E-005-18

ORIGINAL

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Greater Peoria Specialty Hospital LLC d/b/a Kindred Hospital Peoria		
Street Address:	500 West Romeo B. Garrett Avenue		
City and Zip Code:	Peoria, IL 61605		
County: Peoria	Health Service Area 2	Health Planning Area: C-01	

RECEIVED

JAN 31 2018

HEALTH FACILITIES &
SERVICES REVIEW BOARD

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name:	Kindred Healthcare, Inc.
Street Address:	680 South Fourth Street
City and Zip Code:	Louisville, KY 40202
Name of Registered Agent:	CT Corporation System
Registered Agent Street Address:	306 West Main Street Suite 512
Registered Agent City and Zip Code:	Frankfort, KY 40601
Name of Chief Executive Officer:	Benjamin Breier
CEO Street Address:	680 South Fourth Street
CEO City and Zip Code:	Louisville, KY 40202
CEO Telephone Number:	502/596-7300

Type of Ownership of Applicants

☐ Non-profit Corporation
X 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 they are 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:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	675 North Court, Suite 210 Palatine, IL 60067
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7004

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

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

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name:	Greater Peoria Specialty Hospital, LLC
Street Address:	500 West Romeo B. Garrett Avenue
City and Zip Code:	Peoria, IL 61605
Name of Registered Agent:	CT Corporation System
Registered Agent Street Address:	208 S. LaSalle Street Suite 208
Registered Agent City and Zip Code:	Chicago, IL 60604
Name of Chief Executive Officer:	Christopher Curry
CEO Street Address:	500 West Romeo B. Garrett Avenue
CEO City and Zip Code:	Peoria, IL 61605
CEO Telephone Number:	309/680-1500

Type of Ownership of Applicants

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

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Name:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	675 North Court, Suite 210 Palatine, IL 60067
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7004

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

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

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name:	Kentucky Hospital GP, Inc.
Street Address:	c/o TPG Global, LLC
City and Zip Code:	301 Commerce Street Suite 3300 Fort Worth, TX 76107
Name of Registered Agent:	Maples Fiduciary Services (Delaware) Inc.
Registered Agent Street Address:	4001 Kennett Pike Suite 302
Registered Agent City and Zip Code:	County of New Castle Wilmington, DE 19807
Name of Chief Executive Officer:	Jeffrey Rhodes
CEO Street Address:	345 California Street, Suite 3300
CEO City and Zip Code:	San Francisco, CA 94104
CEO Telephone Number:	415/743-1500

Type of Ownership of Applicants

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

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Primary Contact [Person to receive ALL correspondence or inquiries]

Name:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	675 North Court, Suite 210 Palatine, IL 60067
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7004

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

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

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name:	Kentucky Hospital Holdings JV, L.P.
Street Address:	c/o TPG Global, LLC
City and Zip Code:	301 Commerce Street Suite 3300 Fort Worth, TX 76107
Name of Registered Agent:	Maples Fiduciary Services (Delaware) Inc.
Registered Agent Street Address:	4001 Kennett Pike Suite 302
Registered Agent City and Zip Code:	County of New Castle Wilmington, DE 19807
Name of Chief Executive Officer:	Jeffrey Rhodes
CEO Street Address:	345 California Street Suite 3300
CEO City and Zip Code:	San Francisco, CA 94104
CEO Telephone Number:	415/743-1500

Type of Ownership of Applicants

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Name:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	675 North Court, Suite 210 Palatine, IL 60067
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7004

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

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

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name:	TPG VII Kentucky Holdings I, L.P.
Street Address:	c/o TPG Global, LLC
City and Zip Code:	301 Commerce Street Suite 3300 Fort Worth, TX 76107
Name of Registered Agent:	Maples Fiduciary Services (Delaware) Inc.
Registered Agent Street Address:	4001 Kennett Pike Suite 302
Registered Agent City and Zip Code:	County of New Castle Wilmington, DE 19807
Name of Chief Executive Officer:	Michael LaGatta
CEO Street Address:	345 California Street Suite 3300
CEO City and Zip Code:	San Francisco, CA 94104
CEO Telephone Number:	415/743-1500

Type of Ownership of Applicants

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☐ Limited Liability Company
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Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7004

