such as nephrology tube, PIC line, and drain placements; vertebroplasties; disco grams; and bone biopsies. The cardiac cath lab at TRI currently operates an extended daily and weekend schedule to accommodate patient volume. Because TRI also provides heart surgery, high risk cath patients are also being treated at TRI; in fact, with the completion of this proposed project, it will be possible to move patients directly from a cath lab to a heart surgery operating room.

Because of the presence of this full complement of invasive heart services, patients are rarely transferred directly from TRI to another facility. TRI does not have the ability to track the number of transferred patients.

3. Criterion 1110.1330(c), Unnecessary Duplication of Services

*Read the criterion and, if applicable, submit the following information.*

- a. Copies of the letter sent to all facilities within 90 minutes travel time which currently provide cardiac catheterization. This letter must contain a description of the proposed project and a request that the other facility quantify the impact of the proposal on its program.*
- b. Copies of the responses received from the facilities to which the letter was sent.*

Not Applicable. Trinity Medical Center has an established cardiac catheterization service.

4. Criterion 1110.1330(d), Modernization of Existing Cardiac Catheterization Laboratories

*Read the criterion and, if applicable, submit the number of cardiac catheterization procedures performed for the latest 12 months.*

Trinity Rock Island (TRI, Hospital) currently has 3 invasive (cardiac cath/EP) labs. The Hospital's physicians perform only adult procedures (patients age 15+). As part of the project, TRI is proposing add a fourth lab.

During 2011, Trinity Rock Island physicians performed 3,882 diagnostic and intervention caths as well as electrophysiology (EP) procedures (such as radio-frequency ablations implantable cardioverter defibrillators (ICDs), and pacemaker insertions). Peripheral angiography and other visits including placements of nephrology tubes and PIC lines, as well as vertebroplasties and other procedures, accounted for an additional 472 visits.

Attachment 25, Table 2  
Visits to the Trinity Rock Island Cardiac Cath Labs in 2011

Type of Visit	Number of Visits
Diagnostic Caths	1,982
Interventional Caths	1,336
EP Procedures	564
Subtotal	3,882
Peripheral Angiography	415
Other	57
Subtotal	472
Total	4,354

Source: Trinity Rock Island Records

Attachment 25, Exhibit 2 shows procedures by type from 2007 to 2011.

## **Background**

Having the ability to swiftly respond to patients who are experiencing a cardiac event is a daily challenge in Trinity Rock Island's current environment. For more than a year, the Hospital has been operating the cath labs for extended hours on weekdays and scheduling cases on the weekends and even holidays. When urgent or emergency cases must be added to the schedule, the lack of open lab time forces cases to be performed long into the evening. These long days are mentally taxing for staff. They are also physically tiring for the physicians who must wear heavy lead shields that weigh an average of 20 pounds while they are standing and performing procedures that frequently last an hour or more.

### Facility Limitations

The current TRI cardiac cath lab has neither enough lab equipment capacity nor enough square footage. Space is a major limitation for the cath services. The cath labs are small. One of the labs measure 461 NSF and the others measure 443 NSF. The American College of Cardiology recommends that cath labs should be a minimum of 550 NSF. With a total team of typically 5 physicians and support staff in a lab during a procedure, maneuverability and efficiency are greatly compromised. The labs are too small to accommodate contemporary equipment. Available departmental gross square footage (GSF) is also inadequate. The current 3 cath labs and related clinical space are located in 3,460 GSF of space or an average of 1,153 GSF of space per lab. This is 36 percent less than the State Guideline of 1,800 GSF per lab. Consequently support spaces such as control rooms, storage, and patient waiting are also undersized.

The physical layout of the existing labs carries risk of patient infection. For example, the cath labs open into a public corridor. Patients are wheeled directly from a public corridor into the cath lab which is a sterile environment. Other than a sign on the exterior door, there is nothing to prevent a visitor from entering the lab during a procedure or after hours when the lab is closed. Further, the scrub sinks are not immediately adjacent to the cath labs, which require physicians to scrub and then walk the length of the department to enter a lab. These conditions have been identified as potential infection risks by the Infection Control Department.

Further, the control rooms are too small for the equipment and staff. The control areas are open to a semi-restricted corridor. One central area is single while two share an open space. The shared control area is often noisy which has the potential to distract control room staff; the small size makes for extremely cramped working conditions.

Supply storage is a major issue; very few supplies are stored in the labs due to space constraints. Currently supplies are stored in a corridor outside the cath labs. This contributes to inefficiencies as well as risk of costly supplies being lost or damaged. Interventional supplies are stored in a semi-restricted corridor connecting the labs; this restricts passage by staff.

There is no overflow waiting area for patients – the nearby waiting areas are often fully occupied and patients must wait in Surgery Waiting.

#### Equipment Limitations

Trinity Rock Island currently operates 3 cardiac cath units. Of these, 2 are cath labs and 1 is a cath/EP lab.

These 3 units would be replaced regardless of the Heart Center project because they have or will reach the end of their useful lives by the time the Heart Center opens. Because of their age they do not have the same capabilities that newer models have. These advanced capabilities would benefit the cardiac patients treated at TRI. Replacing the existing invasive labs after the new Heart Center opens would cause considerable operational disruption.

TRI is proposing to purchase all four cardiac cath units under a single contract. One of the units will be scheduled for delivery in 2013 and relocation to the new Heart Center; the others will not be scheduled for delivery until 2015 and will be installed in the Heart Center. In order to assure that Trinity will benefit from the most up-to-date technology, the purchase agreement will include language assuring TRI that the manufacturer will provide the latest generation of hardware and software technology at the time of delivery.

TRI is proposing to purchase all four cardiac cath units as well as a CT Scanner, a general radiology units and a portable radiology unit under one contract. In this way, TRI will benefit from the most advantageous pricing.

TRI is considering multiple options for disposing of the cardiac and imaging equipment to be replaced. As of the date of filing this certificate of need, it is assumed that the old equipment will be used as trade-ins on the new equipment.

The following table summarizes the age and useful life of each of the cardiac cath units to be replaced and its specific limitations.

Attachment 25, Table 3  
Replacement of Cardiac Cath Equipment

Model	Year Purchased	Useful Life	Replacement
Lab #1 Allura Xper FD20	2007	5 years	This equipment has exceeded its useful life and will be replaced in 2013. This new equipment will be purchased as routine replacement equipment and installed in the existing cath unit. It will be relocated to the Heart Center when it opens in 2016.
Lab #2 Allura Xper FD 20	2008	7 years	By 2016, the year the new Heart Center will open, this unit will have reached the end of its useful life. It will be purchased as routine replacement equipment and installed in the Heart Center.
Lab #3 Allura Xper FD 20	2009	7 years	This equipment will exceed its useful life the year the Heart Center is complete. It will be purchased as routine replaced equipment and included in the Heart Center when it opens

As noted on the table above, TRI's cardiac cath equipment has either reached or will reach the end of its useful life by project completion. All of the existing labs are experiencing increasing maintenance costs.

#1 Lab – Purchased in 2007

The service record for this equipment indicates an increasing frequency of service calls. Over the last 4 years, the annual number of service calls averaged 11 per year. On three separate occasions, the x-ray tub required replacement. One replacement call caused 7 days of downtime. With the Hospital's very busy cardiac cath schedule, having an extended downtime has serious repercussions for patient care.

#2 Lab – Purchased in 2008

The service record indicates increasing frequency of service calls. Over the last 4 years, the annual number of service calls averaged 7 per year; one visit in 2012 required replacing the x-ray tube.

#3 Lab – Purchased in 2009

The 3-year service record indicates an abnormally high number of service calls, or an average of more than 8 per year. This lab is not capable of serving as a dual purpose cath lab/EP lab.

## Advantages of the New Cardiac Cath Equipment

There are many important clinical advantages of the proposed new cardiac cath equipment.

These include:

- Higher resolution on the imaging chain; this will allow more precise diagnosis and fewer retakes
- Improved radiation dose management via better control of scatter through selectable copper beam filters
- Improved x-ray tube heat dissipation allowing faster turnaround times
- Dose display software fostering greater operator awareness and control of radiation doses
- Improved rotational scan allowing multiple scan ranges with fewer contrast injections administered to the patient, and
- Greater control of C-arm movement and safeguards against C-arm/patient collisions.

All of these features improve patient safety and diagnostic precision.

When the new Heart Center opens, TRI proposes to have 2 cath labs, 1 cath/EP combination lab and 1 EP lab; thereby providing additional capacity and flexibility in the greatest procedural growth area.

4. Criterion 1110.1330 (d), Modernization of Existing Cardiac Catheterization Laboratories

Current Need Based on State Agency Utilization Guideline

Only adult procedures (patients age 15+) are performed in the Trinity cath labs; the following discussion is focused on only adult cath cases statewide and at the Hospital.

The current State Agency guideline for cardiac catheterization labs is 1,500 visits per year for additional units. In 2011, Trinity Rock Island reported 3,882 procedures, as required, in the Annual Hospital Questionnaire.

In addition to the diagnostic, interventional and electrophysiology procedures in the labs, 472 other visits to the labs were recorded. These other visits included peripheral angiography; nephrology tube, PIC line, drain placements; vertebroplasties; disco grams; and bone biopsies. In 2011, the Hospital reported 472 "other" visits, or 53 percent more than in 2007. Hence, in 2011, there were 4,354 visits to the cath labs at the hospital.

3,882 diagnostic, interventional, and EP procedure visits + 472 "other" visits = 4,354 total visits

Based on 2011 volume and the State Guideline of 1,500 visits per room, Trinity Rock Island could justify 2.9 or 3 cath labs.

$$4,354 \text{ total visits} \div 1,500 \text{ visits per room} = 2.9 \text{ or } 3 \text{ cath labs}$$

This calculated need for cath labs is inconsistent with the experience in the cath labs at TRI.

Because of high volume, the existing 3 cath labs at Trinity Rock Island are operating under very stressful conditions. Under more normal circumstances, a lab would be scheduled for 7.5 hours per day and 250 days per year, or 1,875 available hours for one lab and 5,625 available hours for the three labs. If the labs operated at target of 80 percent in order to accommodate emergency patients, unexpected delays, equipment failures, and so on, each lab could be expected to have 1,500 procedure hours; the three labs would be expected to accommodate 4,500 hours of procedure time.

Today, however, the existing 3 labs are staffed long hours to accommodate volume – one lab is staffed for 12 hours a day, the second for 11.5 hours a day, and the third for 10 hours a day on weekdays. The lab is also staffed on weekend and holidays. This staffing results in 7,451 hours of available week daytime or 32.5 percent more available hours under a more normal operating situation.

$$7,451 \text{ current Trinity Rock Island staffed cath lab hours} \div 5,625 \text{ conventional staffed cath hours} \\ = 32.5 \text{ percent more staffed hours}$$

In 2011, the Trinity Rock Island reported 6,074 procedure hours, thus operating at 81.5 percent occupancy in spite of this substantial staffing increase.

$$6,074 \text{ procedure hours} \div 7,451 \text{ available hours} = 81.5 \text{ percent occupancy}$$

Because staffing of Trinity's current 3 cath rooms exceeds a more conventional operating situation, the unit can accommodate more volume; however, these very high occupancies are very difficult to maintain. They cause physician and staff burnout. They provide little opportunity for add-on emergency cases; and they often push the normally scheduled cases into the evening or result in scheduling cases on the weekends and holidays. This may require an unnecessarily longer stay for the inpatients or an otherwise unnecessary admission for outpatients.

Under the current operating situation, it may take a patient as long as 4 weeks to schedule a non-emergency electrophysiology procedure.

#### Reconciling State Guideline with Operational Realities

In order to reconcile the high utilization in the Trinity Rock Island cath labs and the different metrics used in the Annual Hospital Questionnaire and the State Agency rules, TRI investigated approaches that would help explain the apparent need for additional cath lab capacity.

#### Historical and Current Utilization of Cath Labs in Illinois, 2007 to 2010

*Hospital Profiles* is published by the Illinois Department of Public Health and includes a summary of statewide utilization of cath labs as well as other clinical services at all hospitals in Illinois. This data source includes only diagnostic caths, interventional caths and electrophysiology (EP) procedures. The State does not collect utilization of the cath labs by peripheral angiography and other patients that also make up cath lab visits; visits is the metric used to determine the need for cath labs in the current Section 1110, Appendix B of the State Agency Rules.

Between 2007 and 2011, the *Hospital Profiles* statewide summary shows that utilization of diagnostic caths, interventional caths and electrophysiology procedures remained relatively stable; however the distribution of visits by procedure type changed dramatically. During this period, the number of diagnostic caths decreased, interventional caths remained stable, and electrophysiology procedures increased dramatically. The following table is a summary of these utilization trends. See Attachment 25, Exhibit 2 for the year-by-year data.

Attachment 25, Table 4  
 Historical Statewide Utilization of Adult Cardiac Cath, Interventional Cath and EP  
 Procedures

	2007		2011		Change	
	Number	Percent	Number	Percent	Number	Percent
Diagnostic Caths	114,158	64.6	101,349	57.6	-12,809	-11.2
Interventional Caths	40,073	22.7	39,987	22.7	-86	-0.2
EP Procedures	22,407	12.7	34,563	19.7	+12,156	+54.3
Total	176,638	100.0	175,899	100.0	-739	-0.4

Source: *Hospital Profiles*, 2007 and 2011

At first glance, this overview would appear to suggest that the need for cath labs has remained stable. However this is not true. Two variables result in a need for more cardiac cath time; increase in proportion of EP procedures and longer EP procedure times. The average case time for an EP procedure is 3.25 longer than that for a diagnostic cath and 2.36 times longer that that for an interventional cath. Attachment 25, Table 5 shows that at generally accepted procedure times (including 20 minutes for lab clean up and setup), the same number of procedures would require additional laboratory capacity. The following example is based on 1,500 annual procedures and the statewide procedure distribution.

Attachment 25, Table 5  
 Comparison of Cath Lab Utilization on Distribution of Visits between 2007 and 2011

Type of Visit	Percent of Procedures	Number of Procedures	Total Minutes	Total Hours	Minutes Per Visit
2007 Case Mix					
Diagnostic Cath	64.6	968	77,440	1,291	80
Interventional Cath	22.7	341	37,510	624	110
EP Procedures	12.7	191	49,660	828	260
Total Time and Average Time / Case	100.0	1,500	164,610	2,744	110
2011 Case Mix					
Diagnostic Cath	57.6	864	69,120	1,152	80
Interventional Cath	22.7	340	37,400	623	110
EP Procedures	19.7	296	76,790	1,283	260
Total Time and Average Time / Case	100.0	1,500	183,480	3,058	122

Source: Cannon Design

Based on this example, the same number of procedures using actual distribution of cases in 2007 and 2011 and hours by type of case, results in the need for 314 or 20 percent more hours per lab.

$$3,058 \text{ hours} - 2,744 \text{ hours} = 314 \text{ hours additional hours of cath lab time}$$

### Limitations of the Current Target Utilization

The current catheterization rules have not been revised since 1987.

The State Agency could not provide the applicants with the derivation of the State guideline of 1,500 visits per room.

The current target utilization guideline does not appear to reflect either the change in procedures distribution or the significant difference in procedure time, especially for EP procedures. To adjust for this vast difference in visit time, the applicants assumed that the average time for a visit to the cath lab in the State Guideline could be determined by taking room utilization time for surgery (the only such calculation in the State Agency Rules) and the number of visits proposed per lab.

In Section 1110.1540, the State Agency Rules propose the following formula for determining hours of operation per surgical suite:

250 days per year x 7.5 hours per day x 80 percent occupancy = 1,500 hours of surgery per room  
Trinity Rock Island then divided the hours per room by the number of proposed visits required in the cardiac cath rules and determined that the guideline appears to suggest that at 1,500 visits per room, each visit would average 1 hour in duration.

$$1,500 \text{ hours per room} \div 1,500 \text{ visits per room} = 1 \text{ hour or } 60 \text{ minutes per visit}$$

Hence, by using these two factors – hours of time available per room and the number of proposed visits per room, the applicants determined that the average time proposed by the State Standard for cardiac cath was 60 minutes or less than the average time for the least time-consuming procedure, diagnostic catheterizations, or 80 minutes.

### Historical and Current Visits to the Cardiac Catheterization Laboratories at Trinity Rock Island

In addition to the diagnostic caths, interventional caths and EP procedures, visits to the lab also include peripheral angiography (which have historically been reported in the “Other” Angiography Section of the AHQ) as well as other visits.

Trinity Rock Island’s three existing cardiac cath labs have reported very strong growth and are currently heavily utilized. As shown on Attachment 25, Table 6, between 2007 and 2011, lab visits increased 42.5 percent; during this time, the strongest growth, or 340.6 percent, was in electrophysiology procedures, those which require the greatest amount of time.

Attachment 25, Table 6  
Total Visits to the Trinity Rock Island Cardiac Cath Labs, 2007 to 2011

Type of Visit	2007	2008	2009	2010	2011	Percent Change
Diagnostic Caths	1,559	1,524	1,572	1,848	1,982	27.1
Interventional Caths	1,061	664	1,161	1,379	1,336	25.9
EP Procedures	128	453	524	509	564	340.6
Peripheral Angiography	281	429	511	590	415	47.6
Other	27	74	12	44	57	111.1
Total	3,056	3,144	3,780	4,271	4,354	42.5

Source: Trinity Rock Island Records.

The utilization at Trinity Rock Island shows a growth pattern similar to all hospitals in Illinois, with the most robust growth in EP procedures. This category of visit is also expected to show the strongest growth in the future.

Current Need for Cath Labs at Trinity Rock Island

Trinity Rock Island calculated the actual hours of visit time in the cardiac cath labs for 2011.

Because the times were similar, peripheral angiography and “other” were included with diagnostic cath category for a total of 2,454 visits.

$$1,982 \text{ diagnostic caths visits} + 415 \text{ peripheral angiography visits} + 57 \text{ other visits} = 2,454 \text{ visits}$$

Attachment 25, Table 7  
Total Visits, Total Minutes, and Total Hours  
2011 Trinity Rock Island Cardiac Cath Lab Volume, 2011

Type of Visit	Number of Visits	Minutes Per Procedure <sup>1</sup>	Total Minutes	Total Hours
Diagnostic Cath	2,454	80	196,320	3,272
Interventional Cath	1,336	110	146,960	245
EP Procedures	564	260	146,640	2,444
Total	4,354	114	494,274	8,238

<sup>1</sup> Includes cleanup and setup times

Source: Trinity Rock Island Records

Trinity Rock Island thus determined that the average visit time for cardiac catheterization is 114 minutes or 1.9 hours, or almost twice the 1 hour State guideline. Based on current average visit time, Trinity Rock Island's current time justifies 6 cardiac cath laboratories.

$8,238 \text{ visit hours} \div 1,500 \text{ visit hours per cath lab} = 5.5$  or 6 cardiac catheterization labs  
Trinity determined that this volume needed to be adjusted by at least 7 factors:

1. With the new facilities and the ability to implement more efficient operations, Trinity Rock Island's consultants estimated that projected hours of utilization of the cath labs could be reduced in the following areas: patient-in-room-to-procedure-start, procedure time, and procedure-complete-to-patient-out. These more efficient operations are expected to save 2,600 hours in the cath lab utilization.
2. In 2011, 164 cases were performed after 6:00 PM on week days and 264 cases were performed on week-ends and holidays. Although there will always be emergency cases performed after regular hours and on weekends and holidays, the Hospital's cardiac staff expects this number to be reduced 33 percent of current volume at project completion, and the remainder of the volume to move to the regular weekday schedule. This would increase weekday lab utilization by 285 visits or 542 hours.

$428 \text{ after hours/weekend/holiday visits} \times 33.3 \text{ percent} =$   
 $143 \text{ visits to remain as after hours/weekend/and holiday visits}$

$428 \text{ after hours/weekend/holiday visits} \times 66.7 \text{ percent} =$   
 $285 \text{ visits to move to weekday scheduled hours}$

$285 \text{ visits to move to weekday scheduled hours} \times 1.9 \text{ hours per case} =$   
 $542 \text{ additional weekday hours}$

3. Continuing research and resulting improvements in drugs will likely impact patient outcomes in a positive way. Many of these advances are expected to be in the preventive treatment of heart-related ailments.
4. New technology such as coronary CT angiography may provide non-invasive diagnostic capability for low to moderate risk patients.
5. Aging of the local population; at TRI more than 90 percent of caths are for patients 65 or older. This population is expected to increase by 42.4 percent by 2025.
6. A modest increase in average case time because of the increase in the proportion of electrophysiology procedures
7. The introduction of new procedures such as percutaneous replacement of aortic and mitral valves using catheter-based approaches could bring new volume to the cath labs.

## Summary

Based on the estimated impact of operational efficiencies, demographic changes and the introduction and implementation of new technology, Trinity Rock Island is conservatively requesting 4 invasive labs; of these 3 will be replacement labs and 1 will be an additional new lab. These labs will all be equipped with up-to-date invasive cardiac equipment and designed and sized for efficient operation.

Based on more efficient operations and an adjustment for weekend and holiday cases, expected future volume would be:

8,238 visit hours – (2,600 reduced efficiency hours + 542 increased hours shifted from weekends and holidays) = 6,180 visit hours

$6,180 \text{ visit hours} \div 1,500 \text{ visit hours} = 4.12 \text{ needed cath labs}$

Of the other factors that could influence future demand for invasive services, two may reduce the number of visits; these include improvements in drugs and new technology such as CT angiography. Three may increase the number of visits; these include aging of the population, increase in case time, and introduction of new procedures in the lab. The applicants were unable to quantify these potential influences on future volume.

Trinity Rock Island is conservatively requesting 4 cardiac cath labs; of these, 3 are existing and 1 is an additional lab.

5. Criterion 1110.1330(e), Support Services

*Read the criterion and indicate on a service by service basis which of the listed services are available on a 24 hour basis and explain how any services not available on a 24 hour basis will be available when needed.*

Although this criterion is primarily for the establishment of a cardiac catheterization category of service, Trinity Rock Island (TRI) is responding to this criterion to demonstrate the cadre of services at TRI that supports the cardiac catheterization category of service.

Attachment 25, Table 8  
Summary of Support Services at Trinity Medical Center

Support Service	Available on a 24-Hour Basis	Comments
A) Nuclear Medicine Laboratory	Yes	The Nuclear Medicine Department at TRI is equipped to do all nuclear medicine exams with 2 gamma cameras, one having SPECT/CT capability. The department is staffed by qualified, trained staff.
B) Echocardiography Service	Yes	Echocardiography services are provided by a qualified, trained staff.
C) Electrocardiography Lab and Services	Yes	Electrocardiography, continuous cardiogram monitoring, and stress test services are provided by a qualified, trained staff.
D) Pulmonary Function Unit	Yes	Pulmonary function tests and pulmonary screen are provided by qualified respiratory therapists.
E) Blood Bank	Yes	TRI has a blood bank on site.
F) Hematology Laboratory/Coagulation Laboratory	Yes	Performed under contract with Metropolitan Laboratory
G) Microbiology Laboratory	Yes	TRI utilizes an off-site location; even so, services are available on a 24-hour basis
H) Blood Gas Laboratory	Yes	There is a blood gas laboratory on site.
I) Clinical Pathology Laboratory	Yes	Performed under contract with Metropolitan Laboratory

6. Criterion 1110.1330(f), Laboratory Location

*Read the criterion and, if applicable, submit line drawings showing the location of the proposed laboratories. If the laboratories are not in close proximity explain why.*

*Due to safety considerations in the event of a technical breakdown it is preferable to group laboratory facilities. Thus, in projects proposing to establish additional catheterization laboratories such units must be located in close proximity to existing laboratories unless such location is architecturally infeasible.*

Trinity Rock Island is proposing to develop a Heart Center in new construction. The 4 new cardiac laboratories will be located contiguous to each other.

See Attachment 25, Exhibit 3.

7. Criterion 1110.1330(g), Staffing

*Read the criterion and submit a list of names and qualifications of those who will fill the positions detailed in this criterion. Also provide staffing schedules to show the coverage required by this criterion.*

*It is the policy of the State Board that a cardiac catheterization laboratory team can be established. Any applicant proposing to establish such a laboratory must document that the following personnel will be available.*

Trinity Rock Island (TRI) is proposing to expand an existing cardiac catheterization service from 3 to 4 laboratories. TRI is providing the CV's of current staff members in order to demonstrate the qualifications of the current cardiac catheterization staff. The staff includes an RN cardiac catheterization lab manager, an RN clinical educator, 20 RNs with cardiac catheterization experience, and 13 radiology technicians. CV's for key staff members are included in Appendix B.

A new member of the cardiac catheterization lab staff completes approximately 12 weeks of orientation to the department; this orientation includes:

- Review and understanding of policies and procedures
- Radiation safety
- Aseptic techniques
- ECG reading
- Sheath pulling
- Specific medication education
- Procedural sedation (RNs)
- General cardiology knowledge review
- Education on use of cath lab equipment, and
- Patient monitoring.

1) *Lab director board certified in internal medicine, pediatrics or radiology with subspecialty training in cardiology or*

Aswartha Reddy Pothula, MD is Director of the Cardiac Catheterization Lab at Trinity Rock Island. He is board certified in internal medicine and in cardiology.

- 2) *A physician with training and cardiology and/or radiology present during examination with extra physician back up available.*

Coronary catheterization procedures or peripheral vascular procedures are performed by a cardiologist or radiologist with appropriate physician back up at all times.

Each cardiac catheterization case is staffed with at least two RNs and one radiology technician. The roles of the staff personnel for each case include hemodynamic monitoring /documenting, circulator, and scrub assistant.

- 3) *Nurse specially trained in critical care of cardiac patients, knowledge of cardiovascular medication, and understanding of catheterization equipment.*

Jennifer M. Carroll, BSN, RN is one of the staff nurses in the cardiac catheterization laboratory. She has knowledge of cardiovascular medication and an understanding of catheterization equipment. She also has intensive care experience.

Jennifer Moore, BSN, RN also has extensive experience as a cardiac catheterization and electrophysiology lab nurse. She also has knowledge of cardiovascular medication and an understanding of catheterization equipment. In addition, she is Lab Lead and the Lab Coordinator.

- 4) *Radiologic technologist highly skilled in conventional radiographic techniques and angiographic principles, knowledgeable in every aspect of catheterization implementation, and with thorough knowledge of the anatomy and physiology of the cardiovascular system.*

Pauline J. Carnahan, R.T.R. is a radiology technologist at Trinity Rock Island. She is highly skilled in conventional radiographic techniques and angiographic principles, knowledgeable in every aspect of cardiac catheterization implementation, and has a thorough knowledge of the anatomy and physiology of the cardiovascular system. She assisted in the implementation of the cardiac catheterization service at TRI.

- 5) *Cardiopulmonary technician for patient observation, handling of blood samples, and performing blood gas evaluation calculations.*

TRI provides pulmonary function testing round the clock by qualified respiratory therapists to respond to patient care needs including patients in the cath lab.

Robert Johnson is a cardiopulmonary technician and a registered Cardiac Interventional Specialist (RCIS), he is certified by Spectranetics, and he is certified by ACLS.

- 6) *Monitoring and recording technician for monitoring physiological data and alerting physicians to any changes.*

Most staff are cross-trained to perform these functions.

Tara Johnson, for example, can perform these functions. Her other responsibilities include managing the daily operations of the cardiac cath lab. She is responsible for staffing the department, assisting with the education of new staff, making sure daily charges are completed; helping with inventory control and working with physicians to be sure their needs are met.

- 7) *Electronic radiologic repair technicians to perform systematic tests and routine maintenance; must be immediately available in the event of equipment failure during a procedure.*

Radiologic repair technicians are on TRI's bio-technology staff; radiologic repair is also available through cath lab equipment companies for which TRI holds service and maintenance agreements. Routine maintenance on the cath lab equipment is performed at least quarterly.

- 8) *Darkroom technician well trained in photographic processing and in the operation of automatic processors used for both sheet and cine film.*

Trinity Rock Island's cath lab images are stored on a PACS and do not use film; thus TRI has no need for access to a darkroom technician.

8. Criterion 1110.1330(h), Continuity of Care

*Any applicant proposing the establishment, expansion, or modernization of a cardiac catheterization service must first document that written transfer agreements have been established with facilities with open heart surgery capabilities for the transfer of seriously ill patients for continuity of care.*

Trinity Rock Island reported 177 open heart surgery cases in 2011. Seriously ill patients requiring open heart surgery are very seldom transferred to other facilities.

Read the criterion and submit a copy of the fully executed written referral agreement(s).

9. Criterion 1110.1330(i), Multi-institutional Variance

*Read the criterion and, if applicable, submit the following information:*

- a. *A copy of a fully executed affiliation agreement between the two facilities involved.*
- b. *Names and positions of the shared staff at the two facilities.*
- c. *The volume of open heart surgeries performed for the latest 12-month period at the existing operating program.*
- d. *A cost comparison between the proposed project and expansion at the existing operating program.*
- e. The number of cardiac catheterization procedures performed in the last 12 months at the operating program.
- f. The number of catheterization laboratories at the operating program.
- g. The projected cardiac catheterization volume at the proposed facility annually for the next 2 years.
- h. The basis for the above projection.

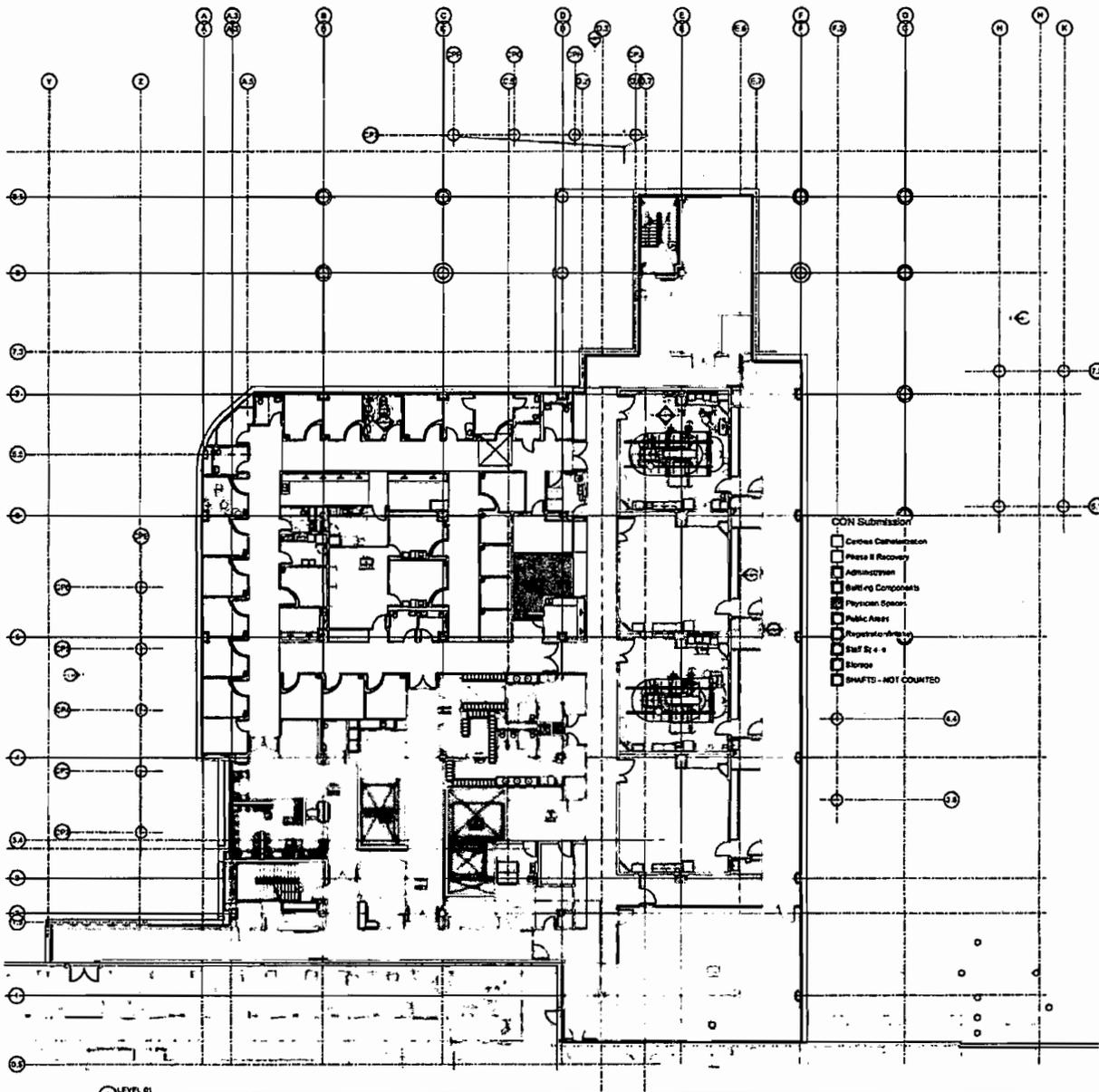
Not Applicable. Trinity Medical Center has an established cardiac catheterization service.



Historical Changes in Utilization of Cardiac Catheterization Services, 2007 – 2011

	2007		2008		2009		2010		2011		Change 2007 - 2011	
	Number	Percent	Number	Percent								
Diagnostic Caths (15+)	114,158	64.6	110,393	63.8	114,487	61.3	117,542	59.6	101,349	57.6	-12,809	-11.2
Interventional Caths (15+)	40,073	22.7	38,274	22.1	46,674	25.0	47,813	24.2	39,987	22.7	-86	-0.2
E.P Caths (15+)	22,407	12.7	24,372	14.1	25,664	13.7	32,002	16.2	34,563	19.7	+9,595	+54.3
Total	176,638	100.0	173,039	100.0	186,825	100.0	197,357	100.0	175,899	100.0	-739	-0.4

Source: *Hospital Profiles, 2007 to 2011*



TRINITY REGIONAL HEALTH SYSTEM  
**HEART CENTER / EMERGENCY  
 DEPARTMENT**

LEVEL 01 CON SF

CANNON DESIGN | gda

SCALE: 1/8" = 1'-0"   
 02/27/12

**R. Criterion 1110.3030 - Clinical Service Areas Other than Categories of Service**

1. Applicants proposing to establish, expand and/or modernize Clinical Service Areas Other than Categories of Service must submit the following information:
2. Indicate changes by Service: Indicate # of key room changes by action(s):

Service	# Existing Key Rooms	# Proposed Key Rooms
<input checked="" type="checkbox"/> Phase II Cardiac Prep/Recovery Stations	11	20
<input checked="" type="checkbox"/> Non Invasive Diagnostic Testing	6	6
<input checked="" type="checkbox"/> Cardiac Rehabilitation	1 with 13 therapy treatment stations	1 with 26 therapy treatment stations
<input checked="" type="checkbox"/> Emergency Department	17 treatment stations	23 treatment stations
<input checked="" type="checkbox"/> General Radiology	4 units	4 units
<input checked="" type="checkbox"/> Computerized Tomography	2 units	2 units
<input checked="" type="checkbox"/> Observation Unit	New Service	12 beds
<input checked="" type="checkbox"/> Crisis Stabilization Unit	New Service	6 beds
<input checked="" type="checkbox"/> Behavioral Health Group Therapy	3 rooms	3 rooms

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

PROJECT TYPE	REQUIRED REVIEW CRITERIA	
New Services or Facility or Equipment	(b) -	Need Determination - Establishment
Service Modernization	(c)(1) -	Deteriorated Facilities
		and/or
	(c)(2) -	Necessary Expansion
		PLUS
	(c)(3)(A) -	Utilization - Major Medical Equipment
		Or
	(c)(3)(B) -	Utilization - Service or Facility
<b>APPEND DOCUMENTATION AS <u>ATTACHMENT-37</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>		

Clinical Service Area  
Phase II Cardiac Prep/Recovery

## c) Service Modernization

The applicant shall document that the proposed project meets one of the following:

Trinity Rock Island (TRI, Hospital) will respond to 1110.c) 2. "Necessary Expansion."

## 1. Deteriorated Equipment or Facilities

*The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to historical utilization data, downtime or time spent out of service due to operational failures, upkeep on annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.*

NA

## 2. Necessary Expansion

*The proposed project is necessary to provide for expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence in changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.*

Trinity Rock Island has a dedicated Phase II Cardiac Prep/Recovery area for cardiac patients. At TRI, this area is most commonly referred to as the Cardiac Treatment Unit (CTU). The existing Phase II Cardiac Recovery area is located on the second floor central of the existing Hospital. It has only 11 stations; these stations cannot support either current or proposed volume of cardiac patients who require monitored care post procedure or test. They are always full. Further, these 11 stations are located in 3,310 GSF of space or 281 GSF per station or only 70.3 percent of the State Guideline of 400 GSF per station. Hence the current unit has too few stations and the stations are substantially undersized. Further, it would not be prudent to expand the cardiac prep/recovery area in its current location which is remote from the new cath labs; quality care and excellent outcomes require that these patients recover in close proximity to the cath labs and the cath clinical team in the event a procedure-related emergency occurs.

As part of the proposed expansion project, the cardiac cath lab will be relocated to Level 1, the lower level of the new construction, and the number of labs will be increased from 3 to 4. TRI proposes to develop 20 Phase II Cardiac Prep/Recovery stations adjacent to the cardiac cath labs to be used by patients undergoing heart-related tests and procedures. In this way, patients will recover near the procedure rooms and specially trained staff, in the case of an emergency.

There are no code requirements for Phase II Prep/Recovery stations, although typically 4 prep/recovery stations are needed to support each lab. Hence, 16 Prep/Recovery stations are required to support the proposed 4 cath labs. Four (4) additional prep/recovery stations are being provided for other cases that will require post test/procedure monitoring.

Although these Phase II Cardiac Prep/Recovery stations may occasionally be used by inpatients, they will primarily be used by outpatients. Upon arrival at the Hospital, outpatients require a private space in which to change from street clothes into a hospital gown, to meet with their cardiologist and /or anesthesiologist and undergo any additional needed tests before their procedure. After their procedure, outpatients are stabilized in the procedure area and then moved to the Phase II Prep/Recovery area. Once in the Phase II Prep/Recovery area, patients will be monitored as they continue to recover, receive nourishment and instruction on post-discharge care. Finally, they will change into their street clothes and be discharged.

In total, the heart-related procedure or test patients will have an average stay of 6 hours in the Phase II Prep/Recovery area – or 1 hour for pre-procedure prep and 5 hours for recovery.

Trinity Rock Island meets the criteria for “Necessary Expansion.”

### 3. Utilization

#### A) Major Medical Equipment

*Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12-months after acquisition.*

There is no major medical equipment as part of the Phase II Prep/Recovery stations.

B) Service or Facility

*Projects involving modernization of a service or facility shall meet or exceed utilization standards for the service, as specified in Appendix B. The number of key rooms being modernized shall not exceed the number justified by historical utilization rates for each of the latest 2 years, unless additional key rooms can be justified per subsection c) 2) Necessary Expansion.*

There are no utilization standards for Phase II Prep/Recovery stations specified in Appendix B.

C) Utilization

*If no utilization standards existing, the applicant shall document in detail its anticipated utilization in terms or incidence of diseases or conditions or population use rates.*

The following assumptions were used in determining the need for 20 Phase II Cardiac Prep/Recovery stations in the proposed project.

Trinity Rock Island justified the need for the existing 3 labs as well as a new fourth lab in Attachment 25. The need for the four labs was based 4,354 visits to the cath labs.

Trinity Rock Island used the following methodology to determine the need for Phase II Cardiac Phase II Prep/Recovery stations.

1. First, the number of patients that would use these prep/recovery stations was determined by adjusting proposed volume in the cath labs to account for a TEE, cardioversion, interventional radiology and other patients that may require monitored recovery. To arrive at an adjusted total, TRI increased the cath lab volume by 10 percent. In total, TRI expects 4,789 Phase II Cardiac Prep/Recovery patients each year.

4,354 cardiac cath patients x 1.10 adjustment factor for other cardiac monitored patients = 4,789 patients

2. Next, Trinity Rock Island assumed that the Phase II prep/recovery stations would be routinely staffed and scheduled for 5 days a week or 250 days per year (excluding weekends and holidays). Based on proposed number of patients requiring prep/recovery capability and the proposed number of

days, TRI determined that there would be an average of 19.2 patients per weekday.

$$4,789 \text{ patients} \div 250 \text{ days} = 19.2 \text{ patients per day}$$

3. Next, TRI then adjusted for peak census. Based on experience, peak census was assumed to be 120 percent of average patients per day and would require planning for 23 patients per day.

$$19.2 \text{ patients per day} \times 120.0 \text{ percent adjustment for peak census} = \\ 23 \text{ patients per day}$$

4. The Hospital assumed that 90 percent of all cath, EP and other procedures and tests would be performed on the day shift. (The unit will have 24/7 staff coverage to accommodate emergency cases.) Hence, there would be 21 patients per day on the day shift.

$$23 \text{ patients per day} \times 90.0 \text{ percent on the day shift} = \\ 20.7 \text{ or } 21 \text{ average patients on the day shift}$$

5. Using 6 hours of room time per patient (pre and post procedure, TRI calculated the average daily room hours.

$$21 \text{ patients per day} \times 6 \text{ hours per patient} = 126 \text{ required daily room hours}$$

6. The Phase II Prep/Recovery rooms will be staffed 8 hours per day. TRI assumed that a 75 percent utilization efficiency level could be achieved. Based on 8 routinely staffed hours per day and 75 percent efficiency, TRI determined that 6 hours per day would be available per day per room.

$$8 \text{ staffed hours per day} \times 75 \text{ percent utilization efficiency} = \\ 6 \text{ available hours per day per room}$$

7. In order to determine total number of rooms needed, the Medical Center divided the required daily hours by 6 available hours per room.

$$126 \text{ required daily hours per room} \div 6 \text{ hours per room} = 21 \text{ required rooms}$$

Trinity Rock Island is conservatively requesting only 20 Phase II Prep/Recovery rooms.

c) Service Modernization

The applicant shall document that the proposed project meets one of the following:

Trinity Rock Island (TRI, Hospital) will respond to both 1110.c) 1. "Deteriorated Facilities" and 1110.c) 2. "Necessary Expansion."

1. Deteriorated Equipment or Facilities

*The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to historical utilization data, downtime or time spent out of service due to operational failures, upkeep on annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.*

Non-invasive diagnostic testing (NIDT) services are located in a 40 year old building. The current NIDT area lacks space and the disconnected unit design detracts from efficient daily operations. Many rooms used for testing are very small and staff workspaces are inadequate. Keeping room temperatures comfortable for patients is difficult even when supplemental evaporative coolers are used. Consequently patient privacy and comfort are compromised.

Trinity Rock Island meets the criteria for "Deteriorated Facilities."

2. Necessary Expansion

*The proposed project is necessary to provide for expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.*

Non-Invasive Diagnostic Testing (NIDT) includes the following services:

1. Electrocardiography (EKG)

EKG is a simple non-invasive procedure used to determine the electrical activity of the heartbeat including heart rhythm, size and function of the heart chambers and heart muscle. EKGs are also routinely done as part of a pre-op work up. EKG exams are performed throughout the hospital. There are no special rooms for EKG equipment in the proposed project.

2. Echocardiography

Echocardiography uses sound waves to produce an image of the heart. This test allows the physician to diagnose abnormal heart valves, atrial fibrillation, congenital heart disease, heart murmurs, pericarditis, and other heart related conditions.

3. Stress Testing

Cardiac stress testing allows the physician to see the wall motion of the heart's pumping chambers before and after exercise. The test can show areas of the heart muscle are not receiving enough oxygen-rich blood.

4. Vascular Lab

The vascular lab provides non-invasive testing to locate areas of vascular blockage and diseases which may be producing a patient's abnormal symptoms. Improvements in ultrasound and other technology have brought the vascular lab to the forefront in the diagnosis of vascular disease.

5. Pulmonary Function Testing

Pulmonary function testing is a basic tool for evaluating a patient's lung capacity speed of exhalation and oxygenation after a period of exertion. These tests are used to diagnose suspected pulmonary diseases and quantify pulmonary disability. Respiratory therapy treatment functions are also performed.

Trinity Rock Island (TRI) is not increasing the number of non-invasive cardiac modalities. The Hospital currently has 6 units and will have 6 units at project completion. All electrocardiography units are portable.

Attachment 37, Table 1  
Current and Proposed Number of Cardio-Diagnostic Units and Utilization

Modality	Number of Units		2010	2011	2018	Percent Change, 2011 to 2018
	Current	Proposed				
Electrocardiology (including cardioversions)	EKG units are portable		24,552	24,541	26,038	
Echocardiography (including TEE)	2	2	2,821	3,201	3,509	9.6
Stress Testing	1	1	771	725	819	13.0
Vascular Lab	2	2	1,816	1,721	2,116	23.0
Pulmonary Function	1	1	1,678	1,418	1,645	16.0
Total	6	6	7,086	7,065	8,089	14.5

Note: One nuclear stress testing unit currently resides in and will remain in the Nuclear Medicine Department. It is not a part of NIDT.

Source: Trinity Rock Island Records and Sg2

The projections prepared by Sg2, a nationally respected health planning firm, are proprietary and include impact factors such as population, epidemiology, economics, payment and policy, and innovation and technology.

