

**ORIGINAL**

13-020

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

**RECEIVED**

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

MAY 06 2013

This Section must be completed for all projects.

HEALTH FACILITIES &  
SERVICES REVIEW BOARD

**Facility/Project Identification**

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

**Applicant /Co-Applicant Identification**

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

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

**Type of Ownership of Applicant/Co-Applicant**

<input type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input checked="" 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:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	675North Court Suite 210 Palatine, IL 6067
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7004

**Additional Contact**

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

Name:	Honey Jacobs Skinner
Title:	Partner
Company Name:	Sidley & Austin
Address:	1 South Dearborn Chicago, IL 60603
Telephone Number:	312/853-7577
E-mail Address:	mskinner@sidley.com
Fax Number:	312/853-7036

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

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

**This Section must be completed for all projects.**

**Facility/Project Identification**

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

**Applicant /Co-Applicant Identification**

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

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

**Type of Ownership of Applicant/Co-Applicant**

<input type="checkbox"/>	Non-profit Corporation	<input type="checkbox"/>	Partnership	
X	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:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	675North Court Suite 210 Palatine, IL 6067
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7004

**Additional Contact**

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

Name:	Honey Jacobs Skinner
Title:	Partner
Company Name:	Sidley & Austin
Address:	1 South Dearborn Chicago, IL 60603
Telephone Number:	312/853-7577
E-mail Address:	mskinner@sidley.com
Fax Number:	312/853-7036

**Post Permit Contact**

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

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

**Site Ownership**

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	VHS Westlake Hospital, Inc.
Address of Site Owner:	1225 Lake Street Melrose Park, IL 60160
Street Address or Legal Description of Site:	1225 Lake Street Melrose Park, IL 60160
Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.	
APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

**Operating Identity/Licensee**

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

Exact Legal Name:	VHS Westlake Hospital, Inc.
Address:	1225 Lake Street Melrose Park, IL 60160
<input type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input checked="" 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)]

Part 1110 Classification:

- Substantive  
 Non-substantive

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

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

## 2. Narrative Description

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

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

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

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

## Project Costs and Sources of Funds

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

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
<b>TOTAL USES OF FUNDS</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
<b>TOTAL SOURCES OF FUNDS</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</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.**

### 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 \$ _____.

### Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings: <input checked="" type="checkbox"/> None or not applicable <input type="checkbox"/> Preliminary <input type="checkbox"/> Schematics <input type="checkbox"/> Final Working
Anticipated project completion date (refer to Part 1130.140): _____
Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140): <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                      not applicable**

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

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
<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.**

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

**CERTIFICATION**

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

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

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

William A. Brown  
SIGNATURE  
WILLIAM A. BROWN  
PRINTED NAME  
CEO - VHS Westlake HOSPITAL  
PRINTED TITLE

William T. Foley  
SIGNATURE  
WILLIAM T. FOLEY  
PRINTED NAME  
SENIOR VP VANGUARD Health Systems  
PRINTED TITLE

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

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

Kathleen M. Fox  
Signature of Notary

Kathleen M. Fox  
Signature of Notary

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

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

\*Insert EXACT legal name of the applicant

**CERTIFICATION**

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

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

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

William A. Brown  
SIGNATURE

WILLIAM A. BROWN  
PRINTED NAME

CEO - VHS Westlake Hospital  
PRINTED TITLE

[Signature]  
SIGNATURE

WILLIAM T. FOLEY  
PRINTED NAME

SR VP, Vanguard Health Systems  
PRINTED TITLE

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

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

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

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

\*Insert EXACT legal name of the applicant

## SECTION II. DISCONTINUATION

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

### Criterion 1110.130 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

#### GENERAL INFORMATION REQUIREMENTS

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

#### REASONS FOR DISCONTINUATION

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

#### IMPACT ON ACCESS

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

**APPEND DOCUMENTATION AS ATTACHMENT-10, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.**

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

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

**VIII. - 1120.120 - Availability of Funds**

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

_____	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: <ol style="list-style-type: none"> <li>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</li> <li>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;</li> </ol>
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
_____	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: <ol style="list-style-type: none"> <li>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;</li> <li>2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate;</li> <li>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.;</li> <li>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;</li> <li>5) For any option to lease, a copy of the option, including all terms and conditions.</li> </ol>
_____	e)	Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
_____	f)	Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
_____	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
n/a	<b>TOTAL FUNDS AVAILABLE</b>	

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

**IX. 1120.130 - Financial Viability not applicable**

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

**Financial Viability Waiver**

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

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

See Section 1120.130 Financial Waiver for information to be provided

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

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

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

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

**2. Variance**

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

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

**X. 1120.140 - Economic Feasibility not applicable**

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

**A. Reasonableness of Financing Arrangements**

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

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

**B. Conditions of Debt Financing**

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

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

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

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New 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

**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.**

<b>Safety Net Information per PA 96-0031</b>			
<b>CHARITY CARE</b>			
<b>Charity (# of patients)</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Inpatient	269	179	65
Outpatient	2,871	498	397
<b>Total</b>	<b>3,140</b>	<b>577</b>	<b>462</b>
<b>Charity (cost in dollars)</b>			
Inpatient	\$548,712	\$680,024	\$837,756
Outpatient	\$307,093	\$242,456	\$210,899
<b>Total</b>	<b>\$855,805</b>	<b>\$922,480</b>	<b>\$1,048,655</b>
<b>MEDICAID</b>			
<b>Medicaid (# of patients)</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Inpatient	2,642	2,871	2,702
Outpatient	21,105	21,927	21,315
<b>Total</b>	<b>23,747</b>	<b>24,798</b>	<b>24,017</b>
<b>Medicaid (revenue)</b>			
Inpatient	\$20,210,772	\$14,231,149	\$32,158,305
Outpatient	\$2,178,863	\$2,964,420	\$1,072,445
<b>Total</b>	<b>\$22,389,635</b>	<b>\$17,195,569</b>	<b>\$33,230,750</b>