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

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

Post Exemption 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:	Ms. Barbara Lankford
Title:	Director, Market Planning
Company Name:	Kindred Healthcare, Inc.
Address:	680 South Fourth Street Louisville, KY 40202
Telephone Number:	502/596-7801
E-mail Address:	Barbara.lankford@kindred.com
Fax Number:	502/596-4007

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: RI Wasco, LLC
Address of Site Owner: 7600 NE 41st Street, Suite 330 Vancouver, WA 98662
Street Address or Legal Description of the Site: 500 West Romeo B. Garrett Avenue Peoria, IL 61605 **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, 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: Greater Peoria Specialty Hospital LLC d/b/a Kindred Hospital Peoria
Address: 500 West Romeo B. Garrett Avenue Peoria, IL 61605

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

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

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

Organizational Relationships

Provide (for each 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.

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: RI Wasco, LLC
Address of Site Owner: 7600 NE 41st Street, Suite 330 Vancouver, WA 98662
Street Address or Legal Description of the Site: 500 West Romeo B. Garrett Avenue Peoria, IL 61605 **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, 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: Greater Peoria Specialty Hospital LLC					
Address: 500 West Romeo B. Garrett Avenue Peoria, IL 61605					
☐	Non-profit Corporation	☐	Partnership		
☐	For-profit Corporation	☐	Governmental		
X	Limited Liability Company	☐	Sole Proprietorship	☐	Other

- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.
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Organizational Relationships

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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 #2006-5 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 #2006-5 **(http:// www.illinois.gov/sites/hfsrb)**.

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

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

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

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

DESCRIPTION OF PROJECT

1. Project Classification

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

Part 1110 Classification:

X Change of Ownership

☐ Discontinuation of an Existing Health Care Facility or of a category of service

☐ Establishment or expansion of a neonatal intensive care or beds

2. Narrative Description

In the space below, provide 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.

Kindred Healthcare, Inc. ("Kindred"), which operates a variety of inpatient and outpatient facilities and services nation-wide, is being acquired through a stock acquisition. The Illinois facilities impacted by Kindred's proposed change of ownership are five IDPH-licensed long-term acute care hospitals and one IDPH-licensed Subacute Care Hospital Demonstration Program. Certificate of Exemption ("COE") applications are being concurrently filed, addressing the six Illinois facilities.

This COE application addresses the change of ownership and control of Kindred Hospital - Peoria, which is located at 500 West Romero B. Garrett Avenue in Peoria, Illinois.

The applicants do not anticipate any changes to the day-to-day operation of the facility, resulting from the proposed change of ownership and control, that would be apparent to patients or the population traditionally served.

Following the change of ownership and control, and as of the date of the filing of this COE application, it is anticipated that:

- Kindred Healthcare, Inc. will continue to manage the above-referenced facility's operations
- The name of the facility will not change
- The services provided in and through the facility will not change in any appreciable fashion
- The number of beds provided will not change
- Employees will retain full credit for Kindred employment, retain current positions, and maintain seniority.

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 **Not Applicable**

Purchase Price: $_____

Fair Market Value: $_____

The project involves the establishment of a new facility or a new category of service

☐ Yes **X** No

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

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

Project Status and Completion Schedules

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

Indicate the stage of the project's architectural drawings:

X None or not applicable ☐ Preliminary

☐ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): ___September 15, 2018_____

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

Not Applicable

☐ Purchase orders, leases or contracts pertaining to the project have been executed. ☐ Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies

☐ Financial Commitment 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 [Section 1130.620(c)]

Are the following submittals up to date as applicable:

X Cancer Registry

X ☐ APORS

X All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted

X All reports regarding outstanding permits

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

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives 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 is filed on the behalf of Kindred Healthcare, Inc.* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application 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 fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

Joseph L. Landenwich
PRINTED NAME

General Counsel and Corporate Secretary
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 24th day of January, 2018

Signature of Notary

Seal

PENNY WILKEY
NOTARY PUBLIC
State at Large, Kentucky
My Commission Expires
Mar. 28, 2018

SIGNATURE

Douglas L. Cumutte
PRINTED NAME

Senior Vice President, Corporate Development
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 24th day of January, 2018

Signature of Notary

Seal

CINDY S. JOHNSON
NOTARY PUBLIC
State at Large, Kentucky
My Commission Expires
June 17, 2018

*Insert the EXACT legal name of the applicant

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives 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);
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- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of Greater Peoria Specialty Hospital, LLC.* 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 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 fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

Christopher Curry
PRINTED NAME

Chief Executive Officer, Kindred Hospital Peoria
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 24 day of January 2018

Tracy A. Driscoll
Signature of Notary

Seal

OFFICIAL SEAL
TRACY A DRISCOLL
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:05/12/18

*Insert the EXACT legal name of the applicant

CERTIFICATION

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- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of __Kentucky Hospital GP, Inc._____* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application 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 fee required for this application is sent herewith or will be paid upon request.