Trinity Rock Island agrees with the projected non-invasive cardiac diagnostic increased volume. This concurrence is based on at least two factors: the aging of the service area population and the implementation of the Accountable Care Act. As the population ages, it experiences more cardiac and pulmonary disease which, in turn, require more non-invasive diagnostic testing. Health reform proposes to manage costs through prevention thereby reducing acute care episodes and hospital inpatient admissions. Non-invasive cardiology technology will be used increasingly to screen and monitor the population for cardiovascular and pulmonary disease; this is expected to result in earlier diagnosis and treatment, thereby reducing admissions, improving overall quality of life, and reducing costs based on applicable clinical practice guidelines. These outcomes are all consistent with national health reform goals.

Some physicians maintain non-invasive cardiology diagnostic modalities in their offices. As current reimbursement policies no longer make it attractive for them to provide these services, these physicians are likely to refer these tests to TRI, further increasing volume at the Hospital.

Trinity Rock Island meets the criteria for "Necessary Expansion."

### 3. Utilization

#### A) Major Medical Equipment

*Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12-months after acquisition.*

NA There is no major medical equipment in the NIDT.

#### B) Service or Facility

*Projects involving modernization of a service or facility shall meet or exceed utilization standards for the service, as specified in Appendix B. The number of key rooms being modernized shall not exceed the number justified by historical utilization rates for each of the latest 2 years, unless additional key rooms can be justified per subsection c) 2) Necessary Expansion.*

NA There are no utilization standards for non-invasive cardiac testing in Appendix B. Justification of the modalities in Non-Invasive Diagnostic Testing are included in c) 2) Necessary Expansion; projections were prepared by TRI and Sg2, based on their proprietary methodology.

#### C) *If no utilization standards exist, the applicant shall document in detail its anticipated utilization in terms or incidence of diseases or conditions or population use rates.*

The State Agency does not have utilization guidelines for non-invasive cardio-pulmonary services. Trinity Rock Island has justified the need for these services in subsection c) 2) Necessary Expansion.

Phase II Clinical Service Area  
Cardiac Rehabilitation

c) Service Modernization

The applicant shall document that the proposed project meets one of the following:

Trinity Rock Island will respond to both 1110.c) 1. "Deteriorated Facilities" and 1110.c) 2. "Necessary Expansion."

1. Deteriorated Facilities

*The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to historical utilization data, downtime or time spent out of service due to operational failures, upkeep on annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.*

Phase II cardiac rehabilitation (cardiac rehab) is a physician-supervised program focused on helping patients with heart disease or recovering from cardiac events and procedures so they can regain their strength and live an active life. A comprehensive cardiac rehab program has three phases:

- Phase I begins while the patient is still in the hospital and includes simple exercise and education.
- Phase II is a 3-month outpatient exercise and education program. Each patient receives a personally tailored exercise plan, continuing nutritional counseling and education as well as stress management skills and smoke cessation information (as required).
- Phase III is a long-term maintenance program for graduates of Phase II.

Both the American College of Cardiology and the American Heart Association recommend cardiac rehab for patients recovering from cardiac events or procedures

Currently, Phase I cardiac rehab for Trinity Rock Island (TRI, Hospital) patients begins on an inpatient unit, Phase II continues at Trinity Moline, and Phase III is conducted at Augustana Fitness Center.

The current Moline cardiac rehab area is small; it is located in only 1,425 GSF of space and can support 13 rehab stations, or only one half of the projected need for 26 therapy stations. Planned capacity of the area is 850 patients a year. In 2011, 1,141 patients were treated; this is 34.2 percent more than the current capacity.

Having essential elements of the overall cardio-pulmonary services located on two campuses detracts from coordinated patient care.

As part of the proposed Heart Center/Emergency Department project, Trinity Rock Island is proposing to relocate the undersized Phase II cardiac rehab unit that is currently on the Moline campus to the Heart Center; as the result of this consolidation of services, coordination of patient care will be improved. An appropriate amount of space will be available to support this growing program.

In addition to cardiac rehabilitation functions, this area at Trinity Moline also supports community outreach, a program known as Heart Aware/Health Aware that provides risk assessments and community education. With the proposed relocation of the cardiac rehab program to Trinity Rock Island, this program will also be relocated with an expanded program to include disease detection and community awareness.

Trinity Rock Island meets the criteria for “Deteriorated Facilities.”

## 2. Necessary Expansion

*The proposed project is necessary to provide for expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence in changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.*

Trinity Rock Island retained Sg2, a nationally respected health care planning firm, to prepare projections of future demand for cardiac rehab services. The projections prepared by Sg2 are proprietary and include impact factors such as population, epidemiology, economics, payment and policy, as well as innovation and technology. Sg2 projected a 42.0 percent increase in cardiac rehab visits between 2011 and 2018, the second full year of utilization for the proposed replacement cardiac rehab unit.

Attachment 37, Table 1  
Current and Projected Utilization of Cardiac Rehab

Modality	2010	2011	2018	Percent Change, 2011 to 2018
Patients	1,202	1,141	1,620	42.0
Cardiac Rehabilitation - Visits	9,372	8,276	12,821	54.9

Source: Trinity Rock Island Records and Sg2

Although there was a decline in cardiac rehabilitation between 2010 and 2011, the Hospital concurs with the Sg2 projections of strong growth in the future for several reasons. The recent decline in cardiac rehab visits is attributable to the departure of physicians from the medical staff who referred patients to cardiac rehab. New physicians to replace those who departed are being recruited. Steady growth in this and other cardiac-related services can be expected because of the aging baby-boomer population and the Accountable Health Care incentives to increase the use of preventive care and rehabilitation services to reduce admissions and readmissions. Cardiac rehab will continue to be of growing importance to the community.

Trinity Rock Island meets the criteria for "Necessary Expansion."

### 3. Utilization

#### A) Major Medical Equipment

*Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12-months after acquisition.*

NA There is no cardiac rehab equipment in this project that meets or exceeds the major medical equipment threshold.

#### B) Service or Facility

*Projects involving modernization of a service or facility shall meet or exceed utilization standards for the service, as specified in Appendix B. The number of key rooms being modernized shall not exceed the number justified by historical utilization rates for each of the latest 2 years, unless additional key rooms can be justified per subsection c) 2) Necessary Expansion.*

NA There are no outpatient utilization standards for cardiac rehab in Appendix B.

Justification of cardiac rehab is included in subsection c) 2.

C) *If no utilization standards exist, the applicant shall document in detail its anticipated utilization in terms or incidence of diseases or conditions or population use rates.*

The State Agency does not have utilization guidelines for cardiac rehabilitation services. Trinity Rock Island justified the need for expanded cardiac rehab services in c) 2. based on expected strong growth of the senior population and the impact of the Accountable Care Act. The proposed unit in will have 4,495 GSF to house 26 therapy equipment stations including rowing machines, elliptical and ergometer bicycles, and treadmills, 6 weight stations, and 1 mat table.

Space for consultation and education will be located in close proximity to the cardiac rehab area, but is not included in this square footage.

Clinical Service Area  
Emergency Department

c) Service Modernization

Trinity Rock Island will respond to both 1110.c) 1. "Deteriorated Facilities" and 1110.c) 2. "Necessary Expansion."

The applicant shall document that the proposed project meets one of the following:

1. Deteriorated Facilities

*The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to historical utilization data, downtime or time spent out of service due to operational failures, upkeep on annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.*

Trinity Rock Island (TRI, Hospital) has been designated as a Level II Trauma Center by the Illinois Department of Public Health. IDPH has also designated the Hospital as an Emergency Department Approved for Pediatrics (EDAP). The Joint Commission has certified it as a Primary Stroke Center. This service is an essential community resource.

The Trauma Center/Emergency Department (ED) opened in 1972.

Trinity Rock Island has been granted waivers by the Center for Medicaid and Medicare Services (CMS) and well as an Equivalency by the Joint Commission so that the Emergency Department can remain in operation; Trinity Rock Island is committed to correcting these deficiencies as part of the proposed project.

Every year the Emergency Department is cited for code deficiencies. For example, the trauma rooms do not meet code; they do not have the required square footage. The floor-to-ceiling heights are inadequate, and the unit is unable to respond to exposure to hazardous material or other decontamination situations. (The current procedure is to perform decontamination in the ambulance garage or outside the building, which is unsuitable on a cold Midwestern winter day.)

The Emergency Department has also been cited for life safety and infection control issues. Because of lack of privacy, there are Health Insurance Portability Accountability Act (HIPAA) issues.

The location of the Emergency Department has created three dead-end corridors at the edge of the suite's boundaries which in the event of an emergency would require exiting through the Emergency Department. This is not permitted under Life Safety regulations.

Visibility on the unit is poor. The reception/registration desk does not have a clear visual access to the patient drop-off through the vestibule. Multiple treatment rooms in the ED are not readily visible from the nurse stations.

The medication room is small; it is located directly off a nurse station. Due to the small size of the room, care givers must queue in order to obtain or prepare medications.

The staff lounge is located outside the unit and is too far away for general use.

Trinity Rock Island has met the criteria for "Deteriorated Facilities."

## 2. Necessary Expansion

*The proposed project is necessary to provide for expansion for diagnostic, treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence in changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.*

Both current volume and existing square footage necessitate the expansion of the Emergency Department (ED).

As shown on the following table, Emergency Department volume increased 13.8 percent over the last 5 years.

$$35,676 \text{ 2011 visits} \div 31,348 \text{ 2007 visits} = 13.8 \text{ percent}$$

Attachment 37, Table 1  
Historical Utilization of the Emergency Department at Trinity Rock Island

Year	Rooms	Visits	Visits per Room	Percent Increase Over Previous Year
2007	17	31,348	1,844	--
2008	17	32,189	1,894	2.7
2009	17	33,162	1,951	3.0
2010	17	33,181	1,952	0.1
2011	17	35,676	2,099	7.5

Source: *Hospital Profiles, 2007-2011*; Trinity Rock Island Records

Trinity Rock Island's Emergency Department has 17 treatment stations. In 2011, the Hospital reported 35,676 emergency visits or 2,099 ED visits per station. The current utilization of the ED exceeds the State Guideline of 2,000 visits per room. This volume is stressing the current capacity of the department. Emergency volume is expected to continue to increase.

TRI's Level II Trauma Center is located in only 6,920 GSF, or 407 GSF per treatment station; this is only 45.2 percent of the State Guideline of 900 GSF per treatment station.

$$6,920 \text{ ED GSF} \div 17 \text{ treatment stations} = 407 \text{ GSF per treatment station}$$

$$407 \text{ GSF per treatment station} \div 900 \text{ allowable GSF per treatment station} = 45.2 \text{ percent}$$

Trinity Rock Island has met the criteria for "Necessary Expansion."

#### Special Considerations Related to the Trinity Rock Island Emergency Department

##### High Proportion of Behavioral Health Patients

Over the last several years, approximately 12 percent of the visits to the Hospital's Emergency Department are by behavioral health patients. This translates to an average of 340 patients per month or almost 12 behavioral health patients per day.

According to the National Hospital Ambulatory Care Survey, 2008 Emergency Department Summary Tables, the most recent edition published by the National Center for Health Statistics, only 3.3 percent of emergency department visits nationally are behavior health (mental health) related. Hence, the proportion of behavior health patients seen in the Trinity Rock Island Trauma Center/Emergency is approximately 3.5 times greater than the national average. This high proportion of behavioral health patients has significant implications for the proposed replacement Emergency Department at TRI.

Attachment 37, Table 2  
Percentage of Behavioral Health Emergency Visits as a Percentage of Total

Year	General Visits	Behavioral Health Visits	Total Visits	Percent Behavioral Health
2007	27,501	3,847	31,348	12.3
2008	28,062	4,127	32,189	12.8
2009	29,299	3,863	33,162	11.6
2010	29,251	3,930	33,181	11.8
2011	31,599	4,077	35,676	11.4

Source: Trinity Rock Island Records

This high behavioral health patient volume adds extra strain on the Emergency Department. These patients are often disruptive, uncooperative, violent or even suicidal and must be seen in the department for medical clearance before any behavioral crisis intervention can begin. The current ED has only limited accommodations in which to care for these patients so they are frequently intermixed with acute emergency patients. These limited accommodations include 2 “safe rooms”; however, one of these rooms is across a public corridor from the ED. Because many of these patients require constant line of sight supervision, this remote “safe room” is unsuitable for many of the behavioral health patients.

In the future, the number of behavioral health patients that present to the Emergency Department is expected to increase because there are no other after hour alternatives for them in the Quad Cities area. Further, Illinois Medicaid recently announced that reimbursement for detoxification in the hospital setting will be eliminated. With reduced care options, these patients have few to no treatment options but to seek help at the Hospital’s ED.

#### High Proportion of Patients Arriving by Ambulance

Approximately 15.2 percent of all visits to Trinity Rock Island’s Emergency Department arrive by ambulance. There are two local Trinity Medical Center facilities on the Illinois side of the Mississippi River – Trinity Rock Island and Trinity Moline. Trinity Moline has a basic category of emergency services and reported 26,915 visits in 2011. Trinity Moline does not receive any patients by ambulance. On the other hand, Trinity Rock Island is a Level II Trauma Center and reported 35,546 visits in 2011 and accepted all Trinity Medical Center (Rock Island and Moline) emergency ambulance patients. Because Trinity Rock Island provides ambulance coverage for two hospital emergency departments, the Hospital believes that they have a somewhat higher acuity of patients in their Emergency Department than similarly sized large community hospitals.

#### Current Need for Emergency Department Treatment Stations

Based on current utilization and the State Agency Guideline of 2,000 visits per treatment station, TRI’s current volume will support redeveloping 18 emergency treatment stations; currently, the Hospital has only 17 stations.

$$35,676 \text{ visits} \div 2,000 \text{ visits per station} = 18 \text{ Emergency Treatment stations}$$

TRI is proposing to develop 23 stations, including 1 trauma room and 3 safe rooms for behavioral health patients.

### Trend Line Methodology

TRI used two methodologies to project future need for emergency treatment stations in the proposed replacement Emergency Department – trend line analysis and the American College of Emergency Physicians’ methodology.

### Trend Line Methodology

First Trinity Rock Island developed three trend line analyses – absolute growth, percent growth, and CAGR (compound annual growth rate) methods. These trend lines suggest that by 2018, the second full year of utilization of the Emergency Department that TRI could justify from 22 to 23 stations. See Attachment 37, Exhibit 1.

- Absolute Growth Method

43,710 projected visits ÷ 2,000 visits per station = 21.9 or 22 projected treatment stations

- Percent Growth Method

45,983 projected visits ÷ 2,000 visits per station = 23 projected treatment stations

- CAGR Method

45,402 projected visits ÷ 2,000 visits per room = 22.7 or 23 projected treatment stations

The average of these three trend line methodologies is 45,032 emergency visits in 2018, the second full year of operation.

$43,710 \text{ visits} + 45,983 \text{ visits} + 45,402 \text{ visits} = 135,093 \text{ visits} \div 3 \text{ years} =$   
45,032 average visits in 2018

45,032 visits ÷ 2,000 visits per station = 22.5 or 23 needed treatment stations

These trend lines project a 26.3 percent growth in emergency visits at TRI between 2011 and 2018.

45,032 projected visits ÷ 35,676 2011 visits = 26.2 percent growth in emergency visits

Trinity Rock Island believes these are reasonable projections because:

- An increase in the senior population in TRI's service area is projected. The senior population in Rock Island County, TRI's primary service area, is expected to increase 42.4 percent between 2010 and 2025. This growth is very important because the senior population already accounts for 24 percent of the emergency visits at TRI.
- With the rebalancing of the mental health system in Illinois, TRI is anticipating that growth rate for behavioral health patients in the Emergency Department will increase.
- The effect of the Accountable Care Act (ACA) (federal health reform) on emergency services is unclear. Many studies suggest that emergency utilization will increase as a result of the new legislation – at least for the next several years. This is because the newly insured population will use more services, including primary care services. Since the number of primary caregivers is not projected to increase at the same rate as the projected insured population, the newly insured will seek alternative sources of care, and especially emergency departments.

American College of Emergency Physicians Methodology

In 2002, the American College of Emergency Physicians published, *Emergency Department Design; A Practical Guide to Planning for the Future*, Jon Huddy, AIA.

This document (pages 69 et seq.) identified several factors that determine the number of emergency treatment stations and observation rooms needed at a given facility. The following is a summary of the American College of Emergency Physicians' (ACEP) criteria for determining need. See Attachment 37, Table 1.

Attachment 37, Table 3

Rating American College of Emergency Physicians' Need Criteria  
with Situation at Trinity Rock Island

CRITERION	LOW	HIGH	TRINITY ROCK ISLAND
Criterion	Low Range Need for patient care spaces and over all department area will be in the LOW Range. If the majority of the following parameters match what you believe your future department to be:	High Range Need for patient care spaces and overall departmental area will be in the High Range. If the majority of following parameters match what you believe your future department will be:	
1. Length of stay	<input type="checkbox"/> Average total length of stay for all emergency department patients will be less than 2.5 hours. With shorter lengths of stay, there is the ability to turn spaces over quickly, and fewer are needed.	<input checked="" type="checkbox"/> Average total length of stay for all emergency department patients will be more than 3.5 hours. With longer lengths of stay, the ability to turn spaces over quickly is reduced and more spaces are needed.	Average length of stay is 3.25 hours.
2. Location of holding or observation beds	<input checked="" type="checkbox"/> Observation or evaluation unit or "admit holding" beds will be located outside the emergency department, which will allow patients to be moved out of the department.	<input type="checkbox"/> Observation or evaluation unit or "admit holding" beds are located within the department, which increases the number of patient care spaces needed.	At the present time, TRI does not have a discrete observation unit. In the proposed project, there will be a unit with 12 observation beds adjacent to the emergency department.
3. Time to admit	<input type="checkbox"/> Emergency department patients will who are to be admitted will be transported out of the department less than 60 minutes after disposition in less than 60 minutes, thereby being able to turn spaces over more quickly .	<input checked="" type="checkbox"/> Emergency department patients who are admitted to the hospital will remain in the department for more than 90 minutes after disposition. A more extended stay reduces the ability to turn spaces over more quickly.	Current time to admit is currently 5 hours. Although having ancillaries in the department and observation beds is expected to reduce this time, time is not to be reduced to 90 minutes or less.

CRITERION	LOW	HIGH	TRINITY ROCK ISLAND
4. Turnaround times for diagnostic tests	<input type="checkbox"/> Average turnaround times for results from laboratory and imaging studies will be 30 minutes or less; this will allow patient care spaces to be turned over more quickly.	<input checked="" type="checkbox"/> Turnaround times for results from laboratory and imaging studies will be more than 90 minutes after disposition. Extended times will limit the ability to turn over cases quickly.	Laboratory test results report in from 30 to 90 minutes. Imaging studies are also expected to be completed within 30 to 90 minutes. Lab results must be available before imaging exams are completed.
5. Percentage of admitted patients	<input type="checkbox"/> Less than 18 percent of emergency department patients will be admitted to the hospital. A lower acuity patient population allows for faster turnover of spaces.	<input checked="" type="checkbox"/> More than 23 percent of TRI's emergency patients will be admitted to the hospital. A higher acuity patient population allows for slower turnover of spaces.	In 2011, the percentage of patients admitted from the Emergency Department was 25.2 of total visits.
6. Percentage of non-urgent versus urgent patient presentations	<input type="checkbox"/> Non-urgent patients will outnumber urgent patients by more than 10 percent, which signifies a lower acuity patient population.	<input checked="" type="checkbox"/> Urgent patients will outnumber non-urgent patients by more than 10 percent, which signifies a higher acuity patient population	TRI's mix of patients in the Emergency Department is currently : 60 percent urgent 10 percent emergent 30 percent non urgent. It is expected that this mix will be the same in the future and that the percent urgent will exceed the percent non urgent by more than 10 percent.
7. Age of patients	<input type="checkbox"/> Less than 20 percent of the emergency department patients are older than 65 years.	<input checked="" type="checkbox"/> More than 25 percent of the emergency department patients will be older than 65 years. Older patients require more time and more diagnostic testing.	In 2011, 24 percent of TRI's emergency patients were age 65 or older. With the aging of the population, particularly the 65 and over cohort., this percent is expected to increase.

CRITERION	LOW	HIGH	TRINITY ROCK ISLAND
8. Need for administrative or teaching spaces	<input checked="" type="checkbox"/> The need for offices or teaching spaces will be minimal.	<input type="checkbox"/> Need for teaching areas, faculty offices, and other administrative office spaces within the emergency department will be extensive, such as in a university teaching hospital.	The proposed Emergency Department at TRI will have teaching space but will not have faculty offices, etc. such as in a university teaching hospital.
9. Imaging services included within the emergency department	<input type="checkbox"/> Imaging services will not be performed within the department	<input checked="" type="checkbox"/> Imaging services will be performed within the department.	General radiography and computerized tomography will be performed within the department. These modalities account for the majority of all imaging procedures for emergency patients.
10. Specialty components of departments  Pediatrics	<input checked="" type="checkbox"/> The provider will not have a pediatric emergency room.	<input type="checkbox"/> The provider will have a pediatric emergency room.	Although TRI will not have a pediatric emergency room, it sees many children and is an Emergency Department Approved for Pediatrics from IDPH, EMS and Highway Safety.
11. Specialty components of departments  Psychiatry (Behavioral Health)	<input type="checkbox"/> The provider will not have a large number of psychiatric patients.	<input checked="" type="checkbox"/> The provider will have a large number of psychiatric patients.	Of the total number of emergency department patients at TRI, approximately 12 percent are behavior health patients. This compares to the national average of 3.3 percent. The number of behavioral health patients in TRI's Emergency Department is expected to increase.
12. Flight services and or trauma services	<input checked="" type="checkbox"/> Flight services and trauma services will not be included within the department.	<input type="checkbox"/> Flight services and trauma services will be included within the department.	Trauma services will be included within the department.

Source: *Emergency Department Design*, Jon Huddy, AIA, American College of Emergency Physicians.

Trinity Rock Island clearly meets 8 of the 12 American College of Emergency Physicians' criteria for "high". Conservatively assuming that TRI is approximately midway between the low and high range, TRI has considered both the high and low range in developing future need for ED treatment stations based on the ACEP methodology.

The American College of Emergency Physicians proposes the following estimates for departmental areas and stations.

Attachment 37, Table 4  
American College of Emergency Physicians'  
Emergency Department Planning Guidelines

Projected Annual Visits	Departmental Gross Square Feet		ED Stations		Visits per Bed		Est. DGSF per Bed	Estimated Observation Beds
	High	Low	High	Low	High	Low		
40,000	28,875	21,875	33	25	1,212	1,600	875	6 to 8
50,000	34,000	25,000	40	30	1,250	1,667	850	8 to 10

Source: American College of Emergency Physicians

The following is a comparison of the American College of Emergency Physicians' Guidelines and Trinity's Rock Island's proposed project

Attachment 37, Table 5  
Comparison of Proposed Trinity Rock Island Emergency Stations and Observation Beds and American College of Emergency Physicians Guidelines

Metric	Trinity Rock Island Emergency Department and Observation Room Proposal		American College of Emergency Physicians' Guideline		Comments
Annual Visits	45,032 in 2018		40,000 to 50,000		Trinity Rock Island is midway in volume in the ACEP range and in the ACEP criterion ranges.
Departmental GSF	ED	18,540	25,000 to 28,874		Trinity Rock Island is lower than the ACEP guideline of from 40,000 visits to 50,000 visits
	Gen. Rad	565	DGSF		
	CT	765			
	Observation	4,890			
	Total	24,760			
Total ED Stations and Observation Rooms	ED	23	ED	30 to 33	Trinity Rock Island is proposing fewer combined ED stations and observation rooms than the combined ACEP guideline of high 40,000 visits and low 50,000 visits. With increasing health reform emphasis on reducing unnecessary admissions, the higher proportion of observation beds being proposed for the Hospital is appropriate.
	Observation	12	Observation	8	
	Total	35	Total	38 to 41	

Source: American College of Emergency Physicians and Trinity Rock Island Records

**Summary**

Trinity Rock Island is projecting continued growth in the Emergency Department based in 3 trend line methodologies and the American College of Physicians' methodology. The Hospital has also applied the American College of Emergency Physicians' guidelines for sizing the proposed new Emergency Department. The number of emergency treatment stations and observation beds being proposed by TRI is fewer than would be suggested by the American College of Emergency Physicians' guidelines. Trinity Rock Island believes that the projected volumes and their need for treatment stations is conservative.

### 3. Utilization

#### A) Major Medical Equipment

*Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12-months after acquisition.*

NA. There is no major medical equipment as part of the proposed Emergency Department expansion at Trinity Rock Island.

#### B) Service or Facility

*Projects involving modernization of a service or facility shall meet or exceed utilization standards for the service, as specified in Appendix B. The number of key rooms being modernized shall not exceed the number justified by historical utilization rates for each of the latest 2 years, unless additional key rooms can be justified per subsection c) 2) Necessary Expansion.*

TRI is requesting 23 emergency treatment stations. Only 18 stations can be justified with current utilization. In section subsection c) 2. Necessary Expansion, above, the additional 5 emergency treatment are justified using 3 trend line analyses as well as a methodology published by the American College of Emergency Physicians. All of the projection methodologies support the need for at least 23 treatment stations by 2018, the second full year of project utilization.

#### C) *If no utilization standards existing, the applicant shall document in detail its anticipated utilization in terms or incidence of diseases or conditions or population use rates.*

The State's Guideline for emergency treatment station is 2,000 visits per station by the second full year of utilization. Trinity Rock Island has conservatively projected 45,032 emergency visits by 2018 or enough to support the proposed 23 stations.

These 23 stations will operate at 1,958 visits per year per treatment station or 97.9 percent of the State Agency Guideline by the second full year they are operational.

The American College of Emergency Physicians suggest that emergency departments with between 40,000 and 50,000 annual visits should operate at from 1,212 to 1,667 annual visits per treatment station. Based on this guideline, TRI's request for 23 treatment stations is very conservative.

Trinity Rock Island All Emergency Visit Projections

All Emergency Visits	Actual							Projected							
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Absolute Growth Method <sup>1</sup>	31,085	31,928	31,348	32,189	33,162	33,181	35,676	36,824	37,972	39,119	40,267	41,415	42,563	43,710	44,858
Annual Growth	843	843	(580)	841	973	19	2,495	1,148	1,148	1,148	1,148	1,148	1,148	1,148	1,148
Percent Growth	2.7%	2.7%	-1.8%	2.7%	3.0%	0.1%	7.5%	3.2%	3.1%	3.0%	2.9%	2.9%	2.8%	2.7%	2.6%
Percent Growth Method <sup>2</sup>	31,085	31,928	31,348	32,189	33,162	33,181	35,676	36,993	38,359	39,775	41,244	42,767	44,346	45,983	47,681
Annual Growth	843	843	(580)	841	973	19	2,495	1,317	1,366	1,416	1,469	1,523	1,579	1,637	1,698
Percent Growth	2.7%	2.7%	-1.8%	2.7%	3.0%	0.1%	7.5%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%
CAGR Growth Method <sup>3</sup>	31,085	31,928	31,348	32,189	33,162	33,181	35,676	36,926	38,220	39,559	40,945	42,380	43,865	45,402	46,992
Annual Growth	843	843	(580)	841	973	19	2,495	1,250	1,294	1,339	1,386	1,435	1,485	1,537	1,591
Percent Growth	2.7%	2.7%	-1.8%	2.7%	3.0%	0.1%	7.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%

All Emergency Visits	Absolute			Percent			
	2007	2011	2011	Change	Growth <sup>1</sup>	Growth <sup>2</sup>	CAGR <sup>3</sup>
	31,085	35,676	4,591	1,148	3.7%	3.7%	3.5%

Absolute Growth Method <sup>1</sup>  
 $(\text{Ending Year Volume} - \text{Beginning Year Volume}) / (\text{Ending Year} - \text{Beginning Year})$   
 $(35676 - 31085) / (2011 - 2005)$

Percent Growth Method <sup>2</sup>  
 $(\text{Ending Year Volume} - \text{Beginning Year Volume}) / (\text{Ending Year} - \text{Beginning Year}) / (\text{Beginning Year Volume})$   
 $((35676 - 31085) / (2011 - 2005)) / 31085$

CAGR Growth Method <sup>3</sup>  
 $(\text{Ending Year Volume} / \text{Beginning Year Volume}) ^ { (1 - (\text{Ending Year} - \text{Beginning Year})) - 1}$   
 $(35676 / 31085) ^ { (1 - (2011 - 2007)) - 1}$

Source: Hospital Records  
 Note: errors due to rounding

## General Radiology

## c) Service Modernization

The applicant shall document that the proposed project meets one of the following:

Trinity Rock Island (TRI, Hospital) will respond to 1110.3030 c) 1. "Deteriorated Facilities."

## 1. Deteriorated Facilities

*The proposed project will result in the replacement of equipment or facilities that have been deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.*

Trinity Rock Island currently has 4 general radiology units; of these there are 2 general radiology/fluoroscopy units, one digital radiology room and one analog radiology room. TRI is proposing to decommission the analog radiology room currently located in the Imaging Department and replace it with a new digital unit in the proposed new Level II Trauma Center/Emergency Department. The total number of radiology/fluoroscopy units at the Hospital will not change.

The unit to be decommissioned is an analog unit Model Super 80 CP. The unit was purchased in November 1998; it is more than 14 years old and has exceeded its useful life by 9 years. It requires frequent maintenance and replacement parts are increasingly difficult to obtain.

There are several reasons for having general radiology equipment in the Emergency Department as well as in the Imaging Department.

- 51.3 percent of all emergency patients seen in the Hospital's Emergency Department require a general radiology exam.
- With the relocation to the new tower, the Emergency Department will be 659 feet, 12 turns, and one elevator ride distant from the Imaging Department. This will be a difficult and time consuming travel distance. It will increase the time to radiology exam, reading and diagnosis. In 2018, the second full year of utilization after project completion, the Emergency Department is projected to

treat 45,032 patients; this is an average of 124 patients per day. Of these 64 (51.3 percent) will require a general radiology procedure and will need to be either escorted or transported to the Imaging Department, unless general radiology equipment is available in the Emergency Department.

- The analog unit has substantially exceeded its useful life and needs to be replaced with newer technology regardless of whether it is located in the Imaging Department or in the Emergency Department.

The proposed replacement of one general radiology unit in the Emergency Department meets the “Deteriorated Equipment or Facilities” criterion.

## 2. Necessary Expansion

*Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training, or other support services to meet the requirements of patient service demand and licensure or fire code deficiency citations involving the proposed project.*

NA

### Data Correction

Trinity Rock Island filed a Declaratory Ruling request with the Health Facilities and Services Review Board to correct imaging utilization data for 2010 and 2011.

The following tables compare originally filed as well as corrected general radiology data for 2010 and 2011.

Attachment 37, Table 1  
Comparison of Corrected and AHQ-Filed General Radiology Utilization, 2010

Corrected Utilization Data			Utilization Data Filed on the 2010 AHQ		
Inpatient	Outpatient	Total	Inpatient	Outpatient	Total
15,019	15,317	30,346	17,038	15,484	32,522

Sources: Trinity Rock Island Financial Data and *Hospital Profiles, 2010*

Attachment 37, Table 2  
Comparison of Corrected and AHQ-Filed General Radiology Utilization, 2011

Corrected Utilization Data			Utilization Data Filed on the 2011 AHQ		
Inpatient	Outpatient	Total	Inpatient	Outpatient	Total
17,199	14,810	32,009	17,575	13,998	31,573

Sources: Trinity Rock Island Financial Data and *Hospital Profiles, 2011*

Further, both in 2010 and 2011, Trinity Rock Island erroneously reported the total of fixed and portable general radiology procedures (rather than just fixed procedures) on IDPH's Annual Hospital Questionnaire.

In years prior to 2012, TRI extracted all AHQ radiology data from the Radiology Information System which is unable to recover more than 1,000 days of data. Due to this and other shortcomings of this information system, management recently decided that the Hospital's financial accounting system should be the official source of imaging utilization data, including that for general radiology.

The financial accounting system, however, prohibits the Hospital from being able to distinguish between fixed and portable general radiology exams because the data is compiled via CPT (current procedural terminology) codes. CPT codes are developed, maintained, and copyrighted by the American Medical Association and are used for analytical, administrative, and financial purposes including the financial accounting system at the Hospital. In October 2011, Trinity deleted the Sunquest order code for portable general radiology exams as exams had the same CPT code as exams performed on the fixed equipment within the department, thereby removing the unique criterion on which to pull portable data. This was completed to align the Hospital's internal departmental revenue practices with the Iowa Health System practices in preparation for conversion to electronic medical record installation. Under this charging/revenue capture policy, there is no way to determine which exams were done on fixed equipment and which on portable equipment within the financial accounting system.

In order to respond to the State's requirement to report only fixed exams, portable exams for 2010 and 2011 were estimated based on annualized data available in the Radiology Information System which spanned the time period prior to losing the portable-specific exam code within the Radiology Information System and is additionally restricted by the 1,000-day recovery capability of the system. The estimated number of portables was subtracted from total procedures to estimate the number of fixed procedures in 2010 and 2011.

In the future, volume will be from the financial accounting system using CPT code criteria; however, a new exam location within the current Radiology Information System has been created to provide a mechanism for accounting for the portable exams which utilize the same CPT codes. In this way, all future AHQ filings will be correct and consistent.

3) Utilization

A) Major Medical Equipment

*Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.*

There is no major medical equipment as part of general radiology.

B) Service or Facility

*Projects involving the modernization of a service or facility shall meet or exceed utilization standards for the service, as specified in Appendix B. The number of key rooms being modernized shall not exceed the number justified by historical utilization rates for each of the latest two years, unless additional key rooms can be justified per subsection c) 2. Necessary Expansion*

Utilization of Trinity Rock Island's 4 general radiology units over the latest 2 years justifies the need for the existing 4 general radiology rooms.

Attachment 39, Table 3

General Radiology (without Portables) Utilization and Calculation of Need, 2010 and 2011

Year	General Radiology Exams(without Portable Exams)	Units Justified at 8,000 Procedures per Unit
2010	24,827	3.1 or 4
2011	25,673	3.2 or 4

Source: Trinity Rock Island Financial Records

The current and proposed radiology equipment meets the 8,000 procedures per unit justification criteria yet has capacity for future growth.

The number of key rooms being modernized does not exceed the number justified by historical utilization rates for each of the latest 2 years. Trinity Rock Island currently has 4 general radiology units and will continue to have 4 general radiology units after project completion.

The proposed new unit will be faster and provide higher quality images than the one being decommissioned.

C) *If no utilization standard exists, the applicant shall document in detail its anticipated utilization in terms of incidence or disease or conditions, or population use rates.*

NA State Guidelines exist and Trinity Rock Island's volume for each of the latest 2 years justified TRI having 4 general radiology/fluoroscopy rooms.

c) Service Modernization

The applicant shall document that the proposed project meets one of the following:

Trinity Rock Island (TRI, Hospital) will respond to 1110.3030 c). 1. "Deteriorated Facilities."

1) Deteriorated Facilities

*The proposed project will result in the replacement of equipment or facilities that have been deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.*

Trinity Rock Island currently has 2 computerized tomography (CT) units. The first was purchased in 2003 and has exceeded its useful life of 5 years; it has been in operation for 10 years. It is a Sensation 16-slice unit; this technology is becoming obsolete. The second unit was purchased in 2008. It is a Somaton Definition; it has a useful life of life of 5 years. This unit is approaching the end of its useful life; however, it is a 64-slice unit which is more contemporary technology than the unit purchased in 2003.

Hence, TRI has one deteriorated computerized tomography unit that it plans to replace. TRI meets the criterion for "Deteriorated Facilities."

2) Necessary Expansion

*The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training, or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citation involving the proposed project.*

NA

Data Correction

Trinity Rock Island filed a Declaratory Ruling request with the Health Facilities and Services Review Board to correct imaging utilization data for 2010 and 2011. The data as originally filed on the Annual Questionnaire was from a data system that has been decommissioned and did not correctly reflect actual utilization. The new financial system will be used by the Hospital in all future filings so that data will be correct and consistent.

Attachment 37, Table 1  
Comparison of the Utilization of Computerized Tomography, 2010

Corrected Utilization Data			Utilization Data Filed on the 2010 AHQ		
Inpatient	Outpatient	Total	Inpatient	Outpatient	Total
5,820	9,823	15,643	5,671	8,763	14,434

Sources: Trinity Rock Island Financial Data and *Hospital Profiles, 2011*

Attachment 37, Table 2  
Comparison of the Utilization of Computerized Tomography, 2011

Corrected Utilization Data			Utilization Data Filed on the 2010 AHQ		
Inpatient	Outpatient	Total	Inpatient	Outpatient	Total
5,518	7,539	13,057	5,334	7,009	12,343

Sources: Trinity Rock Island Financial Data and *Hospital Profiles, 2011*

As part of this project, Trinity Rock Island is proposing to decommission the 16-slice CT unit that is currently located in the Imaging Department and replace it with a more contemporary 64-slice unit in the Level II Trauma Center/Emergency Department. It is prudent to replace this second unit in the Emergency Department because of the high volume of emergency patients that require CT scans. The Hospital's records show that in 2011, 64.9 percent of emergency patients required a computerized tomography scan; this equates to approximately 36 scans per day. With the relocation of the Emergency Department to Level 2 of the new tower, it will be one elevator ride, and 13 turns and 695 feet or more than twice the length of a football field away from the current Imaging Department. This would unnecessarily delay diagnosis, reading, and treatment for emergency patients.

3) Utilization

A) Major Medical Equipment

*Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.*

NA there is no major medical equipment as part of computerized tomography.

B) Service or Facility

*Projects involving the modernization or a service or facility shall meet or exceed the utilization standards for the service, as specified in Appendix B. The number of key rooms being modernized shall not exceed the number justified by historical utilization rates for each of the latest two years, unless additional key rooms can be justified per subsection (c), (2), (Necessary Expansion).*

Utilization of each of TRI's CT units over the last 2 years justifies the need for 2 computerized tomography units.

Attachment 37, Table 3

Volume Adjusted for Portable Exams and Calculation of Need, 2010 and 2011

Year	Inpatient	Outpatient	Total	Units Justified at 7,000 Procedures per Unit
2010	5,820	9,823	15,643	2
2011	5,518	7,539	13,057	2

One computerizing scanning room will be relocated into new construction; the other will remain in its current location in the Imaging Department. The number of key rooms does not exceed the number justified by historical utilization rates for each of the latest two years. Further, there will be no increase in the number of computerized tomography units at the Hospital.

C) If no utilization standards exist, the applicant shall document in detail its anticipated utilization in terms of incidence of disease or conditions, or population use rates.

State Agency Guidelines exist and Trinity Rock Island's volume for each of the latest two years justifies TRI's having 2 CT units.

Clinical Service Area  
Observation Beds

## c) Service Modernization

The applicant shall document that the proposed project meets one of the following:

Trinity Rock Island (TRI, Hospital) will respond to 1110.3030 c). 1. "Necessary Expansion."

## 1) Deteriorated Facilities

*The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to historical utilization data, downtime or time spent out of service due to operational failures, upkeep on annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.*

NA Trinity Rock Island (TRI Hospital) currently does not have a discrete Observation Unit. The 12-bed Observation Unit being proposed will be a new service for the Hospital. Hence there are neither deteriorated facilities nor equipment that require replacement.

## 2) Necessary Expansion

*The proposed project is necessary to provide for expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence in changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.*

Trinity Rock Island is proposing to develop a 12-bed Observation Unit adjacent to the replacement Emergency Department (ED). Observation units are an increasingly important function in a modern hospital. Today about 35 percent of U.S. hospitals have dedicated ED observation units.

Patients who present in the ED with complaints that cannot be quickly or conclusively diagnosed may be transferred to an observation unit; these units are typically located in or adjacent to the ED. This location allows the ED physicians to

provide clinical oversight. The observation unit is well suited for complex cases – especially those who require more management than can be given in a traditional ED, but do not need the level of care or services provided in an inpatient setting.

Typical complaints that are seen in an observation unit are chest pain, abdominal pain, shortness of breath, nausea and vomiting, vertigo and dizziness, and skin infection.

Patient stay in an observation may be up to 48 hours. During this time, at risk patients are monitored and tests are conducted more quickly and at less cost than if the patient were admitted to an inpatient unit. Observation units can help avoid unnecessary inpatient admissions by aggressively diagnosing and treating these patients. The current standard of care is an admission rate of less than 10 percent. All other patients are discharged.

Trinity Rock Island is proposing to introduce an Observation Unit adjacent to the Emergency Department to improve patient care and reduce health care costs.

Trinity Rock Island has met the criterion for “Necessary Expansion.”

### 3) Utilization

#### A) Major Medical Equipment

*Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12-months after acquisition.*

There is no major medical equipment as part of the Observation Unit.

#### B) Service or Facility

*Projects involving modernization of a service or facility shall meet or exceed utilization standards for the service, as specified in Appendix B. The number of key rooms being modernized shall not exceed the number justified by historical utilization rates for each of the latest 2 years, unless additional key rooms can be justified per subsection c) 2) Necessary Expansion.*

There are no utilization standards for observation units provided in Appendix. B.

- C) *If no utilization standards existing, the applicant shall document in detail its anticipated utilization in terms or incidence of diseases or conditions or population use rates.*

The following assumptions were used in determining the number of beds needed in the proposed observation unit at the Hospital.

1. A baseline utilization forecast was developed through use of Sg2s proprietary Impact of Change forecasting tool. Cannon Design then customized the utilization forecast based on assumptions around transition of patients who would be potentially avoidable admissions from inpatient status to outpatient observation status.
2. Next, Cannon Design identified the number of patients at the Hospital seen with these potentially transitional DRGs. In 2010 for example, 5,689 patients we identified; in 2011, there were 5,729.
3. Cannon Design then adjusted the total number of patients in the selected DRGs through an operational assessment. Inpatients with a 48-hour or less stay were included in the adjustment. These were likely observation unit candidates. The consultants calculated 2,533 possible observation patients through 2018, the second full year of operation of the proposed observation unit at TRI.
4. Finally, the consultants sized the observation unit based on four distinct factors:
  - a. Projected volumes developed by Sg2 and Cannon Design
  - b. Projected average length of stay in the observation unit of 23 hours
  - c. Target utilization of 65 percent
  - d. Expected nurse staffing ratio of from 4:1 to 6:1.

First they assumed that one observation bed would have 5,694 annual hours of capacity.

24 hours per day x 365 days per year x 65 percent target occupancy = 5,694 available hours per year.

Next they determined that projected patient volume in 2018, the second full year of utilization) would require 58,259 total hours of care.

2018 patients x 23 hour ALOS = total needed hours

2,533 patients x 23 hours per patient = 58,259 total needed hours

The third step was to convert needed hours into needed rooms.

58,259 needed hours ÷ 5,694 available hours per room per year = 11 rooms

Finally, they determined that the patient to nurse staffing ratio in the Observation Unit would be from 4:1 to 6:1. To optimize nursing productivity, the consultants increased the number of rooms to 12.

Based on this methodology, TRI has justified the need for a 12-bed Observation Unit.

c) Service Modernization

The applicant shall document that the proposed project meets one of the following:

The Crisis Stabilization Unit is a new Clinical Service Area for Trinity Rock Island (Medical Center); therefore TRI will respond to 1110.3030 c) 2. "Necessary Expansion."

1. Deteriorated Facilities

*The proposed project will result in the replacement of equipment or facilities that have been deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.*

NA

2. Necessary Expansion

*The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training, or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citation involving the proposed project.*

Introduction

Behavioral health is a term with broad applicability. It embraces the patients that present at Trinity Rock Island with both psychiatric and substance abuse problems. Crisis Stabilization Unit is a term used by the applicants to describe its new Clinical Service Area.

Trinity Regional Health System includes multiple providers including Trinity Medical Center at Rock Island (TRI, Hospital) and Robert Young Center for Community Mental Health (RYC, Center). The Hospital has an authorized bed complement of 54 acute mental illness beds and a Level II Trauma Center/Emergency Department (ED).

The President of Robert Young Center is also functions as Vice President of Behavioral Health Services for Trinity Regional Health System allowing for the

direct oversight of the Hospital's inpatient unit as well as the behavioral health emergency services at Trinity Rock Island.

The Robert Young Center is an established organization that provides psychiatric emergency services, hospital consultations, central intake, telepsychiatric evaluations, crisis intervention, and a walk-in clinic. In addition, RYC provides behavioral health outpatient services for children, adolescents, adult and geriatric patients including group therapy on and off the Trinity Rock Island campus. The Center also provides community support in conjunction with the State of Illinois, the City of Rock Island, and the Development Association of Rock Island; this unique partnership provides one of the most innovative community support programs in the nation. Finally, RYC is a preferred provider organization (PPO) and an employee assistance program (EAP).

Together Trinity Rock Island and Robert Young Center serve a broad geographic area including not only Rock Island and Mercer counties but also patients from 38 other Illinois counties and 37 counties in Iowa and beyond. Some of these facilities are linked to the emergency services in Rock Island via telepsychiatry capabilities. Behavioral health patients who present in other smaller emergency departments that have neither inpatient nor outpatient behavioral health diagnostic or treatment capabilities often encounter long delays before being evaluated, transferred or discharged. With RYC's telepsychiatric capabilities, evaluation can be accomplished and long delays for patient disposition are reduced.