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

**XII. Charity Care Information**

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

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

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

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

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

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

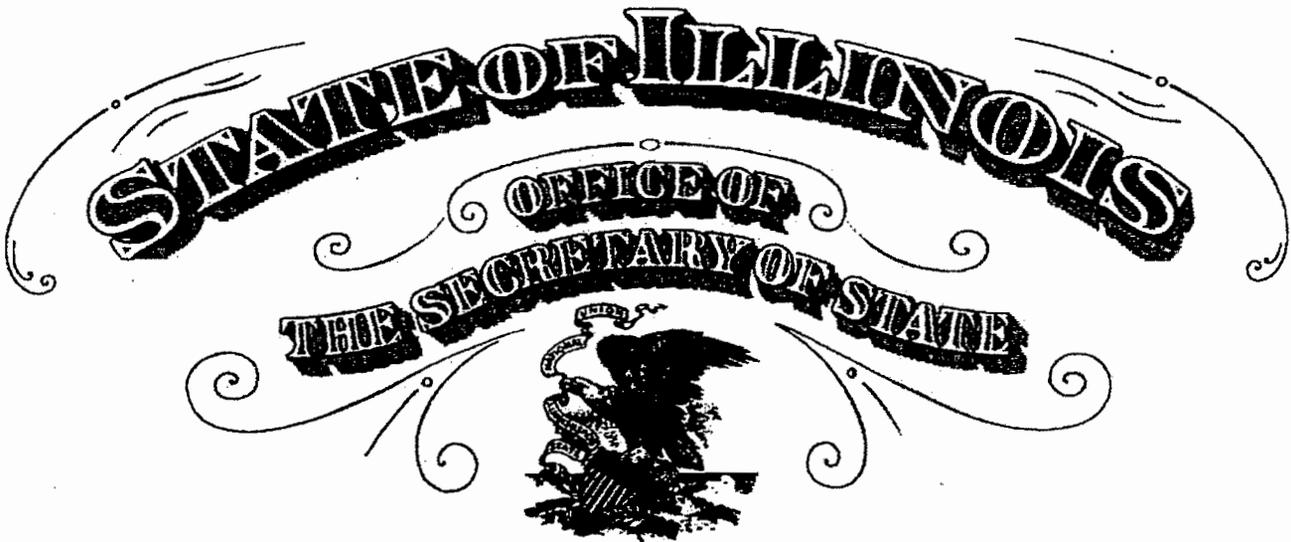
**D. Projected Operating Costs**

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

**E. Total Effect of the Project on Capital Costs**

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

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



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

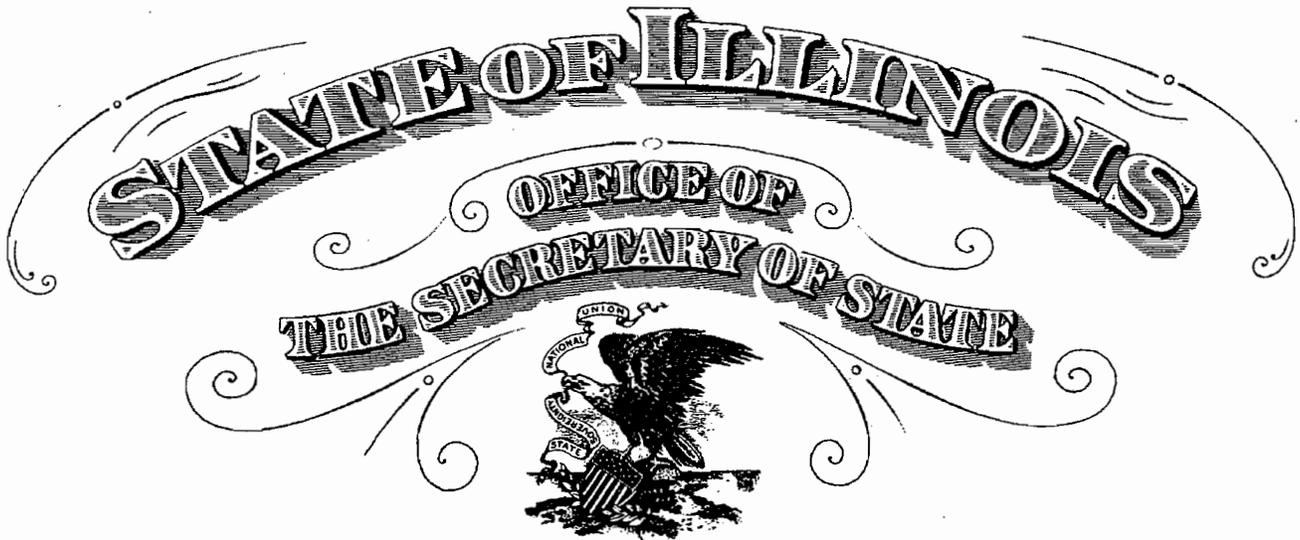
*I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that*

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



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

*Jesse White*



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

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

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



Authentication #: 1311301992

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 23TH day of APRIL A.D. 2013 .***

*Jesse White*

SECRETARY OF STATE  
ATTACHMENT 1

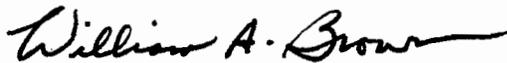
April 26, 2013

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

To Whom It May Concern:

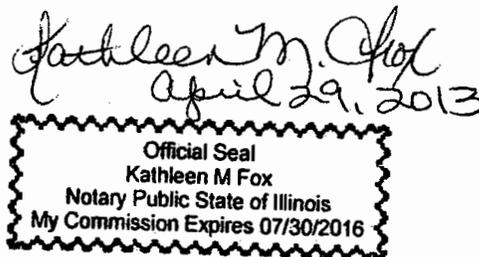
I hereby attest that VHS Westlake Hospital, Inc. is the owner of the hospital' site, 1225 Lake Street, in Melrose Park, Illinois.

Sincerely,



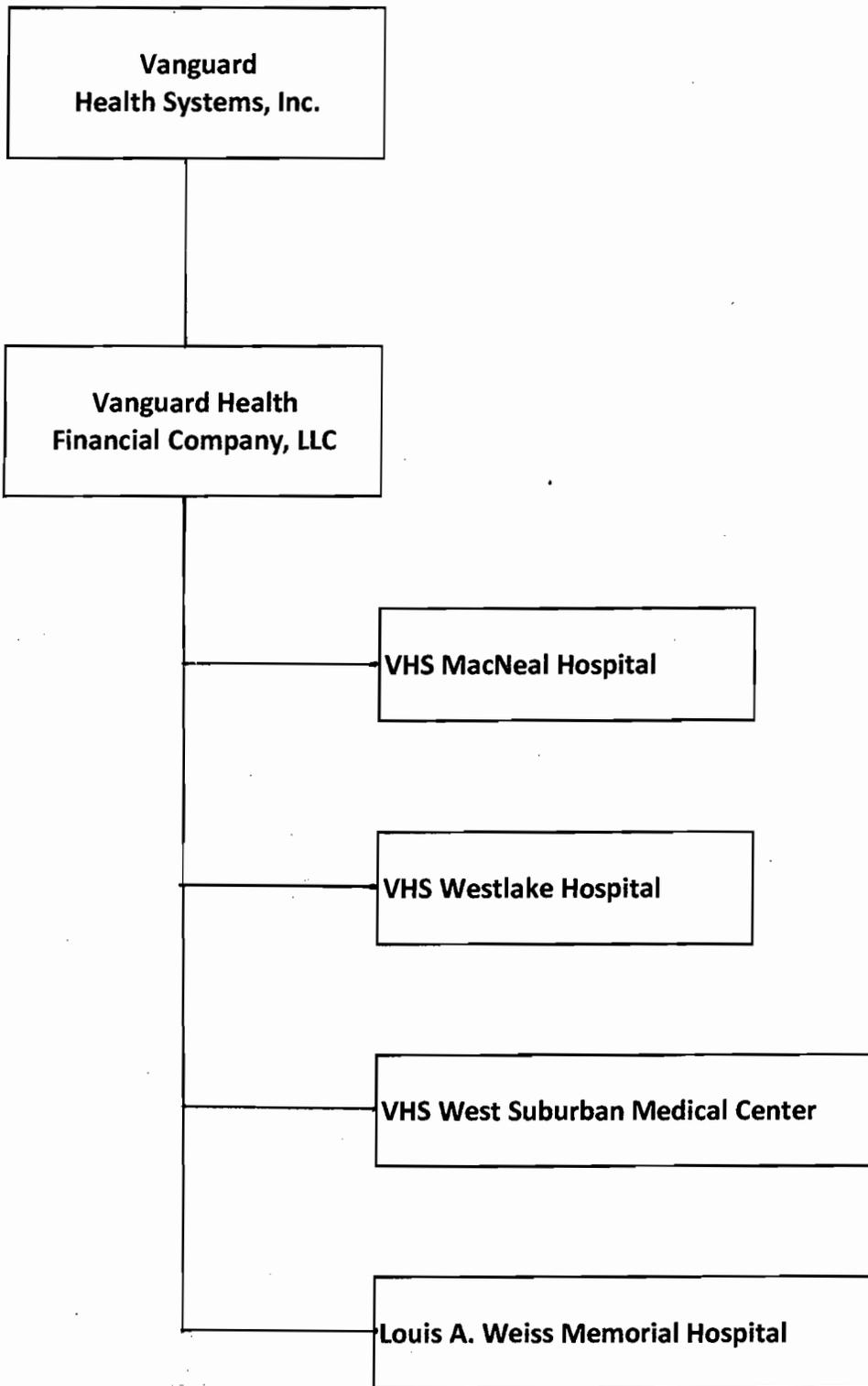
William A. Brown, FACHE  
Chief Executive Officer

WAB/III



ATTACHMENT 2

ORGANIZATIONAL CHART



The screenshot displays the FEMA Intranetix Viewer interface. At the top left is the FEMA logo. To its right is a status bar showing 'Scale: 4%' and 'LOMC: 08-05-4671A-170125'. Below the logo is a 'Help' icon. The main area is a map with a grid overlay. On the left side of the map is a vertical toolbar with icons for 'Zoom Up', 'Zoom Down', 'Zoom In', 'Zoom Out', and 'MAX'. Below the toolbar is a 'Make a FIRMette' button. On the right side of the map is a metadata panel with various fields and text.

ATTACHMENT 5

23

## DISCONTINUATION

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

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

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

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

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

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

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

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

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

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

# Vanguard Health Systems Chicago Market

## HEALTH INFORMATION MANAGEMENT DEPARTMENT

**Section: Record Management**

**Title: Retention, Storage and Destruction Policy**

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

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

### COMPONENTS OF A MEDICAL RECORD:

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

### OTHER DOCUMENTS:

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

### DOCUMENT RETENTION PERIODS:

ATTACHMENT 10

**MEDICAL RECORDS and HEALTH NETWORK RECORDS**

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

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

# Axel & Associates, Inc.

MANAGEMENT CONSULTANTS

by Certified Mail

April 1, 2013

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

Dear Mr. Crowther:

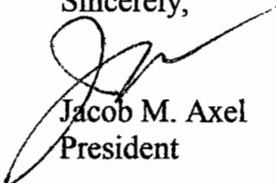
VHS Westlake Hospital is preparing a Certificate of Need application to be filed with the Illinois Health Facilities and Services Review Board ("IHFSRB"), addressing the discontinuation of its obstetrics and open heart surgery categories of service. The hospital is located at 1225 Lake Street in Melrose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

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

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

Thank you for your prompt attention to this request.

