ORIGINAL

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

16-057

RECEIVED
DEC 28 2016
HEALTH FACILITIES & SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION
This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Mercy Hospital and Medical Center		
Street Address:	2525 S Michigan Ave		
City and Zip Code:	Chicago, IL 60616		
County: Cook	Health Service Area	6	Health Planning Area: A-03

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

Exact Legal Name:	Mercy Hospital and Medical Center
Address:	2525 S Michigan Ave Chicago, IL 60616
Name of Registered Agent:	
Name of Chief Executive Officer:	Carol L. Garikes Schneider
CEO Address:	2525 S Michigan Ave Chicago, IL 60616
Telephone Number:	312.567.2100

Type of Ownership of Applicant/Co-Applicant

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

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

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

Exact Legal Name:	Mercy Health System of Chicago
Address:	2525 S Michigan Ave Chicago, IL 60616
Name of Registered Agent:	
Name of Chief Executive Officer:	Carol L. Garikes Schneider
CEO Address:	2525 S Michigan Ave Chicago, IL 60616
Telephone Number:	312.567.2100

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

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

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

Exact Legal Name:	Trinity Health Corporation
Address:	20555 Victor Parkway, Livonia, MI 48152-7018
Name of Registered Agent:	
Name of Chief Executive Officer:	Richard J. Gilfillan, M.D.
CEO Address:	20555 Victor Parkway, Livonia, MI 48152-7018
Telephone Number:	734.343.1000

Type of Ownership of Applicant/Co-Applicant

- [X] Non-profit Corporation
- [ ] For-profit Corporation
- [ ] Limited Liability Company
- Partnership
- Governmental
- Sole Proprietorship
- [O]ther

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

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

Primary Contact

[Person to receive ALL correspondence or inquiries)

Name:	Jeffrey Mark
Title:	Consultant
Company Name:	JSMA LLC
Address:	1182 S Plymouth Ct., 1SW, Chicago, IL 60605
Telephone Number:	312.804.9401
E-mail Address:	jmark@jsma.com
Fax Number:	

Additional Contact

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

Name:	Carol L. Garikes Schneider
Title:	President and CEO
Company Name:	Mercy Hospital and Medical Center
Address:	2525 S Michigan Ave, Chicago IL 60616
Telephone Number:	312.567.2100
E-mail Address:	Carol.Schneider@mercy-chicago.org
Fax Number:	

Post Permit Contact

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

Name:	Carol L. Garikes Schneider
Title:	President and CEO
Company Name:	Mercy Hospital and Medical Center
Address:	2525 S Michigan Ave, Chicago IL 60616
Telephone Number:	312.567.2100
E-mail Address:	Carol.Schneider@mercy-chicago.org
Fax Number:	

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Mercy Hospital and Medical Center
Address of Site Owner:	2525 S Michigan Ave, Chicago IL 60616

Street Address or Legal Description of Site:

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:	Mercy Hospital and Medical Center
Address:	2525 S Michigan Ave, Chicago IL 60616

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

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

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

Organizational Relationships

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

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

Flood Plain Requirements

[Refer to application instructions.]

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

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

Historic Resources Preservation Act Requirements — Not Applicable

[Refer to application instructions.]

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

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

DESCRIPTION OF PROJECT

1. Project Classification

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

Part 1110 Classification:

☐ Substantive

☒ Non-substantive

This project requires a CON permit due to exceeding the capital expenditure threshold. Per the Board's rules it DOES NOT meet the criteria in Section 1110.40 c) Substantive Review Classification.

1. 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.

This application for permit proposes a project that consists of interior modernization to Mercy Hospital and Medical Center in Chicago. Specifically, the project includes:

- Relocation and modernization of the inpatient Behavioral Health Service (AMI) from the 4th level to the 6th level of the existing bed tower.
- Relocation and modernization of the general Intensive Care Unit from the first floor to the 4th level of the existing bed tower.
- Reduction of 10 AMI beds from 39 to 29.

The number of authorized ICU beds does not change. However, there is an internal redistribution of Intensive Care beds. This includes the expansion of the general ICU from 14 to 19 beds and the reduction of the existing Cardio Vascular ICU from 16 to 11 beds.

Overall the project includes the modernization of 37,501 square feet of which 75 percent of the project area is Clinical, and 25 percent is Non-Clinical. The Total Estimated Project Cost is $17,870,536.

The expected completion date is December 31, 2019.

This is a non-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	$ -	$ 825,000	$ 825,000
Off Site Work			
New Construction Contracts			
Modernization Contracts	$ 8,794,041	$ 2,931,347	$ 11,725,388
Contingencies	$ 1,331,301	$ 443,767	$ 1,775,068
Architectural/Engineering Fees	$ 375,000	$ 125,000	$ 500,000
Consulting and Other Fees	$ 180,000	$ 60,000	$ 240,000
Movable or Other Equipment (not in construction contracts)	$ 1,829,850	$ 609,950	$ 2,439,800
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)	$ 281,637	$ 83,642	$ 365,280
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	$ 12,791,829	$ 5,078,706	$ 17,870,536
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	$ 12,791,829	$ 5,078,706	$ 17,870,536
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	$ 12,791,829	$ 5,078,706	$ 17,870,536

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

Related Project Costs

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

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

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

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

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

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.

Indicate the stage of the project's architectural drawings:

☐ None or not applicable ☐ Preliminary

☒ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): December 31, 2019_

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

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

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

State Agency Submittals

Are the following submittals up to date as applicable:

☒ Cancer Registry
☒ APORS
☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
☒ All reports regarding outstanding permits

Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements

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

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							

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

Facility Bed Capacity and Utilization

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert following this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which the data are available. Include observation days in the patient day totals for each bed service.** Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

BED NUMBERS AS REPORTED IN THE ANNUAL BED REPORT CY 2015

FACILITY NAME: Mercy Hospital & Medical Center	CITY: Chicago				
REPORTING PERIOD DATES:	From: Jan. 1, 2015		to: December 31, 2015		
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	250	8,699	39,325	0	250
Obstetrics	30	2,495	5,571	0	30
Pediatrics[1]	28	161	375	0	0
Intensive Care	30	2,020	5,746	0	30
Comprehensive Physical Rehabilitation	24	422	4,541	0	24
Acute/Chronic Mental Illness	39	921	5,093	-10	29
Neonatal Intensive Care[2]	15			0	0
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS CY 2015:[3]	416	14,718	60,651		
TOTALS as of 9/20/2016: [4]	373			-10	363

Note [1] Pediatrics is shown as 28 beds consistent with the calendar year 2015 reporting. On September 20, 2016 the Board approved the discontinuation of Pediatrics service that resulted in a bed count of 0.

Note [2] Neonatal ICU reflects 15 beds authorized by an Exemption approved by the Board. This Exemption was relinquished by Mercy and the beds deleted from the Inventory effective June 20, 2016.

Note [3] Totals include data from 2015.

Note[4] Totals include Authorized bed total effective September 20, 2016 and reflect the 10 bed reduction in Comprehensive Physical Rehabilitation being proposed in this application.

CERTIFICATION -- TRINITY HEALTH CORPORATION

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

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

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

SIGNATURE	SIGNATURE
Benjamin R. Carter	Cynthia A. Clemente
PRINTED NAME	PRINTED NAME
EVP\CFO\Treasurer	SVP Financial Operations & Planning
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this 5th day of August, 2016	Notarization: Subscribed and sworn to before me this 5th day of August
Signature of Notary	Signature of Notary
Seal	Seal
TAMMY LYNN JONES NOTARY PUBLIC - STATE OF MICHIGAN COUNTY OF OAKLAND My Commission Expires May 11, 2022 Acting in the County of Wayne	TAMMY LYNN JONES NOTARY PUBLIC - STATE OF MICHIGAN COUNTY OF OAKLAND My Commission Expires May 11, 2022 Acting in the County of Wayne

Signature of the applicant

CERTIFICATION – Mercy Hospital and Medical Center

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

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

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

SIGNATURE	SIGNATURE
CAROL SCHNEIDER	ERIC KRUEGER
PRINTED NAME	PRINTED NAME
PRESIDENT + CEO	CFO
PRINTED TITLE	PRINTED TITLE
Notarization:	Notarization:
Subscribed and sworn to before me	Subscribed and sworn to before me
this 3 day of AUGUST	this 3 day of AUGUST
Geralyn A. Kilcoyne	Geralyn A. Kilcoyne
Signature of Notary	Signature of Notary
Seal OFFICIAL SEAL GERALYN A KILCOYNE NOTARY PUBLIC - STATE OF ILLINOIS MY COMMISSION EXPIRES:11/29/18	Seal OFFICIAL SEAL GERALYN A KILCOYNE NOTARY PUBLIC - STATE OF ILLINOIS MY COMMISSION EXPIRES:11/29/18

*Insert EXACT legal name of the applicant

CERTIFICATION – MERCY HEALTH SYSTEM OF CHICAGO

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

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

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

SIGNATURE	SIGNATURE
CAROL SCHNEIDER PRINTED NAME	ERIC KRUEGER PRINTED NAME
PRESIDENT & CEO PRINTED TITLE	CFO PRINTED TITLE
Notarization: Subscribed and sworn to before me this 3 day of AUGUST	Notarization: Subscribed and sworn to before me this 3 day of AUGUST
Signature of Notary	Signature of Notary
Seal OFFICIAL SEAL GERALYN A KILCOYNE NOTARY PUBLIC - STATE OF ILLINOIS MY COMMISSION EXPIRES:11/29/18	Seal OFFICIAL SEAL GERALYN A KILCOYNE NOTARY PUBLIC - STATE OF ILLINOIS MY COMMISSION EXPIRES:11/29/18

*Insert EXACT legal name of the applicant

SECTION II. DISCONTINUATION

Not Applicable

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.

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

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

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

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

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

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

PURPOSE OF PROJECT

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

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

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

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

ALTERNATIVES

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

Alternative options **must** include:

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

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

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

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

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

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

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

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

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

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

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

2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following::

   a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;

   b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;

   c. The project involves the conversion of existing space that results in excess square footage.

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

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

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

PROJECT SERVICES UTILIZATION:

This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B. **A narrative of the rationale that supports the projections must be provided.**

A table must be provided in the following format with Attachment 15.

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MET STANDARD?
YEAR 1					
YEAR 2					

APPEND DOCUMENTATION AS ATTACHMENT-15, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE. APPLICATION FORM.

UNFINISHED OR SHELL SPACE: **Not Applicable**

Provide the following information:

1. Total gross square footage of the proposed shell space;
2. The anticipated use of the shell space, specifying the proposed GSF tot be allocated to each department, area or function;
3. Evidence that the shell space is being constructed due to
   a. Requirements of governmental or certification agencies; or
   b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.
4. Provide:
   a. Historical utilization for the area for the latest five-year period for which data are available; and
   b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT-16, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ASSURANCES:

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.
2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and
3. The anticipated date when the shell space will be completed and placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT-17, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION V. - MASTER DESIGN AND RELATED PROJECTS Not Applicable

This Section is applicable only to proposed master design and related projects.

Criterion 1110.235(a) - System Impact of Master Design

Read the criterion and provide documentation that addresses the following:

1. The availability of alternative health care facilities within the planning area and the impact that the proposed project and subsequent related projects will have on the utilization of such facilities;
2. How the services proposed in future projects will improve access to planning area residents;
3. What the potential impact upon planning area residents would be if the proposed services were not replaced or developed; and
4. The anticipated role of the facility in the delivery system including anticipated patterns of patient referral, any contractual or referral agreements between the applicant and other providers that will result in the transfer of patients to the applicant's facility.

Criterion 1110.235(b) - Master Plan or Related Future Projects

Read the criterion and provide documentation regarding the need for all beds and services to be developed, and also, document the improvement in access for each service proposed. Provide the following:

1. The anticipated completion date(s) for the future construction or modernization projects; and
2. Evidence that the proposed number of beds and services is consistent with the need assessment provisions of Part 1100; or documentation that the need for the proposed number of beds and services is justified due to such factors, but not limited to:
   a. limitation on government funded or charity patients that are expected to continue;
   b. restrictive admission policies of existing planning area health care facilities that are expected to continue;
   c. the planning area population is projected to exhibit indicators of medical care problems such as average family income below poverty levels or projected high infant mortality.
3. Evidence that the proposed beds and services will meet or exceed the utilization targets established in Part 1100 within two years after completion of the future construction of modernization project(s), based upon:
   a. historical service/beds utilization levels;
   b. projected trends in utilization (include the rationale and projection assumptions used in such
   c. projections);
   d. anticipated market factors such as referral patterns or changes in population characteristics (age, density, wellness) that would support utilization projections; and
   anticipated changes in delivery of the service due to changes in technology, care delivery techniques or physician availability that would support the projected utilization levels.

Criterion 1110.235(c) - Relationship to Previously Approved Master Design Projects

READ THE CRITERION which requires that projects submitted pursuant to a master design permit are consistent with the approved master design project. Provide the following documentation:

1. Schematic architectural plans for all construction or modification approved in the master design permit;
2. The estimated project cost for the proposed projects and also for the total construction/modification projects approved in the master design permit;
3. An item by item comparison of the construction elements (i.e. site, number of buildings, number of floors, etc.) in the proposed project to the approved master design project; and
4. A comparison of proposed beds and services to those approved under the master design permit.

APPEND DOCUMENTATION AS ATTACHMENT-18, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

Not Applicable

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

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

A. Criterion 1110.240(b), Impact Statement

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

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

B. Criterion 1110.240(c), Access

Read the criterion and provide the following:

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

C. Criterion 1110.240(d), Health Care System

Read the criterion and address the following:

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

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

SECTION VII - SERVICE SPECIFIC REVIEW CRITERIA

This Section is applicable to all projects proposing establishment, expansion or modernization of categories of service that are subject to CON review, as provided in the Illinois Health Facilities Planning Act [20 ILCS 3960]. It is comprised of information requirements for each category of service, as well as charts for each service, indicating the review criteria that must be addressed for each action (establishment, expansion and modernization). After identifying the applicable review criteria for each category of service involved , read the criteria and provide the required information, AS APPLICABLE TO THE CRITERIA THAT MUST BE ADDRESSED:

A. Criterion 1110.530 - Medical/Surgical, Obstetric, Pediatric and Intensive Care

1. Applicants proposing to establish, expand and/or modernize Medical/Surgical, Obstetric, Pediatric and/or Intensive Care categories of service must submit the following information:

2. Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds
☐ **Medical/Surgical**		
☐ **Obstetric**		
☐ **Pediatric**		
☒ **Intensive Care**	30	30

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.530(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.530(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.530(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.530(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.530(b)(5) - Planning Area Need - Service Accessibility	X		
1110.530(c)(1) - Unnecessary Duplication of Services	X		
1110.530(c)(2) - Maldistribution	X	X	
1110.530(c)(3) - Impact of Project on Other Area Providers	X		
1110.530(d)(1) - Deteriorated Facilities			X

APPLICABLE REVIEW CRITERIA		Establish	Expand	Modernize
1110.530(d)(2) -	Documentation			X
1110.530(d)(3) -	Documentation Related to Cited Problems			X
1110.530(d)(4) -	Occupancy			X
110.530(e) -	Staffing Availability	X	X	
1110.530(f) -	Performance Requirements	X	X	X
1110.530(g) -	Assurances	X	X	X

APPEND DOCUMENTATION AS ATTACHMENT-20, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

B. Criterion 1110.730 - Acute Mental Illness and Chronic Mental Illness

1. Applicants proposing to establish, expand and/or modernize Acute Mental Illness and Chronic Mental Illness category of service must submit the following information:

2. Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds
☒ Acute Mental Illness	39	29
☐ **Chronic Mental Illness**		

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.730(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.730(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.730(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.730(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.730(b)(5) - Planning Area Need - Service Accessibility	X		
1110.730(c)(1) - Unnecessary Duplication of Services	X		
1110.730(c)(2) - Maldistribution	X		
1110.730(c)(3) - Impact of Project on Other Area Providers	X		
1110.730(d)(1) - Deteriorated Facilities			X
1110.730(d)(2) - Documentation			X
1110.730(d)(3) - Documentation Related to Cited Problems			X
1110.730(d)(4) - Occupancy			X
1110.730(e(1)) - Staffing Availability	X	X	
1110.730(f) - Performance Requirements	X	X	X
1110.730(g) - Assurances	X	X	X

APPEND DOCUMENTATION AS ATTACHMENT-22, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

EVIDENCE OF "A" Bond rating or better IS PROVIDED IN ATTACHMENT 36

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:**

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

APPEND DOCUMENTATION AS ATTACHMENT-36, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

1. 1120.130 - Financial Viability
EVIDENCE OF "A" Bond rating or better IS PROVIDED IN ATTACHMENT 36

IX.

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. **"A" Bond rating or better**
2. **All of the projects capital expenditures are completely funded through internal sources**
3. **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**
4. **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-37, 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 38, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

X. 1120.140 - Economic Feasibility

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

A. Reasonableness of Financing Arrangements

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

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

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

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

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

B. Conditions of Debt Financing

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

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

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

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

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

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

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

* Include the percentage (%) of space for circulation

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-39, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XI. Safety Net Impact Statement

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

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

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

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

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

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

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

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

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

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

	Medicaid (revenue)				
	Inpatient				
	Outpatient				
	Total				

APPEND DOCUMENTATION AS ATTACHMENT-40, 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			
	Year	Year	Year
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

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

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:

INDEX OF ATTACHMENTS

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3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership./ Operator	34-35
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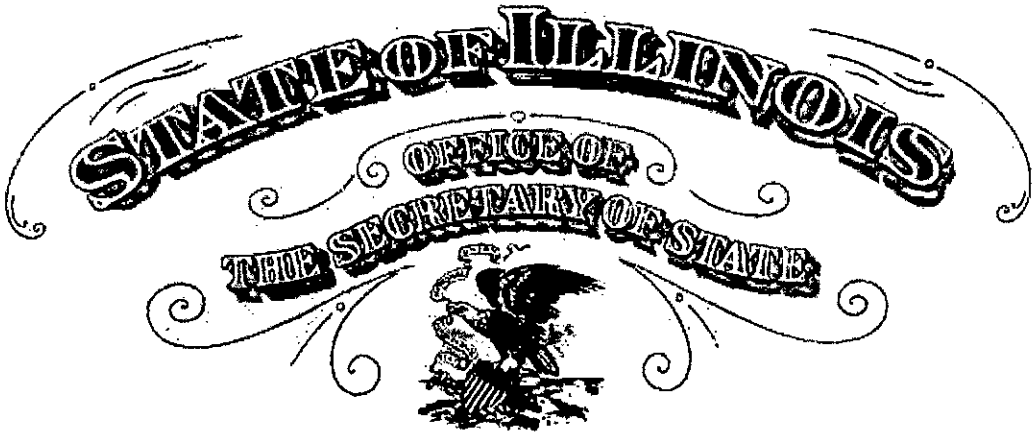
File Number 0114-154-6



To all to whom these Presents Shall Come, Greeting:

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

MERCY HOSPITAL AND MEDICAL CENTER, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 21, 1852, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 27TH *day of* MAY *A.D.* 2016 .

Authentication #: 1614801834 verifiable until 05/27/2017
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

File Number 5257-458-7

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

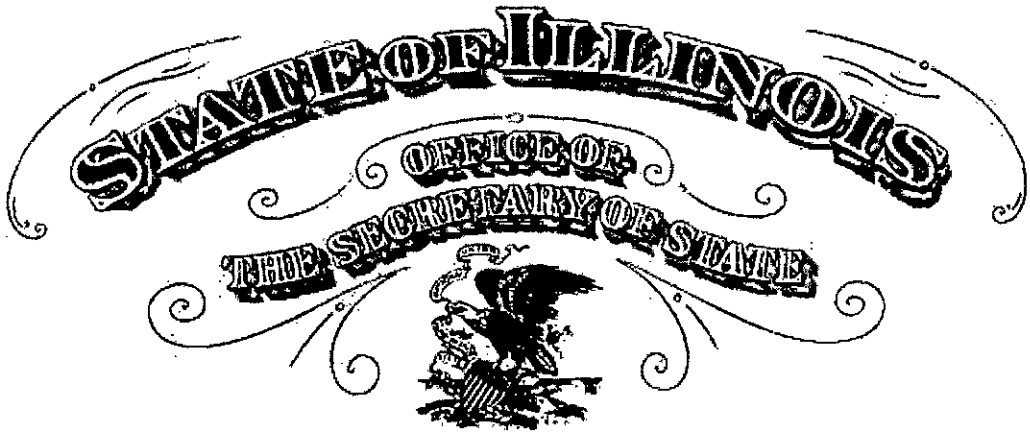
MERCY HEALTH SYSTEM OF CHICAGO, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 20, 1981, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 9TH *day of* JUNE *A.D.* 2016 .

Authentication #: 1616100496 verifiable until 06/09/2017
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

File Number 6775-210-4



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

TRINITY HEALTH CORPORATION, INCORPORATED IN INDIANA AND LICENSED TO CONDUCT AFFAIRS IN THIS STATE ON MARCH 02, 2011, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO CONDUCT AFFAIRS IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 27TH *day of* MAY *A.D.* 2016 .

Authentication #: 1614801558 verifiable until 05/27/2017
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

MERCY

Mercy Hospital & Medical Center
2525 South Michigan Avenue
Chicago, Illinois 60616-2477
312.567.2000 phone

June 8, 2016

Ms. Courtney Avery
Administrator
Health Facilities and Services Review Board
525 West Jefferson St.
Springfield, IL 62761

Dear Ms. Avery:

Mercy Hospital and Medical Center hereby certifies that it is the owner of the site on which Mercy Hospital and Medical Center is located.

Sincerely,

Carol Schneider
President and CEO

(Notarized Signature)

Geralyn A. Kilcoyne

OFFICIAL SEAL
GERALYN A KILCOYNE
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:11/20/18

HF109511

Illinois Department of PUBLIC HEALTH

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

Nirav D. Shah, M.D., J.D.
Director

12/31/2016 0001578

General Hospital

Effective: 01/01/2016

Mercy Hospital & Medical Center
2525 South Michigan Avenue
Chicago, IL 60616

DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 12/31/2016
Lic Number 0001578

Date Printed 10/28/2015

Mercy Hospital & Medical Center

2525 South Michigan Avenue
Chicago, IL 60616

FEE RECEIPT NO.

File Number 0114-154-6

To all to whom these Presents Shall Come, Greeting:

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

MERCY HOSPITAL AND MEDICAL CENTER, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 21, 1852, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

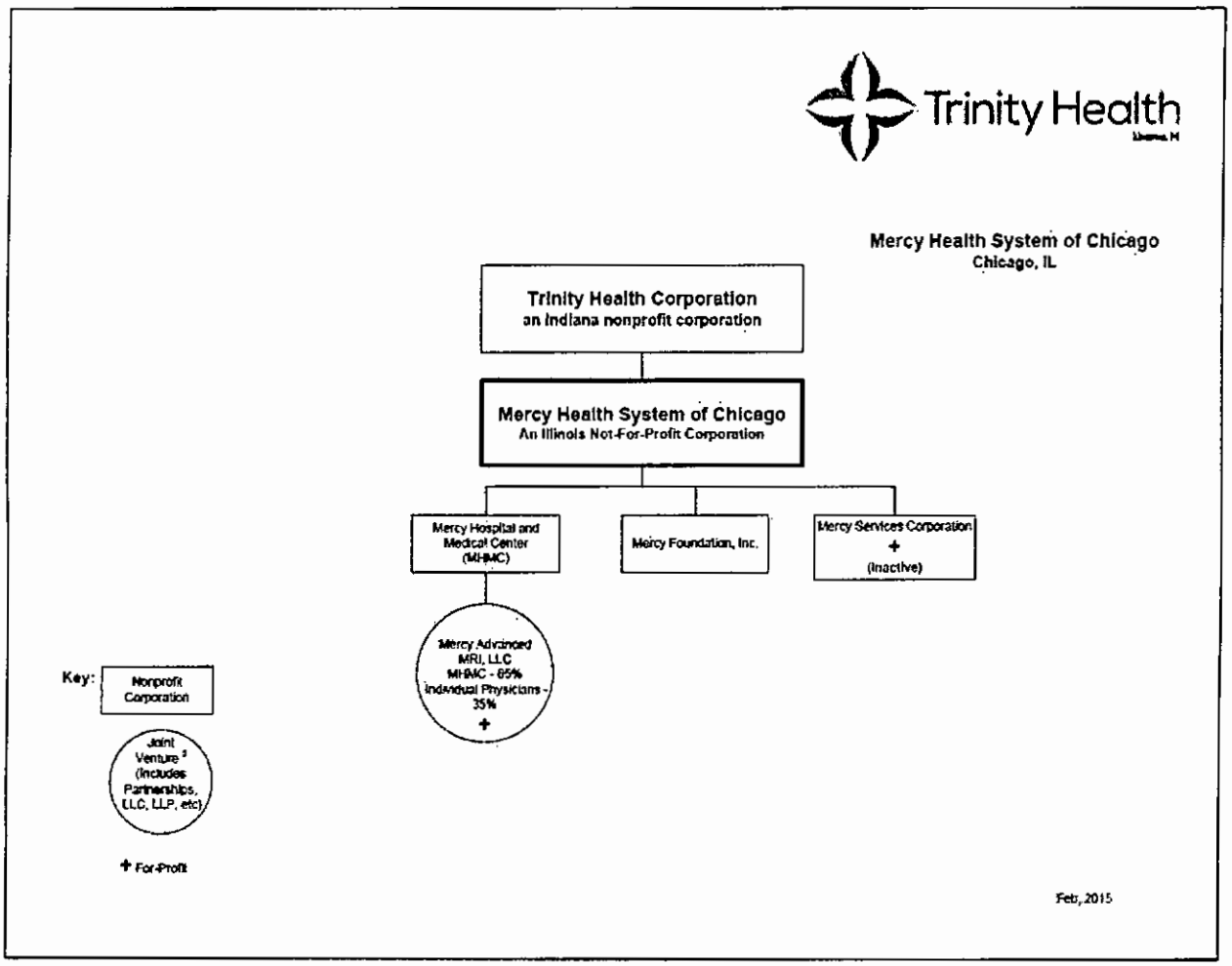
In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 27TH *day of* MAY *A.D.* 2016 .

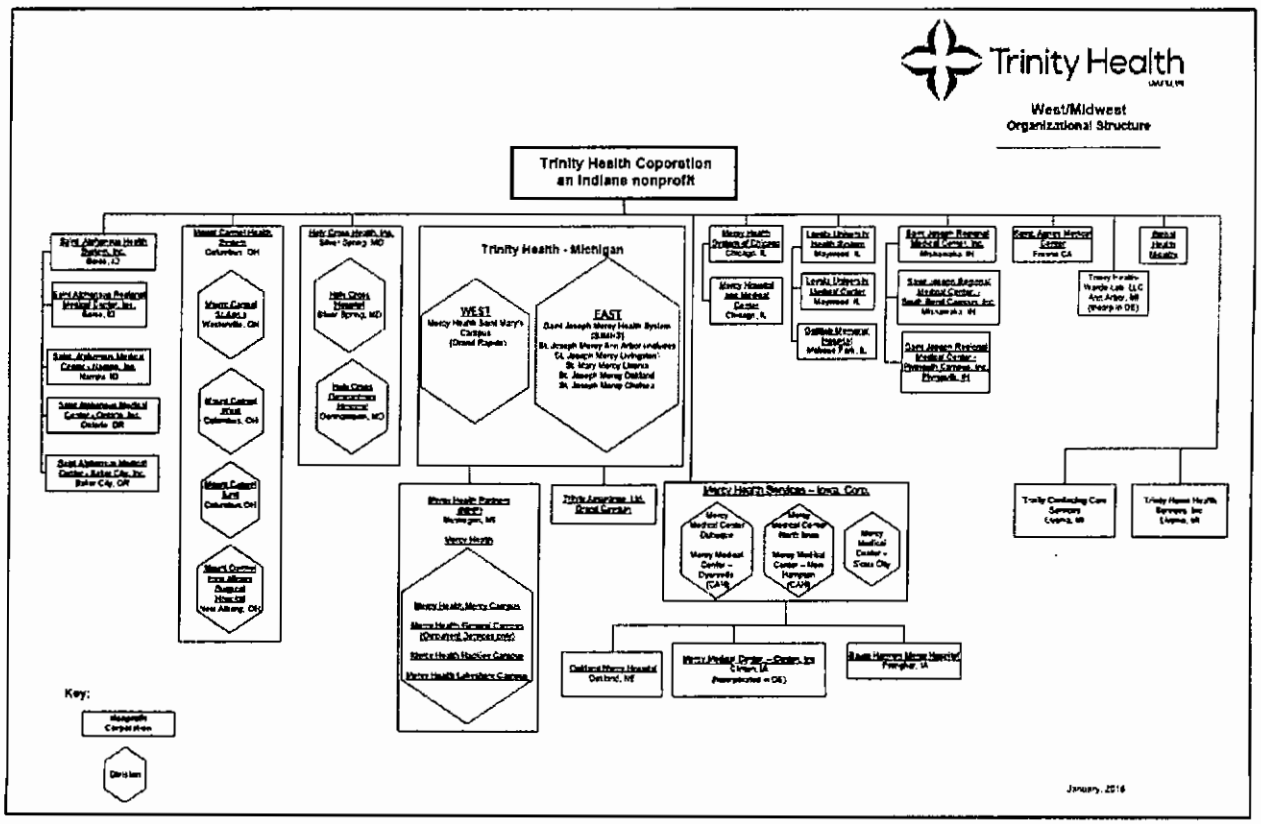
Authentication #: 1614801834 verifiable until 05/27/2017
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

Organizational Relationships




Trinity Health
West/Midwest
Organizational Structure
Trinity Health Coporation
an Indiana nonprofit
Trinity Health - Michigan
WEST
EAST
Key:
January, 2016

Flood Plain Requirements

Anderson Mikos Architects ltd.

October 10, 2016

Re: Mercy Hospital and Medical Center
Chicago, Illinois

To Whom It May Concern:

Based on existing flood plan information and documents Mercy Hospital and Medical Center, Chicago, Illinois is not located in a flood plain.

Sincerely,

Anderson-Mikos Architects, ltd.

David E. Mikos, AIA, NCARB, ACHA, LCI
Chairman and CEO

DEM/go

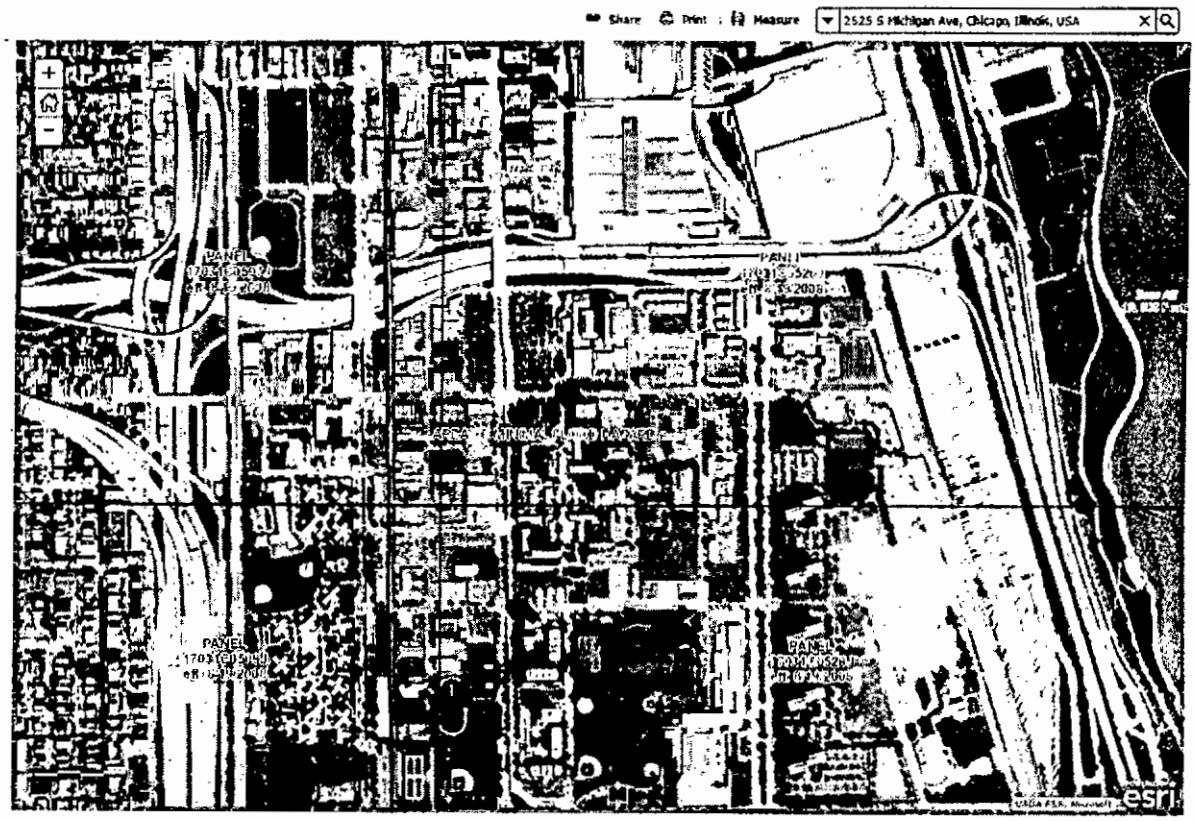
O:\Letters\Brian\Mercy-Flood Plain-101016

One Parkview Plaza

Mercy Hospital and Medical Center, 2525 S. Michigan Ave., Chicago, IL is not located in a flood plain.

As referenced in the Board's application instructions, below is a site map of the applicants' campus obtained from http://www.illinoisfloodmaps.org.

Note the designation of "Area of Minimal Flood Hazard" on **FEMA's National Flood Hazard Layer (Official).**



Historic Preservation

Illinois Historic
Preservation Agency

FAX (217) 524-7525
1 Old State Capitol Plaza • Springfield, Illinois 62701-1507 • (217) 782-4836 • TTY (217) 524-7128

Cook County
Chicago
CON - Interior Rehabilitation of 4th and 6th Floors, Mercy Hospital and Medical Center
2525 S. Michigan Ave.
IHPA Log #004101216

December 20, 2016

Jeffrey Mark
JSMA LLC
1182 S. Plymouth Ct., 1SW
Chicago, IL 60605

Dear Mr. Mark:

We have reviewed the additional information provided for the above referenced project. This property is considered eligible for listing on the National Register of Historic Places. In our opinion the project meets The Secretary of the Interior's "Standards for Rehabilitation and Guidelines for Rehabilitating Historic Buildings" and we have no objection to your proceeding as planned.

Please retain this letter in your files as evidence of compliance with Section 4 of the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420/1 et. seq.).

If you have any further questions, please contact me at 217/785-5031.

Sincerely,

Rachel Leibowitz, Ph.D.
Deputy State Historic
Preservation Officer

Printed on Recycled Paper

Project Costs and Sources of Funds Itemization

Project Costs and Sources of Funds Itemization			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Site Preparation (Building Infrastructure Upgrades)	$ -	$ 825,000	$ 825,000
Asbestos Abatement			$220,000
Plumbing Risers			$200,000
Elevator Rebuild			$255,000
Main Ductwork			$150,000
Modernization Contracts	$ 9,861,600	$ 1,878,400	$ 11,740,000
Contingencies	$ 1,478,783	$ 281,673	$ 1,760,456
Architectural/Engineering Fees	$ 420,000	$ 80,000	$ 500,000
Consulting and Other Fees	$ 201,600	$ 38,400	$ 240,000
Interior Design			
Behavioral Health Consultant			
Project Commissioning			
CON Consultant			
CON Application			
Movable or Other Equipment (not in construction contracts) See next page:	$ 1,881,131	$ 558,669	$ 2,439,800
Net Interest Expense During Construction (project related) Internal Interest Only	$ 281,637	$ 83,642	$ 365,280
TOTAL USES OF FUNDS	**$ 14,124,751**	**$ 3,745,784**	**$ 17,870,536**

Project Costs and Sources of Funds Itemization

Moveable or Other Equipment Summary	Estimate
ICU Furniture & Equipment	1,720,776
Behavioral Health Furniture & Equipment	526,636
Security/Video Surveillance/Access Control	70,000
Hardware - End User Devices / Servers	35,550
Network - Electronics / Wireless / Telecom / Phone	7,338
Structured Cabling System - Low Voltage Cabling, Backbone & CCTV	79,500
Total	2,439,800

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	Cost[2]	Existing	Proposed	New Const.	Modernized	As Is	Vacated Space[1]
REVIEWABLE							
Intensive Care	$5,903,188	12,164	17,391	0	13,005	4,386	7,778
Inpatient Behavioral Health (AMI)	$6,888,641	14,370	15,176	0	15,176	0	0
Total Clinical	**$12,791,829**	**26,534**	**32,567**	**0**	**28,181**	**4,386**	**7,778**
NON REVIEWABLE							
Acupuncture Suite (Leased Space)	$272,492	500	500		500	0	0
On Call Rooms	$782,597	1,310	1,436		1,436	0	0
Hospital Support (Staff Lactation)	$42,509	128	78		78		50
Staff facilities	$673,055	0	1,235	0	1,235		
Education Room	$294,291	0	540	0	540	0	0
Public Lobbies	$1,166,266	0	2,140	0	2,140	0	0
Facility support	$246,878	0	453	0	453	0	0
Storage 6th Floor	$1,537,400	0	2,821		2,821		0
Building Support							
Elevators	$63,218	1,207	1,207		116	1,091	
Total Non-clinical	**$5,078,706**	**3,145**	**10,410**		**9,319**	**1,091**	**50**
TOTAL	**$17,870,535**	**29,679**	**42,977**	**0**	**37,500**	**5,477**	**7,828**

Note 1: The large block of Vacated Space indicates the current 1st floor location of ICU. The use of that space is anticipated being converted to surgical or ambulatory surgical activities. That project is not yet defined but will be well under the CON threshold.

Note 2: Each service area costs are a pro rata share of the Total Project Costs for Clinical Service Areas and Non Clinical Service Areas, respectively from page 6.

Background of Applicants

Mercy Hospital and Medical Center

Founded in 1852, Mercy holds the privilege of being Chicago's first chartered teaching hospital. Since its founding, Mercy has become an integral part of the city, advancing our mission of providing access to compassionate care to our communities. Today, patients find care that combines world-class medicine with compassion, convenience and an undeniable spirit that sets it apart from other city hospitals. Here are just a few ways our experts and nationally ranked programs are leading the way in healthcare:

- pioneering the treatment of heart and vascular disease, providing the most progressive care.
- offering sophisticated and advanced minimally invasive surgical options of the future, including robotic assisted, 3D, and scarless surgery.
- providing comprehensive, academic-level cancer treatment in an accessible, community based setting.
- offering a new, first of its kind, innovative care pathway for the relief of back pain, providing access to a spine specialist within 48 hours .

At Mercy, patients are first, and we are transforming the delivery of healthcare to Chicago and across the nation, helping our communities live well. Every day, we are hard at work finding ways to enrich the patient experience—in service and treatment options.

As a teaching hospital, Mercy patients have access to physicians 24-hours a day, 7-days a week. Patients benefit from the collaborative team approach and critical thinking skills fostered by a teaching environment. Working together, our team of experts offers patients the most advanced treatment and care in a comforting, healing environment helping them live longer, healthier lives. Mercy enjoys affiliations with some of the major academic programs and centers in Chicago, including University of Illinois, University of Chicago, and our sister Trinity Health facility Loyola University Medical Center.

Mercy Health System

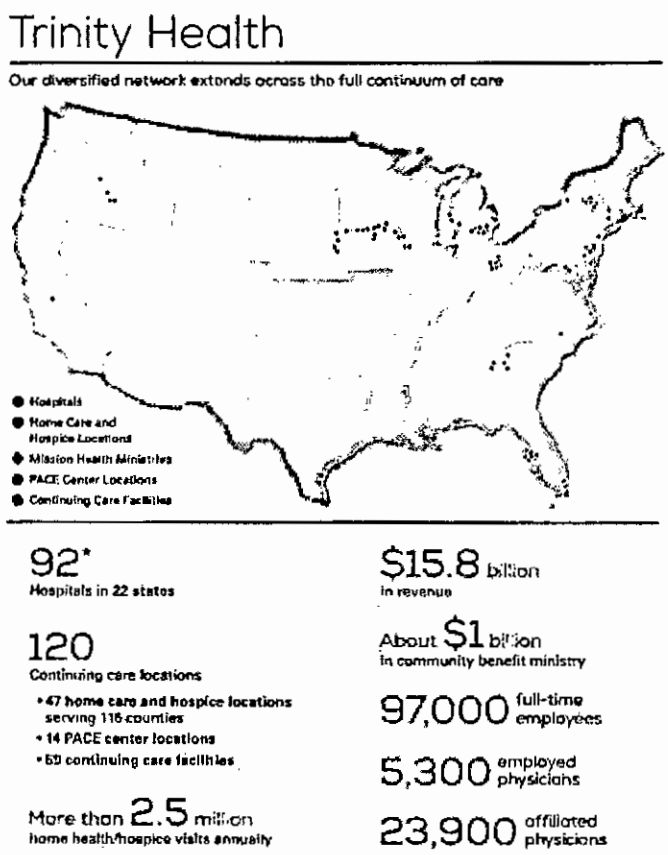
In addition to its hospital, Mercy Health System serves the Chicago community with a comprehensive network that includes the Mercy Family Health Center, a look-alike Federally Qualified Health Center (FQHC), 11 auxiliary care facilities, MercyWORKS occupational health program, two school-based health centers in Wendell Phillips and Dunbar Vocational Career Academies and the Mercy Foundation, Inc., the philanthropic arm of the hospital.