#### Changing Landscape in Behavioral Health Care Delivery in Illinois

In 2012, the Illinois Department of Mental Health began to implement Governor Patrick Quinn's plan to rebalance the State's approach to care for individuals with mental health conditions. This rebalancing plan highlights the Governor's commitment to providing community-based alternatives to institutional care that is consistent with current patient-focused standards of care as well as the Supreme Court's 1999 Olmstead Ruling, mandating that persons in institutional settings be afforded greater opportunities for community living.

The implementation of the plan was segmented into regions. Counties in the north and west of the State comprise the Northwest Crisis Care Region, or Department of Mental Health Region 2 West. Trinity Rock Island and Robert Young Center are located in Region 2 West (which includes Rock Island and Mercer counties).

In July 2012, the IDHS Division of Mental Health issued a request for information from mental health providers that were interested in providing services that would enable the full implementation of the Governor's rebalancing plan. One of the specific services being sought included development of crisis stabilization units. The request for information suggested that these units could be based in an emergency department, but as a distinct area of the emergency department, and be of a minimal size, of from 3 to 8 beds. Patients in these units would be persons with mental illnesses/behavioral health issues presenting in an acute crisis and in need of a safe, secure environment less restrictive than inpatient hospitalization. These crisis stabilization units could be designed for both voluntary and involuntary patients with a typical expected length of stay of from 24 to 36 hours.

The request for information limited responses to licensed community hospitals that are Medicaid/Medicare providers, are willing to assert to maintain full compliance with the State of Illinois Mental Health Code and Confidentiality Code, and Accredited by the Joint Commission or by Healthcare Facilities Accreditation Program.

These providers also were required to document that they could develop multidisciplinary teams of mental health professionals to staff these crisis stabilization units. The team (BILT – Brief Intervention Linkage Team) would have the skills to provide rapid treatment assessment, observation to assess suicidal intent and risk, and medication, counseling, referral, and linkage and coordination to the appropriate level of care to be received post discharge.

Further, these providers had to detail how they would establish a system to efficiently and effectively:

- a) Manage the historical volumes from emergency departments through crisis intervention services

- b) Shift the historical volumes at emergency departments from current hospital intervention points to other awarded community sites, and
- c) Provide details on the projected referral volumes to other levels of purchased care.

Trinity Rock Island and RYC are uniquely qualified to meet all the conditions outlined by the State's request for information, except one. They do not have the facilities to support a needed crisis stabilization unit. At the same time that the rebalancing plan was being made public, planning was underway for the redevelopment of the Emergency Department at Trinity Rock Island. Plans called for special security rooms in the department for behavioral health patients so they would not cause harm to themselves or others. However, there was no space to develop a crisis stabilization unit within the proposed new Emergency Department. However, with the assistance of facility planners who were familiar with the crisis stabilization unit concept from work in other states that have already adopted this approach to care, the applicants determined a 6-bed crisis stabilization unit could be developed by relocating existing Behavioral Health Group Therapy rooms and remodeling that space and adjacent vacant space.

While planning for the crisis intervention unit was proceeding, the H. Douglas Singer Mental Health Hospital (Singer), a chronic mental illness facility in Rockford, Illinois, received approval from the Health Facilities and Services Review Board to close by October 2012. This imminent closure was factored into plans for the crisis stabilization unit. Particular attention was given to the very likely longer length of stays (or greater than the 24 to 36 hours outlined in the request for information). The applicants estimated that about 100 additional patients per year (over and above the projected volume based on historical trends) would be seen from Singer. The patients that formerly were admitted to Singer but would now be seen at RYC would be severely ill patients and would potentially have lengths of stay in the crisis stabilization unit of 72 hours or more.

Currently there is no adequate space for crisis stabilization functions on the Rock Island campus. Once it is determined that a patient requires hospitalization, he/she is admitted to the inpatient unit or transferred to outside facilities. In the event there are

no available beds, the patient remains in the Emergency Department until a bed becomes available. However, this is problematic as the Emergency Department space does not have capacity to hold behavioral health patients due to limited room availability and room security and safety issues.

The proposed crisis stabilization unit had to be designed to support the needs of patients that would be in the unit for more than 1 day – windows, nourishment, sleeping accommodations, and so on would be necessary.

In order to configure the physical crisis stabilization unit, it was determined that 3 rooms could be developed with windows; these rooms could be used to accommodate patients with longer than 1-day stays. To determine how many total crisis stabilization rooms should be provided, the following assumptions were made:

1. 3 trend-line analyses were prepared to determine likely scenarios for future behavioral health emergency department visits—absolute growth, percent growth, and CAGR (compound annual growth rate methods). These trend lines suggest that by 2018, the second full year of utilization of the Emergency Department, Trinity Rock Island could justify from 6 to 7 beds. See Attachment 37, Exhibit 1.
  - Absolute Growth Method determined the need for 5,008 total behavioral health emergency visits in 2018.
  - Percent Growth Method determined the need for 5,276 total behavioral health emergency visits in 2018.
  - CAGR Growth Method determined the need for 5,207 behavioral health emergency visits in 2018.

The average of these three trend line methodologies is 5,164 visits in 2018. This average of the trend lines projects a 26.7 percent growth in behavioral health emergency visits between 2011 and 2018.

$$5,008 \text{ visits} + 5,276 \text{ visits} + 5,207 \text{ visits} = 15,491 \div 3 \text{ years} = 5,164 \text{ average visits in 2018.}$$

2. Of the average visits projected for 2018, it was assumed that 25 percent of those behavioral health visits that had historically been seen in the Emergency Department would need continuing care in the crisis stabilization unit, or 1,291 annual stays in the crisis stabilization unit.

$$5,164 \text{ annual visits} \times 25 \text{ percent to the crisis stabilization unit} = \\ 1,291 \text{ annual stays in the crisis stabilization unit}$$

3. It was assumed that these patients would stay an average of 24 hours before disposition to an inpatient or outpatient setting. Based on this assumption, traditional emergency behavioral health patients would stay a total of 30,984 hours in the proposed crisis stabilization unit.

$$1,291 \text{ patients} \times 24 \text{ hours average stay} = \\ 30,984 \text{ total hours per year in the proposed crisis stabilization unit}$$

4. It was further assumed that approximately 100 high risk behavioral health patients who would have been patients at the Singer Mental Health Center would be admitted to the new crisis stabilization unit and that their average stay would be 72 hours before disposition.

$$100 \text{ high risk behavioral health patients} \times 72 \text{ hours stay in the proposed} \\ \text{crisis stabilization unit} = 7,200 \text{ total hours in the crisis stabilization unit}$$

5. Next, the more traditional days were combined with the high risk days to arrive at total annual days in the crisis stabilization unit.

$$30,984 \text{ traditional days} + 7,200 \text{ high risk days} = \\ 38,184 \text{ total days in the crisis stabilization unit}$$

6. To determine how many rooms would be needed, it was assumed that one room could accommodate 6,132 hours per year. This assumption was based on 365 days per year, 24 hours per day and 70 percent occupancy.

$$365 \text{ days per year} \times 24 \text{ hours per day} = 8,760 \text{ hours per year} \\ 8,760 \times 70 \text{ percent average occupancy} = 6,132 \text{ hours per room per year}$$

7. Finally, RYC divided total projected hours were divided by available hours per room to determine the needed number of crisis stabilization rooms.

$$38,184 \text{ total projected hours} \div 6,132 \text{ available hours per room} = 6.2 \text{ rooms}$$

The applicants are conservatively requesting 6 crisis stabilization rooms.

### 3. Utilization

#### A) Major Medical Equipment

*Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.*

There is no major medical equipment as part of the Crisis Stabilization Unit.

#### B) Service or Facility

*Projects involving the modernization or a service or facility shall meet or exceed the utilization standards for the service, as specified in Appendix B. The number of key rooms being modernized shall not exceed the number justified by historical utilization rates for each of the latest two years, unless additional key rooms can be justified per subsection (c), (2), (Necessary Expansion).*

The State has no utilization standards for crisis stabilization units.

#### C) *If no utilization standards exist, the applicant shall document in detail its anticipated utilization in terms of incidence of disease or conditions, or population use rates.*

Anticipated utilization is described in subsection (c), 2. "Necessary Expansion."

Trinity Rock Island Behavioral Health Emergency Visit Projections

Behavioral Health Emergency Visits	Actual					Projected								
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Absolute Growth Method <sup>1</sup>	3,545	3,647	3,847	4,127	3,863	3,930	4,077	4,210	4,343	4,476	4,609	4,742	4,875	5,008
Annual Growth		102	200	280	(264)	67	147	133	133	133	133	133	133	133
Percent Growth		2.9%	5.5%	7.3%	-6.4%	1.7%	3.7%	3.3%	3.2%	3.1%	3.0%	2.9%	2.8%	2.7%
Percent Growth Method <sup>2</sup>	3,545	3,647	3,847	4,127	3,863	3,930	4,077	4,230	4,389	4,553	4,724	4,901	5,085	5,268
Annual Growth		102	200	280	(264)	67	147	153	159	165	171	177	184	191
Percent Growth		2.9%	5.5%	7.3%	-6.4%	1.7%	3.7%	3.8%	3.8%	3.8%	3.8%	3.8%	3.8%	3.8%
CAGR Growth Method <sup>3</sup>	3,545	3,647	3,847	4,127	3,863	3,930	4,077	4,222	4,372	4,528	4,689	4,856	5,028	5,201
Annual Growth		102	200	280	(264)	67	147	145	150	156	161	167	173	179
Percent Growth		2.9%	5.5%	7.3%	-6.4%	1.7%	3.7%	3.6%	3.6%	3.6%	3.6%	3.6%	3.6%	3.6%

	2007	2011	Change	2011 Growth <sup>1</sup>	2011 Growth <sup>2</sup>	CAGR <sup>3</sup>
Behavioral Health Emergency Visits	3,545	4,077	532	133	3.8%	3.6%

Absolute Growth Method<sup>1</sup>  
 $(\text{Ending Year Volume} - \text{Beginning Year Volume}) / (\text{Ending Year} - \text{Beginning Year})$   
 $(4077 - 3545) / (2011 - 2005)$

Percent Growth Method<sup>2</sup>  
 $(\text{Ending Year Volume} - \text{Beginning Year Volume}) / (\text{Ending Year} - \text{Beginning Year}) / (\text{Beginning Year Volume})$   
 $((4077 - 3545) / (2011 - 2005)) / 3545$

CAGR Growth Method<sup>3</sup>  
 $(\text{Ending Year Volume} / \text{Beginning Year Volume})^{(1 - (\text{Ending Year} - \text{Beginning Year})) - 1}$   
 $(4077 / 3545)^{(1 - (2011 - 2007)) - 1}$

Source: Hospital Records  
 Note: Errors due to rounding

c) Service Modernization

The applicant shall document that the proposed project meets one of the following:

The Robert Young Center's Behavioral Health Group Therapy area is being relocated and modernized as part of the proposed Heart Center/Emergency Department construction and modernization project at Trinity Rock Island. Neither deteriorated facilities nor necessary expansion are justifications for the relocation. Rather the current group therapy area is needed to provide space in which to develop the new Crisis Stabilization Unit (See Attachment 37, 9 Crisis Stabilization Unit).

1. Deteriorated Facilities

*The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to historical utilization data, downtime or time spent out of service due to operational failures, upkeep on annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.*

NA

2. Necessary Expansion

*The proposed project is necessary to provide for expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence in changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.*

NA

3. Utilization

A) Major Medical Equipment

*Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12-months after acquisition.*

There is no major medical equipment in the Behavioral Health Group Therapy area.

B) Service or Facility

*Projects involving modernization of a service or facility shall meet or exceed utilization standards for the service, as specified in Appendix B. The number of key rooms being modernized shall not exceed the number justified by historical utilization rates for each of the latest 2 years, unless additional key rooms can be justified per subsection c) 2) Necessary Expansion.*

There are no utilization standards for behavioral health group therapy specified in Appendix. B.

- C) *If no utilization standards existing, the applicant shall document in detail its anticipated utilization in terms or incidence of diseases or conditions or population use rates.*

Today, the Behavioral Health Therapy area includes 3 group therapy rooms; support functions including medical records, staff offices, reception staff space, patient waiting rooms, and patient toilets are shared with the Robert Young Center's Access Center. At the conclusion of the relocation and modernization of this function, there will continue to be 3 group therapy rooms with shared support space.

The space will continue to be used in much the same way that it is now; patient count reported below is based on current group census rosters.

Substance Abuse Group Therapy

Outpatient Groups (Level 1). There are currently 3 outpatient groups that met once weekly for 1.5 hours per session. The average census for the groups is 12 patients.

Intensive Outpatient Groups (Level 2). There are currently 3 intensive outpatient groups that meet 4 times weekly for 3 hours per each session. The current average census for the groups is 13 patients.

Recovery Support Group. This group currently meets once weekly for 1.5 hours. The group attendance ranges between 20 and 30 patients.

## Sex Offender Group Treatment

Adult Offender Group. There is 1 Adult Offender Group that meets once weekly for a 1-hour session. The census of this group is 13 patients.

Juvenile Offender Group. There is 1 outpatient group that meets once weekly for 1 hour. The current group census is 9 patients.

In addition to the above outlined services, there are plans to provide integrated services with cardiac rehabilitation. This would be a group therapy offering for patients with co-occurring cardiac and behavioral health problems.

Trinity Rock Island and Robert Young Center have justified the need for 3 Behavioral Health Group Therapy rooms based on current activity and related need for these rooms.

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):

Moody's Rating Service giving Iowa Health System an Aa3 bond rating on June 30, 2011 is on the following pages.

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

**VIII. - 1120.120 - Availability of Funds**

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

<u>\$53,221,976</u>	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;
<u>\$10,000,000</u>	b)	Pledges – for anticipated pledges, a summary of the anticipated pledge owing 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;
<u>\$63,221,976</u>	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
<b>TOTAL FUNDS AVAILABLE</b>		

**See Attachment 39, Exhibit 1**

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

Iowa Health System and Trinity Medical Center will provide the cash and securities to fund the Heart Center/Emergency Department project. The Iowa Health System strategic capital pool are funds which will be made available from prior years' operating income and non operating gains. Iowa Health System will loan Trinity Medical Center \$10,000,000.

Note: As noted on Attachment 9, interest expense occurs during the construction phase of the project. Internally, the funds which are supplied by Iowa Health System are treated as a loan from one company to another company within Iowa Health System. As the interest payments are made during the construction, Generally Accepted Accounting Principles (GAAP) require the interest expense to be recorded as an asset, and as such are capitalized.

# MOODY'S

## INVESTORS SERVICE

**Rating Update: MOODY'S AFFIRMS IOWA HEALTH SYSTEM'S Aa3 UNENHANCED BOND RATING;  
OUTLOOK REMAINS STABLE**

Global Credit Research - 30 Jun 2011

**IOWA HEALTH SYSTEM WILL HAVE A TOTAL OF \$626 MILLION OF RATED DEBT OUTSTANDING**

Iowa Finance Authority  
Health Care-Hospital  
IA

### Opinion

NEW YORK, Jun 30, 2011 – Moody's Investors Service has affirmed the Aa3 unenhanced rating assigned to Iowa Health System's (IHS) \$626 million outstanding bonds issued by the Iowa Finance Authority (see RATED DEBT section of this report). The outlook remains stable.

### RATING RATIONALE

The affirmation of the Aa3 rating and stable outlook are attributable to stable operating and operating cash flow margins with a strengthening of the balance sheet through growth in liquidity for this \$2.2 billion revenue integrated health system that is the largest in the state, operating hospitals in seven markets. Restructuring of the pension plans has reduced future risk with movement away from defined benefit plans. Restructuring of the debt portfolio has reduced risk to changes in interest rates on variable rate bonds, and renewal risk to bank support agreements for bonds under tender features. Capital spending is projected to increase in fiscal year 2011 after slower spending than budgeted in fiscal year 2010, and liquidity is expected to flatten.

### STRENGTHS

- \*Largest health care system in Iowa, owning hospitals in seven markets, resulting in strong geographic diversity, plus affiliations with an additional 12 hospitals in the state; total operating revenues of \$2.2 billion in fiscal year (FY) 2010
- \*Strong market position in key urban markets across Iowa and bordering western Illinois with several leading or near leading market positions providing good contracting leverage with payers
- \*Favorable Moody's-adjusted maximum annual debt service coverage of 5.9 times in FY 2010 below bullet payment on Series 1985B bonds; but 4.18 times with bullet payment that is below Aa3 median of 5.6 times
- \*Consistent cash flow generation with system operating cash flow margins in the 8.9%-10.5% range in each of the past eight years
- \*Sizable 59% growth in absolute liquidity since fiscal yearend (FYE) 2008 improved cash on hand to 215 days at FYE 2010 from 151 days two years prior, with monthly cash of 189 days; cash-to-debt is good at 176%
- \*Operating profitability in all seven acute care markets with operating margins ranging from 1.9% to 5.5% and operating cash flow margins from 8.2% to 12.0%, although physician employment losses continue
- \*Restructuring of defined benefit pension plans has reduced the unfunded pension liability and increased funded status to 96% as of FYE 2010

### CHALLENGES

- \*70% of system operating revenues and 63% of system operating cash flow are derived from three urban markets (Des Moines, Quad Cities, Cedar Rapids) which operate with strong competitive pressures
- \*Capital spending budgeted to increase in FY 2011 following delay in spending in FY 2010, projected to result in flat liquidity but days cash budgeted to remain above 200
- \*Increase in operating leases and slight underfunding of defined benefit pension plan as indirect debt increases debt load by 38% and weakening cash-to-debt to 127% and debt-to-cash flow to 3.64 times

### DETAILED CREDIT DISCUSSION

**LEGAL SECURITY:** The bonds are secured by a joint and several obligation of the Obligated Group. The Obligated Group consists of the majority of the system, including Iowa Health System, Central Iowa Health System, Central Iowa Hospital Corporation d/b/a Iowa Methodist Medical Center and d/b/a Iowa Lutheran Hospital, Central Iowa Health Properties Corporation, St. Luke's Healthcare, St. Luke's Methodist Hospital, Allen Health Systems, Inc., Allen Memorial Hospital Corporation, St. Luke's Health Systems, Inc., Northwest Iowa Hospital Corp. d/b/a St. Luke's Regional Medical Center of Sioux City, St. Luke's Health Resources, Finley Tri-States Health Group, Inc., The Finley Hospital, Trinity Health Systems, Inc., Trinity Regional Medical Center of Fort Dodge, Iowa, Trinity Regional Health System, Trinity Medical Center d/b/a Trinity Medical Center - Rock Island, and d/b/a Trinity Medical Center - Bettendorf, and d/b/a Trinity Medical Center - Moline, in Trust, d/b/a Iowa Health Home Care and Iowa Physicians Clinic Medical Foundation d/b/a Iowa Health Physicians. The Obligated Group makes up over 90% of the system's total assets. Current Obligated Group Members may withdraw from the Obligated Group and other entities may become Obligated Group Members, all in accordance with the provisions of the Master Trust Indenture.

**INTEREST RATE DERIVATIVES:** IHS has entered into seven interest rate swap agreements with three counterparties for hedging purposes on existing debt (Series 2009A-E bonds) for an aggregate notional amount of \$241 million (as of December 31, 2010) and maturing in 2023 through 2035. The notional amount of each swap declines annually with a corresponding decline in principal outstanding, and IHS's obligations under

the swap agreements are secured on parity with bonds issued under the Master Indenture. Two of the swaps are with JPMorgan (\$132.0 million notional), three with Morgan Stanley (\$87.4 million notional), and two with Citi (\$21.4 million notional). Interest paid under these swaps ranges from 3.323% to 3.51%, and IHS receives 62.4% of three month LIBOR plus 0.29% or 62.4% of one month LIBOR plus 0.29%, or 61.9% of one month LIBOR plus 0.31%.

IHS has three additional fixed to variable rate swap agreements that are not direct hedges against debt including one with Morgan Stanley (\$72.4 million notional amount, maturing 2037) and two with Citi (\$138.4 million notional amount, maturing 2035-2037). IHS pays 3.268%-3.75% and receives 61.9% of one month LIBOR plus 0.31% or 62.4% of one month LIBOR plus 0.29%. The total net market value of the swaps as of December 31, 2010 was a liability of \$46.2 million. As of May 31 2010, no collateral posting was required.

#### RECENT DEVELOPMENTS/RESULTS

Iowa Health System has reported three years of consistent operating performance, with operating margins of 2.0% each year and an average operating cash flow margin of 9.0%. Total operating revenues increased \$160 million (7.7%), partly due to same store growth and partly due to a full year's recognition of Trinity Muscatine that was added to the system mid-year 2009. Inpatient admissions increased 4.9% to 97,591 in FY 2010 after a severe decline in FY 2009, but reflect an overall multi-year decline with changes in admitting patterns that have moved prior inpatient cases to outpatient classifications. Nonetheless, inpatient surgeries increased across the two year period (5.7%) as did outpatient surgeries (19.7%). Expense growth was held to 7.9% but changes in the economy and increases in co-pays and deductibles increased bad debt expense by 42% and combined charity care and bad debt grew by 22.5%.

Liquidity grew 59% between FYE 2008 and FYE 2010 with improvement in cash flow generation, capital spending below budget, and favorable investment returns. As a result, cash-on-hand improved to 215 days from 151 days and cash-to-debt improved to 176% from 118% despite growth in debt outstanding. At FYE 2010 liquidity was invested 34% in cash (including money market and governmental funds), 18% in fixed income, 42% in equities and 6% in alternative investments. Monthly liquidity was 189 days cash. Capital spending was below budget in FY 2010 and management is budgeting for increased capital spending in FY 2011, partly to catch up on delayed spending in FY 2010. Correspondingly, management projects flat liquidity.

The debt structure has moved away from variable rate bonds toward fixed rate bonds, and is now at 47% variable rate and 53% fixed rate (based upon total system debt at FYE 2010). Variable rate bonds consist of \$50.0 million of Series 2009F bonds issued in a long-term interest rate mode with a mandatory tender on August 14, 2012, and \$205.2 million of Series 2009A, B, D, and E bonds with tenders supported by letters of credit (LOC) with staggered expirations of March 2012 (\$99.4 million) and September 2014 (\$105.7 million). Series 2009C bonds are Index Rate Mode bonds in a direct placement with Wells Fargo Bank until December 1, 2013. Another \$23.0 million of Series 1985B bonds are supported by a letter of credit that expires January 2014. Management renewed certain LOCs before their stated expiration dates to stagger the new expiration dates and reduce renewal risk. Series 1985B bonds have a bullet payment of \$23.0 million in 2015. MADS with the bullet payment is \$63.5 million, generating Moody's-adjusted MADS coverage of 4.18 times in FY 2010. Without the bullet payment MADS is \$44.8 million, generating Moody's-adjusted MADS coverage of 5.92 times in FY 2010.

On June 9, 2011, IHS and Methodist Health Services Corporation (MHSC), the corporate member of The Methodist Medical Center of Illinois executed a Strategic Affiliation Agreement (Agreement), pursuant to which IHS would become the corporate member of MHSC after receipt of necessary state and federal governmental approvals (including the approval of the Illinois Health Facilities and Services Review Board) and the satisfaction of other closing conditions set forth in the Agreement. The potential impact of such an affiliation has not been factored into this rating action. IHS currently has a presence in Illinois across the state border as part of its Quad Cities market headquartered in Rock Island, Illinois. Through this transaction IHS will expand geographically further into Illinois, with Methodist located 90 miles southeast of Rock Island. Methodist is a \$367 million revenue (FY 2010) single hospital integrated health care delivery system (A2 bonds rating, last report dated May 10, 2011) operating a 329-bed tertiary hospital and a 150 physician group with 37 sites serving 19 counties. In FY 2010 Methodist reported a 1.8% operating margin and 8.9% operating cash flow margin, with over 200 days cash on hand and covering its debt load with 174% cash-to-debt, 2.96 times debt-to-cash flow and 5.6 times Moody's-adjusted MADS coverage.

#### Outlook

The stable outlook reflects our belief that IHS will maintain or improve operating cash flow margins, and maintain or strengthen its financial position and liquidity while supporting future capital plans.

#### WHAT COULD MOVE THE RATING UP

Growth in revenue base and geographic expansion; strengthening of debt metrics; strengthening of market positions in key markets

#### WHAT COULD MOVE THE RATING DOWN

Decline in operating cash flow that weakens debt measures; material increase in debt load; weakening of liquidity; material market share loss in key markets

#### KEY INDICATORS

##### Assumptions & Adjustments:

-Based on financial statements for Iowa Health System and Subsidiaries

-First number reflects audit year ended December 31, 2009

-Second number reflects audit year ended December 31, 2010

-Investment returns normalized at 6%

\*Inpatient admissions: 92,998; 97,591

\*Total operating revenues: \$2.07 billion; \$2.23 billion

\*Moody's-adjusted net revenue available for debt service: \$233.1 million; \$265.3 million

- \*Total debt outstanding: \$703.4 million; \$690.4 million
- \*Maximum annual debt service (MADS) with bullet payment in 2015: \$54.0 million; \$63.5 million
- \*Maximum annual debt service (MADS) with removal of bullet payment: \$43.0 million; \$44.8 million
- \*MADS Coverage with reported investment income (including bullet payment): 6.11 times; 6.05 times
- \*Moody's-adjusted MADS Coverage with normalized investment income (including bullet payment): 4.31 times; 4.18 times
- \*Moody's-adjusted MADS Coverage with normalized investment income (excluding bullet payment): 5.42 times; 5.92 times
- \*Debt-to-cash flow: 3.46 times; 2.97 times
- \*Days cash on hand: 193 days; 215 days
- \*Cash-to-debt: 144%; 176%
- \*Operating margin: 2.0%; 2.0%
- \*Operating cash flow margin: 9.2%; 9.0%

**RATED DEBT (debt outstanding as of May 31, 2011)**

- Series 2009A and B variable rate bonds (\$105.7 million outstanding), rated Aa1/MMIG 1 under joint support structure and reflecting letter of credit with JP Morgan Chase (expiring September 1, 2014) and Aa3 rating of IHS
- Series 2009C variable rate bonds (\$30.4 million outstanding), Aa3 unenhanced rating, Index Interest Rate mode direct placement with Wells Fargo Bank, NA (expiring December 1, 2013)
- Series 2009D and E variable rate bonds (\$99.4 million outstanding), rated Aa1/MMIG 1 under joint support structure and reflecting letter of credit with Bank of America NA (expiring March 2, 2012) and Aa3 rating of IHS
- Series 2009F variable rate bonds (\$50.0 million outstanding), rated Aa3 and currently in a long-term interest rate mode with a mandatory tender August 14, 2012
- Series 2008A fixed rate bonds (\$148.0 million outstanding), rated Aa3, insured by Assured Guaranty
- Series 2005A fixed rate bonds (\$192.5 million outstanding), rated Aa3, insured by Assured Guaranty
- Series 1985B variable rate bonds (\$23.0 million outstanding) supported by a bank letter of credit from Wells Fargo Bank, NA expiring January 24, 2014, rated Aa2/MMIG 1

**CONTACT**

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**PRINCIPAL METHODOLOGY USED**

The principal methodology used in this rating was Not-for-Profit Hospitals and Health Systems published in January 2008.

**REGULATORY DISCLOSURES**

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**Iowa Health Systems and Subsidiaries**

**Audited Financial Statements**

See Appendix C

**IX. 1120.130 - Financial Viability**

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

**Financial Viability Waiver**

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.**

NA Iowa Health System has a current Aa3 bond rating from Moody's Rating Service.

IX.

**1120.130 - Financial Viability**

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)
<b>Enter Historical and/or Projected Years:</b>				
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.**

NA Iowa Health System has a current Aa3 bond rating form Moody's Rating Service.

**X. 1120.140 - Economic Feasibility**

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

**A. Reasonableness of Financing Arrangements**

**NA Iowa Health System has a current Aa3 bond rating from Moody's Rating Service.**

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**

**NA There is 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									
<b>TOTALS</b>									

\* Include the percentage (%) of space for circulation

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE																
Department	A		B		C		D		E		F		G		H	
	Cost/Sq. Foot	Mod.	Gross Sq. Feet	New	Circ*	Mod.	Circ*	Mod.	Circ*	New Const. \$	Mod. \$	Total Costs	(G + H)			
<b>Clinical</b>																
Cardiac Catheterization	\$432.70		7,090							\$ 3,067,850.16		\$ 3,067,850.16				
Phase II Recovery (CTU)	\$372.73		7,850							\$ 2,925,950.67		\$ 2,925,950.67				
Non Invasive Cardiology Testing (NIDT)	\$342.31		3,665							\$ 1,254,581.84		\$ 1,254,581.84				
Cardiac Rehabilitation	\$284.98		4,455							\$ 1,269,602.16		\$ 1,269,602.16				
Emergency Department	\$383.05		18,540							\$ 7,101,748.48		\$ 7,101,748.48				
Diagnostic Imaging																
a. General Radiography	\$400.68		565							\$ 226,384.20		\$ 226,384.20				
b. Computerized Tomography	\$400.68		765							\$ 306,520.20		\$ 306,520.20				
Observation Unit	\$372.73		4,890							\$ 1,822,662.27		\$ 1,822,662.27				
Crisis Stabilization Unit		\$296.00				4,650					\$ 1,376,400.00	\$ 1,376,400.00				
Behavioral Health Group Therapy		\$255.00				2,800					\$ 714,000.00	\$ 714,000.00				
<b>Sub Total Clinical / Average Cost / Sq. Ft.</b>	<b>\$ 375.90</b>	<b>\$280.59</b>	<b>47,820</b>	<b>47,820</b>		<b>7,450</b>				<b>\$ 17,975,299.98</b>	<b>\$ 2,090,400.00</b>	<b>\$ 20,065,699.98</b>				
<b>Clinical Contingency</b>	<b>\$ 37.40</b>	<b>\$41.95</b>	<b>47,820</b>	<b>47,820</b>		<b>7,450</b>				<b>\$ 672,276,219.36</b>	<b>\$ 87,692,280.00</b>	<b>\$ 759,968,499.36</b>				
<b>Clinical Total</b>	<b>\$413.30</b>	<b>\$322.64</b>	<b>47,820</b>	<b>47,820</b>		<b>7</b>				<b>\$ 690,251,519.34</b>	<b>\$ 89,782,680.00</b>	<b>\$ 780,034,199.34</b>				
<b>Non Clinical</b>																
Registration / Intake	\$293.03		540							\$ 158,236.55		\$ 158,236.55				
Public Areas	\$265.52	\$220.00	6,995			615			25	\$ 1,857,293.37	\$ 135,300.00	\$ 1,992,593.37				
Physician Spaces	\$263.78		235							\$ 61,988.54		\$ 61,988.54				
Staff Spaces	\$293.03		3,810							\$ 1,116,446.74		\$ 1,116,446.74				
Administration	\$263.78		2,925							\$ 771,559.43		\$ 771,559.43				
Conference Rooms/ Educational Spaces	\$235.47		1,850							\$ 435,612.62		\$ 435,612.62				
Storage	\$240.41		4,005							\$ 962,834.04		\$ 962,834.04				
Security	\$235.47		315							\$ 74,171.88		\$ 74,171.88				
Decontamination	\$235.47		365							\$ 85,945.19		\$ 85,945.19				
Canopies	\$235.47		3,000							\$ 706,398.84		\$ 706,398.84				
Building Components <sup>1</sup>	\$467.46		15,890							\$ 7,504,939.40		\$ 7,504,939.40				
Ambulance Garage	\$235.47		3,015							\$ 709,930.83		\$ 709,930.83				
<b>Total Non-Clinical / Average Cost / Sq. Ft.</b>	<b>\$336.37</b>	<b>\$ 220.00</b>	<b>42,945</b>	<b>42,945</b>		<b>615</b>			<b>-</b>	<b>\$ 14,445,357.42</b>	<b>\$ 135,300.00</b>	<b>\$ 14,580,657.42</b>				
<b>Non-Clinical Contingency</b>	<b>\$33.47</b>	<b>\$51.04</b>	<b>42,945</b>	<b>42,945</b>		<b>615</b>			<b>-</b>	<b>\$ 483,486,112.85</b>	<b>\$ 6,916,877.00</b>	<b>\$ 490,402,989.85</b>				
<b>Non-Clinical Total</b>	<b>\$369.84</b>	<b>\$271.04</b>	<b>42,945</b>	<b>42,945</b>		<b>615</b>			<b>-</b>	<b>\$ 497,931,470.27</b>	<b>\$ 7,052,177.00</b>	<b>\$ 504,983,647.27</b>				
<b>Totals with Contingency / Average Cost / Sq. Ft.</b>	<b>\$13,090.76</b>	<b>\$12,006.80</b>	<b>90,765</b>	<b>90,765</b>		<b>8,065</b>				<b>\$ 1,188,182,989.62</b>	<b>\$ 96,834,857.00</b>	<b>\$ 1,285,017,846.62</b>				

<sup>1</sup> Includes CUP Upgrades, Mechanical, Information Systems, Data Rooms, etc.

**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.**

**D. Projected Operating Costs Section 1120.140**

Completion of the project detailed in the application is planned for July 31, 2016. Accordingly, the second full fiscal year of operation of the new facility proposed by this project is calendar year 2018.

It is estimated that the direct operating costs in 2018 will be \$38,148,425 or \$387.46 per case as follows:

	Calendar Year 2018
Salaries and Wages	\$ 17,598,549
Benefits	\$ 2,838,919
Supplies	\$ 14,811,829
Other	\$ 2,899,130
Estimated Direct Operating Costs	\$ 38,148,425
Projected Cases	98,458
Estimated Direct Operating Costs per Case	\$ 387.46

**E. Effect of the Project on Capital Costs Section 1120.140**

The estimated total project cost is \$63,221,976 including \$768,820 of capitalized interest. Trinity Medical Center anticipates accessing corporate Iowa Health System cash reserves, Trinity Medical Center cash reserves, and philanthropy to fund this project. The net project costs anticipated to be capitalized at the completion of the project are \$63,221,976 (including \$768,820 of capitalized interest).

It is estimated that this \$63,221,976 net capitalizable cost will result in increased annual capital costs to Trinity Medical Center of approximately \$4,417,000 or \$44.86 per case.

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE																			
Department	A		B		C		D		E		F		G		H		H		
	Cost/Sq. Foot		Gross Sq. Feet		New		Circ*		Mod.		Circ*		New Const. \$		Mod. \$		Total Costs		
	New	Mod.	New	Circ*	New	Circ*	Mod.	Circ*	Mod.	Circ*	(AXC)	(BXE)	(G + H)						
<b>Clinical</b>																			
Cardiac Catheterization	\$432.70		7,090										\$ 3,067,850.16			\$ 3,067,850.16			\$ 3,067,850.16
Phase II Recovery (CTU)	\$372.73		7,850										\$ 2,925,950.67			\$ 2,925,950.67			\$ 2,925,950.67
Non Invasive Cardiology Testing (NIDT)	\$342.31		3,665										\$ 1,254,581.84			\$ 1,254,581.84			\$ 1,254,581.84
Cardiac Rehabilitation	\$284.98		4,455										\$ 1,269,602.16			\$ 1,269,602.16			\$ 1,269,602.16
Emergency Department	\$383.05		18,540										\$ 7,101,748.48			\$ 7,101,748.48			\$ 7,101,748.48
Diagnostic Imaging																			
a. General Radiography	\$400.68		565										\$ 226,384.20			\$ 226,384.20			\$ 226,384.20
b. Computerized Tomography	\$400.68		765										\$ 306,520.20			\$ 306,520.20			\$ 306,520.20
Observation Unit	\$372.73		4,890										\$ 1,822,662.27			\$ 1,822,662.27			\$ 1,822,662.27
Crisis Stabilization Unit		\$296.00				4,650							\$ 1,376,400.00			\$ 1,376,400.00			\$ 1,376,400.00
Behavioral Health Group Therapy		\$255.00				2,800							\$ 714,000.00			\$ 714,000.00			\$ 714,000.00
<b>Sub Total Clinical / Average Cost / Sq. Ft.</b>	<b>\$ 375.90</b>	<b>\$280.59</b>	<b>47,820</b>			<b>7,450</b>							<b>\$ 17,975,299.98</b>			<b>\$ 2,090,400.00</b>			<b>\$ 20,065,699.98</b>
<b>Clinical Contingency</b>	<b>\$ 37.40</b>	<b>\$41.95</b>	<b>47,820</b>			<b>7,450</b>							<b>\$ 672,276,219.36</b>			<b>\$ 87,692,280.00</b>			<b>\$ 759,968,499.36</b>
<b>Clinical Total</b>	<b>\$413.30</b>	<b>\$322.64</b>	<b>47,820</b>			<b>7</b>							<b>\$ 690,251,519.34</b>			<b>\$ 89,782,680.00</b>			<b>\$ 780,034,199.34</b>
<b>Non Clinical</b>																			
Registration / Intake	\$293.03		540										\$ 158,236.55			\$ 158,236.55			\$ 158,236.55
Public Areas	\$265.52	\$220.00	6,995			615				25			\$ 1,857,293.37			\$ 135,300.00			\$ 1,992,593.37
Physician Spaces	\$263.78		235										\$ 61,988.54			\$ 61,988.54			\$ 61,988.54
Staff Spaces	\$293.03		3,810										\$ 1,116,446.74			\$ 1,116,446.74			\$ 1,116,446.74
Administration	\$263.78		2,925										\$ 771,559.43			\$ 771,559.43			\$ 771,559.43
Conference Rooms/ Educational Spaces	\$235.47		1,850										\$ 435,612.62			\$ 435,612.62			\$ 435,612.62
Storage	\$240.41		4,005										\$ 962,834.04			\$ 962,834.04			\$ 962,834.04
Security	\$235.47		315										\$ 74,171.88			\$ 74,171.88			\$ 74,171.88
Decontamination	\$235.47		365										\$ 85,945.19			\$ 85,945.19			\$ 85,945.19
Canopies	\$235.47		3,000										\$ 706,398.84			\$ 706,398.84			\$ 706,398.84
Building Components <sup>1</sup>	\$467.46		15,890										\$ 7,504,939.40			\$ 7,504,939.40			\$ 7,504,939.40
Ambulance Garage	\$235.47		3,015										\$ 709,930.83			\$ 709,930.83			\$ 709,930.83
<b>Total Non-Clinical / Average Cost / Sq. Ft.</b>	<b>\$336.37</b>	<b>\$ 220.00</b>	<b>42,945</b>			<b>615</b>							<b>\$ 14,445,357.42</b>			<b>\$ 135,300.00</b>			<b>\$ 14,580,657.42</b>
<b>Non-Clinical Contingency</b>	<b>\$33.47</b>	<b>\$51.04</b>	<b>42,945</b>			<b>615</b>							<b>\$ 483,486,112.85</b>			<b>\$ 6,916,877.00</b>			<b>\$ 490,402,989.85</b>
<b>Non-Clinical Total</b>	<b>\$369.84</b>	<b>\$271.04</b>	<b>42,945</b>			<b>615</b>							<b>\$ 497,931,470.27</b>			<b>\$ 7,052,177.00</b>			<b>\$ 504,983,647.27</b>
<b>Totals with Contingency / Average Cost / Sq. Ft.</b>	<b>\$13,090.76</b>	<b>\$12,006.80</b>	<b>90,765</b>			<b>8,065</b>							<b>\$ 1,188,182,989.62</b>			<b>\$ 96,834,857.00</b>			<b>\$ 1,285,017,846.62</b>

<sup>1</sup> Includes CUP Upgrades, Mechanical, Information Systems, Data Rooms, etc.

**XI. Safety Net Impact Statement**

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

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

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

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.
2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to 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			
<b>Total</b>			
Charity (cost in dollars)	Year	Year	Year
Inpatient			
Outpatient			
<b>Total</b>			
MEDICAID			
Medicaid (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
<b>Total</b>			
Medicaid (revenue)	Year	Year	Year
Inpatient			
Outpatient			
<b>Total</b>			

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

<b>Safety Net Information per PA 96-0031</b>			
<b>CHARITY CARE</b>			
<b>Charity (# of patients)</b>	<b>FY2009</b>	<b>FY2010</b>	<b>FY2011</b>
Inpatient	1,379	1,124	991
Outpatient	3,422	3,865	3,221
<b>Total</b>	<b>4,801</b>	<b>4,989</b>	<b>4,212</b>
<b>Charity (cost in dollars)</b>			
Inpatient	\$ 4,315,085	\$ 2,852,449	\$ 3,314,103
Outpatient	\$ 3,011,507	\$ 2,251,378	\$ 2,726,058
<b>Total</b>	<b>\$ 7,326,592</b>	<b>\$ 5,103,827</b>	<b>\$ 6,040,162</b>
<b>MEDICAID</b>			
<b>Medicaid (# of patients)</b>	<b>FY2009</b>	<b>FY2010</b>	<b>FY2011</b>
Inpatient	1,545	1,535	1,516
Outpatient	10,415	10,169	10,801
<b>Total</b>	<b>11,960</b>	<b>11,704</b>	<b>12,317</b>
<b>Medicaid (revenue)</b>			
Inpatient	\$ 17,537,339	\$ 18,954,180	\$ 19,282,572
Outpatient	\$ 12,239,344	\$ 14,960,135	\$ 15,861,125
<b>Total</b>	<b>\$ 29,776,683</b>	<b>\$ 33,914,315</b>	<b>\$ 35,143,697</b>

## **Introduction**

Trinity Medical Center (Trinity, Medical Center) has an established history of providing safety net services<sup>1</sup> to its community. Trinity Rock Island and Robert Young Center alone provided \$15.3 million in safety net services, \$5.0 million in unpaid cost of Medicare, and \$4.4 million in bad debt for a total of \$24.7 million.

Trinity funds a variety of vital programs that help the organization live its mission of “improving the health of the people and communities it serves.” These include numerous community collaborations, participation in pilot projects, and targeted outreach as Trinity pursues its goal, “To improve the health of the individual in pursuit of better health for populations.” To accomplish this, Trinity recently partnered with Community Health Care, Genesis Health System, the Quad City Health Initiative, the Rock Island County Health Department, and the Scott County Health Department to perform a comprehensive Community Health Needs Assessment. Professional Research Consultants, Inc. was hired to conduct this work with funding provided by Genesis and Trinity Health Systems. Trinity’s own, Berlinda Tyler-Jamison, VP of Community Impact & Advocacy was on the steering committee. While there were many areas of opportunity identified in this study’s findings, some of the most prevalent health issues in the community were identified as mental health, heart disease, and the accessibility of healthcare services in general. This aligns with what Trinity has been experiencing in terms of increased utilization of Emergency Department services, cardiac services, and behavioral health services. It also confirms that Trinity has been focusing its efforts appropriately to be a safety net in the community.

Trinity provides major support to the Quad City Health Initiative which is a community partnership that exists to address all aspects of our region’s physical, mental, economic, social and environmental health including issues of access, affordability and quality. The Initiative raises awareness of health issues, encourages or creates projects to address gaps in health services and fosters community collaboration in all aspects of health. In response, Trinity has teamed with its community partners to address the needs of particularly vulnerable populations residing in the Western Illinois counties of Rock Island, Henry, Mercer, and Whiteside. These collaborations are listed below by category.

<sup>1</sup>. Includes \$3.8 million unpaid cost of Medicaid

**I. Health Literacy and Access for Racial and Ethnic Minorities**

- a. Quad City Alliance of Immigrants and Refugees
- b. Pola Marus in Floreciente
- c. Bi-State Coalition of Hispanic Organizations
- d. Casa Juanuato
- e. League of United Latin American Citizens (LULAC)

**II. Nutrition and Wellness**

- a. Community Health Food Initiative
- b. Pioneering a Healthy Community

**III. Behavioral Healthcare and Access: Specific Populations**

- a. Eating Disorders Consortium
- b. Veterans Service Consortium
- c. Arrowhead Ranch
- d. Homeless Shelter
- e. QC Hearts and Minds

**IV. Behavioral Healthcare and Access: Medical**

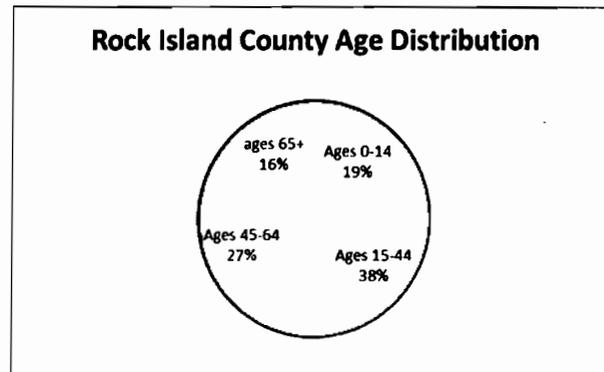
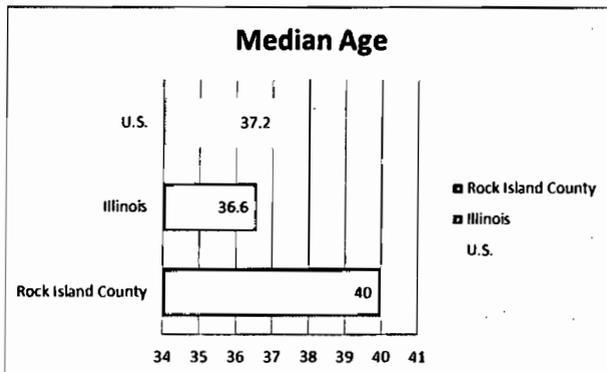
- a. Community Health Care – behavioral health integration with local FQHC
- b. Mercer County Hospital – Emergency Department (tele-psychiatry services)
- c. Hammond Henry Hospital – Emergency Department (tele-psychiatry services)
- d. Area Physician Offices – Behavioral health/primary care integration

**V. Criminal Justice**

- a. Mental Health and Drug Court Planning & Implementation Committee
- b. Rock Island County Jail

Trinity also maintains an excellent working relationship with the Rock Island County Health Department to discuss potentially infectious disease cases and ensure that reporting is both timely and accurate.