SIGNATURE	SIGNATURE
Kendall Garrison	Adam Fliss
PRINTED NAME	PRINTED NAME
Vice President and Treasurer	Secretary
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this _____ day of _____	Notarization: Subscribed and sworn to before me this _____ day of _____
	See attached
Signature of Notary	Signature of Notary
Seal	Seal

*Insert the EXACT legal name of the applicant

CALIFORNIA JURAT WITH AFFIANT STATEMENT **GOVERNMENT CODE § 8202**

☒ See Attached Document (Notary to cross out lines 1–6 below)
☐ See Statement Below (Lines 1–6 to be completed only by document signer[s], *not* Notary)

Signature of Document Signer No. 1 *Signature of Document Signer No. 2 (if any)*

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of San Francisco

Subscribed and sworn to (or affirmed) before me on this 23rd day of January, 2018 by
(1) Adam Fluss
~~(and (2)~~ _____),
Name(s) of Signer(s)

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

Signature Kimberly A Cruz
Signature of Notary Public

Seal
Place Notary Seal Above

OPTIONAL

Though this section is optional, completing this information can deter alteration of the document or fraudulent reattachment of this form to an unintended document.

Description of Attached Document

Title or Type of Document: Certification **Document Date:** _____

Number of Pages: _____ **Signer(s) Other Than Named Above:** _____

©2014 National Notary Association • www.NationalNotary.org • 1-800-US NOTARY (1-800-876-6827) Item #5910

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

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- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
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This Application is filed on the behalf of Kentucky Hospital GP, Inc.* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application 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 fee required for this application is sent herewith or will be paid upon request.

SIGNATURE	SIGNATURE
Kendall Garrison	Adam Fliss
PRINTED NAME	PRINTED NAME
Vice President and Treasurer	Secretary
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this 24 day of January 2018	Notarization: Subscribed and sworn to before me this _____ day of _____
See attached	
Signature of Notary	Signature of Notary
Seal	Seal

*Insert the EXACT legal name of the applicant

CALIFORNIA JURAT WITH AFFIANT STATEMENT **GOVERNMENT CODE § 8202**

☒ See Attached Document (Notary to cross out lines 1–6 below)
☐ See Statement Below (Lines 1–6 to be completed only by document signer[s], *not* Notary)

Signature of Document Signer No. 1 *Signature of Document Signer No. 2 (if any)*

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of San Francisco

Subscribed and sworn to (or affirmed) before me on this 24th day of January, 2018, by
Date *Month* *Year*
(1) Kendall Garrison
~~(and (2)~~ _____),
Name(s) of Signer(s)

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

KIMBERLY A. DRURY
Commission # 2105325
Notary Public - California
San Francisco County
My Comm. Expires Mar 30, 2019

Signature Kimberly A. Drury
Signature of Notary Public

Seal
Place Notary Seal Above

OPTIONAL

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Description of Attached Document

Title or Type of Document: _____ **Document Date:** _____

Number of Pages: _____ **Signer(s) Other Than Named Above:** _____

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- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of __Kentucky Hospital Holdings JV, L.P._* 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 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 fee required for this application is sent herewith or will be paid upon request.

SIGNATURE	SIGNATURE
Kendall Garrison PRINTED NAME	Adam Fliss PRINTED NAME
Vice President and Treasurer of Kentucky Hospital GP, Inc., General Partner of Kentucky Hospital Holdings JV, L.P.	Secretary of Kentucky Hospital GP, Inc., General Partner of Kentucky Hospital Holdings JV, L.P.
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this _____ day of _____	Notarization: Subscribed and sworn to before me this _____ day of _____
Signature of Notary	See attached Signature of Notary
Seal	Seal

*Insert the EXACT legal name of the applicant

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State of California
County of San Francisco

Subscribed and sworn to (or affirmed) before me on this 23rd day of January, 20 18, by
Date Month Year
(1) Adam Fliss
~~(and (2)~~ _____),
Name(s) of Signer(s)

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

KIMBERLY A. DRURY
Commission # 2105325
Notary Public - California
San Francisco County
My Comm. Expires Mar 30, 2019

Signature Kimberly A. Drury
Signature of Notary Public

Seal
Place Notary Seal Above

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Though this section is optional, completing this information can deter alteration of the document or fraudulent reattachment of this form to an unintended document.