Trinity Health

Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation. It serves people and communities in 22 states from coast to coast with 92 hospitals, and 120 continuing care locations — including home care, hospice, PACE and senior living facilities - that provide nearly 2.5 million visits annually.

The organization was formed in May 2013, when Trinity Health and Catholic Health East officially came together to strengthen their shared mission, increase excellence in care and advance transformative efforts with our unified voice. With annual operating revenues of $15.9 billion and assets of $20.4 billion, the new organization returns about $1 billion to its communities annually in the form of charity care and other community benefit programs.

Trinity Health employs more than 97,000 full-time colleagues, including 5,300 employed physicians. Committed to those who are poor and underserved in its communities, Trinity Health is known for its focus on the country's aging population. As a single, unified ministry, the organization is the innovator of Senior Emergency Departments, the largest not-for-profit provider of home health care services — ranked by number of visits — in the nation, as well as the nation's leading provider of PACE (Program of All Inclusive Care for the Elderly) based on the number of available programs.



Facilities owned by Trinity Health nationally include:

Alabama >>

Mercy Medical, Daphne

California >>

Saint Agnes Medical Center, Fresno

Connecticut >>

Trinity Health - New England

- Johnson Memorial Hospital, Stafford Springs
- Mount Sinai Rehabilitation Hospital, Hartford
- Saint Francis Hospital and Medical Center, Hartford

The Mercy Community, West Hartford

Delaware >>

St. Francis Healthcare, Wilmington

Florida >>

Allegany Franciscan Ministries, Palm Harbor

BayCare Health System, Clearwater

- Mease Countryside Hospital, Safety Harbor
- Mease Dunedin Hospital, Dunedin
- Morton Plant Hospital, Clearwater
- Morton Plant North Bay Hospital, New Port Richey
- South Florida Baptist Hospital, Plant City
- St. Anthony's Hospital, St. Petersburg
- St. Joseph's Children's Hospital, Tampa
- St. Joseph's Hospital, Tampa
- St. Joseph's Hospital - North, Lutz
- St. Joseph's Hospital - South
- St. Joseph's Women's Hospital, Tampa
- Winter Haven Hospital, Winter Haven

Holy Cross Hospital, Fort Lauderdale

Georgia >>

St. Mary's Health Care System, Inc., Athens

- St. Mary's Hospital, Athens
- St. Mary's Good Samaritan Hospital, East Greensboro

Saint Joseph's Health System, Atlanta

- Emory Johns Creek Hospital, Johns Creek

Idaho/Oregon >>

Saint Alphonsus Health System

- Saint Alphonsus Regional Medical Center, Boise
- Saint Alphonsus Medical Center, Ontario
- Saint Alphonsus Medical Center, Nampa
- Saint Alphonsus Medical Center, Baker City

Illinois >>

Loyola University Health System

- Gottlieb Memorial Hospital, Melrose Park
- Loyola University Medical Center, Maywood

Mercy Hospital & Medical Center, Chicago

Indiana >>

Saint Joseph Health System

- Saint Joseph Health System Mishawaka Medical Center, Mishawaka
- Saint Joseph Health System Plymouth Medical Center, Plymouth

Iowa/Nebraska/South Dakota >>

Mercy Health Network

- Mercy Medical Center, Clinton
- Mercy Medical Center, Dubuque
- Mercy Medical Center, Dyersville
- Mercy Medical Center – North Iowa, Mason City
- Mercy Medical Center, New Hampton
- Mercy Medical Center, Sioux City
  - Baum Harmon Mercy Hospital, Primghar
  - Oakland Memorial Hospital, Oakland, NE
- Siouxland Surgical Hospital, Dakota Dunes, SD

Managed Hospitals

- Central Community Hospital Elkader
- Franklin General Hospital, Hampton
- Hancock County Memorial Hospital, Britt
- Hansen Family Hospital, Iowa Falls
- Hawarden Community Hospital, Hawarden
- Kossuth Regional Health Center, Algona
- Mitchell County Regional Health Center, Osage
- Palo Alto County Health System, Emmetsburg
- Pender Community Hospital, Pender
- Regional Health Services of Howard County, Cresco

Maryland >>

Holy Cross Health

- Holy Cross Hospital, Silver Spring
- Holy Cross Germantown Hospital, Germantown

Massachusetts >>

Trinity Health – New England

- Mercy Medical Center, Springfield
- Providence Behavioral Health, Springfield
- Sisters of Providence Health System, Springfield

Michigan >>

Mercy Health

- Mercy Health Muskegon
- Mercy Health Hackley Campus
- Mercy Health Lakeshore Campus
- Mercy Health Saint Mary's, Grand Rapids

Saint Joseph Mercy Health System

- St. Joseph Mercy Ann Arbor
- St. Joseph Mercy Chelsea
- St. Joseph Mercy Livingston, Howell
- St. Joseph Mercy Oakland, Pontiac
- St. Mary Mercy Livonia

New Jersey >>

Lourdes Health System

- Lourdes Medical Center of Burlington County, Willingboro
- Our Lady of Lourdes Medical Center, Camden

Saint Michael's Medical Center, Newark

St. Francis Medical Center, Trenton

New York >>

Catholic Health, Buffalo

- Kenmore Mercy Hospital, Kenmore
- Mercy Hospital of Buffalo, Buffalo
- Sisters of Charity Hospital, Buffalo
- Sisters of Charity Hospital, St. Joseph Campus, Cheektowaga

St. Peter's Health Partners, Albany

- Albany Memorial Hospital, Albany
- Samaritan Hospital, Troy
- St. Mary Hospital, Troy
- St. Peter's Hospital, Albany
- Sunnyview Rehab Hospital

North Carolina >>

St. Joseph of the Pines, Southern Pines

Ohio >>

Mount Carmel Health System

- Mount Carmel East, Columbus
- Mount Carmel West, Columbus
- Mount Carmel St. Ann's, Westerville
- Mount Carmel New Albany Surgical Hospital, New Albany
- Diley Ridge Medical Center

Pennsylvania >>

Mercy Health System of Southeastern Pennsylvania, Conshohocken

- Mercy Fitzgerald Hospital, Darby
- Mercy Philadelphia Hospital, Philadelphia
- Nazareth Hospital, Philadelphia

Pittsburgh Mercy, Pittsburgh

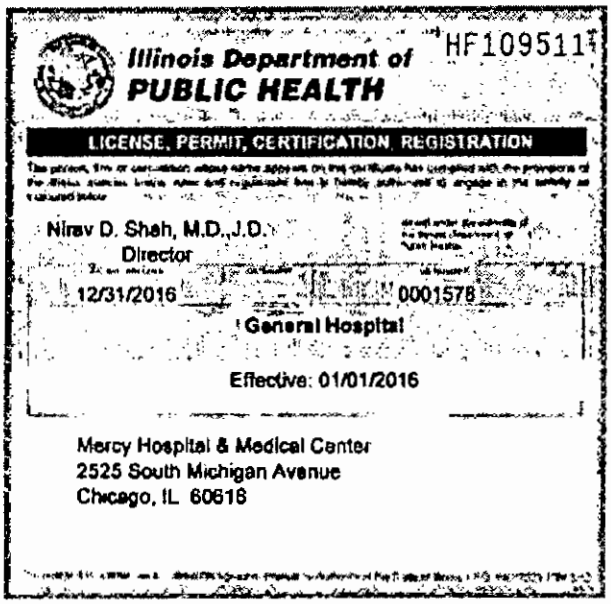
St. Mary Medical Center, Langhorne

There are 3 Illinois healthcare facilities owned and operated by the Co-Applicants include:

Mercy Hospital and Medical Center
Chicago, Illinois

Gottlieb Memorial Hospital
Melrose Park, Illinois

Foster G. McGaw Hospital
Loyola University Medical Center
Maywood, Illinois



Illinois Department of PUBLIC HEALTH

HF109511

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

Nirav D. Shah, M.D., J.D.
Director

12/31/2016 0001578

General Hospital

Effective: 01/01/2016

Mercy Hospital & Medical Center
2525 South Michigan Avenue
Chicago, IL 60616

Healthcare Facilities Accreditation Program

HFAP

grants this

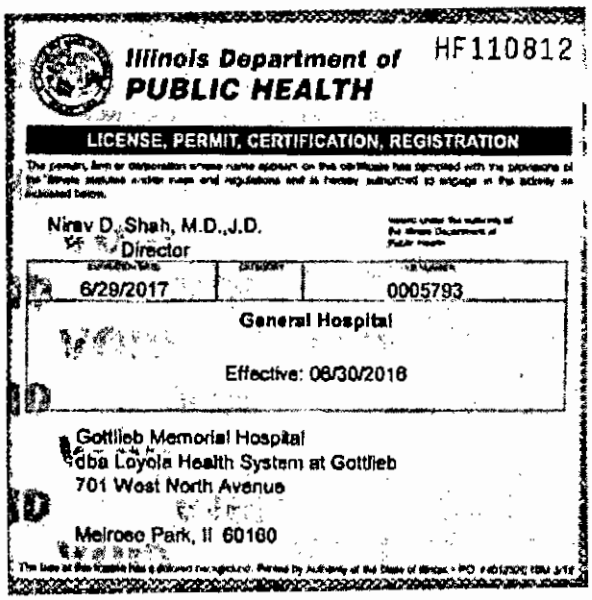
CERTIFICATE OF ACCREDITATION

to

Mercy Hospital and Medical Center
Chicago, IL

This Facility has met the applicable HFAP accreditation requirements and is therefore fully accredited by the Healthcare Facilities Accreditation Program

2016-2019



Illinois Department of PUBLIC HEALTH

HF110812

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.

Nirav D. Shah, M.D., J.D.
Director

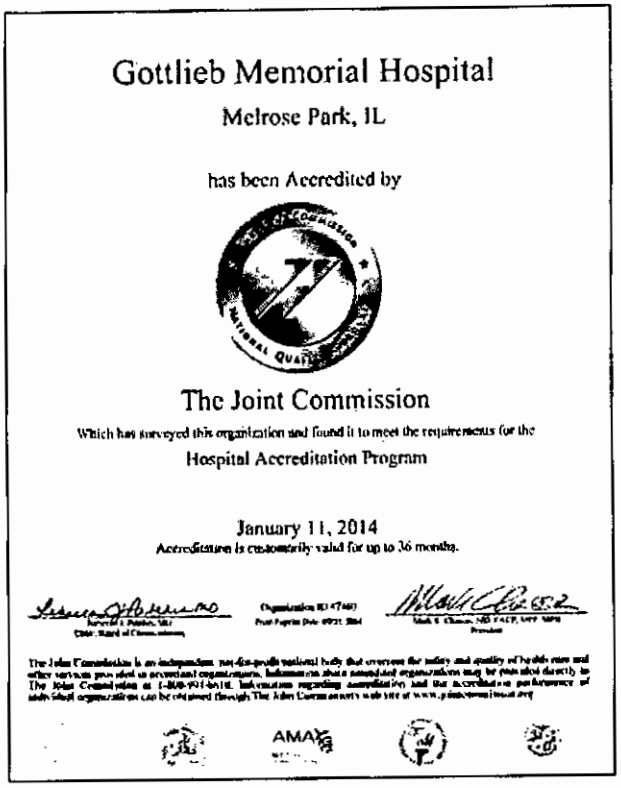
Expiration Date	Category	Number
6/29/2017		0005793

General Hospital

Effective: 08/30/2016

Gottlieb Memorial Hospital
dba Loyola Health System at Gottlieb
701 West North Avenue

Melrose Park, Il 60160



Gottlieb Memorial Hospital

Melrose Park, IL

has been Accredited by

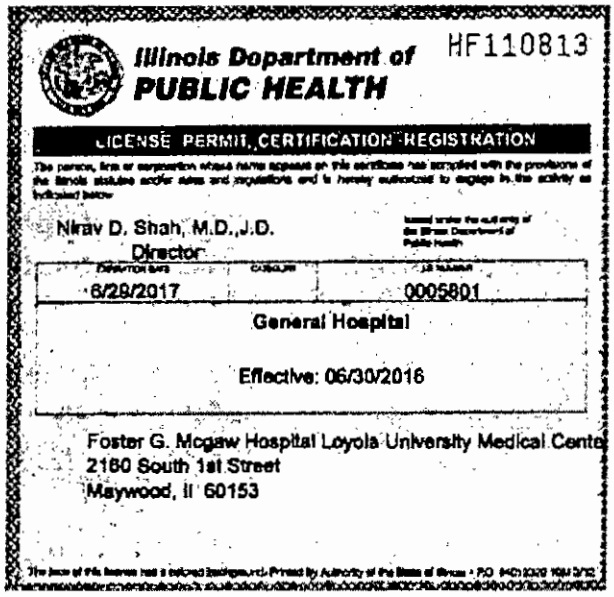
The Joint Commission

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

Hospital Accreditation Program

January 11, 2014

Accreditation is customarily valid for up to 36 months.



Illinois Department of PUBLIC HEALTH HF110813

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.

Nirav D. Shah, M.D., J.D.
Director

Issued under the authority of the Illinois Department of Public Health

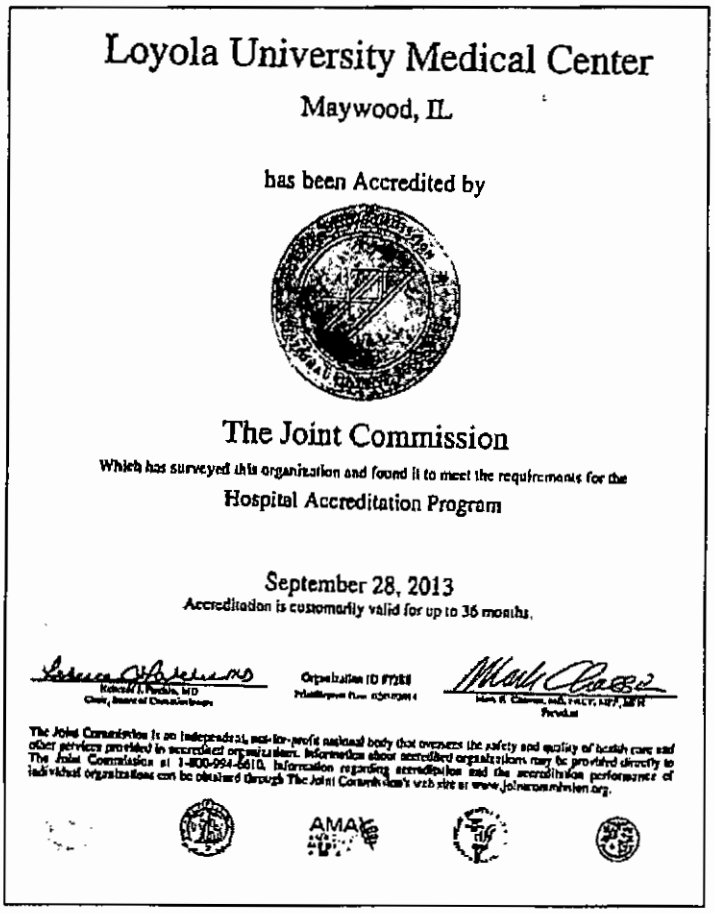
EXPIRATION DATE	CATEGORY	LIC NUMBER
6/29/2017		0005801

General Hospital

Effective: 06/30/2016

Foster G. Mcgaw Hospital Loyola University Medical Cente
2160 South 1st Street
Maywood, Il 60153

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. [illegible]



Loyola University Medical Center

Maywood, IL

has been Accredited by

The Joint Commission

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

Hospital Accreditation Program

September 28, 2013

Accreditation is customarily valid for up to 36 months.

Rebecca J. Perkins, MD
Chair, Board of Commissioners

Organization ID [illegible]
Printed on [illegible]

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

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

AMA

20555 Victor Parkway
Livonia, MI 48152
tel 734-343-1000
trinity-health.org

November 1, 2016

Courtney Avery, Administrator
Health Facilities and Services Review Board
525 West Jefferson Street - Second Floor
Springfield, Illinois 62761

Re: ***Mercy Hospital and Medical Center, ICU/Behavioral Health Modernization Project Application for Certificate Of Need Permit***

Dear Ms. Avery:

In accordance with 77 Ill. Admin. Code 1110.230(b), Background of Applicant, Trinity Health Corporation (the "Applicant") is submitting this letter assuring the Health Facilities and Services Review Board (the "Board") that:

1. To my knowledge, no adverse action has been taken by the Federal government or any Illinois agency against any facility owned and/or operated by the applicant during the three years prior to the filing of this application; and

2. The Applicant authorizes the Board and IDPH access to any documents necessary to verify the information submitted in this application, including, but not limited to: official records of IDPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations.

Sincerely,

Joshua Moore
Assistant Secretary

Sponsored by Catholic Health Ministries

Mercy Health System of Chicago
2525 S. Michigan Avenue
Chicago, Illinois 60616

November 2, 2016

Courtney Avery, Administrator
Health Facilities and Services Review Board
525 West Jefferson Street - Second Floor
Springfield, Illinois 62761

Re: Mercy Hospital and Medical Center, ICU/Behavioral Health Modernization Project
Application for Certificate of Need Permit

Dear Ms. Avery,

In accordance with 77 Ill. Admin. Code 1110.230(b), Background of Applicant, Mercy Health System of Chicago (the "Applicant") is submitting this letter assuring the Health Facilities and Services Review Board (the "Board") that:

1. To my knowledge, no adverse action has been taken by the Federal government or any Illinois agency against any facility owned and/or operated by the applicant during the three years prior to the filing of this application; and

2. The Applicant authorizes the Board and IDPH access to any documents necessary to verify the information submitted in this application, including, but not limited to: official records of IDPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations.

Sincerely,

Jeffrey R. Mathis, Assistant Secretary
Mercy Health System of Chicago

MERCY
Mercy Hospital & Medical Center
2525 South Michigan Avenue
Chicago, Illinois 60616-2477
312.567.2000 phone

November 2, 2016

Courtney Avery, Administrator
Health Facilities and Services Review Board
525 West Jefferson Street - Second Floor
Springfield, Illinois 62761

Re: Mercy Hospital and Medical Center, ICU/Behavioral Health Modernization Project
Application for Certificate of Need Permit

Dear Ms. Avery,

In accordance with 77 Ill. Admin. Code 1110.230(b), Background of Applicant, Mercy Hospital and Medical Center (the "Applicant") is submitting this letter assuring the Health Facilities and Services Review Board (the "Board") that:

1. To my knowledge, no adverse action has been taken by the Federal government or any Illinois agency against any facility owned and/or operated by the applicant during the three years prior to the filing of this application; and

2. The Applicant authorizes the Board and IDPH access to any documents necessary to verify the information submitted in this application, including, but not limited to: official records of IDPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations.

Sincerely,

Jeffrey R. Mathis, Assistant Secretary
Mercy Hospital and Medical Center

Purpose of Project

Mercy Hospital & Medical Center (Mercy) consists of the main hospital building at 2525 South Michigan Avenue as well as outpatient clinics at 11 satellite locations. The core hospital building was constructed in 1965 and serves as one of the area's safety net hospitals, providing inpatient and outpatient services to the urban community. The total area of the facility is 725,000 square feet on 12 floors, a penthouse and 2 basement levels.

Mercy is committed to continuing its current mission in its core service area. The strategic focus of Mercy's Community Benefit Ministry is to use the strengths and capacities of Mercy Hospital and Medical Center to improve the health of the populations it serves, especially the poor and vulnerable, and to assure that all persons receive equitable, safe and effective care.

Repair and replacement priorities have focused on inpatient care and, due to the age of the facility – 50 years old-- compliance with regulatory requirements. This project addresses both quality of care and regulatory requirements. The Intensive Care Unit (ICU) on the first floor of the Main Hospital Building was cited for 5 CMS violations, including lack of windows (K055A) and lack of compliant egress doors (K042A). Both means of egress are located on the west wall and do not comply with minimum distance required between egress doors. To meet these requirements in the existing space, various options were considered, proving to be costly and disruptive, and logistically unmanageable.

The ICU Unit has been in use since the building opened in 1967. It is currently operating at capacity with 14 beds. The unit has 10 single rooms averaging 188 SF/room and two larger double occupancy rooms at 360 SF and 436 SF each. Including support space, the unit averages 570 SF/Bed. The configuration does not meet current standards for room size (>850 SF/Bed), nursing stations are inefficient, and support spaces are located across a public corridor which opens to the Hospital Main Lobby.

This multi-phase project relocates the ICU to the Patient Tower 4th floor as follows:

Phase 1 - Floor 8 East -	Upgrade patient rooms and support areas in the 8th Floor Patient Tower east corridor, and secure the area (5,000 SF).
Phase 2 - Floor 4 East -	Relocate Behavioral Health to the 6th Floor Patient Tower; Renovate the 4th Floor East Wing (21,000 SF)

The current location of the ICU in the northeast corner of the first floor limits any possibility of resolving the regulatory and life safety issues. Furthermore, close proximity to the main entrance has resulted in security issues.

The proposed location, currently occupied by Behavioral Health, meets evaluation criteria for the Intensive Care Suite, including proximity to Surgery, Emergency, and Blood Bank. Also, any location on Floors 5 and above would require that critical patients travel on otherwise heavily used Tower elevators.

ALTERNATIVES

Mercy Hospital and Medical Center has spent significant time exploring alternatives to this project, the primary purpose of which is to modernize our Med/Surg ICU. The objectives have been to develop a state-of-art critical care environment in a cost effective, minimally disruptive manner. Several other options were considered on the lower floors; however, all schemes presented higher costs, difficulties with phasing and constructability.

ALTERNATIVE 1: Modernize the General ICU In-Place

This alternative examined reconstructing the ICU within its existing space on the first level with expansion through an exterior wall. While the physical space could be developed, the project was viewed as untenable for the following reasons:

- Expansion encroached on other departmental areas including Surgery and Ambulatory Surgery;
- There is no construction "swing space" to phase the project, necessitating a shutdown of significant number of ICU beds to construct the project; and
- Required relocation of the Hospital's buried diesel fuel tank servicing the emergency generators.

ALTERNATIVE 2: Relocate and Modernize ICU to the 2nd Floor South/West

This alternative examined relocation of the General ICU from its first level location to the Hospital's second level in the bed tower. The second level is currently occupied by administration, the main kitchen/cafeteria, chapel and other public spaces. Placing ICU on the second level necessitates the relocation of food service (kitchen and cafeteria). The total estimated project cost for the alternative is $36,538,680 and would require phasing over 3.5 years.

ALTERNATIVE 3: Relocate and Modernize Behavior Health and ICU

The modernization of all of the Hospital's beds, over time, has been a major priority. The 1960s beds require modernization in terms of plumbing, HVAC, electrical service and conversion from 2-bed to 1-bed rooms. Efforts towards this modernization have already started incrementally with renovations of the 7th and 9th floor Med/Surg units.

Alternative 3 effectively addresses the two priorities of modernizing ICU and continuing general bed upgrades by the modernization of the Behavioral Health unit. By renovating the 6th floor unit and relocating Behavioral Health to that floor, the 4th floor is made available for the modernization of ICU. An elevator transportation study determined the feasibility of locating ICU on the 4th floor provided that an elevator upgrade is accomplished. That upgrade is included in this project. The total estimated project cost for this alternative is $17,870,536 and requires phasing over 3 years.

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

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

4. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following::

   a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;

   b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;

   c. The project involves the conversion of existing space that results in excess square footage.

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

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

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
Intensive Care	13005	13,015	(10)	YES
Behavioral Health (AMI)	15176	16,240	(1064)	YES

Section 1110.530 Medical/Surgical, Obstetric, Pediatric and Intensive Care – Review Criteria

From the Rules:

Category of Service Modernization	(b)(1) & (3)	– Background of the Applicant
	(e)(1) & (2) & (3)	– Deteriorated Facilities
	(e)(4)	– Occupancy
	(g)	– Performance Requirements

This project includes the Modernization of the Hospital's Intensive Care category of Service. There is no change in the number of Authorized Beds.

Category of Service Modernization

1) If the project involves modernization of a category of hospital bed service, the applicant shall document that the inpatient bed areas to be modernized are deteriorated or functionally obsolete and need to be replaced or modernized.

Section 1110.530 (e)(1) & (2) & (3) Deteriorated Facilities

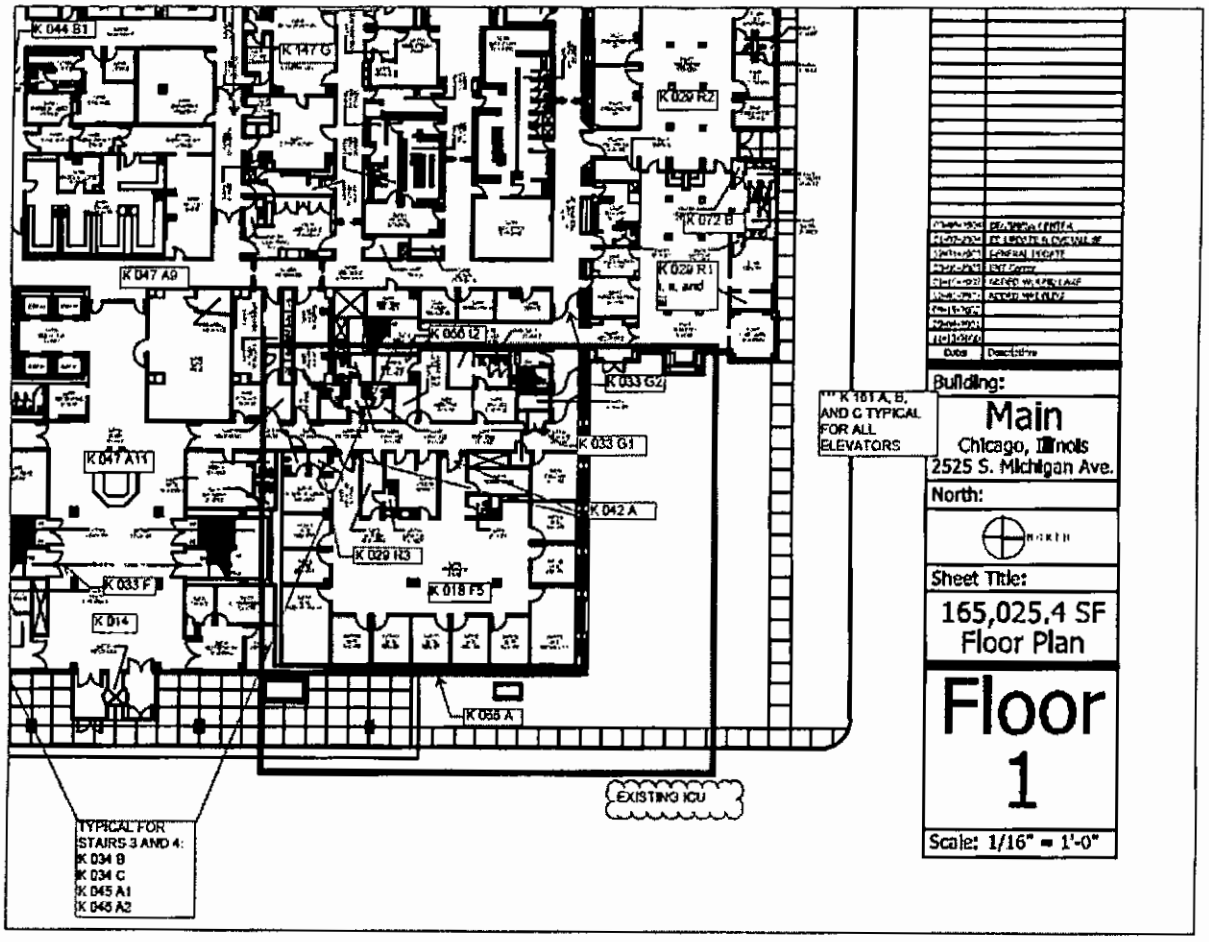
The construction of the existing General ICU is the original 1960s construction. This project addresses both quality of care and regulatory requirements. The ICU in its current location on the first floor of the Main Hospital Building was cited for 5 CMS violations, including lack of windows (K055A) and lack of compliant egress doors (K042A). Both means of egress are located on the west wall and do not comply with minimum distance required between egress doors. To meet these requirements in the existing space, various options were considered, proving to be costly and disruptive, and logistically unmanageable.

Additionally, the ICU Unit has been in use since the building opened in 1967. It is currently operating at capacity with 14 beds. The unit has 10 single rooms averaging 188 SF/room and two larger double occupancy rooms at 360 SF and 436 SF each. Including support space, the unit averages 570 SF/Bed. The configuration is not near the current standards for room size (<850 SF/Bed), nursing stations are inefficient, and support spaces are located across a public corridor which opens to the Hospital Main Lobby.

2) Documentation shall include the most recent:

A) IDPH Centers for Medicare and Medicaid Services (CMMS) inspection reports

Existing General ICU indicating IDPH/CMS K-Tags, or building compliance citations.



Illinois Department of
PUBLIC HEALTH

Pat Quinn, Governor

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.idph.state.il.us

November 6, 2013 CERTIFIED

Richard Cerceo, COO
Mercy Hospital & Medical Center
2525 South Michigan Avenue
Chicago, Illinois 60616

RE: Mercy Hospital & Medical Center - Chicago
Medicare Federal Monitoring Survey of October 31 – November 1, 2013
Statement of Deficiencies and Plan of Correction
(This will replace all earlier versions)

Dear Richard Cerceo

The Illinois Department of Public Health appreciates the courtesies extended to the Department's Life Safety Surveyor. Please find enclosed a copy of the CMS Form 2567 Statement of Deficiencies. These forms have been revised to reflect the deficiencies corrected or found as of the date of the above referenced survey. It is required that the provider prepare a "Plan of Correction" (PoC), for the Statement of Deficiencies on the attached CMS Form 2567. Please transpose the remaining Plans of Correction to the corresponding existing deficiencies and provide Plans of Corrections for any new deficiencies. Update the completion dates and provide a brief explanation why they have not met the dates established by the previous PoC. This Plan of Correction must be prepared and returned to us as soon as possible and within 10 days.

Please forward to us per the following address:

Henry Kowalenko, Division Chief
Division of Life Safety and Construction
Illinois Department of Public Health
525 W. Jefferson, 4th Floor, Springfield, IL 62761

The Plan of Correction must:

- Use the CMS Forms 2567 provided. These original documents may not be scanned or re-created in order to prepare a Plan of Correction. The previous submittal was not submitted on the original forms and the process used modified the statement of deficiencies side of the forms.
- Address each deficiency and explain how corrections will prevent reoccurrence.
- Indicate who is responsible for correction and monitoring.
- Give a specific date for completion of the corrective action.
- Be signed on the first page for each building.

Please also note and respond to each of the following.

1. Prior to the survey of 11/01/13, we requested a synopsis of the architect's facility assessment which was scheduled to be completed in October 2013 and which was identified as a component of the last submitted Plan of Correction (PoC).

   Instead, we received your letter of October 25, 2013, with a revised PoC signed 10/24/13. We reviewed the letter and PoC briefly and we find that is substantially similar to the previously submitted PoC.

   Instead of reviewing this submittal and asking for revisions, we are requesting that you revise your submittal based on the Federal Monitoring Survey of 11/01/13 (CMS Forms attached).

2. The Plan of Correction is incomplete and long term extensions of the Termination Date cannot be granted without a synopsis report of the findings of the architect's assessment which was completed in October 2013.

   a. While on site on 10/31/13, we were told that the assessment was completed and that is was in the form of 168 pages of raw data, without any conclusions. Submit this assessment with the revised PoC for the survey of 11/01/13

   b. The assessment and the PoC are incomplete without a detailed report which identifies what was found, what if any additional deficiencies were found relative to each K-tag citation which also do not comply with NFPA 101 and/or referenced standards. What other deficiencies were found which require correction?

   c. The assessment report should also include an evaluation of the deficiencies cited, an estimate of how long it will take to correct them, a justification as to why a project is necessary to correct each category, of deficiencies by K-tag, and an analysis of why it might be necessary to correct more than one K-tag within the scope of the same project.

   d. The assessment report should identify each project proposed by scope and indicate whether it needs to be submitted to IDPH, in accordance with the Hospital Licensing Requirement rules for project submittals.

3. The previous PoC submittal is currently too vague. The PoC needs to be revised by K-tag and by deficiencies, cited under each K-tag or found in the assessment. Remove any indication that quantities are unknown; this information was to be provided by the assessment. The assessment may no longer be relevant as a component identified in the PoC, except to justify specific projects.

4. Some of the deficiencies cited were not corrected in accordance with the last submitted PoC. This should not be repeated. If an item will not be corrected in

accordance with the PoC, a revised PoC on the sheet (2567 Form) where the change in date is necessary should be submitted prior to the date to be changed.

5. Adequate interim life safety measures must be implemented to prevent re-occurrence of deficiencies.

6. The previously submitted PoC had no priorities. The Statement of Deficiencies for the Survey of 11/01/13 includes requirements for specific interim life safety measures, by K-tag, where immediate correction is not proposed and/or where a delay and the extended risks mandate such.

7. Revise the PoC for each K-tag and for each item identified under each K-tag. Identify a final correction date for each item in the far right column in the space provided. If additional deficiencies have been found from the architect's assessment, identify them by K-tag, in the appropriate K-tag in the PoC and provide a correction date item.

   For deficiencies which must be corrected but which do not appear to match any K-tag, use K130. Please note that CMS provided a limited number of K-tags and expects citations under the K-tag that is similar or closest to what the K-tag appears to cover.

   If a project is necessary in order to correct a K-tag. Identify the project by name and identify the scope of work for that specific project. Provide a phasing for each K-tag project which includes the priorities. Please note that longer term corrective actions require enhanced interim measures.

8. CMS Categorical Waivers: CMS has promulgated categorical waivers to allow the use of certain provisions of the 2012 Edition of NFPA 101 and other referenced standards. This in advance of the adoption of NFPA 101 – 2012. These categorical waivers do not need to be submitted to or approved by CMS. If is only necessary to adopt in writing the use of each individual provision of a categorical waiver and then confirm that it complies with the requirements stated in the waiver. Obtain a copy of these categorical waivers from CMS's website.

   a. K033 D 4 on page 25 does not require correction and/or a request for a waiver if the conditions cited meet the listed requirements of a specific categorical waiver and if the Hospital has adopted in writing a policy to use a specific categorical waiver.

   b. K033 G 1 on page27: see item "a" above

   c. The Hospital may be able to use other categorical waivers, such as semi-annual testing of sprinkler flow switches instead of quarterly, but only if they are adopted in writing.

9. Two, eight foot wide exit stairs provide means of egress from the 2nd Floor

Dining and Chapel areas and discharge into the 1st Floor Main Lobby. Two adjacent stairs from the Basement Level discharge into the 1st Floor Main Lobby. This condition creates four exit stairs which currently only appear to comply with 7.7.2 of NFPA 101.

a. Although both stairs from the Basement Level are identified with exit signs, are both stairs really required as an exit from the Basement Level? If both are required, how will they comply with 7.7.1 or 7.7.2?

b. Are two, eight foot wide stairs from the 2nd Floor, near the cafeteria, necessary for exiting capacity? Will it be necessary to include both of these stairs as required stairs and evaluate them for compliance with 7.7.1 or 7.7.2?

10. The Life Safety Plans identify Stair # 6 as not an exit on every floor. Are illuminated exit signs or illuminated stair signs installed on any level at this stair? Are signs installed on the doors to Stair # 6 which indicate "not an exit?"

11. K160: Provide a phasing schedule in the PoC which includes each elevator: as complying or identifying when it will comply

If you have any questions, please do not hesitate to call us at 217/785-4264. The Department's TTY# is 800/547-0466, for use by the hearing impaired.

Sincerely,

Lynn W. Manley,
Staff Architect
Design and Construction Section
Division of Life Safety and Construction

cc: Henry Kowalenko – IDPH
Toni Colón - Deputy Director - IDPH
Arch File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 05 - MERCY MEDICAL ON PULASKI B. WING	(X3) DATE SURVEY COMPLETED
	140158		R 11/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY HOSPITAL AND MEDICAL CENTER	2525 S MICHIGAN AVE CHICAGO, IL 60616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS	{K 000}		
	Surveyor: 20224			
	A Medicare Federal Monitoring Survey was conducted on October 31, 2013 and November 1, 2013, by surveyor 07113. A revised PoC was requested.			
	The Life Safety Code portion of a Sample Validation Survey was conducted at Mercy Hospital and Medical Center. The survey also included two off-site outpatient service buildings referred to as Mercy Medical Building located on 5525 Pulaski Street Chicago, IL(Building #5) and Mercy Medical at Dearborn Station located at 47 W Polk Street, IL (Building #6).			
	This Form 2567 is for Building 05, Mercy Medical Building located on 5525 Pulaski Street Chicago, IL This survey was conducted on the morning of May 9, 2013. The surveyor was accompanied during the survey walk-through by the provider's representative.			
	The three story building houses Doctor's Offices on all levels.			
	This off-site outpatient service was surveyed as an Existing Business Occupancy under the 2000 Edition of the NFPA 101 Life Safety Code, including Chapter 39.			
	Deficiencies were observed, therefore, the requirements of 42 CFR Subpart 482.41 are NOT MET.			
{K 046}	NFPA 101 LIFE SAFETY CODE STANDARD	{K 046}		
	Emergency lighting of at least 1½ hour duration is			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 05 - MERCY MEDICAL ON PULASKI B. WING	(X3) DATE SURVEY COMPLETED
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{K 046}	Continued From page 1 provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Surveyor: 20224 Based on random observation during the survey walk-through while accompanied by engineering staff, not all egress paths are illuminated in such a manner that the failure of one fixture will not leave the area in darkness to comply with 39.2.9. These deficiencies could affect any patients, staff, or visitors in the building because the failure of the emergency lighting could prevent them from safely exiting the building under fire conditions. The finding is:: A. 05/09/13 at 10:01 AM the 3rd floor battery powered emergency lighting did not comply with 39.2.9 and 7.9.2.1. due to the following: 1. Corrected 11/01/13 2. During an interview held in the office of the building manager the battery powered emergency lighting is not tested at least 30 seconds every 30 days to comply with 7.9.3. 11/01/13: The provider replaced some devices completely and replaced the batteries in other devices. The provide lacks written documentation by device and by location of each device, for each month, from the date when the device was repaired or replaced (previous three to four months).	{K 046}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 05 - MERCY MEDICAL ON PULASKI B. WING	(X3) DATE SURVEY COMPLETED
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{K 046}	Continued From page 2 3. During an interview held in the office of the building manager the battery powered emergency lighting is not tested at least 90 minutes every year to comply with 7.9.3. 11/01/13: The provider replaced some devices completely and replaced the batteries in other devices. The provide lacks written documentation by device and by location of each device which clearly indicates the date that the device was replaced and tested and/or the date where the battery was replaced and tested.	{K 046}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MERCY HOSPITAL B. WING	(X3) DATE SURVEY COMPLETED
	140158		R 11/01/2013

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{K 000}	INITIAL COMMENTS	{K 000}		

Surveyor: 13755

A Medicare Federal Monitoring Survey was conducted on October 31, 2013 and November 1, 2013, by surveyor 07113. A revised PoC was requested.

The Life Safety Code portion of a Sample Validation Survey was conducted at Mercy Hospital and Medical Center, 2525 S. Michigan Avenue, Chicago, IL 60616 on May 6-9, 2013 by surveyors 13755, 14416, 16339, 17659 and 20224.

The survey was conducted at the Main hospital building and at two off-site out-patient only locations identified as Mercy Medical On Pulaski located at 5525 S. Pulaski, Chicago and Mercy Medical At Dearborn Station located at 47 W. Polk Street, Chicago. The surveyors were accompanied during the survey walk-thru by the Facility Management Engineering Dept Director, the Director of Construction, the Engineering Lead Electrician, and several Engineering and Maintenance staff members.

The Main hospital building was noted to be constructed in 1968 with several additions and renovations and consists of a Basement level, Floors 1 thru 12, plus an 11th floor mechanical mezzanine and a Penthouse level. A partial level noted as the Basement Mezzanine level was also identified. The Main building was identified as being of Type I (332) construction type and fully sprinkler protected.