Rock Island County's population is aging. With a median age of 40.00 years, Rock Island's median age exceeds that of both Illinois and the U.S. In fact 43 percent of Rock Island's population is age 45 or greater. This aging population is typically comprised of more medically complex patients who tend to have higher utilization rates of Emergency Department and cardiovascular services.



Source: <http://www.usa.com/rock-island-county-il-population-and-races.htm>

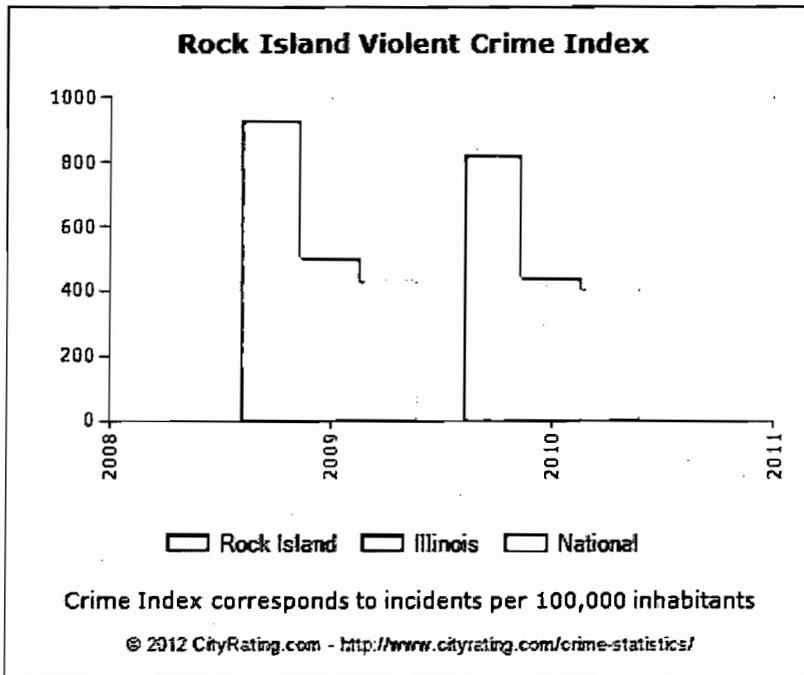
The following examples demonstrate Trinity's commitment to filling healthcare gaps and providing much needed services to the residents of its service area and beyond.

### **Heart Center Services**

Over the last decade Trinity has been recognized for its cardiovascular excellence by many of the nation's leading health care ratings companies such as HealthGrades and Thomson Reuters. Trinity continues to pursue clinical and operational excellence through physician alignment initiatives and strategic partnerships. Trinity is the only Illinois facility with an open-heart program from Rock Island to the Rockford/Peoria area. This represents a minimum distance of 100 miles. Having this service in Rock Island is invaluable for patients who need to go from the cath lab environment to the operating room, as it prevents them from having to travel excessive distances at a time when a delay in care can result in compromised outcomes. Trinity also provides cardiac rehabilitation services to keep patients on their journey back to health.

### **Trauma Services**

Trinity Medical Center is a Level II Trauma Center for Region 2 in the State of Illinois, as well as a designated Emergency Department Approved for Pediatrics (EDAP) and a Joint Commission certified Primary Stroke Center. Having this level of care immediately available in the Rock Island community is vital as the next closest Illinois facility with a higher level of care is 100 miles away. This is particularly important in light of Rock Island County's high incidence of violent crime. Trinity is not only receiving the injured victims of these crimes but also must manage with the multitude of people that converge on-site when these victims arrive. With consistently demonstrated gang activity in the area, the architectural solutions proposed in this project will greatly enhance staff and patient safety.



Trinity Medical Center is a designated Resource Hospital within Illinois Region II Emergency Medical Services (EMS) and continues to provide education and training for pre-hospital care providers. As rural ambulances struggle to maintain their voluntary services, Trinity has been instrumental in offering ongoing education that allows new volunteers to supplement workforces who are challenged with education costs and availability to attend courses outside their immediate response boundaries. Dr. Barr who serves as Trinity's EMS Medical Director has worked to update the EMS standing medical orders that are used by over 30 ambulances in our system. These updated protocols include protocols for post resuscitation induced hypothermia, use of the Cincinnati stroke scale to initiate Stroke Alerts, and performance of 12 lead EKGs in the field. Having EMS providers coordinate care that complements what is being done in the ED has allowed for better patient outcomes.

Trinity Ambulance Service supports the emergent healthcare needs of the community by offering 24-hour Paramedic Level ambulance coverage for southern Rock Island County, as well as parts of Mercer and Henry counties. It also provides Paramedic Assist for Basic Life Support ambulances in these areas. With many rural and volunteer fire departments in the region, it is not uncommon for a Trinity Ambulance to intercept these ambulances en route and provide Advanced Life Support. The Ambulance Service also supports community events by providing coverage.

At Trinity, patients seeking emergency care are treated by board certified emergency physicians who believe quality emergency care is a fundamental right and that unobstructed access to emergency services should be available to all patients who perceive the need for emergency services. At Trinity Rock Island, the Emergency Department's payer mix is comprised of 30 percent Medicare, 29 percent Medicaid, 15 percent self-pay, 1 percent work comp, and just 25 percent commercially insured. With 1 in 5 children in Rock Island County living in poverty at one end of the spectrum, and its aging population on the opposite end, Trinity's Emergency Department acts as the safety net that its residents need.

Trinity's Emergency Services commitment to the community is further demonstrated by its care of victims of sexual assault. Since 2005 Trinity has been able to offer sexual assault trained nurses to respond 24 hours a day, seven days a week to care for any patient who presents with a complaint of alleged sexual assault. Trinity recognizes the need to have trained staff available to provide services for these victims. Our nurses work in collaboration with local law enforcement, the state's attorney's office, and the children's advocacy center, leading to a higher reporting and conviction rate in Rock Island County. Today most national, state, and institutional protocols recommend that evidentiary exams be completed within 72 hours after a sexual assault. Having nurses trained and committed to do this work is a great asset to our community, patients, and entities involved prosecuting these cases.

### **Mental Health**

Robert Young Center for Community Mental Health provides a full continuum of behavioral health services for the greater Quad Cities region and specifically for the catchment area of Rock Island and Mercer Counties in Illinois. The service continuum includes the Access Center which serves as a central intake site for behavioral health services. The Access Center also provides a 24/7 psychiatric crisis response system that functions as the primary provider of psychiatric crisis service in the Illinois Quad Cities including regional coverage for area hospital emergency departments through a mobile crisis team and the use of telepsychiatry. The need for such continues to grow as funding is challenged and facilities like Singer Mental Health Hospital close. The continuum also includes a full range of outpatient behavioral health services for mental health and substance abuse for adult and children. Outpatient behavioral health services are also integrated into primary care practices including the local Federally Qualified Health Center. The Community Support Program provides community-based services for the severe and

persistent mentally ill. Programming is focused on maintaining individuals in the community and reducing utilization of higher cost more restrictive inpatient utilization. Additionally, Robert Young inpatient behavioral health services include 54 licensed beds serving adults, adolescents and children.

### **Health Outreach and Wellness**

In addition to providing free or subsidized care in accordance with Trinity's financial assistance policy, the hospital also offers programs and services that respond to the community's unique healthcare needs. Trinity sponsors outreach efforts including health and disease prevention programs such as health fairs, assessments, and free or low-cost screenings. Trinity also provides corporate sponsorship to many health-related events to raise awareness and funds. For instance, Trinity partners with the American Cancer Society through its Daffodil Days, Look Good/Feel Better, Smoke Free-That's Me, Relay for Life, and Patient Navigator programs. Trinity also provides space on-site for Gilda's Club and various cancer-related support groups. Trinity is also a major supporter of the American Heart Association's Annual Heart Walk and Go Red campaign. In 2011, Trinity was the Heart Walk's presenting sponsor and raised \$28,000 through employee giving, earning it the top fundraising company title for 2 years running. In 2012, Trinity was the presenting sponsor for a "Go Red for Women" luncheon and raised over \$100,000 for the American Heart Association.

Trinity also offers free, online risk assessment through 13 different modules in its HealthAware program. These modules include HeartAware, StrokeAware, VascularAware, WeightAware, DiabetesAware, CancerAware Colon, CancerAware Prostate, CancerAware Lung, CancerAware Breast, Joint Aware, SpineAware, SleepAware, and LungAware. If participants are found at risk for something, they are offered additional assessment or referral at no cost. In 2011, 8935 patients took advantage of the free online assessment and 2059 accepted Trinity's offer for additional follow up.

Trinity's Parish Nurse Program works within a faith community under the direction of a pastor to support community health through an array of activities such as blood pressure checks, flu shot clinics, screenings, support groups, health fairs, etc. By seeing patients in their communities, Trinity is better able to reach at-risk patient populations. Trinity currently has parish nurses in 31 Illinois parishes.

To effectively meet the needs of Rock Island's aging population, Trinity has developed some programs to ensure these patients are getting the right care, at the right time, and in the right setting. For instance, Trinity offers welcome home visits to any discharged patient that would benefit from a home nursing visit after an acute stay. This visit ensures the patient understands his or her discharge plan and medications. Trinity also provides in-home telehealth services for 30 days post discharge for those patients who may need a daily touch point by a healthcare professional. Trinity also has an Emergency Medication Program which provides a voucher for 30 days of medication (at no cost) to those patients who meet criteria. An additional resource available to any Trinity patient aged 60 or over is the Area on Aging's in-house staff. These individuals consult with any patient who has self-care concerns or worries about transitioning to a different healthcare or home setting. They can link these patients to resources they may otherwise not know about or be able to receive. Trinity has also launched a palliative care program to make sure patients are receiving symptom management in accordance with their needs, wants, and wishes. This has been having a profound impact on bringing families together to have the difficult conversations that are most important to the patient and his or her healthcare team.

### **Medical Education and Training**

Trinity is committed to providing programs to recruit, educate, and train healthcare professionals as it is widely recognized that the demand is growing amidst an aging population.

Trinity pursues this matter through a variety of avenues. The first is through Trinity's College of Nursing and Health Sciences which prepares competent healthcare practitioners in the fields of nursing, radiography, and respiratory care. The second is through a collaborative between the Medical Center and the College called the Health Occupations Academy. This is an in-depth exploration of health care careers and employment expectations to assist high school students in healthcare-related career development decisions. Clinical rotations throughout the medical center and community health care environments provide the students with a wide range of health care career experiences.

Trinity also has a Family Practice Residency Program which is a resident-driven clinic with primary emphasis on teaching. At the residency clinic, residents provide care to patients from birth to geriatrics, including wellness checks, school and sports physicals, continuity of care for

chronic illnesses, treatment of acute illnesses, minor surgeries and osteopathic manipulative treatment.

### **Health Education**

Trinity offers various seminars and educational lectures to both the public and other healthcare professionals. In-service speaking engagements are available upon request.

Trinity also maintains a medical library to assist anyone seeking to obtain medical information. Consumers can ask the full time librarian for assistance in locating recent articles and publications on their health care topic. The library is a member of many consortiums and organizations providing access to many other collections across the country.

### **Research**

Trinity has been involved in Cardiac Research since 2001, working with all of its credentialed/on-staff cardiologists as well as some of its endovascular physicians. Cardiac research is involved in different phases of clinical research protocols/studies (Phase 1b – Phase 4); in multi-center, nationwide or global research studies in pharmaceuticals (investigational and FDA approved drugs) and devices (pacemakers, ICD, BiV ICD) and also post-market registries. The objective of the program is for Trinity Medical Center to be part of a dynamic evidence-based community and to be able to contribute to that endeavor. Another prime objective is to be able to help participants (patients/community) who qualify for these studies in some way, whether it is via free prescription drugs, free laboratory tests, or free medical exams while they are part of a research study.

Similarly, the local oncologists recognize the importance of research in finding new and better treatments for cancer and are committed to participation in clinical trials. In 1988, a relationship with the physician practice of Cedar Rapids Oncology Program was developed to create a strong clinical research department and to create a CCOP. The CCOP designation created an alliance with the North Central Cancer Treatment Group at the Mayo Clinic in Rochester, giving Trinity direct access to research protocols and clinical staff. This is a coveted and prestigious designation given to only 52 community-based centers in the nation. The cancer research department has approximately 50 open NCI sponsored studies for patient accrual and maintains an annual accrual rate of 2 percent of the cancer registry population. The cancer research staff is

currently following 90 active patients on clinical trials. The research department also participates in cancer prevention and symptom control studies as well.

In all, 8.7 percent of Trinity Regional Health System's total expenses were for community benefit. This represents \$56,952,215. In Illinois alone, this figure was \$36,520,088, and in Rock Island specifically, it was \$24,759,731. Trinity is acutely aware of the region's aging population and declining cardiovascular health, as well as the ongoing changes in the mental health delivery system and the anticipated growth in emergency department utilization, especially with health reform. It is Trinity's intent to invest in new construction and modernization of its facilities to meet the community's needs and expectations as a safety net provider now and into the future.

**XII. Charity Care Information**

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

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

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

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

CHARITY CARE			
	Year	Year	Year
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

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

The Iowa Health System Financial Assistance Policy is included as Attachment 44, Exhibit 1.

The Robert Young Center Financial Assistance Policy is included as Attachment 44, Exhibit 2.

CHARITY CARE			
	FY2009	FY2010	FY2011
Net Patient Revenue	\$ 159,647,666	\$ 175,738,076	\$ 176,831,076
Amount of Charity Care (charges)	\$ 16,354,000	\$ 13,417,000	\$ 16,632,000
Cost of Charity Care	\$ 7,326,592	\$ 5,103,827	\$ 6,040,162



**Title: Financial Assistance**

**1.BR.34**

Effective Date: 9/9/05; Rev: 4/07, 12/07, 10/10, 8/11, 2/12

**POLICY:** IHS affiliates shall fulfill their charitable missions by providing health care services to all individuals without regard to their ability to pay. IHS affiliates shall provide fair discounts and financial protection to low income underinsured or uninsured patients. IHS affiliates shall use consistent and fair collection practices for all patients.

**SCOPE:** IHS system wide. All IHS and wholly owned affiliate facilities including, but not limited to, hospitals and ambulatory surgery centers.

**PROCEDURE:** IHS affiliates are committed to meeting the needs of everyone in their communities, including those who cannot pay for their care. Similarly, patients who are able to pay have an obligation to pay and providers have a duty to seek payment from these individuals.

1. Financial Assistance Guidelines. Financial assistance will be available for only medically necessary health care services provided to persons who meet the financial and documentation criteria defined in this policy. Certain substance abuse and mental health programs reserve the right to offer different discounts as determined appropriate by the facility. Discounts shall be based on the following guidelines:

*Hospital Patients, Physician Clinic Patients and Home Health Patients*

- 1.1 Full charity care shall be provided to underinsured and uninsured patients earning 200% or less of the Federal Poverty Income Guideline (FPIG).
- 1.2 For financially needy underinsured or uninsured patients earning between 201% and 400% of the FPIG, discounts shall be provided to limit such patient's payment obligation to the amount of the patient account balance after subtracting the percentage discount applicable to the patient's FPIG Household Income provided in the following table.

Discount	Current Year's Federal Poverty Income Guidelines for Family Size
100%	Family income is less than or equal to 200% of FPIG
80%	Family income is 201% to 225% of FPIG

60%	Family income is <b>226%</b> to <b>250%</b> of FPIG
40%	Family income is <b>251%</b> to <b>300%</b> of FPIG
20%	Family income is <b>301%</b> to <b>400%</b> of FPIG
0%	Family income is <u>greater than</u> <b>400%</b> of FPIG

An individual who is presumed eligible under these criteria will continue to remain eligible for six months following the date of the initial approval, unless facility personnel have reason to believe the patient no longer meets the criteria.

- 1.3 Iowa Health System reserves the right to limit eligibility to a shorter period and/or may require periodic reviews to confirm continuing eligibility.
- 1.4 Iowa Health System reserves the right, on a case-by-case basis and at the discretion of the affiliate CFO or CFO designee, to extend eligibility for financial assistance to patients whose Household Income exceeds 400% of the FPIG.
- 1.5 **Presumptive Eligibility.** Patients who qualify and are receiving benefits from the following programs may be presumed eligible for 100% financial assistance:
- 1.5.1 The U.S. Department of Agriculture Food and Nutrition Service *Food Stamp Program*.
- 1.5.2 *Family Investment Program*, under Iowa Code Chapter 239B.
- 1.5.3 Limited eligibility - illegal undocumented persons 3-day emergency window. The Iowa Department of Human Services allows for up to three days of Medicaid benefits to pay for the cost of emergency services for undocumented persons who do not meet citizenship, alien status, or social security number requirements. The emergency services must be provided in a facility such as a hospital, clinic, or office that can provide the required care after the emergency medical condition has occurred. Presumptive eligibility for this category will be considered valid 6 months from the date of the emergent event.
- 1.5.4 County and state relief programs. Some Iowa counties offer a financial assistance program designed to provide emergency short term assistance to persons lacking the resources to meet their basic needs for food, shelter, fuel, utilities, clothing, medical, dental, hospital care and burial. The state also offers programs providing energy assistance to applicants who qualify (i.e., LIHEAP State of Iowa Energy

Assistance). Accepted programs also include WIC nutrition assistance.

1.5.5 *Barnabas Uplift, Mission Health* program. Barnabas Uplift assists local, faith and community-based organizations in building individual, family and community self-sufficiency; its Mission Health program provides affordable health care. Eligibility under Mission Health may be limited to the approval term determined by Mission Health if the patient doesn't choose to apply with Iowa Health system.

1.5.6 Other programs may be added at the discretion of the facility.

Patients who meet presumptive eligibility criteria under this Section 1.5 may be granted financial assistance without completing the financial assistance application. Documentation supporting the patient's qualification for or participation in a program must be obtained and kept on file. Documentation may include a copy of a government issued card or other documentation listing eligibility or qualification, or print screen of web page listing the patient's eligibility. Unless otherwise noted, an individual who is presumed eligible under these presumptive criteria will continue to remain eligible for six months following the date of the initial approval, unless facility personnel have reason to believe the patient no longer meets the presumptive criteria.

- 1.6 The Federal Poverty Income Guidelines will be updated annually from updates published by the United States Department of Health and Human Services.
- 1.7 This policy can be applicable to patient deductibles. It is not applicable to discounts provided under Policy 1.BR.33, Discounts for Uninsured Patients.
- 1.8 In determining whether a patient meets the eligibility criteria for financial assistance, the affiliate will consider the extent to which the patient's household has assets other than income that could be used to meet his or her financial obligation. The affiliate will also take into account any liabilities that are the responsibility of the patient's household.

Unlike income, assets and liabilities have a lot of variability. Assets will include such things as cash, savings and checking accounts, certificates of deposit, stocks and bonds, individual retirement accounts (IRAs), trust funds, real estate and motor vehicles. This list is not intended to be inclusive.

- 1.9 Household income will be considered in determining whether a patient is eligible for assistance. Household income includes but is not limited to the following: traditional married couples, children (biological, step, or adoption) and couples living together. (Married or couples living together requires that

the parties present as a couple and share expenses, whether same sex or male/female.)

1.10 Waivers or discounts of Medicare or Medicaid copays or deductibles may be granted based on financial need as provided in Section 3 of this policy.

1.11 Medical Indigency. Financial assistance may be provided to patients who are determined to be medically indigent. "Medically indigent" means patients who are unable to pay some or all of their medical bills because their medical bills exceed a certain percentage of their family or household income or assets (for example, due to catastrophic costs or conditions), even though they have income or assets that otherwise exceed the generally applicable eligibility requirements for free or discounted care under the IHS guidelines.

1.11.1 The patient shall apply for financial assistance in accordance with this policy. The patient shall supply documentation to support his/her medically indigent status. Examples of documentation that may be used include but are not limited to, copies of patient medical bills, information related to patient's drug costs, or other evidence of healthcare costs for which the patient is responsible.

1.11.2 In most cases, the patient shall be expected to pay a portion of the medical bill.

## 2. Hospital Patient Financial Assistance Calculation.

2.1 Amounts charged for hospital emergency or other medically necessary hospital care that is provided to individuals eligible for assistance under this policy may not be more than the amounts generally billed to individuals who have insurance covering such care. Amounts billed to those who qualify for financial assistance may be based on either the best, or an average of the three best, negotiated commercial rates, or Medicare rates. Hospitals may not use gross charges to calculate such amounts.

2.1.1 The following method should be used to calculate "amounts generally billed to individuals who have insurance" in 2.1 above. A hospital must first establish a collection rate per contract based on historical negotiated commercial rates (for example, 70% of billed charges) based upon the past three years (for example, 69%, 70%, 71% = 70%).

For underinsured patients, the total billed charges will be reduced by the applicable rate (for example, under the scenario above, an underinsured patient's responsibility should be equal to or less than 70% of total billed charges).

For uninsured patients who qualify for financial assistance, the total billed charges will be reduced by the applicable discount (30% in the example above) prior to application of any financial assistance to such bill.

3. Discounts for Government Sponsored Program Patients (Medicare or Medicaid).
  - 3.1 IHS affiliates may waive or reduce Medicare or Medicaid coinsurance or deductibles only based on financial need if the following requirements are met:
    - 3.1.1 The waiver or discount is not advertised. (It is proper to advise patients on an individual basis that waivers of copays or deductibles in the event of financial need are possible and the patient may apply for such benefits at the time or immediately before treatment is provided.).
    - 3.1.2 The discount is not routinely offered, but only to those patients in financial need who wish to apply.
    - 3.1.3 The waiver or discount satisfies one of the following:
      - 3.1.3.1 The waiver or discount is made following an individualized good faith assessment of financial need;
      - 3.1.3.2 The waiver or discount is made after reasonable efforts have failed to collect the copayment, deductibles or full payment directly from the patient; or
      - 3.1.3.3 The waiver or discount is in settlement of a disputed claim resulting from services provided to the beneficiary.
  - 3.2 Written records documenting the reasons for each waiver or discount shall be considered cost report supporting documents and therefore shall be retained as such in accordance with Policy 1.AD.03, Record Retention.
4. Communicating Availability of Charity Care and Financial Assistance.
  - 4.1 Affiliate Responsibilities. Each affiliate will have a means of widely communicating the availability of charity care and financial assistance to all patients and within the community served by the affiliate. Examples of mechanisms that the provider may use to do this include:
    - 4.1.1 Placing signage, information, or brochures in appropriate areas of the provider (e.g., the emergency department, and registration and check-out/cashier areas) stating that the provider/physician practice offers

charity care and describing how to obtain more information about financial assistance.

- 4.1.2 Placing a note on the health care bill and statements regarding how to request information about financial assistance.
  - 4.1.3 Placing a notice on the opening page of the website of hospital providers.
  - 4.1.4 Placing a notice which summarizes the hospital's policy concerning charity care and financial assistance in a media outlet of general circulation in the community at least two times/year.
  - 4.1.5 Designating departments or individuals who can explain the provider's charity care policy.
  - 4.1.6 Staff who interact with patients will be instructed to direct questions regarding the charity care policy to the proper provider representative.
- 4.2 After receiving the patient's request for financial assistance and any financial information or other documentation needed to determine eligibility for financial assistance, the patient will be notified of the patient's eligibility determination within a reasonable period of time.
5. Patient Responsibilities Regarding Financial Assistance. If applicable, prior to being considered for financial assistance, the patient/family must cooperate with the provider to furnish information and documentation to apply for other existing financial resources that may be available to pay for the patient's health care, such as Medicaid, Medicare, third party liability, etc. Patients with valid health care coverage through non-IHS network providers may be required to access their primary network before being considered for financial assistance.
- 5.1 To be considered for charity care or financial assistance the patient/family must furnish the provider with a completed application provided by the provider or, if requested, documentation to support the presumptive eligibility criteria described in Section 1.3.
  - 5.2 In the event the patient does not initially qualify for charity care or financial assistance after providing the requested information and documentation, the patient may re-apply if there is a change in their income, assets, or family responsibilities.
  - 5.3 A patient who qualifies for partial discounts must cooperate with the provider to establish a reasonable payment plan that takes into account available income and assets, the amount of the discounted bill(s), and any prior payments.

- 5.4 Patients who qualify for partial discounts must make a good faith effort to honor the payment plans for their discounted health care bills. They are responsible for communicating to the provider any change in their financial situation that may impact their ability to pay their discounted health care bills or to honor the provisions of their payment plans.
6. Collection Guidelines. Affiliates' collection efforts shall not include wage garnishments or other legal process seizures without the prior approval of the Central Billing Office, the affiliate CFO or Compliance Officer. Personal property (other than cash or cash equivalents) attachment or seizure will not occur. The entry of a judgment automatically attaches to real estate; however, no seizure of the patient's primary residence will occur.

*/s/ William B. Leaver*

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William B. Leaver  
IHS President

For Education Department Use Only			
<b>Trinity Medical Center</b>		PAGE 1 of 2	Revised/Reviewed Date
POLICY: <b>Financial Assistance Policy – RYC</b>		POLICY #: R50000.074 (770)	2-21-11, 7-29-11, 4-28-12
Accreditation Standards:		EFFECTIVE DATE: 4-1-10	
<b>TJC: LD.04.01.07</b>	<b>CMS CoP TAG: A None</b>	RESPONSIBLE PARTY: RYC-Administration	SUBMIT/RETIRED BY (most recent submission only): Diana Zogg – s42812
DEPT(s): RYC-Administration		APPROVED BY: Diana Zogg/Director, Administrative Support Services	
MANUAL: RYC-Administration			RELATED POLICY: Reviewed Policy

**PURPOSE:**

To assure that individuals requesting mental health or substance abuse services at the Robert Young Center (RYC) are able to access care regardless of their ability to pay, financial assistance may be provided subject to the availability of State and Local funds to subsidize this care.

**POLICY:**

The RYC is committed to meeting the needs of clients, including those who cannot pay for their care. Similarly, clients who are able to pay have an obligation to pay and the RYC has a duty to seek payment from those individuals. Clients in need of financial assistance or reduced fee based on their documented ability to pay for care shall have access to such care upon the completion of a financial application. The RYC shall provide fair discounts and financial assistance to low income underinsured or uninsured clients. The RYC shall use consistent and fair collection practices for all clients.

**PROCEDURE:**

- I. Charity care and financial assistance discounts may be available only for medically necessary mental health or substance abuse services provided to clients who meet the financial and documentation criteria defined in this policy. Discounts and co-pays will be based on the following guidelines.
- II. For financially needy underinsured or uninsured clients earning up to 400% of the Federal Poverty Income Guidelines (FPIG), discounts may be provided.
- III. Clients exceeding 400% of the FPIG percentage will be charged full fee.
- IV. Financial assistance for Outpatient or Community Support Program (CSP) services for the Severe and Persistent Mentally ill (SPMI) will only be offered to clients residing in Rock Island or Mercer Counties.
- V. Financial assistance for Chemical Dependency Residential Rehabilitation services will only be offered to clients residing in Illinois.
- VI. The Federal Poverty Income Guidelines will be updated annually from updates published by the United States Department of Health and Human Services.

- VII. In determining whether a client meets eligibility criteria for financial assistance, RYC may consider the extent to which the client has assets other than income that could be used to meet the financial obligation. The RYC may also take into account any liabilities that are the responsibility of the client.
- VIII. A client's annual household income is the total of the gross income(s) for all members of the client's household as shown on the IRS Form 1040 for all household members or obtained from relevant Social Security records, paychecks, or other reliable documentation from which annual household income can reasonably be determined.
- VIX. New clients will be required to complete a Financial Assistance Application and to provide supporting documentation prior to scheduling their first appointment. (This does not apply to those clients seeking crisis services). A financial representative will be available to assist in completion of the application. The amount of the co-payment will be calculated based on financial and medical necessity. The client's eligibility will be communicated to the client within a reasonable period of time. Appointments will be scheduled at that time.
- X. It is expected that any co-payments will be paid at the time of service. If payment is not made at the time of service, additional appointments will not be scheduled until the co-payments have been paid. Any scheduled appointments or groups may be cancelled until payment is made.
- XI. Financial Assistance Applications are effective for twelve (12) months and will require re-application to confirm continuing eligibility.
- XII. Financial Assistance Applications and supporting documentation will be scanned into the client's electronic health record.
- XIII. In the event the client does not initially qualify for charity care or financial assistance after providing the requested information and documentation, the client may re-apply if there is a change in their income, assets, or family responsibilities.
- XIV. Court ordered services will not be eligible for financial assistance.
- XV. Clients are expected to pay their fees at the time of service. If they do not, and payment is not made, the RYC reserves the right to turn their account over to a collection agent.
- XVI. If the Client uses other IHS services, additional requirements may apply.

Reference:

DHS/DMH Provider Manual FY 2011 (9/30/10)  
RYC Fee Schedule for Persons without Medicaid

R50000.074 (770)

Appendix A	Site Ownership documentation
Appendix B	Cath Staffing
Appendix C	Audited Financial Statements

Appendix A

Site Ownership Documentation

# Rock Island County Abstract & Title Guaranty Co.

Representative For  
Lawyers Title Insurance Corporation  
and  
First American Title Insurance Company  
Title Insurance - Abstracts - Escrow Service

211 - 18th Street, Suite 300  
Rock Island, Illinois 61201

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Phone (309) 786-5476  
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P.O. Box 3308  
Rock Island, Illinois 61204-3308

Snyder, Park & Nelson, P.C.  
Attn: Dee A. Runnels  
1600 - 4th Avenue, Ste 200  
P O Box 3700  
Rock Island, IL 61204-3700  
Ph.: 309-786-8497  
Fx.: 309-786-0463

Date: April 14, 2008  
FED ID # 36-169-4210

## INVOICE

File No. F88-110-L

RE: TRINITY WEST CAMPUS

<u>Date</u>	<u>Services Description</u>	<u>Amount</u>
April 11, 2008	Owners & Lenders Title Insurance - Commitment Fee	\$250.00
	Additional Tract Searches (2 @ 100.00 each)	\$200.00
	Owner's Policy Premium (liability: \$TBD)	\$TBD

*Note: Billing does not include escrows, future updates, endorsement(s), additional policies, premlums, recording fees, document copies, document preparation, overnight deliveries, closing fees nor revenue stamps...as may be applicable.*

TOTAL \$450.00

Description: Commitment and Invoice to above VIA EMAIL

TRACT 1 - CON - SRI 5014-1  
TRACT 2 - HELIPAD - SRI 251  
TRACT 3 - WEST CAMPUS - SRI 252

TO:  
Snyder, Park & Nelson, P.C.  
Attn: Dee A. Runnels  
1600 - 4th Avenue, Ste 200  
P O Box 3700  
Rock Island, IL 61204-3700  
Ph.: 309-786-8497  
Fx.: 309-786-0463



COMMITMENT FOR TITLE INSURANCE

ISSUED BY

*First American Title Insurance Company*

AGREEMENT TO ISSUE POLICY

We agree to issue a policy to you according to the terms of this Commitment. When we show the policy amount and your name as the proposed insured in Schedule A, this Commitment becomes effective as of the Commitment Date shown in Schedule A.

If the Requirements shown in this Commitment have not been met within six months after the Commitment Date, our obligation under this Commitment will end. Also, our obligation under this Commitment will end when the Policy is issued and then our obligation to you will be under the Policy.

Our obligation under this Commitment is limited by the following:

- The Provisions in Schedule A.
  - The Exceptions in Schedule B.
  - The Conditions, Requirements and Standard Exceptions
- On the other side of this page.

The Commitment is not valid without Schedule A and Schedule B.



*First American Title Insurance Company*

BY *Parker S. Kennedy* PRESIDENT

ATTEST *Maureen A. Arneson* SECRETARY

BY *[Signature]* COUNTERSIGNED

! UNDERWRITER - FIRST AMERICAN TITLE INSURANCE COMPANY !  
! Issuing Agency: Rock Island County Abstract & Title Guaranty Company, 211 - 18<sup>th</sup> Street, Suite 306, Rock Island, Illinois 61201 Phone: 309-786-5476 !

## CONDITIONS

1. **DEFINITIONS**  
(a) "Mortgage" means mortgage, deed of trust or other security instrument. (b) "Public Record" means title records that give constructive notice of matters affecting the title according to the state law where the land is located.
2. **LATER DEFECTS**  
The Exceptions in Schedule B may be amended to show any defects, liens or encumbrances that appear for the first time in the public records or are created or attached between the Commitment Date and the date on which all of the Requirements (a) and (c) shown below are met. We shall have no liability to you because of this amendment.
3. **EXISTING DEFECTS**  
If any defects, liens or encumbrances existing at Commitment Date are not shown in Schedule B, we may amend schedule B to show them. If we do amend Schedule B to show these defects, liens or encumbrances, we shall be liable to you according to Paragraph 4 below unless you knew of this information and did not tell us about it in writing.
4. **LIMITATION OF OUR LIABILITY**  
Our only obligation is to issue to you the Policy referred to in this Commitment, when you have met its Requirements. If we have any liability to you for any loss you incur because of an error in this Commitment, our liability will be limited to you actual loss caused by your relying on this Commitment when you acted in good faith to:  

comply with the Requirements shown below  
or  
eliminate with our written consent any Exceptions shown  
in Schedule B or the Standard Exceptions noted below.

We shall not be liable for more than the Policy Amount shown in Schedule A of this Commitment and our liability is subject to the terms of the Policy form to be issued to you.
5. **CLAIMS MUST BE BASED ON THIS COMMITMENT**  
Any claim, whether or not based on negligence, which you may have against us concerning the title to the land must be based on this Commitment and is subject to its terms.

## REQUIREMENTS

The following requirements must be met:

- (a) Pay the agreed amounts for the interest in the land and/or the mortgage to be insured.
- (b) Pay us the premiums, fees and charges for the policy.
- (c) Documents satisfactory to us creating the interest in the land and/or the mortgage to be insured must be signed, delivered and recorded.
- (d) You must tell us in writing the name of anyone not referred to in this Commitment who will get an interest in the land or who will make a loan on the land. We may then make additional requirements or exceptions.
- (e) Proper documentation to dispose of such exceptions as you wish deleted from Schedule B or the Standard Exceptions noted below.

## STANDARD EXCEPTIONS

The following Standard Exceptions will be shown on your policy:

- (1) Rights or claims of parties in possession not shown by the public records.
- (2) Easements, or claims of easements, not shown by the public records.
- (3) Encroachments, overlaps, boundary line disputes, or other matters which would be disclosed by an accurate survey or inspection of the premises.
- (4) Any Lien, or right to a lien, for services, labor, or material heretofore or hereafter furnished, imposed by law and not shown by the public records.
- (5) Taxes, or special assessments which are not shown as existing liens by the public records.

! UNDERWRITER - FIRST AMERICAN TITLE INSURANCE COMPANY !  
! Issuing Agency: Rock Island County Abstract & Title Guaranty Company, 211 - 18<sup>th</sup> Street, Suite 300, Rock Island, Illinois 61201 Phone: 309-786-5476 !

SCHEDULE A

COMMITMENT NO. F88-110-L

1. Commitment Date: **April 2, 2008 at 8:00 a.m.**

2. Policy (or policies) to be issued:

(a) ALTA Owner's Policy  
Proposed Insured:

Policy Amount **\$TDB**

**TBD**

(b) ALTA Loan Policy  
Proposed Insured:

Policy Amount **\$TDB**

**TBD**

3. The estate or interest in the land described or referred to in this Commitment and covered herein is a fee simple and title thereto is at the effective date hereof vested in:

**Trinity Medical Center**

4. The land referred to in this Commitment is described as follows:

**See Schedule A, No. 4 - continued, attached.**

**! UNDERWRITER - FIRST AMERICAN TITLE INSURANCE COMPANY !**

**! Issuing Agency: Rock Island County Abstract & Title Guaranty Company, 211 - 18<sup>th</sup> Street, Suite 300, Rock Island, Illinois 61201 Phone: 309-786-5476 !**

**Schedule A - continued**  
**File No. : F88-110-L**

**4. TRACT 1**

All of Lot 3 in Bailey Addition to the City of Rock Island, Illinois, EXCEPTING the following Tract, more particularly described as follows:  
Commencing at the Northwest corner of said Lot 3, said point being the point of beginning;  
Thence South 89 degrees 42 minutes 20 seconds East along the North line of said Lot 3, a distance of 33.55 feet;  
Thence South 0 degrees 32 minutes 00 seconds West, a distance of 352.25 feet to the South line of said Lot 3;  
Thence North 89 degrees 59 minutes 08 seconds West along said South line, a distance of 6.48 feet to the Southwest corner of said Lot 3;  
Thence North 0 degrees 02 minutes 56 seconds East along the West line of said Lot 3, a distance of 271.81 feet;  
Thence North 16 degrees 35 minutes 44 seconds West along said West line, a distance of 84.10 feet to the point of beginning;

situated in the County of Rock Island and State of Illinois.

**TRACT 2**

Beginning at the Northeast corner of Lot One (1) of White Oak Hill Addition to the City of Rock Island;  
thence South along the East line of said Subdivision, 125 feet for a place of beginning;  
thence South 45°45'30" East for a distance of 295 feet;  
thence South 44°14'30" West, 295 feet, more or less to the East line of White Oak Hill Addition aforesaid;  
thence Northerly along the Easterly line of White Oak Hill Addition to the City of Rock Island, 417.19 feet, more or less to the place of beginning;

situated in the County of Rock Island and State of Illinois.

**TRACT 3**

Part of Lots 4, 5, 6, 8 and 9 of the Assessor's Plat of 1870 in the Northeast Quarter (NE 1/4) of Section Eleven (11), Township Seventeen North (T 17 N), Range Two (2) West (R 2 W) of the Fourth Principal Meridian (4th P.M.), City of Rock Island, County of Rock Island, State of Illinois, being more particularly described as follows:  
Beginning at the Northeast Corner of said Lot 8;  
Thence South 0 degrees - 29 minutes - 23 seconds East along the East line of said Lot 8, a distance of 478.64 feet;  
Thence South 0 degrees - 48 minutes - 57 seconds East along the East line of said Lots 8 and 9, a distance of 359.97 feet;  
Thence South 0 degrees - 10 minutes - 36 seconds East along the East line of said Lot 9, a distance of 421.65 feet to the North Right-of-Way line of 31st Avenue;  
Thence South 89 degrees - 57 minutes - 24 seconds West along said North Right-of-Way line, a distance of 80.00 feet;  
Thence North 0 degrees - 10 minutes - 36 seconds West, a distance of 313.78 feet;  
Thence North 89 degrees - 53 minutes - 2 seconds West, a distance of 569.09 feet;  
Thence North 31 degrees - 8 minutes - 33 seconds East, a distance of 300.12 feet;  
Thence North 46 degrees - 23 minutes - 57 seconds West, a distance of 75.00 feet;  
Thence South 43 degrees - 36 minutes - 3 seconds West, a distance of 295.23 feet;  
Thence along the arc of a circle concave to the Northwest, a distance of 104.37 feet, said arc has a chord bearing of South 69 degrees - 35 minutes - 59 seconds West, a distance of 100.83 feet with a radius of 115.00 feet;

**1 UNDERWRITER - FIRST AMERICAN TITLE INSURANCE COMPANY !**

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**Schedule A - continued**  
**File No. : F88-110-L**

Thence North 84 degrees - 23 minutes - 27 seconds West, a distance of 93.38 feet to the East line of White Oak Hill Addition;  
Thence North 0 degrees - 6 minutes - 52 seconds West along said East line, a distance of 307.26 feet;  
Thence North 0 degrees - 36 minutes - 18 seconds West along said East line, a distance of 29.59 feet;  
Thence North 44 degrees - 23 minutes - 42 seconds East, a distance of 295.00 feet;  
Thence North 45 degrees - 36 minutes - 18 seconds West, a distance of 295.00 feet to the East line of White Oak Hill Addition;  
Thence North 0 degrees - 36 minutes - 18 seconds West along said East line, a distance of 125.00 feet;  
Thence North 89 degrees - 50 minutes - 6 seconds West along the North line of said White Oak Hill Addition, a distance of 233.50 feet to the East Right-of-Way line of 17th Street;  
Thence North 0 degrees - 9 minutes - 13 seconds West along said East Right-of-Way line, a distance of 328.02 feet;  
Thence North 89 degrees - 50 minutes - 6 seconds West along said Right-of-Way line, a distance of 15.00 feet;  
Thence North 0 degrees - 9 minutes - 13 seconds West along said Right-of-Way line, a distance of 50.00 feet;  
Thence South 89 degrees - 50 minutes - 6 seconds East, a distance of 236.50 feet;  
Thence North 0 degrees - 9 minutes - 13 seconds West, a distance of 278.02 feet to the South line of DeJaegher's Subdivision;  
Thence South 89 degrees - 50 minutes - 6 seconds East along said South line, a distance of 217.09 feet;  
Thence South 0 degrees - 57 minutes - 18 seconds East along said Subdivision line, a distance of 50.00 feet;  
Thence South 89 degrees - 47 minutes - 31 seconds East along said Subdivision line, a distance of 666.89 feet;  
Thence North 1 degree - 5 minutes - 18 seconds West along said Subdivision line, a distance of 50.00 feet to the Southwest corner of Lot 4 of Ruby E. Penny's Addition;  
Thence North 89 degrees - 28 minutes - 37 seconds East along the South line of said Ruby E. Penny's Addition, a distance of 259.53 feet;  
Thence South 0 degrees - 58 minutes - 24 seconds East, a distance of 255.68 feet;  
Thence South 89 degrees - 50 minutes - 6 seconds East, a distance of 90.52 feet to the West Right-of-Way line of 24th Street;  
Thence South 0 degrees - 21 minutes - 51 seconds East along said West Right-of-Way line, a distance of 75.00 feet;  
Thence South 89 degrees - 50 minutes - 6 seconds East along said Right-of-Way line, a distance of 10.00 feet;  
Thence South 0 degrees - 21 minutes - 51 seconds East along said Right-of-Way line, a distance of 218.64 feet;  
Thence North 89 degrees - 49 minutes - 18 seconds West along the North line of Adolph's 1<sup>st</sup> Addition, a distance of 365.88 feet;  
Thence South 1 degree - 8 minutes - 34 seconds East along the West line of said Adolph's 1<sup>st</sup> Addition, a distance of 109.50 feet;  
Thence North 89 degrees - 56 minutes - 24 seconds East along the South line of said Adolph's 1<sup>st</sup> Addition, a distance of 63.68 feet to the Point of Beginning.

The above described real estate contains 37.256 acres, more or less.

For the purpose of this description, the North Right-of-Way line of 31st Avenue has an assumed bearing of South 89 degrees - 57 minutes - 24 seconds West.

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## SCHEDULE B

COMMITMENT NO. F88-110-L

Any policy we issue will have the following exceptions unless they are taken care of to our satisfaction.