Sincerely,



Jacob M. Axel  
President

ATTACHMENT 10



Trip to:

**Northwestern Memorial Hospital**  
**541 N Fairbanks Ct**

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

Notes



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

- 1. Start out going **north** toward **Chicago Ave.** [Map](#)

**0.04 Mi**  
0.04 Mi Total
- ↘

2. Take the 1st **right** onto **Chicago Ave.** [Map](#)

**0.7 Mi**  
0.7 Mi Total
- ↘

3. Turn **right** onto **N 1st Ave / IL-171.** [Map](#)  
*N 1st Ave is just past N 2nd Ave  
 If you reach Thatcher Ave you've gone about 0.4 miles too far*

**1.6 Mi**  
2.3 Mi Total
- ↙

4. Merge onto **I-290 E / IL-110 E / Eisenhower Expy E** via the ramp on the **left.** [Map](#)  
*If you are on S 1st Ave and reach Lexington St you've gone a little too far*

**9.6 Mi**  
11.9 Mi Total
- ↙

5. Merge onto **I-90 W / I-94 W / Kennedy Expy W** toward **Wisconsin.** [Map](#)

**1.5 Mi**  
13.4 Mi Total
- 6. Take **EXIT 50B** toward **East Ohio St.** [Map](#)

**0.8 Mi**  
14.2 Mi Total
- ↑

7. Stay **straight** to go onto **W Ohio St.** [Map](#)

**0.9 Mi**  
15.1 Mi Total
- ↘

8. Turn **right** onto **N Fairbanks Ct.** [Map](#)  
*N Fairbanks Ct is 0.1 miles past N St Clair St  
 Markethouse is on the corner  
 If you reach N McClurg Ct you've gone about 0.1 miles too far*

**0.04 Mi**  
15.1 Mi Total
- 9. **541 N FAIRBANKS CT** is on the **left.** [Map](#)  
*If you reach E Grand Ave you've gone a little too far*

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

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

©2013 MapQuest, Inc. Use of directions and maps is subject to the MapQuest Terms of Use. We make no guarantee of the accuracy of their content, road conditions or route usability. You assume all risk of use. [View Terms of Use](#)

ATTACHMENT 10

30



Notes

Trip to:

**Resurrection Medical Center  
7435 W Talcott Ave**

Chicago, IL 60631

(773) 792-5032

9.17 miles / 22 minutes



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



1. Start out going north toward **Chicago Ave.** [Map](#) **0.04 Mi**  
*0.04 Mi Total*



2. Take the 1st **right** onto **Chicago Ave.** [Map](#) **0.7 Mi**  
*0.7 Mi Total*



3. Turn **left** onto **N 1st Ave / IL-171.** Continue to follow **IL-171 N.** [Map](#) **6.1 Mi**  
*6.9 Mi Total*



4. Merge onto **I-90 E / Kennedy Expy E.** [Map](#) **1.2 Mi**  
*8.1 Mi Total*



5. Take **EXIT 81A** toward **IL-43 / Harlem Ave.** [Map](#) **0.2 Mi**  
*8.3 Mi Total*



6. Stay **straight** to go onto **W Higgins Ave / IL-72 E.** [Map](#) **0.2 Mi**  
*8.5 Mi Total*



7. Turn **left** onto **N Harlem Ave / IL-43.** [Map](#) **0.3 Mi**  
*8.8 Mi Total*



8. Turn **left** onto **W Talcott Ave.** [Map](#) **0.4 Mi**  
*9.2 Mi Total*



9. **7435 W TALCOTT AVE** is on the **left.** [Map](#)



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

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

©2013 MapQuest, Inc. Use of directions and maps is subject to the MapQuest Terms of Use. We make no guarantee of the accuracy of their content, road conditions or route usability. You assume all risk of use. [View Terms of Use](#)

ATTACHMENT 10

31



Notes

Trip to:

**St Joseph Hospital-ER**  
**2900 N Lake Shore Dr**

Chicago, IL 60657  
 (773) 665-3086  
 17.33 miles / 33 minutes

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

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

ATTACHMENT 10

32



14. Turn **right** onto **N Lake Shore Dr W**. [Map](#)

**0.1 Mi**

*17.3 Mi Total*



15. **2900 N LAKE SHORE DR** is on the **right**. [Map](#)



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

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

©2013 MapQuest, Inc. Use of directions and maps is subject to the MapQuest Terms of Use. We make no guarantee of the accuracy of their content, road conditions or route usability. You assume all risk of use. [View Terms of Use](#)

ATTACHMENT 10

33



Notes

Trip to:

**ATM - Swedish Covenant Hospital  
5140 N California Ave**

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

Notes area (empty)

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

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

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

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

©2013 MapQuest, Inc. Use of directions and maps is subject to the MapQuest Terms of Use. We make no guarantee of the accuracy of their content, road conditions or route usability. You assume all risk of use. [View Terms of Use](#)

ATTACHMENT 10

34



Notes

Trip to:

**John H Stroger Jr Hospital-ER**  
**1901 W Harrison St**

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



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

- 
1. Start out going **north** toward **Chicago Ave.** [Map](#)
0.04 Mi  
0.04 Mi Total
- 
2. Take the 1st **right** onto **Chicago Ave.** [Map](#)
0.7 Mi  
0.7 Mi Total
- 

3. Turn **right** onto **N 1st Ave / IL-171.** [Map](#)
1.6 Mi  
2.3 Mi Total
- 

4. Merge onto **I-290 E / IL-110 E / Eisenhower Expy E** via the ramp on the **left.** [Map](#)
8.0 Mi  
10.3 Mi Total
- 
5. Take **EXIT 28A** toward **Damen Ave.** [Map](#)
0.1 Mi  
10.5 Mi Total
- 
6. Stay **straight** to go onto **W Congress Pky.** [Map](#)
0.03 Mi  
10.5 Mi Total
- 
7. Take the 1st **right** onto **S Damen Ave.** [Map](#)
0.07 Mi  
10.6 Mi Total
- 
8. Take the 1st **left** onto **W Harrison St.** [Map](#)
0.08 Mi  
10.6 Mi Total
- 
9. **1901 W HARRISON ST** is on the **right.** [Map](#)

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

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

©2013 MapQuest, Inc. Use of directions and maps is subject to the MapQuest Terms of Use. We make no guarantee of the accuracy of their content, road conditions or route usability. You assume all risk of use. [View Terms of Use](#)

ATTACHMENT 10

35



mapquest

Notes

Trip to:

**Mount Sinai Hospital  
Ogden At California Ave**

Chicago, IL 60608

(773) 542-2000

10.37 miles / 18 minutes



**Westlake Hospital-ER**

1225 W Lake St, Melrose Park, IL 60160

(708) 938-7190

- 
 1. Start out going **north** toward **Chicago Ave.** [Map](#) **0.04 Mi**  
0.04 Mi Total
- 
 2. Take the **1st right** onto **Chicago Ave.** [Map](#) **0.7 Mi**  
0.7 Mi Total
- 

 3. Turn **right** onto **N 1st Ave / IL-171.** [Map](#) **1.6 Mi**  
2.3 Mi Total
- 

 4. Merge onto **I-290 E / IL-110 E / Eisenhower Expy E** via the ramp on the **left.** [Map](#) **6.7 Mi**  
9.0 Mi Total
- 
 5. Take the **Sacramento Blvd** exit, **EXIT 27A.** [Map](#) **0.2 Mi**  
9.2 Mi Total
- 
 6. Turn **right** onto **S Sacramento Blvd.** [Map](#) **0.5 Mi**  
9.8 Mi Total
- 
 7. Turn **left** onto **W Roosevelt Rd.** [Map](#) **0.3 Mi**  
10.0 Mi Total
- 
 8. Turn **right** onto **S California Ave.** [Map](#) **0.4 Mi**  
10.4 Mi Total
- 
 9. **OGDEN AT CALIFORNIA AVE.** [Map](#)



**Mount Sinai Hospital**

Ogden At California Ave, Chicago, IL 60608

(773) 542-2000

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

©2013 MapQuest, Inc. Use of directions and maps is subject to the MapQuest Terms of Use. We make no guarantee of the accuracy of their content, road conditions or route usability. You assume all risk of use. [View Terms of Use](#)

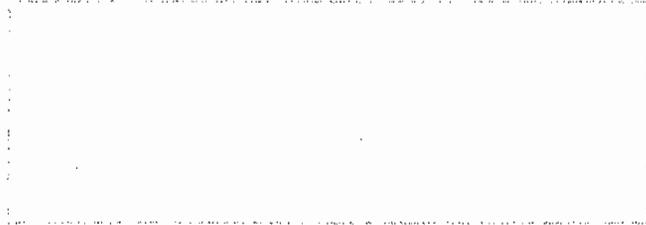
ATTACHMENT 10

3 f



**mapquest**

Notes



Trip to:

**Rush University Medical Center**  
**1653 W Congress Pkwy**

Chicago, IL 60612  
(312) 942-5000  
10.92 miles / 18 minutes



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



1. Start out going **north** toward **Chicago Ave.** [Map](#) **0.04 Mi**  
*0.04 Mi Total*



2. Take the **1st right** onto **Chicago Ave.** [Map](#) **0.7 Mi**  
*0.7 Mi Total*



3. Turn **right** onto **N 1st Ave / IL-171.** [Map](#) **1.6 Mi**  
*2.3 Mi Total*



4. Merge onto **I-290 E / IL-110 E / Eisenhower Expy E** via the ramp on the **left.** [Map](#) **8.4 Mi**  
*10.7 Mi Total*



5. Take **EXIT 28B** toward **Paulina St / Ashland Ave.** [Map](#) **0.2 Mi**  
*10.8 Mi Total*



6. Stay **straight** to go onto **W Congress Pky.** [Map](#) **0.03 Mi**  
*10.9 Mi Total*



7. Take the **1st right.** [Map](#) **0.05 Mi**  
*10.9 Mi Total*



8. Turn **left.** [Map](#) **0.01 Mi**  
*10.9 Mi Total*



9. **1653 W CONGRESS PKWY.** [Map](#)