Refer to the Building 05-Mercy Medical On

LABORATORY DIRECTOR'S OR PROVIDER/S' /PPLIER REPRESENTATIVE'S SIG' ,RE TITLE (X6) DATE

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

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{K 000}	Continued From page 1 Pulaski and the Building 06-Mercy Medical At Dearborn Station 2567 documents for survey information relative to those off-site facilities. The Main Hospital facility was surveyed under Chapter 19 of the 2000 Edition of NFPA 101 Life Safety Code and other NFPA Codes referenced therein as an Existing Healthcare Occupancy. Portions of the facility were surveyed under other occupancy chapters where appropriate. Unless otherwise noted, those code sections listed herein that do not include a reference to a specific NFPA code and year of issue (such as NFPA 70 1999) are taken from the 2000 Edition of the NFPA 101 Life Safety Code. Unless otherwise noted, all deficiencies cited herein were found through random observation during the survey walk-thru, staff interview or document review. The requirements of 42 CFR Subpart 482.41 are NOT MET as evidenced by the deficiencies cited under the following K-tags.	{K 000}		
{K 012}	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Surveyor: 16339 Based on random observation during the survey walk-through while accompanied by engineering	{K 012}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	140158	A. BUILDING 01 - MERCY HOSPITAL B. WING	R 11/01/2013
NAME OF PROVIDER OR SUPPLIER MERCY HOSPITAL AND MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2525 S MICHIGAN AVE CHICAGO, IL 60616	

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{K 012}	Continued From page 2 staff, not all portions of the building are of fire resistive construction in accordance with 19.1.6.2. These deficiencies could affect any patients, staff, or visitors in the building by permitting the building structure to be compromised during fire conditions. A. On the morning of 05/08/13, Building - 01, Second Floor: Portions of the structural steel beam, deck and a column were observed to be missing fire proofing materials in accordance with the designated UL Design. Locations observed include: 1. Above the ceiling panels of the Auditorium near the double entrance doors. 2. Exit access corridor leading to the Stair 13A and by the exit stair doors. Surveyor: 20224 B. On 05/08/13 at 11:00 am, Day Surgery, Nourishment room #1R-29 (from facility Life Safety plan dated 2/22/13) unprotected steel beam flanges were observed at the south and and east walls, which do not maintain the building's designated construction type.	{K 012}		
{K 014}	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2	{K 014}		

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{K 014}	Continued From page 3 This STANDARD is not met as evidenced by: Surveyor: 13755 Based on observation during the survey walk-through, not all interior finishes for corridors comply with applicable requirements of the Life Safety Code. These deficiencies could affect all patients in the smoke compartment, as well as any staff and visitors present, because the lack of compliance can expose occupants to harmful fire and smoke conditions. Findings include: A. (Modified 11/01/13): At 1:45 pm on 5/8/13 the Main Lobby was observed to have wood panel wall finishes on multiple walls. Further, the surveyor observes that this material has been painted. The provider lacks specific documentation for the material and the finish which demonstrate that these walls comply with NFPA 101-2000, 19.3.3.2 as minimum Class B Interior Finish.	{K 014}		
{K 015}	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2	{K 015}		

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	140158	A. BUILDING 01 - MERCY HOSPITAL B. WING _____	R 11/01/2013

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{K 015}	Continued From page 4 This STANDARD is not met as evidenced by: Surveyor: 13755 Based on observation during the survey walk-through, not all interior finishes of rooms comply with applicable requirements of the Life Safety Code. These deficiencies could affect all patients in the smoke compartment, as well as any staff and visitors present, because the lack of compliance can expose occupants to harmful fire and smoke conditions. Findings include: A. At 10:45am on 5/8/13 the Cafeteria Dining room on the 2nd floor was observed to have a wood slat ceiling system which could not be documented by staff at the time of the survey to meet the minimum finish rating requirements of NFPA 101-2000, 13.3.3 for an existing Assembly occupancy. The provider is not able to demonstrate that the above ceiling provides at least a Class C Finish if the occupant load is less than 300 or a Class B Finish if the occupant load is greater than 300. 11/01/13: The provider has written documentation for an intumescent coating which they believe was used on the above referenced ceiling but lacks written documentation including when and who, which indicates that the coating was used on the ceiling. B. Corrected 11/01/13 C. (Note: 11/01/13) Basement Mezzanine Level Engineering spaces: Although the paneling in the old blueprint room was removed, other spaces on	{K 015}		

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{K 015}	Continued From page 5 the same level (including the conference room A-351, A-354 and a glass wall receptionist space) was observed to have wood paneling walls that could not be documented to meet the Class C minimum finish rating requirements of NFPA 101-2000, 39.3.3.2.	{K 015}		
{K 017}	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Surveyor: 13755 Based on observation during the survey walk-through, not all exit access corridors are separated from use areas in accordance with 19.3.6.1. These deficiencies could affect all patients in the locations, as well as any staff and visitors present, because the lack of smoke	{K 017}		

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{K 017}	Continued From page 6 detectors leaves the exit access corridors unprotected against early and prompt notification of a fire event that could render the exit access corridors unusable. Findings include: A. Corrected 11/01/13 B. Corrected 10/31/13 Surveyor: 16339 Based on random observation during the survey walk-through, not all exit access corridors are separated from use areas in accordance with 19.3.6.1. These deficiencies could affect any building occupants in the exit access corridors adjacent to the rooms listed, because smoke and fire could pass from them into the corridors. Findings include: C. Deleted 10/31/13; area under construction and not part of a means of egress. D. Modified 11/01/13: Building - 01. The First Floor Lab/Radiology Reception and Waiting Area is greater than 600 square feet and was observed to be open to and not separated from the exit access corridor. This space is not supervised 24/7 and therefore lacks smoke detection installed to protect the entire space (spacing per NFPA 72) to comply with 19.3.6.1. Exception 6.	{K 017}		
{K 018}	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as	{K 018}		

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{K 018}	Continued From page 7	{K 018}		

those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3

Roller latches are prohibited by CMS regulations in all health care facilities.

This STANDARD is not met as evidenced by:
Surveyor: 13755

Based on observation during the survey walk-through, not all doors in exit access corridors are in compliance with 19.3.6.3. This deficiency could affect all patients in the locations as well as any staff and visitors present, by allowing smoke to pass from one side of the corridor wall to the other; either compromising the building's exit access corridors or the rooms occupied.

Findings include:

A. Corrected 10/31/13

B. At 10:05am on 5/8/13 it was observed that corridor doors to 4th floor rooms 401, 402 & 403

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{K 018}	Continued From page 8	{K 018}		

were equipped with push/pull hardware in combination with deadbolt locks operated with key only from the corridor side. The hardware does not provide latching to comply with 19.3.6.3.2 and the deadbolt lock can prevent egress in noncompliance with 19.2.2.2.2. The rooms were not equipped to provide direct observation of a patient if considered to be used for seclusion.

11/01/13: What are the specific interim life safety measures proposed until the above item is corrected?

C. During the survey walk-through, Janitor closets observed to be storing combustible materials were equipped with corridor doors containing louvers in noncompliance with 19.3.6.4 Exception. Locations observed include:

1. At 2:00pm on 5/7/13 6th floor Janitor Closet 633-A used to store paper supplies.

2. Corrected 10/31/13

3. Corrected 10/31/13

Surveyor: 16339

Based on random observation during the survey walk-through and staff interview, not all doors in exit access corridors are in compliance with 19.3.6.3. This condition could affect patients, visitors and staff within an exit access corridor during a fire condition.

Findings include:

D. Doors in exit access corridor doors were observed with a transfer grille that is not resistive

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{K 018}	Continued From page 9 to the passage of smoke as required by 19.3.6.4. Locations observed include: 1. Morning of 05/07/13, Building -01, Tenth Floor, Med/Surg Unit: Storage Room 1033A. 2. Afternoon of 05/07/13, Building -01, Ninth Floor, Med/Surg Unit: Storage Room 933A. 11/01/13: What are the specific interim life safety measures proposed until the above two items are corrected? Surveyor: 20224 Based on random observation while accompanied by engineering staff, corridor doors are not always positive latching in accordance with 19.3.6.3.2 and/or that corridor doors are not installed to maintain a smoke tight condition. Failure to maintain corridor doors in accordance with NFPA 101 could allow smoke to spread from room to room in a fire emergency. Findings include: E. 05/08/13 at 2:35 pm, 1st floor corridor doors are provided with a push/pull with deadbolt hardware. These corridor doors do not comply with 19.3.6.3.2 for providing positive latching hardware. Example locations observed: 1. Cystology 2. Stage I Recovery 3. Endoscopy F. 05/08/13 at 2:55 pm, 1st floor means of	{K 018}		

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{K 018}	Continued From page 10 egress corridor doors from the ICU contain a pair of pocket doors with motion detection and a swing door with a hold open device within the same framed opening. 1. Corrected 11/01/13 2. Corrected 11/01/13 3. Corrected 11/01/13 4. Corrected 11/01/13 5. New 11/01/13: Two pairs of pocket sliding doors break and swing into the corridor but do not swing 180 degrees. They obstruct the exit access corridor by more than 7" when fully open. (7.2.4.4)	{K 018}		
{K 020}	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Surveyor: 13755 Based on observation during the survey walk-through, not all vertical openings are constructed or maintained as fire resistive assemblies in accordance with NFPA 101, 19.3.1.1. These deficiencies could affect all patients within the areas of the facility, as well as	{K 020}		

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{K 020}	Continued From page 11 any staff and visitors present, by not providing the intended fire barrier protection between the floor levels. Findings include: A. At 10:55am on 5/7/13 it was observed at the 8th floor Communications closet 833B that miscellaneous through-floor conduit (sleeves for wiring) were not sealed to maintain the floor barrier rating against fire and smoke to comply with 8.2.3.2.4.2. B. At 11:05am on 5/7/13 it was observed that the fire rated access door to the shaft accessed from the 8th floor Janitor closet located within the Eye Clinic File room lacked a latch strike to provide a complete rated door assembly to comply with NFPA 80. C. At 11:30am on 5/7/13 it was observed that the fire rated access door to the shaft accessed from the 8th floor Janitor closet 815A lacked a latch strike to provide a complete rated door assembly to comply with NFPA 80. D. At 1:15pm on 5/7/13 it was observed that the fire rated access door to the shaft accessed from the 7th floor old Janitor closet 733A lacked a latching door and a strike to provide a complete rated door assembly to comply with NFPA 80. Surveyor: 16339 Based on random observation during the survey walk-through, not all shafts are constructed or maintained as fire resistive assemblies in accordance with NFPA 101, 19.3.1.1. These deficiencies could affect any patients, as well as any staff and visitors becaues the failure to provide self-closing doors and proper installation	{K 020}		

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{K 020}	Continued From page 12 of shaft could result in smoke or fire passing from one part of the building to another. Findings include: E. Morning of 05/9/2013, Building - 01, Tenth Floor, The door to a shaft (dumbwaiter) located inside the Soiled Utility Room did not self-close all the way to positively latched as required by 8.2.3.2.1. Surveyor: 20224 Based on random observation during the survey walk through while accompanied by engineering staff, not all vertical openings are protected to comply with 19.3.1 and 8.2.5.2. This could contribute to the lack of containment during a fire event. These deficiencies could affect any patients, staff, or visitors in the building by permitting smoke and fire to pass between building stories. Findings include: F. 05/07/13 at 10:30 am, a series of pipe penetrations through the 2 hour fire rated floor assembly, in an 11th floor Electrical Closet (#1121 A) were observed to not be sealed against the passage of fire/smoke to comply with 8.2.3.2.4.2. G. 05/08/13 at 2:30 pm, a duct was observed above the ceiling of the 12th floor at the intersection of corridor 1236 D and 1201 G (as shown on the facility provided Life Safety plan dated 2/22/13), which penetrates the floor of the Penthouse above (near Passage P 014-as shown on the facility Life Safety plans dated 2/22/13). This penetration lacks the installation of a fire damper within the plane of the floor to comply	{K 020}		

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{K 020}	Continued From page 13	{K 020}		
	with NFPA 90 A 1999 3-3.2.			
{K 021}	NFPA 101 LIFE SAFETY CODE STANDARD	{K 021}		
	Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:			
	a) the required manual fire alarm system;			
	b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and			
	c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2			
	This STANDARD is not met as evidenced by: Surveyor: 13755 Based on observation during the survey walk-through, not all doors required to be self-closing are in compliance with 7.2.1.8.1. This deficiency could affect all persons within the smoke compartment by allowing the products of combustion to pass from one side of the door to the other; either compromising the building's exit access corridors or the rooms occupied or adjacent to the space designed to be separated.			
	Finding include:			

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{K 021}	Continued From page 14 A. At 2:45pm on 5/6/13 it was observed that the Penthouse P107 Mechanical room door was propped open with a concrete block in noncompliance with 39.3.2.1, 8.4.1.2, 8.2.4.3.5 and 7.2.1.8.1. This room was also considered to be part of a shaft due to the inability to locate access to fire dampers at the ducts entering the adjacent shaft(s). The door to this room was not labeled to comply with 8.2.3.2.1. B. At 11:00am on 5/7/13 it was observed that the 8th floor Eye Clinic file room door was being held open with a wood wedge in noncompliance with 8.4.1.2, 8.2.4.3.5 and 7.2.1.8.1. Surveyor: 16339 C. On the morning of 05/08/13, Building - 01, First Floor - Family Health Center (FHC) Billing Office is also being used for storing Medical Records Files and the door to this room is pegged with un-approved hold-open device to comply with 8.4.1.2, 8.2.4.3.5 and 7.2.1.8.1.	{K 021}		
{K 025}	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4	{K 025}		

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{K 025}	Continued From page 15 This STANDARD is not met as evidenced by: Surveyor: 16339 Based on random observation during the survey walk-through while accompanied by engineering staff, not all designated or required smoke barrier walls are constructed or maintained as minimum 30 minute fire rated assemblies in accordance with 19.3.7.3. These deficiencies could affect any patients, staff, or visitors in the building by allowing smoke to pass between smoke compartments. The finding is: A. Designated 2 hour fire rated existing and smoke barrier walls on the Life Safety Plan were observed to contain penetrations like conduits that are not fire sealed. Location observed include: 1. On the morning 05/08/13, Building - 01, First Floor: Radiology above the ceiling of double doors near the Locker Room 1-665. Surveyor: 20224 B. On 05/07813, at 10:45 am,1st floor smoke barrier within the Day Surgery area at the east wall of the Nourishment room contains multiple holes along with pipe and conduit penetrations that are not sealed against the passage of smoke to comply with 19.3.7.3. and 8.3.2.	{K 025}		
{K 027}	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 46 inches	{K 027}		

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{K 027}	Continued From page 16 from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Surveyor: 20224 Based on random observation during the survey walk-through, while accompanied by engineering staff, not all designated or required smoke barrier doors are constructed or maintained as minimum 30 minute fire rated assemblies in accordance with 19.3.7.3. These deficiencies could affect any patients, staff, or visitors in the building by allowing smoke to pass between smoke compartments. The finding is: A. 05/09/13 at 1:45 pm, 10 th floor pairs of cross corridor doors located in the West corridor failed to close to a smoke tight position. This condition was discovered during the testing of the fire alarm system. One door contains an extended bolt throw which did not allow the other door to close completely to comply with 7.2.1.8.2. 11/01/13: What are the specific interim life safety measures proposed until the above item is corrected?	{K 027}		
{K 029}	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour	{K 029}		

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{K 029}	Continued From page 17 fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 13755 Based on observation during the survey walk-through, not all hazardous areas are separated from the remainder of the building in accordance with NFPA 101-2000, 19.3.2.1 and 8.4.1. These deficiencies could affect all patients within the smoke compartment of the location, as well as any staff and visitors present, by allowing smoke and fire to escape from hazardous rooms into the exit access in the event of a fire condition. Findings include: A. Corrected 11/01/13 B. At 2:35pm on 5/6/13 it was observed that the door to Storage room P100 at the Penthouse level was not self-closing and contained an operable louver in non-compliance with 8.2.4.3.3 and 8.2.4.3.5. C. Corrected 11/01/13	{K 029}		

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{K 029}	Continued From page 18 D. Corrected 11/01/13 E. At 9:30am on 5/8/13 it was observed that the 4th floor Mechanical/storage room 448 corridor door was not self-closing to a latched condition. This room is designated as 2-hour enclosed. Two sets of pairs of doors to this room are equipped with knob hardware on both leafs of the doors where the active leaf is also equipped with an astragal. The arrangement does not comply with 7.2.1.5.5 because the inactive leaf can be mistaken as an active leaf and cannot be opened without first opening the active leaf. Stored material obstructed the swing of the active leaf at the north door to the Mechanical room. The south door to the mechanical room had both a slide bolt and a knob set on the inactive leaf. F. (Modified 11/01/13): At 10:45am on 5/8/13 it was observed that the exit corridor west of the 2nd floor kitchen outside the entrance to Stair #5 was being utilized for the storage of carts, wheeled waste bins, and equipment related to the kitchen in noncompliance with 7.5.1.7 and 8.4.1. Surveyor notes that exit signage from the adjacent corridor is directed into this service corridor utilized for storage which makes it a required exit access corridor. Also the pair of doors to the Kitchen from this corridor lack positive latching hardware. G. At 11:00am on 5/8/13 it was observed that the 2nd floor kitchen storage rooms 240B & 240C lack self-closing doors to comply with 8.4.1.2 and 8.2.4.3.5. H. At 2:30pm on 5/8/13 it was observed that the 1st floor Physical Therapy storage room 14-91A	{K 029}		

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{K 029}	Continued From page 19 lacks a self-closing door to comply with 8.4.1.2 and 8.2.4.3.5. I. At 2:40pm on 5/8/13 it was observed that the 1st floor file storage/workroom 1-484B lacks two self-closing doors to comply with 8.4.1.2 and 8.2.4.3.5. J. At 2:41pm on 5/8/13 it was observed that the 1st floor storage room 1-498 lacks a self-closing door to comply with 8.4.1.2 and 8.2.4.3.5. K. At 11:00am on 5/9/13 it was observed that the hydraulic elevator equipment room A364 door was not self-closing and fire rated to comply with 8.4.1.1(3). (The equipment room is considered a severe hazard relative to the quantity of hydraulic fluid.) Surveyor: 16339 L. On the Morning of 05/07/13, Building -01, Tenth Floor - Med/Surg Unit: An electrical conduit located above the north east door to the Soiled Utility Room penetrates the wall that is not sealed against fire to comply with 8.2.3.2.4.2. M. On the afternoon of 05/07/13, Building - 01, 9th Floor - Med/Surg Unit: The Clean Holding which is a designated one hour enclosure room was observed with a conduit penetration above the NW door that is not fire sealed to comply with 8.2.3.2.4.2. N. On the afternoon of 05/07/13, Building - 01, 9th Floor - Med/Surg Unit: Identified 920A Exam Room which is less than 100 sq. ft. is being used for storage, the door to this room is not self-closing to comply with 8.2.3.2.3.1(2). O. On the afternoon of 05/07/13, Building - 01,	{K 029}		

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{K 029}	Continued From page 20 9th Floor - Med/Surg Unit: The Soiled Holding noted to be separated by two hour construction was observed with conduit penetrations (3) that are not fire sealed to comply with 8.2.3.2.4.2 and 19.3.2.1. P. On the morning of 05/08/13, Building - 01, 2nd Floor - Auditorium: The double doors to the Storage Room are required to be self-closing but one of the leafs was broken. Q. On the afternoon of 05/08/13, Building - 01, First Floor - The Family Health Center (FHC) Billing Office is also being used for storing Medical Records Files and was observed with a pipe and a conduit penetrations that are not sealed against the passage of smoke. Surveyor: 20224 Based on random observation during the survey walk-through while accompanied by engineering staff, not all hazardous areas are separated from the remainder of the building in accordance with 19.3.2.1 and 8.4.1. These deficiencies could affect all patients, staff and visitors within the smoke compartment, by allowing smoke and fire to escape from hazardous rooms into the exit access corridor during a fire emergency. Findings include: R. 05/08/13 at 1:15 pm, various rooms which do not meet the minimum requirements for hazardous areas are being used as storage rooms and deemed hazardous due to the amount of combustible materials, boxes, files, equipment and furniture. These rooms/areas do not comply with 19.3.2.1 for protection of hazardous areas due to the following:	{K 029}		

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{K 029}	Continued From page 21 1. Day Surgery designated 1 R-11 Waiting room (located south of the 1 R-22 Vestibule Center) is being used as storage and does not comply with 19.3.2.1 due to the following: i. The sprinkler system does not provide adequate coverage due to openings within finished ceilings along with missing ceiling tiles in suspended acoustical ceiling systems. For example: Men's and Women's toilet areas, and vending area. ii. The perimeter walls are not smoke tight due to numerous holes and unsealed penetrations. iii. The entry doors are not self closing. For example, the doors leading to Doctor Offices. 2. Day Surgery 1 R-22 Vestibule Center adjacent to the nurses station contains numerous gurneys stored within the means of egress. 3. 1st floor, ICU patient isolation room is being used as storage and does not comply with 19.3.2.1 for smoke tight perimeter walls, self closing and latching door. 05/07/13 at 10:05 am Third floor janitor closet located within the Delivery corridor, contains large holes in the wall behind the mop sink which does	{K 029}		

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{K 029}	Continued From page 22 not allow a smoke tight enclosure. T. 05/08/13 at 10:15 am Third floor Equipment storage room #3-303-referred to as Clean Holding by facility staff (per life safety floor plans) contains an entry door with a hold open device which does not comply with 19.3.2.1 and 7.2.1.8.1. U. 05/08/13 at 2:15 pm 1st floor Surgery Sterile Core contains numerous shelves and material storage and it is not designated as a hazardous area to comply with 8.4.1. It does not have perimeter smoke tight walls with doors with a means for maintaining a closed position to comply with 19.3.2.1, 8.4.1.2 and 8.2.4.3.5.	{K 029}		
{K 033}	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Surveyor: 07113 A. 11/01/13: After reviewing the currently cited deficiencies in the field and the current PoC for K033, K034 and K038, the surveyor finds that the provider lacks an exit study by floor which clearly identifies the exits for each floor and an evaluation of each exit for compliance with 7.7.1	{K 033}		

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{K 033}	Continued From page 23 and 7.7.2, based on the requirements for each floor. B. Multiple floor plans available onsite identify the use of horizontal exits on multiple floors. Based on previous submittals, the surveyor observes that some of these horizontal exits are required exits. However, the fire barriers which define these designated horizontal exits are not shown continuously from foundation to roof in accordance with 7.2.4.3.1 (NFPA 101). Accordingly, under 7.2.4.3.1 (c) all exits must discharge directly to the outside and most or all of the required exit stairs may not use 7.7.2 for compliance (see "A" above). Surveyor: 13755 Based on observation during the survey walk-through, not all exits are enclosed with construction having a fire resistance rating to comply with 19.3.1.1 and 8.2.5.2 and 7.1.3.2. These deficiencies could affect all patients in the facility, as well as any staff and visitors present, by preventing those occupants from reaching an exit from the building. Findings include: A. At 2:30pm on 5/6/13 it was observed that the fire rating labels on the stair doors of the Penthouse level were painted which did not allow confirmation of the opening protection required by NFPA 101-2000, 8.2.3.2.1. Painted fire protection rated labels for other doors to storage rooms, mechanical spaces, and shafts were also noted on this floor. 11/01/13: The surveyor observed that the labels are still painted. The surveyor finds that the 2015	{K 033}		

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{K 033}	Continued From page 24 proposed date of correction for the above item is not reasonable. B. At 11:15am on 5/7/13 it was observed that conduit penetrations above the east door of Stair #4 on the 8th floor were not sealed to comply with NFPA 101-2000, 8.2.3.2.4.2. C. At 1:00pm on 5/7/13 it was observed that the enclosure wall at Stair #4 on the 7th floor above the east door 703B was incomplete in non-compliance with NFPA 101-2000, 8.2.3.1. D. At 9:30am on 5/9/13 it was observed that the exit passageway serving as the discharge for Stair #4 leads through Stair #14A. 1. Stair 14A contains elevator openings (do not comply with 9.4.7) and has the elevator machine room (considered a normally unoccupied space) accessing the stair in noncompliance with 7.1.3.2.1(d). Stair #13A also has these conditions. 2. The exit passageway does not terminate directly at a public way or at an exterior exit discharge to comply with 7.7.1 and 7.1.3.2.2 (without going through Stair 14A). 3. (Modified 11/01/13): The exit passageway contains recessed medical gas zone valves in the enclosing walls. The provider lacks information which demonstrates how fire rating for the walls are maintained at these zone valve boxes. This is not a deficiency if this space is not an exit passageway.	{K 033}		

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{K 033}	Continued From page 25 4. The exit passageway has openings onto it from normally unoccupied spaces such as the Cath Lab storage rooms and telecom/electrical rooms in noncompliance with 7.1.3.2.1(d). Surveyor: 16339 Based on random observation, the surveyor find that required exit stair enclosures do not provide a continuous path of escape and do not provide protection against fire or smoke from other parts of the building to comply with Chapter 7. These deficiencies could affect any patients from this building and as well as any staff and visitors because designated exit stairs are not protected against fire or smoke conditions to comply with 8.2.5.2. Findings include: E. On the afternoon 05/09/13, Building - 01, Basement Level: Exit Stair #13A was observed with stored construction materials like gypsum boards located behind the Elevator #13. F. On the afternoon 05/09/13, Building - 01, Basement Level: Identified Stairwell 2A B-326A discharges into the First Floor near the Main Lobby, surveyor observed that one leaf of the pair of doors on the First Floor level does not latch upon closing to comply with 8.2.5.2. Surveyor: 20224 Based on random observation during the survey walk through, while accompanied by engineering staff, not all designated exit stair enclosures provide a protected means of egress to an exit discharge. This condition may affect patients, staff and visitors on the upper floors from a safe	{K 033}		

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{K 033}	Continued From page 26 means of egress during a fire/smoke event. G. 05/07/13, at 11:15 am The Life Safety plans indicate that Stair # 3 and Stair # 9 are both served by a 2-hour fire rated exit passageway on the 1st floor (North side). The exit passageway does not comply with 19.3.1.1 due to the following: 1. A Storage room opens into the exit passageway which does not comply with 7.1.3.2.1 (d) which limits openings into an exit passageway for those necessary for access from occupied spaces. 2. A pair of fire rated entry doors from the Surgery area did not close to latch under fire alarm conditions. 11/01/13: The PoC does not clearly identify immediate correction of the above item.	{K 033}		
{K 034}	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4 This STANDARD is not met as evidenced by: Surveyor: 13755 Based on observation during the survey walk-through, not all exit stairs are constructed in accordance with the requirements of 19.2.2.3 & 7.2.2. These deficiencies could affect all patients	{K 034}		

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{K 034}	Continued From page 27 of the facility, as well as any staff and visitors present, by impeding the use of the stairs during building exiting. Findings include: A. On the morning of 5/9/13 it was observed that stair enclosures were being used as storage stations for housekeeping equipment/misc supplies in noncompliance with 7.1.3.2.3. Observations include: 1. At 9:50 am a trash cart was observed at the 1st floor level of Stair #4 1-162. 2. At 10:30am a trash receptacle was observed at the landing of Stair #8. 3. At 10:35am a snow-melt spreader and bags of snow-melt were observed to be stored at the top landing of Stair #7. 4. At 10:45am a housekeeping cart was observed within Stair #10 at the Basement level. 11/01/13: The PoC does not include a correction date for the above items and does not indicate that immediate correction is proposed. B. Facility Stairs serving five or more stories are not provided with stair identification signage in accordance with NFPA 101-2000, 7.2.2.5.4. Surveyor was unable to locate signage within the stair enclosures at each landing that identifies the story, the top and bottom terminus, and the identification of the stair enclosure. Stairs serving five or more stories include #3, #4, #5, #6.	{K 034}		

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{K 034}	Continued From page 28 11/01/13: The PoC does not include a correction date for the above items and does not include the use of temporary signage as an interim measure until the item is corrected. C. Facility Stairs serving four stories or more did not comply with the provisions of 7.2.1.5.2 to allow re-entry from the stair enclosures to the building interior. Not all levels were unlocked for re-entry; unlocked during fire alarm activation; or otherwise compliant with all provisions of Exception No. 1 to 7.2.1.5.2. Stairs serving five or more stories include #3, #4, #5, #6. 11/01/13: The items remain uncorrected. The PoC does not include a correction date for the above items and does not include the use of temporary signage as an interim measure until the item is corrected.	{K 034}		
{K 038}	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 07113 A. In spite of the deficiencies cited on the previous survey relative to the use of pad locks, on 10/31/13, the surveyor observed and 8th Floor patient wing where the wing was vacant and all of the patient rooms doors had padlocks installed to prevent the doors from being opened (example:	{K 038}		

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{K 038}	Continued From page 29	{K 038}		

804A and 805). This condition does not comply with 7.2.1.5. The locks cannot be release from inside the room at all and immediate correction was required. The provider lacks adequate interim life safety measures to prevent re-occurrence.

B. (New 11/01/13): From direct observation, the surveyor finds that there is an identified exit path from the 2nd Floor Cafeteria, through the Doctor's Dining Room to Exit Stair # 3:

1) The exit path is then through a small space marked as a corridor on plans immediately adjacent to Exit Stair # 3. This space is a vestibule rather than a corridor. Two doors from the adjacent Kitchen open into this vestibule. The doors have U L Labels as 90 minute fire doors. The doors have magnetic hold open devices but lack smoke detection in accordance with 7.2.1.8 an 19.2.2.2.6

2) The Kitchen doors have slide bolts in addition to latching hardware. The slide bolts do not comply with 7.2.1.5 and/or ADA.

3) A large gray kitchen cart in the above space prevents one of the two doors from closing
Surveyor: 13755
Based on observation during the survey walk-through, not all exit doors are arranged so that exits are readily accessible at all times in accordance with 19.2.1 and Chapter 7. These deficiencies could affect all patients in the area of the facility, as well as any staff and visitors present, by preventing those occupants from reaching an exit from the building.

Findings include:

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{K 038}	Continued From page 30 A. Doors were observed to be provided with dead bolt locks in addition to lock/latchsets; are provided with dead bolt locks operated only by a key from either side; or are provided with locking hardware which can prevent egress. The dead bolt lock constitutes a second releasing operation to operate the the door when used in combination with latching hardware in noncompliance with 7.2.1.5.4. The key-only dead bolt locks are not operable for exiting without a key in noncompliance with 7.1.10.1. Padlocks, hasps and slidebolts can either prevent egress or constitute a second releasing operation. Locations observed include but are not necessarily limited to the following: 1. At 1:20pm on 5/7/13 the 6th floor Men's & Women's toilet room doors were observed to have both thumbturn deadbolts and privacy locksets in noncompliance with 7.2.1.5.4. 2. At 2:10pm on 5/7/13 the 6th floor On call rooms were observed to have both deadbolt locks and combination locksets in noncompliance with 7.2.1.5.4. 3. At 2:15pm on 5/7/13 the 6th floor Anesthesia/Cardiology On-call room 622 was observed to have a deadbolt lock, a latchset and a slidebolt lock in noncompliance with 7.2.1.5.4. 4. At 3:00pm on 5/7/13 the 4th floor Activity rooms 410, 427 &440 were observed to have corridor doors to the rooms equipped with deadbolt locks and latchsets in noncompliance with	{K 038}		

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{K 038}	Continued From page 31 7.2.1.5.4. 5. Deleted 11/01/13 6. Deleted 11/01/13 7. At 9:45am on 5/8/13 the 4th floor patient rooms were observed to have corridor doors with deadbolt locks key operated only from the corridor side which can prevent egress from the room in noncompliance with 19.2.2.2.2. The rooms were not equipped to be provided with visual observation by staff to permit use as seclusion rooms. Some doors also have multiple mortise latches which appear to be operational. If both latchsets are operational, the installation does not comply with 7.2.1.5.4. If only one latchset is operational, the presence of two sets of hardware could confuse occupants when selecting the intended operational hardware set. 8. At 10:45am on 5/8/13 it was observed that the 2nd floor Kitchen Dishwashing room and the Kitchen have marked exit path doors with panic hardware that also have slide bolt locks in noncompliance with 7.2.1.5.4 and 7.2.1.5.6. 11/01/13: The PoC does not indicate that the slide bolts will be removed immediately. 9. At 10:50am on 5/8/13 it was observed	{K 038}		

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{K 038}	Continued From page 32 that the 2nd floor Kitchen dry storage room door was equipped with a deadbolt lock keyed from one side only. 11/01/13: The PoC does not indicate that a thumbturn will be installed immediately. 10. At 11:30am on 5/8/13 it was observed that the 2nd floor Volunteers office door was equipped with a combination lock and a knobset. The door could not be opened to verify that the door could be operated with a single releasing operation to comply with 7.2.1.5.4. 11. At 1:30pm on 5/8/13 it was observed that the corridor door from the 1st floor Elevator #9 lobby was equipped with a deadbolt lock and latching hardware. 12. At 2:30pm on 5/8/13 it was observed that the corridor door at the 1st floor Physical Therapy dept. was equipped with a deadbolt lock and latching hardware. 13. At 10:30am on 5/9/13 it was observed that two of three doors at the exterior discharge of Stair #7 were not able to be opened. 11/01/13: Immediate correction of the above item is not identified in the PoC. 14. At 11:15am on 5/9/13 it was observed that the Basement level materials management storage area caged records area was provided with a padlock at the	{K 038}		

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{K 038}	Continued From page 33 single available entry/exit point of the caged area. Although a door to the adjacent laundry area exists, it was not available for use because shelving units had been placed in front of it to make it unusable. 15. At 10:45am on 5/9/13 it was observed that numerous rooms at the Basement level OB/GYN training rooms (old cobalt treatment area) were equipped with hasps and padlocks and deadbolt locks which can prevent egress from the rooms. 11/01/13: The PoC does not identify immediate removal of all hasps and padlocks and also removal of all deadbolts which do not at least have thumbturns inside. Surveyor: 16339 Based on random observation during the survey walk-through and staff interview, not all exit accesses are arranged so that exits are readily accessible at all times in accordance with 19.2.1. Findings include: B. Doors in exit access corridors were observed that are equipped with thumbturn deadbolt retractor, which require more than one releasing mechanism operation toexit the room as prohibited by 7.2.1.5.4. These deficiencies could affect patients receiving treatment, as well as any staff and visitors present, by preventing them from exiting the building under emergency conditions. Locations observed include:	{K 038}		

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{K 038}	Continued From page 34 1. Building - 01, 5th Floor: Dizziness Center Room 522. 2. Deleted 11/01/13 3. Building - 01, 5th Floor: EMG Patient Room 520. 4. Building - 01, 5th Floor: Wash Room across Staff Corridor 529. 5. Building - 01, 5th Floor: Doors (two) to Physical Therapy Unit. 6. Building - 01, First Floor (Radiology Unit): Radiology Room I, Rad Room 2, CT Scan 3, Rad Room 5, Room 6. 7. Building - 01, First Floor (Radiology Unit): CT Scanner 2 and Room 1-658. 8. Building - 01, First Floor, Family Health Center (FHC): The corridor door (Door 1-370) to the FHC on the north east aisle of the D &T Staff Area. Surveyor: 20224 Based on random observation during the survey walk-through while accompanied by engineering staff, exit access was not readily accessible at all times in accordance with 7.1 and 19.2.1. These deficiencies could affect all patients within the areas of the facility, as well as any staff and visitors present, by preventing those occupants from readily utilizing an available exit from the building during an event requiring such exiting. Findings include:	{K 038}		

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{K 038}	Continued From page 35 C. Deleted 10/31/13 D. Deleted 10/31/13 - see K018 E. 05/08/13 10:15 am, 3rd floor LDR wing, Stair #5 and Stair #6 both contain magnetic locking devices and alarms. These doors do have a delayed egress device. However, the doors do not comply with 7.2.1.6.1 for identification signage. 11/01/13: The above item has a 2015 correction date; interim measures are not included for this item which provide temporary signs until correction is completed.	{K 038}		
{K 040}	NFPA 101 LIFE SAFETY CODE STANDARD Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. 19.2.3.5 This STANDARD is not met as evidenced by: Surveyor: 13755 Based upon observation during the survey walk-through, not all exit access doors provide a minimum 32" clear width to comply with 19.2.3.5. Locations observed include: Findings include: A. At 9:30am on 5/9/13 it was observed that the 1st floor level pair of doors leading to the southeast glass enclosed stair through the 2-hour rated wall were provided with a center mullion which reduced the clear width of each door leaf	{K 040}		

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{K 040}	Continued From page 36 opening to less than 32". Surveyor: 16339 Based from observation exit access doors used by healthcare occupants are not meeting the 32" minimum door width requirements to comply with 19.2.3.5. These deficiencies could affect all patients in the Family Health Center by preventing occupants from immediately reaching an exit from the building because the minimum exit access door width is not met. Findings include: B. Afternoon of 05/08/13, Building - 01, First Floor - Family Health Center (FHC): During the survey walk-through and staff interview, it was determined that the FHC Suite is being used for outpatients and for ED patients. The surveyor observed egress doors to Examination Rooms to be 24" in width which are less than the minimum width requirements of 19.2.3.5.	{K 040}		
{K 042}	NFPA 101 LIFE SAFETY CODE STANDARD Any room or suite of rooms of more than 1,000 sq. ft. has at least 2 exit access doors remote from each other. 19.2.5.2 This STANDARD is not met as evidenced by: Surveyor: 20224 From random observation during the survey walk-through while accompanied by the Facilities Representative not all designated suites comply with 19.2.5 concerning the remotely located exit access doors. This condition may affect patients, staff and visitors during a fire emergency by	{K 042}		

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{K 042}	Continued From page 37	{K 042}		
	increasing the amount of time and travel distance required to reach an exit access corridor.			
	Findings include:			
	A. (Modified 11/01/13): 05/08/13 at 2:50 1st floor ICU was identified as a suite of approximately 4,500 square feet with two means of egress, which are both located on the West corridor wall, and do not comply with 19.2.5.2 and 7.5.1.4 for the minimum distance required (remoteness) between means of egress doors from this space.			
	B. 05/07/13 at 2:50 1st floor Surgery was identified as a suite of approximately 6,900 square feet with one means of egress from the sterile core which does not comply with 19.2.6.2.2 for a maximum travel distance of 200 feet from any point in a room to an exit. Due to the measured distance of 145 feet to an exit access door there is no exit within 55 feet of the exit access door for this room.			
{K.044}	NFPA 101 LIFE SAFETY CODE STANDARD	{K 044}		
	Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5			
	This STANDARD is not met as evidenced by: Surveyor: 16339 Based on random observation during the survey walk-through, not all designated or required horizontal exits or fire barriers are constructed or maintained as fire resistive assemblies. These deficiencies could affect all patients within the areas of the facility, as well as any staff and			

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{K 044}	Continued From page 38 visitors present, because failure to construct and maintain fire resistive assemblies could allow fire and smoke to pass from one compartment into adjacent fire/smoke compartments. Findings include: A. Pipe or other penetrations through designated 2 hour fire/smoke separation walls was observed that is not capped against the passage of fire as required by 8.2.3.2.4.2. Locations observed include: 1. On the morning of 05/08/13, Building - 01, First Floor : Abandoned or discontinued pneumatic tube station located in the exit access corridor outside the Cancer Center penetrates the designated 2-hour fire/smoke separation wall was observed that is un-capped or not fire sealed. 2. On the morning of 05/08/13, Building - 01, First Floor - Family Health Center (FHC): The 4-hour "Chicago Vestibule" near the Welcoming Center/Registration Center was observed with a conduit penetration that is not fire sealed to comply with 8.2.3.2.4.2. 3. On the afternoon of 05/08/13, Building - 01, First Floor - Radiology Unit: Conduit penetrations located in the 4- hour Chicago Vestibule near the CT Scanner 2 Room were observed that are not fire sealed. B. Doors in two hour fire barriers and designated 4 hour Chicago Vestibule are not constructed in accordance with 7.2.4. Locations include: 1. On the afternoon of 05/08/13, Building -01,	{K 044}		

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{K 044}	Continued From page 39 First Floor - Designated two (2) hour fire separation wall was observed with a door that does not carry a 1 1/2 hour fire rating to comply with 8.2.3.2.3.1(1). This is the door to the Director's Office Room 1-338. 2. On the afternoon of 05/08/13, Building - 01, First Floor - Pair of doors to identified 4-hour Chicago Vestibule near the Family Health Center (FHC) west corridor were observed to be broken.	{K 044}		
{K 045}	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Surveyor: 20224 Based on random observation during the survey walk through while accompanied by the facility representative, light switches within the exit enclosure provided a manual means to discontinue illumination within a means of egress which does not comply with 7.8.1.2. This condition may prevent staff and visitors, within the exit stair, from a safe passage to an exit discharge A. 05/7/13, at 1:50 pm and 05/8/13 at 10:45 am, Numerous exit stairs contain light switches at each floor landing. It could not be verified that the minimum continuous illumination level is being provided to comply with 7.8.1.3. The	{K 045}		

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{K 045}	Continued From page 40 flipping of the switch turned off lights within the following example exit stairs: 1. Stair #3 2. Stair #4 11/01/13: The PoC for the above item does not include specific interim measures for the above items until the items are corrected.	{K 045}		
{K 046}	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Surveyor: 20224 Based on random observation during the survey walk-through while accompanied by engineering staff, battery powered emergency illumination is not provided in accordance with NFPA 101-2000, 19.2.9.1, 7.9 and NFPA 99-1999, 3-3.2.1.2. This deficiency could affect any patients, staff, or visitors on this floor level because the failure of the normal lighting could prevent them from safely exiting the building under fire conditions. Findings include: A. 05/08/13 2:45 pm 3rd floor Delivery rooms (C-Section) were observed to not be provided with battery powered emergency lighting to comply with NFPA 99-1999, 3-3.2.1.2(a)5(e). 11/01/13: According to the provider's information there may be 14 locations with this same deficiency. A 6/15/2015 correction date is	{K 046}		

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{K 046}	Continued From page 41	{K 046}		
	proposed. What specific interim life safety measures for location are proposed until correction?			
{K 047}	NFPA 101 LIFE SAFETY CODE STANDARD	{K 047}		
	Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1			
	This STANDARD is not met as evidenced by: Surveyor: 13755 Based on observation during the survey walk-through, exit signs were not provided, were not fully visible, or incorrectly identified paths of egress in accordance with 19.2.10.1. and 7.10. These deficiencies could affect all patients within the areas of the facility, as well as any staff and visitors present, by preventing those occupants from readily identifying the path to an available exit from the building.			
	Findings include:			
	A. Exit signs are not provided to identify the 2nd means of egress from corridors to comply with 19.2.5.9. Locations noted include the following:			
	1. It was observed at 2:30pm on 5/6/13 that the corridors north and south of the center meeting room at the Penthouse level lack exit signage on the corridor side of four doors to define the egress path to the other stair serving the floor level.			