1. Taxes for the years 2007 and 2008 are liens but are not yet due or payable. Taxes for the year 2006 were assessed in the amount of \$ -0-. (Tract 1 - Parcel South Rock Island 5014-1; taxpayer number 10-347-0650); (Tract 2 - Parcel South Rock Island 251; taxpayer number 10-027-0800); (Tract 3 - Parcel South Rock Island 252; taxpayer number 10-027-0850)
2. Matters shown on Plat of Bailey Addition recorded December 20, 1995 in Plat Book 47 at page 35.(Tract 1)
3. Easement given to the City of Rock Island, Illinois, for Sewer purposes shown by instrument recorded July 13, 1939 in Mortgage Book 276 at page 185. (Tract 2)
4. Restrictions as contained in Warranty Deed to Robert A. Klockau, et al, recorded April 19, 1971 in Record Book 481 at page 84 which states as follows (Tract 2):
  - a) Existing sewer easements.
  - b) Reservation of the right to construct a sewer to connect with the existing sewer from the property East of and adjoining the property conveyed, which new line shall be located not over 90 feet from the most Northerly corner of said tract of land.
  - c) Reserving the right to grade the North 90 feet of the tract conveyed and to construct a culvert running in a Northerly and Southerly direction according to the contour of the land. The Southerly end of said culvert to be not over 90 feet from the most Northerly corner of the tract conveyed.
  - d) Reserving also the right to grade the Southerly end of the tract conveyed in accordance with the grading plans for the hospital located East of and adjoining said premises.
  - e) The grantee, his heirs and assigns, shall only use the premises hereby conveyed for the purpose of constructing a Medical Arts Building, not to exceed five stories in height and to be architecturally in conformity with the hospital to be erected on the tract East of and adjoining same. Said building shall be used exclusively for Doctors Offices but may include space for selling and dispensing pharmaceutical supplies. No laboratory or x-ray laboratory shall be maintained on the premises without the permission of the Owners of the premises East of and adjoining said premises.
5. Easement between Rock Island Franciscan Hospital and Robert A. Klockau and Elinor T. Moran, as shown by instrument recorded August 30, 1972 in Record Book 532 at page 77. (Tract 2)
6. Easement between Rock Island Franciscan Hospital and Robert A. Klockau and Elinor T. Moran, as shown by instrument recorded December 3, 1971 in Record Book 504 at page 114. (Tract 2)

*! UNDERWRITER - FIRST AMERICAN TITLE INSURANCE COMPANY !*

*! Issuing Agency: Rock Island County Abstract & Title Guaranty Company, 211 - 18<sup>th</sup> Street, Suite 300, Rock Island, Illinois 61201 Phone: 309-786-5476 !*

**Schedule A - continued**  
**File No. : F88-110-L**

7. Rights of the United States of America and the State of Illinois, or either of them to recover any public funds advanced under either or both provisions of the Hill Burton Act (Title 42 U.S.C., SS291 et seq.) or the Illinois Hospital Construction Act (Illinois Revised Statutes Chapter 23, pp. 1301 et seq.) (Tract 3)
8. Easement granted to the City of Rock Island, Illinois, for the purpose of an intercepting sewer across the premises by instrument dated July 6, 1939 and recorded in Mortgage Book 276 at page 185. (Tract 3)
9. Rights of the City of Rock Island to a sewer easement under Grant from Emma Nowack dated May 2, 1939 and recorded May 18, 1939 in Mortgage Book 274 at paged 594, to a strip 10 feet in width, as therein described. (Tract 3)
10. Perpetual Easement created by instrument dated May 9, 1939 and recorded May 18, 1939 in Mortgage Book 274 at page 608 from the County of Rock Island to the City of Rock Island, Illinois to construct, operate and maintain an intercepting Sanitary Sewer in, over and across the following described property (Tract 3):

A strip of land 8 feet in width, the centerline of which 8 foot strip is described as follows:

Beginning at a point on the South line of the following described property:  
The West 7 acres of Lot 5 according to the Assessor's Plat of 1870 in the Northeast Quarter of Section 11, Township 17 North, Range 2 West of the Fourth Principal Meridian, said point on the South line of the aforesaid described property, being a distance of 8.5 feet West of the Southeast corner of the aforesaid described property; thence along a line having a bearing of North 5 degrees 13 minutes West, a distance of 333 feet, more or less, to a point on the North line of the aforesaid described property, said point being a distance of 40.3 feet West of the Northeast corner of the aforesaid described property.

11. Perpetual Easement created by instrument dated March 11, 1940 and recorded April 20, 1940 in Book 282 at page 151, from the County of Rock Island, Illinois, to Cam J. Replogle, to connect to an intercepting Sanitary Sewer together with the right of access to build, construct, operate and maintain said connection sewer in, over and across the following described premises (Tract 3):

A strip of land 3 feet in width, the centerline of which 3 foot strip is described as follows:

Beginning at a point on the East line of the West 7 acres of Lot 5 in the Northeast Quarter of Section 11, Township 17 North, Range 2 West of the Fourth Principal Meridian, Rock Island County, Illinois, a distance of 197 feet North of the Southeast corner of the West 7 acres of Lot 5 aforesaid; thence West and at right angles to the aforesaid last line of said West 7 acres of Lot 5, a distance of 31 feet, more or less, to the centerline of the City of Rock Island's intercepting sewer which has heretofore been installed in the West 7 acres of Lot 5 aforesaid.

12. Restrictions contained in the Deed from the County of Rock Island, Illinois to the Franciscan Sisters of the Immaculate Conception of the Order of St. Francis, an Illinois not-for-profit corporation, dated August 1, 1966 and recorded August 8, 1966 as document 638428, that the parcel in question shall be used for Hospital purposes only for a period of 50 years from the date thereof. (Tract 3)

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**Schedule A - continued**

**File No. : F88-110-L**

13. Rights of City of Rock Island Illinois to construct, repair, maintain, etc., a Sanitary Sewer System across parcel in question under Grant from William L. Carson and others, dated May 1, 1939 and recorded May 18, 1939 in Mortgage Book 274 at page 616, along a line described as follows (Tract 3):  
Beginning at a point on the South line of the East 3 acres of Lot 6, 215.5 feet East of the Southwest corner thereof, thence North 9 degrees 24 minutes East, 331.1 feet to a point on the North line of said tract, at a point 257 feet East of the Northwest corner of said tract.
14. Grant of Perpetual Easement by Franciscan Sisters of the Immaculate Conception of the Order of St. Francis, an Illinois not-for-profit corporation, to Ethel I. Fisher, for Sewer across the parcel in question dated October 25, 1966 and recorded January 3, 1967 in Record Book 327 as document 644638 over premises described as follows (Tract 3):  
A strip of land 20 feet in width, lying 10 feet on each side of a centerline, located in Section 11, Township 17 North, Range 2 West of the Fourth Principal Meridian, City of Rock Island, County of Rock Island, and State of Illinois, said centerline being described as follows:  
Commencing at the Northeast corner of said Section 11, thence South 00 degrees 00 minutes 00 seconds West, 718.18 feet along the East line of said Section 11; thence North 90 degrees 00 minutes 00 seconds West, 40.00 feet to the West right-of-way line of 24th Street; thence North 90 degrees 00 minutes 00 seconds West, 93 feet, more or less, to the East line of the land owned by the Franciscan Sisters of the Immaculate Conception of the Order of St. Francis, an Illinois not-for-profit corporation, being the point of beginning; thence North 90 degrees 00 minutes 00 seconds West, 333.00 feet, more or less, to an existing 21 inch sanitary interceptor sewer owned by the City of Rock Island; the East line of Section 11 is assumed to have a bearing of North 00 degrees 00 minutes 00 seconds; and the Covenants, Agreements and Conditions therein contained.
15. Easement affecting the portion of subject property and for purposes stated therein and incidental purposes in favor of Robert A. Klockau and Elinor T. Moran for right-of-way for Egress and Ingress over and upon Grantors premises now or hereafter designed for Parking, recorded December 3, 1971 as document 714654. (Tract 3)
16. Easement dated January 30, 1972 from Rock Island Franciscan Hospital to Robert A. Klockau and Elinor t. Moran, granting an Easement to connect to an existing underground tunnel and a surface right-of-way for Ingress and Egress and parking of Motor Vehicles, recorded August 30, 1972 as document 726536. (Tract 3)
17. Easement for the benefit of Trinity Medical Center over land known as Lot 7, White Oak Hill Addition to the City of Rock Island, adjacent to the Southwesterly corner of the subject property resulting from the terms of a Sanitary Sewer Storage Access Basin Easement instrument filed April 26, 1991 as document 91-07003. (Tract 3)
18. Terms and conditions as to matters that appear on that ALTA Survey dated December 11, 1992 and signed by Cornelius C. Blevins for Missman, Stanley Associates, P.C. and update thereof dated June 17, 1996. (Tract 3)
19. Permanent Easement for Construction of Traffic Signal Light granted to the City of Rock Island along the East side of subject property at the entrance area on 24th Street being dated February 18, 1999 and recorded February 18, 1999 as document number 99-04855. (Tract 3)

**! UNDERWRITER - FIRST AMERICAN TITLE INSURANCE COMPANY !**

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**Schedule A - continued**

**File No. : F88-110-L**

20. Permanent Easement for Construction of Traffic Signal Light granted to the City of Rock Island along the East side of subject property at the entrance area on 24th Street being dated June 17, 1999 and recorded June 21, 1999 as document number 99-18050. (Tract 3)
21. Rights of the public, the State of Illinois, the County of Rock Island, the Township and the Municipality in and to that part of the premises in question taken or used or dedicated for roads, streets, alleys or highways. (All Tracts)
22. Rights of way for drainage ditches, drain tiles, feeders, laterals and underground pipes, if any. (All Tracts)
23. Easements for public and quasi-public utilities, if any. (All Tracts)
24. Matters which would be disclosed by a current and accurate Survey of the premises in question. (All Tracts)
25. Covenants, easements, setback lines and other matters created by platting of the premises in question.  
Note: A breach or violation of said covenants and restrictions will not cause a forfeiture or reversion of title.
26. Existing Leases, if any, and rights of parties in possession. (All Tracts)

For purposes of the Lien Search, we conducted our name search for matters filed against the following specific names and spellings, to-wit: Trinity Medical Center

! UNDERWRITER - FIRST AMERICAN TITLE INSURANCE COMPANY !

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Appendix B

Cath Staffing



**AMA Physician Reappointment Profile**

**Federal Drug Enforcement Administration:**

\* Only the last three characters of active DEA number(s) are displayed.

<u>DEA Number *</u>	<u>Schedule</u>	<u>Expiration Date</u>	<u>Last Reported</u>
XXXXXX324	22N 33N 4 5	03/31/2015	05/07/2012
Address: 855 Illini Dr, Silvis, IL 61282-2907			
XXXXXX856	22N 33N 4 5	03/31/2013	05/07/2012
Address: 350 John Deere Rd, Moline, IL 61265-6899			

Note: Many states require their own controlled substances registration/license. Please check with your state licensing authority for requirement information as the AMA does not maintain this information.

**Specialty Board Certification(s):**

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by Joint Commission. The AMA is also an NCQA-approved source for verification of medical school, postgraduate medical training, ABMS Board certification, and Federal DEA registration.

**Certifying Board:** AMERICAN BOARD OF INTERNAL MEDICINE  
**Certificate:** CARDIOVASCULAR DISEASE  
**Certificate Type:** SUB-SPECIALTY

<u>Duration</u>	<u>Effective</u>	<u>Expiration</u>	<u>Reverification Occurrence</u>	<u>Last Reported</u>
TIME LIMITED	09/09/2010	12/31/2020	RE-CERT	06/07/2012
TIME LIMITED	11/08/2000	12/31/2010	INITIAL(**)	06/07/2012

**Certifying Board:** AMERICAN BOARD OF INTERNAL MEDICINE  
**Certificate:** INTERNAL MEDICINE  
**Certificate Type:** GENERAL

<u>Duration</u>	<u>Effective</u>	<u>Expiration</u>	<u>Reverification Occurrence</u>	<u>Last Reported</u>
TIME LIMITED	08/20/1997	12/31/2007	INITIAL(**)	06/07/2012

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**AMA Physician Reappointment Profile**

**Certifying Board:** AMERICAN BOARD OF INTERNAL MEDICINE  
**Certificate:** INTERVENTIONAL CARDIOLOGY  
**Certificate Type:** SUB-SPECIALTY

<u>Duration</u>	<u>Effective</u>	<u>Expiration</u>	<u>Reverification</u>	<u>Occurrence</u>	<u>Last Reported</u>
TIME LIMITED	09/01/2011	12/31/2021		RE-CERT	06/07/2012
TIME LIMITED	11/07/2001	12/31/2011		INITIAL(**)	06/07/2012

Note: For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information. (\*\*) Indicates an expired certificate.

\*This information is proprietary data maintained in a copyrighted database compilation owned by the American Board of Medical Specialties. Copyright 2012 American Board of Medical Specialties. All right reserved.

**Medicare/Medicaid Sanction(s):**

TO DATE, THERE HAVE BEEN NO SUCH SANCTIONS REPORTED TO THE AMA BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

**Other Federal Sanction(s):**

TO DATE, THERE HAVE BEEN NO FEDERAL SANCTIONS REPORTED TO THE AMA BY ANY BRANCH OF THE US MILITARY, THE VETERAN'S ADMINISTRATION OR THE US PUBLIC HEALTH SERVICE.

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JUN 0-6 2008

**Aswartha Pothula, M. D.**350 John Deere Road  
Moline, IL 61265  
309-743-6700**EDUCATION & TRAINING**

July 2001-Present	Attending / Practicing Interventional Cardiologist Quad City HeartCenter Trinity Medical Center
July 2000-June 2001	Interventional Cardiology Fellowship Brown University, Providence, Rhode Island
1997-2000	Cardiology Fellowship University of Missouri, Columbia, Missouri
1994-1997	Internal Medicine Residency Wayne State University, Detroit Michigan
1993-1994	Transitional Year Residency Flushing Medical Center, Flushing, New York
1991-1992	Consultant / Pediatrician, Noble Nursing Home Kurnool, India
1988-1991	Pediatric Medicine Residency Kurnool Medical College, Kurnool, India
1986-1987	Internship, Government General Hospital Kurnool, India
1981-1987	Medical Undergraduate Kurnool Medical College, Kurnool, India

**RESEARCH EXPERIENCE & PUBLICATIONS**

1999	Working on Clinical Project "V-A Conduction and Prediction of Ventricular Tachycardia" under the guidance of Dr. Greg Flaker, MD, Director of Cardiology, University of Missouri, Columbia, MO.
1998	Authored and Presented an abstract on "Comparison of traditional medical treatment vs. Intra-aortic Balloon

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07/31/2012 3:30PM (GMT-05:00)

- Pump" on end organ failure before transplantation (published in the Journal International Society of Cardiology, August 1998).
- 1996-1997 Authored and presented an abstract on comparison of "traditional vs. Laser Balloon Angioplasty on thrombus remodeling in vitro" (presented at the American College of Physicians, Michigan Chapter at Traverse City, Michigan, Sept 1996)
- 1995-1996 Full time research on applications and effects of "Supersaturated oxygen on Inflammation Ischemia and Reperfusion in Murine and Rabbit animals models, under the guidance of Dr. Richard Spears at Wayne University, Detroit, MI
- 1994-1995 Authored a case report on "Atypical Reverberation Artifacts" from central line (accepted for publication in Echocardiography Journal).
- 1993-1994 Participated in "Cost effective analysis of Syncope Evaluation" under the guidance of Dr. Pries and Lehman At Sinai Hospital, Detroit, Michigan.
- 1990-1991 Presented a dissertation on "Clinical and Biochemical Study of Nephrotic Syndrome" in children in particular Reference to serum proteins (Presented at University of Health Sciences, Vijayawada, India Sept. 1991)

#### LICENSURE & BOARD CERTIFICATION

Board Certified in Internal Medicine  
 Board Certified in Cardiology  
 Board Certified in Pediatric Medicine, India

#### HONORS & AWARDS FOR ACADEMIC ACHIEVEMENTS

##### GOLD MEDALS

1986-1987 Sri Venkataswamy Setty Gold Medal in Surgery  
 1986-1987 Smt. Annapumamma Memorial Cert. in Internal Medicine  
 1984-1985 Dr. Srinivasa Reddy Memorial Medal in Ear, Nose and Throat Surgery  
 1984-1985 Dr. Jagabandu Memorial Gold Medal in Microbiology  
 1984-1985 4<sup>th</sup> Southern Regional Conference Prize Medal in Pharmacology

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# JENNIFER M. CARROLL, B.S.N., RN

3042 35<sup>th</sup> Avenue, Rock Island, IL 61201  
309-732-1599 • Carrolljm@ihs.org

## QUALIFICATIONS PROFILE

Dedicated and patient-focused registered nurse with proven strengths in acute patient care, staff development, and family advocacy.

- Exceptional capacity to multi-task: manage numerous, often competing priorities with ease and foster the provision of superior patient care.
- Administrative and referral experience including admissions, assessment, treatment, referral, and education for a wide range of patients.
- Widely recognized as an excellent care provider and patient advocate.
- Demonstrated ability to forge, lead, and motivate outstanding healthcare teams that provide top-quality patient care.
- Outstanding interpersonal and communication skills; superior accuracy in patient history, charting, and other documentation.

ACLS, NIH stroke scale certification, Iowa and Illinois

CVS

of open heart patients; Circulating nurse/procedural sedation, diac catheterization procedures, and accurately log and mic during catheterization procedures; Care plan creation and review; Patient/family education; Training and in-; Hemodynamic system documentation.

nois 2/2010-PRESENT

es  
ular service line. Directly oversee orientation of new line including Cardiac catheterization lab, Cardiac treatment unit, non-invasive diagnostic testing, Cardiac rehab and Respiratory. Maintain and support current staff education needs. Coordinate scheduling of product representatives and educational offerings. Maintain current STEMI information. Perform monthly chart audits to verify procedural sedation policy compliance. Utilized as a Clinical resource on a variety of Cath lab specific issues.

TRINITY MEDICAL CENTER, Rock Island, Illinois 10/2004-2/2010

**Staff Nurse, Cardiac Catheterization Lab**  
Provided care for patients suffering from acute myocardial infarction, scheduled coronary catheterization procedures, peripheral angiograms, pacemaker insertions and assist with other special procedures. Give direct patient care by administering proccdural sedation under the direction of the

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physician; assist the physician in all angiogram procedures including coronary stent deployment and intra aortic balloon pump insertion; monitor ekg rhythms and hemodynamics during angiogram procedures; supply the physician with products needed and charge the patient correctly; work well as a room leader by motivating and delegating room assignments to co-workers in a respectful manner; supper user of Wit/Apollo monitoring system.

- Implemented and coordinated Cardiac Cath. Lab/C.T.U. Shared Decision Making
- Contributed substantially to successful Six Sigma Project/room turn over process change
- Maintain, support staff, and education new employees on various education topics in the lab
- Maintain current STEMI information
- Clinical Advancement Portfolio available to review upon request

TRINITY MEDICAL CENTER, Rock Island, Illinois

5/2003-10/2004

**Staff Nurse, Surgical Intensive Care Unit**

Serve as charge nurse caring for patients with acute illnesses, including acute congestive failure, acute myocardial infraction, drug overdose, massive trauma, respiratory failure, brain injuries and head traumas. Promote health and support patients and families in coping with illness. Skilled in Hewlett Packard bedside monitoring, 12-lead EKG, and ventilator systems.

- Provide strong contributions as key member of unit quality assurance program designed to identify and evaluate problems, manage patient census, and allocate staff assignments.
- Exhibit motivation and dedication by providing the highest quality of care to each patient

**EDUCATIONAL BACKGROUND**

**Associate in Applied Science (2003)**  
BLACK HAWK COLLEGE - Moline, Illinois

**Bachelor in Science of Nursing (2007)**  
TRINITY COLLEGE OF NURSING AND ALLIED HEALTH-Rock Island, Illinois

**Licensure**  
Registered Nurse (RN), State of Illinois  
Registered Nurse (RN), State of Iowa

References available upon request

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## Jennifer Moore

4854 Kynnelworth Dr. Bettendorf, Iowa 52722  
 Phone: 563-388-4949 Cell: 563-676-3470 E-Mail: jen@gabeandjen.com

### Experience

Trinity Medical Center Electrophysiology Lab RN / Cardiac Catheterization Lab RN 1999-Present

- Circulate, scrub, supply and hemodynamic monitoring during cardiac catheterization and electrophysiology procedures, recognizing and responding to patient needs.
- Scrubbed pacemakers, ICDs and Bi-Ventricular device procedures.
- Electrophysiology staff member for procedures including EP studies and ablations
- Scrubbed Cardiac Cath Lab procedures and Radiology Special procedures.
- Trained more than 15 staff members in Cardiac Cath Lab and Electrophysiology Lab.
- Communicates with physicians, staff, patients and families.
- Developed and presented PowerPoint education tool for new staff members in EP Lab.
- Super user on G.E. Prucka monitoring system for EP procedures.
- Super user on Bloom stimulator for EP procedures
- Proficient user of both EP Med system and Encite 3D mapping system for EP procedures.
- Clinical Advancement Program level III since 2005.

Cardiac Catheterization Lab Lead / Electrophysiology Lab Coordinator 2007-2010/2006-present

- Plan and coordinate daily staffing to ensure adequate personal for scheduled procedures.
- Provides nursing expertise, clinical coach and mentor with 12 years Cath Lab experience, 10 years Electrophysiology experience.
- Provides training, orientation and in-services for staff including PowerPoint presentations.
- Guides and delegates responsibilities and supervises staff in delivery of care.
- Maintains electrophysiology equipment, supplies and procedure charges.
- Communicates with physicians to provide efficient care for their patients.
- Assists physicians by scheduling cases and communicating patient care needs.
- Assisted in the development of contract purchases with vendors.
- Communicates with hospital staff, ancillary staff and families.
- Register RN in Iowa and Illinois
- CPR and ACLS certified

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**Genesis Medical Center Cardiac Catheterization Lab**

1998-1999

- Circulate, scrub and hemodynamic monitoring during cardiac catheterization procedures recognizing and responding to patient care needs.
- Communication with physicians, staff, patients and family.

**Genesis Medical Center Cardiovascular Unit Lead RN**

1997-1998

- Plan and coordinate daily staffing.
- Communication with staff and physicians regarding patient condition and needs.
- Communication with nursing supervisor regarding patient and staffing needs.
- Care of patients pre and post angioplasty, recognizing changes in patient condition and communicating changes to physician and implementing care.

**Education**

Bachelor of Science in Nursing graduating Cum Laude

Trinity College of Nursing and Allied Health

2008-2010

Associates of Applied Science in Nursing / RN

Scott Community College

1994-1997

**Skills**

Extensive knowledge of Electrophysiology procedures including EP studies, ablations and all device implants. EP staff member for 10 years and EP Lab Coordinator for 4 years. Maintain EP supplies and cables. Proficient uses of 2 monitoring systems in EP and 2 different stimulators. Assisted with the development of contact purchases and bulk buys with vendors. Proficient in both circulating and scrubbing all types of EP procedures including device implants. Trainer of many staff members in circulating, scrubbing procedures and EP procedures. Communicates well with physicians, staff members and company representatives.

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**Pauline J. Carnahan R.T.R.**

1677 320<sup>TH</sup> Street  
Sherrard, IL 61281  
Phone: cell 309-236-7060  
Email: [carnahanp@ihs.org](mailto:carnahanp@ihs.org)

**Experience:**

**Trinity Medical Center** 1971 - Present  
**Radiology technologist, ARRT, ASRT, ACLS and CPR certified.**

- Licensed in Illinois and Iowa.
- Special procedures Technologist in Radiology and Cardiac catheterization and angiography and intervention.
- Coding specialist and charge entries.
- In lab supply coordinator and the go to person for physicians for supplies, equipment and procedures.
- Proficient and super user of all Cardiac interventional and peripheral interventional equipment, including Balloon pumps, IVUS and FFR.
- Off sight training courses with the laser, IVUS, FFR, and Medtronic Champions courses.
- Helped initiate the cardiology interventional program at Trinity Medical center, and now have helped coordinate the new Radial approach for diagnostic and interventional cardiac procedures.
- Assist the Trinity School of Radiography Technology teaching the students in the class room about coronary angiography, as well as instruct them in our Labs.
- Preceptor to new Radiology techs to the department. Also train new staff of any modality to scrub for cases using sterile technique, train on the appropriate usage of Cath lab procedure equipment and supplies and understanding the procedures they are doing.
- Involvement on the committees for enlarging the cath lab from one lab in 1995 to three at this time as well as equipment selection. And am now involved with the creation of a new Heart Center and Cardiac cath labs.
- In 1981 began using one of the first digital subtraction angiography machines.
- In 1977 started doing cardiac diagnostic catheterizations with the cardiologist.

I still work full time and share my knowledge and experiences with my team mates and take regular call. I scrub for Pacemaker devices as well as interventional and diagnostic cases. I always try to set a great example of what a cath lab team member should be!

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**Moline Pubic Hospital radiology staff technologist May 1971-Sept 1971**

- Did routine radiology exams, and took call evenings and week ends.

**Passivant Memorial Hospital, Chicago Sept 1971-Jan 1972**

- Routine radiology exams and call evenings and weekends.
- During this time I worked in a private orthopedic doctor's office, to cover days off and vacations. There I developed films by hand, and was in charge of the developing tanks.

**Children's Memorial Hospital of Northwestern University Jan 1972-Aug. 1975**

- Radiology technologist in the evenings and week ends .
- Special procedures Lab working with a renound Neuro surgeon doing angiograms of cerebral and thoracic areas, for research and diagnostic.
- Assisted with the training of the fellows in angiography.

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**Robert Johnson**

Phone: Home (309) 912-7095), Cell (309) 798-8093

E-mail: [Robertj005@aol.com](mailto:Robertj005@aol.com)

**Objective:**

To become a leading technologist in the healthcare industry.

**Major Accomplishments:**

- Passed the CCI RCIS (Registered Cardiac Interventional Specialist) test in April of 2012.
- Initiated the ITAP (Imaging Technologist Advancement Program) at Trinity Medical Center. Covered bi-state area including three hospitals.
- Consultant with Abbott Vascular promoting technical skills for their closure division. Met and trained multiple personnel including staff nurses, technologist as well as doctors on the various platforms on the closure system. Consulted with Abbott from May, 2008 till April 2011.
- Completed bachelor's degree in Health Care Administration while working full time and volunteering in the community soccer and basketball programs.

**Education and Certifications:**

Saint Leo University - Bachelors of Science, Health Care Administration – 2009

**Cath Lab Certifications**

- Registered Cardiac Interventional Specialist (RCIS) April, 2012.
- Certified in all closure devices with Abbott Vascular.
- Certified by Volcano to perform all IVUS procedures dealing with peripheral and cardiac procedures.
- Certified by Spectranetics to complete peripheral procedures utilizing their laser machine.
- ACLS Certified – Recertified May, 2011

Magnetic Resonance Imaging ARRT Certification – 2003

ARRT Certified Radiology Technologist – 1995

Naval School of Health and Science – Radiology Certification – 1994

CPR Instructor – 1995 -Present

- Trained over 500 individuals while in the military and at Ocala Regional Medical Center.
- BLS instructor at Trinity Medical Center.

**Experience:**

Trinity Medical Center -June 2002 to Present

- Cath Lab Technologist – Performed all diagnostic, intervention and electrophysiology studies. Other duties included working with sales representatives, checking charges, and have been designated a CardioPacs specialist. Served on a departmental board to improve the organization of the cath lab department.

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- Initiated Technologists Advancement Program (ITAP) at Trinity Medical Center for the radiologic technologists covering three campuses in a by-state hospital. Committee selected by myself and one other. Clinical ladder covers all of imaging services, and non-evasive technologists.

**Experience:**

**Trinity Medical Center -June 2002 to Present (Continued)**

- Worked with multiple physicians on trials done at area hospital. Trials included both cardiac and peripheral procedures relevant to carotid, balloon angioplasty vs atherectomy.
- Trained Cath Lab personnel on proper usage of other equipment to be utilized for procedures including Rotoblade, IVUS, FFR, Laser Atherectomy as well as balloon angioplasty and stenting of both peripheral and cardiac procedures.
- Work with team of four to re-evaluate PVI procedure and designed a better platform for performing procedure focusing on efficiently treating the patient from pre-op to discharge.
- Served on a panel to select new department manager and leads and assisted in interviewing new cath lab employees.
- Assisted Cath Lab Nurse Educator in developing new orientation check-off list for department.
- Obtained Level 3 status as a technologist working at Trinity Medical Center.
- Assist and train new cath lab employees on proper set-up and knowledge of inserting and removing of pacemakers and change outs.
- BLS instructor for Trinity Medical Center and surrounding community.
- Supply Coordinator - Served as Supply Coordinator for Terrace Park and Rock Island campuses. Responsibilities included both special procedures as well as electrophysiology procedures of the heart.
- Serve on Wellness Committee for Trinity hospitals in helping to promote wellness with the three hospitals and community we serve
- Operating Room Technician - Performed operating room exams including AAA procedures and all routine radiographic procedures from June 2001-October 2004.
- Clinical Educator for Trinity School of Radiology from 2002-2004.

**Ocala Regional Medical Center – June 2000 to May 2002**

- Radiographer -Performed angiography, fluoroscopy, routine, emergency and operating room procedures.

**United States Navy – July 1991 – April 2000**

- Served as a Hospital Corpsman/Radiographer. Supervised 10 staff radiographers in daily procedures including routine exams and fluoroscopy procedures.

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- Supervised and trained over 50 students annually from Naval School of Health Science on their clinical rotations.
- Other duties included being in charge of quality assurance on all equipment, responsible for ordering all supplies for radiology department and Monitored Silver recovery on all processors.

**Personal:**

**Community Involvement - East Moline Soccer Club**

- Served on East Moline Youth Soccer Board of Directors for five years.
- Coached girls competitive soccer program from 2005-2009.

**References Available on Request**

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TARA JOHNSON

2701 - 17th St  
Rock Island, IL 61201

T (309) 779-3918  
F (309) 779-2160  
[tjohnsonk@trhs.org](mailto:tjohnsonk@trhs.org)

**PROFILE**

**EXPERIENCE**

CARDIAC CATH LAB LEAD, TRINITY MEDICAL CENTER --- 2010 - 2012

Responsibilities include but not limited to running the daily operations of the cardiac cath lab. These include staffing each room appropriately to handle the case load for the day; scheduling all add on cases for that day; making sure doctors are aware of any delays in the schedule; helping with turn overs of rooms, helping with bed control of all out patients. Other responsibilities include helping with education of new staff, making sure daily charges are completed; helping with inventory control; initiating daily huddles to keep staff up to date on any changes being made in the cath lab; and working with physicians to make sure they have the supplies and support they need for special cases; as well as working with physicians and staff to make sure we are efficient with our daily processes. Additional responsibilities include scrubbing and monitoring any and all cases when necessary.

CARDIAC CATH LAB AND CARDIAC TREATMENT UNIT MANAGER, TRINITY MEDICAL CENTER --- 2003 - 2010

Responsibilities of operations of the cardiac cath lab including budgeting of all capital and minor equipment purchases; working with material management and physicians to contract all high dollar supplies and equipment used in the cath lab; hiring of all new staff; making sure all staff was up to date with all education and licensing; working with physicians to develop block scheduling; daily bed control of all outpatients; and overseeing daily staffing needs of the department

ELECTROPHYSIOLOGY LEAD, TRINITY MEDICAL CENTER --- 2000 - 2005

Responsibilities include staffing of department; helping with education of new staff, making sure daily charges are completed; helping with inventory control; and working with physicians to make sure they have the supplies and support they need for special cases; as well as working with physicians and staff to make sure we are efficient with our daily processes. Also scrubbing and monitoring cases.

CARDIAC CATH LAB STAFF RADIOGRAPHER, TRINITY MEDICAL CENTER --- 1998 - 2000

Responsibilities includes working as daily staff team member, scrubbing, monitoring, and knowledge of all supplies and equipment in the cath lab. Maintaining all x-ray equipment in the department; keeping staff educated on radiation safety; as well as making sure all staff have and know how to wear the radiation film badges; posting and monitoring monthly radiation badge reports.

LUMNERAN HOSPITAL SCHOOL OF RADIOGRAPHY -- RADIOGRAPHIC TECHNOLOGIST 1988

**SKILLS**

Skills include being able to radiograph all bones in the body with knowledge of special trauma views and anatomy and physiology. Also knowing how to complete an appropriate medical history for the body part being radiographed, along with excellent patient care and communication skills.

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Appendix C

Iowa Health Systems and Subsidiaries

Audited Financial Statements

**Iowa Health System and Subsidiaries**  
**Accountants' Report and Consolidated Financial Statements**  
December 31, 2011 and 2010



**Iowa Health System and Subsidiaries**  
**December 31, 2011 and 2010**

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**Independent Accountants' Report on  
Financial Statements and Supplementary Information**

Board of Directors  
Iowa Health System and Subsidiaries

We have audited the accompanying consolidated balance sheets of Iowa Health System and Subsidiaries (the Health System) as of December 31, 2011 and 2010 and the related consolidated statements of operations, changes in net assets and cash flows for the years then ended. These consolidated financial statements are the responsibility of the Health System's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the consolidated financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Iowa Health System and Subsidiaries as of December 31, 2011 and 2010 and the results of their operations, changes in net assets and cash flows for the years then ended, in conformity with accounting principles generally accepted in the United States of America.

As discussed in Note 1, in 2011 the Health System changed its method of presentation and disclosure of patient service revenue and provision for uncollectible accounts in accordance with Accounting Standards Update 2011-07.

Our audits were performed for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating schedules of the Health System and the statement of operations for the Methodist College of Nursing listed in the table of contents are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

*BKD, LLP*

April 19, 2012

experience **BKD**

**Praxity**  
MEMBER OF  
GLOBAL ALLIANCE OF  
INDEPENDENT FIRMS

**Iowa Health System and Subsidiaries**  
**Consolidated Balance Sheets**  
**December 31, 2011 and 2010**

**Assets**

	<u>2011</u>	<u>2010</u>
	<i>(in thousands)</i>	
<b>Current Assets</b>		
Cash and cash equivalents	\$ 96,536	\$ 80,121
Short-term investments	183,951	230,061
Assets limited as to use – required for current liabilities	11,914	11,443
Patient accounts receivable, less estimated uncollectibles; 2011 – \$62,455, 2010 – \$43,507	344,880	255,702
Other receivables	43,277	20,271
Inventories	49,109	45,460
Prepaid expenses	<u>30,409</u>	<u>21,005</u>
Total current assets	<u>760,076</u>	<u>664,063</u>
<b>Assets Limited As to Use, Noncurrent</b>		
Held by trustee under bond indenture agreements	2,924	2,924
Internally designated	<u>783,197</u>	<u>771,232</u>
Total assets limited as to use, noncurrent	786,121	774,156
<b>Property, Plant and Equipment, Net</b>	1,257,472	943,349
<b>Other Long-term Investments</b>	348,581	205,434
<b>Investments in Joint Ventures and Other Investments</b>	54,665	36,264
<b>Contributions Receivable, Net</b>	61,189	54,141
<b>Other</b>	<u>30,332</u>	<u>25,420</u>
Total assets	<u>\$ 3,298,436</u>	<u>\$ 2,702,827</u>

*See Notes to Consolidated Financial Statements*

**Liabilities and Net Assets**

	<u>2011</u>	<u>2010</u>
	<i>(in thousands)</i>	
<b>Current Liabilities</b>		
Current maturities of long-term debt	\$ 73,258	\$ 33,552
Accounts payable	128,153	72,266
Accrued payroll	127,908	111,608
Accrued interest	9,685	9,629
Estimated settlements due to third-party payers	67,348	39,024
Other current liabilities	<u>55,284</u>	<u>38,681</u>
Total current liabilities	461,636	304,760
<b>Long-term Debt, Net</b>	720,837	657,979
<b>Other Long-term Liabilities</b>	<u>383,859</u>	<u>167,184</u>
Total liabilities	<u>1,566,332</u>	<u>1,129,923</u>
<b>Net Assets</b>		
Unrestricted	1,627,211	1,484,242
Temporarily restricted	57,824	45,494
Permanently restricted	<u>47,069</u>	<u>43,168</u>
Total net assets	<u>1,732,104</u>	<u>1,572,904</u>
Total liabilities and net assets	<u>\$ 3,298,436</u>	<u>\$ 2,702,827</u>

**Iowa Health System and Subsidiaries**  
**Consolidated Statements of Operations**  
**Years Ended December 31, 2011 and 2010**

	<b>2011</b>	<b>2010</b>
	<i>(in thousands)</i>	
<b>Unrestricted Revenues</b>		
Patient service revenue (net of contractual allowances)	\$ 2,327,416	\$ 2,126,978
Provision for patient uncollectible accounts	(93,586)	(96,333)
Net patient service revenue	2,233,830	2,030,645
Other operating revenue	140,273	105,565
Net assets released from restrictions used for operations	6,064	8,376
	2,380,167	2,144,586
<b>Expenses</b>		
Salaries and wages	867,878	790,573
Physician compensation and services	263,883	222,940
Employee benefits	230,462	216,145
Supplies	407,434	375,614
Other expenses	377,559	324,686
Depreciation and amortization	131,439	124,127
Interest	30,936	32,239
Provision for uncollectible accounts	818	632
	2,310,409	2,086,956
<b>Operating Income</b>	<b>69,758</b>	<b>57,630</b>
<b>Nonoperating Gains (Losses)</b>		
Investment income	(1,094)	117,427
Contribution received in affiliation with Methodist Peoria	180,325	-
Other, net	(37,068)	(9,587)
	142,163	107,840
<b>Excess of Revenues Over Expenses</b>	<b>211,921</b>	<b>165,470</b>
Change in the fair value of interest rate swaps	(20,281)	(7,294)
Net assets released from restrictions used for capital expenditures	5,705	4,948
Change in defined benefit pension plan gains (losses) and prior costs (credits)	(53,479)	(1,987)
Contributions of or for acquisition of property and equipment	245	1,061
Other, net	(1,142)	1,163
	142,969	163,361
<b>Increase in Unrestricted Net Assets</b>	<b>\$ 142,969</b>	<b>\$ 163,361</b>

See Notes to Consolidated Financial Statements

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**Iowa Health System and Subsidiaries**  
**Consolidated Statements of Changes in Net Assets**  
**Years Ended December 31, 2011 and 2010**

	<u>2011</u>	<u>2010</u>
	<i>(in thousands)</i>	
<b>Unrestricted Net Assets</b>		
Excess of revenues over expenses	\$ 211,921	\$ 165,470
Change in the fair value of interest rate swaps	(20,281)	(7,294)
Net assets released from restrictions used for capital expenditures	5,705	4,948
Change in defined benefit pension plan gains (losses) and prior costs (credits)	(53,479)	(1,987)
Contributions of or for acquisition of property and equipment	245	1,061
Other, net	(1,142)	1,163
	<u>142,969</u>	<u>163,361</u>
<b>Temporarily Restricted Net Assets</b>		
Contribution received in affiliation with Methodist Peoria	8,635	-
Contributions	12,734	3,908
Investment income	1,549	1,546
Government grants	3,674	723
Net assets released from restrictions used for operations	(6,064)	(8,376)
Net assets released from restrictions used for capital expenditures	(5,705)	(4,948)
Change in net unrealized gains (losses) on investments	(411)	192
Change in beneficial interest in net assets of affiliates	1,695	7,578
Other, net	(3,777)	(138)
	<u>12,330</u>	<u>485</u>
<b>Permanently Restricted Net Assets</b>		
Contribution received in affiliation with Methodist Peoria	3,897	-
Contributions	384	250
Investment income (loss)	(357)	1,213
Change in net unrealized gains (losses) on investments	(31)	163
Change in beneficial interest in net assets of affiliates	7	139
Other, net	1	32
	<u>3,901</u>	<u>1,797</u>
<b>Increase in Net Assets</b>	<u>159,200</u>	<u>165,643</u>
<b>Net Assets, Beginning of Year</b>	<u>1,572,904</u>	<u>1,407,261</u>
<b>Net Assets, End of Year</b>	<u>\$ 1,732,104</u>	<u>\$ 1,572,904</u>

See Notes to Consolidated Financial Statements

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**Iowa Health System and Subsidiaries**  
**Consolidated Statements of Cash Flows**  
**Years Ended December 31, 2011 and 2010**

	2011	2010
	(in thousands)	
<b>Operating Activities</b>		
Increase in net assets	\$ 159,200	\$ 165,643
Items not requiring (providing) operating cash		
Net (gains) losses on investments	17,912	(103,686)
Net unrealized losses on swaps	51,482	17,254
Restricted contributions, investment income and government grants received	(17,984)	(7,640)
Contributions of or for acquisition of property and equipment	(245)	(1,061)
Depreciation and amortization	131,439	124,127
Change in defined pension plans' liability	53,479	1,987
Contribution received in affiliation with Methodist Peoria	(192,857)	-
Amortization of debt issuance costs	430	375
(Gain) loss on disposition of assets	1,494	(968)
Equity in earnings of joint ventures	(18,635)	(16,795)
Change in beneficial interest in net assets of affiliates	(1,702)	(7,717)
Changes in		
Receivables	(44,478)	(13,101)
Inventories and prepaid expenses	(12,727)	(4,103)
Accounts payable, accrued liabilities and other liabilities	9,981	11,998
Due to third-party payers	580	(5,932)
Net cash provided by operating activities	137,369	160,381
<b>Investing Activities</b>		
Capital expenditures	(174,356)	(98,457)
Proceeds from sale of assets	2,536	3,281
Increase in assets limited as to use, net	(15,224)	(5,794)
Acquisition of Des Moines Parking Associates, less cash acquired	-	(2,550)
Cash acquired in affiliation with Methodist Peoria	27,082	-
(Increase) decrease in short-term investments	46,110	(62,655)
Increase in other long-term investments	(17,048)	(12,250)
Investments in joint ventures	(2,613)	(343)
Distributions received from joint ventures	18,985	15,807
Net cash used in investing activities	(114,528)	(162,961)
<b>Financing Activities</b>		
Proceeds from issuance of long-term debt	-	441
Payments of long-term debt	(24,655)	(18,478)
Proceeds from restricted contributions, investment income and government grants	17,984	7,640
Proceeds from contributions for acquisition of property and equipment	245	1,061
Net cash used in financing activities	(6,426)	(9,336)
<b>Increase (Decrease) in Cash and Cash Equivalents</b>	16,415	(11,916)
<b>Cash and Cash Equivalents, Beginning of Year</b>	80,121	92,037
<b>Cash and Cash Equivalents, End of Year</b>	\$ 96,536	\$ 80,121

See Notes to Consolidated Financial Statements

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**Iowa Health System and Subsidiaries**  
**Consolidated Statements of Cash Flows (Continued)**  
**Years Ended December 31, 2011 and 2010**

	2011	2010
	<i>(in thousands)</i>	
<b>Supplemental Cash Flows Information</b>		
Interest paid (net of amount capitalized)	\$ 32,307	\$ 34,477
Capital lease obligations incurred for property and equipment	10,974	2,829
Property and equipment purchases in accounts payable	27,614	7,407
Acquisition of Des Moines Parking Associates		
Assets acquired	-	5,262
Liabilities assumed	-	2,725
Affiliation with Methodist Peoria		
Assets acquired	514,903	-
Liabilities assumed	322,046	-

See Notes to Consolidated Financial Statements

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## Iowa Health System and Subsidiaries

### Notes to Consolidated Financial Statements

*(Dollars in Thousands)*

December 31, 2011 and 2010

#### Note 1: Nature of Operations and Summary of Significant Accounting Policies

##### **Organization**

Iowa Health System is an Iowa nonprofit corporation formed in December 1994. Iowa Health System and its subsidiaries (the Health System) provide inpatient and outpatient care and physician services from fifteen hospital facilities and various ambulatory service and clinic locations in Iowa and Illinois. Primary, secondary and tertiary care services are provided to residents of Iowa, Illinois and adjacent states.

##### **Basis of Presentation**

The consolidated financial statements include the accounts of Iowa Health System and its subsidiaries listed below:

- Central Iowa Health System and Subsidiaries (d/b/a Iowa Health - Des Moines) (Des Moines)
- Trinity Regional Health System and Subsidiaries (Rock Island)
- Methodist Health Services Corporation and Subsidiaries (Peoria)
- St. Luke's Healthcare and Subsidiaries (Cedar Rapids)
- Allen Health Systems, Inc. and Subsidiaries (Waterloo)
- Trinity Health Systems, Inc. and Subsidiaries (Fort Dodge)
- St. Luke's Health System, Inc. (Sioux City)
- Finley Tri-States Health Group, Inc. and Subsidiaries (Dubuque)
- Iowa Physicians Clinic Medical Foundation (d/b/a Iowa Health Physicians)
- Intrust (d/b/a Iowa Health Home Care)

Effective October 1, 2011, the Health System entered into an Affiliation agreement with Methodist Health Services Corporation (MHSC) under which MHSC became an affiliate of the Health System. At December 31, 2011, \$513,021 of total assets and net revenues of \$89,832 for the three months ended December 31, 2011 have been recorded in the consolidated financial statements.

All significant intercompany balances and transactions have been eliminated in consolidation.

##### **Use of Estimates**

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

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**Iowa Health System and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**(Dollars in Thousands)**  
**December 31, 2011 and 2010**

***Cash Equivalents and Short-term Investments***

Cash equivalents consist of demand deposits, repurchase agreements, money market funds and other debt securities with original maturities of three months or less at the date of purchase, other than those included in assets limited as to use. Short-term investments consist of debt securities with maturities between 91 and 365 days of the balance sheet date.

At times, the Health System's cash accounts exceeded federally insured limits. Management believes that these institutions are financially stable and that the credit risk related to deposits is minimal.

***Assets Limited as to Use***

Assets limited as to use include amounts held by trustees under bond indenture agreements and related documents and assets internally designated by the Board of Directors for identified purposes and over which the Board of Directors retains control and may, at its discretion, subsequently use for other purposes. Amounts required to meet current liabilities are classified as current assets.

***Inventories***

Inventories consist of supplies and are stated at the lower of cost or market.

***Investments and Investment Income***

Investments in equity securities with readily determinable fair values and all investments in fixed income securities are measured at fair value in the consolidated balance sheets. The fair values are based on quoted market prices or dealer quotes.

Investments in joint ventures and other affiliates, which are more than 20% and not more than 50% owned, are recorded using the equity method. Other investments are reported at cost, as adjusted for permanent impairment in value, if any.

Realized gains and losses from the sale of investments, interest and dividends, except those earned as a function of operations, and unrealized gains and losses on investments classified as trading securities and those carried at fair value pursuant to ASC Topic 825, are reported as non-operating gains (losses) unless restricted by a donor. Unrealized and realized gains and losses and investment income on investments restricted by donors are included as a component of the change in net assets.