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

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

©2013 MapQuest, Inc. Use of directions and maps is subject to the MapQuest Terms of Use. We make no guarantee of the accuracy of their content, road conditions or route usability. You assume all risk of use. [View Terms of Use](#)

ATTACHMENT 10

37



Notes

Trip to:

**ATM - St Mary of Nazareth**  
**2222 W Division St**

Chicago, IL 60622

(800) 432-1000

12.14 miles / 23 minutes



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

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

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

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

©2013 MapQuest, Inc. Use of directions and maps is subject to the MapQuest Terms of Use. We make no guarantee of the accuracy of their content, road conditions or route usability. You assume all risk of use. [View Terms of Use](#)

ATTACHMENT 10

38



Notes

Trip to:

**University of Illinois Medical Center  
At Chicago Outpatient Centers  
1801 W Taylor St**

Chicago, IL 60612  
(312) 996-3500  
11.14 miles / 19 minutes



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

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

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

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

©2013 MapQuest, Inc. Use of directions and maps is subject to the MapQuest Terms of Use. We make no guarantee of the accuracy of their content, road conditions or route usability. You assume all risk of use. [View Terms of Use](#)

ATTACHMENT 10

39



Notes

Trip to:

**Mercy Hospital & Medical Center**

**2525 S Michigan Ave**

Chicago, IL 60616

(312) 567-2141

15.87 miles / 25 minutes

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

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

ATTACHMENT 10

40



**Mercy Hospital & Medical Center**

Patient Information

2525 S Michigan Ave, Chicago, IL 60616

(312) 567-2141

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

©2013 MapQuest, Inc. Use of directions and maps is subject to the MapQuest Terms of Use. We make no guarantee of the accuracy of their content, road conditions or route usability. You assume all risk of use. [View Terms of Use](#)

ATTACHMENT 10

41

Notes

Trip to:  
**Advocate II Masonic Medical Center**  
**836 W Wellington Ave**  
Chicago, IL 60657

17.75 miles / 31 minutes

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

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

 **Advocate II Masonic Medical Center**  
(773) 975-1600

Notes



**mapquest**

Trip to:

**University of Chicago Med Ctr-ER**  
**5841 S Maryland Ave**

Chicago, IL 60637

(773) 702-6250

19.90 miles / 33 minutes



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

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

ATTACHMENT 10

43



14. Rainey Dr becomes Payne Dr. [Map](#)

0.05 Mi  
19.4 Mi Total



15. Turn right onto E Garfield Blvd / E 55th St. [Map](#)

0.06 Mi  
19.5 Mi Total



16. Turn right onto S Cottage Grove Ave. [Map](#)

0.4 Mi  
19.8 Mi Total



17. Turn left onto E 58th St. [Map](#)

0.06 Mi  
19.9 Mi Total



18. Take the 1st right onto S Maryland Ave. [Map](#)

0.01 Mi  
19.9 Mi Total



19. 5841 S MARYLAND AVE is on the left. [Map](#)



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

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

©2013 MapQuest, Inc. Use of directions and maps is subject to the MapQuest Terms of Use. We make no guarantee of the accuracy of their content, road conditions or route usability. You assume all risk of use. [View Terms of Use](#)

ATTACHMENT 10

44



Notes

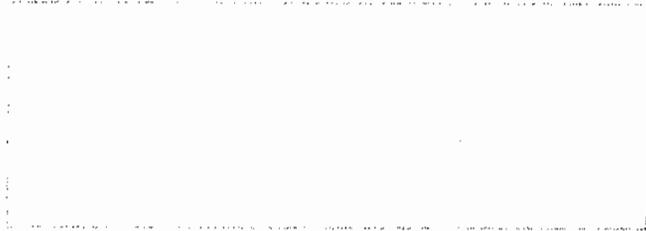
Trip to:

**Adventist La Grange Memorial Hospital**  
**5101 Willow Springs Rd**

La Grange, IL 60525

(708) 245-9000

9.98 miles / 25 minutes



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



1. Start out going north toward **Chicago Ave.** [Map](#) **0.04 Mi**  
*0.04 Mi Total*



2. Take the 1st **right** onto **Chicago Ave.** [Map](#) **0.7 Mi**  
*0.7 Mi Total*



3. Turn **right** onto **N 1st Ave / IL-171.** [Map](#) **5.6 Mi**  
*6.4 Mi Total*



4. Turn **right** onto **Plainfield Rd.** [Map](#) **1.0 Mi**  
*7.3 Mi Total*



5. Turn **slight right** onto **W 47th St / 47th St.** Continue to follow **W 47th St.** [Map](#) **2.1 Mi**  
*9.4 Mi Total*



6. Turn **left** onto **Willow Springs Rd / Gilbert Ave / S Gilbert Ave.** Continue to follow **Willow Springs Rd / Gilbert Ave.** [Map](#) **0.5 Mi**  
*10.0 Mi Total*



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

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

©2013 MapQuest, Inc. Use of directions and maps is subject to the MapQuest Terms of Use. We make no guarantee of the accuracy of their content, road conditions or route usability. You assume all risk of use. [View Terms of Use](#)

ATTACHMENT 10

45



mapquest

Notes

Trip to:

4440 W 95th St

Advocate Christ

Oak Lawn, IL 60453-2600

17.83 miles / 39 minutes



**Westlake Hospital-ER**

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



1. Start out going north toward Chicago Ave. [Map](#)

**0.04 Mi**  
0.04 Mi Total



2. Take the 1st right onto Chicago Ave. [Map](#)

**0.7 Mi**  
0.7 Mi Total



3. Turn right onto N 1st Ave / IL-171. [Map](#)

**1.6 Mi**  
2.3 Mi Total



4. Merge onto I-290 E / IL-110 E / Eisenhower Expy E via the ramp on the left. [Map](#)

**4.4 Mi**  
6.7 Mi Total



5. Take EXIT 24B toward IL-50 / Cicero Ave. [Map](#)

**0.2 Mi**  
6.9 Mi Total



6. Turn slight left onto W Lexington St. [Map](#)

**0.06 Mi**  
6.9 Mi Total



7. Take the 1st right onto S Cicero Ave / IL-50 S. Continue to follow IL-50 S. [Map](#)

**10.5 Mi**  
17.4 Mi Total



8. Turn left onto US-20 / US-12 / Ulysses S Grant Memorial Hwy / W 95th St. [Map](#)

**0.4 Mi**  
17.8 Mi Total



9. 4440 W 95TH ST is on the left. [Map](#)



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

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

©2013 MapQuest, Inc. Use of directions and maps is subject to the MapQuest Terms of Use. We make no guarantee of the accuracy of their content, road conditions or route usability. You assume all risk of use. [View Terms of Use](#)

ATTACHMENT 10

46

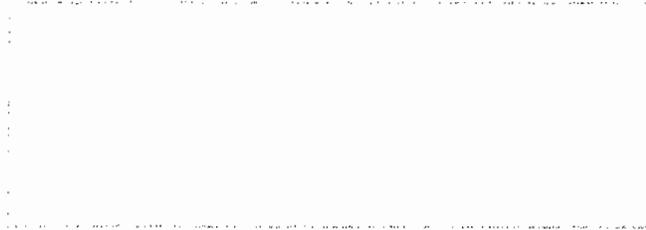


Notes

Trip to:

**Palos Community Hospital**  
**12251 S 80th Ave**

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



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

- 
1. Start out going **north** toward **Chicago Ave.** [Map](#)
0.04 Mi  
0.04 Mi Total
- 
2. Take the 1st **right** onto **Chicago Ave.** [Map](#)
0.7 Mi  
0.7 Mi Total
- 

3. Turn **right** onto **N 1st Ave / IL-171.** Continue to follow **IL-171 S.** [Map](#)
7.1 Mi  
7.9 Mi Total
- 

4. Merge onto **I-55 S / Stevenson Expy S** toward **St Louis.** [Map](#)
3.1 Mi  
10.9 Mi Total
- 
5. Take the **US-12 / US-20 / US-45** exit, **EXIT 279A-B,** toward **La Grange Rd.** [Map](#)
0.2 Mi  
11.2 Mi Total
- 

6. Merge onto **US-45 S** via the ramp on the **left.** [Map](#)
6.4 Mi  
17.6 Mi Total
- 
7. Take the **Calumet Sag Rd / IL-83** ramp. [Map](#)
0.2 Mi  
17.7 Mi Total
- 

8. Turn **right** onto **W Cal Sag Rd / IL-83.** [Map](#)
2.3 Mi  
20.1 Mi Total
- 
9. Turn **right** onto **S 80th Ave.** [Map](#)
0.4 Mi  
20.5 Mi Total
- 
10. **12251 S 80TH AVE** is on the **left.** [Map](#)