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{K 047}	Continued From page 42 2. It was observed at 2:30pm on 5/7/13 that the 4th floor Paint Shop elevator lobby area lacked exit signage to define the available path of egress. 3. It was observed at 10:30am on 5/8/13 that the 4th floor corridors on each side of the smoke barrier doors near 411 lacked exit signage to identify the egress paths to a second exit. 4. It was observed at 10:45am on 5/8/13 that the 4th floor rooftop court utilized by patients is not provided with exit signage to identify the required egress paths. 5. It was observed at 10:45am on 5/8/13 that the 4th floor corridor outside the locked Behavioral Health unit lacks exit signage to identify access to two available exits. The doors at the secured unit are only operable by staff with a key in accordance with 19.2.2.2.4, Exception No. 1. However, occupants outside the locked unit who do not have keys are not capable of utilizing the doors. Exit signage is not provided to identify two available egress paths from the non-secured side of the Behavioral Health unit. The two sets of cross corridor doors at the corridors leading to the west are marked as egress paths only from the west side and are equipped with dead bolt locks operated with thumbturns from the west side and key from the east side. These doors can be locked to prevent egress from the east side. These doors swing against egress travel from the west side and are not identified as existing smoke barrier/horizontal exit doors as permitted by 7.2.1.4.2 Exception No. 1 or 2. 6. It was observed at 11:00am on 5/8/13 that the	{K 047}		

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{K 047}	Continued From page 43 exit signage at the 2nd floor cafeteria cashier area is not directional to make clear the path to the Stairs and may inadvertently direct occupants into the serving line room. 7. It was observed at 1:30pm on 5/8/13 that the corridors north and south of the 1st floor Emergency Dept. lack exit signage to identify two compliant available paths of egress when cross corridor doors close. 8. It was observed at 1:35pm on 5/8/13 that the corridors outside the 1st floor G.I. Procedure room lack exit signage to identify two compliant available paths of egress when cross corridor doors close. 9. It was observed at 1:40pm on 5/8/13 that the corridor outside the Blood Bank on the 1st floor lacks exit signage to identify two compliant available paths of egress when cross corridor doors close. 10. It was observed at 2:00pm on 5/8/13 that the corridor west of the 1st floor Cashier suite lacks exit signage to identify two compliant available paths of egress when cross corridor doors close. 11. It was observed at 2:15pm on 5/8/13 that the Main Lobby lacks exit signage to identify a 2nd path of exit. 12. It was observed at 2:45pm on 5/8/13 that the corridor west of the Ear Nose & Throat Center lacks exit signage to identify two compliant available paths of egress when cross corridor doors close. 11/01/13: A 6/30/2015 correction date is	{K 047}		

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{K 047}	Continued From page 44 proposed. What specfic interim life safety measures for location are proposed until correction? B. Exit signs are inappropriately placed to define available exit paths. Locations observed include the following: 1. It was observed at 11:00am on 5/7/13 that the 8th floor Eye Clinic file room door to the workroom is provided with an exit sign but the door is equipped with locking hardware that prevents egress through the door the exit sign identifies. Surveyor notes that another marked exit door from the room is provided that does not prevent egress. 2. It was observed at 2:50pm on 5/8/13 that the Cath Lab 1 passage has exit signage which directs an exit path through a swinging door which is also equipped with a rolling shutter at the 4-hour barrier wall. The shutter did not close upon testing of the smoke detection provided at the opening to maintain the 4-hour barrier. The shutter is not a compliant means of egress component in accordance with 7.2. 3. It was observed at 10:15am on 5/9/13 that the Basement Mezzanine level (identified as an Exit Passageway) is provided with exit signage at the entrance to the Stair #5 exit stair. The door at this level swings against the direction of egress travel identified by the exit signage in noncompliance with 7.2.1.4.3. The 1st floor level of Stair #5 is marked within the stair with exit signage to identify the 1st floor as the level of exit discharge but the swing of the door at this level does not swing in the direction of egress travel to comply with 7.2.1.4.3. An interrupter gate is not	{K 047}		

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{K 047}	Continued From page 45 provided at a discharge level to comply with 7.7.3 to prevent travel beyond the discharge level. The exit signage and the door swings did not match to determine which level was the intended discharge level. 4. It was observed at 10:30am on 5/9/13 that directional exit signage provided at the west end of the Basement Mezzanine level exit passageway directs the exit path to both Stair #7 and Stair #8. Stair #8 serves as an exit for the Basement level and discharges to the Basement Mezzanine level exit passageway which leads to Stair #7. Stair #8 is not an exit for the Basement Mezzanine level exit passageway. 5. It was observed at 11:30am on 5/9/13 that directional exit signage provided at the west end door of the Basement level material management storage area directs the exit path north and south prior to proceeding through the door which leads to the corridor leading to exit Stair #8. The directional exit sign at this location is not appropriate. 11/01/13: A 6/30/2015 correction date is proposed. What specfic interim life safety measures for location are proposed until correction? Surveyor: 16339 Based on random observation during the survey walk-through on 05/08/13, exit signs did not identify available paths of egress in all cases in accordance with 19.2.5.9, 19.2.10.1. and 7.10. These deficiencies could affect all patients in the smoke compartment, as well as any staff and visitors present, by preventing those occupants from reaching an exit from the smoke compartment or building.	{K 047}		

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{K 047}	Continued From page 46	{K 047}		
	Findings include:			
	C. On the afternoon of 05/08/13, Building - 01, 9th Floor - Med/Surg Unit: The exit access corridor by the Central Nurse Station lacks an exit signage to direct occupants to the nearest exit.			
	D. On the afternoon of 05/07/13, Building - 01, Fifth Floor-Rehabilitation Floor: The east exit access corridor near Room 512 was not provided with fully visible exit signage from all points in the corridor.			
	E. On the morning of 05/08/13, Building -01, Second Floor - Auditorium Building: One of the exit signs in the Auditorium was observed to not be continuously lit as required by 7.10.5.2.			
	11/01/13: A 6/30/2015 correction date is proposed. What specfic interim life safety measures for location are proposed until correction?			
{K 048}	NFPA 101 LIFE SAFETY CODE STANDARD	{K 048}		
	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1			
	This STANDARD is not met as evidenced by: Surveyor: 16339 Based on document review, the facility's written plan for the protection of patients and visitors is not updated as required by 19.7.1.1. Failure to provide a specific information for exiting could result in a delayed response in a fire emergency.			

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{K 048}	Continued From page 47	{K 048}		
	Findings include:			
	A. Corrected 11/01/13			
	B. At 3:00pm on 5/8/13 it was observed that the Evacuation plan(s) posted in the Cath Lab area did not accurately depict the floor plan that existed. A review of the accuracy of the posted Evacuation plans throughout the building may be required due to renovation projects undertaken since the posting of the plans.			
	C. (New 11/01/13): At the time of this survey, the provider lacked the means to track and identify those items which have been confirmed by hospital personnel to be corrected.			
{K 050}	NFPA 101 LIFE SAFETY CODE STANDARD	{K 050}		
	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2			
	This STANDARD is not met as evidenced by: Surveyor: 13755			
	Based on record review it was determined that the facility may not conduct fire drills at unexpected times under varying conditions, at			

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{K 050}	Continued From page 48 least quarterly on each shift to familiarize facility personnel (nurses, interns, maintainance engineers, and adminsitrative staff) with the signals and emergency action as required. Findings include: A. Corrected 11/01/13 B. Corrected 11/01/13 Surveyor: 20224 Based on document review and staff interview with facility engineering staff, fire drills are not held at varying times and varying conditions in accordance with 19.7.1.2. These deficiencies could affect any patients, staff, or visitors in the facility because the staff may not be properly prepared to respond under emergency circumstances. Findings include: C. 05/08/13 at 9:10 am Based on document review, fire drills are not conducted at varying times to comply with 19.7.1.2. During the calendar year 2012, fire drills for the following quarters/shifts were conducted at the similar times and at the end of the month as listed: 1. First Shift: a. 03/29/13 10:00am: b. 09/27/13 10:00am. c. 12/21/12 10:00am 2. Second Shift: a. 03/28/13 4:00pm. b. 09/27/12 4:00pm	{K 050}		

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{K 050}	Continued From page 49 3. Third Shift a. 9/28/12 5:30am b. 12/21/12 5:30am D. 11/01/13: The PoC has no correction date proposed and the provider did not institute immediate corrections. 1. Fire dill report forms are filled out for multiple locations where the observers are located during each fire drill; however, the specific location of each observer is not clearly identified at each individual form. The provider has multiple sheets for a 9-9-13 fire drill which all indicate the same thing without any deviation where the reports wee intended to document the response on different floors or in different zones. 2. The fire alarm system has been replaced and it has a new automatic voice annunciation system. The provider's fire drill report forms do not included whether personnel can hear the voice announcement in the area observed and does not include the voice announcement (location announced automatically) for each drill. 3. A fire drill for the 3rd shift was conducted on 09/09/13 at 5:00 AM. The provider was previously cited for not varying the times the fire drills are conducted. This has not been corrected to comply with 19.7.1.2. Only one floor was observed and documented for this drill. 4. A fire drill for the 2nd shift was conducted on 09/12/13 at 4:00 PM. The provider was previously cited for not varying the times the fire drills are conducted. This has not been corrected to comply with 19.7.1.2.	{K 050}		

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{K 055}	Continued From page 50	{K 055}		
{K 055}	NFPA 101 LIFE SAFETY CODE STANDARD	{K 055}		
	Every patient sleeping room has an outside window or outside door, except for newborn nurseries and rooms intended for occupancy for less than 24 hours. 19.3.8			
	This STANDARD is not met as evidenced by: Surveyor: 20224			
	Based on random observation during the survey walk-through while accompanied by facility staff, patient sleeping rooms do not have visual access to the outside to comply with 19.3.8. These deficiencies could affect all patients within the area of the facility, as well as any staff and visitors present, by allowing those occupants to be trapped in a smokey fire incident.			
	The finding is:			
	A. 05/08/13 at 2:55 pm, 1st floor ICU patient rooms located along an interior wall of the building, on the South side of the suite do not have an outside window.			
	11/01/13: The 1st Floor ICU is cited for multiple deficiencies, not limited to K018, K029, K038 and K055. The PoC includes a 7/31/14 correction date but does not include a phasing schedule which identifies:			
	1. The submittal date for construction documents for a project or multiple projects to correct the above			
	2. Start date for construction project(s),			

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{K 056}	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Surveyor: 13755 Based on observation during the survey walk-through, the facility failed to install and maintain automatic sprinkler protection in accordance with the requirements of NFPA 101-2000, 19.3.5, NFPA 13-1999, Chapter 5 and NFPA 25-1998, 2-2.1.1. Findings include: A. At 11:00am on 5/7/13 it was observed that the sprinkler protection provided at the 8th floor Mechanical room adjacent room 834-B was compromised by the lack of a ceiling and was open to the above ceiling space of adjacent areas. The room was not enclosed with 2-hour rated construction as indicated by the Life Safety Reference plans. The open ceiling can compromise the activation of the sprinkler	{K 056}		

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{K 056}	Continued From page 52 protection provided for the room. 11/01/13: The PoC proposes a project submittal and a 2/28/15 correction date but does not identify any priorities and does not indcate why the above item should not be corrected immediately Specific interim life safety measures for teh above item are not identifeid until completion. B. At 11:00am on 5/8/13 It was observed that the2nd floor Janitor closet adjacent Stair #4 230B contained an open ceiling access door which could not be secured in the closed position. The open ceiling can compromise the activation of the sprinkler protection provided for the room. 11/01/13: The PoC does not identify what temporary solutoins will be implemented and what Specific interim life safety measures for teh aboveneed to be implemented until completion. C. On the afternoon of 5/8/13 it was observed that sprinkler head escutcheons were observed to be missing at the following locations: 1. At a head located in the Emergency Dept. Soiled Holding 2. At a head in the employee entrance vestibule south of the Emergency Dept. 3. At a head at the P.T. storage room 1-902B. D. At 10:00am on 5/9/13 it was observed that the Basement level Soiled Laundry room sprinkler heads were covered with a heavy accumulation of lint and numerous ceiling access panels were left open. Both conditions can impair the activation of	{K 056}		

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{K 056}	Continued From page 53 sprinkler protection. 11/01/13: The PoC proposes a project submittal and a 2/28/15 correction date but does not identify any priorities and does not indcate why the above item should not be corrected immediately. The above item should be corrected as part of teh annual testing and maintenance inspectoins of teh sprinkler system in accordance with NFPA 25. E. At 10:20am on 5/9/13 it was observed that the Basement Mezzanine Ladies Washroom A-130 had a ceiling cutout which did not have an access door installed. The open ceiling can compromise the activation of the sprinkler protection provided for the room. 11/01/13: What temporary solutions are proposed? F. At 10:30am on 5/9/13 it was observed that Electric room A-125 located at the Basement Mezzanine level was not sprinkler protected. The room was not maintained separated by 2-hour rated construction to comply with NFPA 13-1999, 5-13.11 Exception because the door was not self-closing to a latched condition. G. At 10:45am on 5/9/13 it was observed that the Basement level OB/GYN training area was open to the above ceiling cavity at the old cobalt room sliding door head. The open head framing can compromise the activation of the sprinkler protection provided for the area. H. At [illegible]00am on 5/9/13 it was observed that Electric room A-355 located at the Basement Mezzanine level near the Engineering offices was	{K 056}		

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{K 056}	Continued From page 54 not sprinkler protected. The room was not maintained separated by 2-hour rated construction to comply with NFPA 13-1999, 5-13.11 Exception because the door assembly was not labeled as fire resistance rated. Surveyor: 14416 I. Based on direct observation, the facility failed to provide automatic sprinkler protection for the following areas. 1. Corrected 10/31/13 2. Electrical closet located within Room 1 109. This closet does not meet the exception of NFPA 13, 1999, 5-13.11 in that the enclosure appears to be of 2 hour rated construction however the door is not rated. 3. The electrical switchgear room B-302-B located in the basement does not meet the exception of NFPA 13, 1999, 5-13.11 in that the enclosure appears to be of 2 hour rated construction however the doors are held in the open position and do not close upon alarm activation 4. The emergency generators room is not provided with sprinkler protection. The exception of NFPA 13, 1999, 5-13.11 does not apply to this enclosure and the absence of sprinkler protection does not comply with NFPA 13, 1-6.1 & 5-1 5. The entry vestibule to the Day Surgery Department 6. The Outpatient entry vestibule 7. Electrical Closet 1-571 8. Corrected 11/01/13 J. Corrected 11/01/13 Surveyor: 20224 Based on random observation during the survey walk, while accompanied by facility staff, failure to install and maintain the sprinkler system could result in failure of the sprinkler system and	{K 056}		

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{K 056}	Continued From page 55 delayed response during a fire event, which could affect patients, staff and visitors. The installation does not comply with NFPA 13 1999. K. Corrected 11/01/13 L. The facility failed to provide fire suppression for the following area: 1. 05/07/13 at 1:30 pm, equipment alcove on the 11th floor (directly adjacent to Stair # 3) lacks sprinkler protection. The closest sprinkler head is located within the corridor and is more than 9 feet from the back wall of the alcove. This does not comply with NFPA 13, 5-5.5.1.	{K 056}		
{K 062}	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 16339 Based on random observation during the survey walk-through, not all portions of the facility's automatic sprinkler system are inspected, tested and maintained in accordance with NFPA 25. This condition can lead to a poorly maintained system which can fail during a fire emergency affecting all patients, staff and visitors. Findings include: A. Sprinkler heads missing escutcheons to	{K 062}		

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{K 062}	Continued From page 56 comply with NFPA 25 1998 2-2.1.1. Locations observed include: 1. Building - 01, Tenth Floor: Treatment Room 102A and the Janitor's Closet across Room 1015. 2. Building - 01, Fifth Floor: Room 517A Observation/ED. Case Management. 3. Building -01, First Floor: Pharmacy Office and Storage Room in the Pharmacy. 4. Building - 01, First Floor (Radiology Unit): Corridor near CT Scanner I. 5. Building - 01, First Floor (Radiology Unit): Room 1677. 6. Building - 01, First Floor IBCCP Room. 7. Building - 01, Basement - Engineering Office, Room B-117A. 8. Building - 01, First Floor - Designated 4-hour Chicago Vestibule near the CT Scanner 2. B. Sprinkler head has been painted to not comply with NFPA 25 1998 2-4.1.8. Location observed include: 1. Building - 01, First Floor - Entrance to Family Health Center (FHC) Lobby. C. Sprinkler heads were observed coated with dust to comply with NFPA 25 1998 2-2.1.1. Locations observed include: 1. Building - 01, First Floor - Flouroscopy	{K 062}		

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{K 062}	Continued From page 57	{K 062}		
	Room near IR Holding.			
{K 067}	NFPA 101 LIFE SAFETY CODE STANDARD	{K 067}		
	Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2			
	This STANDARD is not met as evidenced by: Surveyor: 13755 Ventilation systems are not maintained in accordance with applicable standards.			
	Findings include:			
	A. At 3:00pm on 5/7/13 it was observed that the 4th floor patient's personal laundry facility, room 439, contained residential laundry equipment which vented the dryer exhausts to a duct and filter assembly which appeared to lack periodic cleaning and maintenance to comply with CFR 482.41(a). The lint filter assembly was full with lint to the point it was difficult to remove to check. The filter location on the floor behind the dryers was lint covered. It was not clear that the vent ductwork was functional or otherwise not severely restricted due to lint accumulation.			
	11/01/13: The surveyor observed that no corrective actions have been implemented and that the area behind the dryers was coated with lint. The surveyor further observed that only one of two dryer exhausts had an in-line lint trap behind the dryer and that that lint trap was			

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{K 067}	Continued From page 58 clogged with lint build up. Based on these observations, the surveyor also expects to find the exhaust duct after the lint trap to be full of lint. On 11/01/13, the surveyor required that the dryers be taken out of service until the above item has been corrected. Surveyor: 14416 B. Mechanical room #248: The surveyor did not find the installation of fire dampers for the duct penetration to the floor below or to the floor above from this second floor mechanical room. Through staff interview it was determined that fire dampers and protections are not provided for the duct penetrations of supply and return/exhaust ventilation systems originating in this second floor mechanical space. (NFPA 90A, 1999, 3-3.2) C. On review of the fire and smoke damper inspection dated December 2008 there was no evidence to indicate deficiencies cited in that inspection have been corrected. The 4 year inspection has not been competed at this time. The facility indicated they would opt for the 6 year CMS Categorical Waiver for damper inspection and maintenance. However, correction of the 2008 deficiencies need to be completed. 11/01/13: The PoC does not indicate why any assessment is require from something which should have been completed in 2008. The PoC does not clearly indicate how a 2/28/2015 correction date of this item is necessary.	{K 067}		
{K 069}	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96	{K 069}		

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{K 069}	Continued From page 59	{K 069}		
	This STANDARD is not met as evidenced by: Surveyor: 13755 Based on observation during the survey walk-through, not all portions of the facilities commercial cooking equipment is installed and maintained in accordance with NFPA 96 1998. Findings include: A. Corrected 11/01/13 Surveyor: 14416 B. By direct observation the surveyor finds the grease filter assemblies under the kitchen hoods to have gaps and spaces that allow grease laden vapor to bypass the filters. 11/01/13: The surveyor observed that the filters in the Kitchen hood had significant gaps between the filters and at the end of the filter racks at all of the Kitchen hoods in the kitchen. This condition allows grease to by-pass the filters and constitutes and fire hazard. The provider failed to correct this in accordance with the last submitted PoC and failed to implement adequate interim measures to insure that the deficiency is not repeated. The above condition also applies to the grease filters in the hood above the cafeteria range where the filters are damaged and no longer grease tight.			
{K 071}	NFPA 101 LIFE SAFETY CODE STANDARD	{K 071}		
	Rubbish Chutes, Incinerators and Laundry Chutes:			

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{K 071}	Continued From page 60	{K 071}		
	(1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor is sealed by fire resistive construction to prevent further use or is provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes comply with section 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, is provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute discharges into a trash collection room used for no other purpose and protected in accordance with 8.4. (4) Existing flue-fed incinerators are sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This STANDARD is not met as evidenced by: Surveyor: 13755 Based on observation during the survey walk-through, not all portions of the building linen chute system are installed in accordance with NFPA 82-1999. Findings include; A. At 10:45am on 5/7/13 it was observed that the linen chute door on the 8th floor in room 805A was not positive latching to comply with 3-2.4.2. 11/01/13: The above chute door would not close			

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{K 071}	Continued From page 61	{K 071}		
	to a latched position.			
{K 077}	NFPA 101 LIFE SAFETY CODE STANDARD	{K 077}		
	Piped in medical gas systems comply with NFPA 99, Chapter 4.			
	This STANDARD is not met as evidenced by: Surveyor: 13755			
	Based on observation during the survey walk-through and staff interview, not all portions of the building piped medical gas system are installed in accordance with NFPA 99-1999.			
	Findings include;			
	A. Medical gas piping zone valves were observed to lack labeling to adequately identify the locations served by the valves to comply with NFPA 99-1999, 4-3.1.2.14(b). Locations observed include:			
	1. Corrected 10/31/13			
	2. At 9:30am on 5/8/13 it was observed that the 4th floor medical gas valves near Soiled 432A and Janitor 415A were not labeled to identify the area(s) served. Surveyor notes that the Behavioral Health patient rooms do have medical gas outlets.			
	3. At 1:15pm on 5/8/13 it was observed that the 1st floor medical gas valves located within the Emergency Dept. may not be accurately labeled to identify all outlets served. Labeling indicated "Peds 1-7 Treatment 8-13", but treatment rooms			

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{K 077}	Continued From page 62 14-25 existed and a shut-off valve was not located. 4. At 2:00pm on 5/8/13 it was observed that a zone valve on the 1st floor near the service elevators was marked as serving "1-180 to 1-480" but the rooms could not be located. 5. At 11:00am on 5/9/13 it was observed that two oxygen zone valves located at the Basement level OB/GYN training area (old cobalt room) were labeled as serving "all rooms" rather than identifying the specific room(s) each valve served. Surveyor: 14416 B. Based on direct observation, the facility failed to provide separation of medical gas zone control valves from outlets and inlets they serve. The valves serving Cardiac Cath Prep/Recovery are located within the same room as the outlets and inlets they serve. NFPA 99, 1999, 4-3.1.2.3 (d). 11/01/13: The above item is also related to the K078 citation. Correction of both items may require 3rd party testing per NFPA 99. Revise the PoC as needed. Surveyor: 20224 Based on random observation during the survey walk-through while accompanied by engineering staff, not all piped-in medical gas systems are installed and maintained in accordance with NFPA 99. Findings include: C. 05/07/13 at 3:10 pm Manual medical gas shutoff (zone) valves were observed that are not labeled as to the station outlets they serve, this	{K 077}		

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{K 077}	Continued From page 63 does not comply with NFPA 99 1999 Locations observed: 1. Third floor Delivery rooms. 2. Third floor LDR rooms 3. Third floor corridor leading to office adjacent to LDR #3.	{K 077}		
{K 078}	NFPA 101 LIFE SAFETY CODE STANDARD Anesthetizing locations are protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Shutoff valves are located outside each anesthetizing location and are arranged so that shutting off one room or location will not affect others. (b) Relative humidity is maintained equal to or greater than 35%. NFPA 99 4.3.1.2.3(n) and 5.4.1.1, 19.3.2.3 This STANDARD is not met as evidenced by: Surveyor: 14416 Anesthetizing locations are not protected in accordance with NFPA 99-1999. This deficiency may result in discontinuation of medical gas services for patients outside the room of fire incident origin. A. Based on direct observation, the facility failed	{K 078}		

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{K 078}	Continued From page 64	{K 078}		
	to provide separate medical gas zone valves for Cath Lab #2. The same valves that serves the Cardiac Cath Prep/Recovery also serves Cath Lab 2 In non-compliance with NFPA 99, 1999, 4-3.1.2.3 (n).			
{K 106}	NFPA 101 LIFE SAFETY CODE STANDARD	{K 106}		
	Hospitals, and nursing homes and hospices with life support equipment, have a Type I Essential Electrical System powered by a generator with a transfer switch and separate power supply. The EES is in accordance with NFPA 99, 3.4.2.2, 3.4.2.1.4.			
	This STANDARD is not met as evidenced by: Surveyor: 17659			
	Based on random observation during the survey walk-through while accompanied by a member of the engineering staff the surveyor found that the generator equipment does not meet all requirements of NFPA-110.			
	Findings include:			
	A. The five emergency generators did not have remote shut down switches to comply with NFPA-110, Section 3-5.5.6. This could affect emergency personnel in the event of a fire in the generator room.			
	11/01/13: A 9/30/14 correction date is proposed; what specific interim life safety measures will be implemented to mitigate this condition until it is			

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{K 106}	Continued From page 65 corrected?	{K 106}		
{K 130}	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Surveyor: 13755 A. Due to the number, variety, and severity of the life safety deficiencies observed during the survey walk-through, the provider shall institute appropriate interim life safety measures until all cited deficiencies are corrected. The provider shall include, as an attachment to its Plan of Correction (PoC) and referenced therein, a detailed narrative and proposed schedule for all such measures. The narrative shall describe all measures to be implemented, as well as the frequency with which they are to be conducted, and shall indicate the manner in which the measures are to be documented. The narrative shall also include comments related to changes in the interim life safety measures to remain in place as work toward the completion of its PoC progresses. 11/01/13: Adequate interim life safety measures were not implemented. See each K-tag; a response is required where cited under each K-tag.	{K 130}		
{K 145}	NFPA 101 LIFE SAFETY CODE STANDARD The Type I EES is divided into the critical branch, life safety branch and the emergency system in accordance with NFPA 99. 3.4.2.2.2.	{K 145}		

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{K 145}	Continued From page 66	{K 145}		
	This STANDARD is not met as evidenced by: Surveyor: 17659 Based on random observation during the survey walk-through while accompanied by a member of the building engineering staff, the surveyor found that the building emergency electrical system is not properly divided into Life Safety, Critical and Equipment branches in accordance with NFPA-99, and NFPA-70, Section 517. These deficiencies could affect all building occupants because emergency egress and the provision of services could be compromised by the loss of a single transfer switch. Findings include: A. Some of the critical panels were serving items other than those allowed on the critical power system. Critical panels11CLB, 7CLA, 4CLB, 4CLC, and 3CLD had circuits feeding the fire alarm panels, med gas alarm panels, and elevator cab lighting (these items should be served from the life safety panel). This does not meet the requirements of NFPA-70, Section 517-32 and 33. B. Critical panels PHCLA, PHCLB, BCLC (in loading dock area), and 2CLF are designated as critical panels, but they are serving mostly equipment and do not meet the requirements of NFPA-70, Section 517-33 and 517-34.			
{K 147}	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9 1.2	{K 147}		

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{K 147}	Continued From page 67	{K 147}		
	This STANDARD is not met as evidenced by: Surveyor: 13755 Based on observation during the survey walk-through, not all portions of the building electrical system is in accordance with NFPA 70-1999. Noncompliance can result in electrical shock hazard. Findings include: A. Corrected 11/01/13 B. At 1:40pm on 5/7/13 open junction boxes without covers were observed at the 6th floor Janitor closet 615A in noncompliance with NFPA 70-1999, 370-25. 11/01/13: The proposed correction date for teh above item is not reasonable; it can be corrected in ten to twenty minutes. C. Corrected 11/01/13 D. Corrected 11/01/13 E. At 10:45am on 5/8/13 open junction boxes without covers were observed at the 2nd floor Kitchen at the west end of the large hood pedestal wall in noncompliance with NFPA 70-1999, 370-25. 11/01/13: The proposed correction date for teh above item is not reasonable; it can be corrected in ten to twenty minutes. F. At 10:00am on 5/9/13 an open junction box			

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{K 147}	Continued From page 68 without cover was observed above the ceiling at the 1st floor near the discharge of Stair #4. 11/01/13: The proposed correction date for teh above item is not reasonable; it can be corrected in ten to twenty minutes. Surveyor: 17659 Based on random observation during the survey walk-through while accompanied by a member of the building engineering staff, the surveyor found that not all portions of the building systems are installed in accordance with NFPA 70 (1999). Findings include: G. Normal power receptacles were not provided in the first floor endoscopy room, cystoscopy room, and in pediatrics rooms 629 and 630, treatment rooms in same day surgery as required by NFPA-70, Section 517-19, and NFPA-99, Section 3-3.2.1.2(a)1. In the event of a transfer switch failure upon return to normal power, these rooms could be left with no power. H. Bonding of the piping for the medical gas system could not be located by staff as required by NFPA-70, Section 250-104(c). This could cause a potential difference between med gas piping and other grounded metal surfaces which would create a shock hazard for staff and patients. I. The operating rooms, and procedure rooms in same day surgery were not equipped with battery lights to comply with NFPA-99, Section 3-3.2.1.2(a)5e. During surgery battery lights provide lighting upon loss of power during the transition from normal to emergency power.	{K 147}		

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{K 147}	Continued From page 69 11/01/13: What specific interim life safety measures will be implemented to mitigate this condition until it is corrected? J. The water service was not grounded at the main water service entrance in accordance with NFPA-70, Section 250-50. This could create a shock hazard for all building occupants. K. Electrical panels 1LP-L01 in the ENT center, panel 2EM-3, and kitchen panel PK5 need blanks over empty circuit breaker spaces to comply with NFPA-70, Section 110-12(a). 11/01/13: The proposed correction date for teh above item is not reasonable; it can be corrected in ten to twenty minutes. Surveyor: 20224 Based on random observation during the survey walk-through, while accompanied by engineering staff, electrical wiring and equipment was not installed and maintained in accordance with NFPA 70 National Electric Code and NFPA 101, 9.1.2. This deficiency could result in exposure of occupants to electrical shock. Finding is: L. 05/06/13, 2:00 pm, 12th floor Electrical panel located in Communication closet 1219 A was observed with an open breaker space missing complete enclosure to comply with NFPA 70-1999, 384-[illegible] 11/01/13: The proposed correction date for the	{K 147}		

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{K 147}	Continued From page 70 above item is not reasonable; it can be corrected in ten to twenty minutes. M. 05/07/13 at 2:00 pm Through direct observation Normal power receptacles were not provided in the following locations to comply with NFPA-70, Section 517-19, and NFPA-99, Section 3-3.2.1.2(a)1: 1. 1st floor Operating rooms 2. 1st floor Stage I Recovery room 3. 3 rd floor Delivery rooms 4. 3 rd floor LDR rooms N. 05/07/13 at 2:00 pm Emergency power electrical receptacles are not labeled to identify the circuit and panel from which they are fed to comply with NFPA 70-1999, 517-19 a. This condition was observed throughout critical care areas of the facility. Example locations include: 1. 1st floor Operating rooms 2. 1st floor Stage I Recovery 3. 3rd floor Delivery rooms (C-Section) 4. 3rd floor LDR rooms	{K 147}		
K 160	NFPA 101 LIFE SAFETY CODE STANDARD All existing elevators, having a travel distance of 25 ft. or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2 This STANDARD is not met as evidenced by:	K 160		

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K 160	Continued From page 71 Surveyor: 07113 A) Based on personnel interview, including the CEO and the Director of Engineering, on 11/01/13, the provider indicates that eleven of eleven traction elevators in their facility do not comply with the automatic recall requirements to a primary floor and to an alternate floor in accordance with the requirements of ASME A17.1. The extent of this condition was not determine by the surveyor. The surveyor also did not attempt to determine whether this condition applies to multiple hydraulic elevators. A phasing schedule for the correction of each deficient elevator was not available. Surveyor: 17659 11/01/13 - moved from K161 Based on random observation during the survey walk-through while accompanied by a member of the building engineering staff, the surveyor found that portions of the elevator control system are not installed in accordance with ASME A17.1. Any elevator user could be put in a dangerous situation without the proper safety devices installed. Findings include: A. The surveyor did not find a single lockable disconnect or proper labeling for the emergency lighting, receptacle, and ventilation of each elevator as required by NFPA-70, Section 620-53. B. The surveyor did not find that the disconnect	K 160		

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MERCY HOSPITAL AND MEDICAL CENTER	2525 S MICHIGAN AVE CHICAGO, IL 60616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 160	Continued From page 72 for the emergency lighting and controls for each elevator was fed from the life safety panel in accordance with NFPA-70, Section 517-32(f). C. The surveyor observed that the hydraulic elevator machine rooms were equipped with sprinklers, but there was not a heat detector within 2' of each sprinkler head to initiate a shunt trip device to automatically disconnect the main power supply prior to the application of water in the machine room or shaft as required by ASME A17.1-102.2.c.3.	K 160		

4) Projects involving the replacement or modernization of a category of service or hospital shall meet or exceed the occupancy standards for the categories of service, as specified in 77 Ill. Adm. Code 1100.

Mercy Hospital and Medical Center maintains two Intensive Care Units, remote from each other. The General ICU is located on the first floor of the hospital, proximate to the Emergency Department and Surgery. This is the unit of 14 existing beds that is the subject of this proposed project. The 2nd unit is the Cardiac ICU, located on the 11th floor, consisting of 16 existing beds.

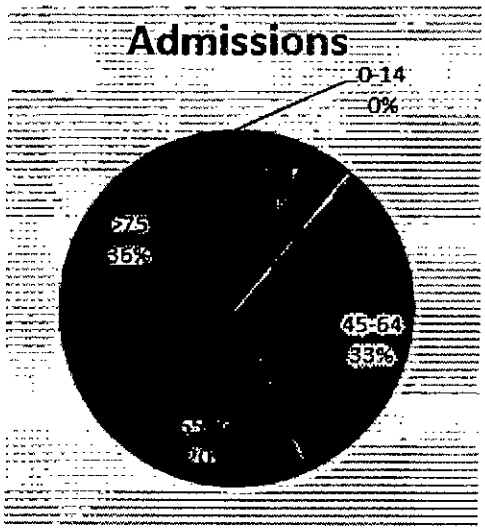
The data and experience confirms that a total of 30 authorized ICU beds is sufficient for the current and projected populations. However, the General and CICU beds are not interchangeable for patient care. The demand for beds and services for the General ICU has been overwhelming its capacity to the point whereby the unit is often full and cannot accept patients. When this occurs, patients have been deflected to the CVICU when treatment there may be appropriate. When General ICU beds are full, and the patient's treatment must be overseen by the General ICU Intensivists, patients have been boarded within the Emergency Department and PACU or recovery.

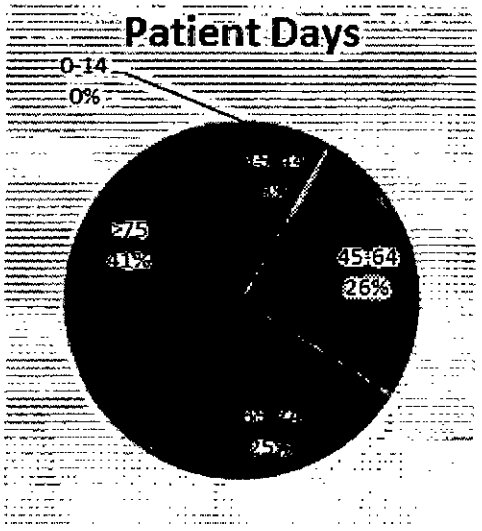
The data in the chart below indicates historical data, and projections to two years after project completion. Note that the General ICU's experienced occupancy has been exceptionally high -- consistently around 80%, or 20% higher than the Board's target occupancy rate of 60%. These numbers do not include the latent demand for General ICU beds by patients deflected or boarded elsewhere.

As a result of this proposed project, the projections reflect the redistribution of beds among the General and Cardiac ICUs. The overall patient days are projected to increase approximately 3% per year, reflected in both ICU services based upon:

- The modernization of the General ICU as well as this redistribution of beds will result in both ICU units operating more effectively;
- The latent demand for General ICU beds will be accommodated with those patient days appropriately being reflected in ICU; and
- The aging of the Hospital's service area population. The Hospital's ICU services are provided disproportionately to the service area population 65 and older. This segment of the population is significantly increasing.

A study commissioned by the Hospital in 2015 assessed the use of its critical care services. Among the findings were that patients aged 65 and older account for 57% of Admissions and 67% of all Patient Days for ICU services.





According to the Board's population data 2013 to 2018 (Inventory Of Health Care Facilities And Services And Need Determinations, 2015) the Hospital's planning area (A-03) population is decreasing. However, the age cohorts of 65 and older are increasing by 15% over this time period. As a percentage of overall population, the same groups are increasing from 8.8% to 10.6% of the overall population.

HISTORICAL AND PROJECTED ICU UTILIZATION

	CY 2013	CY 2014	CY 2015	CY 2016 YTD 10/31	CY 2016 Annualized	Projected	
						2020	2021
General ICU							
Beds	14	14	14	14	14	19	19
Patient Days[1]	4,253	4,088	4,170	3,555	4266	4500	4500
Occupancy	83%	80%	82%	79%	83%	65%	65%
CVICU							
Beds	16	16	16	16	16	11	11
Admissions							
Patient Days[1]	1,583	1,657	1569	1,220	1464	2070	2070
Occupancy	27%	28%	27%		25%	52%	52%
All ICU							
Beds	30	30	30	30	30	30	30
Admissions	1,373	1,390	2020				
Patient Days[1]	5,836	5,745	5739	4,775	5,730	6,570	6,570
Occupancy	53%	52%	52%		52%	60%	60%

Note1: ICU Patient Days include direct admissions and transfers.

g) Performance Requirements – Bed Capacity Minimum

The Intensive Care Unit exceeds the minimum size of 4 beds.

A. Criterion 1110.730 - Acute Mental Illness and Chronic Mental Illness

1. Applicants proposing to establish, expand and/or modernize Acute Mental Illness and Chronic Mental Illness category of service must submit the following information:

2. Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds
☒ Acute Mental Illness	39	29
☐ **Chronic Mental Illness**		

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

APPLICABLE REVIEW CRITERIA		Establish	Expand	Modernize
1110.730(b)(1) -	Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.730(b)(2) -	Planning Area Need - Service to Planning Area Residents	X	X	
1110.730(b)(3) -	Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.730(b)(4) -	Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.730(b)(5) -	Planning Area Need - Service Accessibility	X		
1110.730(c)(1) -	Unnecessary Duplication of Services	X		
1110.730(c)(2) -	Maldistribution	X		
1110.730(c)(3) -	Impact of Project on Other Area Providers	X		
1110.730(d)(1) -	Deteriorated Facilities			X
1110.730(d)(2) -	Documentation			X
1110.730(d)(3) -	Documentation Related to Cited Problems			X
1110.730(d)(4) -	Occupancy			X
1110.730(e(1)) -	Staffing Availability	X	X	
1110.730(f) -	Performance Requirements	X	X	X
1110.730(g) -	Assurances	X	X	X

APPEND DOCUMENTATION AS ATTACHMENT-22, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Section 1110.730 Acute Mental Illness – Review Criteria

From Rules:

Category of Service Modernization	(b)(1) & (3)	– Background of the Applicant
	(e)(1)	– Deteriorated Facilities
	(d)(2) & (3)	– Documentation
	(e)(4)	– Occupancy
	(g)	– Performance Requirements

(b)(1) & (3) Background of the Applicant

See Attachment 11

(e)(1) – Deteriorated Facilities

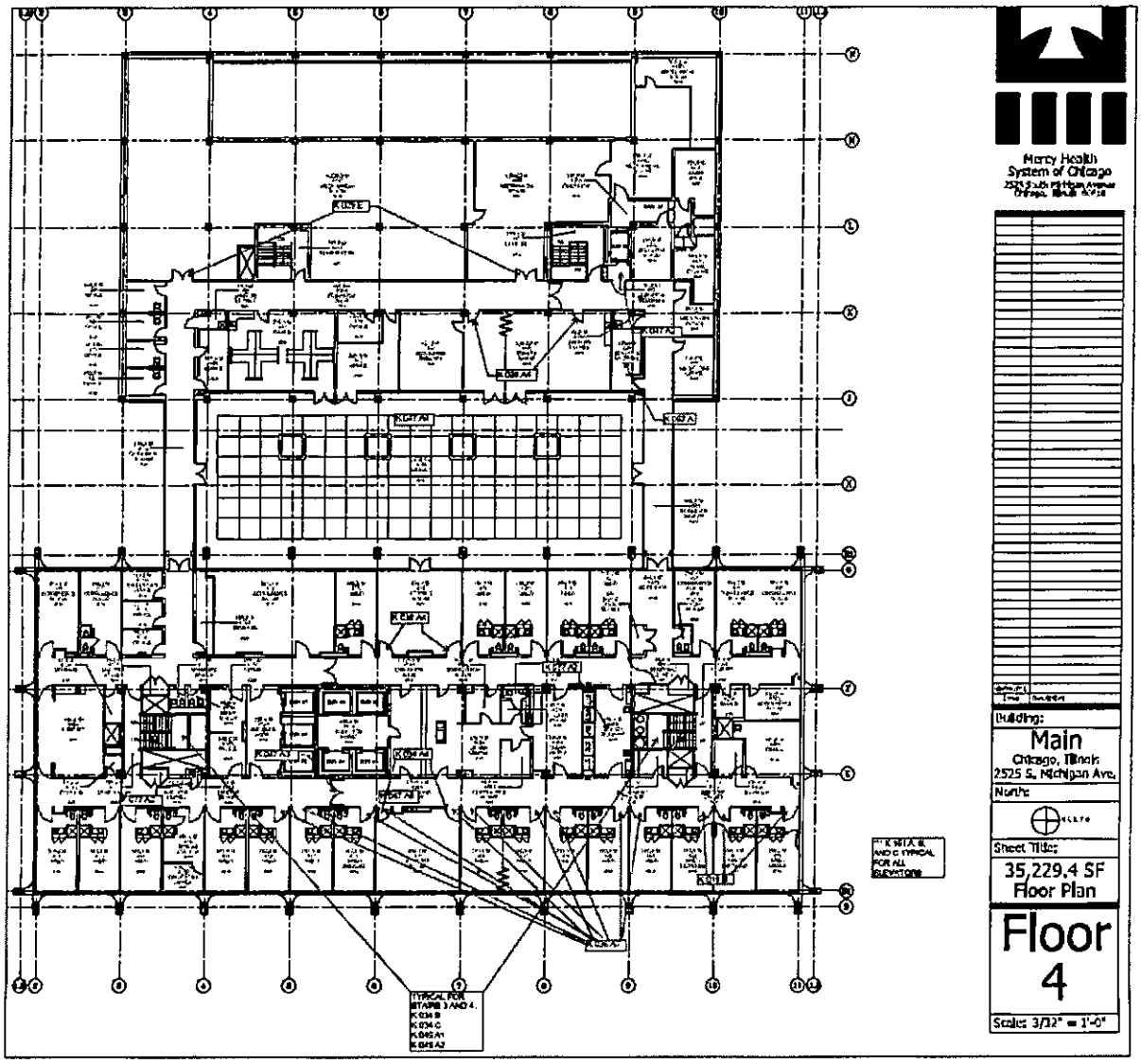
The existing Behavioral Health unit is original construction in the 1960's bed tower. As is, the unit has significant deterioration of infrastructure. Basic systems serving the inpatient bed unit have exceeded their useful life expectancy. Among these are:

- Plumbing
- Electrical
- Safety

Additionally, as an inpatient unit of 50 years old, the physical facility does not meet basic criteria of a contemporary service. Among these deficiencies to be corrected, include:

- Seclusion Room
- Interview
- Intake Room
- Activity Spaces

Existing Behavioral Health Unit indicating IDPH/CMS K-Tags, or building compliance citations.