The Health System elected the fair value option for its private investment funds (PIF) that are primarily limited liability corporations and partnerships. Management has elected the fair value option for the PIFs because it more accurately reflects the portfolio returns and financial position of the Health System. Gains and losses on investments subject to the fair value option are reported in investment income in non-operating gains (losses) on the accompanying consolidated statements of operations.

Refer to *Notes 5 and 13* for additional disclosures regarding balance sheet line items and fair value of those investments carried under Topic 825.

Transfers in and out of Level 1 (quoted market prices), Level 2 (other significant observable inputs) and Level 3 (significant unobservable inputs) are recognized on the actual transfer date.

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## Iowa Health System and Subsidiaries

### Notes to Consolidated Financial Statements

*(Dollars in Thousands)*

December 31, 2011 and 2010

#### **Property, Plant and Equipment**

Property, plant and equipment acquisitions are recorded at cost less accumulated depreciation. Depreciation is provided primarily using the straight-line method over the estimated useful lives of the assets. Depreciation of assets under capital lease is provided using the straight-line method over the shorter of the lease term or the estimated useful life of the assets. Donated property, plant and equipment are recorded at fair market value at the date of donation.

The Health System capitalizes interest costs as a component of construction in progress, based on interest costs of borrowing specifically for a project, net of interest earned on investments acquired with the proceeds of the borrowing. During 2011 and 2010, the Health System capitalized \$1,067 and \$242 of interest expense, respectively.

#### **Long-lived Asset Impairment**

The Health System evaluates the recoverability of the carrying value of long-lived assets whenever events or circumstances indicate the carrying amount may not be recoverable. If a long-lived asset is tested for recoverability and the undiscounted estimate future cash flows expected to result from the use and eventual disposition of the asset is less than the carrying amount of the asset, the asset cost is adjusted to fair value and an impairment loss is recognized as the amount by which the carrying amount of a long-lived asset exceeds its fair value.

No asset impairment was recognized during the years ended December 31, 2011 and 2010.

#### **Other Assets**

Other assets include certain patient records and other intangible assets that are stated at cost less accumulated amortization. In addition, other assets include goodwill. Annually, the Health System performs an impairment test of all goodwill and any identified impairment loss is recognized as expense. Other assets also include deferred financing costs, which are amortized over the period the obligation is expected to be outstanding. The Health System has \$3,804 and \$3,446 of goodwill at December 31, 2011 and 2010, respectively. Other intangible assets at December 31, 2011 and 2010 were \$18,710 and \$12,346, respectively, which are subject to amortization.

#### **Net Assets**

Net assets are classified into three mutually exclusive classes: unrestricted, temporarily restricted and permanently restricted. The three classes are based on the presence or absence of donor-imposed restrictions. Temporarily restricted net assets are those whose use has been limited by donors to a specific time period or purpose. Permanently restricted net assets have been restricted by donors in perpetuity. The expiration of donor restrictions is recorded in the period in which the restrictions expire.

Temporarily restricted net assets are generally restricted for capital expenditures, passage of time or other donor specified restrictions.

**Iowa Health System and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**(Dollars in Thousands)**  
**December 31, 2011 and 2010**

***Excess of Revenues Over Expenses***

Excess of revenues over expense transactions affecting unrestricted net assets are reflected in the consolidated statements of operations. Consistent with industry practice, the effective portion of derivative instruments qualifying for hedge accounting carried at fair value, change in defined benefit plans and contributions of long-lived assets (including assets acquired with donor-restricted cash contributions) are excluded from determination of the excess of revenues over expenses. Transactions related to temporarily or permanently restricted net assets are recorded as additions or deductions to net assets and reflected in the consolidated statements of changes in net assets. Non-controlling interest included as part of excess of revenues over expenses was \$1,058 and \$1,142 as of December 31, 2011 and 2010, respectively.

***Change in Accounting Principle***

In 2011, the Health System changed its method of presentation and disclosure of patient service revenue, provision for uncollectible accounts and the allowance for uncollectible accounts in accordance with Accounting Standards Update (ASU) 2011-07, *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts and Allowance for Doubtful Accounts for Certain Health Care Entities*. The major changes associated with ASU 2011-07 are to reclassify the provision for uncollectible accounts related to patient service revenue to a deduction from patient service revenue and to provide enhanced disclosures around the Health System's policies related to uncollectible accounts. The provision for uncollectible accounts related to certain physician and home health services will continue to be presented in operating expenses for purposes of consolidation because the patient's ability to pay is assessed as part of initial revenue recognition. As a result of adopting ASU 2011-07, total net patient service revenue, total revenues and total expenses decreased by \$93,586 and \$96,333 for the years ended December 31, 2011 and 2010, respectively. The change had no effect on operating income or on prior year change in net assets.

***Net Patient Service Revenue and Accounts Receivable***

Net patient service revenue is reported at the estimated net realizable amount primarily from patients and third-party payers for services provided, including retroactive adjustments under reimbursement agreements with third-party payers. Retroactive adjustments are accrued on an estimated basis in the period in which the related services are provided, and adjusted in future periods as final settlements are determined.

The Health System recognizes patient service revenue associated with services provided to patients who have third-party payer coverage on the basis of contractual rates for the services rendered. For uninsured patients that do not qualify for charity care, the Health System recognizes revenue on the basis of its standard rates for services provided. On the basis of historical experience, a significant portion of the Health System's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Health System records a significant provision for uncollectible accounts related to uninsured patients in the period the services are provided. This provision for uncollectible accounts is presented on the accompanying statements of operations as a component of net patient service revenue.

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## Iowa Health System and Subsidiaries

### Notes to Consolidated Financial Statements

(Dollars in Thousands)

December 31, 2011 and 2010

As a service to the patient, the Health System bills third-party payers directly and bills the patient when the patient's liability is determined. Patient accounts receivable are due in full when billed. Accounts receivable are reduced by an allowance for uncollectible accounts. In evaluating the collectability of accounts receivable, the Health System analyzes its past history and identifies trends for each of its major payer sources of revenue to estimate the appropriate allowance for uncollectible accounts and provision for uncollectible accounts. Management regularly reviews data about these major payer sources of revenue in evaluating the sufficiency of the allowance for uncollectible accounts.

For receivables associated with services provided to patients who have third-party coverage, the Health System analyzes contractually due amounts and provides contractual allowances based on these amounts. Additionally, an allowance for uncollectible accounts is provided for expected uncollectible deductibles and copayments on accounts for which the patient is responsible. For receivables associated with self-pay patients, the Health System records a significant provision for uncollectible accounts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated or provided by policy) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for uncollectible accounts.

The Health System's allowance for uncollectible accounts increased from \$43,507 at December 31, 2010 to \$62,455 at December 31, 2011. Allowances associated with MHSC accounted for \$17,054 of the increase. The Health System's allowance for uncollectible accounts for self-pay patients was approximately 92% of self-pay accounts receivable at December 31, 2011 and 2010. The provision for patient uncollectible accounts for the year ended December 31, 2011 was \$93,586 (\$90,933 when excluding MHSC) compared to \$96,333 for the year ended December 31, 2010. The decrease in expense was a result of improved collection and recovery experiences in 2011.

Patient service revenue at established rates less third-party payer contractual adjustments (but before the provision for uncollectible accounts), recognized in the year ended December 31, 2011, was approximately:

Third-party payers	\$ 2,113,093
Self-pay	<u>214,323</u>
Total	<u>\$ 2,327,416</u>

#### Charity Care

The Health System provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than established rates. Amounts determined to be charity care are not reported as revenue.

## Iowa Health System and Subsidiaries

### Notes to Consolidated Financial Statements

(Dollars in Thousands)

December 31, 2011 and 2010

#### Functional Expenses

The Health System provides general health care services, including acute inpatient, outpatient, physician, ambulatory, long-term and home health care, and incurs related general and administrative expenses. Expenses related to providing these services for the years ended December 31 were as follows:

	2011	2010
General health care services	\$ 1,908,342	\$ 1,752,338
Management, general and administrative	399,386	331,733
Research	2,681	2,885
	<u>\$ 2,310,409</u>	<u>\$ 2,086,956</u>

#### Contributions and Beneficial Interest in Net Assets

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. All contributions are considered to be available for unrestricted use unless specifically restricted by the donor. Donor-imposed restrictions are considered fulfilled as soon as the stipulated time has expired or the qualifying expenditure has been made. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions.

Contributions not expected to be collected within a year are recorded at the present value of expected future cash flows using a risk-free interest rate over the term of the contribution. Contributions of property are recorded at fair value when received.

Interest in charitable trusts and perpetual trusts is carried at the present value of expected future cash flows. The Health System's interest in the net assets (the Interest) of certain foundations that raise and hold assets on behalf of the Health System is accounted for in a manner similar to the equity method. The Interest is stated at fair value, and changes in the Interest are included in the change in net assets. Transfers of assets between these foundations and the Health System are recognized as increases or decreases in the Interest.

#### Estimated Malpractice Costs, Health Insurance and Workers' Compensation

An annual estimated provision is accrued for the self-insured portion of medical malpractice, health insurance and workers' compensation claims and includes an estimate of the ultimate costs for both reported claims and claims incurred but not reported.

**Iowa Health System and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
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**December 31, 2011 and 2010**

In 2011, the Health System adopted the provisions of Accounting Standards Update (ASU) 2010-24, *Health Care Entities (Topic 954): Presentation of Insurance Claims and Related Insurance Recoveries*, which eliminates the practice of netting claim liabilities with expected insurance recoveries for balance sheet presentation. Claim liabilities are to be determined without consideration of insurance recoveries. Expected recoveries are presented separately. Prior to the adoption of ASU 2010-24, accounting principles generally accepted in the United States of America required a health care provider to accrue only an estimate of the malpractice claims cost for both reported claims and claims incurred but not reported where the risk of loss had not been transferred to a financially viable insurer. There was no material impact of the ASU adoption to the Health System's financial statements.

***Interest Rate Swap Agreements***

The Health System has entered into various interest rate swap agreements (the Swaps) to reduce the effect of changes in cash flows primarily related to interest rate fluctuations on the Health System's various variable rate demand bond issues. The Swaps were entered into for the risk management purpose of reducing the variability in cash flows related to the Health System's variable rate debt.

As described in *Note 8*, the Health System has designated certain swaps as hedges, while other swaps have not been designated as hedging instruments. The effective portion of changes in the fair value of swaps designated as hedges is recognized as a component of other changes in net assets, while the ineffective portion of these swaps changes in fair value, and all changes in fair value of swaps not designated as hedges, is recorded as a component of nonoperating gains (losses) in excess of revenues over expenses.

The Swaps are recognized on the consolidated balance sheets at fair value. The net cash payments or receipts under the Swaps designated as hedging instruments are recorded as an increase or decrease to interest expense. The net cash payments or receipts under the Swaps not designated as hedges are recorded as an increase or decrease to other nonoperating income (loss).

***Income Taxes***

Iowa Health System and most of its subsidiaries are classified as tax-exempt organizations as described in Sections 501(c)(3) and 501(c)(2) of the Internal Revenue Code (the Code). Tax-exempt organizations are not subject to federal and state income taxes on related income, pursuant to Section 501(a) of the Code. These organizations are subject to federal and state income taxes to the extent they have unrelated business income as described under provisions of Section 511 of the Code.

The Health System files Form 990 for substantially all of its operating entities in the U.S. federal jurisdiction and is no longer subject to examination by tax authorities for the years before 2008. The Health System has no material uncertain tax positions.

Certain subsidiaries are subject to federal and state income taxes. Some of these corporations have accumulated net operating loss carryforwards that are available to offset future taxable income during the carryforward period. No income tax benefit has been recognized for the net operating loss carryforwards or other potential deferred tax assets in the consolidated financial statements because the Health System believes realization of these benefits is unlikely.

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**Iowa Health System and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**(Dollars in Thousands)**  
**December 31, 2011 and 2010**

***Retirement Plans***

Substantially all employees meeting age and length of service requirements participate in defined contribution plans. Certain subsidiaries also have defined benefit plans, most of which have been substantially frozen. Pension costs for the defined benefit plans, which are composed of normal costs and amortization of prior service costs related to defined benefit plans, are funded currently.

***Reclassifications***

Certain reclassifications have been made to the 2010 financial statements to conform to the 2011 financial statement presentation. These reclassifications had no effect on the change in net assets.

**Note 2: Affiliation with Methodist Peoria**

On October 1, 2011, the Health System executed an affiliation agreement with MHSC, a not-for-profit health care organization operating as The Methodist Medical Center of Illinois, located in Peoria, Illinois. The results of MHSC's operations have been included in the consolidated financial statements since that date. As a result of the affiliation, the Health System will have an opportunity to expand its service area into Central Illinois and further the mission and strategic goals of the Health System in the ever changing health care provider landscape. The Health System also expects that the affiliation will allow it to achieve cost savings through elimination of certain duplicative administrative and other functions. The affiliation was accomplished by the Health System becoming the sole member of MHSC and having the ability to appoint the board members of MHSC. No consideration was transferred for the net assets of MHSC, thus the fair value of unrestricted net assets received by the Health System is shown as contribution revenue in the consolidated statements of operations.

The Health System incurred \$787 of costs in connection with this affiliation. These costs are included in other expenses in the consolidated statements of operations.

**Iowa Health System and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
*(Dollars in Thousands)*  
**December 31, 2011 and 2010**

The following table summarizes the fair value of the assets acquired and liabilities assumed recognized at the affiliation date:

<b>Recognized fair value of identifiable assets acquired and liabilities assumed</b>	
Current assets	\$ 104,780
Property, plant and equipment	244,919
Noncurrent assets	<u>165,203</u>
Total assets	<u>514,902</u>
Current liabilities	89,268
Long-term debt	109,891
Long-term liabilities	<u>122,886</u>
Total liabilities	<u>322,045</u>
Total contribution received	<u>\$ 192,857</u>
<b>Summary of contribution received by net asset classification</b>	
Unrestricted contribution received	\$ 180,325
Temporarily restricted contribution received	8,635
Permanently restricted contribution received	<u>3,897</u>
Total contribution received	<u>\$ 192,857</u>

The affiliation resulted in an inherent contribution received of \$192,857, which represents the net recognized amount of the identifiable assets acquired over the liabilities assumed. Acquisition of the unrestricted net assets has been included in contribution revenue in the consolidated statements of operations. The temporarily and permanently restricted net assets have been included as increases to those classes of net assets in the amounts of \$8,635 and \$3,897, respectively.

MHSC contributed revenues of \$89,832, excess revenues over expenses of \$8,646, and changes in unrestricted, temporarily restricted, and permanently restricted net assets of \$3,177, \$356 and \$23 to the Health System for the period from the affiliation date through December 31, 2011. The following unaudited pro forma summary presents consolidated information of the Health System as if the affiliation had occurred on January 1, 2010:

	<b>Pro Forma Year Ended December 31, 2011</b>	<b>Pro Forma Year Ended December 31, 2010</b>
Revenue	\$ 2,647,365	\$ 2,488,989
Excess of revenues over expenses	20,192	388,261
Change in		
Unrestricted net assets	(72,740)	383,070
Temporarily restricted net assets	2,807	10,009
Permanently restricted net assets	(6)	5,704

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**Iowa Health System and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**(Dollars in Thousands)**  
**December 31, 2011 and 2010**

Supplemental pro forma earnings for the year ended December 31, 2011 were adjusted to exclude \$3,719 of affiliation-related costs incurred by both the Health System and MHSC in 2011, \$2,467 of nonrecurring expense related to an adjustment to self-insurance liabilities, and \$4,000 of additional contribution revenue related to the fair value adjustment to joint ventures at the affiliation date. The 2010 supplemental pro forma earnings were adjusted to include these adjustments. The unaudited pro forma amounts are not indicative of what actual consolidated results of operations might have been if the affiliation had been effective at the beginning of 2010.

**Note 3: Charity Care**

The Health System provides charity care and financial assistance discounts for medically necessary health care services provided to persons who meet the Health System's policy. The policy provides a percentage discount to the patient that decreases at gradually higher income levels or higher levels of household net assets. The benchmark upon which the income level is compared to is the Federal Poverty Income Guideline and is updated annually. Patients who are already receiving benefits from certain identified government programs qualify for presumptive eligibility.

The availability of charity care is widely communicated to all patients and patients are notified prior to receiving services if their treatment does not fall within the guidelines of the policy. Amounts charged for care that is provided to individuals eligible for charity may not be more than the amounts generally billed to individuals who have insurance covering such care. Amounts billed are based on either the best, or an average of the three best, negotiated commercial rates, or Medicare rates.

Accounts that are classified by the Health System as charity care are not reported as net patient service revenue. In some cases, the charity care is subsidized by contributions from volunteer organizations or other donors. Charity care subsidies are not material to the consolidated financial statements.

Cost of charity care is calculated by applying hospital specific cost to charge ratios to the total amount of charity care deductions from gross revenue. The cost-to-charge ratio is calculated by taking the hospital total expenses and gross charges and applying adjustments to remove the cost of non-patient care activity, Medicaid provider taxes paid, identifiable community benefit expenses, as well as gross patient charges that are generated for identifiable community benefit services.

The amount of charity care provided at cost was \$39,045 and \$33,969 for the years ended December 31, 2011 and 2010, respectively. The portion of the increase related to the addition of MHSC was \$1,795 for the year ended December 31, 2011.

Community benefit is also provided through reduced price services and free programs offered throughout the year. The Health System provides an array of uncompensated activities and services intended to meet the community health needs. These activities include wellness programs, community education programs and various health screening programs. The cost of providing these community benefit services is reported on Schedule H of the Health System's IRS Form 990.

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# Iowa Health System and Subsidiaries

## Notes to Consolidated Financial Statements

(Dollars in Thousands)

December 31, 2011 and 2010

### Note 4: Third-Party Reimbursement

As a provider of health care services, the Health System generally grants credit to patients without requiring collateral or other security. The Health System routinely obtains assignments of (or is otherwise entitled to receive) patients' benefits payable under their health insurance programs, plans or policies. These health insurance programs or providers are commonly referred to as third-party payers and include the Medicare and Medicaid programs, Wellmark and various health maintenance and preferred provider organizations.

A major portion of the Health System's revenues is derived from these third-party payers. Significant changes have been made, and may be made, in certain of these programs, which could have a material, adverse impact on the financial condition of the Health System. These changes include federal and state laws and regulations, particularly those pertaining to Medicare and Medicaid.

The Health System has agreements with certain third-party payers that provide for payment of services at amounts different from established rates. Third-party payer payment rates vary by payer and include established charges; contracted rates less than established charges; prospectively determined rates per discharge, per procedure, or per diem; retroactively determined cost-based rates.

Gross patient service revenue (based on established rates) by payer for the years ended December 31 was as follows:

	2011	2010
Medicare	43%	43%
Medicaid	12	11
Wellmark	21	21
Commercial and other	19	19
Self-pay	5	6
	<u>100%</u>	<u>100%</u>

Gross patient accounts receivable (based on established rates) by payer at December 31 was as follows:

	2011	2010
Medicare	29%	32%
Medicaid	15	10
Wellmark	17	17
Commercial and other	26	27
Self-pay	13	14
	<u>100%</u>	<u>100%</u>

## Iowa Health System and Subsidiaries

### Notes to Consolidated Financial Statements

(Dollars in Thousands)

December 31, 2011 and 2010

#### ***Iowa Medicaid State Plan***

In 2011, the state of Iowa enacted a Medicaid State Plan in which an annual tax assessment is levied on certain hospital providers in order to provide funding for Medicaid to obtain federal matching funds. A portion of these additional federal funds are then redistributed to participating Iowa hospitals through increased Medicaid payments in order to help bring Medicaid reimbursement closer to the cost of providing care. The allocation of these funds to specific health care providers is based primarily on the amount of care provided to Medicaid recipients.

The Health System's tax assessment and contribution during 2011 was \$16,566 and is included in operating expenses in the consolidated statements of operations. Additional Medicaid reimbursement in the same period was approximately \$28,738 and is included in net patient service revenue in the consolidated statements of operations, resulting in a net increase in operating income of \$12,172.

#### ***Illinois Medicaid State Plan***

The Illinois Medicaid State Plan serves a similar purpose as the Iowa plan but has been in place since 2006. Under the amended Illinois Medicaid State Plan, proceeds from the tax assessment are used to obtain federal matching funds, all of which must be distributed to Illinois hospitals and physicians to help bring Medicaid reimbursement closer to the cost of providing care. The allocation of these funds to specific health care providers is based primarily on the amount of care provided to Medicaid recipients. The Health System's tax assessment and contribution in 2011 relate to Trinity Regional Health System and MHSC while in 2010 related to Trinity Regional Health System only.

In 2011 and 2010, the Health System's tax assessment and contribution was \$10,632 and \$8,312, respectively, and is included in operating expenses in the consolidated statements of operations. Additional Medicaid reimbursement in the same periods was approximately \$19,577 and \$14,375 and is included in net patient service revenue in the consolidated statements of operations, resulting in a net increase in operating income of \$8,945 and \$6,063 in 2011 and 2010, respectively.

#### ***Electronic Health Records Incentive Program***

The Electronic Health Records Incentive Program, enacted as part of the *American Recovery and Reinvestment Act of 2009*, provides for one-time incentive payments under both the Medicare and Medicaid programs to eligible health systems that demonstrate meaningful use of certified electronic health records technology (EHR). Payments under both the Medicare and Medicaid program are generally made for up to four years based on a statutory formula. The Medicaid programs are determined on a state by state basis, which are approved by the Centers for Medicare and Medicaid Services. Payment under both programs are contingent on the Health System initially attesting to being a meaningful user of EHR technology and then continuing to meet escalating criteria, including other specific requirements that are applicable, for consecutive reporting periods. The final amount for any payment year is determined based upon an audit by the fiscal intermediary. Events could occur that would cause the final amounts to differ materially from the initial payments under the program.

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**Iowa Health System and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
***(Dollars in Thousands)***  
**December 31, 2011 and 2010**

The Health System recognizes revenue ratably over the reporting period starting at the point when management is reasonably assured it will meet all of the meaningful use objectives and any other specific grant requirements applicable for the reporting period.

In 2011, several of the Health System's affiliates completed the first-year requirements under the Medicaid program and the Health System has recorded revenue of \$9,789, which is included in other operating revenue in the consolidated statements of operations. The Medicaid program EHR funds are related to the implementation of EHR technology for the hospitals and physician groups. One affiliate completed the first-year requirements under the Medicare program during 2011 and has recorded revenue of \$1,362 in the same manner. The remaining affiliates of the Health System have not completed the initial attestation under the Medicare program and have not recorded any revenue pertaining to this program.

## Iowa Health System and Subsidiaries

### Notes to Consolidated Financial Statements

(Dollars in Thousands)

December 31, 2011 and 2010

#### Note 5: Investments

##### Investment Summary

Short-term investments consist of debt securities, primarily bonds, and totaled \$183,951 and \$230,061 at December 31, 2011 and 2010, respectively.

A summary of investments reported as assets limited as to use at December 31 is as follows:

	<u>2011</u>	<u>2010</u>
Held by trustees under bond indenture agreements		
Cash and short-term investments	\$ 2,887	\$ 2,874
Mortgage-backed securities	37	50
	<u>2,924</u>	<u>2,924</u>
Internally designated		
Cash and short-term investments	13,686	12,085
U.S. Treasury obligations	18,658	30,826
U.S. Government agency obligations	6,625	15,168
Asset-backed securities		
Home equity	14,398	9,507
Other	5,455	2,117
Mortgage-backed securities		
Government	48,191	26,199
Non-government	33,280	31,548
Certificates of deposit	474	474
Corporate bonds	44,451	38,169
Corporate bonds - PIF	155,250	139,008
Equity securities		
Domestic	95,087	92,407
International	34	-
Equity securities - PIF		
Domestic	121,574	121,367
International	59,729	69,351
Mutual funds		
International	58,595	61,142
Emerging markets	47,582	68,293
Index	975	-
Equity	665	-
Fixed income	2,801	-
Other	283	-
Hedge fund of funds	66,189	63,607
Interest receivable	1,129	1,407
	<u>795,111</u>	<u>782,675</u>
Total assets limited as to use	798,035	785,599
Less amount required to meet current obligations	11,914	11,443
Noncurrent portion of assets limited as to use	<u>\$ 786,121</u>	<u>\$ 774,156</u>

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**Iowa Health System and Subsidiaries**  
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Assets held by trustee under bond indenture agreements are required to be held in separate trust accounts. A summary of these trust accounts aggregated by their required use at December 31 is as follows:

	<b>2011</b>	<b>2010</b>
Collateral and other accounts	\$ 2,924	\$ 2,924

Internally designated assets are summarized below based on their designation at December 31:

	<b>2011</b>	<b>2010</b>
Capital improvements	\$ 758,060	\$ 749,503
Self-insured reserves	37,049	32,803
Bond interest account	2	369
	\$ 795,111	\$ 782,675

**Iowa Health System and Subsidiaries**  
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Investments presented as other long-term investments at December 31 are summarized as follows:

	2011	2010
Restricted cash and short-term investments	\$ 5,116	\$ 3,106
U.S. Treasury obligations	4,591	7,422
U.S. Government agency obligations	1,593	3,403
Asset-backed securities		
Home equity	3,293	2,084
Other	1,248	464
Mortgage-backed securities		
Government	11,024	5,841
Non-government	7,613	7,033
Corporate bonds	9,648	8,261
Corporate bonds - PIF	35,513	30,471
Equity securities		
Domestic	25,956	32,654
International	179	-
Equity securities - PIF		
Domestic	27,809	26,604
International	13,663	15,202
Mutual funds		
Domestic	19,659	15,419
International	26,878	14,547
Emerging markets	11,375	14,655
Index	2,217	-
Equity	29,718	-
Fixed income	65,126	-
Other	4,482	-
Hedge fund of funds	35,256	13,943
Notes receivable	15	-
Interest receivable	422	299
Insurance policies	4,199	4,026
Real estate	1,050	-
Interest rate swaps <i>(see Note 8)</i>	938	-
	\$ 348,581	\$ 205,434

**Iowa Health System and Subsidiaries**  
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The following schedule summarizes the investment return and its classification in the consolidated statements of operations and changes in net assets for the years ended December 31:

	2011	2010
<b>Investment return</b>		
Interest and dividends	\$ 18,859	\$ 18,802
Realized gains on sales of investments	31,383	53,890
Unrealized gains (losses) on trading investments	(55,890)	11,918
Unrealized gains (losses) on other than trading investments	(442)	355
Equity in earnings of joint ventures	18,635	16,795
Change in fair value of investments accounted for under the fair value option of FASB ASC Topic 825	7,037	37,523
	\$ 19,582	\$ 139,283
<b>Investment return classification</b>		
Unrestricted net assets		
Other operating revenue	\$ 19,926	\$ 18,742
Nonoperating gains (losses) – investment income	(1,094)	117,427
Temporarily restricted net assets	1,138	1,738
Permanently restricted net assets	(388)	1,376
	\$ 19,582	\$ 139,283

**Private Investment Funds**

At December 31, 2011 and 2010, 45% and 48%, respectively, of the Health System's investments were invested in PIFs whose portfolios are primarily invested in debt and marketable equity securities. These investments are included in either internally designated or other long-term investments in the investment summary tables (previously presented) based on the underlying investments. The amounts included in the investment summary tables at December 31 are as follows:

	2011	2010
Corporate bonds	\$ 190,763	\$ 169,479
Equity securities	222,775	232,524
Hedge fund of funds	101,445	77,550
	\$ 514,983	\$ 479,553

## Iowa Health System and Subsidiaries

### Notes to Consolidated Financial Statements

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The PIFs are primarily limited partnerships and limited liability companies, including three hedge fund-of-funds and one private equity fund. The underlying investments of these funds are primarily debt and marketable equity securities. The investment strategies for each fund vary but include low return volatility through tactical investment strategies, investing in growth or value securities for long-term growth and to earn a total rate of return in excess of rates of return compared to a standard index. The private equity fund has a strategy of investing in early-stage companies and entrepreneurs within the healthcare industry. There is no public market for shares in the private investment funds. The value of the investments in the PIFs is determined based on the fair values of the underlying securities.

In situations when investments do not have readily determinable fair values (private investment funds), the fund managers provide the net asset value (NAV) per share, or its equivalent, to the Health System. The NAV provided by the fund managers is supported by underlying audit reports of the private investment funds. The Health System previously adopted ASU 2009-12, which provided a practical expedient for certain investments to use net asset value per share to measure fair value. Accordingly, the Health System uses the NAV as a practical expedient for fair value for each of its PIFs.

The PIFs generally have certain limits regarding advance notice and timing of withdrawals. They generally require advance notice of at least two days prior to a month end to withdraw funds. One fund that represents about 16% of the private investment funds requires a 95-day notice to withdraw funds either quarterly or semiannually based on the initial purchase date of the investments. In addition, withdrawals may be limited by the PIFs underlying investment funds ability to liquidate their holdings.

During 2011, the Health System committed to investing \$10,000 in a PIF with a lock-up period of ten years. The Health System's interest is nonredeemable and the Health System has contributed a nominal amount to this investment as of December 31, 2011.

#### **Investments in Joint Ventures**

At December 31, 2011 and 2010, investments in joint ventures amounted to \$42,710 and \$26,327, respectively. The new joint ventures added in the affiliation with MHSC were \$14,107. Other investments consist primarily of cash surrender value of life insurance policies and real estate held for investment.

The joint ventures consist of 39 privately held health care organizations in which the Health System's ownership interest ranges from 18% to 50%. The joint ventures had the following financial information as of and for the years ended December 31:

	2011	2010
Total assets	\$ 160,253	\$ 137,522
Net revenues	151,325	139,626
Net income	43,065	39,971

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**Iowa Health System and Subsidiaries**  
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The Health System's share of earnings on the investments in joint ventures is included in other operating revenue in the consolidated statements of operations. The Health System recorded activity related to joint ventures for the years ended December 31 as follows:

	<u>2011</u>	<u>2010</u>
Earnings on investments in joint ventures	\$ 18,635	\$ 16,795
New investments in joint ventures	2,613	343
Distributions received from joint ventures	18,668	15,807

The Health System both purchases services and sells services and supplies to several joint ventures. In 2011 and 2010, services purchased from joint ventures totaled \$11,016 and \$10,370, respectively. Services and supplies sold to joint ventures in 2011 and 2010 were \$9,105 and \$7,261, respectively.

**Note 6: Property, Plant and Equipment**

Property, plant and equipment are stated at cost and are summarized at December 31 as follows:

	<u>2011</u>	<u>2010</u>
Land	\$ 95,753	\$ 52,940
Land improvements	64,770	43,758
Buildings, improvements and fixed equipment	1,547,915	1,362,863
Moveable equipment	1,007,797	864,826
	<u>2,716,235</u>	<u>2,324,387</u>
Less accumulated depreciation and amortization	1,504,900	1,413,950
	<u>1,211,335</u>	<u>910,437</u>
Construction/information systems installation in progress	46,137	32,912
Net property, plant and equipment	<u>\$ 1,257,472</u>	<u>\$ 943,349</u>

As of December 31, 2011 and 2010, the Health System has committed approximately \$123,272 and \$96,223, respectively, for costs related to various hospital construction and information systems projects. The Health System plans to fund the projects through internal funds.

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**Note 7: Long-term Debt**

Long-term debt at December 31, 2011 and 2010 is summarized as follows:

	<b>Payable Through</b>	<b>Issuance Type</b>	<b>Interest Rate (1)</b>	<b>2011</b>	<b>2010</b>
Hospital Facility Revenue Bonds					
Series 2011A	2021	Fixed	3.29%	\$ 57,960	\$ -
Series 2011B	2041	Variable	0.10%	51,220	-
Series 2009A	2035	Variable	0.06%, 0.28%	52,860	54,375
Series 2009B	2035	Variable	0.06%, 0.28%	52,860	54,375
Series 2009C	2035	Variable	1.16%, 1.16%	30,375	31,245
Series 2009D	2035	Variable	0.16%, 0.36%	56,445	58,065
Series 2009E	2039	Variable	0.16%, 0.36%	43,000	43,000
Series 2009F	2039	Fixed	5.00%	50,000	50,000
Series 2008A	2037	Fixed	2.5% - 5.625%	146,040	148,050
Series 2008	2028	Variable	13.45%, 13.16%	4,528	4,528
Series 2006	2031	Variable	0.25%, 1.34%	13,110	13,485
Series 2005	2031	Fixed	4.50%	3,622	3,722
Series 2005A	2035	Fixed	2.5% - 5.625%	192,540	198,060
Series 1985	2015	Fixed	4.40%	-	1,980
Series 1985B	2015	Variable	0.14%, 0.27%	23,000	23,000
Total hospital facility revenue bonds				777,560	683,885
Capital lease obligations, due through 2015			0% - 10.16%	14,669	4,328
Other notes and mortgages			Various	775	2,194
				793,004	690,407
Current maturities				(73,258)	(33,552)
Unamortized bond discount				1,091	1,124
Long-term portion				\$ 720,837	\$ 657,979

(1) Variable rates shown represent rates as of December 31, 2011 and 2010, respectively.

The Series 2011 Bonds are obligations of MHSC that were issued prior to their affiliation with the Health System. The Methodist Medical Center of Illinois, a subsidiary of MHSC, is the sole obligor under the bond indenture, which requires the maintenance of certain financial ratios through the master trust indenture and letter of credit agreement (related to the variable rate demand bonds).

The Series 2009, 2008, and 2005 Bonds (collectively "the Bonds") are general obligations of the Health System and its affiliates. The Health System is required to meet certain operating and financial ratios contained in the master bond trust indenture, bond insurance agreements and bank letter of credit agreements (related to the variable rate demand bonds). The Bonds are subject to the provisions of amended and restated master trust indentures, which generally require monthly or quarterly deposits for principal and interest payments be made, and certain funds be maintained by the trustee for interest payment and bond retirement purposes.

## Iowa Health System and Subsidiaries

### Notes to Consolidated Financial Statements

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The variable interest rates on substantially all of the bonds are adjusted daily or weekly by remarketing agents. The bonds may be tendered by the bond holders each interest rate period. The Health System maintains a combination of letters of credit and standby purchase agreements that can be drawn on should the bonds not be remarketed. The agreements will expire beginning in 2014 through 2016. The agreements are renewable, subject to trustee approval and at the option of the agreement providers, throughout the term of the bonds. Outstanding amounts under the agreements are due at the earlier of expiration of the agreements or over a period of three years commencing after an initial outstanding period of 366 days or more.

In December 2010, the Health System completed an interest rate mode conversion for the 2009C bonds converting the interest rate from a daily rate to an index rate. The interest rate modification was not considered a significant modification of terms; thus, all costs incurred from the mode conversion were expensed during the year. In 2010, a Direct Note Obligation for the 2009C bonds was issued to a financial institution, eliminating the supporting letter of credit requirement.

The \$50,000 of 2009F bonds outstanding are subject to a mandatory tender on August 14, 2012 and therefore are classified as current maturities within the consolidated balance sheet at December 31, 2011. The Health System is in the preliminary stages of developing a financing plan to cover any redemption required on bonds put to the Health System under exercise of the tender agreement.

Aggregate annual maturities of long-term debt during the years ending December 31 are as follows:

	<b>Accelerated Maturities with Letter of Credit Terms</b>	<b>Scheduled Maturities Based on Loan Agreements</b>
2012	\$ 73,258	\$ 73,258
2013	186,875	21,666
2014	157,924	21,665
2015	11,116	42,671
2016	16,364	23,394
Thereafter	347,467	610,350
	<b>\$ 793,004</b>	<b>\$ 793,004</b>

At December 31, 2011 and 2010, the Health System has included \$0 and \$17,097, respectively, in current maturities of long-term debt related to letters of credit and standby purchase agreements for related bonds that if not remarketed would require a payment within the next year.

**Iowa Health System and Subsidiaries**  
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**Note 8: Interest Rate Swaps**

**Swaps Designated as Hedging Instruments**

As a risk management strategy to maintain acceptable levels of exposure to the risk of changes in future cash flows due to interest rate fluctuations, the Health System entered into the following interest rate swap agreements:

Trade Date	Maturity Date	Current Notional Amount	Health System Pays	Health System Receives	Accounting Treatment	Fair Value	
						2011	2010
2005	2035	\$ 192,540	3.5%	62.4% of LIBOR + 29 bps	Cash Flow Hedge	\$ (37,026)	\$ (16,684)

In 2005, the Health System entered into three interest rate swap agreements, which effectively converted the Series 2005B variable rate bonds into fixed rate debt at a rate of 3.5% (4.1% including transaction costs). During 2009, these swaps were redesignated to hedge the Series 2009 A-D Bonds. The swap agreements have an aggregate notional amount of \$192,540 at December 31, 2011.

Management has designated the above interest rate swap agreements as cash flow hedging instruments, and has determined that these agreements are highly effective. The aggregate fair value of the swap agreements is recorded as a long-term liability of \$(37,026) at December 31, 2011 and \$(16,684) at December 31, 2010. The change in fair value of \$(20,342) and \$(6,819) for the years ended December 31, 2011 and 2010, respectively, is reported as part of the change in unrealized gains and losses on swaps. Interest, the net of what the Health System pays and receives under the two legs of the swaps, is settled monthly on each swap agreement and is reported as interest expense.

The Health System has provisions within certain interest rate swap agreements that would require it to post collateral should the negative fair value of the agreements exceed \$25,000 individually, the Health System's credit rating fall below Aa3 by Moody's or AA- by S&P, or the bond insurers rating fall below A- by S&P. As of December 31, 2011, the Health System has not been requested to post collateral under these agreements.

The table below presents certain information regarding the Health System's interest rate swap agreements designated as cash flow hedges. The Health System has additional derivative instruments at December 31, 2011 and 2010 that are no longer designated as hedging instruments under ASC 815 (*Derivatives and Hedging*), as shown below:

	2011	2010
<b>Other Long-term Liabilities</b>		
Fair value of interest rate swap agreements	\$ (37,026)	\$ (16,684)
<b>Unrestricted Net Assets</b>		
Loss recognized in changes in unrealized gains and losses on investments (effective portion)	(20,342)	(6,819)

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**Other Swap Agreements**

The Health System has also entered into the following interest rate swap agreements which are not designated as hedging instruments. The Health System has elected to carry these swaps as an investing activity, until such time that satisfactory termination value can be obtained, or their respective maturity date.

Trade Date	Maturity Date	Notional Amount	Health System Pays	Health System Receives	Fair Value	
					2011	2010
2006	2030	\$ 60,000	100% of SIFMA*	68.0% of LIBOR + 59.2 bps*	\$ 938	\$ -
2006	2037	143,000	3.8%	61.9% of LIBOR + 31 bps	(42,529)	(20,531)
2006	2023	42,700	3.5	61.9% of LIBOR + 31 bps	(7,593)	(4,251)
2005	2035	64,180	3.3	62.4% of LIBOR + 29 bps	(11,312)	(4,758)
					<u>\$ (60,496)</u>	<u>\$ (29,540)</u>

\*Rate represents the terms of the swap agreement, as originated. The agreement has been amended for the period until November 15, 2014. Until that date, MHSC will not make a quarterly payment and will receive fixed quarterly payments of \$188,250. After that date, the terms revert back to the original contracted terms, which are as stated in the table above.

The aggregate fair value of the unhedged swap agreements are recorded as long-term investments of \$938 and \$0 and long-term liabilities of \$(61,434) and \$(29,540), as of December 31, 2011 and 2010, respectively. The change in fair value of \$(31,141) and \$(7,640) are included as a component of other income (loss) as of December 31, 2011 and 2010, respectively. Interest, the net of what the Health System pays and receives, is settled monthly or quarterly on each swap agreement and is reported as other income (loss).

In prior years, certain swap agreements previously designated as hedges by the Health System were deemed to be ineffective. The effective portion of these changes in fair value, previously deemed effective, is being amortized into other income (loss) over the remaining life of the swap. As of December 31, 2011 and 2010, \$(699) and \$(760) of net unrealized losses remain in net assets to be amortized and \$(61) and \$475 was amortized into other income (loss), respectively.

In January 2010, the Health System terminated a swap agreement with a notional value of \$67,090, at a cost of \$(2,795). The Health System's counterparty also called swap agreements with a notional amount of \$80,760, in accordance with the agreement, in February 2010.

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Other Swaps:

	2011	2010
<b>Other Long-term Investments</b>		
Fair value of interest rate swap agreement	\$ 938	\$ -
<b>Other Long-term Liabilities</b>		
Fair value of interest rate swap agreements	(61,434)	(29,540)
<b>Unrestricted Net Assets</b>		
Change in unrestricted net assets amortizing into		
Other, net	61	(475)
<b>Nonoperating Other, Net</b>		
Loss recognized in income from changes in		
fair value of interest rate swaps	(31,141)	(7,640)
Gain (loss) recognized in income from amortization of		
unrecognized gains (losses) in unrestricted net assets	(61)	475
Loss recognized in income from termination of		
interest rate swap	-	(2,795)

**Note 9: Related-Party Transactions**

The Health System leases real estate from certain companies controlled by members of the Board of Directors of the Health System or its subsidiaries. Minimum payments under these operating leases are \$4,842 per year. The leases expire in various periods through 2021. Rent expense under these leases, including a pro rata portion of certain operating expenses of the facilities, was \$4,915 and \$7,107 for 2011 and 2010, respectively. At December 31, 2011 and 2010, the Health System also had outstanding debt related to real estate capital lease obligations of \$10,963 and \$1,503, respectively. The Health System also leases real estate to physicians who may serve the Health System through board of director or medical director roles.

The Health System purchases a variety of services and products from companies affiliated with members of the Boards of Directors of the Health System and/or its subsidiaries. Services and products purchased from these affiliated companies during 2011 and 2010 totaled \$13,693 and \$13,382, respectively, of which \$4,902 and \$7,526, respectively, were related to construction project costs. In addition, the Health System purchases services from several joint ventures and sells services and supplies to several joint ventures in which the Health System is also an investor. The Health System believes these transactions are consummated under commercially reasonable business arrangements.

The Health System has recorded receivables for amounts held by nonconsolidated foundations on behalf of the Health System of \$41,527 and \$40,594 as of December 31, 2011 and 2010, respectively. Contributions received from nonconsolidated foundations and other related parties were \$2,326 and \$3,562 in 2011 and 2010, respectively.

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**Note 10: Retirement Benefit Plans**

***Defined Contribution Retirement Plans***

The Health System has several defined contribution benefit plans, which are available to substantially all employees meeting age and length of service requirements. Participating employers annually determine the amount, if any, of the Health System's contributions to the plan. Total benefit expenses under the defined contribution plans were approximately \$46,250 and \$44,537 for 2011 and 2010, respectively. The Health System also has deferred compensation plans for certain employees. Total expenses under the deferred compensation plans were \$2,394 and \$2,534 for 2011 and 2010, respectively.

***Defined Benefit Plans***

Prior to 2001, substantially all employees of four of the Health System's subsidiaries were covered by noncontributory defined benefit pension plans, all of which have subsequently been frozen to new participants or terminated. The Health System's funding policy is to make the minimum annual contribution that is required by applicable regulations, plus such amounts as the Health System may determine to be appropriate from time to time.

Upon the affiliation with MHSC (Peoria) during the year, the Health System inherited their noncontributory defined benefit pension plan, which has been frozen to new participants since 2007. Pension benefits are based on compensation of employees and years of service and are actuarially determined. As part of the accounting for the affiliation transaction, unrecognized pension benefit costs in unrestricted net assets were eliminated as they will not be recognized through earnings on the Health System's financial statements.

The Health System expects to contribute \$15,592 to the plans in 2012.

In 2010, the Sioux City affiliate completed its plan for termination and distribution of the assets in its defined benefit pension plan. The plan was terminated effective January 31, 2008. In December 2009, a determination letter was received from the IRS approving the termination.