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

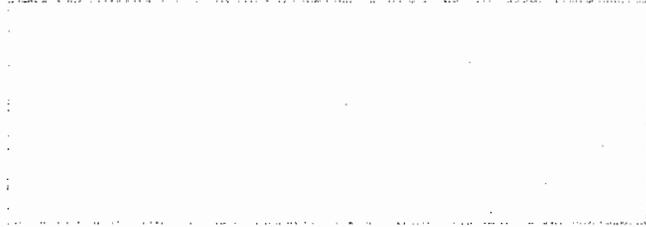
**Total Travel Estimate: 20.47 miles - about 36 minutes**

©2013 MapQuest, Inc. Use of directions and maps is subject to the MapQuest Terms of Use. We make no guarantee of the accuracy of their content, road conditions or route usability. You assume all risk of use. [View Terms of Use](#)

47



Notes



Trip to:

**Adventist Hinsdale Hospital**  
**120 N Oak St**

Hinsdale, IL 60521  
 (630) 856-9000  
 10.10 miles / 21 minutes

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

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

ATTACHMENT 10

48



14. Turn **right** onto **E Hickory St.** [Map](#)

**0.05 Mi**  
*10.0 Mi Total*



15. Take the 1st **left** onto **N Oak St.** [Map](#)

**0.1 Mi**  
*10.1 Mi Total*



16. **120 N OAK ST** is on the **right.** [Map](#)



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

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

©2013 MapQuest, Inc. Use of directions and maps is subject to the MapQuest Terms of Use. We make no guarantee of the accuracy of their content, road conditions or route usability. You assume all risk of use. [View Terms of Use](#)

ATTACHMENT 10

49



**mapquest**

Notes

Trip to:

**Advocate Good Samaritan Hospital  
4924 Forest Ave**

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



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

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

ATTACHMENT 10

50



14. Highland Ave becomes Main St. [Map](#)

**1.3 Mi**  
*13.7 Mi Total*



15. Turn right onto Franklin St. [Map](#)

**0.07 Mi**  
*13.7 Mi Total*



16. Take the 1st left onto Forest Ave. [Map](#)

**0.08 Mi**  
*13.8 Mi Total*



17. 4924 FOREST AVE is on the right. [Map](#)



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

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

©2013 MapQuest, Inc. Use of directions and maps is subject to the MapQuest Terms of Use. We make no guarantee of the accuracy of their content, road conditions or route usability. You assume all risk of use. [View Terms of Use](#)



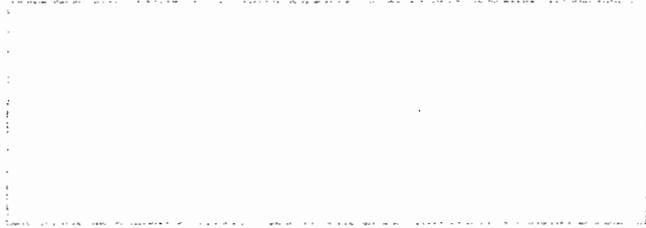
**mapquest**

Trip to:

**Central Dupage Hospital**  
**25 N Winfield Rd**

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

Notes



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



1. Start out going **north** toward **Chicago Ave.** [Map](#) **0.04 Mi**  
*0.04 Mi Total*



2. Take the 1st **left** onto **Chicago Ave.** [Map](#) **0.3 Mi**  
*0.3 Mi Total*



3. Turn **left** onto **N 17th Ave.** [Map](#) **0.02 Mi**  
*0.4 Mi Total*



4. Take the 1st **right** onto **W Lake St.** [Map](#) **0.5 Mi**  
*0.9 Mi Total*



5. Turn **right** onto **N 25th Ave.** [Map](#) **0.9 Mi**  
*1.8 Mi Total*



6. Turn **left** onto **W North Ave / IL-64 W.** Continue to follow **IL-64 W.** [Map](#) **14.7 Mi**  
*16.5 Mi Total*



7. Turn **slight left.** [Map](#) **0.08 Mi**  
*16.6 Mi Total*



8. Turn **left** onto **County Farm Rd.** [Map](#) **1.4 Mi**  
*17.9 Mi Total*



9. Turn **right** onto **Geneva Rd.** [Map](#) **0.3 Mi**  
*18.2 Mi Total*



10. Turn **left** onto **Winfield Rd.** [Map](#) **1.0 Mi**  
*19.2 Mi Total*



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

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

ATTACHMENT 10

52



**mapquest**

Notes

Trip to:

**Edward Hospital**  
**801 S Washington St**

Naperville, IL 60540  
 (630) 527-3000  
 22.95 miles / 39 minutes



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

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

ATTACHMENT 10

53



14. Merge onto **Hobson Rd.** [Map](#)

**4.7 Mi**

*21.7 Mi Total*



15. Turn **right** onto **S Washington St.** [Map](#)

**1.2 Mi**

*23.0 Mi Total*



16. **801 S WASHINGTON ST** is on the **left.** [Map](#)



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

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

©2013 MapQuest, Inc. Use of directions and maps is subject to the MapQuest Terms of Use. We make no guarantee of the accuracy of their content, road conditions or route usability. You assume all risk of use. [View Terms of Use](#)

ATTACHMENT 10

54

Notes



**mapquest**

Trip to:

**Elmhurst Memorial Hospital**  
**155 E. Brush Hill Road**

Elmhurst, IL 60126

(331) 221-1000

6.78 miles / 15 minutes



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

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

ATTACHMENT 10

55



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

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

©2013 MapQuest, Inc. Use of directions and maps is subject to the MapQuest Terms of Use. We make no guarantee of the accuracy of their content, road conditions or route usability. You assume all risk of use. [View Terms of Use](#)

ATTACHMENT 10

52

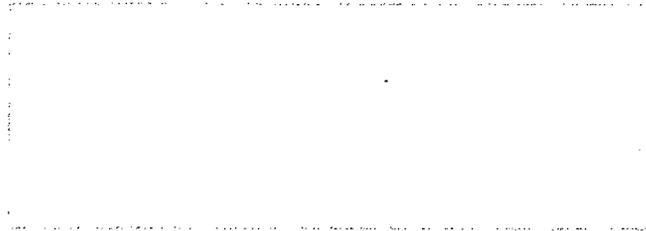


Trip to:

**Gottlieb Memorial Hospital  
701 W North Ave**

Melrose Park, IL 60160  
(708) 450-4510  
2.28 miles / 6 minutes

Notes



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

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

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

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

©2013 MapQuest, Inc. Use of directions and maps is subject to the MapQuest Terms of Use. We make no guarantee of the accuracy of their content, road conditions or route usability. You assume all risk of use. [View Terms of Use](#)

ATTACHMENT 10

57



**mapquest**

Notes

[Empty dashed box for notes]

Trip to:

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

*Loyola*



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



1. Start out going north toward **Chicago Ave.** [Map](#)

**0.04 Mi**

*0.04 Mi Total*



2. Take the 1st right onto **Chicago Ave.** [Map](#)

**0.7 Mi**

*0.7 Mi Total*



3. Turn right onto **N 1st Ave / IL-171.** [Map](#)

**2.2 Mi**

*2.9 Mi Total*



4. **2160 S 1ST AVE** is on the right. [Map](#)



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

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

©2013 MapQuest, Inc. Use of directions and maps is subject to the MapQuest Terms of Use. We make no guarantee of the accuracy of their content, road conditions or route usability. You assume all risk of use. [View Terms of Use](#)

ATTACHMENT 10

*SP*



Trip to:

**Macneal Hospital**  
**3249 Oak Park Ave**

Berwyn, IL 60402

(708) 783-3158

7.26 miles / 18 minutes

Notes



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



1. Start out going **north** toward **Chicago Ave.** [Map](#)

**0.04 Mi**  
0.04 Mi Total



2. Take the **1st right** onto **Chicago Ave.** [Map](#)

**0.7 Mi**  
0.7 Mi Total



3. Turn **right** onto **N 1st Ave / IL-171.** [Map](#)

**1.6 Mi**  
2.3 Mi Total



4. Merge onto **I-290 E / IL-110 E / Eisenhower Expy E** via the ramp on the **left.** [Map](#)

**1.3 Mi**  
3.6 Mi Total



5. Take the **IL-43 / Harlem Ave** exit, **EXIT 21B**, on the **left.** [Map](#)

**0.2 Mi**  
3.8 Mi Total



6. Turn **right** onto **Harlem Ave / S Harlem Ave / IL-43.** Continue to follow **Harlem Ave / IL-43.** [Map](#)

**2.1 Mi**  
5.9 Mi Total



7. Turn **left** onto **26th St.** [Map](#)

**0.5 Mi**  
6.5 Mi Total



8. Turn **right** onto **Oak Park Ave.** [Map](#)

**0.8 Mi**  
7.3 Mi Total



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

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

©2013 MapQuest, Inc. Use of directions and maps is subject to the MapQuest Terms of Use. We make no guarantee of the accuracy of their content, road conditions or route usability. You assume all risk of use. [View Terms of Use](#)

ATTACHMENT 10

59



Notes

Trip to:

**West Suburban Medical Center  
3 Erie Ct**

Oak Park, IL 60302

(708) 763-2327

4.21 miles / 13 minutes



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

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



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

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

©2013 MapQuest, Inc. Use of directions and maps is subject to the MapQuest Terms of Use. We make no guarantee of the accuracy of their content, road conditions or route usability. You assume all risk of use. [View Terms of Use](#)