For IDPH/CMS Inspection report, see Attachment 20.

(e)(4) - Occupancy

Our projected occupancy is based upon fundamental changes that have occurred in our program recently to reverse significant issues and operational setbacks the past few years.

In evaluating future bed capacity needs for the inpatient behavioral health program of Mercy Hospital several relevant factors should be considered.

A new management company has been in place for one year overseeing the management of behavioral health services. The onboarding of this management company came at a time of significant transition for the program.

- The University of Chicago residency program, which included attending psychiatrists and residents along with a significant patient flow from it's hospital had terminated its affiliation and left the program.
- A newly employed psychiatrist left shortly after arriving in search of an alternative position.
- An attending psychiatrist affiliated with the program was out on medical leave and did not return.

During the first year of operation these limiting factors significantly impacted the growth of the program. Since that time a new Medical Director, several APNs and a full time attending psychiatrist are now treating patients in the facility. This new stability in attending staff will allow for program growth and increased census.

In addition to psychiatrist capacity the census has been limited in 2016 by the availability of nursing staff to maintain the unit. Through a consistent titration of staffing upward, the program is better able to grow the census capacity while maintaining proper safety.

Despite the turnover in medical staff and nursing the program has seen a 50 percent increase in admissions on a year-over-year basis from 82 in October of 2015 to 123 in October 2016. This significant increase provides evidence of the demand for behavioral health services in the area.

As Trinity continues to build a regional market with other facilities such as Loyola and Gottlieb Memorial, Mercy is the only facility offering Behavioral Health Services. Through ongoing discussions Mercy will become the identified location for transfer of patients needing behavioral health services.

As the availability of health insurance and Medicaid expands more patients are arriving at the facility with coverage and/or leaving with presumptive eligibility for government programs. As the number of insured continues to increase their ability to access needed behavioral health programs will also grow.

While the past year at Mercy Hospital has been one of great change, the inpatient behavioral unit is poised for significant growth in 2017 and beyond. This growth will require the availability of inpatient behavioral health capacity.

As admissions and treatment is seasonal, the following is our projected census:

Mercy Behavioral Health

Projected Inpatient Average Daily Census Budget

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2017	17	18	19	19	20	21	22	22	23	23	23	23
2018	24	24	24	24	24	24	24	24	25	25	25	25
2019	25	26	26	26	26	25	25	25	26	26	26	25
2020	25	26	26	26	26	25	25	25	26	26	26	25
2021	25	26	26	26	26	25	25	25	26	26	26	25
2022	25	26	26	26	26	25	25	25	26	26	26	25

Historic and Projected utilization is shown below. Note that the data reflect the historic issues and projected program improvements noted in the narrative.

	CY 2013	CY 2014	CY 2015	CY 2016 YTD	CY 2016 Annualized	Projected		
						2020	2021	2022
Behavioral Health								
Beds	39	39	39	39	39	29	29	29
Patient Days	5,652	6,707	5,093	2,177	5,225	8,468	8,997	9,080
ADC	15	18	14		14	24	25	25
Occupancy	40%	47%	36%		37%	83%	85%	86%

(g) – Performance Requirements

This project is compliant with the performance requirements of Section 1110.730 g), that the

"1) The minimum unit size for a new AMI unit within an MSA is 20"

Trinity Health

Consolidated Financial Statements as of and for the Years Ended June 30, 2016 and 2015, Supplemental Consolidating Schedules as of and for the Year Ended June 30, 2016, and Independent Auditors' Reports

TRINITY HEALTH

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INDEPENDENT AUDITORS' REPORT

To the Board of Directors of
Trinity Health Corporation
Livonia, Michigan

We have audited the accompanying consolidated financial statements of Trinity Health Corporation and its subsidiaries (the "Corporation"), which comprise the consolidated balance sheets as of June 30, 2016 and 2015, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended, and the related notes to consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We did not audit the consolidated financial statements of Baycare Health System, the Corporation's investment which is accounted for by the use of the equity method. The accompanying consolidated financial statements of the Corporation include its investment in the net assets of Baycare Health System of $2.1 billion and $1.9 billion as of June 30, 2016, and 2015, respectively, and its equity-method income from Baycare Health System of $145.0 million and $168.1 million for the years ended June 30, 2016 and 2015, respectively. The consolidated financial statements of Baycare Health System for the years ended December 31, 2015 and 2014, were audited by other auditors whose reports have been furnished to us, and our opinion, insofar as it relates to the amounts included for Baycare Health System, is based on the reports of the other auditors and the procedures that we considered necessary in the circumstances with respect to the inclusion of the Corporation's equity investment and equity-method income in the accompanying consolidated financial statements taking into consideration the differences in fiscal years. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Corporation's preparation

and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Corporation's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, based on our audits and the reports of the other auditors, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Corporation as of June 30, 2016 and 2015, and the results of its operations and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Deloitte & Touche LLP

September 21, 2016

TRINITY HEALTH

CONSOLIDATED BALANCE SHEETS
JUNE 30, 2016 AND 2015
(In thousands)

ASSETS	2016	2015
CURRENT ASSETS:		
Cash and cash equivalents	$ 1,044,683	$ 843,210
Investments	3,617,501	3,728,883
Security lending collateral	262,035	266,572
Assets limited or restricted as to use - current portion	314,706	271,567
Patient accounts receivable, net of allowance for doubtful accounts of $385.2 million and $349.6 million at June 30, 2016 and 2015, respectively	1,849,736	1,631,417
Estimated receivables from third-party payors	248,179	192,894
Other receivables	336,705	299,667
Inventories	248,092	222,976
Assets held for sale	64,272	189,660
Prepaid expenses and other current assets	212,008	179,966
Total current assets	8,197,917	7,826,812
ASSETS LIMITED OR RESTRICTED AS TO USE - noncurrent portion:		
Held by trustees under bond indenture agreements	4,881	1,622
Self-insurance, benefit plans and other	780,102	738,846
By Board	2,959,641	3,098,445
By donors	409,493	298,332
Total assets limited or restricted as to use - noncurrent portion	4,154,117	4,137,245
PROPERTY AND EQUIPMENT - Net	7,676,734	6,773,283
INVESTMENTS IN UNCONSOLIDATED AFFILIATES	2,681,778	2,370,799
GOODWILL	304,845	293,696
OTHER ASSETS	363,480	373,484
TOTAL ASSETS	$ 23,378,871	$ 21,775,319

LIABILITIES AND NET ASSETS	2016	2015
CURRENT LIABILITIES:		
Commercial paper	$ 145,958	$ 99,990
Short-term borrowings	1,067,730	1,098,710
Current portion of long-term debt	106,345	106,226
Accounts payable	987,225	759,187
Accrued expenses	374,213	249,718
Salaries, wages and related liabilities	861,757	714,599
Current portion of self-insurance reserves	255,552	215,011
Payable under security lending agreements	262,035	266,572
Liabilities held for sale	67,455	256,088
Estimated payables to third-party payors	374,014	372,076
Total current liabilities	4,502,282	4,138,177
LONG-TERM DEBT - Net of current portion	5,132,377	4,382,456
SELF-INSURANCE RESERVES - Net of current portion	933,362	878,588
ACCRUED PENSION AND RETIREE HEALTH COSTS	1,857,639	971,153
OTHER LONG-TERM LIABILITIES	705,998	609,039
Total liabilities	13,131,658	10,979,413
NET ASSETS:		
Unrestricted net assets	9,576,379	10,274,277
Noncontrolling ownership interest in subsidiaries	186,595	150,994
Total unrestricted net assets	9,762,974	10,425,271
Temporarily restricted net assets	326,651	275,666
Permanently restricted net assets	157,588	94,969
Total net assets	10,247,213	10,795,906
TOTAL LIABILITIES AND NET ASSETS	$ 23,378,871	$ 21,775,319

The accompanying notes are an integral part of the consolidated financial statements.

TRINITY HEALTH

CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
YEARS ENDED JUNE 30, 2016 AND 2015
(In thousands)

	2016	2015
UNRESTRICTED REVENUE:		
Patient service revenue, net of contractual and other allowances	$ 14,718,528	$ 12,843,346
Provision for bad debts	(459,558)	(358,820)
Net patient service revenue less provision for bad debts	14,228,970	12,484,526
Premium and capitation revenue	869,030	790,948
Net assets released from restrictions	36,352	24,476
Other revenue	1,204,695	1,038,200
Total unrestricted revenue	16,339,047	14,338,150
EXPENSES:		
Salaries and wages	7,056,453	6,093,539
Employee benefits	1,457,253	1,211,902
Contract labor	205,916	117,471
Total labor expenses	8,719,622	7,422,912
Supplies	2,676,637	2,293,317
Purchased services	1,889,460	1,601,894
Depreciation and amortization	835,213	740,321
Occupancy	698,198	592,182
Medical claims	414,648	362,848
Interest	195,829	163,060
Other	758,103	691,576
Total expenses	16,187,710	13,868,110
OPERATING INCOME BEFORE OTHER ITEMS	151,337	470,040
Premium revenue adjustment	(65,335)	-
Asset impairment charges	(39,623)	(23,402)
Pension curtailment gain	-	11,054
OPERATING INCOME	46,379	457,692
NONOPERATING ITEMS:		
Investment (losses) earnings	(199,326)	106,553
Equity in earnings of unconsolidated affiliates	162,075	182,907
Change in market value and cash payments of interest rate swaps	(94,785)	(10,223)
Loss from early extinguishment of debt	(43,056)	(96,924)
Gain on controlling interest related to acquisition of Siouxland Surgery Center, LLP ("Siouxland")	-	40,317
Inherent contributions related to acquisitions	133,355	-
Inherent contributions related to acquisitions - unconsolidated organizations	87,170	-
Other, including income taxes	(2,011)	(8,692)
Total nonoperating items	43,424	213,938
EXCESS OF REVENUE OVER EXPENSES	89,803	671,630
EXCESS OF REVENUE OVER EXPENSES ATTRIBUTABLE TO NONCONTROLLING INTEREST	(48,460)	(34,836)
EXCESS OF REVENUE OVER EXPENSES, net of noncontrolling interest	$ 41,343	$ 636,794

	2016	2015
UNRESTRICTED NET ASSETS:		
Unrestricted net asset attributable to Trinity Health:		
Excess of revenue over expenses	$ 41,343	$ 636,794
Net assets released from restrictions for capital acquisitions	28,031	49,080
Net change in retirement plan related items - consolidated organizations	(838,812)	(440,493)
Net change in retirement plan related items - unconsolidated organizations	8,544	(40,463)
Other	12,396	(256)
(Decrease) increase in unrestricted net assets before discontinued operations	(748,498)	204,662
Discontinued operations:		
Loss from operations	(56,165)	(47,638)
Gain (loss) on disposals and settlement of debt	106,765	(7,750)
(Decrease) increase in unrestricted net assets attributable to Trinity Health	(697,898)	149,274
Unrestricted net asset attributable to noncontrolling interests:		
Excess of revenue over expenses attributable to noncontrolling interests	48,460	34,836
Noncontrolling interest related to acquisitions	29,272	99,008
Dividends	(42,133)	(21,048)
Other	(45)	(135)
Increase in unrestricted net assets attributable to noncontrolling interest before discontinued operations	35,554	112,661
Discontinued operations attributable to noncontrolling interests:		
Income from operations	47	243
Increase in unrestricted net assets attributable to noncontrolling interest	35,601	112,904
TEMPORARILY RESTRICTED NET ASSETS:		
Contributions	84,422	60,249
Net investment (loss) gain	(9,165)	2,072
Net assets released from restrictions	(64,383)	(73,556)
Acquisitions	38,669	-
Other	1,442	(6,405)
Increase (decrease) in temporarily restricted net assets	50,985	(17,640)
PERMANENTLY RESTRICTED NET ASSETS:		
Contributions for endowment funds	3,763	3,215
Net investment gain	1,361	1,665
Acquisitions	56,411	-
Other	1,084	3,026
Increase in permanently restricted net assets	62,619	7,906
(DECREASE) INCREASE IN NET ASSETS	(548,693)	252,444
NET ASSETS - BEGINNING OF YEAR	10,795,906	10,543,462
NET ASSETS - END OF YEAR	$ 10,247,213	$ 10,795,906

The accompanying notes are an integral part of the consolidated financial statements.

TRINITY HEALTH

CONSOLIDATED STATEMENTS OF CASH FLOWS
YEARS ENDED JUNE 30, 2016 AND 2015
(In thousands)

	2016	2015
OPERATING ACTIVITIES:		
(Decrease) increase in net assets	$ (548,693)	$ 252,444
Adjustments to reconcile (decrease) increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	835,213	740,321
Provision for bad debts	489,558	358,820
Asset impairment charges	39,623	23,402
Inherent contributions in acquisitions	(133,355)	-
Inherent contributions in acquisitions - unconsolidated organizations	(87,170)	-
Gain on acquisition of a controlling interest in Siouxland	-	(40,317)
Loss on extinguishment of debt	43,056	96,924
Change in net unrealized and realized gains on investments	267,459	(65,367)
Change in market values of interest rate swaps	72,950	(6,838)
Undistributed equity in earnings of unconsolidated affiliates	(184,225)	(154,177)
Deferred retirement items - consolidated organizations	838,812	440,493
Deferred retirement items - unconsolidated organizations	(8,544)	40,463
Noncash items including net (gains) losses on disposal - discontinued operations	(88,595)	50,546
Increase in noncontrolling interest related to acquisitions	(29,272)	(99,003)
Restricted contributions and investment income received	(22,148)	(29,372)
Restricted net assets acquired	(95,030)	-
Other adjustments	(3,282)	3,371
Changes in:		
Patient accounts receivable	(525,800)	(510,294)
Other assets	2,450	(116,596)
Accounts payable and accrued expenses	199,364	83,043
Estimated receivables from third-party payors	(46,375)	(37,367)
Estimated payables to third-party payors	10,809	48,530
Self-insurance reserves and other liabilities	(5,107)	14,894
Accrued pension and retiree health costs	(159,797)	(189,317)
Net cash provided by (used) in operating activities of discontinued operations	15,142	(21,121)
Total adjustments	1,425,666	631,033
Net cash provided by operating activities	876,973	883,477

	2016	2015
INVESTING ACTIVITIES:		
Purchases of investments	(3,373,316)	(15,035,339)
Proceeds from sales of investments	3,471,276	14,397,910
Purchases of property and equipment	(977,362)	(920,597)
Proceeds from disposal of property and equipment	19,784	4,607
Net cash acquired from (used in) acquisitions	100,807	(17,585)
Proceeds from the sale of divestitures	37,487	51,692
Change in investments in unconsolidated affiliates	(9,659)	5,261
Loans made to affiliates, net of repayments	(34,100)	-
Decrease in assets limited as to use	6,766	9,109
Net cash provided by (used in) investing activities of discontinued operations	1,311	(537)
Net cash used in investing activities	(757,006)	(1,505,477)
FINANCING ACTIVITIES:		
Proceeds from issuance of debt	982,400	1,504,384
Repayments of debt	(924,445)	(819,672)
Net change in commercial paper	45,968	(139,971)
Increase in financing costs and other	(45,136)	(3,085)
Proceeds from restricted contributions and restricted investment income	22,148	29,372
Net cash provided by (used in) financing activities of discontinued operations	571	(4,097)
Net cash provided by financing activities	81,506	564,931
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	201,473	(57,069)
CASH AND CASH EQUIVALENTS - BEGINNING OF YEAR	843,210	900,279
CASH AND CASH EQUIVALENTS - END OF YEAR	$ 1,044,683	$ 843,210
SUPPLEMENTAL DISCLOSURES OF CASH FLOW INFORMATION:		
Cash paid for interest (net of amounts capitalized)	$ 198,809	$ 165,586
New capital lease obligations for buildings and equipment	4,459	6,093
Accruals for purchases of property and equipment and other long-term assets	157,984	112,593
Unsettled investment trades, purchases	135,619	71,745
Unsettled investment trades, sales	74,631	76,676
(Increase) in security lending collateral	(4,537)	(78,689)
Increase in payable under security lending agreements	4,537	78,689

The accompanying notes are an integral part of the consolidated financial statements.

1. ORGANIZATION AND MISSION

Trinity Health Corporation and its subsidiaries ("Trinity Health" or the "Corporation"), an Indiana nonprofit corporation headquartered in Livonia, Michigan, controls one of the largest health care systems in the United States. It is the result of the consolidation of Catholic health systems over the last 16 years.

The Corporation is sponsored by Catholic Health Ministries, a Public Juridic Person of the Holy Roman Catholic Church. The Corporation operates a comprehensive integrated network of health services, including inpatient and outpatient services, physician services, managed care coverage, home health care, long-term care, assisted living care, and rehabilitation services located in 21 states. The operations are organized into Regional Health Ministries, National Health Ministries, and Mission Health Ministries ("Health Ministries"). The mission statement for the Corporation is as follows:

We, Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

Community Benefit Ministry – Consistent with its mission, the Corporation provides medical care to all patients regardless of their ability to pay. In addition, the Corporation provides services intended to benefit the poor and underserved, including those persons who cannot afford health insurance or other payments such as co-pays and deductibles because of inadequate resources and/or are uninsured or underinsured, and to improve the health status of the communities in which it operates. The following summary has been prepared in accordance with the Catholic Health Association of the United States', *A Guide for Planning and Reporting Community Benefit*, 2015 Edition.

The quantifiable costs of the Corporation's community benefit ministry for the years ended June 30 are as follows (in thousands):

	2016	2015
Ministry for the poor and underserved:		
Charity care at cost	$ 187,310	$ 190,723
Unpaid cost of Medicaid and other public programs	446,393	380,673
Programs for the poor and the underserved:		
Community health services	30,200	27,596
Subsidized health services	47,948	48,767
Financial contributions	16,493	12,409
Community building activities	1,480	1,886
Community benefit operations	4,380	2,827
Total programs for the poor and underserved	100,501	93,485
Ministry for the poor and underserved	734,204	664,881
Ministry for the broader community:		
Community health services	15,396	12,928
Health professions education	132,845	101,048
Subsidized health services	46,398	42,040
Research	3,321	3,672
Financial contributions	29,404	29,403
Community building activities	1,764	1,615
Community benefit operations	3,983	3,199
Ministry for the broader community	233,111	193,905
Community benefit ministry	$ 967,315	$ 858,786

The Corporation provides a significant amount of uncompensated care to its uninsured and underinsured patients, which is reported as bad debt at cost and not included in the amounts reported above. During the years ended June 30, 2016 and 2015, the Corporation reported bad debt at cost (determined using a cost-to-charge ratio applied to the provision for bad debts) of $157.2 million and $116.4 million, respectively.

Ministry for the poor and underserved represents the financial commitment to seek out and serve those who need help the most, especially the poor, the uninsured and the indigent. This is done with the conviction that health care is a basic human right.

Ministry for the broader community represents the cost of services provided for the general benefit of the communities in which the Corporation operates. Many programs are targeted toward populations that may be poor, but also include those areas that may need special health services and support. These programs are not intended to be financially self-supporting.

Charity care at cost represents the cost of services provided to patients who cannot afford health care services due to inadequate resources and/or are uninsured or underinsured. A patient is classified as a charity patient in accordance with the Corporation's established policies as further described in Note 4. The cost of charity care is calculated using a cost-to-charge ratio methodology.

Unpaid cost of Medicaid and other public programs represents the cost (determined using a cost-to-charge ratio) of providing services to beneficiaries of public programs, including state Medicaid and indigent care programs, in excess of governmental and managed care contract payments.

Community health services are activities and services carried out to improve community health and well-being, for which no patient bill exists. These services are not expected to be financially self-supporting. Some examples include community health education, free immunization services, free or low-cost

prescription medications, and rural and urban outreach programs. The Corporation actively collaborates with community groups and agencies to assist those in need in providing such services.

Health professions education includes the unreimbursed cost of training health professionals, such as medical residents, nursing students, technicians, and students in allied health professions.

Subsidized health services are net costs for billed services that are subsidized by the Corporation. These include services offered despite a financial loss because they are needed in the community and either other providers are unwilling to provide the services or the services would otherwise not be available in sufficient amount. Examples of services include free-standing community clinics, hospice care, mobile units and behavioral health services.

Research includes unreimbursed clinical and community health research and studies on health care delivery, which is generalizable and shared with the public.

Financial contributions are made by the Corporation on behalf of the poor and underserved to community agencies and restricted to support community benefit activities. These amounts include special system-wide funds used to improve community health and well-being as well as resources contributed directly to programs, organizations, and foundations for efforts on behalf of the poor and underserved. Amounts included here also represent certain in-kind donations.

Community building activities include programs that address the root causes of health problems and focus on policy, systems and environmental changes. Examples include the costs of programs that improve the physical environment, promote economic development, enhance other community support systems, advocacy for community health improvement, develop leadership skills training, and build community coalitions.

Community benefit operations include costs associated with dedicated staff, community health needs and/or asset assessments, and other costs associated with community benefit strategy and operations.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Principles of Consolidation – The consolidated financial statements include the accounts of the Corporation, and all wholly owned, majority-owned, and controlled organizations. Investments where the Corporation holds less than 20% of the ownership interest are accounted for using the cost method. All other investments that are not controlled by the Corporation are accounted for using the equity method of accounting. The equity share of income or losses from investments in unconsolidated affiliates is recorded in other revenue if the unconsolidated affiliate is operational and projected to make routine and regular cash distributions; otherwise, the equity share of income or losses from investments in unconsolidated affiliates is recorded in nonoperating items in the consolidated statements of operations and changes in net assets. All material intercompany transactions and account balances have been eliminated in consolidation.

The consolidated financial statements for the years ended June 30, 2016 and 2015, present the operations of Mercy Suburban Hospital and East Norriton Physician Services ("Mercy Suburban"), St. Joseph Mercy Port Huron ("Port Huron"), and Saint Michael's Medical Center ("St. Michael's") as discontinued operations. Saint James Mercy Hospital ("SMJH"), Hornell, New York, and Mercy Health Partners, North ("North"), located in Cadillac, Michigan, and Grayling, Michigan were divested in fiscal year 2015 and the operations of these entities are reflected as discontinued operations for the fiscal year ended June 30, 2015. The consolidated statements of cash flows include impacts of cash flows related to these entities. Notes to these consolidated financial statements exclude these entities.

Use of Estimates – The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America ("GAAP") requires management of the Corporation to make assumptions, estimates, and judgments that affect the amounts reported in the consolidated financial statements, including the notes thereto, and related disclosures of commitments and contingencies, if any. The Corporation considers critical accounting policies to be those that require more

significant judgments and estimates in the preparation of its consolidated financial statements, including the following: recognition of net patient service revenue, which includes contractual allowances, provisions for bad debts and charity care; premium revenue; recorded values of investments, derivatives, and goodwill; reserves for losses and expenses related to health care professional and general liabilities; and risks and assumptions for measurement of pension and retiree medical liabilities. Management relies on historical experience and other assumptions believed to be reasonable in making its judgments and estimates. Actual results could differ materially from those estimates.

Cash and Cash Equivalents – For purposes of the consolidated statements of cash flows, cash and cash equivalents include certain investments in highly liquid debt instruments with original maturities of three months or less.

Investments – Investments, inclusive of assets limited or restricted as to use, include marketable debt and equity securities. Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value and are classified as trading securities. Investments also include investments in commingled funds, hedge funds and other investments structured as limited liability corporations or partnerships. Commingled funds and hedge funds that hold securities directly are stated at the fair value of the underlying securities, as determined by the administrator, based on readily determinable market values or based on net asset value, which is calculated using the most recent fund financial statements. Limited liability corporations and partnerships are accounted for under the equity method.

Investment Earnings – Investment earnings include interest, dividends, realized gains and losses, unrealized gains and losses, and equity earnings. Investment earnings on assets held by trustees under bond indenture agreements, assets designated by the Corporation's board of directors (the "Board") for debt redemption, assets held for borrowings under the intercompany loan program, assets held by grant-making foundations, and assets deposited in trust funds by a captive insurance company for self-insurance purposes in accordance with industry practices are included in other revenue in the consolidated statements of operations and changes in net assets. Investment earnings from all other investments and Board-designated funds are included in nonoperating investment income, unless the income or loss is restricted by donor or law.

Derivative Financial Instruments – The Corporation periodically utilizes various financial instruments (e.g., options and swaps) to hedge interest rates, equity downside risk and other exposures. The Corporation's policies prohibit trading in derivative financial instruments on a speculative basis. The Corporation recognizes all derivative instruments in the consolidated balance sheets at fair value.

Securities Lending – The Corporation participates in securities lending transactions whereby a portion of its investments are loaned, through its agent, to various parties in return for cash and securities from the parties as collateral for the securities loaned. Each business day, the Corporation, through its agent, and the borrower determine the market value of the collateral and the borrowed securities. If on any business day the market value of the collateral is less than the required value, additional collateral is obtained as appropriate. The amount of cash collateral received under securities lending is reported as an asset and a corresponding payable in the consolidated balance sheets and is up to 105% of the market value of securities loaned. As of June 30, 2016 and 2015, the Corporation had securities loaned of $272.6 million and $280.1 million, respectively, and received collateral (cash and noncash) totaling $277.7 million and $286.4 million, respectively, relating to the securities loaned. The fees received for these transactions are recorded in investment income in the consolidated statements of operations and changes in net assets. In addition, certain pension plans participate in securities lending programs with the Northern Trust Company, the plans' agent.

Assets Limited as to Use – Assets set aside by the Board for future capital improvements, future funding of retirement programs and insurance claims, retirement of debt, held for borrowings under the intercompany loan program, and other purposes over which the Board retains control and may at its discretion subsequently use for other purposes, assets held by trustees under bond indenture and certain other agreements, and self-insurance trust and benefit plan arrangements are included in assets limited as to use.

Donor-Restricted Gifts – Unconditional promises to give cash and other assets to the Corporation are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions in the consolidated statements of operations and changes in net assets.

Inventories – Inventories are stated at the lower of cost or market. The cost of inventories is determined principally by the weighted-average cost method.

Assets and Liabilities Held for Sale – The Corporation has classified certain assets as assets held for sale in the consolidated balance sheets when the assets have met applicable criteria for this classification. The Corporation has also classified as held for sale those liabilities related to assets held for sale.

Property and Equipment – Property and equipment, including internal-use software, are recorded at cost, if purchased, or at fair value at the date of donation, if donated. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using either the straight-line or an accelerated method and includes capital lease and internal-use software amortization. The useful lives of these assets range from two to 50 years. Interest costs incurred during the period of construction of capital assets are capitalized as a component of the cost of acquiring those assets.

Gifts of long-lived assets, such as land, buildings, or equipment, are reported as unrestricted support and are excluded from the excess of revenue over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support.

Goodwill – Goodwill represents the future economic benefits arising from assets acquired in a business combination that are not individually identified and separately recognized.

Asset Impairments –

Property and Equipment – The Corporation evaluates long-lived assets for possible impairment whenever events or changes in circumstances indicate that the carrying amount of the asset, or related group of assets, may not be recoverable from estimated future undiscounted cash flows. If the estimated future undiscounted cash flows are less than the carrying value of the assets, the impairment recognized is calculated as the carrying value of the long-lived assets in excess of the fair value of the assets. The fair value of the assets is estimated based on appraisals, established market values of comparable assets or internal estimates of future net cash flows expected to result from the use and ultimate disposition of the assets.

Goodwill – Goodwill is tested for impairment on an annual basis or when an event or change in circumstance indicates the value of a reporting unit may have changed. Testing is conducted at the reporting unit level. If the carrying amount of the reporting unit goodwill exceeds the implied fair value of that goodwill, an impairment loss is recognized in an amount equal to that excess. Estimates of fair value are based on appraisals, established market prices for comparable assets or internal estimates of future net cash flows.

The following table provides information on changes in the carrying amount of goodwill, which is included in the accompanying consolidated financial statements of the Corporation as of June 30 (in thousands):

	2016	2015
As of July 1:		
Goodwill	$ 303,921	$ 161,651
Accumulated impairment loss	(10,225)	(7,878)
Total	293,696	153,773
Goodwill acquired during the year	11,149	142,270
Impairment loss	-	(2,347)
Total	$ 304,845	$ 293,696
As of June 30:		
Goodwill	$ 315,070	$ 303,921
Accumulated impairment loss	(10,225)	(10,225)
Total	$ 304,845	$ 293,696

Other Assets – Other assets includes long-term notes receivable, reinsurance recovery receivables, definite and indefinite-lived intangible assets other than goodwill, prepaid pension and retiree health costs. The net balances of definite-lived intangible assets include noncompete agreements, physician guarantees and other definite-lived intangible assets with finite lives amortized using the straight-line method over their estimated useful lives, which generally range from two to 10 years. Indefinite-lived intangible assets primarily include trade names.

Short-Term Borrowings – Short-term borrowings include puttable variable rate demand bonds supported by self-liquidity or liquidity facilities considered short-term in nature.

Other Long-Term Liabilities – Other long-term liabilities include deferred compensation, asset retirement obligations, interest rate swaps and deferred revenue from entrance fees. Deferred revenue from entrance fees are fees paid by residents of facilities for the elderly upon entering into continuing care contracts (net of the portion that is refundable to the resident), which are recorded as deferred revenue and amortized to income using the straight-line method over the estimated remaining life expectancy of the resident.

Temporarily and Permanently Restricted Net Assets – Temporarily restricted net assets are those whose use by the Corporation has been limited by donors to a specific time period or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Corporation in perpetuity.

Patient Accounts Receivable, Estimated Receivables from and Payables to Third-Party Payors and Net Patient Service Revenue – The Corporation has agreements with third-party payors that provide for payments to the Corporation's Health Ministries at amounts different from established rates. Patient accounts receivable and net patient service revenue are reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered. Estimated retroactive adjustments under reimbursement agreements with third-party payors and other changes in estimates are included in net patient service revenue and estimated receivables from and payables to third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods, as final settlements are determined. Estimated receivables from third-party payors include amounts receivable from Medicare and state Medicaid meaningful use programs.

Self-Insured Employee Health Benefits – The Corporation administers self-insured employee health benefit plans for employees. The majority of the Corporation's employees participate in the programs. The provisions of the plans permit employees and their dependents to elect to receive medical care at either the Corporation's Health Ministries or other health care providers. Gross patient service revenue has been reduced by an allowance for self-insured employee health benefits, which represents revenue attributable to medical services provided by the Corporation to its employees and dependents in such years.

Allowance for Doubtful Accounts – The Corporation recognizes a significant amount of patient service revenue at the time the services are rendered even though the Corporation does not assess the patient's ability to pay at that time. As a result, the provision for bad debts is presented as a deduction from patient service revenue (net of contractual provisions and discounts). For uninsured and underinsured patients that do not qualify for charity care, the Corporation establishes an allowance to reduce the carrying value of such receivables to their estimated net realizable value. This allowance is established based on the aging of accounts receivable and the historical collection experience by the Health Ministries and for each type of payor. A significant portion of the Corporation's provision for doubtful accounts relates to self-pay patients, as well as co-payments and deductibles owed to the Corporation by patients with insurance.

Premium and Capitation Revenue – The Corporation has certain Health Ministries that arrange for the delivery of health care services to enrollees through various contracts with providers and common provider entities. Enrollee contracts are negotiated on a yearly basis. Premiums are due monthly and are recognized as revenue during the period in which the Corporation is obligated to provide services to enrollees. Premiums received prior to the period of coverage are recorded as deferred revenue and included in accrued expenses in the consolidated balance sheets.

Certain of the Corporation's Health Ministries have entered into capitation arrangements whereby they accept the risk for the provision of certain health care services to health plan members. Under these agreements, the Corporation's Health Ministries are financially responsible for services provided to the health plan members by other institutional health care providers. Capitation revenue is recognized during the period for which the Health Ministry is obligated to provide services to health plan enrollees under capitation contracts. Capitation receivables are included in other receivables in the consolidated balance sheets.

Reserves for incurred but not reported claims have been established to cover the unpaid costs of health care services covered under the premium and capitation arrangements. The premium and capitation arrangement reserves are classified with accrued expenses in the consolidated balance sheets. The liability is estimated based on actuarial studies, historical reporting, and payment trends. Subsequent actual claim experience will differ from the estimated liability due to variances in estimated and actual utilization of health care services, the amount of charges, and other factors. As settlements are made and estimates are revised, the differences are reflected in current operations.

Income Taxes – The Corporation and substantially all of its subsidiaries have been recognized as tax-exempt pursuant to Section 501(a) of the Internal Revenue Code. The Corporation also has taxable subsidiaries, which are included in the consolidated financial statements. Certain of the taxable subsidiaries have entered into tax sharing agreements and file consolidated federal income tax returns with other corporate taxable subsidiaries. The Corporation includes penalties and interest, if any, with its provision for income taxes in other nonoperating items in the consolidated statements of operations and changes in net assets.

Excess of Revenue Over Expenses – The consolidated statements of operations and changes in net assets includes excess of revenue over expenses. Changes in unrestricted net assets, which are excluded from excess of revenue over expenses, consistent with industry practice, include the effective portion of the change in market value of derivatives that meet hedge accounting requirements, permanent transfers of assets to and from affiliates for other than goods and services, contributions of long-lived assets received or gifted (including assets acquired using contributions, which by donor restriction were to be used for the purposes of acquiring such assets), net change in retirement plan related items, discontinued operations, extraordinary items and cumulative effects of changes in accounting principles.

Adopted Accounting Pronouncements –

On June 30, 2016, the Corporation adopted Accounting Standards Update ("ASU") No. 2015-03, *"Simplifying the Presentation of Debt Issuance Costs."* This guidance requires debt issuance costs to be presented as a direct deduction from the related debt rather than as an asset. The adoption of this guidance resulted in a $32.6 million reduction to total assets and total liabilities as previously reported in the June 30, 2015 consolidated balance sheet as retrospective application is required. As of June 30, 2016, $34.8 million of debt issuance costs are included in long-term debt.

On July 1, 2015, the Corporation adopted ASU No. 2014-08, *"Reporting Discontinued Operations and Disclosures of Disposals of Components of an Entity."* This guidance amends the definition of a discontinued operation and requires additional disclosures about discontinued operations as well as disposal transactions that do not meet the discontinued operations criteria on a prospective basis. The adoption of this guidance had no impact on the Corporation's consolidated financial statements.

Forthcoming Accounting Pronouncements –

In August 2016, the Financial Accounting Standards Board ("FASB") issued ASU No. 2016-15, *"Classification of Certain Cash Receipts and Cash Payments."* This guidance adds or clarifies guidance on the classification of certain cash receipts and payments in the consolidated statements of cash flows. This guidance is effective for the Corporation beginning July 1, 2019. The Corporation is still evaluating the impact this guidance may have on its consolidated financial statements.

In August 2016, the FASB issued ASU No. 2016-14, *"Presentation of Financial Statements of Not-For-Profit Entities."* This guidance simplifies and improves how not-for-profit entities classify net assets as well as the information presented in financial statements and notes about liquidity, financial performance and cash flows. This guidance is effective for the Corporation beginning July 1, 2018. The Corporation is still evaluating the impact this guidance may have on its consolidated financial statements.

In May 2016, the FASB issued ASU No. 2016-12, *"Revenue From Contracts with Customers: Narrow-Scope Improvements and Practical Expedients,"* which amends certain aspects of the FASB's revenue standard ASU 2014-09, *"Revenue From Contracts with Customers"*. In March 2016, the FASB issued ASU No. 2016-08, *"Revenue From Contracts With Customers: Principal Versus Agent Considerations (Reporting Revenue Gross Versus Net)."* This guidance amends the principal versus agent implementation guidance and illustrations in the FASB's revenue standard, ASU No. 2014-09. In July 2015, the FASB issued ASU No. 2015-14, *"Revenue From Contracts With Customers (Topic 606): Deferral of the Effective Date,"* which defers the effective date of the FASB's revenue standard, ASU 2014-09, by one year for all entities and permits early adoption on a limited basis. In May 2014, the FASB issued ASU No. 2014-09. This guidance outlines a single comprehensive model for entities to use in accounting for revenue arising from contracts with customers. After the deferral of the effective date, this guidance is effective for the Corporation beginning July 1, 2018. The Corporation is still evaluating the impact this guidance may have on its consolidated financial statements.

In March 2016, the FASB issued ASU No. 2016-07, *"Investments – Equity Method and Joint Ventures: Simplifying the Transition to the Equity Method of Accounting."* This guidance eliminates the requirement to retrospectively apply the equity method to an investment that subsequently qualifies for such accounting as a result of an increase in the level of ownership interest or degree of influence. This guidance is effective for the Corporation beginning July 1, 2016. The Corporation does not expect this guidance to have a material impact on its consolidated financial statements.

In March 2016, the FASB issued ASU No. 2016-06, *"Derivatives & Hedging: Contingent Put & Call Options in Debt Instruments."* This guidance clarifies that in assessing whether an embedded contingent put or call option is clearly and closely related to the debt host, an entity is required to perform only the four-step sequence in Accounting Standards Codification 815-15-25-42. This guidance is effective for the Corporation beginning July 1, 2018. The Corporation is still evaluating the impact this guidance may have on its consolidated financial statements.

In February 2016, the FASB issued ASU No. 2016-02, *"Leases."* This guidance introduces a lessee model that brings substantially all leases on the consolidated balance sheet. This guidance is effective for the Corporation beginning July 1, 2019. Retrospective application is required. The Corporation is still evaluating the impact this guidance may have on its consolidated financial statements.

In January 2016, the FASB issued ASU No. 2016-01, *"Recognition and Measurement of Financial Assets and Financial Liabilities."* This guidance revises accounting related to (1) the classification and measurement of investments in equity securities and (2) the presentation of certain fair value changes for financial liabilities measured at fair value. It also amends certain disclosure requirements associated with the fair value of financial instruments. This guidance is effective for the Corporation beginning July 1, 2019. The Corporation is still evaluating the impact this guidance may have on its consolidated financial statements.

In September 2015, the FASB issued ASU No. 2015-16, *"Simplifying the Accounting for Measurement-Period Adjustments."* This guidance requires an acquirer in a business combination to recognize adjustments to provisional amounts that are identified during the measurement period in the reporting period in which the adjustment amounts are determined. The effect on earnings of changes in depreciation or amortization, or other income effects (if any) as a result of change to the provisional amounts, calculated as if the accounting had been completed as of the acquisition date, must be recorded in the reporting period in which the adjustment amounts are determined rather than retrospectively. Also, the acquirer must present separately on the face of the income statement, or disclose in the notes, the portion of the amount recorded in current-period earnings by line item that would have been recorded in previous reporting periods if the adjustment to the provisional amounts had been recognized as of the acquisition date. This guidance is effective for the Corporation beginning July 1, 2017. The Corporation does not expect this guidance to have a material impact on its consolidated financial statements.