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The following tables set forth information about each defined benefit plan:

	As of December 31, 2011			
	Des Moines	Cedar Rapids	Waterloo	Peoria
<b>Change in benefit obligation</b>				
Benefit obligation, beginning of year	\$ 175,394	\$ 106,552	\$ 53,275	\$ 219,916 *
Service cost	3,941	116	353	1,320
Interest cost	10,313	6,271	3,126	2,870
Actuarial loss	20,639	15,580	6,111	8,417
Benefits paid	(8,682)	(3,956)	(1,849)	(1,464)
Benefit obligation, end of year	<u>201,605</u>	<u>124,563</u>	<u>61,016</u>	<u>231,059</u>
<b>Change in fair value of plan assets</b>				
Fair value of plan assets, beginning of year	181,094	89,605	50,064	118,836 *
Actual return on plan assets	9,639	3,730	3,951	5,441
Employer contributions	7,275	4,939	3,300	1,582
Benefits paid	(8,682)	(3,956)	(1,850)	(1,464)
Fair value of plan assets, end of year	<u>189,326</u>	<u>94,318</u>	<u>55,465</u>	<u>124,395</u>
Funded status, end of year	<u>\$ (12,279)</u>	<u>\$ (30,245)</u>	<u>\$ (5,551)</u>	<u>\$ (106,664)</u>
Accumulated benefit obligation	<u>\$ 201,605</u>	<u>\$ 124,349</u>	<u>\$ 61,016</u>	<u>\$ 206,435</u>
*As of October 1, 2011.				
<b>Liabilities recognized in the balance sheets</b>				
Noncurrent liabilities	<u>\$ (12,279)</u>	<u>\$ (30,245)</u>	<u>\$ (5,551)</u>	<u>\$ (106,664)</u>
<b>Amounts recognized in unrestricted net assets but not yet recognized as components of net periodic benefit cost</b>				
Net loss	\$ 36,115	\$ 47,394	\$ 18,205	\$ 5,569
Net prior service cost (credit)	42	-	(4,476)	-
	<u>\$ 36,157</u>	<u>\$ 47,394</u>	<u>\$ 13,729</u>	<u>\$ 5,569</u>
<b>Amounts expected to be recognized within one year</b>				
Net loss	\$ 1,994	\$ 3,882	\$ 1,567	\$ -
Net prior service cost (credit)	42	-	(651)	-
	<u>\$ 2,036</u>	<u>\$ 3,882</u>	<u>\$ 916</u>	<u>\$ -</u>
<b>Other changes in plan assets recognized in changes in net assets</b>				
Net loss	\$ 25,240	\$ 18,976	\$ 6,087	\$ 5,569
Amortization of				
Net loss	-	(2,166)	(859)	-
Prior service (cost) credit	(46)	-	651	-
Total recognized in changes in net assets	<u>\$ 25,194</u>	<u>\$ 16,810</u>	<u>\$ 5,879</u>	<u>\$ 5,569</u>

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	As of December 31, 2011			
	Des Moines	Cedar Rapids	Waterloo	Peoria
<b>Weighted-average assumptions used to determine benefit obligations for the year ended December 31, 2011</b>				
Discount rate	5.00%	5.00%	5.00%	5.00%
Rate of compensation increase	4.00%	5.00%	N/A	3.25%
<b>Weighted-average assumptions used to determine benefit costs for the year ended December 31, 2011</b>				
Discount rate	6.00%	6.00%	6.00%	5.25%
Expected return on plan assets	8.00%	8.00%	8.00%	8.50%
Rate of compensation increase	4.00%	N/A	N/A	3.25%
<b>Components of net periodic benefit cost</b>				
Service cost	\$ 3,941	\$ 116	\$ 353	\$ 1,320
Interest cost	10,313	6,271	3,126	2,870
Expected return on plan assets	(14,239)	(7,126)	(3,928)	(2,594)
Amortization of prior service cost (credit)	46	-	(651)	-
Recognized net actuarial loss	-	2,166	859	-
Net periodic benefit cost (benefit)	<u>\$ 61</u>	<u>\$ 1,427</u>	<u>\$ (241)</u>	<u>\$ 1,596</u>
	As of December 31, 2010			
	Des Moines	Cedar Rapids	Waterloo	Sioux City
<b>Change in benefit obligation</b>				
Benefit obligation, beginning of year	\$ 158,490	\$ 97,288	\$ 48,520	\$ 13,422
Service cost	3,530	122	489	-
Interest cost	9,966	6,203	3,104	-
Actuarial loss	10,442	6,607	2,793	-
Benefits paid	(7,034)	(3,668)	(1,680)	(13,422)
Curtailment gain from freezing benefits	-	-	49	-
Benefit obligation, end of year	<u>175,394</u>	<u>106,552</u>	<u>53,275</u>	<u>-</u>
<b>Change in fair value of plan assets</b>				
Fair value of plan assets, beginning of year	166,024	79,108	44,017	14,740
Actual return on plan assets	21,104	10,532	4,427	-
Employer contributions	1,000	3,633	3,300	-
Benefits paid	(7,034)	(3,668)	(1,680)	(13,473)
Settlement	-	-	-	(1,267)
Fair value of plan assets, end of year	<u>181,094</u>	<u>89,605</u>	<u>50,064</u>	<u>-</u>
Funded status, end of year	<u>\$ 5,700</u>	<u>\$ (16,947)</u>	<u>\$ (3,211)</u>	<u>\$ -</u>
Accumulated benefit obligation	<u>\$ 172,110</u>	<u>\$ 106,045</u>	<u>\$ 53,275</u>	<u>\$ -</u>
<b>Assets and liabilities recognized in the balance sheets</b>				
Noncurrent assets	\$ 5,700	\$ -	\$ -	\$ -
Noncurrent liabilities	\$ -	\$ (16,947)	\$ (3,211)	\$ -

**Iowa Health System and Subsidiaries**  
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	As of December 31, 2010			
	Des Moines	Cedar Rapids	Waterloo	Sioux City
<b>Amounts recognized in unrestricted net assets but not yet recognized as components of net periodic benefit cost</b>				
Net loss	\$ 10,875	\$ 30,584	\$ 12,977	\$ -
Net prior service cost (credit)	88	-	(5,127)	-
	<u>\$ 10,963</u>	<u>\$ 30,584</u>	<u>\$ 7,850</u>	<u>\$ -</u>
<b>Amounts expected to be recognized within one year</b>				
Net loss	\$ -	\$ 2,166	\$ 859	\$ -
Net prior service cost (credit)	46	-	(651)	-
	<u>\$ 46</u>	<u>\$ 2,166</u>	<u>\$ 208</u>	<u>\$ -</u>
<b>Other changes in plan assets recognized in changes in net assets</b>				
Net loss	\$ 2,543	\$ 2,375	\$ 1,886	\$ -
Prior service cost	-	-	49	-
Amortization of				
Net loss	-	(2,174)	(590)	(2,995)
Prior service (cost) credit	(46)	-	642	-
	<u>\$ 2,497</u>	<u>\$ 201</u>	<u>\$ 1,987</u>	<u>\$ (2,995)</u>
<b>Total recognized in changes in net assets</b>				
	<u>\$ 2,497</u>	<u>\$ 201</u>	<u>\$ 1,987</u>	<u>\$ (2,995)</u>
<b>Weighted-average assumptions used to determine benefit obligations for the year ended December 31, 2010</b>				
Discount rate	6.00%	6.00%	6.00%	N/A
Rate of compensation increase	4.00%	5.00%	N/A	N/A
<b>Weighted-average assumptions used to determine benefit costs for the year ended December 31, 2010</b>				
Discount rate	6.50%	6.50%	6.50%	N/A
Expected return on plan assets	8.00%	8.00%	8.00%	N/A
Rate of compensation increase	4.00%	5.00%	N/A	N/A
<b>Components of net periodic benefit cost</b>				
Service cost	\$ 3,530	\$ 122	\$ 489	\$ -
Interest cost	9,966	6,203	3,104	-
Expected return on plan assets	(13,204)	(6,300)	(3,519)	-
Amortization of prior service cost (credit)	46	-	(642)	-
Recognized net actuarial loss	-	2,174	590	2,995
	<u>\$ 338</u>	<u>\$ 2,199</u>	<u>\$ 22</u>	<u>\$ 2,995</u>
<b>Net periodic benefit cost</b>				
	<u>\$ 338</u>	<u>\$ 2,199</u>	<u>\$ 22</u>	<u>\$ 2,995</u>

## Iowa Health System and Subsidiaries

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The Health System has estimated the long-term rate of return on plan assets based primarily on historical returns on plan assets, adjusted for changes in target portfolio allocations and recent changes in long-term interest rates based on publicly available information.

Plan assets are held by a bank-administered trust fund, which invests the plan assets in accordance with the provisions of the plan agreement. The plan agreements permit investment in common stocks, corporate bonds and debentures, U.S. Government securities and other specified investments, based on certain target allocation percentages.

Asset allocation is primarily based on a strategy to provide stable earnings while still permitting the plans to recognize potentially higher returns through a limited investment in equity securities. The target asset allocation percentages for 2011 and 2010 are as follows:

		2011			
		Des Moines	Cedar Rapids	Waterloo	Peoria
Equity securities	Not to exceed	20%	50%	25%	60%
Fixed income	Not to exceed	80	50	75	25
Private investment funds	Not to exceed	-	-	-	15

		2010		
		Des Moines	Cedar Rapids	Waterloo
Equity securities	Not to exceed	20%	35%	35%
Fixed income	Not to exceed	50	35	35
Private investment funds	Not to exceed	30	30	30

**Iowa Health System and Subsidiaries**  
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Plan assets are re-balanced quarterly. At December 31, 2011 and 2010, plan asset allocations are as follows:

	2011				2010	
	Des Moines	Cedar Rapids	Waterloo	Peoria	Des Moines	Cedar Rapids
Cash and short term investments	-	2%	3%	-	4%	4%
U.S. Treasury obligations	-	8	10	-	13	12
U.S. Government agency obligations	-	10	12	-	2	2
Asset-backed securities						
Home equity	-	1	1	-	1	1
Other	-	2	2	-	-	-
Mortgage-backed securities						
Government	-	2	2	-	1	1
Non-government	-	3	4	-	4	3
Corporate bonds	11%	27	34	-	25	12
Corporate bonds - PIF	69	-	6	-	-	1
Equity securities						
Domestic	3	7	3	-	2	3
Equity securities - PIF						
Domestic	8	17	10	-	8	17
International	3	6	3	-	3	6
Mutual funds						
Domestic	1	3	2	-	1	2
International	3	6	4	13 %	4	6
Emerging markets	2	5	3	-	3	5
Equity	-	-	-	30	-	-
Other	-	-	-	4	-	-
Fixed Income	-	-	-	27	-	-
Hedge fund of funds	-	-	1	26	-	-
Interest receivable	-	1	-	-	29	25
	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>

**Defined Benefit Plan Assets**

Following is a description of the valuation methodologies used for pension plan assets measured at fair value on a recurring basis and recognized in the accompanying consolidated balance sheets, as well as the general classification of pension plan assets pursuant to the valuation hierarchy.

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Where quoted market prices are available in an active market, plan assets are classified within Level 1 of the valuation hierarchy. Level 1 plan assets include highly liquid U.S. Treasuries and exchange traded equities. If quoted market prices are not available, then fair values are estimated by using pricing models, quoted prices of plan assets with similar characteristics or discounted cash flows. Level 2 plan assets include U.S. Government agency obligations, collateralized mortgage obligations, corporate bonds and PIFs. For these investments, the inputs used by the pricing service to determine the fair value include one or a combination of observable inputs, such as broker/dealer quotes, issuer spreads, benchmark securities, bid offers and reference data market research publications. In certain cases where Level 1 and Level 2 inputs are not available, plan assets are classified within Level 3 hierarchy. The plans have no Level 3 investments.

PIFs include interest in fixed income and equity security investment portfolios as well as alternative asset partnerships. PIFs are valued based on the Health System's proportionate interest in the fair value of the underlying investment assets held by the fund, adjusted to reflect risk associated with liquidity of their investment in the partnership, restrictions on transfer and other matters, if any. Interest in funds that consist of underlying securities with observable inputs, such as quoted market prices or quoted prices of securities with similar characteristics, are categorized as Level 2 of the fair value hierarchy.

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The fair values of the Health System's pension plans' assets at December 31, 2011 and 2010, by asset category are as follows:

	2011			
	Fair Value Measurements Using			
	Fair Value	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Cash and short-term investments	\$ 3,830	\$ 457	\$ 3,373	\$ -
U.S. Treasury obligations	12,717	-	12,717	-
U.S. Government agency obligations	15,490	-	15,490	-
Asset-backed securities				
Home equity	1,122	-	1,122	-
Other	2,707	-	2,707	-
Mortgage-backed securities				
Government	3,323	-	3,323	-
Non-government	5,158	-	5,158	-
Corporate bonds	64,543	46	64,497	-
Corporate bonds - PIF	134,808	-	134,808	-
Equity securities				
Domestic	13,457	13,457	-	-
Equity securities - PIF				
Domestic	35,814	-	35,814	-
International	12,796	-	12,796	-
Mutual funds				
Domestic	6,639	6,639	-	-
International	29,358	29,358	-	-
Emerging markets	11,034	11,034	-	-
Equity	36,856	36,856	-	-
Other	5,415	5,415	-	-
Fixed income	34,277	34,277	-	-
Hedge fund of funds - PIF	33,124	-	33,124	-
	<u>\$ 462,468</u>	<u>\$ 137,539</u>	<u>\$ 324,929</u>	<u>\$ -</u>

**Iowa Health System and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
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	2010				
	<u>Fair Value Measurements Using</u>				
	<u>Quoted Prices</u>	<u>Significant</u>		<u>Significant</u>	
	<u>in Active</u> <u>Markets for</u> <u>Identical</u> <u>Assets</u> <u>(Level 1)</u>	<u>Other</u> <u>Observable</u> <u>Inputs</u> <u>(Level 2)</u>	<u>Unobservable</u> <u>Inputs</u> <u>(Level 3)</u>		
Fair Value					
Cash and short-term investments	\$ 11,706	\$ -	\$ 11,706	\$ -	
U.S. Treasury obligations	39,674	-	39,674	-	
U.S. Government agency obligations	7,841	-	7,841	-	
Asset-backed securities					
Home equity	2,953	-	2,953	-	
Other	1,276	-	1,276	-	
Mortgage-backed securities					
Government	3,388	-	3,388	-	
Non-government	11,643	-	11,643	-	
Corporate bonds	62,775	235	62,540	-	
Corporate bonds - PIF	2,866	-	2,866	-	
Equity securities					
Domestic	7,940	7,940	-	-	
Equity securities - PIF					
Domestic	35,714	-	35,714	-	
International	14,978	-	14,978	-	
Mutual funds					
Domestic	5,940	5,940	-	-	
International	15,509	15,509	-	-	
Emerging markets	13,354	13,354	-	-	
Hedge fund of funds - PIF	81,586	-	81,586	-	
	<u>\$ 319,143</u>	<u>\$ 42,978</u>	<u>\$ 276,165</u>	<u>\$ -</u>	

The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid as of December 31, 2011:

2012	\$ 21,046
2013	22,372
2014	24,667
2015	26,733
2016	28,371
2017 - 2021	182,412

## Iowa Health System and Subsidiaries

### Notes to Consolidated Financial Statements

(Dollars in Thousands)

December 31, 2011 and 2010

#### Note 11: Risk Management

The Health System's hospitals are primarily self-insured for professional and general liability for amounts of \$5,000 per claim and \$25,000 in the aggregate annually. Professional and general liability insurance coverage is maintained on a claims-made basis, with a liability limit of \$25,000. Other entities of the Health System maintain their professional and general liability coverage on a claims-made basis with no significant deductibles.

The Health System is primarily self-insured for workers' compensation and employee health care claims. Workers' compensation claims individually and in the aggregate that exceed certain amounts are covered by insurance.

Property insurance is maintained with at least 90% replacement value coverage and minimal deductibles. Business interruption insurance coverage is also maintained by the Health System.

The Health System has accrued as other liabilities \$72,724 and \$50,241 for self-insured losses at December 31, 2011 and 2010, respectively. As the Health System adopted ASU 2010-24 in 2011 (see Note 1), the liabilities are presented on a gross basis as of December 31, 2011 and the Health System has recorded the expected offsetting insurance recoveries as a receivable. The accrued liabilities are based on management's evaluation of the merits of various claims, historical experience and consultation with external insurance consultants and actuaries, and include estimates for incurred but not reported claims. There can be no assurance that the accrued liabilities will be sufficient for the ultimate amounts that will be paid for claims and settlements. Also, in the ordinary course of business, the Health System is involved in other litigation and claims, none of which management believes will ultimately result in losses that will adversely affect the Health System's consolidated net assets or results of operations to a material degree.

Cash and investments have been internally designated to be held for payments of claims, if any, which may result from the self-insured or uninsured portion of liability insurance and workers' compensation claims. At December 31, 2011 and 2010, the cash and investments amounted to \$37,049 and \$32,803, respectively.

#### Note 12: Lease Commitments

Certain property and equipment is being leased under long-term noncancelable operating leases. In most cases, management expects that, in the normal course of operations, the leases will be renewed or replaced by other leases. The total rent expense under operating leases during 2011 and 2010 was \$46,499 and \$41,629, respectively.

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The following is a schedule by year of future minimum rental payments required under noncancelable operating leases that have initial or remaining noncancelable lease terms in excess of one year as of December 31, 2011.

2012	\$ 33,980
2013	25,436
2014	16,967
2015	12,046
2016	8,874
Thereafter	<u>40,846</u>
Total minimum payments required	<u>\$ 138,149</u>

**Note 13: Disclosures About Fair Value of Financial Instruments**

ASC Topic 820, *Fair Value Measurements*, defines fair value as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. Topic 820 also specifies a fair value hierarchy which requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. The standard describes three levels of inputs that may be used to measure fair value:

- Level 1 Quoted prices in active markets for identical assets or liabilities
- Level 2 Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities; quoted prices in active markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities
- Level 3 Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities

***Financial Instruments Measured at Fair Value on a Recurring Basis***

Following is a description of the valuation methodologies used for instruments measured at fair value on a recurring basis and recognized in the accompanying consolidated balance sheets, as well as the general classification of such instruments pursuant to the valuation hierarchy.

## Iowa Health System and Subsidiaries

### Notes to Consolidated Financial Statements

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#### **Investments**

Where quoted market prices are available in an active market, securities are classified within Level 1 of the valuation hierarchy. Level 1 securities include highly liquid U.S. Treasuries, exchange traded equities and mutual funds. If quoted market prices are not available, then fair values are estimated by using pricing models, quoted prices of securities with similar characteristics or discounted cash flows. Level 2 securities include U.S. government agency obligations, collateralized mortgage obligations, corporate debt obligations and PIFs. For these investments, the inputs used by the pricing service to determine the fair value include one or a combination of observable inputs, such as broker/dealer quotes, issuer spreads, benchmark securities, bid offers and reference data market research publications. In certain cases where Level 1 or Level 2 inputs are not available, securities are classified within Level 3 of the hierarchy and include certain less liquid securities. The Health System has no Level 3 investments.

PIFs include interests in fixed income and equity security investment portfolios as well as alternative asset partnerships. PIFs are valued based on the Health System's proportionate interest in the fair value of the underlying investment assets held by the fund, adjusted to reflect risk associated with liquidity of their investment in the partnership, restrictions on transfer and other matters, if any. Interest in funds that consist of underlying securities with observable inputs, such as quoted market prices or quoted prices of securities with similar characteristics, are categorized as Level 2 of the fair value hierarchy.

Quoted market prices were used to determine the fair value of Level 1 items. For Level 2 investments, inputs include: maturity and coupon rates and/or closing prices of similar securities from comparable industry financial data, as well as private investment fund's net asset values.

#### **Interest Rate Swap Agreements**

The fair value of interest rate swap agreements are estimated by a third party using inputs that are observable or that can be corroborated by observable market data and, therefore, are classified within Level 2 of the valuation hierarchy.

#### **Beneficial interests In Trusts**

The fair value is estimated at the present value of the future distributions expected to be received over the term of the agreement. Due to the nature of the valuation inputs, the interest is classified within Level 2 of the hierarchy.

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**Fair Value Measurements**

The following table presents the fair value measurements of assets and liabilities recognized in the accompanying consolidated balance sheets measured at fair value on a recurring basis and the level within the fair value hierarchy in which the fair value measurements fall at December 31, 2011 and 2010:

	Fair Value	2011 Fair Value Measurements Using		
		Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
<b>Financial Assets</b>				
Cash and short-term investments	\$ 205,626	\$ 17,410	\$ 188,216	\$ -
U.S. Treasury obligations	23,249	-	23,249	-
U.S. Government agency obligations	8,140	-	8,140	-
Asset-backed securities				
Home equity	17,691	-	17,691	-
Other	6,703	-	6,703	-
Mortgage-backed securities				
Government	59,252	-	59,252	-
Non-government	40,893	-	40,893	-
Certificates of deposit	474	474	-	-
Corporate bonds	53,718	-	53,718	-
Corporate bonds - PIF	190,763	-	190,763	-
Equity securities				
Domestic	120,855	120,855	-	-
International	135	135	-	-
Equity securities - PIF				
Domestic	149,383	-	149,383	-
International	73,392	-	73,392	-
Mutual funds				
Domestic	19,659	19,659	-	-
International	85,031	85,031	-	-
Emerging markets	58,811	58,811	-	-
Index	3,192	3,192	-	-
Equity	30,383	30,383	-	-
Fixed Income	67,927	67,927	-	-
Other	4,780	4,780	-	-
Hedge fund of funds - PIF	101,444	-	101,444	-
Insurance policies	4,199	-	4,199	-
Beneficial interests in trusts	11,521	-	11,521	-
<b>Financial Liabilities</b>				
Interest rate swap agreements (net)	(97,522)	-	(97,522)	-
	<u>\$ 1,239,699</u>	<u>\$ 408,657</u>	<u>\$ 831,042</u>	<u>\$ -</u>

**Iowa Health System and Subsidiaries**  
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	2010			
	Fair Value Measurements Using			
	Fair Value	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
<b>Financial Assets</b>				
Cash and short-term investments	\$ 247,437	\$ 6,987	\$ 240,450	\$ -
U.S. Treasury obligations	38,742	-	38,742	-
U.S. Government agency obligations	18,587	-	18,587	-
<b>Asset-backed securities</b>				
Home equity	11,728	-	11,728	-
Other	2,626	-	2,626	-
<b>Mortgage-backed securities</b>				
Government	32,509	-	32,509	-
Non-government	39,140	-	39,140	-
Certificates of deposit	474	474	-	-
Corporate bonds	46,631	-	46,631	-
Corporate bonds - PIF	171,449	-	171,449	-
<b>Equity securities</b>				
Domestic	124,520	124,520	-	-
<b>Equity securities - PIF</b>				
Domestic	147,252	-	147,252	-
International	84,292	-	84,292	-
<b>Mutual funds</b>				
Domestic	15,419	15,419	-	-
International	75,241	75,241	-	-
Emerging markets	82,498	82,498	-	-
Hedge fund of funds - PIFs	78,627	-	78,627	-
Insurance policies	4,026	-	4,026	-
Beneficial interests in trusts	5,487	-	5,487	-
<b>Financial Liabilities</b>				
Interest rate swap agreements (net)	(46,224)	-	(46,224)	-
	<u>\$ 1,180,461</u>	<u>\$ 305,139</u>	<u>\$ 875,322</u>	<u>\$ -</u>

**Iowa Health System and Subsidiaries**  
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**Financial Instruments Not Measured at Fair Value**

The fair value for certain financial instruments approximates the carrying value because of the short-term maturity of these instruments, which include cash and cash equivalents, short-term investments, receivables, accounts payable, accrued liabilities, estimated settlements due to third-party payers and other current liabilities.

The carrying amount of the variable rate bonds and notes is assumed to approximate fair value. For the fixed-rate bonds, the estimated fair value is based on quoted prices for similar liabilities and is obtained from a financial institution that deals in these types of instruments. Other debt obligations are insignificant, and the carrying amounts are assumed to approximate fair value.

Estimates of fair values are subjective in nature and involve uncertainties and matters of significant judgment and, therefore, cannot be determined with precision. Changes in assumptions could affect the estimates. The fair market value of the Health System's financial instruments at December 31 approximates the carrying value except as follows:

	2011		2010	
	Carrying Value	Fair Value	Carrying Value	Fair Value
Long-term debt, excluding capital leases	\$ 779,426	\$ 803,109	\$ 687,203	\$ 674,486

**Note 14: Temporarily and Permanently Restricted Net Assets**

Temporarily restricted net assets are available for the following purposes or periods as of December 31:

	2011	2010
Purchase of equipment	\$ 7,555	\$ 6,257
Indigent care/operations	12,278	6,308
Health education	5,670	5,791
For use in future periods	3,433	6,629
Other	28,888	20,509
Total temporarily restricted net assets	<u>\$ 57,824</u>	<u>\$ 45,494</u>

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Permanently restricted net assets are restricted to the following as of December 31:

	2011	2010
Investments (generally including net investment appreciation and depreciation) to be held in perpetuity (income is restricted)	\$ 24,875	\$ 24,904
Investments (generally including net investment appreciation and depreciation) to be held in perpetuity (income is restricted for various purposes as directed by the donors)	12,810	13,001
Other	9,384	5,263
Total permanently restricted net assets	\$ 47,069	\$ 43,168

**Note 15: Asset Retirement Obligation**

Accounting principles generally accepted in the United States of America require that an asset retirement obligation (ARO) associated with the retirement of a tangible long-lived asset be recognized as a liability in the period in which it is incurred or becomes determinable (as defined by the standard) even when the timing and/or method of settlement may be conditional on a future event. The Health System's conditional asset retirement obligations primarily relate to asbestos contained in various buildings. Environmental regulations in many of the states where the Health System operates require the Health System to handle and dispose of asbestos in a special manner if a building undergoes major renovations or is demolished.

A summary of changes in asset retirement obligations, which is included on the accompanying consolidated balance sheets in other long-term liabilities, during 2011 and 2010 is included in the table below.

	2011	2010
Liability, beginning of year	\$ 12,108	\$ 11,910
Liabilities settled	(1,052)	(501)
Accretion expense	718	700
Liabilities assumed in affiliation with MHSC	1,024	-
Changes in estimates, including timing	-	(1)
Liability, end of year	\$ 12,798	\$ 12,108

# Iowa Health System and Subsidiaries

## Notes to Consolidated Financial Statements

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### Note 16: Commitments and Contingencies

The health care industry is subject to numerous laws and regulations of federal, state and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Government activity has increased with respect to investigations and allegations concerning possible violations of regulations by health care providers, which could result in the imposition of significant fines and penalties as well as significant repayments of previously billed and collected revenues for patient services. The Health System has a corporate compliance plan intended to meet federal guidelines. As a part of this plan, the Health System performs periodic internal reviews of its compliance with laws and regulations. As part of the Health System's compliance efforts, the Health System investigates and attempts to resolve and remedy all reported or suspected incidents of material noncompliance with applicable laws, regulations or policies on a timely basis. The Health System believes that these compliance programs and procedures lead to substantial compliance with current laws and regulations.

The Health System is in various stages of responding to inquiries and investigations. These various inquiries and investigations could result in fines and/or financial penalties, which could be material. At this time, the Health System is unable to estimate the possible liability, if any, that may be incurred as a result of these inquiries and investigations, but the Health System does not believe it would materially affect the financial position of the Health System.

#### Guarantees

The Health System has guaranteed approximately \$13,236 and \$7,302 at December 31, 2011 and 2010, respectively, relating to long-term debt for the construction of two cancer centers, an endoscopy center, a medical office building that includes clinic and office space, and debt related to joint ventures.

#### Employment Contracts

The Health System is committed for noncancelable physician employment contracts in the following amounts, prior to inflationary adjustments and bonuses based on future events:

2012	\$	12,726
2013		980
2014		429

#### Current Economic Conditions

The current protracted economic decline continues to present healthcare organizations with difficult circumstances and challenges, which in some cases have resulted in large and unanticipated declines in the fair value of investments and other assets, large declines in contributions and constraints on liquidity. The financial statements have been prepared using values and information currently available to the Health System.

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## Iowa Health System and Subsidiaries

### Notes to Consolidated Financial Statements

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Some of the Health System's patients are covered by government sponsored Medicare or Medicaid programs. The effect of the current economic conditions on government budgets may have an adverse effect on the cash flow from these programs.

Further, current economic conditions have made it difficult for certain of the Health System's other patients to pay for services rendered. As employers make adjustments to health insurance plans or more patients become unemployed, services provided to self-pay and other payers may significantly impact net patient service revenue, which could have an adverse impact on the Health System's future operating results.

#### **Note 17: Subsequent Events**

Subsequent events have been evaluated through April 19, 2012, which is the date the financial statements were issued.

On January 6, 2012, the Health System entered into a revolving line of credit facility (Revolver) that provides for an aggregate principal amount of \$50,000 in borrowings and bears an interest rate of LIBOR plus 60 basis points for funds drawn against the facility. Additionally, a facility fee of 10 basis points is required on the undrawn portion of the Revolver. The maturity date of this facility is January 5, 2014.

Iowa Health System and Subsidiaries  
 Consolidating Schedule - Balance Sheet Information  
 (In Thousands)  
 December 31, 2011

Assets	IHDH	TRHS	HOEC	ILHC	ANS	TW	ILHS	TRST	HP	BHC	DS & Oth	Elmhurst	Consolidated
<b>Current Assets</b>													
Cash and cash equivalents	\$ 1,356	\$ 16,093	\$ 20,517	\$ 17,796	\$ 4,114	\$ 11,507	\$ 7,899	\$ 4,949	\$ 1,533	\$ 287	\$ 7,839	\$ -	\$ 65,336
Short-term investments	8,663	43,216	-	40,711	12,264	5,442	12,239	5,461	12,112	2,012	-	-	182,911
Assets held as to be acquired for current liabilities	2,411	3,128	-	2,938	1,222	712	1,391	-	-	-	-	-	11,914
Prepaid accounts receivable, less allowance for collectibles	28,475	31,450	54,787	48,146	23,136	14,946	23,428	12,860	14,977	15,573	-	-	344,882
Other receivables:													
Insurance	11,891	2,558	4,138	4,985	4,490	1,435	2,827	2,285	713	1,551	-	-	42,277
Prepaid expenses	10,517	9,265	1,668	3,778	6,011	2,944	3,338	2,152	1,993	1,881	-	-	49,105
Due from affiliates	2,341	1,579	7,024	1,872	866	496	781	312	879	29	-	-	35,409
Total other receivables	26,549	24,687	32,633	58,691	25,424	11,776	17,447	10,061	14,662	4,463	-	-	164,672
Total current assets	177,079	128,534	116,112	126,511	57,427	43,944	49,092	37,277	43,031	28,144	-	-	760,878
<b>Assets Held As To Be Acquired</b>													
Held by trust under loan indemnity agreements	2,924	-	-	-	-	-	-	-	-	-	-	-	2,924
Intentionally delinquent	440,215	116,727	6,764	85,736	1,457	35,261	41,726	46,464	-	-	-	-	724,146
Total assets held as to be acquired	443,139	116,727	6,764	85,736	1,457	35,261	41,726	46,464	-	-	-	-	727,070
<b>Property, Plant and Equipment, net</b>	280,258	143,537	218,922	164,613	103,498	74,457	55,862	47,847	6,813	6,377	120,820	-	1,237,472
Other Long-term Investments	42,271	1,815	130,805	18,578	84,826	12,895	1,185	157	23,328	14,183	6,579	-	345,581
Investments in Other Ventures and Other Investments	22,728	5,887	13,779	15,323	7,171	2,122	11,438	4,325	556	-	32,615	68,497	54,843
Contributions Receivable, net	8,786	1,248	5,497	31,396	3,185	1,937	2,874	6,845	-	-	-	-	61,285
Other	3,147	2,796	1,919	2,884	3,823	893	744	851	759	15	13,377	-	30,331
<b>Debt From Affiliates</b>	-	-	-	-	158	-	-	50	-	-	472,048	-	472,256
<b>Total assets</b>	\$ 768,483	\$ 481,515	\$ 513,071	\$ 437,735	\$ 257,317	\$ 113,177	\$ 178,931	\$ 139,061	\$ 78,629	\$ 43,953	\$ 767,931	\$ 681,172	\$ 3,228,436
<b>Liabilities and Net Assets</b>													
<b>Current Liabilities</b>													
Accounts payable of long-term debt	\$ 314	\$ 2,012	\$ 5,702	\$ 796	\$ 48	\$ 395	\$ -	\$ 333	\$ 1,021	\$ 1,654	\$ 2,611	\$ -	\$ 72,258
Accounts payable	22,877	16,126	24,832	12,815	8,040	3,813	4,333	3,821	4,140	4,154	3,326	-	128,157
Accounts payable	39,913	16,529	9,270	21,324	10,778	4,812	3,412	4,140	4,154	3,326	-	-	122,586
Accounts payable	-	-	776	-	-	419	-	-	-	-	-	-	5,481
Estimated retirement due to third party plans	18,694	7,096	27,934	5,730	5,895	1,521	2,603	2,341	-	722	-	-	67,348
Due to affiliates	19,883	8,516	-	9,339	4,719	1,484	5,923	1,729	1,064	478	-	-	54,887
Other current liabilities	7,452	7,274	13,041	5,583	4,791	2,343	2,693	2,306	3,011	123	-	-	55,284
Total current liabilities	94,793	58,765	88,367	55,327	35,671	16,639	22,413	13,824	20,527	18,614	-	-	441,337
Long-term Debt, net	33,978	14,770	104,379	7	43	2,027	-	-	-	-	-	-	326,837
Other Long-term Liabilities	39,352	12,330	131,371	26,196	14,942	11,096	5,489	1,491	18,939	805	-	-	283,537
<b>Debt to Affiliates</b>	139,326	126,116	262,748	26,116	59,880	16,276	13,877	7,624	-	212	478,128	-	1,046,373
<b>Total liabilities</b>	368,097	291,641	516,494	171,336	105,616	45,942	83,716	25,419	39,436	11,835	777,067	478,128	1,546,373
<b>Net Assets</b>													
Unrestricted	411,873	183,991	182,562	231,384	132,999	67,547	87,085	159,281	31,773	31,720	(28,815)	48,497	1,632,211
Temporarily restricted	8,140	4,329	8,991	17,840	17,840	4,124	2,683	5,947	757	757	103	-	25,244
Permanently restricted	16,726	1,282	3,518	18,817	3,992	1,844	1,256	1,463	-	-	-	-	47,665
<b>Total net assets</b>	652,749	199,882	194,613	268,041	154,831	73,512	91,648	166,741	33,527	32,477	(28,812)	48,497	1,732,124
<b>Total liabilities and net assets</b>	\$ 1,021,232	\$ 681,515	\$ 711,107	\$ 699,776	\$ 412,147	\$ 186,689	\$ 270,579	\$ 305,802	\$ 112,156	\$ 76,430	\$ 749,155	\$ 1,126,300	\$ 4,970,560

**Definitions**  
 IHDH - Iowa Health - Des Moines and Subsidiaries (Des Moines)  
 TRHS - Trinity Regional Health System and Subsidiaries (Rock Hill)  
 HOEC - Holyoke Health Services Corp. and Subsidiaries (Holyoke)  
 ILHC - Iowa Lutheran Health Center and Subsidiaries (Iowa City)  
 ANS - Ankeny Health System and Subsidiaries (Ankeny)  
 TW - Tabor Health System and Subsidiaries (Tabor)  
 ILHS - Iowa Lutheran Health Services (Iowa City)  
 TRST - Trinity Regional Health System and Subsidiaries (Rock Hill)  
 HP - Holyoke Health Services Corp. and Subsidiaries (Holyoke)  
 BHC - Bethel Health Center and Subsidiaries (Bethel)  
 DS & Oth - Des Moines Health System and Subsidiaries (Des Moines)  
 Elmhurst - Elmhurst Health System and Subsidiaries (Elmhurst)  
 Consolidated - All other subsidiaries

**Iowa Health System and Subsidiaries**  
**Consolidating Schedule - Revenue and Gains, Expenses and Losses Information**  
 (In Thousands)  
**Year Ended December 31, 2011**

	IHDM	TRHS	MHSC	SLHC	AHS	THS	SLHS	TRI-ST	IHP	HDIC	IHS & Other	Eliminations	Consolidated
<b>Revenue</b>													
Patient service revenue (net of contractual allowances)	\$ 654,127	\$ 417,621	\$ 86,967	\$ 249,182	\$ 205,954	\$ 139,791	\$ 152,295	\$ 93,413	\$ 143,231	\$ 86,004	\$ -	\$ 985	\$ 2,227,416
Provision for patient uncollectible accounts	(22,118)	(27,864)	(2,252)	(12,558)	(6,141)	(6,932)	(9,219)	(2,652)	(2,282)	(2,282)	-	-	(93,362)
Net patient service revenue	632,009	389,757	84,715	236,624	199,813	132,859	143,076	90,761	140,949	83,722	-	985	2,134,054
Other operating revenue	42,881	17,275	5,184	19,675	10,574	10,332	7,366	5,739	15,471	2,497	170,120	167,051	140,273
Net assets released from restrictions used for operations	2,730	613	314	1,000	434	249	-	-	-	568	-	36	6,064
<b>Total revenue</b>	<b>677,615</b>	<b>437,655</b>	<b>90,832</b>	<b>257,324</b>	<b>210,760</b>	<b>143,388</b>	<b>149,742</b>	<b>95,122</b>	<b>155,500</b>	<b>86,977</b>	<b>170,216</b>	<b>(68,035)</b>	<b>2,380,167</b>
<b>Expenses</b>													
Salaries and wages	241,453	152,403	28,840	119,763	70,096	49,853	21,175	34,142	42,384	47,300	40,289	34	857,878
Physician compensation and services	77,182	32,438	11,333	24,153	15,642	22,989	11,910	3,010	63,772	117	-	2,985	263,883
Employee benefits	60,758	40,087	9,006	35,757	16,527	12,145	12,710	9,450	11,189	12,912	-	9,933	230,462
Supplies	118,719	85,844	12,985	55,744	47,661	20,519	21,493	13,538	13,396	12,890	760	-	437,434
Other expenses	115,685	84,692	17,642	62,591	35,832	24,457	31,716	23,221	32,437	13,220	-	145,657	375,658
Depreciation and amortization	34,505	15,990	6,511	17,584	12,392	6,447	7,262	5,782	2,632	1,893	-	-	131,439
Interest	8,192	7,212	664	3,971	3,239	1,515	3,048	524	-	87	-	-	30,926
Provision for uncollectible accounts	145	-	-	53	13	-	46	33	-	430	-	-	818
<b>Total expenses</b>	<b>676,165</b>	<b>399,677</b>	<b>87,009</b>	<b>315,217</b>	<b>201,334</b>	<b>146,245</b>	<b>147,420</b>	<b>91,760</b>	<b>162,327</b>	<b>85,819</b>	<b>171,720</b>	<b>(74,704)</b>	<b>2,316,479</b>
<b>Operating Income (Loss)</b>	<b>21,450</b>	<b>37,978</b>	<b>3,823</b>	<b>42,107</b>	<b>9,426</b>	<b>(2,857)</b>	<b>2,322</b>	<b>3,362</b>	<b>(6,827)</b>	<b>158</b>	<b>(1,504)</b>	<b>(7,719)</b>	<b>63,688</b>
<b>Nonrecurring Gains (Losses)</b>													
Insurance income (loss)	(1,835)	(431)	4,910	(719)	(1,145)	(873)	(371)	(491)	(365)	(117)	(73)	(411)	(1,894)
Contributions received in affiliation with Methodist Parish	-	-	180,325	-	-	-	-	-	-	-	-	-	180,325
Other net	472	482	992	31	32	171	188	319	51	-	(29,810)	(432)	(27,869)
<b>Total nonrecurring gains (losses), net</b>	<b>(1,363)</b>	<b>(29)</b>	<b>184,227</b>	<b>(688)</b>	<b>(1,113)</b>	<b>(702)</b>	<b>(253)</b>	<b>297</b>	<b>(314)</b>	<b>(117)</b>	<b>(29,883)</b>	<b>(443)</b>	<b>151,473</b>
<b>Revenue Over (Under) Expenses</b>	<b>\$ 20,087</b>	<b>\$ 37,949</b>	<b>\$ 3,823</b>	<b>\$ 41,419</b>	<b>\$ 8,313</b>	<b>\$ (3,579)</b>	<b>\$ 2,069</b>	<b>\$ 3,659</b>	<b>\$ (7,141)</b>	<b>\$ 41</b>	<b>\$ (1,418)</b>	<b>\$ (7,099)</b>	<b>\$ 213,921</b>

**Definitions**  
 IHDM - Iowa Health - Des Moines and Subsidiaries (Des Moines)  
 TRHS - Trinity Regional Health System and Subsidiaries (Rock Island)  
 MHSC - Methodist Health Services Corp. and Subsidiaries (Des Moines)  
 SLHC - St. Luke's Healthcare and Subsidiaries (Cedar Rapids)  
 AHS - Allam Health Systems, Inc. and Subsidiaries (Waterloo)  
 THS - Trinity Health Systems, Inc. and Subsidiaries (Fort Dodge)  
 SLHS - St. Luke's Health System, Inc. (Sioux City)  
 TRI-ST - Trinity Tri-State Health Group, Inc. and Subsidiaries (Dubuque)  
 IHP - Iowa Health Properties  
 HDIC - Iowa Health Home Care  
 IHS & Other - Iowa Health System and other Subsidiaries

**Iowa Health System and Subsidiaries**  
**Iowa Health - Des Moines and Subsidiaries (Des Moines)**  
**Consolidating Schedule - Balance Sheet Information**  
**(In Thousands)**  
**December 31, 2011**

Assets	BDM	CHC	IHF	CNP	IHP	Eliminations	Consolidated
<b>Current Assets</b>							
Cash and cash equivalents	\$ -	\$ 31	\$ 747	\$ 378	\$ -	\$ -	\$ 1,356
Short-term investments		8,663					8,663
Assets limited as to use - required for current liabilities		2,031					2,031
Patient accounts receivable, less estimated noncollectibles		88,475					88,475
Other receivables		11,861	14	16			11,891
Inventories		10,811	106				10,917
Prepaid expenses		2,288	38	17			2,341
Due from affiliates		3,116		5,125		7,476	765
<b>Total current assets</b>		<u>127,874</u>	<u>902</u>	<u>5,236</u>		<u>7,476</u>	<u>137,889</u>
<b>Assets Limited As to Use, noncurrent</b>							
Held by trustee under bond indenture agreements		2,924					2,924
Intentionally designated		387,737	61,578				449,315
<b>Total assets limited as to use, noncurrent</b>		<u>390,661</u>	<u>61,578</u>				<u>452,239</u>
Property, Plant and Equipment, net		253,877	13	26,268			280,258
Other Long-term Investments		9,084	33,187				42,271
Investments in Joint Ventures and Other Investments		29,475	54	4,758	17,428	22,987	28,728
Contributions Receivable, net			6,786				6,786
Other		2,954		193			3,147
Due From Affiliates		2,725				2,725	-
<b>Total assets</b>	\$ -	\$ <u>816,650</u>	\$ <u>102,523</u>	\$ <u>37,055</u>	\$ <u>17,428</u>	\$ <u>33,188</u>	\$ <u>940,468</u>
<b>Liabilities and Net Assets</b>							
<b>Current Liabilities</b>							
Current maturities of long-term debt		\$ 514					\$ 514
Accounts payable		22,783	\$ 1	\$ 853			23,637
Accrued payroll		30,679	232				30,911
Accrued interest		12					12
Estimated settlements due to third-party payers		13,664					13,664
Due to affiliates		24,452	95	2,502		7,476	19,683
Other current liabilities	\$ -	7,237	25	190	\$ -		7,452
<b>Total current liabilities</b>		<u>99,361</u>	<u>363</u>	<u>3,545</u>		<u>7,476</u>	<u>94,792</u>
Long-term Debt, net		33,978					33,978
Other Long-term Liabilities		38,650	942				39,592
Due to Affiliates		125,216		3,745		2,725	136,236
<b>Total liabilities</b>		<u>306,305</u>	<u>1,305</u>	<u>7,290</u>		<u>10,201</u>	<u>304,899</u>
<b>Net Assets</b>							
Unrestricted		487,000	77,680	29,765	17,428		611,873
Temporarily restricted		8,946	8,782			8,588	9,140
Permanently restricted		14,399	14,756			14,399	14,756
<b>Total net assets</b>		<u>510,345</u>	<u>101,218</u>	<u>29,765</u>	<u>17,428</u>	<u>23,997</u>	<u>633,769</u>
<b>Total liabilities and net assets</b>	\$ -	\$ <u>816,650</u>	\$ <u>102,523</u>	\$ <u>37,055</u>	\$ <u>17,428</u>	\$ <u>33,188</u>	\$ <u>940,468</u>

BDM - Iowa Health - Des Moines  
 CHC - Central Iowa Hospital Corporation  
 IHF - Iowa Health Foundation

CNP - Central Iowa Health Properties Corporation  
 IHP - Iowa Health Properties, INC/LLP partner

**Iowa Health System and Subsidiaries**  
**Iowa Health - Des Moines and Subsidiaries (Des Moines)**  
**Consolidating Schedule - Revenue and Gains, Expenses and Losses Information**  
(In Thousands)  
Year Ended December 31, 2011

	IHDM	CIHC	IHF	CIHP	IHP	Eliminations	Consolidated
<b>Revenue</b>							
Patient service revenue (net of contractual allowances)	\$ -	\$ 654,517	\$ -	\$ -	\$ -	\$ 394	\$ 654,123
Provision for patient uncollectible accounts		(22,119)					(22,119)
Net patient service revenue		632,398				394	632,004
Other operating revenue		43,383		5,867	(225)	6,144	42,881
Net assets released from restrictions used for operations		2,739	11				2,750
Total revenue		678,520	11	5,867	(225)	6,538	677,635
<b>Expenses</b>							
Salaries and wages		240,279	1,114	62			241,455
Physician compensation and services		79,310				2,127	77,183
Employee benefits		60,454	281	23			60,758
Supplies		118,708	5	6			118,719
Other expenses	93	115,551	561	3,291		4,411	115,085
Depreciation and amortization		33,172	26	1,370			34,568
Interest		7,985		207			8,192
Provision for uncollectible accounts		145					145
Total expenses	93	655,604	1,987	4,959	-	6,538	656,105
Operating Income (Loss)	(93)	22,916	(1,976)	908	(225)	-	21,530
<b>Nonoperating Gains (Losses)</b>							
Investment income (loss)		(2,860)	1,166	1	(140)		(1,833)
Other, net			437				437
Total nonoperating gains (losses), net		(2,860)	1,603	1	(140)		(1,396)
Revenue Over (Under) Expenses	\$ (93)	\$ 20,056	\$ (373)	\$ 909	\$ (365)	\$ -	\$ 20,134