ATTACHMENT 10

40

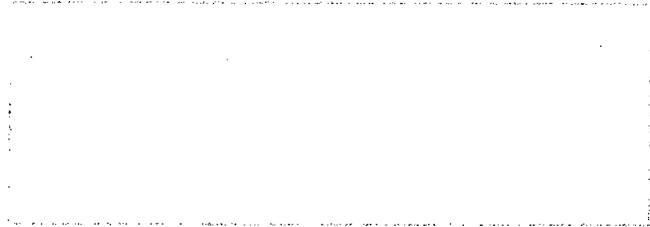


Notes

Trip to:

**Alexian Brothers Medical Center**  
**800 Biesterfield Rd**

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



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

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



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

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

©2013 MapQuest, Inc. Use of directions and maps is subject to the MapQuest Terms of Use. We make no guarantee of the accuracy of their content, road conditions or route usability. You assume all risk of use. [View Terms of Use](#)

ATTACHMENT 10

61



Notes

Trip to:

**Northwest Community Hospital**  
**800 W Central Rd**

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

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

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

ATTACHMENT 10

62



14. Turn right. [Map](#)

0.1 Mi

18.4 Mi Total



15. Turn left. [Map](#)

0.04 Mi

18.4 Mi Total



16. 800 W CENTRAL RD. [Map](#)



**Northwest Community Hospital**

800 W Central Rd, Arlington Heights, IL 60005

(847) 618-4002

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

©2013 MapQuest, Inc. Use of directions and maps is subject to the MapQuest Terms of Use. We make no guarantee of the accuracy of their content, road conditions or route usability. You assume all risk of use. [View Terms of Use](#)

ATTACHMENT 10

63



Notes

Trip to:

**Advocate Lutheran General Hospital  
1775 Dempster St**

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

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

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

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

Total Travel Estimate: 13.32 miles - about 27 minutes

ATTACHMENT 10

64



# Palos Community Hospital

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

Executive Offices

April 3, 2013

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

Dear Mr. Axel:

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

Sincerely,

Timothy J. Brosnan  
Vice President, Planning & Community Relations

TJB:gmk

ATTACHMENT 10

65

**VANGUARD | MACNEAL  
HOSPITAL**

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

April 4, 2013

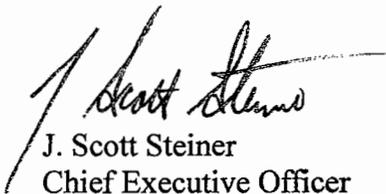
Jacob M. Axel  
Axel & Associates, Inc.  
675 North Court  
Suite 210  
Palatine, Illinois 60067

Dear Mr. Axel:

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

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

Sincerely,

  
J. Scott Steiner  
Chief Executive Officer

SS/mo

ATTACHMENT 10



Elmhurst Memorial  
Healthcare

April 11, 2013

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

Dear Jack:

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

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

Sincerely,

A handwritten signature in black ink, appearing to read "James F. Doyle".

James F. Doyle  
Acting President / CEO  
Elmhurst Memorial Healthcare

ATTACHMENT 10



April 8, 2013

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

Dear Jack:

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

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

Sincerely,

A handwritten signature in cursive script that reads "Brian J. Lemon".

Brian J. Lemon  
President  
Central DuPage Hospital

25 N. Winfield Road  
Winfield, Illinois 60190

ATTACHMENT 10

TTY for the hearing  
impaired 630.933.4833  
cdh.org

68

April 4, 2013

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

Dear Mr. Axel:

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

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

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

Sincerely,



William A. Brown, FACHE  
Chief Executive Officer



LOYOLA  
UNIVERSITY  
HEALTH SYSTEM

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

April 15, 2013

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

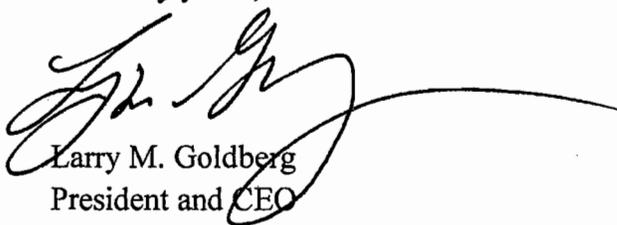
Re: VHS Westlake Hospital CON Application

Dear Mr. Axel,

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

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

Sincerely yours,



Larry M. Goldberg  
President and CEO  
Loyola University Health System



Gottlieb  
Memorial  
Hospital

April 15, 2013

Mr. Jacob M. Axel

President

Axel & Associates, Inc.

675 North Court Suite 210

Palatine, Illinois

Re: VHS Westlake Hospital CON Application

Dear Mr. Axel,

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

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

Sincerely yours,

Ken Fishbain

Chief Operating Officer

ATTACHMENT 10  
We also treat the human spirit.®

**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:

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

2. Article Number

(Transfer from service label)

7012 0470 0001 9673 7925

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature

X

*Mark* Agent Addressee

B. Received by (Printed Name)

*Maureen*

C. Date of Delivery

*4/2/13*D. Is delivery address different from item 1?  YesIf YES, enter delivery address below:  No

3. Service Type

 Certified Mail  Express Mail Registered Return Receipt for Merchandise Insured Mail  C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes**SENDER: COMPLETE THIS SECTION**

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

Article Addressed to:

Paul Whelton  
Loyola University  
Medical Center  
2160 South First Ave.  
Maywood, IL 60153

2. Article Number

(Transfer from service label)

7012 0470 0001 9673 7901

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature

X

*Charles Bell* Agent Addressee

B. Received by (Printed Name)

*Charles Bell*

C. Date of Delivery

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

3. Service Type

 Certified Mail  Express Mail Registered Return Receipt for Merchandise Insured Mail  C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:

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

2. Article Number

(Transfer from service label)

7012 0470 0001 9673 7949 ATTACHMENT 10

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

72

**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:

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

2. Article Number

(Transfer from service label)

7012 0470 0001 9673 7895

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature

X *M Lytle* Agent  
 Addressee

B. Received by (Printed Name)

*M LYTLE*

C. Date of Delivery

4/2/13

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

3. Service Type

- Certified Mail  Express Mail  
 Registered  Return Receipt for Merchandise  
 Insured Mail  C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:

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

2. Article Number

(Transfer from service label)

7011 0470 0003 2497 3332

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature

X *Daniel J. Dyer* Agent  
 Addressee

B. Received by (Printed Name)

*Dyer*

C. Date of Delivery

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

3. Service Type

- Certified Mail  Express Mail  
 Registered  Return Receipt for Merchandise  
 Insured Mail  C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:

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

2. Article Number

(Transfer from service label)

7011 0470 0003 2497 3349

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature

X *Julie O'Connell* Agent  
 Addressee

B. Received by (Printed Name)

*Julie O'Connell*

C. Date of Delivery

4-2-13

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

3. Service Type

- Certified Mail  Express Mail  
 Registered  Return Receipt for Merchandise  
 Insured Mail  C.O.D.

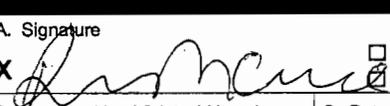
4. Restricted Delivery? (Extra Fee)

 Yes

ATTACHMENT 10

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> <li>Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.</li> <li>Print your name and address on the reverse so that we can return the card to you.</li> <li>Attach this card to the back of the mailpiece, or on the front if space permits.</li> </ul>	A. Signature <input checked="" type="checkbox"/> Agent <input type="checkbox"/> Addressee 	
	B. Received by (Printed Name)	C. Date of Delivery
1. Article Addressed to:	D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No	
2. Article Number (Transfer from service label)	7011 0470 0003 2499 2906	
PS Form 3811, February 2004	Domestic Return Receipt	102595-02-M-1540

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> <li>Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.</li> <li>Print your name and address on the reverse so that we can return the card to you.</li> <li>Attach this card to the back of the mailpiece, or on the front if space permits.</li> </ul>	A. Signature <input checked="" type="checkbox"/> Agent <input type="checkbox"/> Addressee 	
	B. Received by (Printed Name)	C. Date of Delivery
1. Article Addressed to:	D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No	
2. Article Number (Transfer from service label)	7012 0470 0001 9673 7864	
PS Form 3811, February 2004	Domestic Return Receipt	102595-02-M-1540

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> <li>Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.</li> <li>Print your name and address on the reverse so that we can return the card to you.</li> <li>Attach this card to the back of the mailpiece, or on the front if space permits.</li> </ul>	A. Signature <input checked="" type="checkbox"/> Agent <input type="checkbox"/> Addressee 	
	B. Received by (Printed Name)	C. Date of Delivery
1. Article Addressed to:	D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No	
2. Article Number (Transfer from service label)	7011 0470 0003 2499 2968 ATTACHMENT 10	
PS Form 3811, February 2004	Domestic Return Receipt	102595-02-M-1540

74

**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:

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

2. Article Number

(Transfer from service label)