In July 2015, the FASB issued ASU No. 2015-11, *"Simplifying the Measurement of Inventory."* This guidance requires entities to measure most inventories at the lower of cost or net realizable value. This guidance is effective for the Corporation beginning July 1, 2017. The Corporation does not expect this guidance to have a material impact on its consolidated financial statements.

In May 2015, the FASB issued ASU No. 2015-09, *"Disclosures About Short-Duration Contracts."* This guidance expands the disclosures that an insurance entity must provide about its short-duration insurance contracts. This guidance is effective for the Corporation beginning July 1, 2017. The Corporation does not expect this guidance to have a material impact on its consolidated financial statements.

In February 2015, the FASB issued ASU No. 2015-02, *"Amendments to the Consolidation Analysis."* This guidance significantly changes the consolidation analysis required under GAAP. This guidance is effective for the Corporation beginning July 1, 2017. The Corporation does not expect this guidance to have a material impact on its consolidated financial statements.

In August 2014, the FASB issued ASU No. 2014-15, *"Disclosure of Uncertainties About an Entity's Ability to Continue as a Going Concern,"* which provides guidance on determining when and how reporting entities must disclose going-concern uncertainties in their financial statements. This guidance is effective for the Corporation beginning July 1, 2017. The Corporation does not expect this guidance to have an impact on its consolidated financial statements.

3. INVESTMENTS IN UNCONSOLIDATED AFFILIATES, BUSINESS ACQUISITIONS, DIVESTITURES, AND DISCONTINUED OPERATIONS

Investments in Unconsolidated Affiliates – The Corporation and certain of its Health Ministries have investments in entities that are recorded under the cost and equity methods of accounting. As of June 30, 2016 and 2015, the Corporation maintained investments in unconsolidated affiliates with ownership interests ranging from 0.4% to 51% and 3% to 51%, respectively. The Corporation's share of equity earnings from entities accounted for under the equity method was $213.9 million and $179.8 million for the years ended June 30, 2016 and 2015, respectively, of which $51.8 million and $(3.1) million, respectively, is included in other revenue and $162.1 million and $182.9 million, respectively, is included in nonoperating items in the consolidated statements of operations and changes in net assets. The most significant of these investments include the following:

BayCare Health System – The Corporation has a 50.4% interest in BayCare Health System Inc. and Affiliates ("BayCare"), a Florida not-for-profit corporation exempt from state and federal income taxes. BayCare was formed in 1997 pursuant to a Joint Operating Agreement ("JOA") among the not-for-profit and tax-exempt members of the CHE BayCare Participants, Morton Plant Mease Health Care, Inc., and South Florida Baptist Hospital, Inc. (collectively, the "Members"). BayCare consists of three community health alliances located in the Tampa Bay area of Florida, including St. Joseph's-Baptist Healthcare Hospital, St. Anthony's Health Care, and Morton Plant Mease Health Care. The Corporation has the right to appoint nine of the 21 voting members of the board of directors of BayCare; therefore, the Corporation accounts for BayCare under the equity method of accounting. As of June 30, 2016 and 2015, the Corporation's investment in BayCare totaled $2,079 million and $1,934.2 million, respectively.

Gateway Health Plan – The Corporation has a 50% interest in Gateway Health Plan, L.P. and subsidiaries ("GHP"), a Pennsylvania limited partnership. GHP has two general partners, Highmark Ventures Inc., formerly known as Alliance Ventures, Inc., and Mercy Health Plan (a wholly owned subsidiary of the Corporation), each owning 1%. In addition to the general partners, there are two limited partners, Highmark Inc. and Mercy Health Plan, each owning 49%. As of June 30, 2016 and 2015, the Corporation's investment in GHP totaled $147.6 million and $135.7 million, respectively.

Catholic Health System, Inc. – The Corporation has a one-third interest in Catholic Health System, Inc. and subsidiaries ("CHS"). CHS, formed in 1998, is a not-for-profit integrated delivery health care system in western New York jointly sponsored by the Sisters of Mercy, Ascension Health System, the Franciscan Sisters of St. Joseph, and the Diocese of Buffalo. The Corporation, Ascension Health System, and the Diocese of Buffalo are the corporate members of CHS. CHS operates several organizations, the largest of which are four acute care hospitals located in Buffalo, New York: Mercy Hospital of Buffalo; Kenmore Mercy Hospital; Sisters of Charity Hospital; and St. Joseph Hospital. As of June 30, 2016 and 2015, the Corporation's investment in CHS totaled $73.3 million and $51.7 million, respectively.

Emory Healthcare/St. Joseph's Health System – The Corporation has a 49% interest in Emory Healthcare/St. Joseph's Health System ("EH/SJHS"). EH/SJHS operates several organizations, including two acute care hospitals, St. Joseph's Hospital of Atlanta and John's Creek Hospital. As of June 30, 2016 and 2015, the Corporation's investment in EH/SJHS totaled $82.3 million and $72.5 million, respectively.

Mercy Health Network – The Corporation has a 50% interest in Mercy Health Network ("MHN"), a nonstock basis membership corporation with Catholic Health Initiatives ("CHI") holding the remaining 50% interest. Effective March 1, 2016, the Corporation and CHI amended and restated their existing MHN joint operating agreement ("JOA") that governs certain of their legacy operations in Iowa to strengthen MHN's management responsibilities over the Iowa Operations, to jointly acquire health care operations in Iowa and contiguous markets, and to provide for greater financial, governance, and clinical integration. The JOA provides for the Corporation and CHI to maintain ownership of their respective assets in Iowa while agreeing to operate the Corporations Iowa hospitals in collaboration with CHI's Mercy Hospital Medical Center, Des Moines, Iowa, as one organization with common governance and

management. MHN has developed a regional health care network that provides for a collaborative effort in the areas of community health care development, enhanced access to health services for the poor and sharing of other common goals. Under the JOA, the Corporation and CHI equally share adjusted operating cash flow from Iowa operations commencing in July 2016.

On May 1, 2016, MHN became the sole member of Wheaton Franciscan Services, Inc. ("WFSI"). WFSI operates three hospitals in Iowa located in Waterloo (Covenant Medical Center), Cedar Falls (Sartori Memorial Hospital) and Oelwein (Mercy Hospital of Franciscan Sisters). WFSI will be consolidated into MHN's financial statements. As a result of this transaction, MHN recognized an inherent contribution in their consolidated statements of operations and changes in net assets, of which, the Corporation's share is $87.2 million. As of June 30, 2016, the Corporation's investment in MHN totaled $91.0 million.

Condensed consolidated balance sheets of BayCare, GHP, CHS, EH/SJHS and MHN as of June 30 are as follows (in thousands):

	2016				
	Baycare	GHP	CHS	EH/SJHS	MHN
Total assets	$ 6,378,411	$ 984,457	$ 1,105,078	$ 452,892	$ 240,151
Total liabilities	$ 2,068,541	$ 689,217	$ 884,839	$ 283,450	$ 53,768

	2015				
	Baycare	GHP	CHS	EH/SJHS	MHN
Total assets	$ 5,810,907	$ 832,004	$ 1,084,263	$ 448,082	$ 14,502
Total liabilities	$ 1,781,550	$ 560,609	$ 923,740	$ 292,955	$ 4,115

Condensed consolidated statements of operations of BayCare, GHP, CHS, EH/SJHS and MHN for the years ended June 30 are as follows (in thousands):

	2016				
	Baycare	GHP	CHS	EH/SJHS	MHN
Revenue, net	$ 3,236,962	$ 2,347,557	$ 1,076,954	$ 506,107	$ 71,664
Excess of revenue over expenses	$ 287,766	$ 32,497	$ 29,131	$ 18,846	$ 176,908

	2015				
	Baycare	GHP	CHS	EH/SJHS	MHN
Revenue, net	$ 2,898,550	$ 2,005,540	$ 977,555	$ 478,177	$ 14,726
Excess (deficiency) of revenue over expenses	$ 336,011	$ (76,960)	$ 30,833	$ 1,165	$ 28

The following amounts have been recognized in the accompanying consolidated statements of operations and changes in net assets related to the investments in BayCare, GHP, CHS, EH/SJHS and MHN for the years ended June 30 (in thousands):

	2016				
	Baycare	GHP	CHS	EH/SJHS	MHN
Other revenue	$ -	$ 16,695	$ -	$ -	$ 1,200
Equity in earnings of unconsolidated organizations	145,034	-	9,701	9,511	-
Inherent contribution	-	-	-	-	87,170
Other changes in unrestricted net assets	(391)	7,505	11,558	51	2,649
Total	$ 144,643	$ 24,200	$ 21,259	$ 9,562	$ 91,019

	2015				
	Baycare	GHP	CHS	EH/SJHS	MHN
Other revenue	$ -	$ (38,480)	$ -	$ -	$ -
Equity in earnings of unconsolidated organizations	172,361	-	9,635	377	-
Other changes in unrestricted net assets	(9,654)	(8,492)	(25,982)	36,130	-
Total	$ 162,707	$ (46,972)	$ (16,347)	$ 36,507	$ -

The unaudited summarized financial position and results of operations for the entities accounted for under the equity method excluding BayCare, GHP, CHS, EH/SJHS and MHN as of and for the years ended June 30 are as follows (in thousands):

	2016					
	Medical Office Buildings	Outpatient and Diagnostic Services	Ambulatory Surgery Centers	Physician Hospital Organizations	Other Investees	Total
Total assets	$ 87,351	$ 174,519	$ 60,695	$ 14,454	$ 521,628	$ 858,647
Total liabilities	$ 63,605	$ 78,936	$ 22,640	$ 12,482	$ 228,791	$ 406,454
Net assets	$ 23,746	$ 95,583	$ 38,055	$ 1,972	$ 292,838	$ 452,194
Revenue, net	$ 17,943	$ 246,410	$ 91,053	$ 20,938	$ 1,288,857	$ 1,665,201
Excess (deficiency) of revenue over expenses	$ 7,036	$ 24,449	$ 25,702	$ (1,987)	$ 7,015	$ 62,215

	2015					
	Medical Office Buildings	Outpatient and Diagnostic Services	Ambulatory Surgery Centers	Physician Hospital Organizations	Other Investees	Total
Total assets	$ 88,670	$ 145,832	$ 41,681	$ 33,589	$ 492,431	$ 802,203
Total liabilities	$ 68,634	$ 56,137	$ 22,633	$ 27,053	$ 234,938	$ 409,395
Net assets	$ 20,036	$ 89,694	$ 19,047	$ 6,537	$ 257,493	$ 392,807
Revenue, net	$ 17,956	$ 179,947	$ 77,285	$ 39,119	$ 1,149,781	$ 1,464,088
Excess (deficiency) of revenue over expenses	$ 4,120	$ 23,850	$ 21,480	$ (455)	$ 39,008	$ 88,003

Acquisitions:

Saint Francis Care ("SFC") – On October 1, 2015, the Corporation became the sole corporate member of SFC, a Connecticut non-stock corporation. On November 17, 2015, Saint Francis Care, Inc. changed its name to Trinity Health-New England, Inc. SFC is the sole member of Saint Francis Hospital and Medical Center ("SFHMC"), a Connecticut nonstock corporation that operates a hospital in Hartford, Connecticut, and is also the sole member of Mount Sinai Rehabilitation Hospital, a Connecticut nonstock corporation, that operates a rehabilitation facility. As a result, the Corporation recognized an inherent contribution of $70.9 million in the consolidated statements of operations and changes in net assets. The Corporation is still in the process of assessing the economic characteristics of certain assets acquired and liabilities assumed. The Corporation expects to substantially complete this assessment during the period ended September 30, 2016, and may adjust the amounts recorded as of October 1, 2015, to reflect revised evaluations. Summarized consolidated balance sheet information for SFC at October 1, 2015, is shown below (in thousands):

Cash, cash equivalents, and investments	$ 135,568	Current portion of long-term debt	$ 7,298
Patient accounts receivable, net	75,415	Accounts payable and accrued expenses	98,922
Other receivables	10,159	Other current liabilities	17,381
Inventories	9,701	Long-term debt	244,154
Other current assets	16,418	Accrued pension and retiree health costs	197,562
Property and equipment	411,067	Other long-term liabilities	106,717
Assets limited or restricted as to use -		Total liabilities acquired	672,034
noncurrent portion	145,992		
Other assets	18,069	Unrestricted net assets	70,996
Total assets acquired	$ 822,389	Temporarily restricted net assets	26,180
		Permanently restricted net assets	53,179
		Total net assets	$ 150,355

As part of the transaction, an investment of $275 million in capital has been committed over a five-year period by the Corporation. As disclosed in Note 6, the transaction included the extinguishment of bonds. In addition, as disclosed in Note 11, on October 1, 2015, the Corporation novated an interest rate swap from SFC that increased other long-term liabilities in the consolidated balance sheets by $44.0 million.

For the year ended June 30, 2016, SFC reported revenue of $727.9 million and excess of revenue over expenses of $2.4 million in the consolidated statements of operations. These amounts represent nine months of SFC activity since being acquired by the Corporation and are inclusive of six months of Johnson Memorial Medical Center, Inc. activity as noted below.

Johnson Memorial Medical Center, Inc. ("Johnson") – On January 1, 2016, SFC acquired the assets of Johnson, a non-profit, non-stock holding company located in Stafford Springs, Connecticut. Johnson, through its subsidiaries, provides health care services throughout the Hartford and Tolland Connecticut counties. For the six-month period ended June 30, 2016, Johnson reported revenue of $32.2 million and deficiency of revenue over expenses of $3.3 million in the consolidated statements of operations. As a result of the acquisition, the Corporation recognized an inherent contribution of $4.0 million in the consolidated statements of operations and changes in net assets. The Corporation is still in the process of assessing the economic characteristics of certain assets acquired and liabilities assumed. The Corporation expects to substantially complete this assessment during the period ending December 31, 2016, and may adjust the amounts recorded as of January 1, 2016, to reflect revised evaluations.

Summarized consolidated balance sheet information for Johnson at January 1, 2016, is shown below (in thousands):

Patient accounts receivable, net	$ 9,330	Current portion of long-term debt	$ 801
Other receivables	777	Accounts payable and accrued expenses	11,765
Inventories	1,577	Other current liabilities	2,682
Other current assets	1,585	Long-term debt	22,749
Property and equipment	25,908	Other long-term liabilities	141
Other assets	3,472	Total liabilities acquired	38,138
Total assets acquired	$ 42,649		
		Unrestricted net assets	3,971
		Temporarily restricted net assets	540
		Total net assets	$ 4,511

Saint Joseph's Hospital Health Center ("SJHHC") – On July 1, 2015, the Corporation became the sole corporate member of SJHHC, a regional health care system located in Syracuse, New York, as part of a member substitution. As a result, the Corporation recognized an inherent contribution of $58.3 million in the consolidated statement of operations and changes in net assets. Summarized consolidated balance sheet information for SJHHC at July 1, 2015, is shown below (in thousands):

Cash, cash equivalents, and investments	$ 104,827	Current portion of long-term debt	$ 20,723
Patient accounts receivable, net	98,584	Accounts payable and accrued expenses	113,513
Assets limited or restricted as to use, current portion	16,057	Long-term debt	321,459
		Accrued pension and retiree health costs	19,176
Other current assets	25,684	Other long-term liabilities	40,074
Property and equipment	316,294	Total liabilities acquired	514,945
Assets limited or restricted as to use, noncurrent portion	34,759		
		Unrestricted net assets	60,460
Other assets	23,003	Unrestricted noncontrolling interest	28,623
Total assets acquired	$ 619,208	Total unrestricted net assets	89,083
		Temporarily restricted net assets	11,948
		Permanently restricted net assets	3,232
		Total net assets	$ 104,263

As part of the transaction, an investment of $60 million in capital has been committed over a four-year period by the Corporation. This amount may be increased to $90 million if certain operating thresholds are met. As disclosed in Note 6, the transaction included the extinguishment of bonds. For the year ended June 30, 2016, SJHHC reported revenue of $663.8 million and deficiency of revenue over expenses of $13.1 million in the consolidated statements of operations.

Consolidation of Siouxland Surgery Center, LLP ("Siouxland") – Effective July 1, 2014, a venture was created between Mercy Health Services – Iowa, Corp. ("Mercy") and USP Health Ventures, LLC ("USP") (collectively, "Mercy/USP"). Mercy owns a controlling interest of 55.71% and USP owns the remaining 44.29% interest of the venture. Mercy/USP then entered into a securities purchase agreement with SSC Physician Investors, LLC ("Physician Investors"), whereby Mercy contributed 30.9% of their preexisting ownership of Siouxland and USP contributed their newly acquired 24.6% ownership of Siouxland, resulting in Mercy/USP owning a controlling interest of 55.54% of Siouxland with the remaining 44.46% interest owned by Physician Investors. As a result of the transaction, Mercy reported a gain of $40.3 million on its preexisting ownership interest in nonoperating items in the consolidated statements of operations and changes in net assets in July 2014 and recognized goodwill of $136.3 million in the consolidated balance sheets. Siouxland operates a surgical specialty hospital and medical facility in Dakota Dunes, South Dakota.

Summarized consolidated opening balance sheet information for Mercy/USP is shown below and includes the acquisition of $13.2 million of long-term debt, including the current portion (in thousands):

Cash	$ 1,778	Current portion of long-term debt	$ 1,031
Patient accounts receivable	9,949	Accounts payable and accrued expenses	7,180
Other current assets	3,301	Salary, wages, and related liabilities	2,154
Property and equipment	24,313	Long-term debt, net of current portion	12,154
Goodwill	136,251	Total liabilities acquired	$ 22,519
Other assets	318		
Total assets acquired	$ 175,910	Unrestricted net assets	$ 54,383
		Unrestricted noncontrolling interest	99,008
		Total net assets	$ 153,391

The operating results for Siouxland for the years ended June 30, 2016 and 2015, include revenue of $82.0 million and $74.0 million and excess of revenue over expenses, prior to the adjustment for noncontrolling interest, of $36.8 million and $29.2 million, respectively.

Divestitures:

The consolidated financial statements for all periods present the operations of the following entities as discontinued operations as the transactions were in process prior to the adoption of ASU No. 2014-8 "*Reporting Discontinued Operations and Disclosures of Disposals of Components of an Entity*".

Saint Michael's Medical Center ("St. Michael's") – On August 10, 2015, St. Michael's and certain of its affiliates voluntarily filed for reorganization under Chapter 11 of the Bankruptcy Code. Pursuant to the provisions of the Bankruptcy Code, the transaction with Prime Healthcare Services ("Prime") was subject to an "auction sale" process. By order of November 12, 2015, the Bankruptcy Court approved Prime as the successful bidder for the hospital resulting in a first amended and restated asset purchase agreement between the parties. Effective May 1, 2016, the Corporation sold substantially all of the health care operations and assets of St. Michael's to Prime, a hospital system based in Ontario, California, and recorded a loss on disposal of $35.7 million in discontinued operations in the consolidated statements of operations and changes in net assets. The Corporation has provided a debtor-in-possession revolving loan facility to St. Michael's of up to $15 million with availability restricted to achievement of certain milestones in the bankruptcy process. St. Michael's continues to operate their remaining businesses as debtor in possession under the jurisdiction of the Court and in accordance with the applicable provisions of the Bankruptcy Code and orders of the Court. St. Michael's prepetition liabilities retained by the Corporation remain subject to settlement under the Bankruptcy Code.

As part of a court order to settle St. Michael's outstanding debt and accrued interest, the Corporation paid $55.8 million in July 2016 to settle $233.4 million of St. Michael's debt, resulting in a $177.6 million gain in discontinued operations in the consolidated statement of operations and changes in net assets.

Mercy Suburban Hospital and East Norriton Physician Services ("Mercy Suburban") – Effective February 1, 2016, the Corporation sold substantially all of the health care operations and assets of Mercy Suburban to Prime. The impact of the disposal recorded in discontinued operations in the consolidated statements of operations and changes in net assets at the effective date was immaterial to the Corporation. As disclosed in Note 6, the transaction resulted in the defeasance of bonds.

St. Joseph Mercy Port Huron ("Port Huron") – Effective September 1, 2015, the Corporation sold substantially all of the Corporation's health care operations located in Port Huron, Michigan, to Prime. As a result of the sale, a loss on disposal of $10.2 million was recorded in the consolidated statement of operations and changes in net assets. As disclosed in Note 6, the transaction resulted in the defeasance of bonds.

Saint James Mercy Hospital, Hornell, NY ("SJMH") – Effective May 1, 2015, the Corporation spun-off substantially all of the operations of SJMH to form an independent entity. As a result of the spin-off, a loss on disposal of $4.9 million and an asset impairment charge of $12.7 million was recorded in unrestricted net assets.

Mercy Health Partners, North ("North") – Effective February 1, 2015, the Corporation sold substantially all of the Corporation's health care operations located in Cadillac, Michigan; and Grayling, Michigan, to Munson Healthcare. As a result of the sale, a loss on disposal of $5.1 million was recorded in unrestricted net assets.

Condensed consolidated statements of operations and changes in net assets of St. Michael's, Mercy Suburban, Port Huron, SJMH, and North for the years ended June 30 are as follows (in thousands):

	2016				
	St. Michael's	Mercy Suburban	Port Huron	SJMH	North
Revenue, net	$ 148,420	$ 52,652	$ 26,864	$ -	$ -
Deficiency of revenue over expenses	$ (38,087)	$ (10,404)	$ (1,427)	$ -	$ -

	2015				
	St. Michael's	Mercy Suburban	Port Huron	SJMH	North
Revenue, net	$ 195,677	$ 104,224	$ 76,094	$ 40,108	$ 112,760
Deficiency of revenue over expenses	$ (19,614)	$ (2,598)	$ (2,468)	$ (13,136)	$ (3,916)

4. NET PATIENT SERVICE REVENUE

A summary of the payment arrangements with major third-party payors is as follows:

Medicare – Acute inpatient and outpatient services rendered to Medicare program beneficiaries are paid primarily at prospectively determined rates. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Certain items are reimbursed at a tentative rate with final settlement determined after submission of annual cost reports and audits thereof by the Medicare fiscal intermediaries.

Medicaid – Reimbursement for services rendered to Medicaid program beneficiaries includes prospectively determined rates per discharge, per diem payments, discounts from established charges, fee schedules, and cost reimbursement methodologies with certain limitations. Cost reimbursable items are reimbursed at a tentative rate with final settlement determined after submission of annual cost reports and audits thereof by the Medicaid fiscal intermediaries.

Other – Reimbursement for services to certain patients is received from commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for reimbursement includes prospectively determined rates per discharge, per diem payments, and discounts from established charges.

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. Compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action, including fines, penalties, and exclusion from the Medicare and Medicaid programs.

Charity Care – The Corporation provides services to all patients regardless of ability to pay. In accordance with the Corporation's policy, a patient is classified as a charity patient based on income eligibility criteria as established by the Federal Poverty Guidelines. Charges for services to patients who meet the Corporation's guidelines for charity care are not reflected in the accompanying consolidated financial statements.

Patient service revenues, net of contractual and other allowances (but before the provision for bad debts), recognized during the years ended June 30 are as follows (in thousands):

	2016	2015
Medicare	$ 5,674,206	$ 4,924,529
Blue Cross	3,068,119	2,623,777
Medicaid	2,279,151	1,859,985
Uninsured	422,365	366,871
Commercial and Other	3,274,687	3,068,184
Total	$ 14,718,528	$ 12,843,346

A summary of net patient service revenue before provision for bad debts for the years ended June 30 is as follows (in thousands):

	2016	2015
Gross charges:		
Acute inpatient	$ 20,274,353	$ 17,563,491
Outpatient, nonacute inpatient, and other	23,195,830	20,183,959
Gross patient service revenue	43,470,183	37,747,450
Less:		
Contractual and other allowances	(28,097,663)	(24,180,845)
Charity care charges	(653,992)	(723,259)
Net patient service revenue before provision for bad debts	$ 14,718,528	$ 12,843,346

The Affordable Care Act resulted in a reduction in charity care charges during the year ended June 30, 2016, as well as an increase in contractual and other allowances as a result of self-pay patients obtaining insurance coverage under state insurance exchanges or Medicaid programs.

5. PROPERTY AND EQUIPMENT

A summary of property and equipment as of June 30 is as follows (in thousands):

	2016	2015
Land	$ 348,265	$ 325,846
Buildings and improvements	8,867,512	8,057,499
Equipment	5,899,324	5,486,909
Capital leased assets	179,315	177,290
Total	15,294,416	14,047,544
Accumulated depreciation and amortization	(8,213,922)	(7,764,610)
Construction in progress	596,240	490,349
Property and equipment, net	$ 7,676,734	$ 6,773,283

As of June 30, 2016, commitments to purchase property and equipment of approximately $659 million were outstanding. Significant commitments are primarily for facility expansion at existing campuses and related infrastructures at the following Health Ministries: Mount Carmel Health System in Columbus, Ohio – $352.0 million; St. Peter's Health Partners ("St. Peter's") in Albany, New York – $59.6 million; Saint Alphonsus Health System of Oregon, Idaho – $58.3 million; Saint Joseph Mercy Health System of Southeast Michigan – $44.3 million; and Mercy Health System of Chicago in Chicago, Illinois – $31.9 million with the remaining amount due to several smaller projects across the Corporation.

The following table details the Corporation's committed capital spending in conjunction with recent acquisitions of affiliates:

RHM	Capital Commitment	Commitment Period Ending	Capital Spending through June 30, 2016
Mercy Health System of Chicago	$140 million over 5 years, $150 million if performance metrics are achieved	June 30, 2017	$94 million
Loyola University Health System	$300 million over 7 years, $400 million if performance metrics are achieved	June 30, 2018	$290 million
SJHHC	$60 million over 4 years, $90 million if performance metrics are achieved	June 30, 2019	$18 million
SFC	$275 million over 5 years if performance metrics are achieved	June 30, 2020	$27 million

During the year ended June 30, 2016, the Corporation recorded impairment charges of $39.6 million in the consolidated statements of operations and changes in net assets related to St. Peter's, Albany, New York. Material adverse trends in the most recent estimates of future undiscounted cash flows of certain St. Peter's hospitals indicated that the carrying value of the long-lived assets were not recoverable from estimate future cash flows. Fair value was determined using a third-party valuation.

During the year ended June 30, 2015, the Corporation recorded total impairment charges of $36.1 million, of which $12.7 million is included in discontinued operations, loss from operations, in the consolidated statements of operations and changes in net assets. These impairments relate primarily to facilities that the Corporation significantly underutilized. Impairments were recorded at the following locations as fair value estimates were lower than carrying value: St. Francis, Trenton, New Jersey – $19.1 million; SJMH, Hornell, New York – $12.7 million; and Saint Joseph Mercy Health System, in Southeast Michigan – $4.3 million.

6. LONG-TERM DEBT AND OTHER FINANCING ARRANGEMENTS

A summary of short-term borrowings and long-term debt as of June 30 is as follows (in thousands):

	2016	2015
Short-term borrowings:		
Variable rate demand bonds with contractual maturities through 2048. Interest payable monthly at rates ranging from 0.01% to 0.6% during 2016 and 0.01% to 0.67% during 2015	$ 1,067,730	$ 1,098,710
Long-term debt:		
Tax-exempt revenue bonds and refunding bonds:		
Fixed rate term and serial bonds, payable at various dates through 2048. Interest rate ranges from 2.0% to 7.62% during 2016 and 2015	$ 3,540,345	$ 3,163,765
Variable rate term bonds, payable at various dates through 2051. Interest rate ranges from 0.4% to 1.25% during 2016 and 0.22% to 1.01% during 2015	815,950	560,466
Taxable revenue bonds:		
Fixed rate term, payable in 2046. Interest rate of 4.13% during 2016 and 2015	350,000	350,000
Variable rate term bonds, payable at various dates through 2048. Interest rate ranges from 0.88% to 0.91% during 2016	54,680	-
Notes payable to banks. Interest payable at rates ranging from 1.4% to 3.4%, fixed and variable, payable in varying monthly installments through 2035	36,606	39,976
Capital lease obligations (excluding imputed interest of $47.1 million at June 30, 2016 and $44.6 million at June 30, 2015)	129,157	126,975
Mortgage obligations. Interest payable at rates ranging from 4.0% to 6.25% during 2016 and 4.1% to 11.0% during 2015	91,363	97,427
Other	40,540	32,680
Total long-term debt	5,058,641	4,371,289
Less current portion, net of current discounts	(106,345)	(106,226)
Unamortized debt issuance costs	(34,776)	(32,599)
Unamortized premiums, net	214,857	149,992
Long-term debt, net of current portion	$ 5,132,377	$ 4,382,456

Contractually obligated principal repayments on short-term borrowings and long-term debt are as follows (in thousands):

	Short-Term Borrowings	Long-Term Debt
Years ending June 30:		
2017	$ 27,890	$ 108,825
2018	29,300	103,481
2019	28,200	102,126
2020	36,000	99,527
2021	33,425	101,825
Thereafter	912,915	4,542,857
Total	$ 1,067,730	$ 5,058,641

A summary of interest costs on borrowed funds primarily under the revenue bond indentures during the year ended June 30 is as follows (in thousands):

	2016	2015
Interest costs incurred	$ 200,625	$ 171,222
Less capitalized interest	(4,796)	(8,162)
Interest expense included in operations	$ 195,829	$ 163,060

Obligated Group and Other Requirements – The Corporation has debt outstanding under a master trust indenture dated October 3, 2013, as amended and supplemented, the amended and restated master indenture ("ARMI"). The ARMI permits the Corporation to issue obligations to finance certain activities. Obligations issued under the ARMI are joint and several obligations of the obligated group established thereunder (the "Obligated Group", which currently consists of the Corporation). Proceeds from tax-exempt bonds and refunding bonds are to be used to finance the construction, acquisition and equipping of capital improvements. Proceeds from taxable bonds are to be used to finance corporate purposes. Certain Ministries of the Corporation constitute designated affiliates and the Corporation covenants to cause each designated affiliate to pay, loan or otherwise transfer to the Obligated Group such amounts necessary to pay the amounts due on all obligations issued under the ARMI. The Obligated Group and the designated affiliates are referred to as the Credit Group.

The Credit Group does not include certain affiliates that borrow on their own or are (or may become) members of a separate New York obligated group, but which are included in the Corporation's consolidated financial statements. St. Peter's Hospital of the City of Albany currently is the Obligated Group agent of an obligated group created under that certain master trust indenture dated as of January 1, 2008, among St. Peter's Hospital of the City of Albany; St Peter's Health Partners; Memorial Hospital, Albany, New York.; Samaritan Hospital of Troy, New York; Seton Health System, Inc.; Sunnyview Hospital and Rehabilitation Center: the Capital Region Geriatric Center, Inc.; and Manufacturers and Traders Trust Company, as the master trustee. In addition, St. Joseph's Hospital Health Center, acquired on July 1, 2015, is not a designated affiliate and is not part of the Credit Group.

Pursuant to the ARMI, the Obligated Group agent has caused the designated affiliates representing, when combined with the Obligated Group members, at least 85% of the consolidated net revenues of the Credit Group to grant to the master trustee security interests in their pledged property which security interests secure all obligations issued under the master trust indenture. There are several conditions and covenants required by the ARMI with which the Corporation must comply, including covenants that require the Corporation to maintain a minimum historical debt-service coverage and limitations on liens or security interests in property, except for certain permitted encumbrances, affecting the property of the Corporation or any material designated affiliate (a designated affiliate whose total revenues for the most recent fiscal year exceed 5% of the combined total revenues of the Corporation for the most recent fiscal year). Long-term debt outstanding as of June 30, 2016 and 2015 that has not been secured under the ARMI is generally collateralized by certain property and equipment.

Mercy Health System of Chicago ("MHSC") has a $60.4 million mortgage loan outstanding at June 30, 2016, that is insured by the US Department of Housing and Urban Development ("HUD"). MHSC's payment obligations under the two mortgage notes evidencing this loan are guaranteed by the Corporation. The mortgage loan agreements with HUD contain various covenants, including those relating to limitations on incurring additional debt, transactions with affiliates, transferring or disposing of designated property, use of funds and other assets of the mortgaged property, financial performance, required reserves, insurance coverage, timely submission of specified financial reports, and restrictions on prepayment of the mortgage loan. MHSC and the Corporation provided covenants to HUD not to interfere in the performance of MHSC's obligations under the HUD-insured loan documents. MHSC is not a Designated Affiliate and is not part of the Credit Group.

Commercial Paper – The Corporation's commercial paper program is authorized for borrowings up to $600 million. As of June 30, 2016 and 2015, the total amount of commercial paper outstanding was $146 million and $100 million, respectively. Proceeds from this program are to be used for general purposes of the Corporation. The notes are payable from the proceeds of subsequently issued notes and from other funds available to the Corporation, including funds derived from the liquidation of securities held by the Corporation in its investment portfolio. The interest rate charged on borrowings outstanding during the years ended June 30, 2016 and 2015, ranged from 0.09% to 0.50% and 0.07% to 0.16%, respectively.

Liquidity Facilities – In July 2015, the Corporation amended and restated the Trinity Health credit agreements (collectively, the "Credit Agreements") previously entered into between the Corporation and US Bank National Association, which acts as an administrative agent for a group of lenders thereunder. The Credit Agreements establish a revolving credit facility for the Corporation, under which that group of lenders agree to lend to the Corporation amounts that may fluctuate from time to time and totaled $931 million as of June 30, 2016. Amounts drawn under the Credit Agreements can only be used to support the Corporation's obligation to pay the purchase price of bonds that are subject to tender and that have not been successfully remarketed and the maturing principal of and interest on commercial paper notes. Of the $931 million available balance, $325 million expires in July 2017, $321 million expires in July 2018, and $285 million expires in July 2019. The Credit Agreements are secured by obligations under the master trust indenture. As of June 30, 2016 and 2015, there were no amounts outstanding on these credit agreements. In addition, in July 2015, the Corporation renewed a three-year general purpose credit facility of $200 million. As of June 30, 2016 and 2015, there were no amounts outstanding under this credit facility.

Standby Letters of Credit – The Corporation entered into various standby letters of credit totaling approximately $9.9 million and $8.2 million as of June 30, 2016 and 2015, respectively. These standby letters of credit are renewed annually and are available to the Corporation as necessary under its insurance programs and for unemployment liabilities. The Corporation also maintained a general purpose facility of $45 million, of which $42 million is related to letters of credit. In July 2015, this general purpose facility was terminated and all letters of credit were merged into the same program. There were no draws on the general purpose facility or letters of credit during the years ended June 30, 2016 and 2015.

Transactions – The acquisitions of SJHHC and SFC, as described in Note 3, resulted in the assumption of debt of $342.2 million and $251.5 million, respectively. The majority of this debt was retired or defeased using proceeds from the issuance of $372 million of commercial paper and a $190 million draw on a general purpose credit facility, both of which were later replenished with proceeds from the issuance of long-term debt in January and February 2016 as described below. In addition, the acquisition of Johnson, as described in Note 3, resulted in the assumption of debt of $23.3 million, the majority of which was subsequently redeemed.

As the result of the divestiture of Port Huron on September 1, 2015, described in Note 3, the Corporation defeased approximately $31.9 million of bonds through the funding of various escrow accounts on November 5, 2015. In addition, the Corporation redeemed approximately $12.2 million of bonds on November 25, 2015.

On November 24, 2015, the Corporation issued $55.0 million of commercial paper that was used to redeem $53.3 million in outstanding revenue bonds. On January 15, 2016, the Corporation issued $63 million of commercial paper to finance the construction, acquisition and equipping of capital improvements.

During January 2016, the Credit Group issued $555.6 million par value in tax-exempt fixed-rate hospital revenue bonds at a premium of $76.7 million under the ARMI. During February 2016, the Credit Group issued $263.8 million par value in tax-exempt variable-rate private placement bonds and $54.7 million par value in taxable variable-rate private placement bonds. Proceeds from these issuances were used to retire $600 million of then-outstanding taxable commercial paper obligations, paydown $152.1 million of the then-outstanding line of credit draw, extinguish the remaining $43.9 million of debt assumed with the acquisition of SJHHC and pay related transaction costs and to defease $25.5 million of tax-exempt bonds. The remaining

proceeds will be used to finance, refinance and reimburse a portion of the costs of acquisition, construction, renovation and equipping of health facilities, and to pay related costs of issuance.

In February 2016, the Corporation issued $100 million of commercial paper for general corporate purposes and $21 million to pay down the remaining outstanding line of credit draw.

As the result of the divestiture of Mercy Suburban described in Note 3, the Corporation defeased approximately $25 million of bonds through the funding of various escrow accounts on April 27, 2016.

7. PROFESSIONAL AND GENERAL LIABILITY PROGRAMS

The Corporation operates a wholly owned insurance company, Trinity Assurance, Ltd. ("TAL"). Effective July 1, 2015, TAL's name was changed from Venzke Insurance Company, Ltd. TAL qualifies as a captive insurance company and provides certain insurance coverage to the Corporation's Ministries under a centralized program. The Corporation is self-insured for certain levels of general and professional liability, workers' compensation and certain other claims. The Corporation has limited its liability by purchasing reinsurance and commercial coverage from unrelated third-party commercial insurers.

Effective October 1, 2015, TAL policies include the facilities and individuals that were previously insured with Saint Francis Indemnity Company, LLC ("SFICL"), a captive insurance company domiciled in the State of Vermont, whose sole member is SFHMC. Policies issued and reinsurance purchased by SFICL prior to October 1, 2015 will remain in effect. SFICL did not, nor does it intend to, write or renew any insurance business after September 30, 2015. SFICL was merged into TAL on May 1, 2016 at which time all losses previous to October 1, 2015 for SFICL were assumed by TAL.

The Corporation's current self-insurance program includes $20 million per occurrence for the primary layers of professional and general liability, as well as $10 million per occurrence for hospital government liability, $5 million per occurrence for miscellaneous errors and omission liability, and $1 million per occurrence for management liability (directors' and officers' and employment practices), network security and privacy liability and certain other coverages. In addition, through TAL and its various commercial reinsurers, the Corporation maintains integrated excess liability coverage of $100 million in aggregate for the period July 1, 2014, through July 1, 2016. The Corporation self-insures $750,000 per occurrence for workers' compensation in most states, with commercial insurance providing coverage up to the statutory limits, and self-insures up to $500,000 in property values per occurrence with commercial insurance providing coverage up to $1 billion.

The liability for self-insurance reserves represents estimates of the ultimate net cost of all losses and loss adjustment expenses, which are incurred but unpaid at the consolidated balance sheet date. The reserves are based on the loss and loss adjustment expense factors inherent in the Corporation's premium structure. Independent consulting actuaries determined these factors from estimates of the Corporation's expenses and available industry-wide data. The Corporation discounts the reserves to their present value using a discount rate of 3%. The reserves include estimates of future trends in claim severity and frequency. Although considerable variability is inherent in such estimates, management believes that the liability for unpaid claims and related adjustment expenses is adequate based on the loss experience of the Corporation. The estimates are continually reviewed and adjusted as necessary. The changes to the estimated self-insurance reserves were determined based upon the annual independent actuarial analyses.

Claims in excess of certain insurance coverage and the recorded self-insurance liability have been asserted against the Corporation by various claimants. The claims are in various stages of processing and some may ultimately be brought to trial. There are known incidents occurring through June 30, 2016, that may result in the assertion of additional claims and other claims may be asserted arising from services provided in the past. While it is possible that settlement of asserted claims and claims that may be asserted in the future could result in liabilities in excess of amounts for which the Corporation has provided, management, based upon the advice of the legal counsel, believes that the excess liability, if any, should not materially affect the consolidated financial position, operations, or cash flows of the Corporation.

8. PENSION AND OTHER BENEFIT PLANS

Deferred Compensation – The Corporation has nonqualified deferred compensation plans at certain Ministries that permit eligible employees to defer a portion of their compensation. The deferred amounts are distributable in cash after retirement or termination of employment. As of June 30, 2016 and 2015, the assets under these plans totaled $171.3 million and $160.5 million and liabilities totaled $183.7 million and $170.0 million, respectively, which are included in self-insurance, benefit plans and other assets and other long-term liabilities in the consolidated balance sheets.

Defined Contribution Benefits – The Corporation sponsors defined contribution pension plans covering substantially all of its employees. These programs are funded by employee voluntary contributions, subject to legal limitations. Effective January 1, 2015, employer contributions to these plans include nonelective contributions of 3% of eligible compensation, and varying levels of matching contributions based on employee service. The employees direct their voluntary contributions and employer contributions among a variety of investment options. The Corporation suspended the majority of employer-matching contributions for the Trinity Health 403(b) Retirement Savings Plan for the six months ended December 2014. Contribution expense under the plans totaled $296.0 million and $172.3 million for the years ended June 30, 2016 and 2015, respectively.

Noncontributory Defined Benefit Pension Plans ("Pension Plans") – The Corporation maintains qualified, noncontributory defined benefit pension plans under which benefit accruals are frozen for the majority of employees. Certain nonqualified, supplemental plan arrangements also provide retirement benefits to specified groups of participants.

Certain plans are subject to the provisions of the Employee Retirement Security Act of 1974 ("ERISA"). The remaining plans have church plan status as determined by the Internal Revenue Service ("IRS") and are not governed by ERISA. Effective June 2014, the Trinity Health Pension Plan was amended to freeze all future benefit accruals as of December 31, 2014. The Corporation's adopted funding policy for the majority of its qualified church plans, which is reviewed annually, is to fund the current normal cost or service cost based on the accumulated benefit obligations and amortization of any under or over funding. The remaining church plan has historically funded amounts equal to annual pension expense.