**Definitions**

IHDM - Iowa Health - Des Moines  
CIHC - Central Iowa Hospital Corporation  
IHF - Iowa Health Foundation  
CIHP - Central Iowa Health Properties Corporation  
IHP - Iowa Health Physicians, IHDM portion

**Iowa Health System and Subsidiaries**  
**Trinity Regional Health System and Subsidiaries (Rock Island)**  
**Consolidating Schedule - Balance Sheet Information**  
(In Thousands)  
December 31, 2011

Assets	TRHS	TMC	VNHA	TIF	THE	TM	IHP	Philanthropy	Consolidated
<b>Current Assets</b>									
Cash and cash equivalents	\$ 516	\$ 13,789	\$ -	\$ 757	\$ 1,106	\$ 523	\$ -	\$ -	\$ 16,691
Short-term investments		42,454		7		816		1	43,276
Assets limited as to use - required for current liabilities		1,320							1,320
Patient accounts receivable, less estimated uncollectibles		45,576			443	7,477		8	51,490
Other receivables		2,476		1		151			2,628
Inventories		7,655			604	946			9,205
Prepaid expenses	2	1,402		11	41	223			1,679
Due from affiliates	(15)	9,968			81	(33)		9,659	9,659
<b>Total current assets</b>	<b>503</b>	<b>124,640</b>		<b>776</b>	<b>2,277</b>	<b>10,166</b>		<b>9,668</b>	<b>128,634</b>
<b>Assets Limited As to Use, noncurrent</b>									
Internally designated	12,407	97,038		2,242		5,110			116,797
Property, Plant and Equipment, net		129,819			497	15,521			140,837
Other Long-term Investments		1,723		92					1,815
Investments in Joint Ventures and Other Investments	2,721	8,700	(673)		183		1,300	6,544	5,887
Contributions Receivable, net				32		1,717			1,749
Other		2,323				473			2,796
<b>Total assets</b>	<b>\$ 15,631</b>	<b>\$ 364,243</b>	<b>\$ (673)</b>	<b>\$ 3,142</b>	<b>\$ 2,957</b>	<b>\$ 30,927</b>	<b>\$ 1,500</b>	<b>\$ 16,212</b>	<b>\$ 401,515</b>
<b>Liabilities and Net Assets</b>									
<b>Current Liabilities</b>						\$ 2,012			\$ 2,012
Current maturities of long-term debt	\$ 49	\$ 15,729	\$ -	\$ 5	\$ 56	995	\$ -	\$ 8	16,836
Accounts payable	648	13,359		23	100	2,499			16,539
Accrued payroll		7,206				410			7,696
Estimated settlements due to third-party payors	4,111	8,589		201	219	5,056		9,660	8,616
Due to affiliates	33	6,129		16	(131)	1,028			7,074
Other current liabilities	4,843	51,892		345	241	11,910		9,668	58,760
<b>Total current liabilities</b>									
Long-term Debt, net						14,720			14,720
Other Long-term Liabilities		31,265		73		592			32,090
Due to Affiliates		126,100							126,100
<b>Total liabilities</b>	<b>4,843</b>	<b>188,557</b>		<b>418</b>	<b>241</b>	<b>27,222</b>		<b>9,668</b>	<b>211,613</b>
<b>Net Assets</b>									
Unrestricted	10,788	172,006	(673)	(1,385)	2,716	1,988	1,500	2,949	183,991
Temporarily restricted		2,324		2,527		1,717		2,239	4,329
Permanently restricted		1,336		1,382				1,336	1,382
<b>Total net assets</b>	<b>10,788</b>	<b>175,666</b>	<b>(673)</b>	<b>2,724</b>	<b>2,716</b>	<b>3,705</b>	<b>1,500</b>	<b>6,544</b>	<b>189,902</b>
<b>Total liabilities and net assets</b>	<b>\$ 15,631</b>	<b>\$ 364,243</b>	<b>\$ (673)</b>	<b>\$ 3,142</b>	<b>\$ 2,957</b>	<b>\$ 30,927</b>	<b>\$ 1,500</b>	<b>\$ 16,212</b>	<b>\$ 401,515</b>

TRHS - Trinity Regional Health System  
TMC - Trinity Medical Center  
VNHA - Trinity Visiting Nurses and Homecare Association  
TIF - Trinity Health Foundation

THE - Trinity Health Enterprises, Inc  
TM - Trinity Magazine  
IHP - Iowa Health Physicians, TRHS person

**Iowa Health System and Subsidiaries**  
**Trinity Regional Health System and Subsidiaries (Rock Island)**  
**Consolidating Schedule - Revenue and Gains, Expenses and Losses Information**  
(In Thousands)  
Year Ended December 31, 2011

	TRHS	TMC	VNHA	THF	THE	TN	DHP	Eliminations	Consolidated
<b>Revenue</b>									
Patient service revenue (net of contractual allowances)	\$ -	\$ 354,277	\$ -	\$ -	\$ 6,739	\$ 56,615	\$ -	\$ 10	\$ 417,621
Provision for patient uncollectible accounts		(23,193)			(126)	(4,583)			(27,902)
Net patient service revenue		331,084			6,613	52,032		10	389,737
Other operating revenue	353	18,065	(611)	20	34	3,009	(1,793)	1,460	17,573
Net assets released from restrictions used for operations		3		610					613
<b>Total revenue</b>	<b>353</b>	<b>349,150</b>	<b>(611)</b>	<b>630</b>	<b>6,647</b>	<b>55,041</b>	<b>(1,793)</b>	<b>1,470</b>	<b>407,503</b>
<b>Expenses</b>									
Salaries and wages	372	111,431		345	1,550	18,705			132,403
Physician compensation and services		24,825				8,138		5	32,958
Employee benefits	70	33,906		81	443	5,677		90	40,087
Supplies	30	73,293		9	3,567	6,907		(38)	83,844
Other expenses	1,049	71,069		954	758	12,021		1,249	84,602
Depreciation and amortization		14,846			111	1,833			16,900
Interest		6,969				344		100	7,213
<b>Total expenses</b>	<b>1,521</b>	<b>336,339</b>		<b>1,389</b>	<b>6,429</b>	<b>55,423</b>		<b>1,406</b>	<b>399,697</b>
<b>Operating Income (Loss)</b>	<b>(1,168)</b>	<b>10,811</b>	<b>(611)</b>	<b>(759)</b>	<b>218</b>	<b>1,618</b>	<b>(1,793)</b>	<b>64</b>	<b>8,208</b>
<b>Nonoperating Gains (Losses)</b>									
Investment income (loss)	(220)	(82)	(22)	73		(55)	(20)	105	(401)
Other, net				279	(49)	172			402
<b>Total nonoperating gains (losses), net</b>	<b>(220)</b>	<b>(82)</b>	<b>(22)</b>	<b>352</b>	<b>(49)</b>	<b>117</b>		<b>105</b>	<b>(29)</b>
<b>Revenue Over (Under) Expenses</b>	<b>\$ (1,388)</b>	<b>\$ 10,729</b>	<b>\$ (673)</b>	<b>\$ (407)</b>	<b>\$ 169</b>	<b>\$ 1,735</b>	<b>\$ (1,813)</b>	<b>\$ 169</b>	<b>\$ 8,179</b>

## Definitions

TRHS - Trinity Regional Health System

TMC - Trinity Medical Center

VNHA - Trinity Visiting Nurses and Homemakers Association

THF - Trinity Health Foundation

THE - Trinity Health Enterprises, Inc

TN - Trinity Macazine

DHP - Iowa Health Physicians, TRHS portion

**Iowa Health System and Subsidiaries**  
**Methodist Health Services Corporation and Subsidiaries (Peoria)**  
**Consolidating Schedule - Balance Sheet Information**  
(In Thousands)  
December 31, 2011

Assets	MHSC	MMCI	MSI	MMCF	Eliminations	Consolidated
<b>Current Assets</b>						
Cash and cash equivalents	\$ 2,441	\$ 17,420	\$ 63	\$ 593	\$ -	\$ 20,517
Patient accounts receivable, less estimated uncollectibles	85	56,662	734	-	-	57,481
Other receivables	209	7,204	-	-	-	7,413
Inventories	502	3,166	-	-	-	3,668
Prepaid expenses	20	7,010	-	4	-	7,034
Due from affiliates	47	2,592	-	-	2,637	2
Total current assets	3,395	94,034	797	597	2,637	96,106
<b>Assets Limited As to Use, noncurrent</b>						
Intentionally designated	-	6,956	-	-	-	6,956
Property, Plant and Equipment, net	161	172,144	76,615	-	-	249,920
Other Long-term Investments	-	124,427	-	15,379	-	139,806
Investments in Joint Ventures and Other Investments	344	29,069	-	139	15,775	13,777
Contributions Receivable, net	-	5,497	-	-	-	5,497
Other	122	1,837	-	-	-	1,959
Total assets	\$ 3,922	\$ 433,984	\$ 77,412	\$ 16,115	\$ 18,412	\$ 513,021
<b>Liabilities and Net Assets</b>						
<b>Current Liabilities</b>						
Current maturities of long-term debt	-	\$ 5,702	-	-	-	\$ 5,702
Accounts payable	\$ 143	24,320	\$ 167	-	-	24,630
Accrued payroll	476	8,803	-	-	-	9,279
Accrued interest	-	276	-	-	-	276
Estimated settlements due to third-party payers	-	27,934	-	-	-	27,934
Due to affiliates	776	47	1,814	-	2,637	-
Other current liabilities	-	12,318	639	64	-	13,041
Total current liabilities	1,395	79,400	2,640	64	2,637	80,862
Long-term Debt, net	-	104,375	-	-	-	104,375
Other Long-term Liabilities	-	131,095	-	276	-	131,371
Total liabilities	1,395	314,870	2,640	340	2,637	316,608
<b>Net Assets</b>						
Unrestricted	2,527	106,203	74,772	8,419	8,419	183,502
Temporarily restricted	-	8,991	-	3,456	3,456	8,991
Permanently restricted	-	3,920	-	3,900	3,900	3,920
Total net assets	2,527	119,114	74,772	15,775	15,775	196,413
Total liabilities and net assets	\$ 3,922	\$ 433,984	\$ 77,412	\$ 16,115	\$ 18,412	\$ 513,021

## Definitions

MHSC - Methodist Health Services Corporation  
MMCI - Methodist Medical Center of Illinois  
MSI - Methodist Services, Inc.  
MMCF - Methodist Medical Center Foundation

**Iowa Health System and Subsidiaries**  
**Methodist Health Services Corporation and Subsidiaries (Peoria)**  
**Consolidating Schedule - Revenue and Gains, Expenses and Losses Information**  
(In Thousands)  
**Three Months Ended December 31, 2011**

	MHSC	MMCI	MSI	MMCF	Eliminations	Consolidated
<b>Revenue</b>						
Patient service revenue (net of contractual allowances)	\$ 219	\$ 87,233	\$ -	\$ -	\$ 465	\$ 86,987
Provision for patient uncollectible accounts		(2,653)				(2,653)
Net patient service revenue	219	84,580			465	84,334
Other operating revenue	3,047	5,107	1,763	73	4,806	5,184
Net assets released from restrictions used for operations		90		224		314
Total revenue	3,266	89,777	1,763	297	5,271	89,837
<b>Expenses</b>						
Salaries and wages	2,530	26,275		43		28,848
Physician compensation and services		11,333				11,333
Employee benefits	650	8,447	5	11	107	9,006
Supplies	2	12,981	2			12,985
Other expenses	148	20,901	1,409	348	5,164	17,642
Depreciation and amortization	7	5,919	685			6,611
Interest		678	(14)			664
Total expenses	3,337	86,534	2,087	402	5,271	87,089
Operating Income (Loss)	(71)	3,243	(324)	(105)	-	2,743
<b>Nonoperating Gains</b>						
Investment income	1	4,560		349		4,910
Contribution received in affiliation with Methodist Peoria	2,597	102,632	75,096	8,114	8,114	180,325
Other, net		941		52		993
Total nonoperating gains, net	2,598	108,133	75,096	8,515	8,114	186,228
Revenue Over Expenses	\$ 2,527	\$ 111,376	\$ 74,772	\$ 8,410	\$ 8,114	\$ 188,971

**Definitions**

MHSC - Methodist Health Services Corporation  
MMCI - Methodist Medical Center of Illinois  
MSI - Methodist Services, Inc.  
MMCF - Methodist Medical Center Foundation

Iowa Health System and Subsidiaries  
 St. Luke's Healthcare and Subsidiaries (Cedar Rapids)  
 Consolidating Schedule - Balance Sheet Information  
 (In Thousands)  
 December 31, 2011

Assets	SLMH	CARF	CC-STL	STL-NR	JONES	CARDIO LC	STEAM, INC.	IMP	Eliminations	Consolidated
<b>Current Assets</b>										
Cash and cash equivalents	\$ 10,930	\$ 1,418	\$ 331	\$ 459	\$ 4,583	\$ 9	\$ -	\$ -	\$ -	\$ 17,730
Short-term investments	71,227				3,484					40,711
Assets limited as to use - restricted for current liabilities	2,538									2,638
Prepaid accounts receivable, less estimated uncollectibles	42,330	1,345	1,186		2,326	999				48,186
Other receivables	4,793			20	3	84	69			4,979
Investments	7,478		48		232					7,758
Prepaid expenses	1,504	57	15		49	205	30			1,872
Due from affiliates	1,192			1,482		3	182		2,314	504
<b>Total current assets</b>	<b>108,133</b>	<b>2,820</b>	<b>1,600</b>	<b>1,986</b>	<b>10,899</b>	<b>1,300</b>	<b>281</b>	<b>-</b>	<b>2,314</b>	<b>124,511</b>
<b>Assets Limited As to Use, noncurrent</b>										
Intentionally designated	74,513				6,123					80,736
Property, Plant and Equipment, net	137,034	4,251	372	1,877	13,920	58	4,818		(67)	164,013
Other Long-term Investments	19,024			92		460				19,776
Investments in Joint Ventures and Other Investments	11,547							5,704	5,228	15,523
Consolidation Receivable	30,563				833					31,396
Other	1,039			202		767				2,008
Due From Affiliates	11,630			1,421					13,101	-
<b>Total assets</b>	<b>\$ 399,739</b>	<b>\$ 6,981</b>	<b>\$ 1,972</b>	<b>\$ 5,578</b>	<b>\$ 31,775</b>	<b>\$ 3,481</b>	<b>\$ 5,099</b>	<b>\$ 9,704</b>	<b>\$ 20,570</b>	<b>\$ 477,739</b>
<b>Liabilities and Net Assets</b>										
<b>Current Liabilities</b>										
Current liabilities of long-term debt		\$ 247	\$ 2		\$ 47					\$ 296
Accounts payable	\$ 11,425	323	240	\$ 4	391	\$ 291	\$ 218			12,855
Accounts payable	18,715	328	287		891	1,725				21,824
Estimated liabilities due to third-party payors	4,331		11		1,397					5,729
Tax to affiliates	11,213	75	55		507					9,536
Other current liabilities	5,027	111		335		130		\$ 2,314		5,397
<b>Total current liabilities</b>	<b>50,751</b>	<b>1,094</b>	<b>604</b>	<b>339</b>	<b>3,057</b>	<b>2,124</b>	<b>258</b>	<b>-</b>	<b>2,314</b>	<b>53,083</b>
Long-term Debt, net										
Other Long-term Liabilities	38,095			641		460				39,196
Due to Affiliates	77,326	340	4,681		6,660				13,301	76,314
<b>Total liabilities</b>	<b>166,202</b>	<b>1,434</b>	<b>5,285</b>	<b>980</b>	<b>9,717</b>	<b>2,584</b>	<b>258</b>	<b>-</b>	<b>15,615</b>	<b>179,389</b>
<b>Net Assets</b>										
Invested	197,297	5,577	(3,316)	4,598	21,225	897	477	9,704	5,155	231,304
Temporarily restricted	11,843				933		4,264			18,017
Permanently restricted	18,017									18,017
<b>Total net assets</b>	<b>227,157</b>	<b>5,577</b>	<b>(3,316)</b>	<b>4,598</b>	<b>22,058</b>	<b>897</b>	<b>4,264</b>	<b>9,704</b>	<b>5,155</b>	<b>266,361</b>
<b>Total liabilities and net assets</b>	<b>\$ 399,739</b>	<b>\$ 6,981</b>	<b>\$ 1,972</b>	<b>\$ 5,578</b>	<b>\$ 31,775</b>	<b>\$ 3,481</b>	<b>\$ 5,099</b>	<b>\$ 9,704</b>	<b>\$ 20,570</b>	<b>\$ 477,739</b>

**Definitions**  
 SLMH - St. Luke's Methodist Hospital  
 CARF - STL Care Company  
 CC-STL - Centennial Care Hospital, STL  
 STL-NR - STL Health Services

JONES - Jones Regional Medical Center  
 CARDIO LC - CardioLogic, L.C.  
 STEAM, INC. - St. Luke's Cox Stearns, Inc.  
 IMP - Iowa Health Physicians, SLHC partner

**Iowa Health System and Subsidiaries**  
**St. Luke's Healthcare and Subsidiaries (Cedar Rapids)**  
**Consolidating Schedule - Revenue and Gains, Expenses and Losses Information**  
**(In Thousands)**  
**Year Ended December 31, 2011**

	ELMHI	CARR	CC-STL	STL-HR	JONES	CARDIO LC	STEAM, INC.	IHP	Elmhurst	Consolidated
<b>Revenue</b>										
Patient service revenue (net of cash actual allowances)	\$ 256,802	\$ 11,210	\$ 7,032	\$ -	\$ 20,494	\$ 14,566	\$ -	\$ -	\$ 922	\$ 349,182
Provision for patient uncollectible accounts	(11,435)		(30)		(375)	(307)				(12,557)
Net patient service revenue	245,367	11,210	6,999		19,819	14,259			922	336,625
Other operating revenue	22,396	344	2	(624)	233	272	1,335	(543)	3,878	19,875
Net grants and related grant restrictions used for operations	1,000									1,000
<b>Total revenue</b>	<b>268,763</b>	<b>11,454</b>	<b>6,999</b>	<b>(624)</b>	<b>20,132</b>	<b>14,431</b>	<b>1,335</b>	<b>(543)</b>	<b>4,800</b>	<b>357,234</b>
<b>Expenses</b>										
Salaries and wages	111,697	5,417	2,729		5,651	4,069			(170)	129,753
Pharmacy, computer and services	12,535	26	13		1,444	10,364			233	24,155
Employer health	52,093	792	484		1,502	838			(20)	55,727
Supplies	5,176	1,087	250		1,393	1,157	40		69	10,042
Other expenses	60,157	2,868	3,074	23	4,128	1,865	1,434		4,735	68,584
Depreciation and amortization	14,702	278	83	96	1,150	2,031	292		617	17,594
Interest	3,967	33	(83)		155	48				3,970
Provision for uncollectible accounts	131									131
<b>Total expenses</b>	<b>247,677</b>	<b>10,494</b>	<b>6,681</b>	<b>119</b>	<b>13,613</b>	<b>19,292</b>	<b>1,721</b>		<b>5,436</b>	<b>335,317</b>
<b>Operating Income (Loss)</b>	<b>21,452</b>	<b>860</b>	<b>117</b>	<b>(643)</b>	<b>4,545</b>	<b>(4,861)</b>	<b>(216)</b>	<b>(543)</b>	<b>(636)</b>	<b>21,877</b>
<b>Nonoperating Gains (Losses)</b>										
Investment income (Loss)	(624)	3			(19)			(79)		(719)
Other, net	(650)	3			12			(72)		(687)
<b>Total nonoperating gain (loss), net</b>	<b>(1,274)</b>	<b>6</b>			<b>(7)</b>			<b>(151)</b>		<b>(1,426)</b>
<b>Revenue Over (Under) Expenses</b>	<b>\$ 20,822</b>	<b>\$ 863</b>	<b>\$ 117</b>	<b>\$ (643)</b>	<b>\$ 4,537</b>	<b>\$ (4,861)</b>	<b>\$ (216)</b>	<b>\$ (619)</b>	<b>\$ (673)</b>	<b>\$ 20,755</b>

**Elmhurst**  
 ELMHI - St. Luke's Methodist Hospital  
 CARR - STL Care Company  
 CC-STL - Centennial Care Hospital, ETL  
 STL-HR - STL Health Resources

**JONES** - Jones Rogstad Medical Center  
**CARDIO LC** - CardioLogic, L.P.  
**STEAM, INC.** - St. Luke's Care Group, Inc.  
**IHP** - Iowa Health Physicians, LLC portion

**Iowa Health System and Subsidiaries**  
**Allen Health Systems, Inc. and Subsidiaries (Waterloo)**  
**Consolidating Schedule - Balance Sheet Information**  
(In Thousands)  
December 31, 2011

Assets	AHS	AMH	MFAH	ACN	IHP	IHHC	EBHealthcare	Consolidated
<b>Current Assets</b>								
Cash and cash equivalents	\$ -	\$ 3,422	\$ 683	\$ -	\$ -	\$ -	\$ -	\$ 4,114
Short-term investments		12,245	3					12,248
Assets limited as to use - required for current liabilities		1,222						1,222
Patient accounts receivable, less estimated uncollectibles		23,136						23,136
Other receivables		4,066		424				4,490
Inventories		6,011						6,011
Prepaid expenses		766	1	99				866
Due from affiliates		580					180	600
<b>Total current assets</b>		<b>31,458</b>	<b>686</b>	<b>523</b>			<b>180</b>	<b>32,847</b>
<b>Assets Limited As to Use, noncurrent</b>								
Internally designated		1,281	76					1,457
Property, Plant and Equipment, net		100,498						100,498
Other Long-term Investments		77,388	6,624	804				84,816
Investments in Joint Ventures and Other Investments		4,204	1,828	3,741	6,541	(652)	7,701	7,171
Contributions Receivable		1,786	1,319					3,105
Other		3,823						3,823
Due From Affiliates		150						150
<b>Total assets</b>	<b>\$ -</b>	<b>\$ 240,688</b>	<b>\$ 9,753</b>	<b>\$ 5,066</b>	<b>\$ 6,541</b>	<b>\$ (652)</b>	<b>\$ 7,881</b>	<b>\$ 253,517</b>
<b>Liabilities and Net Assets</b>								
<b>Current Liabilities</b>								
Current maturities of long-term debt		\$ 48						\$ 48
Accounts payable		8,202		\$ 28				8,040
Accounts payable		10,978						10,978
Estimated settlements due to third-party payers		5,895						5,895
Due to affiliates	\$ 2	6,920	\$ 3,156	(2,979)			\$ 180	6,919
Other current liabilities		4,771	12	8				4,791
<b>Total current liabilities</b>	<b>2</b>	<b>36,614</b>	<b>3,168</b>	<b>(2,933)</b>	<b>\$ -</b>	<b>\$ -</b>	<b>180</b>	<b>36,671</b>
<b>Long-term Debt, net</b>		<b>43</b>						<b>43</b>
<b>Other Long-term Liabilities</b>		<b>13,481</b>	<b>58</b>	<b>503</b>				<b>14,042</b>
Due to Affiliates		59,080						59,080
<b>Total liabilities</b>	<b>2</b>	<b>109,218</b>	<b>3,226</b>	<b>(1,430)</b>			<b>180</b>	<b>109,836</b>
<b>Net Assets</b>								
Unrestricted	(2)	125,520	(1,174)	3,757	6,541	(652)		133,990
Temporarily restricted		4,164	5,895	1,933			5,893	6,899
Permanently restricted		1,786	1,806	1,806				3,592
<b>Total net assets</b>	<b>(2)</b>	<b>131,470</b>	<b>6,527</b>	<b>7,496</b>	<b>6,541</b>	<b>(652)</b>	<b>7,701</b>	<b>143,681</b>
<b>Total liabilities and net assets</b>	<b>\$ -</b>	<b>\$ 240,688</b>	<b>\$ 9,753</b>	<b>\$ 5,066</b>	<b>\$ 6,541</b>	<b>\$ (652)</b>	<b>\$ 7,881</b>	<b>\$ 253,517</b>

Definitions

AHS - Allen Health System  
AMH - Allen Memorial Hospital Corporation  
MFAH - Memorial Foundation of Allen Hospital

ACN - Allen College of Nursing  
IHP - Iowa Health Physicians, AHS partner  
IHHC - Iowa Health Home Care, AHS partner

**Iowa Health System and Subsidiaries**  
**Allen Health Systems, Inc. and Subsidiaries (Waterloo)**  
**Consolidating Schedule - Revenue and Gains, Expenses and Losses Information**  
(In Thousands)  
Year Ended December 31, 2011

	AHS	AMH	MFAH	ACN	DIP	IRHC	Eliminations	Consolidated
<b>Revenue</b>								
Patient service revenue (net of contractual allowances)	\$ -	\$ 205,054	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 205,054
Provision for patient uncollectible accounts		(6,214)						(6,214)
Net patient service revenue		199,740						199,740
Other operating revenue		7,938	38	7,532	(4,267)	(640)	27	10,574
Net assets released from restrictions used for operations		281		193				474
<b>Total revenue</b>		<b>207,959</b>	<b>38</b>	<b>7,725</b>	<b>(4,267)</b>	<b>(640)</b>	<b>27</b>	<b>210,788</b>
<b>Expenses</b>								
Salaries and wages		65,721	265	4,111				70,098
Physician compensation and services		15,642						15,642
Employee benefits		15,349	80	1,105			27	16,507
Supplies		47,486	9	167				47,661
Other expenses	38	34,447	197	1,150				35,832
Depreciation and amortization		12,392						12,392
Interest		3,230	9					3,239
Provision for uncollectible accounts		-		13				13
<b>Total expenses</b>	<b>38</b>	<b>194,267</b>	<b>559</b>	<b>6,547</b>			<b>27</b>	<b>201,384</b>
<b>Operating Income (Loss)</b>	<b>(38)</b>	<b>13,692</b>	<b>(521)</b>	<b>1,178</b>	<b>(4,267)</b>	<b>(640)</b>		<b>5,404</b>
<b>Nonoperating Gains (Losses)</b>								
Investment income (loss)		(966)	(5)		(75)	(11)		(1,148)
Other, net		30						30
<b>Total nonoperating gains (losses), net</b>		<b>(936)</b>	<b>(5)</b>		<b>(75)</b>	<b>(12)</b>		<b>(1,118)</b>
<b>Revenue Over (Under) Expenses</b>	<b>\$ (38)</b>	<b>\$ 12,756</b>	<b>\$ (616)</b>	<b>\$ 1,178</b>	<b>\$ (4,342)</b>	<b>\$ (652)</b>	<b>\$ -</b>	<b>\$ 8,286</b>

**Definitions**

AHS - Allen Health System  
AMH - Allen Memorial Hospital Corporation  
MFAH - Memorial Foundation of Allen Hospital

ACN - Allen College of Nursing  
DIP - Iowa Health Physicians, AHS portion  
IRHC - Iowa Health Home Care, AHS portion

**Iowa Health System and Subsidiaries**  
**Trinity Health Systems, Inc. and Subsidiaries (Fort Dodge)**  
**Consolidating Schedule - Balance Sheet Information**  
**(In Thousands)**  
**December 31, 2011**

Assets	TBS	TRMC	BMHC	THF	TBC	TRIMARK	IHFC	Winnebago	Consolidated
<b>Current Assets</b>									
Cash and cash equivalents	\$ 185	\$ 6,492	\$ 173	\$ 946	\$ 1,345	\$ 2,396	\$ -	\$ -	\$ 11,537
Short-term investments		9,695							9,695
Assets limited as to use - restraints for current liabilities		712							712
Patient accounts receivable, less estimated uncollectibles		13,169	189			3,611			16,969
Other receivables	230	823			(6)	392			1,439
Debtors		2,436				510			2,946
Prepaid expenses	6	423	2			6			436
Due from affiliates	(71)	1,853	11	24	8			2,025	(377)
<b>Total current assets</b>	<b>350</b>	<b>35,292</b>	<b>374</b>	<b>970</b>	<b>1,371</b>	<b>6,571</b>	<b>-</b>	<b>2,025</b>	<b>43,566</b>
<b>Assets Limited as to Use, noncurrent</b>									
Intentionally designated		29,153		10,148					39,301
Property, Plant and Equipment, net	499	56,107	932	4	12,757	1,158			71,457
Other Long-term Investments	544			3,609		8,742			12,895
Investments in Joint Ventures and Other Investments	38,248	14,333					612	32,788	3,122
Contributions Receivable				1,937					1,937
Other	21	556				170			849
Due From Affiliates		95		220	17			328	-
<b>Total assets</b>	<b>\$ 39,664</b>	<b>\$ 128,134</b>	<b>\$ 1,306</b>	<b>\$ 16,898</b>	<b>\$ 14,140</b>	<b>\$ 17,041</b>	<b>\$ 632</b>	<b>\$ 54,678</b>	<b>\$ 173,127</b>
<b>Liabilities and Net Assets</b>									
<b>Current Liabilities</b>									
Current maturities of long-term debt		355							355
Accounts payable	\$ 8	3,174	\$ 6	\$ 10	\$ 20	\$ 597			3,813
Accrued payroll	348	3,683	48	12	8	2,765			6,812
Accrued interest		412							412
Estimated settlements due to third-party payers		1,887	(760)						1,127
Due to affiliates	1,099	1,497	386	436	43	87		2,062	1,486
Other current liabilities	26	1,895	111	4	453	52	\$ -		2,341
<b>Total current liabilities</b>	<b>1,481</b>	<b>12,697</b>	<b>237</b>	<b>462</b>	<b>494</b>	<b>3,539</b>	<b>-</b>	<b>2,062</b>	<b>16,949</b>
<b>Long-term Debt, net</b>		<b>5,027</b>							<b>5,027</b>
<b>Other Long-term Liabilities</b>	<b>610</b>	<b>1,688</b>	<b>34</b>			<b>8,742</b>			<b>11,096</b>
<b>Due to Affiliates</b>		<b>16,772</b>	<b>86</b>					<b>328</b>	<b>16,546</b>
<b>Total Liabilities</b>	<b>2,113</b>	<b>36,315</b>	<b>337</b>	<b>462</b>	<b>494</b>	<b>12,281</b>	<b>-</b>	<b>2,390</b>	<b>45,612</b>
<b>Net Assets</b>									
Unrestricted	37,551	96,073	969	10,151	13,646	4,760	632	46,235	117,547
Temporarily restricted		3,866		4,431				4,173	4,134
Permanently restricted		1,887		1,644				1,880	1,844
<b>Total net assets</b>	<b>37,551</b>	<b>101,812</b>	<b>969</b>	<b>16,426</b>	<b>13,646</b>	<b>4,760</b>	<b>632</b>	<b>52,288</b>	<b>123,515</b>
<b>Total liabilities and net assets</b>	<b>\$ 39,664</b>	<b>\$ 128,134</b>	<b>\$ 1,306</b>	<b>\$ 16,898</b>	<b>\$ 14,140</b>	<b>\$ 17,041</b>	<b>\$ 632</b>	<b>\$ 54,678</b>	<b>\$ 173,127</b>

**Definitions**  
 TBS - Trinity Health System  
 TRMC - Trinity Regional Medical Center  
 BMHC - Bemis Medical Health Center  
 THF - Trinity Health Foundation

TBC - Trinity Building Corporation  
 TRIMARK - Tricare Physicians Group  
 IHFC - Iowa Health Home Care, THF partner

**Iowa Health System and Subsidiaries**  
**Trinity Health Systems, Inc. and Subsidiaries (Fort Dodge)**  
**Consolidating Schedule - Revenue and Gains, Expenses and Losses Information**  
**(In Thousands)**  
**Year Ended December 31, 2011**

	THS	TRMC	BMHC	THF	TBC	TRIMARK	IRHC	Eliminations	Consolidated
<b>Revenue</b>									
Patient service revenue (net of contractual allowances)	\$ -	\$ 95,319	\$ 2,236	\$ -	\$ -	\$ 42,236	\$ -	\$ -	\$ 139,791
Provision for patient uncollectible accounts		(5,305)	(20)			(1,087)			(6,697)
Net patient service revenue		90,014	2,216			41,149			133,399
Other operating revenue	3,072	6,567	77	26	2,123	4,507	(281)	5,759	10,332
Net assets released from restrictions used for operations		215		34					249
<b>Total revenue</b>	<b>3,072</b>	<b>96,796</b>	<b>2,293</b>	<b>60</b>	<b>2,123</b>	<b>45,656</b>	<b>(281)</b>	<b>5,759</b>	<b>143,980</b>
<b>Expenses</b>									
Salaries and wages	1,968	36,349	1,148	119	202	10,047			49,833
Physician compensation and services		7,720	362			19,907			27,999
Employee benefits	483	8,391	267	29	55	2,930			12,145
Supplies	7	17,344	23	5	5	3,155			20,590
Other expenses	167	22,669	429	525	1,140	9,422	5,895		28,637
Depreciation and amortization	60	5,205	89	2	729	362			6,447
Interest		1,510	5						1,515
<b>Total expenses</b>	<b>2,685</b>	<b>99,288</b>	<b>2,343</b>	<b>680</b>	<b>2,131</b>	<b>45,813</b>	<b>(281)</b>	<b>5,895</b>	<b>146,945</b>
<b>Operating Income (Loss)</b>	<b>387</b>	<b>(2,392)</b>	<b>(50)</b>	<b>(620)</b>	<b>(8)</b>	<b>(137)</b>	<b>(281)</b>	<b>(136)</b>	<b>(2,965)</b>
<b>Nonoperating Gains (Losses)</b>									
Investment income (loss)	2	(129)		(757)	3	6	(10)		(685)
Other, net	2			171					171
<b>Total nonoperating gains (losses), net</b>	<b>2</b>	<b>(129)</b>		<b>(586)</b>	<b>3</b>	<b>6</b>	<b>(10)</b>		<b>(714)</b>
<b>Revenue Over (Under) Expenses</b>	<b>\$ 389</b>	<b>\$ (2,221)</b>	<b>\$ (50)</b>	<b>\$ (1,206)</b>	<b>\$ (5)</b>	<b>\$ (131)</b>	<b>\$ (291)</b>	<b>\$ (136)</b>	<b>\$ (3,679)</b>

**Definitions**

THS - Trinity Health Systems  
TRMC - Trinity Regional Medical Center  
BMHC - Berryhill Mental Health Center  
THF - Trinity Health Foundation

TBC - Trinity Banking Corporation  
TRIMARK - TriMark Physicians Group  
IRHC - Iowa Health Home Care, THS portion

**Iowa Health System and Subsidiaries**  
**St. Luke's Health System, Inc. (Sioux City)**  
**Consolidating Schedule - Balance Sheet Information**  
**(In Thousands)**  
**December 31, 2011**

Assets	SLHS	SLRMC	SLHR	PACE	Elmhurst	Consolidated
<b>Current Assets</b>						
Cash and cash equivalents	\$ 31	\$ 7,197	\$ 638	\$ 33	\$ -	\$ 7,899
Short-term investments		12,229				12,229
Assets limited as to use - required for current liabilities		1,291				1,291
Patient accounts receivable, less estimated uncollectibles		19,165	1,085	212	34	20,428
Other receivables	28	2,749	37	13		2,827
Inventories		3,246	42			3,288
Prepaid expenses	15	708	31	27		781
Due from affiliates	36	41,046			40,926	156
<b>Total current assets</b>	<b>110</b>	<b>87,801</b>	<b>1,833</b>	<b>285</b>	<b>40,960</b>	<b>49,099</b>
<b>Assets Limited As to Use, noncurrent</b>						
Internally designated		41,796				41,796
Property, Plant and Equipment, net	14,789	49,849	2,134	90		66,862
Other Long-term Investments		1,105				1,105
Investments in Joint Ventures and Other Investments	10,667	791				11,458
Contributions Receivable		3,874				3,874
Other		726	18			744
<b>Total assets</b>	<b>\$ 25,566</b>	<b>\$ 185,972</b>	<b>\$ 3,985</b>	<b>\$ 375</b>	<b>\$ 40,960</b>	<b>\$ 174,938</b>
<b>Liabilities and Net Assets (Deficit)</b>						
<b>Current Liabilities</b>						
Accounts payable	\$ 528	\$ 4,939	\$ 324	\$ 626	\$ 34	\$ 6,383
Accrued payroll		5,701	77	34		5,812
Estimated settlements due to third-party payers		2,289		13		2,602
Due to affiliates	2,243	3,243	39,036	327	40,926	5,923
Other current liabilities	368	1,999	293			2,690
<b>Total current liabilities</b>	<b>3,169</b>	<b>20,471</b>	<b>39,730</b>	<b>1,000</b>	<b>40,960</b>	<b>23,410</b>
<b>Other Long-term Liabilities</b>						
Due to Affiliates	10,660	43,215	242			53,875
<b>Total liabilities</b>	<b>13,829</b>	<b>63,686</b>	<b>39,972</b>	<b>1,000</b>	<b>40,960</b>	<b>83,774</b>
<b>Net Assets (Deficit)</b>						
Unrestricted	11,737	111,880	(35,987)	(625)		87,005
Temporarily restricted		2,603				2,603
Permanently restricted		1,556				1,556
<b>Total net assets (deficit)</b>	<b>11,737</b>	<b>116,039</b>	<b>(35,987)</b>	<b>(625)</b>		<b>91,164</b>
<b>Total liabilities and net assets (deficit)</b>	<b>\$ 25,566</b>	<b>\$ 185,972</b>	<b>\$ 3,985</b>	<b>\$ 375</b>	<b>\$ 40,960</b>	<b>\$ 174,938</b>

**Abbreviations:**  
SLHS - St. Luke's Health System  
SLRMC - St. Luke's Regional Medical Center  
SLHR - St. Luke's Health Resources  
PACE - Sola and PACE

**Iowa Health System and Subsidiaries**  
**St. Luke's Health System, Inc. (Sioux City)**  
**Consolidating Schedule - Revenue and Gains, Expenses and Losses Information**  
**(In Thousands)**  
**Year Ended December 31, 2011**

	SLHS	SLRMC	SLHR	PACE	Eliminations	Consolidated
<b>Revenue</b>						
Patient service revenue (net of contractual allowances)	\$ -	\$ 136,793	\$ 12,319	\$ 3,720	\$ 537	\$ 152,295
Provision for patient uncollectible accounts		(9,255)	(664)			(9,919)
Net patient service revenue		127,538	11,655	3,720	537	142,376
Other operating revenue	3,443	4,460	65		602	7,366
Total revenue	3,443	131,998	11,720	3,720	1,139	149,742
<b>Expenses</b>						
Salaries and wages	10	46,761	3,743	661		51,175
Physician compensation and services		7,064	4,725	121		11,910
Employee benefits		11,656	931	123		12,710
Supplies	7	24,277	590	619		25,493
Other expenses	1,698	25,446	2,987	2,784	1,139	31,776
Depreciation and amortization	981	5,898	346	37		7,262
Interest	579	2,469				3,048
Provision for uncollectible accounts		46				46
Total expenses	3,275	123,617	13,322	4,345	1,139	143,420
Operating Income (Loss)	168	8,381	(1,602)	(625)	-	6,322
<b>Nonoperating Gains (Losses)</b>						
Investment income (loss)	(8)	(363)				(371)
Other, net	(18)		126			108
Total nonoperating gains (losses), net	(26)	(363)	126			(263)
Revenue Over (Under) Expenses	\$ 142	\$ 8,018	\$ (1,476)	\$ (625)	\$ -	\$ 6,059

**Definitions**  
SLHS - St. Luke's Health System  
SLRMC - St. Luke's Regional Medical Center  
SLHR - St. Luke's Health Resources  
PACE - Southland PACE

**Iowa Health System and Subsidiaries**  
**Finley Tri-States Health Group, Inc. and Subsidiaries (Dubuque)**  
**Consolidating Schedule - Balance Sheet Information**  
**(In Thousands)**  
**December 31, 2011**

Assets	TRI-ST	Finley	VNA	Eliminations	Consolidated
<b>Current Assets</b>					
Cash and cash equivalents	\$ -	\$ 4,293	\$ 354	\$ -	\$ 4,949
Short-term investments		9,481			9,481
Patient accounts receivable, less estimated uncollectibles		12,600	277		12,880
Other receivables		2,197	8		2,205
Inventories		2,132			2,132
Prepaid expenses		511	1		512
Due from affiliates		110	4	67	47
<b>Total current assets</b>		<u>31,629</u>	<u>644</u>	<u>67</u>	<u>32,206</u>
<b>Assets Limited As to Use, noncurrent</b>					
Internally designated		46,664			46,664
Property, Plant and Equipment, net		47,746	141		47,887
Other Long-term Investments		197			197
Investments in Joint Ventures and Other Investments	14	4,311			4,325
Contributions Receivable		5,228	1,617		6,845
Other		645	6		651
Due From Affiliates		90			90
<b>Total assets</b>	<u>\$ 14</u>	<u>\$ 136,710</u>	<u>\$ 2,408</u>	<u>\$ 67</u>	<u>\$ 139,065</u>
<b>Liabilities and Net Assets</b>					
<b>Current Liabilities</b>					
Accounts payable	\$ -	\$ 3,196	\$ 5	\$ -	\$ 3,601
Accrued payroll		3,999	183		4,180
Estimated settlements due to third-party payers		2,516	29		2,545
Due to affiliates		1,281	62	67	1,276
Other current liabilities		2,036	170		2,206
<b>Total current liabilities</b>		<u>13,428</u>	<u>447</u>	<u>67</u>	<u>13,808</u>
<b>Other Long-term Liabilities</b>		1,483	13		1,498
Due to Affiliates		7,626			7,626
<b>Total liabilities</b>		<u>22,537</u>	<u>460</u>	<u>67</u>	<u>22,992</u>
<b>Net Assets</b>					
Unrestricted	14	108,943	301		109,288
Temporarily restricted		3,426	1,617		5,043
Permanently restricted		1,802			1,802
<b>Total net assets</b>	<u>14</u>	<u>114,171</u>	<u>1,948</u>		<u>116,133</u>
<b>Total liabilities and net assets</b>	<u>\$ 14</u>	<u>\$ 136,710</u>	<u>\$ 2,408</u>	<u>\$ 67</u>	<u>\$ 139,065</u>

**Definitions**  
 TRI-ST - Finley Tri-States Health Group, Inc.  
 Finley - The Finley Hospital  
 VNA - Visiting Nurse Association

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**Iowa Health System and Subsidiaries**  
**Finley Tri-States Health Group, Inc. and Subsidiaries (Dubuque)**  
**Consolidating Schedule - Revenue and Gains, Expenses and Losses Information**  
**(In Thousands)**  
**Year Ended December 31, 2011**

	TRI-ST	Finley	VNA	Eliminations	Consolidated
<b>Revenue</b>					
Patient service revenue (net of contractual allowances)	\$ -	\$ 92,643	\$ 570	\$ -	\$ 93,213
Provision for patient uncollectible accounts		(2,630)			(2,630)
Net patient service revenue		90,013	570		90,583
Other operating revenue		3,609	2,130		5,739
Total revenue		93,622	2,700		96,322
<b>Expenses</b>					
Salaries and wages		32,205	1,937		34,142
Physician compensation and services		5,010			5,010
Employee benefits		8,890	568		9,458
Supplies		13,484	46		13,530
Other expenses		23,050	221		23,271
Depreciation and amortization		5,760	22		5,782
Interest		534			534
Provision for uncollectible accounts		26	7		33
Total expenses		88,959	2,801		91,760
<b>Operating Income (Loss)</b>		4,663	(101)		4,562
<b>Nonoperating Gains (Losses)</b>					
Investment income (loss)		(497)	6		(491)
Other, net		444	75		519
Total nonoperating gains (losses), net		(53)	81		28
<b>Revenue Over (Under) Expenses</b>	\$ -	\$ 4,610	\$ (20)	\$ -	\$ 4,590

**Definitions**  
TRI-ST - Finley Tri-States Health Group, Inc.  
Finley - The Finley Hospital  
VNA - Visiting Nurse Association

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**Iowa Health System and Subsidiaries**  
**The Methodist Medical Center of Illinois**  
**Statement of Operations for the Methodist College of Nursing**  
**Three-Month Period Ended December 31, 2011**

<b>Unrestricted Revenues, Gains and Other Support</b>	
Student revenue	\$ 194,178
Tuition	1,834,988
Foundation grants	<u>11,294</u>
<b>Total operating revenue</b>	<b><u>2,040,460</u></b>
<b>Expenses</b>	
Salaries and benefits	1,085,604
Supplies and other expenses	320,232
Depreciation and amortization	<u>48,280</u>
<b>Total operating expenses</b>	<b><u>1,454,116</u></b>
<b>Revenues in Excess of Expenses</b>	<b><u>\$ 586,344</u></b>