7012 0470 0001 9673 7932

PS Form 3811, February 2004

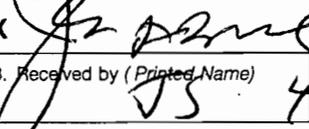
Domestic Return Receipt

102595-02-M-1540

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature

X


 Agent Addressee

B. Received by (Printed Name)

JS

C. Date of Delivery

4-2-03

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

3. Service Type

 Certified Mail Express Mail Registered Return Receipt for Merchandise Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:

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

2. Article Number

(Transfer from service label)

7011 0470 0003 2499 2937

PS Form 3811, February 2004

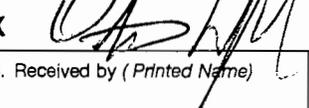
Domestic Return Receipt

102595-02-M-1540

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature

X


 Agent Addressee

B. Received by (Printed Name)

M. Baird

C. Date of Delivery

4/3/03

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

3. Service Type

 Certified Mail Express Mail Registered Return Receipt for Merchandise Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:

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

2. Article Number

(Transfer from service label)

7011 0470 0003 2499 2975 ATTACHMENT 10

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

75

**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:

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

2. Article Number

(Transfer from service label)

7012 0470 0001 9673 7888

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature

X

 Agent Addressee

B. Received by (Printed Name)

C. Date of Delivery

4/3/13

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

3. Service Type

 Certified Mail  Express Mail Registered  Return Receipt for Merchandise Insured Mail  C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:

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

2. Article Number

(Transfer from service label)

7012 0470 0001 9673 7871

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature

X

 Agent Addressee

B. Received by (Printed Name)

C. Date of Delivery

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

3. Service Type

 Certified Mail  Express Mail Registered  Return Receipt for Merchandise Insured Mail  C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:

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

2. Article Number

(Transfer from service label)

7011 0470 0003 2499 2920

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature

X

 Agent Addressee

B. Received by (Printed Name)

C. Date of Delivery

Richard Bamfo

4/4/13

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

3. Service Type

 Certified Mail  Express Mail Registered  Return Receipt for Merchandise Insured Mail  C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes

ATTACHMENT 10

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> <li>Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.</li> <li>Print your name and address on the reverse so that we can return the card to you.</li> <li>Attach this card to the back of the mailpiece, or on the front if space permits.</li> </ul>	A. Signature <input checked="" type="checkbox"/> Agent <input type="checkbox"/> Addressee	
	B. Received by (Printed Name) <i>J. Azpea</i>	C. Date of Delivery  
D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No		
3. Service Type <input checked="" type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.		
4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes		
1. Article Addressed to:  <i>David L. Crane            Adventist Hinsdale            Hospital            120 N. Oak St.            Hinsdale, IL 60521</i>		
2. Article Number (Transfer from service label)	7012 0470 0001 9673 7840	
PS Form 3811, February 2004	Domestic Return Receipt	102595-02-M-1540

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> <li>Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.</li> <li>Print your name and address on the reverse so that we can return the card to you.</li> <li>Attach this card to the back of the mailpiece, or on the front if space permits.</li> </ul>	A. Signature <input checked="" type="checkbox"/> Agent <input type="checkbox"/> Addressee	
	B. Received by (Printed Name)  	C. Date of Delivery <i>4/3/13</i>
D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No		
3. Service Type <input checked="" type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.		
4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes		
1. Article Addressed to:  <i>CEO            VHS MacNeal Hospital            3249 Oak Park Ave.            Berwyn, IL 60402</i>		
2. Article Number (Transfer from service label)	7012 0470 0001 9673 7918	
PS Form 3811, February 2004	Domestic Return Receipt	102595-02-M-1540

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> <li>Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.</li> <li>Print your name and address on the reverse so that we can return the card to you.</li> <li>Attach this card to the back of the mailpiece, or on the front if space permits.</li> </ul>	A. Signature <input checked="" type="checkbox"/> Agent <input type="checkbox"/> Addressee	
	B. Received by (Printed Name)  	C. Date of Delivery <i>4/2/13</i>
D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No		
3. Service Type <input checked="" type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.		
4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes		
1. Article Addressed to:  <i>Larry Goodman, MD            Rush University Hospital            1653 W. Congress Pkwy            Chicago, IL 60612</i>		
2. Article Number (Transfer from service label)	7011 0470 0003 2499 2876 ATTACHMENT 10	
PS Form 3811, February 2004	Domestic Return Receipt	102595-02-M-1540

77

**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:

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

2. Article Number

(Transfer from service label)

7011 0470 0003 2497 3295

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature

X

Tasha Sun

 Agent Addressee

B. Received by (Printed Name)

C. Date of Delivery

4-28-13

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

3. Service Type

 Certified Mail Express Mail Registered Return Receipt for Merchandise Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:

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

2. Article Number

(Transfer from service label)

7011 0470 0003 2497 3363

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature

X

SR

 Agent Addressee

B. Received by (Printed Name)

C. Date of Delivery

Rau...

4/11/13

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

3. Service Type

 Certified Mail Express Mail Registered Return Receipt for Merchandise Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:

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

2. Article Number

(Transfer from service label)

7011 0470 0003 2497 2011 ATTACHMENT 10

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

78

**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:

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

2. Article Number

(Transfer from service label)

7011 0470 0003 2497 3325

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature

X *W.L. Colter*

- 
- Agent
- 
- 
- Addressee

B. Received by (Printed Name)

WILLIAM COLTER

C. Date of Delivery

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

3. Service Type

- 
- Certified Mail
- 
- Express Mail
- 
- 
- Registered
- 
- Return Receipt for Merchandise
- 
- 
- Insured Mail
- 
- C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:

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

2. Article Number

(Transfer from service label)

7011 0470 0003 2497 3226

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature

X *R. McEwen*

- 
- Agent
- 
- 
- Addressee

B. Received by (Printed Name)

C. Date of Delivery

4/2

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

3. Service Type

- 
- Certified Mail
- 
- Express Mail
- 
- 
- Registered
- 
- Return Receipt for Merchandise
- 
- 
- Insured Mail
- 
- C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:

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

2. Article Number

(Transfer from service label)

7012 0470 0001 9673 7857 ATTACHMENT 10

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature

X *MCA*

- 
- Agent
- 
- 
- Addressee

B. Received by (Printed Name)

M ROTHBERG

C. Date of Delivery

4-4-03

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

3. Service Type

- 
- Certified Mail
- 
- Express Mail
- 
- 
- Registered
- 
- Return Receipt for Merchandise
- 
- 
- Insured Mail
- 
- C.O.D.

4. Restricted Delivery? (Extra Fee)

 Yes

**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:  
 Sr. Sheila Lyne  
 Mercy Hospital and  
 Medical Center  
 2525 S. Maryland Ave.  
 Chicago, IL 60616

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

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

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature  
 Agent  
 Addressee

B. Received by (Printed Name)  
 Stanley [Signature]

C. Date of Delivery  
 4/13/13

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

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

4. Restricted Delivery? (Extra Fee)  Yes

**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:  
 Presence St. Mary of  
 Nazareth Hospital  
 2222 W. Division St.  
 Chicago, IL 60622

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

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

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature  
 Agent  
 Addressee

B. Received by (Printed Name)  
 MANCER [Signature]

C. Date of Delivery

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

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

4. Restricted Delivery? (Extra Fee)  Yes

**SENDER: COMPLETE THIS SECTION**

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

1. Article Addressed to:  
 Stroger Hospital of  
 Cook County  
 1901 W. Harrison St.  
 Chicago, IL 60612

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

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

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature  
 Agent  
 Addressee

B. Received by (Printed Name)  
 H-Kran

C. Date of Delivery  
 APR 10 2013

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

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

4. Restricted Delivery? (Extra Fee)  Yes

80

ATTACHMENT 10



**State of Illinois 2090079**  
**Department of Public Health**

**LICENSE, PERMIT, CERTIFICATION, REGISTRATION**

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

**LA MAR HASBROUCK, MD, MPH**  
 DIRECTOR

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

EXPIRATION DATE	CATEGORY	ID NUMBER
07/31/13	6600	9005702
<b>FULL LICENSE</b> <b>GENERAL HOSPITAL</b> <b>EFFECTIVE: 08/01/12</b>		

**BUSINESS ADDRESS**

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

**MELROSE PARK IL 60160**

The face of this license has a colored background. Printed by Authority of the State of Illinois • 4187 •