Postretirement Health Care and Life Insurance Benefits ("Postretirement Plans") – The Corporation sponsors both funded and unfunded contributory plans to provide health care benefits to certain of its retirees. All of the Postretirement Plans are closed to new participants. The Postretirement Plans cover certain hourly and salaried employees who retire from certain Ministries. Medical benefits for these retirees are subject to deductibles and copayment provisions. Effective January 1, 2011, the funded plans provide benefits to certain retirees at fixed dollar amounts in health reimbursement account arrangements for Medicare eligible participants.

Plan Acquisitions – As discussed in Note 3, the Corporation acquired SJHHC on July 1, 2015, and SFC on October 1, 2015, including all related benefit plans. SJHHC maintains one qualified, noncontributory defined benefit pension plan that provides retirement benefits for substantially all full-time employees. Benefit accruals were frozen and the plan was closed to new participants in April 2014. The plan is subject to the provisions of ERISA. In addition, SJHHC provides other postretirement benefits (primarily health benefits) to an eligible group of employees. The postretirement plan was closed to new participants in 2000, and is unfunded. SFC maintains two qualified, noncontributory defined benefit plans that provide benefits for substantially all full-time employees. One of the plans is subject to ERISA, and one of the plans has Church Plan status. Both plans were frozen and closed to new participants in September 2006. SFC also provides other postretirement benefits, primarily health benefits, to an eligible group of employees. The postretirement plan is closed to new participants.

The following table sets forth the changes in projected benefit obligations, accumulated postretirement obligations, and changes in plan assets and funded status of the plans for both the Pension Plans and Postretirement Plans for the years ended June 30 (in thousands):

	2016	2015	2016	2015
	Pension Plans		Postretirement Plans	
Change in Benefit Obligation:				
Benefit obligation, beginning of year	$ 6,553,044	$ 6,228,019	$ 110,004	$ 108,518
Service cost	2,058	71,182	420	478
Interest cost	335,564	297,711	6,121	4,879
Amendments / plan change	(112,790)	1,327	-	-
Actuarial loss	746,309	238,729	5,924	1,099
Benefits paid	(328,328)	(277,849)	(6,571)	(5,073)
Medicare Part D reimbursement	-	-	63	103
Curtailments	(783)	(6,075)	-	-
Plan acquisitions	520,270	-	26,294	-
Benefit obligation, end of year	7,715,344	6,553,044	142,255	110,004
Change in Plan Assets:				
Fair value of plan assets, beginning of year	5,599,192	5,524,841	97,092	96,109
Actual return on plan assets	168,312	166,464	4,184	4,916
Employer contributions	137,098	185,736	2,735	1,140
Benefits paid	(328,328)	(277,849)	(6,571)	(5,073)
Plan acquisitions	329,910	-	-	-
Fair value of plan assets, end of year	5,906,184	5,599,192	97,440	97,092
Unfunded amount recognized June 30	$(1,809,160)	$ (953,852)	$ (44,815)	$ (12,912)
Recognized in other long-term assets	$ -	$ -	$ 3,664	$ 4,389
Recognized in accrued pension and retiree health costs	$(1,809,160)	$ (953,852)	$ (48,479)	$ (17,301)

Certain plans were amended during 2016 to allow for participants active on or after January 1, 2016, to take their benefit as a lump sum when they terminate employment or retire. These amendments resulted in a decrease in accumulated plan benefits of $113 million. Actuarial losses during 2016 are primarily related to changes in discount rates used to measure plan liabilities.

Mortality assumptions for participants in the Corporation's pension and postretirement plans incorporate future mortality improvements from tables published by the Society of Actuaries ("SOA"). During 2014, the SOA issued new mortality and mortality improvement tables that raise life expectancies and thereby indicate the amount of estimated aggregate benefit payments to participants of the plans is increasing. The Corporation incorporated a modified version of the SOA mortality and mortality improvement tables into the measurement of the plans' benefit obligations. This change resulted in an increase in the pension plan's benefit obligations of $257.1 million and an increase in the postretirement plans' benefit obligations of $7.5 million as of June 30, 2015. These losses were partially offset by actuarial gains related to changes in the discount rates used to measure the plans' liabilities as of June 30, 2015.

The accumulated benefit obligation and fair value of plan assets for the qualified defined benefit pension plans for the years ended June 30 are as follows (in thousands):

	2016	2015
	Pension Plans	
Accumulated benefit obligation	$ 7,704,254	$ 6,537,321
Fair value of plan assets	5,906,184	5,599,192
Funded status	$ (1,798,070)	$ (938,129)

Components of net periodic benefit cost for the years ended June 30 consisted of the following (in thousands):

	2016	2015	2016	2015
	Pension Plans		Postretirement Plans	
Service cost	$ 2,058	$ 71,182	$ 420	$ 478
Interest cost	335,564	297,711	6,121	4,879
Expected return on assets	(403,283)	(382,930)	(7,052)	(6,984)
Amortization of prior service credit	(4,568)	(5,877)	(564)	(564)
Recognized net actuarial loss (gain)	42,791	31,319	(159)	(261)
Net periodic benefit cost (income) before curtailments	$ (27,438)	$ 11,405	$ (1,234)	$ (2,452)
Curtailment/settlement loss (gain)	390	(11,054)	-	-
Net periodic benefit cost (income)	$ (27,048)	$ 351	$ (1,234)	$ (2,452)

The amounts in unrestricted net assets, including amounts arising during the year and amounts reclassified into net periodic benefit cost, are as follows (in thousands):

	Pension Plans		
	Net Loss (Gain)	Prior Service Credit	Total
Balance at July 1, 2014	$ 1,761,070	$ (194,499)	$ 1,566,571
Curtailments	(155,811)	160,788	4,977
Reclassified into net periodic benefit cost	(31,319)	5,877	(25,442)
Arising during the year	455,643	1,328	456,971
Balance at June 30, 2015	$ 2,029,583	$ (26,506)	$ 2,003,077
Curtailments/settlements	(1,173)	-	(1,173)
Reclassified into net periodic benefit cost	(42,791)	4,568	(38,223)
Arising during the year	981,482	(112,789)	868,693
Balance at June 30, 2016	$ 2,967,101	$ (134,727)	$ 2,832,374

	Postretirement Plans			All Plans
	Net Loss (Gain)	Prior Service Credit	Total	Grand Total
Balance at July 1, 2014	$ (6,075)	$ (4,396)	$ (10,471)	$ 1,556,100
Curtailments	-	-	-	4,977
Reclassified into net periodic benefit cost	261	564	825	(24,617)
Arising during the year	3,162	-	3,162	460,133
Balance at June 30, 2015	$ (2,652)	$ (3,832)	$ (6,484)	$ 1,996,593
Curtailments	-	-	-	(1,173)
Reclassified into net periodic benefit cost	159	564	723	(37,500)
Arising during the year	8,792	-	8,792	877,485
Balance at June 30, 2016	$ 6,299	$ (3,268)	$ 3,031	$ 2,835,405

The following are estimated amounts to be amortized from unrestricted net assets into net periodic benefit cost during the year ended June 30, 2017 (in thousands):

	Pension Plans	Postretirement Plans
Amortization of prior service credit	$ (9,057)	$ (562)
Recognized net actuarial loss	87,217	(11)
Total	$ 78,160	$ (573)

Assumptions used to determine benefit obligations and net periodic benefit cost as of and for the years ended June 30 were as follows:

	2016	2015	2016	2015
	Pension Plans		Postretirement Plans	
Benefit Obligations:				
Discount rate	3.75% - 4.35%	4.50% - 5.15%	3.40% - 4.10%	4.10% - 4.80%
Rate of compensation increase graduated to 4% by 2017	2.50%	3.00%	N/A	N/A
Net Periodic Benefit Cost:				
Discount rate	4.50% - 5.15%	4.60% - 5.20%	4.10% - 4.80%	4.00% - 4.75%
Expected long-term return on plan assets	7.00%	7.00%	7.50%	7.50%
Rate of compensation increase	2.50%	3.00%	N/A	N/A

Approximately 73% and 93% of the Corporation's pension plan liabilities were measured using a 4.10% and 4.95% discount rate as of June 30, 2016 and 2015, respectively.

The Corporation utilizes a pension-liability-driven investment strategy in determining its asset allocation and long-term rate of return for plan assets. This risk management strategy uses a glide path methodology based on funded status to initiate asset allocation changes across the efficient frontier. Efficient frontier analysis models the risk and return trade-offs among asset classes while taking into consideration the correlation among the asset classes. Historical market returns and risks are examined as part of this process, but risk-based adjustments are made to correspond with modern portfolio theory. Long-term historical correlations between asset classes are used, consistent with widely accepted capital markets principles. Current market factors, such as inflation and interest rates, are evaluated before long-term capital market assumptions are determined. The long-term rate of return is established using the efficient frontier analysis approach with proper consideration of asset class diversification and rebalancing. Peer data and historical returns are reviewed to check for reasonableness and appropriateness.

Health Care Cost Trend Rates – Assumed health care cost trend rates have a significant effect on the amounts reported for the postretirement plans. The postretirement benefit obligation includes assumed health care cost trend rates as of June 30 as follows:

	2016	2015
Medical and drugs, pre-age 65	6.9%	7.2%
Medical and drugs, post-age 65	6.9%	7.2%
Ultimate trend rate	5.0%	5.0%
Year rate reaches the ultimate rate	2023	2023

A one-percentage point change in assumed health care cost trend rates would have the following effects as of June 30 (in thousands):

	One-Percentage-Point Increase	One-Percentage-Point Decrease
Effect on postretirement benefit obligation	$ 4,050	$ (3,424)
Effect on total of service cost and interest cost components	$ 203	$ (171)

The Corporation's investment allocations as of June 30 by investment category are as follows:

	2016	2015	2016	2015
	Pension Plans		Postretirement Plans	
Investment Category:				
Cash and cash equivalents	2%	3%	1%	1%
Marketable securities:				
U.S. and non-U.S equity securities	6%	7%	-	-
Equity mutual funds	5%	7%	-	-
Debt securities	35%	34%	25%	29%
Other investments:				
Commingled funds	27%	19%	74%	70%
Hedge funds	20%	24%	-	-
Private equity funds	5%	6%	-	-
Total	100%	100%	100%	100%

The Corporation employs a total return investment approach whereby a mix of equities and fixed-income investments are used to maximize the long-term return of plan assets for a prudent level of risk. Risk tolerance is established through careful consideration of plan liabilities, plan funded status, and corporate financial condition. The investment portfolio contains a diversified blend of equity and fixed-income investments. Furthermore, equity investments are diversified across US and non-US stocks, as well as growth, value, and small and large capitalizations. Other investments, such as hedge funds, interest rate swaps, and private equity are used judiciously to enhance long-term returns while improving portfolio diversification. Derivatives may be used to gain market exposure in an efficient and timely manner; however, derivatives may not be used to leverage the portfolio beyond the market value of the underlying investments. Investment risk is measured and monitored on an ongoing basis through quarterly investment portfolio reviews, annual liability measurements, and periodic asset/liability studies. For the majority of the Corporation's pension plan investments, the combined target investment allocation as of June 30, 2016, was global and traditional equity securities 42%; long/short equity 10%; fixed-income obligations 30%; hedge funds 11%; alternative debt 5%; and cash 2%.

The following tables summarize the Pension Plans' and Postretirement Plans' assets measured at fair value as of June 30 (in thousands). See Note 10 for definitions of Level 1, Level 2, and Level 3 of the fair value hierarchy.

	2016			
	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total Fair Value
Pension Plans:				
Cash and cash equivalents	$ 138,056	$ 1,522	$ -	$ 139,578
Equity securities	369,431	309	-	369,740
Debt securities				
Government and government agency obligations	-	687,292	-	687,292
Corporate bonds	-	1,253,192	-	1,253,192
Asset backed securities	-	75,871	-	75,871
Exchange traded/mutual funds				
Equity funds	294,113	-	-	294,113
Fixed income funds	74,315	-	-	74,315
Private equity	-	-	5,405	5,405
Other	(28,410)	-	-	(28,410)
Subtotal	847,505	2,018,186	5,405	2,871,096
Investments measured at net asset value:				
Commingled funds				
Equity funds				1,530,706
Fixed income funds				61,906
Hedge funds				1,134,007
Private equity				308,469
Total assets				$ 5,906,184
Postretirement Plans:				
Exchange traded/mutual funds				
Short term investment funds	$ 1,178	$ -	$ -	$ 1,178
Fixed income funds	24,724	-	-	24,724
Other	145	-	-	145
Subtotal	26,047	-	-	26,047
Investment measured at net asset value:				
Equity commingled fund				71,393
Total assets				$ 97,440

	2015			
	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total Fair Value
Pension Plans:				
Cash and cash equivalents	$ 183,877	$ 1,774	$ -	$ 185,651
Equity securities	395,812	245	-	396,057
Debt securities				
Government and government agency obligations	-	592,587	-	592,587
Corporate bonds	-	1,215,556	-	1,215,556
Asset backed securities	-	81,561	-	81,561
Exchange traded/mutual funds				
Equity funds	404,082	338	-	404,420
Fixed income funds	15,625	-	-	15,625
Private equity	-	-	7,568	7,568
Other	(42,400)	-	-	(42,400)
Subtotal	956,996	1,892,061	7,568	2,856,625
Investments measured at net asset value:				
Commingled funds				
Equity funds				970,386
Fixed income funds				56,508
Hedge funds				1,410,511
Private equity				305,142
Other				20
Total assets				$ 5,599,192
Postretirement Plans:				
Exchange traded/mutual funds				
Short term investment funds	$ 915	$ -	$ -	$ 915
Fixed income funds	27,560	-	-	27,560
Other	1,968	-	-	1,968
Subtotal	30,443	-	-	30,443
Investment measured at net asset value:				
Equity commingled fund				66,649
Total assets				$ 97,092

Unfunded capital commitments related to private equity investments totaled $70.2 million and $95.5 million as of June 30, 2016 and 2015, respectively.

The Corporation's policy is to recognize transfers between all levels as of the beginning of the reporting period. There were no significant transfers to or from Level 1 and Level 2 during the years ended June 30, 2016 and 2015.

See Note 10 for the Corporation's methods and assumptions to estimate the fair value of equity and debt securities, mutual funds, commingled funds, and hedge funds.

Private Equity – These assets include two private equity funds that invest primarily in Europe, both directly and on the secondary market. These funds are valued based on competitive bid evaluation.

Other – Represents unsettled transactions relating primarily to purchases and sales of plan assets, accrued income, and derivatives. Due to the short maturity of these assets and liabilities, the fair value approximates the carrying amounts. The fair value of the derivatives is estimated utilizing the terms of the derivative instruments and publicly available market yield curves. The Pension Plans' investment policies specifically prohibit the use of derivatives for speculative purposes.

The following table summarizes the changes in Level 3 Pension Plans' assets for the years ended June 30 (in thousands):

	Asset Backed Securities	Private Equity	Total
Balance at July 1, 2014	$ 2,467	$ 9,683	$ 12,150
Realized gain	-	751	751
Unrealized loss	-	(870)	(870)
Settlements	-	(1,996)	(1,996)
Transfers out to Level 2	(2,467)	-	(2,467)
Balance at June 30, 2015	$ -	$ 7,568	$ 7,568
Realized gain	-	610	610
Unrealized loss	-	(780)	(780)
Settlements	-	(1,993)	(1,993)
Balance at June 30, 2016	$ -	$ 5,405	$ 5,405

Transfers out of Level 3 into Level 2 in 2015 for asset-backed securities were made as a result of the availability of observable market pricing data for those securities as of June 30, 3015.

The preceding methods may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Corporation believes the valuation methodologies are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

Expected Contributions – The Corporation expects to contribute $211.6 million to its Pension Plans and $3.3 million to its Postretirement Plans during the year ended June 30, 2017, under the Corporation's stated funding policies.

Expected Benefit Payments – The Corporation expects to pay the following for pension benefits for the year ending June 30, which reflect expected future service as appropriate, and expected postretirement benefits before deducting the Medicare Part D subsidy (in thousands):

	Pension Plans	Postretirement Plans	Postretirement Medicare Part D Subsidy
Years ending June 30:			
2017	$ 455,542	$ 9,389	$ 76
2018	440,561	9,531	73
2019	449,222	9,630	69
2020	454,669	9,706	65
2021	457,055	9,768	61
Years 2022 - 2026	2,288,853	46,663	232

9. COMMITMENTS AND CONTINGENCIES

Operating Leases – The Corporation leases various land, equipment and facilities under operating leases. Total rental expense, which includes provisions for maintenance in some cases, was $227 million and $207 million for the years ended June 30, 2016 and 2015, respectively.

The following is a schedule of future minimum lease payments under operating leases as of June 30, 2016, that have initial or remaining lease terms in excess of one year (in thousands):

Years ending June 30:		
2017	$	171,287
2018		142,171
2019		121,168
2020		101,447
2021		87,161
Thereafter		219,516
Total	$	842,750

Litigation and Settlements – The Corporation, as successor to Catholic Health East ("CHE"), is the defendant in a purported class action lawsuit in New York state court brought by Emmet & Co, Inc. and First Manhattan Co., with respect to one series of certificates (the "Bonds") issued for the benefit of a hospital acquired by CHE. The Bonds were defeased in 1998 at the time of CHE's acquisition of the hospital. The Corporation does not currently control the hospital. Plaintiffs alleged that CHE breached the indenture relating to the Bonds and violated the covenant of good faith and fair dealing in the exercise of its optional redemption rights for the Bonds in connection with the CHE's tender offer for the Bonds. The Corporation has reached an agreement of settlement with the named plaintiffs. The matter will be dismissed upon completion of documentation of the settlement. The Corporation does not believe that the settlement will have a material adverse effect on the financial condition of the Corporation.

In June 2013, the Corporation received notices from the IRS that each of the three series initially at issue in the Emmet & Co., Inc. case was under separate examination and requested certain information. Closing agreements with respect to all of the bond issues have been fully executed and implemented and the IRS examination of each of those bond issues is closed. The resolution of these matters will not have a material adverse effect on the financial condition of the Corporation.

On March 29, 2013, CHE was notified that it is a defendant in a lawsuit filed in the US District Court for the Eastern District of Pennsylvania that challenges the church plan status of the CHE Employee Pension Plan. This is similar to other purported class action cases that have been brought against religiously affiliated health care systems or providers. On July 17, 2014, Trinity Health Corporation was notified that it is a defendant in a lawsuit filed in the US District Court for the District of Maryland that challenges the church plan status of the Trinity Health Pension Plan. In response thereto, the Corporation filed a partial motion to dismiss the complaint, which was granted on February 23, 2015. In August 2015, the parties commenced a mediation process to explore opportunities for the settlement of both cases. A final settlement agreement covering both litigations was executed on April 26, 2016. A hearing on a motion for preliminary approval of the settlement is scheduled for October 7, 2016. Final approval remains subject to class notification and further judicial approval. The terms of the final settlement, if approved, will not have a material adverse effect on the financial condition of the Corporation.

On July 21, 2015, Saint Francis Hospital and Medical Center in Hartford, Connecticut, was notified that it was a defendant in a similar class action lawsuit filed in the US Court for the District of Connecticut challenging the church plan status of its employee pension plan. Saint Francis Hospital and Medical Center became a subsidiary of the Corporation on October 1, 2015. Although a motion to dismiss the complaint was filed, a mediation process has resulted in a settlement term sheet being executed on February 18, 2016. A final settlement agreement has been executed and has received preliminary judicial approval. Final approval of the settlement remains subject to class notification and further judicial approval. The terms of the final settlement, if approved, will not have a material adverse effect on the financial condition of the Corporation.

The Corporation is involved in other litigation and regulatory investigations arising in the ordinary course of doing business. After consultation with legal counsel, management expects that these matters will be resolved without material adverse effect on the Corporation's future consolidated financial position or results of operations.

Premium Revenue Adjustment – For the year ended June 30, 2016, the Corporation recorded a $65.3 million liability for the estimated impact of identified data submission errors, ranging over a six-year period, related to Medigold, the Corporation's Medicare Advantage plans in Ohio. The impact of these errors has been determined to not be material to any of the prior-period consolidated financial statements. The Corporation currently is working to resolve this matter.

Health Care Regulatory Environment – The health care industry is subject to numerous and complex laws and regulations of federal, state, and local governments. These laws and regulations include, but are not limited to, matters, such as licensure, accreditation, privacy, government health care program participation requirements and government reimbursement for patient services, fraud and abuse, and requirements for tax exemption for tax-exempt organizations. Compliance with such laws and regulations is complex and can be subject to future government interpretation as well as regulatory enforcement actions, including fines, penalties, and exclusion from government health care programs, such as Medicare and Medicaid. The Corporation and its Ministries periodically receive notices from governmental agencies requesting information regarding billing, payment, or other reimbursement matters or notices of the initiation of government investigations. The health care industry in general is experiencing an increase in these activities as federal and state governments increase their enforcement activities and institute new programs designed to identify potential irregularities in reimbursement or quality of patient care. Based on the information received to date, management does not believe the ultimate resolution of these matters will have a material adverse effect on the Corporation's future consolidated financial position or results of operations.

10. FAIR VALUE MEASUREMENTS

The Corporation's consolidated financial statements reflect certain assets and liabilities recorded at fair value. Assets and liabilities measured at fair value on a recurring basis in the Corporation's consolidated balance sheets include cash, cash equivalents, security-lending collateral, equity securities, debt securities, mutual funds, commingled funds, hedge funds, and derivatives. Defined benefit retirement plan assets are measured at fair value on an annual basis (see Note 8 for further details). Liabilities measured at fair value on a recurring basis for disclosure only include debt.

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The fair value should be based on assumptions that the market participants would use, including a consideration of nonperformance risk.

To determine fair value, the Corporation uses various valuation methodologies based on market inputs. For many instruments, pricing inputs are readily observable in the market; the valuation methodology is widely accepted by market participants and involves little to no judgment. For other instruments, pricing inputs are less observable in the marketplace. These inputs can be subjective in nature and involve uncertainties and matters of considerable judgment. The use of different assumptions, judgments and/or estimation methodologies may have a material effect on the estimated fair value amounts.

The Corporation assesses the inputs used to measure fair value using a three-level hierarchy based on the extent to which inputs used in measuring fair value are observable in the market. The fair value hierarchy is as follows:

Level 1 – Quoted (unadjusted) prices for identical instruments in active markets

Level 2 – Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar instruments in active markets
- Quoted prices for identical or similar instruments in nonactive markets (few transactions, limited information, noncurrent prices, high variability over time, etc.)
- Inputs other than quoted prices that are observable for the instrument (interest rates, yield curves, volatilities, default rates, etc.)
- Inputs that are derived principally from or corroborated by other observable market data

Level 3 – Unobservable inputs that cannot be corroborated by observable market data

Valuation Methodologies – Exchange-traded securities whose fair value is derived using quoted prices in active markets are classified as Level 1. In instances where quoted market prices are not readily available, fair value is estimated using quoted market prices and/or other market data for the same or comparable instruments and transactions in establishing the prices. discounted cash flow models and other pricing models. These models are primarily industry standard models that consider various assumptions, including time value and yield curve as well as other relevant economic measures. The inputs to these models depend on the type of security being priced, but are typically benchmark yields, credit spreads, prepayment speeds, reported trades, and broker-dealer quotes, all with reasonable levels of transparency. Generally, significant changes in any of those inputs in isolation would result in a significantly different fair value measurement. The Corporation classifies these securities as Level 2 within the fair value hierarchy. The Corporation also has certain investments that are classified as Level 3. These investments are primarily valued using competitive bid evaluations or cost if it approximates fair value.

The Corporation maintains policies and procedures to value instruments using the best and most relevant data available. The Corporation has not adjusted the prices obtained. Third-party administrators do not provide access to their proprietary valuation models, inputs, and assumptions. Accordingly, the Corporation reviews the independent reports of internal controls for these service providers. In addition, on a quarterly basis, the Corporation performs reviews of investment consultant industry peer group benchmarking and supporting relevant market data. Finally, all of the fund managers have an annual independent audit performed by an accredited accounting firm. The Corporation reviews these audited financials for ongoing validation of pricing used. Based on the information available, the Corporation believes that the fair values provided by the third-party administrators and investment fund managers are representative of prices that would be received to sell the assets.

In instances where the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement has been determined based on the lowest-level input that is significant to the fair value measurement in its entirety. The Corporation's assessment of the significance of a particular item to the fair value measurement in its entirety requires judgment, including the consideration of inputs specific to the asset.

Following is a description of the valuation methodologies the Corporation used for instruments recorded at fair value, as well as the general classification of such instruments pursuant to the valuation hierarchy:

Cash and Cash Equivalents – The carrying amounts reported in the consolidated balance sheets approximate their fair value. Certain cash and cash equivalents are included in investments and assets limited or restricted as to use in the consolidated balance sheets. Included in this category is commercial paper. The fair value of commercial paper is based on amortized cost. Commercial paper is designated as Level 2 investments with significant observable inputs, including security cost, maturity, and credit rating.

Security Lending Collateral – The security lending collateral is invested in a Northern Trust sponsored commingled collateral fund, which is composed primarily of short-term securities. The fair value amounts of the commingled collateral fund are determined using the calculated net asset value per share (or its equivalent) for the fund with the underlying investments valued using techniques similar to those used for instruments noted below.

Equity Securities – Equity securities are valued at the closing price reported on the applicable exchange on which the security is traded or are estimated using quoted market prices for similar securities.

Debt Securities – Debt securities are valued using quoted market prices and/or other market data for the same or comparable instruments and transactions in establishing the prices, discounted cash flow models, and other pricing models. These models are primarily industry standard models that consider various assumptions, including time value and yield curve as well as other relevant economic measures.

Exchange-Traded/Mutual Funds – Exchange-traded funds are valued at the closing price reported on the applicable exchange on which the fund is traded or estimated using quoted market prices for similar securities. Mutual funds are valued using the net asset value based on the value of the underlying assets owned by the fund, minus liabilities, divided by the number of shares outstanding, and multiplied by the number of shares owned.

Commingled Funds – Commingled funds are developed for investment by institutional investors only and, therefore, do not require registration with the Securities and Exchange Commission. Commingled funds are recorded at fair value based on either the underlying investments that have a readily determinable market value or based on net asset value, which is calculated using the most recent fund financial statements.

Hedge Funds – Hedge funds utilize either a direct or a "fund-of-funds" approach resulting in diversified multistrategy, multimanager investments. Underlying investments in these funds may include equity securities, debt securities, commodities, currencies and derivatives. These funds are valued at net asset value, which is calculated using the most recent fund financial statements.

The Corporation classifies its equity and debt securities, mutual funds, commingled funds, and hedge funds as trading securities. The amount of holding (losses) gains included in the excess of revenue over expenses related to securities still held as of June 30, 2016 and 2015, were $(170.5) million and $222.0 million, respectively.

Equity-Method Investments – Certain other investments are accounted for using the equity method. These investments are structured as limited liability corporations and partnerships and are designed to produce stable investment returns regardless of market activity. These investments utilize a combination of "fund-of-funds" and direct fund investment strategies resulting in a diversified multistrategy, multimanager investments approach. Some of these funds are developed by investment managers specifically for the Corporation's use and are similar to mutual funds, but are not traded on a public exchange. Underlying investments in these funds may include other funds, equity securities, debt securities, commodities, currencies and derivatives. Audited information is only available annually based on the limited liability corporations, partnerships or funds' year-end. Management's estimates of the fair values of these investments are based on information provided by the third-party administrators and fund managers or the general partners. Management obtains and considers the audited financial statements of these investments when evaluating the overall

reasonableness of the recorded value. In addition to a review of external information provided, management's internal procedures include such things as review of returns against benchmarks and discussions with fund managers on performance, changes in personnel or process, along with evaluations of current market conditions for these investments. Because of the inherent uncertainty of valuations, values may differ materially from the values that would have been used had a ready market existed. Unfunded capital commitments related to equity-method investments totaled $249.3 million and $232.1 million as of June 30, 2016 and 2015, respectively.

Interest Rate Swaps – The fair value of the Corporation's derivatives, which are mainly interest rate swaps, are estimated utilizing the terms of the swaps and publicly available market yield curves along with the Corporation's nonperformance risk as observed through the credit default swap market and bond market and based on prices for recent trades. These swap agreements are classified as Level 2 within the fair value hierarchy.

The following tables present information about the fair value of the Corporation's financial instruments measured at fair value on a recurring basis and recorded as of June 30 (in thousands):

	2016			
	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total Fair Value
Assets:				
Cash and cash equivalents	$ 1,600,092	$ 48,603	$ -	$ 1,648,695
Security lending collateral	-	262,035	-	262,035
Equity securities	1,484,897	1,814	5,468	1,492,179
Debt securities:				
Government and government agency obligations	-	674,012	1,433	675,445
Corporate bonds	-	654,335	617	654,952
Asset backed securities	-	249,606	-	249,606
Bank loans	-	76,087	-	76,087
Other	-	13,143	-	13,143
Exchange traded/mutual funds:				-
Equity funds	545,077	-	-	545,077
Fixed income funds	151,113	-	-	151,113
Real estate investment funds	42,816	-	-	42,816
Other	66,389	-	-	66,389
Interest rate swaps	-	15,832	-	15,832
Subtotal	$ 3,890,384	$ 1,995,467	$ 7,518	$ 5,893,369
Investments measured at net asset value:				
Commingled funds				1,407,636
Hedge funds				844,464
Equity method investments				1,176,699
Total assets				$ 9,322,168
Liabilities:				
Interest rate swaps	$ -	$ 250,965	$ -	$ 250,965

	2015			
	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total Fair Value
Assets:				
Cash and cash equivalents	$ 1,373,372	$ 52,477	$ -	$ 1,425,849
Security lending collateral		266,571		266,571
Equity securities	1,320,679	1,700	5,997	1,328,376
Debt securities:				
Government and government agency obligations	-	557,472	2,555	560,027
Corporate bonds	-	573,002	1,318	574,320
Asset backed securities	-	210,534	-	210,534
Bank loans	-	64,370	-	64,370
Other	-	14,091	-	14,091
Exchange traded/mutual funds:				-
Equity funds	623,628	-	-	623,628
Fixed income funds	442,865	-	-	442,865
Real estate investment funds	27,235	-	-	27,235
Other	57,319	-	-	57,319
Interest rate swaps	-	52,977	-	52,977
Subtotal	$ 3,845,098	$ 1,793,194	$ 9,870	$ 5,648,162
Investments measured at net asset value:				
Commingled funds				994,584
Hedge funds				1,243,483
Equity method investments				1,323,988
Total assets				$ 9,210,217
Liabilities:				
Interest rate swaps	$ -	$ 163,553	$ -	$ 163,553

The following table reconciles the information about the fair value of the Corporation's financial instruments measured at fair value on a recurring basis presented in the table above to amounts presented in the consolidated balance sheets as of June 30 (in thousands):

	2016	2015
Assets:		
Cash and cash equivalents	$ 1,044,683	$ 843,210
Investments	3,617,501	3,728,883
Security lending collateral	262,035	266,572
Assets limited or restricted as to use - current portion	314,706	271,567
Assets limited or restricted as to use - noncurrent portion:		
Held by trustees under bond indenture agreements	4,881	1,622
Self-insurance, benefit plans and other	780,102	738,846
By Bond	2,959,641	3,098,445
By donor	409,493	298,332
Interest rate swaps in other long-term assets	15,832	47,870
Less items not recorded at fair value:		
Total unconditional promises to give, net	(57,765)	(48,287)
Reinsurance recovery receivable	(28,941)	(36,843)
Total assets	$ 9,322,168	$ 9,210,217

The Corporation's policy is to recognize transfers between all levels as of the beginning of the reporting period. There were no significant transfers to or from Level 1 and Level 2 during the years ended June 30, 2016 and 2015.

The following table summarizes the changes in Level 3 assets for the years ended June 30 (in thousands):

	Equity Securities	Government and Government Agency Obligations	Corporate Bonds	Asset Backed Securities	Total
Balance at July 1, 2014	$ 972	$ 1,529	$ 583	$ 100	$ 3,184
Realized gain	-	-	5	-	5
Unrealized loss	(9)	(128)	(56)	-	(193)
Purchases	5,034	1,732	1,085	-	7,851
Settlements	-	-	(299)	-	(299)
Transfers to Level 2	-	(578)	-	(100)	(678)
Balance at June 30, 2015	$ 5,997	$ 2,555	$ 1,318	$ -	$ 9,870
Realized (loss) gain	(14)	(56)	24	-	(46)
Unrealized loss	(495)	(81)	(57)	-	(633)
Purchases	-	-	-	-	-
Settlements	(20)	(985)	(915)	-	(1,920)
Transfers from Level 2	-	-	247	-	247
Balance at June 30, 2016	$ 5,468	$ 1,433	$ 617	$ -	$ 7,518

Investments in Entities that Calculate Net Asset Value per Share – The Corporation holds shares or interests in investment companies at year-end, included in commingled funds and hedge funds, where the fair value of the investment held is estimated based on the net asset value per share (or its equivalent) of the investment company. There were no unfunded commitments as of June 30, 2016 and 2015. The fair value and redemption rules of these investments are as follows as of June 30 (in thousands):

	2016		
	Fair Value	Redemption Frequency	Redemption Notice Period
Commingled funds	$ 1,407,636	Daily and semi-monthly	0 - 2 days
Hedge funds	844,464	Monthly, quarterly, semi-annually, bi-annually	15 - 95 days
Total	$ 2,252,100		

	2015		
	Fair Value	Redemption Frequency	Redemption Notice Period
Commingled funds	$ 994,584	Daily, semi-monthly, monthly	0 - 60 days
Hedge funds	1,243,483	Monthly, quarterly, semi-annually	15 - 95 days
Total	$ 2,238,067		

The hedge fund category includes equity long/short hedge funds, multistrategy hedge funds, and relative value hedge funds. Equity long/short hedge funds invest both long and short, primarily in US common stocks. Management of the fund has the ability to shift investments from value to growth strategies, from small to large capitalization stocks, and from a net long position to a net short position. Multistrategy hedge funds pursue multiple strategies to diversify risks and reduce volatility. Relative value hedge fund's strategy is to exploit structural and technical inefficiencies in the market by investing in financial instruments that are perceived to be inefficiently priced as a result of business, financial, or legal uncertainties. Investments representing approximately 3.2% and 3.4% of the value of the investments in this category as of June 30, 2016 and 2015, respectively, can only be redeemed biannually subsequent to the initial investment date. Investments representing 42.3% and 17.0% of the investments in this category as of June 30, 2016 and 2015, respectively, can only be redeemed at the rate of 25% per quarter.

The commingled fund category primarily includes investments in funds that invest in financial instruments of US and non-US entities, primarily bonds, notes, bills, debentures, currencies, and interest rate and derivative products.

The composition of investment returns included in the consolidated statements of operations and changes in net assets for the years ended June 30 is as follows (in thousands):

	2016	2015
Dividend, interest income and other	$ 103,255	$ 111,691
Realized (loss) gain, net	(76,215)	226,065
Realized equity earnings, other investments	26,072	60,178
Change in net unrealized loss on investments	(217,316)	(238,451)
Total investment return	$ (159,204)	$ 159,483
Included in:		
Operating income	$ 47,926	$ 49,193
Nonoperating items	(199,326)	106,553
Changes in restricted net assets	(7,804)	3,737
Total investment return	$ (159,204)	$ 159,483

In addition to investments, assets restricted as to use include receivables for unconditional promises to give cash and other assets net of allowances for uncollectible promises to give. Unconditional promises to give consist of the following as of June 30 (in thousands):

	2016	2015
Amounts expected to be collected in:		
Less than one year	$ 24,343	$ 25,452
One to five years	35,471	24,454
More than five years	4,644	4,694
	64,458	54,600
Discount to present value of future cash flows	(2,927)	(2,517)
Allowance for uncollectible amounts	(3,766)	(3,796)
Total unconditional promises to give, net	$ 57,765	$ 48,287

Patient Accounts Receivable, Estimated Receivables from Third-Party Payors, and Current Liabilities – The carrying amounts reported in the consolidated balance sheets approximate their fair value.

Long-Term Debt – The carrying amounts of the Corporation's variable-rate debt approximate their fair values. The fair value of the Corporation's fixed-rate long-term debt is estimated using discounted cash flow analyses, based on current incremental borrowing rates for similar types of borrowing arrangements. Under the fair value hierarchy, these financial instruments are valued primarily using Level 2 inputs. The fair value of the tax-exempt fixed-rate long-term revenue and refunding bonds was $4,107 million and $3,467 million as of June 30, 2016 and 2015, respectively. The related carrying value of the tax-exempt fixed-rate long-term revenue and refunding bonds was $3,540 million and $3,164 million as of June 30, 2016 and 2015, respectively. The fair value of the taxable fixed-rate long-term revenue bonds was $382 million and $320 million as of June 30, 2016 and 2015, respectively. The related carrying value of the taxable fixed-rate long-term revenue bonds was $350 million as of June 30, 2016 and 2015, respectively. The fair values of the remaining fixed-rate capital leases, notes payable to banks, and mortgage loans are not materially different from their carrying values.

11. DERIVATIVE FINANCIAL INSTRUMENTS

Derivative Financial Instruments – In the normal course of business, the Corporation is exposed to market risks, including the effect of changes in interest rates and equity market volatility. To manage these risks, the Corporation enters into various derivative contracts, primarily interest rate swaps. Interest rate swaps are used to manage the effect of interest rate fluctuations.

Management reviews the Corporation's hedging program, derivative position, and overall risk management on a regular basis. The Corporation only enters into transactions it believes will be highly effective at offsetting the underlying risk.

Interest Rate Swaps – The Corporation utilizes interest rate swaps to manage interest rate risk related to the Corporation's variable interest rate debt and a fixed-income investment portfolio. Cash payments on interest rate swaps totaled $21.3 million and $17.4 million for the years ended June 30, 2016 and 2015, respectively, and are included in nonoperating income.

Certain of the Corporation's interest rate swaps contain provisions that give certain counterparties the right to terminate the interest rate swap if a rating is downgraded below specified thresholds. If a ratings downgrade threshold is breached, the counterparties to the derivative instruments could demand immediate termination of the swaps. Such termination could result in a payment from the Corporation or a payment to the Corporation depending on the market value of the interest rate swap.

Effect of Derivative Instruments on Excess of Revenue over Expenses – The following table represents the effect derivative instruments had on the Corporation's financial performance for the years ended June 30 (in thousands):

Derivatives Not Designated as Hedging Instruments	Location of Net Loss Recognized in Excess of Revenue over Expenses or Unrestricted Net Assets	Amount of Net Loss Recognized in Excess of Revenue over Expenses 2016	2015
Excess of Revenue over Expenses:			
Interest rate swaps	Change in market value and cash payment on interest rate swaps	$ (94,783)	$ (10,223)
Interest rate swaps	Investment (losses) earnings	(5,107)	(749)
		$ (99,890)	$ (10,972)

Balance Sheet Effect of Derivative Instruments – The following table summarizes the estimated fair value of the Corporation's derivative financial instruments as of June 30 (in thousands):

Derivatives Not Designated as Hedging Instruments	Consolidated Balance Sheet Location	Fair Value 2016	2015
Asset Derivatives:			
Interest rate swaps	Investments	$ -	$ 5,107
Interest rate swaps	Other long-term assets	15,832	47,870
	Total asset derivatives	$ 15,832	$ 52,977
Liability Derivatives:			
Interest rate swaps	Other long-term liabilities	$ 250,965	$ 163,553

As disclosed in Note 3, as part of the acquisition of SFC, on October 1, 2015, the Corporation novated an interest rate swap from SFC that increased other long-term liabilities in the consolidated balance sheets by $44.0 million.

The counterparties to the interest rate swaps expose the Corporation to credit loss in the event of nonperformance. As of June 30, 2016 and 2015, an adjustment for nonperformance risk reduced derivative assets by $1.2 million and $1.6 million and derivative liabilities by $13.2 million and $5.3 million, respectively.

12. TEMPORARILY AND PERMANENTLY RESTRICTED NET ASSETS

Temporarily restricted net assets are those whose use by the Corporation has been limited by donors to a specific time period or purpose. Permanently restricted net assets have been restricted by donors to be maintained in perpetuity. Temporarily restricted net assets and permanently restricted net assets as of June 30 are available for the following purposes (in thousands):

	2016	2015
Temporarily Restricted Net Assets:		
Education and research	$ 27,197	$ 19,495
Building and equipment	122,738	91,266
Patient care	48,070	48,390
Cancer center/research	16,956	15,351
Services for elderly care	29,944	32,234
Other	81,746	68,930
Total	$ 326,651	$ 275,666
Permanently Restricted Net Assets:		
Hospital operations	$ 81,850	$ 27,030
Medical programs	10,316	10,302
Scholarship funds	5,765	4,574
Research funds	11,857	9,916
Community service funds	16,413	14,924
Other	31,387	28,223
Total	$ 157,588	$ 94,969

The Corporation's endowments consist of funds established for a variety of purposes. Endowments include both donor-restricted endowment funds and funds designated by the Board to function as endowments. Net assets associated with endowment funds, including funds designated by the Board to function as endowments, are classified and reported based on the existence or absence of donor-imposed restrictions. The Corporation considers various factors in making a determination to appropriate or accumulate donor-restricted endowment funds.