## SAFETY NET IMPACT STATEMENT

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

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

**P O L I C I E S &  
P R O C E D U R E S**

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

<p><b>SCOPE:</b> All Company-affiliated hospitals.</p>
<p><b>PURPOSE:</b> This Policy and Procedure is established to provide the operational guidelines for the Company's hospitals ( each a "Hospital" and, collectively, the "Hospitals") to identify uninsured patients who are Financially Indigent or Medically Indigent that may qualify for charity care (free care) or financial assistance, to process patient applications for charity care or financial assistance and to bill and collect from uninsured patients, including those who qualify as Financially Indigent or Medically Indigent under this Policy.</p>
<p><b>POLICY:</b></p> <ol style="list-style-type: none"> <li>1. <u>Charity Care or Financial Assistance.</u> The Company's Hospitals shall provide charity care (free care) or financial assistance to uninsured patients for their emergency, non-elective care who qualify for classification as Financially Indigent or Medically Indigent in accordance with the Charity Care Financial Assistance Process set forth below. The Company's Hospitals shall adopt a written policy in conformity with the Company's Policy and Procedure set forth herein. Charity Care (100% discounts) under this Policy shall be available for uninsured patients with incomes below 200% of the Federal Poverty Level (the "Financially Indigent"). 40 to 80% discounts shall be available for uninsured patients either (1) with income below 500% FPL or (2) with balances due for hospital services in excess of 50% of their annual income (the "Medially Indigent"). See attached Financial Assistance Eligibility Guidelines.</li> <li>2. <u>Billing and Collection Processes for Uninsured Patients.</u> All uninsured patients receiving care at the Company's Hospitals will be treated with respect and in a professional manner before, during and after receiving care. Each of the Company's Hospitals should adopt a written policy in conformity with the Company's Policy and Procedure set forth herein for its billing and collection practices in respect of all uninsured patients, including those uninsured patients who qualify for classification as Financially Indigent or Medically Indigent under this Policy.</li> </ol>

P O L I C I E S &  
P R O C E D U R E S

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

**PROCEDURE:**

**A. CHARITY CARE AND FINANCIAL ASSISTANCE PROCESS**

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

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

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

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

B. Calculation of Income.

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

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

**P O L I C I E S &  
P R O C E D U R E S**

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

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

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

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

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

1. By having the patient sign the Assistance Application attesting to the veracity of the Income information provided or
2. Through the written attestation of the Hospital personnel completing the Assistance Application that the patient verbally verified Hospital's calculation of Income.

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

**P O L I C I E S &  
P R O C E D U R E S**

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

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

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

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

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

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

**P O L I C I E S &  
P R O C E D U R E S**

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

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

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

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

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

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

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

**P O L I C I E S &  
P R O C E D U R E S**

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

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

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

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

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

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

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

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

**P O L I C I E S &  
P R O C E D U R E S**

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

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

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

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

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

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

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

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

**P O L I C I E S &  
P R O C E D U R E S**

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

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

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

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

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

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

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

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

**P O L I C I E S &  
P R O C E D U R E S**

<b>DEPARTMENT:</b> Business Office	<b>POLICY DESCRIPTION:</b> Charity Care, Financial Assistance and Billing & Collection Policies for Uninsured Patients
<b>PAGE:</b> 9 of 10	<b>REVISED</b> January 23, 2009
<b>APPROVED:</b>	<b>RETIRED:</b>
<b>EFFECTIVE DATE:</b> January 23, 2009	<b>REFERENCE NUMBER:</b> 11-0801

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

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

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

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

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

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

**P O L I C I E S &  
P R O C E D U R E S**

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

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

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

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

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

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

**REFERENCES**

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

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

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

## FINANCIAL ASSISTANCE ELIGIBILITY GUIDELINES

Based on Federal Poverty Guidelines Effective January 23, 2009

**Schedule A (shaded)**  
Financially Indigent

**Schedule B (unshaded)**  
Medically Indigent

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

### Schedule C

#### Catastrophic Eligibility as Medically Indigent -

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

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

[HOSPITAL LETTERHEAD]

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

[DATE]

Re: «PATIENT»  
Admission: «ACCOUNT»  
Balance Due: \$«TOTAL\_CHARGES»

Dear «GUARANTOR»,

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

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

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

Sincerely,

[Customer Service Representative]

**FINANCIAL ASSISTANCE ELIGIBILITY DETERMINATION  
OFFICE USE ONLY**

Patient Name: \_\_\_\_\_

Account Number(s): \_\_\_\_\_ Total Yearly Income: \$ \_\_\_\_\_ Total Charges: \$ \_\_\_\_\_

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

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

- YES Approved for 100% financial assistance as Financially Indigent.
- NO Does not qualify for assistance as Financially Indigent. Continue to Step 2.

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

- YES Continue to Step 3.
- NO Patient does not qualify for Financial Assistance.

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

- YES Total Yearly Income is greater than \_\_\_\_\_ % and less than \_\_\_\_\_ % of the Federal Poverty Guidelines. Patient qualifies for \_\_\_\_\_ % discount as Medically Indigent pursuant to Financial Assistance Eligibility Guidelines - Schedule B.
- NO: Continue to Step 4.

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

- YES Balance due is \_\_\_\_\_ % of the total yearly income. Eligible for \_\_\_\_\_ % discount as Medically Indigent pursuant to Financial Assistance Eligibility Guidelines - Schedule C. Continue to Step 5.
- NO: Patient does not qualify for Financial Assistance.

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

Employee Name (Print) \_\_\_\_\_

Employee Signature \_\_\_\_\_ Approved By \_\_\_\_\_

Date \_\_\_\_\_ Approved By \_\_\_\_\_

\$1 - \$2,000 Director Approved By \_\_\_\_\_

\$2,001 - \$10,000 Director and CFO

\$10,001 & above Director, CFO and CEO

**Income Verification Codes**

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

95

## FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

### **Instructions:**

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

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

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

\_\_\_\_\_ Hospital  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **Income Verification:**

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

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

**PLEASE ALSO INCLUDE ONE OR MORE OF THE FOLLOWING:**

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

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

### **Notification of Determination:**

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

### **Physician Services:**

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

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

GRNTOR #: \_\_\_\_\_

HOSP CODE: \_\_\_\_\_

**PATIENT INFORMATION/INFORMACION DEL PACIENTE**

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

**GUARANTOR INFORMATION/PERSONA RESPONSABLE**

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

77

I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge.

I agree to tell the provider of service within ten (10) days if there are any changes in my (or the persons on whose behalf I am acting) income, property, expenses or in the persons household or any change of address.

I understand that I may be asked to prove my statements and my eligibility statements will be subject to verification by contact with my employer, bank credit verification and property searches.

I understand the county is required by law to keep any information I provide confidential.

I further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse the county from the proceeds of litigation or settlement resulting from such an act.

Declaro bajo pena de perjurio que las respuestas que he dado son verdaderas y correctas al mejor de mi conocimiento.

Acuerdo decirle al abastecedor del servicio en el plazo de diez dias si hay algunos cambios en mi (o personas en el favor que yo este actuando) renta, propiedad, gastos o en la casa de las personas o cualquier cambio de direccion.

Entiendo que puedo ser pedido probar mis declaraciones de la elegibilidad estaran conforme a la verificacion al lado de contacto con mi patron, verificacion del credito de banco y busquedas de propiedad.

Entiendo que el condado es requerido por ley de proteger cualquier informacion que yo proporcione confidencial.

Tambien convengo, en la consideracion de recibir servicios del cuidado medico como resultado de un accidente o lesion, de tener que reembolsarle al condado de los ingresos de la demanda o cualquier resultado de tal acto.

Signature/Firma

Date/Fecha

For Hospital Use Only/Usó Solamente Para el Hospital

Facility/Facilidad: \_\_\_\_\_

Accepted/Aceptar: \_\_\_\_\_

Denied/Negacion: \_\_\_\_\_

COMMENTS/COMETARIOS:

Signature Approval

Date

98



[Hospital Logo]

---

---

Date:

Re:

Admission #

Balance Due:

Dear ,

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

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

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

Sincerely,

Customer Service Representative

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

<b>INDEX OF ATTACHMENTS</b>		
<b>ATTACHMENT NO.</b>		<b>PAGES</b>
1	Applicant/Coapplicant Identification including Certificate of Good Standing	19
2	Site Ownership	21
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	22
5	Flood Plain Requirements	23
6	Historic Preservation Act Requirements	
7	Project and Sources of Funds Itemization	
8	Obligation Document if required	
9	Cost Space Requirements	
10	Discontinuation	24
11	Background of the Applicant	81
12	Purpose of the Project	
13	Alternatives to the Project	
14	Size of the Project	
15	Project Service Utilization	
16	Unfinished or Shell Space	
17	Assurances for Unfinished/Shell Space	
18	Master Design Project	
19	Mergers, Consolidations and Acquisitions	
	<b>Service Specific:</b>	
20	Medical Surgical Pediatrics, Obstetrics, ICU	
21	Comprehensive Physical Rehabilitation	
22	Acute Mental Illness	
23	Neonatal Intensive Care	
24	Open Heart Surgery	
25	Cardiac Catheterization	
26	In-Center Hemodialysis	
27	Non-Hospital Based Ambulatory Surgery	
28	General Long Term Care	
29	Specialized Long Term Care	
30	Selected Organ Transplantation	
31	Kidney Transplantation	
32	Subacute Care Hospital Model	
33	Post Surgical Recovery Care Center	
34	Children's Community-Based Health Care Center	
35	Community-Based Residential Rehabilitation Center	
36	Long Term Acute Care Hospital	
37	Clinical Service Areas Other than Categories of Service	
38	Freestanding Emergency Center Medical Services	
	<b>Financial and Economic Feasibility:</b>	
39	Availability of Funds	
40	Financial Waiver	
41	Financial Viability	
42	Economic Feasibility	
43	Safety Net Impact Statement	82
44	Charity Care Information	