The Corporation employs a total return investment approach whereby a mix of equities and fixed-income investments are used to maximize the long-term return of endowment funds for a prudent level of risk. The Corporation targets a diversified asset allocation to achieve its long-term return objectives within prudent risk constraints. The Corporation can appropriate each year all available earnings in accordance with donor restrictions. The endowment corpus is to be maintained in perpetuity. Certain donor-restricted endowments require a portion of annual earnings to be maintained in perpetuity along with the corpus. Only amounts exceeding the amounts required to be maintained in perpetuity are expended.

The following table summarizes net asset composition by type of fund as of June 30 (in thousands):

	2016			
	Unrestricted Net Assets	Temporarily Restricted Net Assets	Permanently Restricted Net Assets	Total
Donor-restricted endowment funds	$ -	$ 44,728	$ 157,588	$ 202,316
Board-designated endowment funds	76,384	-	-	76,384
Total endowment funds	$ 76,384	$ 44,728	$ 157,588	$ 278,700

	2015			
	Unrestricted Net Assets	Temporarily Restricted Net Assets	Permanently Restricted Net Assets	Total
Donor-restricted endowment funds	$ -	$ 35,313	$ 94,969	$ 130,282
Board-designated endowment funds	81,674	-	-	81,674
Total endowment funds	$ 81,674	$ 35,313	$ 94,969	$ 211,956

Changes in endowment net assets for the years ended June 30 include (in thousands):

	Unrestricted Net Assets	Temporarily Restricted Net Assets	Permanently Restricted Net Assets	Total
Endowment net assets, July 1, 2014	$ 90,942	$ 36,340	$ 87,063	$ 214,345
Investment return:				
Investment income	4,697	954	2,353	8,004
Change in net realized and unrealized losses	(3,638)	(1,025)	(688)	(5,351)
Total investment return	1,059	(71)	1,665	2,653
Contributions	1,242	3,849	3,215	8,306
Appropriation of endowment assets for expenditures	(407)	(4,897)	-	(5,304)
Termination of board designated endowments	(11,361)	-	-	(11,361)
Transfer to create board designated endowment	500	-	-	500
Other	(301)	92	3,026	2,817
Endowment net assets, June 30, 2015	81,674	35,313	94,969	211,956
Investment return:				
Investment income	590	990	1,509	3,089
Change in net realized and unrealized losses	(6,770)	(2,719)	(148)	(9,637)
Total investment return	(6,180)	(1,729)	1,361	(6,548)
Contributions	1,157	-	3,763	4,920
Appropriation of endowment assets for expenditures	(1,217)	(1,706)	-	(2,923)
Transfer to create board designated endowment	950	-	-	950
Acquisition of SJHHC	-	-	3,232	3,232
Acquisition of SFC	-	12,623	53,179	65,802
Other	-	227	1,084	1,311
Endowment net assets, June 30, 2016	$ 76,384	$ 44,728	$ 157,588	$ 278,700

The table below describes the restrictions for endowment amounts classified as temporarily restricted net assets and permanently restricted net assets as of June 30 (in thousands):

	2016	2015
Temporarily Restricted Net Assets:		
Term endowment funds	$ 3,668	$ 4,313
The portion of perpetual endowment funds subject to a purpose restriction	41,060	31,000
Total endowment funds classified as temporarily restricted net assets	$ 44,728	$ 35,313
Permanently Restricted Net Assets:		
Investments for which income is unrestricted	$ 137,262	$ 84,868
Investments for which income is temporarily restricted	14,658	4,261
Endowments requiring income to be added to the original gift	5,668	5,840
Total	$ 157,588	$ 94,969

Funds with Deficiencies – Periodically the fair value of assets associated with the individual donor-restricted endowment funds may fall below the level that the donor requires the Corporation to retain as a fund of perpetual duration. Deficiencies of this nature are reported in unrestricted net assets. These deficiencies result from unfavorable market fluctuations and/or continued appropriation for certain programs that was deemed prudent by the Corporation.

13. SUBSEQUENT EVENTS

Management has evaluated subsequent events through September 21, 2016, the date the consolidated financial statements were issued. The following subsequent events were noted:

The Corporation acquired the following entities effective July 1, 2016: Riverbend Medical Group Inc., a physician practice in Springfield, Massachusetts; Glacier Hills, Inc., a continuing care retirement community in Ann Arbor, Michigan; and Mount St. Joseph, a senior living community in Waterville, Maine. The impact of these acquisitions was not material to the consolidated financial statements.

Effective August 1, 2016 the Corporation became, through its Trinity Health-New England subsidiary, the sole corporate member of St. Mary's Health System ("SMHS"), a regional health care system located in Waterbury, Connecticut, as part of a member substitution. The fair value of identifiable assets acquired and liabilities assumed have not yet been determined as the Corporation is still assessing the economic characteristics of certain assets acquired and liabilities assumed. Thus the opening balance sheet of SMHS at the date of the acquisition is not yet available. The Corporation expects to substantially complete this assessment within 12 months following the acquisition date. SMHS reported $295.5 million of unrestricted revenue for their fiscal year ended September 30, 2015. Pro forma financial data is not disclosed as SMHS financial data is not readily available.

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INDEPENDENT AUDITORS' REPORT ON SUPPLEMENTAL CONSOLIDATING SCHEDULES

To the Board of Directors of
Trinity Health Corporation
Livonia, Michigan

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplemental consolidating schedules (the "Schedules") listed in the table of contents are presented for the purpose of additional analysis and are not a required part of the consolidated financial statements. These Schedules are the responsibility of Trinity Health's management and were derived from and relate directly to the underlying accounting and other records used to prepare the consolidated financial statements. Such Schedules have been subjected to the auditing procedures applied in our audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such Schedules directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion such Schedules are fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Deloitte & Touche LLP

September 21, 2016

TRINITY HEALTH
Supplemental Condensed Consolidating Balance Sheets - Information
June 30, 2016
(In thousands)

	Saint Agnes Medical Center, Fresno	Saint Alphonsus Health System, Oregon-Idaho	Mercy Health Services, Iowa-Nebraska	Loyola University Health System, Chicago	Mercy Hospital and Medical Center, Chicago	Saint Joseph Regional Medical Center, South Bend	Mercy Health, West Michigan	Saint Joseph Mercy Health System, Southeast Michigan	Mount Carmel Health System, Columbus
ASSETS									
CURRENT ASSETS:									
Cash, cash equivalents and investments	$ 81,917	$ 319,186	$ 184,421	$ 268,136	$ 38,931	$ 96,998	$ 225,461	$ 731,364	$ 825,100
Assets limited as to use - current portion	231	494	705	461	5,276	361	978	3,559	648
Patient and other receivables, net	158,955	127,830	136,616	221,881	63,610	59,208	163,277	295,989	213,114
Other current assets	8,792	15,196	26,370	32,124	3,589	8,627	28,724	32,786	32,520
Total current assets	249,895	462,706	348,112	522,602	111,406	165,194	418,440	1,063,698	1,071,382
ASSETS LIMITED OR RESTRICTED AS TO USE -									
Noncurrent portion:									
Held in trust	-	6,340	15,962	21,848	3,090	5,141	12,150	18,870	19,984
By Board	252,765	73,898	184,900	8,556	-	-	307,488	121,174	381,579
By donors	6,178	6,426	9,111	34,618	-	10,027	15,351	40,435	8,371
Total assets limited or restricted as to use - noncurrent portion	258,943	86,664	209,973	65,022	3,090	15,168	334,989	180,479	409,934
PROPERTY AND EQUIPMENT, Net	199,441	473,618	296,098	557,509	203,288	355,844	399,858	955,920	655,999
OTHER ASSETS	27,078	67,769	296,557	76,580	12,709	23,569	71,507	211,229	149,375
TOTAL ASSETS	$ 735,357	$ 1,090,757	$ 1,150,740	$ 1,221,713	$ 330,493	$ 559,775	$ 1,224,794	$ 2,411,326	$ 2,286,690
LIABILITIES AND NET ASSETS									
CURRENT LIABILITIES	$ 84,591	$ 149,057	$ 102,893	$ 255,755	$ 59,824	$ 50,081	$ 136,167	$ 248,703	$ 318,931
LONG-TERM DEBT, Noncurrent portion	98,401	269,709	217,148	524,632	87,826	310,152	292,526	655,231	657,587
OTHER LIABILITIES	2,133	8,024	25,129	187,040	7,756	5,716	19,121	33,341	19,612
NET ASSETS:									
Unrestricted	543,823	657,047	795,857	219,572	170,128	183,435	760,652	1,431,316	1,281,537
Restricted	6,409	6,920	9,713	34,714	4,959	10,391	16,328	42,735	9,023
TOTAL LIABILITIES AND NET ASSETS	$ 735,357	$ 1,090,757	$ 1,150,740	$ 1,221,713	$ 330,493	$ 559,775	$ 1,224,794	$ 2,411,326	$ 2,286,690

TRINITY HEALTH
Supplemental Condensed Consolidating Balance Sheets - Information
June 30, 2016
(In thousands)

	Holy Cross Hospital, Silver Spring	St. Peter's Health Partners, Albany	Saint Joseph Health, Inc., Syracuse	Trinity Health – New England, Inc., Connecticut	Mercy Health System of SEPA, Philadelphia	St. Mary Medical Center, Langhorne	Lourdes Health System, Camden	St. Francis Medical Center, Trenton	Saint Francis Healthcare, Wilmington
ASSETS									
CURRENT ASSETS:									
Cash, cash equivalents and investments	$ 214,777	$ 302,094	$ 116,461	$ 147,477	$ 105,221	$ 285,122	$ 42,314	$ 5,077	$ 22,456
Assets limited as to use - current portion	1,690	20,815	7,499	2,827	-	429	25	-	-
Patient and other receivables, net	84,402	162,488	98,749	163,017	80,996	71,116	78,990	18,309	17,924
Other current assets	10,866	19,302	13,148	26,023	12,280	13,179	14,370	4,126	4,020
Total current assets	311,735	504,699	235,857	339,344	198,497	369,846	135,699	27,512	44,400
ASSETS LIMITED OR RESTRICTED AS TO USE -									
Noncurrent portion:									
Held in trust	286	18,173	17	5,772	-	1,706	3,563	131	-
By Board	-	145,379	5,901	26,494	10,000	-	-	1,687	-
By donors	3,069	71,719	4,472	86,417	3,948	20,202	1,379	1,725	1,244
Total assets limited or restricted as to use - noncurrent portion	3,355	235,271	10,390	118,683	13,948	21,908	4,942	3,543	1,244
PROPERTY AND EQUIPMENT, Net	492,595	600,062	294,489	537,347	93,361	230,889	134,400	36,995	28,922
OTHER ASSETS	54,596	41,502	26,407	36,138	194,493	10,369	50,180	3,135	3,535
TOTAL ASSETS	$ 862,281	$ 1,381,534	$ 567,143	$ 1,031,512	$ 500,299	$ 633,012	$ 325,221	$ 71,185	$ 78,101
LIABILITIES AND NET ASSETS									
CURRENT LIABILITIES	$ 89,230	$ 185,562	$ 140,624	$ 190,473	$ 114,035	$ 52,036	$ 70,449	$ 27,910	$ 27,334
LONG-TERM DEBT, Noncurrent portion	408,579	291,125	297,235	357,907	115,191	127,823	211,339	79,964	115,428
OTHER LIABILITIES	7,789	104,328	52,659	259,262	18,399	5,594	4,229	1,957	42
NET ASSETS:									
Unrestricted	351,922	714,336	64,630	132,615	247,060	426,830	37,825	(40,402)	(65,947)
Restricted	4,761	86,183	11,995	91,255	5,614	20,729	1,379	1,726	1,244
TOTAL LIABILITIES AND NET ASSETS	$ 862,281	$ 1,381,534	$ 567,143	$ 1,031,512	$ 500,299	$ 633,012	$ 325,221	$ 71,185	$ 78,101

TRINITY HEALTH
Supplemental Condensed Consolidating Balance Sheets - Information
June 30, 2016
(In thousands)

	St. Mary's Health Care System, Inc., Athens	Holy Cross Hospital, Inc., Ft. Lauderdale	Trinity Continuing Care Services	Trinity Home Health Services	Trinity Health PACE	Mercy Medical Corporation, Daphne	Pittsburgh Mercy Health System Inc., Pittsburgh	Mercy Primary Care Center, Detroit	Trinity Health Consolidated Labs
ASSETS									
CURRENT ASSETS:									
Cash, cash equivalents and investments	$ 51,336	$ 59,392	$ 66,653	$ 14,081	$ 8,101	$ 650	$ 19,009	$ 6,301	$ 1,834
Assets limited as to use - current portion	(162)	838	1,046	59	373	-	-	-	-
Patient and other receivables, net	34,985	76,298	46,334	21,589	2,837	10	18,673	133	5,818
Other current assets	6,221	12,584	2,341	475	200	7	974	-	2,698
Total current assets	92,380	149,112	116,374	36,204	11,511	667	38,656	6,434	10,350
ASSETS LIMITED OR RESTRICTED AS TO USE -									
Noncurrent portion:									
Held in trust	1,048	13,251	13,223	-	-	-	-	-	-
By Board	14,977	37,561	-	-	-	846	98,992	-	-
By donors	3,607	20,310	1,195	292	-	-	8,390	453	-
Total assets limited or restricted as to use - noncurrent portion	19,632	71,122	14,418	292	-	846	107,382	453	-
PROPERTY AND EQUIPMENT, Net	122,882	234,092	224,105	2,349	7,365	200	9,212	486	2,024
OTHER ASSETS	6,017	43,506	13,054	4,944	15,155	192	(1)	-	1,402
TOTAL ASSETS	$ 240,911	$ 497,832	$ 367,951	$ 43,789	$ 34,031	$ 1,905	$ 155,249	$ 7,373	$ 13,776
LIABILITIES AND NET ASSETS									
CURRENT LIABILITIES	$ 32,240	$ 66,519	$ 38,383	$ 16,148	$ 9,399	$ 443	$ 21,302	$ 3,313	$ 6,024
LONG-TERM DEBT, Noncurrent portion	66,857	158,442	223,331	542	22,864	-	2,015	-	2,282
OTHER LIABILITIES	1,049	55,478	55,721	-	91	541	1,095	-	211
NET ASSETS:									
Unrestricted	136,779	197,405	49,085	26,745	1,304	921	122,447	3,607	5,259
Restricted	3,986	19,988	1,431	354	373	-	8,390	453	-
TOTAL LIABILITIES AND NET ASSETS	$ 240,911	$ 497,832	$ 367,951	$ 43,789	$ 34,031	$ 1,905	$ 155,249	$ 7,373	$ 13,776

TRINITY HEALTH
Supplemental Condensed Consolidating Balance Sheets - Information
June 30, 2016
(In thousands)

	Trinity Health Wards Lab LLC	Global Health Ministry	St. Joseph's Health System, Inc., Atlanta	Trinity Health Partners	Trinity Health ACO, Inc.	Allegany Franciscan Ministries	SJSA Foundation	Cadillac Foundation	Intracoastal
ASSETS									
CURRENT ASSETS:									
Cash, cash equivalents and investments	$ 928	$ 3,625	$ 157,227	$ 26,258	$ 11,359	$ 113,998	$ 9,606	$ -	$ -
Assets limited as to use - current portion	-	17	174	-	-	1,510	855	-	-
Patient and other receivables, net	-	3	896	222	439	-	-	-	-
Other current assets	15	1	220	(1)	(1)	8	43	-	-
Total current assets	943	3,646	158,517	26,479	11,797	115,516	10,504	-	-
ASSETS LIMITED OR RESTRICTED AS TO USE -									
Noncurrent portion:									
Held in trust	-	-	19	-	-	-	-	-	-
By Board	-	-	20,823	-	-	-	879	13,344	-
By donors	-	-	29,257	-	-	-	20,755	-	-
Total assets limited or restricted as to use - noncurrent portion	-	-	50,099	-	-	-	21,634	13,344	-
PROPERTY AND EQUIPMENT, Net	7,576	-	18,097	-	-	20	25	-	-
OTHER ASSETS	-	-	82,311	-	-	6	-	-	-
TOTAL ASSETS	$ 8,519	$ 3,646	$ 309,024	$ 26,479	$ 11,797	$ 115,542	$ 32,163	$ 13,344	$ -
LIABILITIES AND NET ASSETS									
CURRENT LIABILITIES	$ -	$ 1,582	$ 2,719	$ 159	$ 6,330	$ 5,815	$ -	$ 116	$ -
LONG-TERM DEBT, Noncurrent portion	-	-	2,222	-	-	-	-	-	-
OTHER LIABILITIES	-	-	958	-	-	-	1,649	-	-
NET ASSETS:									
Unrestricted	8,519	2,075	273,068	26,320	5,467	109,727	8,904	13,228	-
Restricted	-	(11)	30,057	-	-	-	21,610	-	-
TOTAL LIABILITIES AND NET ASSETS	$ 8,519	$ 3,646	$ 309,024	$ 26,479	$ 11,797	$ 115,542	$ 32,163	$ 13,344	$ -

TRINITY HEALTH

Supplemental Condensed Consolidating Balance Sheets - Information

June 30, 2016

(In thousands)

	Trinity Assurance Insurance Company	Investment in Baycare Health System	Investment in Catholic Health System, Inc.	Mercy Health Services, North	St. Joseph Mercy, Port Huron	Mercy Health System of Maine, Portland	Saint Michael's Medical Center and Related Entities, Newark	St. James Mercy Health System, Inc., Hornell	Mercy Hospital, Inc., Miami
ASSETS									
CURRENT ASSETS:									
Cash, cash equivalents and investments	$ 82	$ -	$ -	$ 10,819	$ 22,280	$ -	$ 11	$ 5,182	$ 327
Assets limited as to use - current portion	117,419	-	-	-	-	-	4,013	-	-
Patient and other receivables, net	2,807	-	-	4,864	(911)	-	-	(1)	-
Other current assets	26	-	-	13	(1)	-	61,536	123	-
Total current assets	120,334	-	-	15,696	21,368	-	65,560	5,304	327
ASSETS LIMITED OR RESTRICTED AS TO USE -									
Noncurrent portion:									
Held in trust	521,095	-	-	-	238	-	8,248	-	4,086
By Board	-	-	-	-	-	-	-	-	-
By donors	-	-	-	-	-	-	-	-	-
Total assets limited or restricted as to use - noncurrent portion	521,095	-	-	-	238	-	8,248	-	4,086
PROPERTY AND EQUIPMENT, Net	-	-	-	-	-	-	-	630	-
OTHER ASSETS	-	2,079,047	73,341	-	2,115	-	1,410	345	4,030
TOTAL ASSETS	$ 641,429	$ 2,079,047	$ 73,341	$ 15,696	$ 23,721	$ -	$ 75,218	$ 6,279	$ 8,443
LIABILITIES AND NET ASSETS									
CURRENT LIABILITIES	$ 183,126	$ -	$ -	$ 8,044	$ 7,731	$ 3,353	$ 209,779	$ 11,975	$ 26,561
LONG-TERM DEBT, Noncurrent portion	-	-	-	-	-	-	8,335	159	-
OTHER LIABILITIES	429,104	-	-	-	239	-	8,201	1,133	19
NET ASSETS:									
Unrestricted	29,199	2,054,411	70,767	7,652	15,751	(3,353)	(155,158)	(6,988)	(18,137)
Restricted	-	24,636	2,574	-	-	-	4,061	-	-
TOTAL LIABILITIES AND NET ASSETS	$ 641,429	$ 2,079,047	$ 73,341	$ 15,696	$ 23,721	$ -	$ 75,218	$ 6,279	$ 8,443

MOODY'S
INVESTORS SERVICE

CREDIT OPINION
21 December 2015

New Issue

Rate this Research

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Trinity Health Credit Group

New Issue - Moody's assigns Aa3 to Trinity Health Credit Group's Series 2016MI,CT,ID,&MD; outlook stable

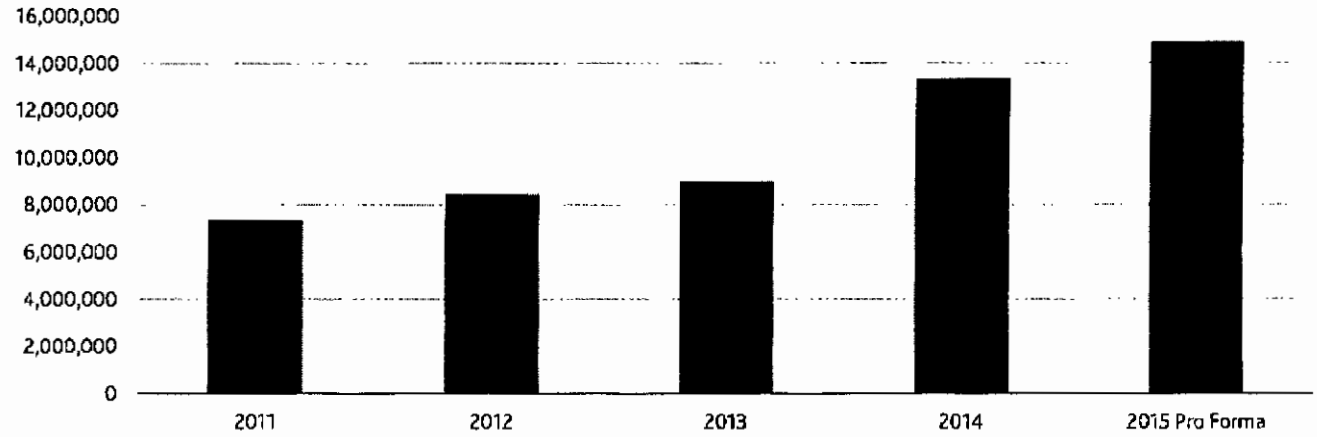
Summary Rating Rationale

Moody's Investors Service assigns Aa3 rating to Trinity Health Credit Group's (Trinity) proposed $553 million of Series 2016MI ($258 million), Series 2016CT ($228 million), Series 2016ID ($23 million), and Series 2016MD ($44 million) fixed rate revenue bonds (2046 maturity). The bonds are to be issued through the Michigan Finance Authority, Connecticut Health and Educational Facilities Authority, Idaho Health Facilities Authority, and Montgomery County, MD. Concurrently, we affirm Trinity's Aa3, Aa3/VMIG 1, and P-1 ratings. The outlook remains stable.

The Aa3 rating reflects Trinity's presence as one of the largest not-for-profit healthcare systems in the U.S., enabling cash flow diversification across several states. The Aa3 rating also reflects Trinity's track record of sound operating cash flow margins and adequate balance sheet metrics. The system's challenges include a leveraged position (including operating leases and defined benefit pension plan) and noticeably weaker performance through five months FY 2016.

The short-term VMIG 1 and P-1 ratings on Trinity's variable rate debt and commercial paper (CP), supported by internal liquidity, reflect adequate coverage provided by daily assets (after applying Moody's discounts) and bank facilities.

Exhibit 1
Total Operating Revenue Continues to Grow Organically and Via Merger Activity



Source: Moody's Investors Service

Credit Strengths

» Very sizeable health system (nearly $15 billion of total operating revenue including recent acquisitions) with strong diversification of cash flow across 21 states provides scale and leverage

» Adequate balance sheet with pro forma 219 days cash on hand

» Track-record of profitability and sound operating cash flow margins averaging 9%-10% over the last several years; after weaker margins in interim FY 2016, management is deploying considerable resources to ensure a return to historical trends

» Demonstrated willingness to divest stressed assets

» Manageable capital spending plans

Credit Challenges

» Considerably weaker operating cash flow margin through five months FY 2016 (6.8%)

» Modest debt coverage ratios for a Aa-rated health system (133% cash-to-direct debt pro forma)

» Material operating lease and defined benefit pension plan liabilities; pro forma 98% cash-to-comprehensive debt

Rating Outlook

The stable outlook reflects our expectation that operating margins will improve for the remainder of FY 2016 and approach an operating cash flow margin of 8% (or better), despite a notable decline in performance through five months of FY 2016. Also, we expect continued improvement in FY 2017 leading to margins in line with historical trends.

Factors that Could Lead to an Upgrade

» Sustained improved operating cash flow margin resulting in stronger debt ratios

» Material growth in liquidity ratios

This publication does not announce a credit rating action. For any credit ratings referenced in this publication, please see the ratings tab on the issuer/entity page on www.moodys.com for the most updated credit rating action information and rating history.

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Factors that Could Lead to a Downgrade

» Failure to show meaningful improvement over the modest operating margins recorded through five-months FY 2016

» Addition of materially dilutive assets through mergers and acquisitions

» Reduction in absolute and relative liquidity metrics

» Issuance of material additional debt that results in significant weakening of debt service ratios

Key Indicators

Exhibit 2
Trinity Health Credit Group, MI

	2011	2012	2013	2014	2015 Pro Forma
Operating Revenue ($'000)	7,344,895	8,456,153	8,968,785	13,324,722	14,903,161
3 Year Operating Revenue CAGR (%)	4.6	9.4	10.3	23.8	6.0
Operating Cash Flow Margin (%)	9.6	9.7	9.9	8.9	9.0
PM: Medicare (%)	38.5	37.4	38.0	45.3	45.8
PM: Medicaid (%)	11.0	10.6	12.1	14.9	16.9
Days Cash on Hand	246	225	236	213	219
Cash to Debt (%)	163.2	143.3	157.3	142.2	133.4
Debt to Cash flow (x)	2.9	2.9	2.8	2.7	3.2

Trinity Health Consolidated Financial Statements, years ended June 30
2015 Pro Forma includes proposed Series 2016 financing and FY 2014 results for St. Joseph's, NY (Saint Francis, CT, which was added to the system effective October 1, 2015, operating metrics excluded from pro forma)
Investment returns normalized at 6% prior to FY 2015 and 5% in FY 2015 and beyond
Source: Moody's Investors Service

Recent Developments

Recent developments are incorporated into the Detailed Rating Consideration section.

Detailed Rating Considerations

Market Position: Very Sizeable Health System with Favorable Distribution of Cash Flow

An important credit strength, Trinity reported over $14 billion in total operating revenues in FY 2015 (nearly $15 billion pro forma) with acute care operations in 21 states spread across the continental U.S. This scale generates good cash flow diversification, as the largest regional ministry (Saint Joseph Mercy Health System in Southeastern Michigan) accounts for just under 13% of system pro forma operating revenue. Likewise, the largest state in Trinity's portfolio (Michigan) accounts for approximately one-quarter of operating revenue. This reduces the exposure to unfavorable fluctuations in any one market or state. Most of Trinity's key regional ministries are in competitive healthcare markets.

Management has a demonstrated willingness to divest of struggling ministries. Effective September 2015, Trinity completed the sale of its Port Huron operations to for-profit Prime Healthcare. Management has been working for over two years to divest St. Michael's Medical Center in Newark, NJ. The State of New Jersey recently deemed the certificate of need (CON) for the sale of St. Michael's to Prime to be complete and management expects the sale to be complete by early 2016. In August 2015, St. Michael's voluntarily filed for Chapter 11 bankruptcy; St. Michael's continues to operate. Other assets are under consideration for divestiture, demonstrating management's willingness to divest assets in order to strengthen the system's fiscal health and judicious expenditure of capital.

Simultaneously, management also continually considers growth strategies. For example, Effective October 1, 2015 Saint Francis Care in Hartford, CT joined Trinity and effective July 2015, St. Joseph's Hospital Health Center (Ba2) in Syracuse, NY also joined the system. We expect that management will examine other strategic additions in the normal course of business.

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Operating Performance, Balance Sheet, and Capital Plans: Weaker Margins in Interim FY 2016

Trinity has a track-record of stable operating cash flow margins, although margins in interim FY 2016 are notably weaker. Between FY 2010 and FY 2015, Trinity's adjusted operating cash flow margin ranged from 8.9% (FY 2014, the initial year of the merger with Catholic Health East) to 9.9%. In FY 2015, the system's adjusted operating cash flow margin measured 9.3% (adjustments include removing the portion of investment income included in operating revenue to non-operating). The Aa3 median operating cash flow margin is 10.0%.

Historically strong regional ministries include: Saint Joseph Mercy (MI) (14.4% operating cash flow margin in FY 2015); Mount Carmel Health System (Columbus, OH) (9.8% in FY 2015, which includes a health plan); Mercy Health West Michigan (Muskegon) (11.6% in FY 2015); and Saint Alphonsus Health System (Boise, ID) (13.4% in FY 2015). Regional ministries that have struggled recently include: Loyola University Health System & Mercy Chicago (6.1% operating cash flow margin in FY 2015); and Mercy Health System (Philadelphia, PA) (-0.7% in FY 2015, which includes a health plan).

In the first five months of FY 2016, Trinity's operating cash flow margin measured a thin 6.8%, compared to 9.3% for the same period FY 2015. The system's challenges during interim FY 2016 have largely been on the expense side, as same-store revenue growth fueled by admissions and outpatient volumes continues. Challenges during interim FY 2016 include: (a) integration of St. Joseph's in Syracuse and Saint Francis in Hartford (the latter of which is affected by Connecticut's steep Medicaid provider tax reimbursement cuts); (b) unbudgeted growth in pharmaceutical costs and, to a greater extent, labor costs (due to rising turnover rates among key staff in key markets); and (c) challenges at the MediGold Medicare Advantage product (which operates in lower Ohio, centered around Columbus).

The affirmation of the stable rating outlook at the Aa3 rating level reflects our expectation that Trinity will improve its operating cash flow margin during the rest of FY 2016 and beyond. Failure to approach an operating cash flow margin of 8% for full year FY 2016 (with further improvement beyond) likely would pressure the outlook and rating. In reaction to the challenges in interim FY 2016, Trinity is deploying teams to stressed ministries to generate improvement and reduce costs. Also, management is reducing capital spending by approximately $100 million during FY 2016 until operating performance rebounds.

LIQUIDITY

Trinity's cash position is adequate with $7.9 billion in unrestricted cash and investments at FYE 2015, translating to 219 days cash on hand (Aa3 median is 267 days). Based on management data, at FYE 2015, Trinity's unrestricted cash and investments were 69% liquid on a monthly basis and allocated among 38% cash and fixed income, 22% equities, and 39% other investments (which includes funds that have a mix of comingled equity and fixed income investments, in addition to hedge funds and private equity).

Trinity's capital spending plans are digestible in the coming years. The system expects to spend approximately $1.0 to $1.1 billion annually on capital, which should translate to an average annual capital spending ratio of roughly 1.3 times.

Debt Structure and Legal Covenants: Diversified Debt Structure

Trinity is leveraged in comparison to other Aa3 rated health systems. Based on FY 2015 results (including St. Joseph's FY 2014, but excluding operating metrics Saint Francis) and including the proposed Series 2016 bonds, adjusted cash-to-direct debt is 133% (Aa3 median is 199%), debt-to-cash flow is 3.2 times (Aa3 median is 2.5 times), maximum annual debt service (MADS) coverage is 5.3 times (Aa3 median is 6.3 times), and debt-to-total operating revenue is 42% (Aa3 median is 32%). We expect Trinity will continue to access the debt markets to support strategic initiatives.

Financial covenants included in Trinity's bond documents include: Rate covenant of 1.1 times; and minimum debt service coverage ratio of 1.10 times. Trinity has adequate headroom to financial covenants.

DEBT STRUCTURE

Trinity's pro forma debt structure is approximately 65% fixed rate and 35% demand debt. Demand debt includes a mix of long-mode put bonds, variable rate demand obligation (VRDOs) and CP supported by internal liquidity, and private placements.

Trinity provides adequate coverage of its self-liquidity debt. As of November 30, 2015, self-liquidity debt is comprised of $356 million in weekly VRDO bonds and $850 million in CP and daily assets total $804 million (after applying Moody's discounts). As part of the Issuing Paying Agreement executed in October 2014, management directed the agent to adhere to the procedures memo that limits

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the amount of commercial paper that can roll within a five-day period to $400 million; Based on management data, during FY 2015, at no point was more than $345 million of CP set to mature within one week.

In support of the self-liquidity program, Trinity has an extensive bank facility program that we include in coverage computations. Ten banks provide $931 million in committed capital available solely to support Trinity's variable rate debt portfolio. These bank agreements have staggered expiration dates ranging between July 2017 and July 2019, reducing renewal risk.

DEBT-RELATED DERIVATIVES

Trinity has an extensive swap portfolio with $2.4 billion in outstanding notional amount with diversification of counterparties across six firms. At FYE 2015, the net termination value of the swaps was a negative $110.6 million to Trinity. Collateral posting requirements are in place.

PENSIONS AND OPEB

The recent freezing of Trinity legacy defined benefit pension plan (effective December 31, 2014) reduces the system's future indirect debt. CHE's legacy defined benefit pension plans were frozen earlier. Both legacy health plans are named in two lawsuits challenging their Church Plan status. At FYE 2015, Trinity's defined benefit pensions were 85% funded compared to a projected benefit obligation of $6.6 billion. The debt equivalent of operating leases measured $1.2 billion (based on a six times lease expense method). Including direct debt, operating leases, and pension obligations, pro forma cash-to-comprehensive debt measures 98% (Aa3 median is 139%).

Management and Governance

All senior management positions have been filled, removing a prior credit concern. A new Chief Clinical Officer, who joined earlier this year, fills the last vacancy in the executive suite. Trinity has a deep and seasoned management team, including considerable treasury management capabilities. Management does not provide detailed budgets or projections to outside parties.

Legal Security

All debt of the legacy organizations are secured on parity through Master Trust Indenture dated October 3, 2013. Trinity Health may not withdraw from the Obligated Group. The Credit Group consists of Members of the Obligated Group and the Designated Affiliates. The Designated Affiliates include the majority of the hospitals except for the New York facilities and Mercy Chicago. The Obligated Group pledges to cause the Designated Affiliates to pay, loan or otherwise transfer to the Obligated Group such moneys as are necessary to pay amounts due on the bonds. Pledge of revenue derived from the operation of all facilities of the majority of the Designated Affiliates, including rights to receivable accounts and health care insurance receivables.

Use of Proceeds

Proceeds from the proposed Series 2016 fixed rate revenue bonds and private placement debt ($881.5 million total par amount) will be used to: (1) refund and repay various outstanding series, including debt at St. Joseph's, NY and CP drawn as part of the Saint Francis merger related refinancing; (2) provide new money and cash reimbursement in support of projects in Idaho, Maryland, and Michigan; and (3) pay the costs of issuance.

Obligor Profile

Trinity Health is one of the largest not-for-profit healthcare systems in the U.S. and represents the May 2013 merger of Trinity Health and Catholic Health East. The system operates nearly 90 hospitals in 21 states across the U.S. and is headquartered in Livonia, Michigan.

Methodology

The principal methodology used in this rating was Not-For-Profit Healthcare Rating Methodology published in November 2015. The additional methodology used in the short-term rating was Rating Methodology for Municipal Bonds and Commercial Paper Supported by a Borrower's Self-Liquidity published in January 2012. Please see the Credit Policy page on www.moodys.com for a copy of these methodologies.

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Ratings

Exhibit 3

MICHIGAN FINANCE AUTHORITY

Issue	Rating
Series 2016CT Fixed Rate Revenue Bonds	Aa3
Rating Type	Underlying LT
Sale Amount	$227,840,000
Expected Sale Date	01/11/2016
Rating Description	Revenue: Other
Series 2016MI Fixed Rate Revenue Bonds	Aa3
Rating Type	Underlying LT
Sale Amount	$258,105,000
Expected Sale Date	01/11/2016
Rating Description	Revenue: Other
Series 2016ID Fixed Rate Revenue Bonds	Aa3
Rating Type	Underlying LT
Sale Amount	$22,970,000
Expected Sale Date	01/11/2016
Rating Description	Revenue: Other
Series 2016MD Fixed Rate Revenue Bonds	Aa3
Rating Type	Underlying LT
Sale Amount	$44,305,000
Expected Sale Date	01/11/2016
Rating Description	Revenue: Other

Source: Moody's Investors Service

ATTACHMENT 37

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REPORT NUMBER 1011410

ATTACHMENT 37

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Japan	81-3-5408-4100
EMEA	44-20-7772-5454

Financial Viability

See Attachment 37 : Applicant has Bond Rating of "A" or better

Economic Feasibility

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Livonia, MI 48152
tel 734-343-1000
trinity-health.org

October 11, 2016

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

RE: Mercy Hospital and Medical Center, Application for CON Permit – ICU/Behavioral Health Modernization

Dear Ms. Avery:

This letter is to affirm that the total estimated project costs and related costs of $ 17.9 Million will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation.

Sincerely,

Signature
Benjamin R. Carter
Executive Vice President/Chief Financial Officer/Treasurer
Trinity Health Corp.

Notarization:

Subscribed and sown to before me this 12th day of October, 2016.

Signature of Notary

Seal

Claudia A. Crane, Notary Public
State of Michigan, County of Oakland
My Commission Expires 11/17/2019
Acting in the County of Wayne

Sponsored by Catholic Health Ministries

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)	
ICU		332.45			13005	Includ		$4,908,087	$ 4,323,527
Behavioral		307.72			15176	Includ		$4,914,006	$ 4,669,976
Contingency		40.88			27232	Includ		$1,476,247	$ 1,152,007
TOTALS					2732			$11,298,340	$ 10,145,510
* Include the percentage (%) of space for circulation									

Notes on Unit Costs:

This renovation project encompasses two entire floors of the main tower of Mercy Hospital. The structure was first occupied in 1968. The first phase of the project is the relocation of the Behavioral Health unit from the fourth floor to the sixth floor. This relocation enables the ICU unit to relocate from the first floor to the fourth floor, currently a space inadequate by all standards. This location meets criteria for moving patients from the first floor surgery.

To meet regulatory requirements, substantial improvements to the aging infrastructure are required for successful project delivery. These improvements include and are not limited to the following:

- *HVAC:* Mercy is in the process of replacing air handling units serving the tower floors. Five of six air handling units serving the tower floors are original to the building and the mains feeding tower floors 4 to 10 are lined ducts. This project will include installation of a new dedicated air handling unit for the ICU on the fourth floor, and significant rework to meet current standards for 6th floor.
- *Plumbing:* A combination of aging piping and reconfiguration of the patient rooms requires significant work to upgrade and, in some cases, reroute drain lines. Secondary work in the patient floors on the 3rd floor and 5th floor is included in this budget.
- *Behavioral Health standards:* The Behavioral Health unit requires interior security windows in the inpatient areas, in addition to security features to prevent elopement and anti-ligature features.
- *ICU Standards:* The new patient units will meet current standards for effective patient care, including lifts for patient and staff safety and room-ready equipment.

Physical constraints on the execution of these projects also significantly impact costs:

- *Limited use elevators:* The removal of construction debris and delivery of materials is restricted to elevators which service patient floors for routine operations.
- *Maintaining patient floor operations:* Both projects will impact patient floors. While Mercy Hospital is committed to rapid completion of these projects, closure of patient rooms below the projects will need to be staged to maintain service levels.

D. Projected Operating Costs

Target Date 2 years after completion or Dec.31, 2021

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.

$2049 per patient day

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.

-$184 per patient day

XI. Safety Net Impact Statement

Mercy Hospital and Medical Center is a designated Safety Net Hospital in the State of Illinois. It was established in 1852, is Chicago's first hospital. From its very inception, Mercy Hospital, sponsored by the Religious sisters of Mercy, has had an unwavering commitment to serving the community, including the underinsured and underprivileged.

The applicants maintain that this project will enhance the Safety Net services provided for the community. It will do this by improving the physical environments for both ICU and Behavioral Health and bringing those units up to 21st century standards. The project will also redistribute ICU beds within the hospital – between general ICU and CVICU (Cardo-Thoracic ICU) -- reflecting anticipated demand and utilization.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	2013	2014	2015
Inpatient	39	24	9
Outpatient	2,348	1,222	1,406
Total	2,387	1,246	1,415
Charity (cost in dollars)			
Inpatient	$2,307,687	$2,899,512	$1,141,376
Outpatient	$2,209,380	$2,175,376	$1,386,431
Total	$4,517,067	$5,074,888	$2,527,807
MEDICAID			
Medicaid (# of patients)	2013	2014	2015
Inpatient	4,623	6,080	6,440
Outpatient	101,091	148,048	159,314
Total	105,704	154,128	165,754
Medicaid (revenue)			
Inpatient	$58,421,225	$61,917,548	$69,803,854
Outpatient	$10,369,704	$10,024,713	$16,592,065
Total	$68,790,929	$71,942,261	$86,395,919

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

ATTACHMENT 40

Charity Care Information

Mercy Hospital and Medical Center

CHARITY CARE (Fiscal Year)			
	2013	2014	2015
Net Patient Revenue	$232,199,015	$232,939,000	$244,087,374
Amount of Charity Care (charges)	$13,082,874	$12,894,275	$79,845,841
Cost of Charity Care	$4,517,067	$5,074,888	$2,527,807

Foster G. Mcgaw Hospital Loyola University Medical Center

CHARITY CARE (Fiscal Year)			
	2013	2014	2015
Net Patient Revenue	$931,057,687	$992,702,434	$1,049,908,960
Amount of Charity Care (charges)	$46,916,462	$52,283,829	$52,351,579
Cost of Charity Care	$ 15,683,254	$ 16,275,351	$15,215,254

Gottlieb Hospital

CHARITY CARE (Fiscal Year)			
	2013	2014	2015
Net Patient Revenue	$ 119,922,002	$ 121,943,765	$103,062,805
Amount of Charity Care (charges)	$18,928,156	$15,843,213	$12,496,318
Cost of Charity Care	$ 3,797,687	$ 3,008,912	$2,466,036