Description of Attached Document

Title or Type of Document: Certification **Document Date:** _____

Number of Pages: _____ **Signer(s) Other Than Named Above:** _____

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CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives 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 is filed on the behalf of __Kentucky Hospital Holdings JV, L.P._* 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 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 fee required for this application is sent herewith or will be paid upon request.

SIGNATURE	SIGNATURE
Kendall Garrison PRINTED NAME	Adam Fliss PRINTED NAME
Vice President and Treasurer of Kentucky Hospital GP, Inc., General Partner of Kentucky Hospital Holdings JV, L.P.	Secretary of Kentucky Hospital GP, Inc., General Partner of Kentucky Hospital Holdings JV, L.P.
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this 24 day of January 2018	Notarization: Subscribed and sworn to before me this _____ day of _____
See attached Signature of Notary	Signature of Notary
Seal	Seal

*Insert the EXACT legal name of the applicant

CALIFORNIA JURAT WITH AFFIANT STATEMENT **GOVERNMENT CODE § 8202**

☒ See Attached Document (Notary to cross out lines 1–6 below)
☐ See Statement Below (Lines 1–6 to be completed only by document signer[s], *not* Notary)

1
2
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4
5
6

Signature of Document Signer No. 1 *Signature of Document Signer No. 2 (if any)*

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of San Francisco

Subscribed and sworn to (or affirmed) before me on this 24th day of January, 2018, by
Date *Month* *Year*
(1) Kendall Garrison
~~(and (2)~~ _____),
Name(s) of Signer(s)

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

KIMBERLY A. DRURY
Commission # 2105325
Notary Public - California
San Francisco County
My Comm. Expires Mar 30, 2019

Signature Kimberly A Drury
Signature of Notary Public

Seal
Place Notary Seal Above

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- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of __TPG VII Kentucky Holdings I, L. P.___* 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 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 fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

Michael LaGatta

PRINTED NAME

President and Treasurer of TPG VII Kentucky GP, Inc., General Partner of TPG VII Kentucky Holdings I, L.P.

PRINTED TITLE

Notarization:
Subscribed and sworn to before me this 23 day of January 2018

Signature of Notary

Seal

MARTI C MCDONALD
Notary Public, State of Texas
Comm. Expires 04-26-2019
Notary ID 126059496

SIGNATURE

Adam Fliss

PRINTED NAME

Vice President and Secretary of TPG VII Kentucky GP, Inc., General Partner of TPG VII Kentucky Holdings I, L.P.

PRINTED TITLE

Notarization:
Subscribed and sworn to before me this _____ day of _____

Signature of Notary

Seal

*Insert the EXACT legal name of the applicant.

CERTIFICATION

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SIGNATURE	SIGNATURE
Michael LaGatta	Adam Fliss
PRINTED NAME	PRINTED NAME
President and Treasurer of TPG VII Kentucky GP, Inc., General Partner of TPG VII Kentucky Holdings I, L.P.	Vice President and Secretary of TPG VII Kentucky GP, Inc., General Partner of TPG VII Kentucky Holdings I, L.P.
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this _____ day of _____	Notarization: Subscribed and sworn to before me this _____ day of _____
	See attached
Signature of Notary	Signature of Notary
Seal	Seal

*Insert the EXACT legal name of the applicant

CALIFORNIA JURAT WITH AFFIANT STATEMENT **GOVERNMENT CODE § 8202**

☒ See Attached Document (Notary to cross out lines 1–6 below)
☐ See Statement Below (Lines 1–6 to be completed only by document signer[s], *not* Notary)

Signature of Document Signer No. 1 *Signature of Document Signer No. 2 (if any)*

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of San Francisco

Subscribed and sworn to (or affirmed) before me on this 23rd day of January, 2018.
Date *Month* *Year*
by
(1) Adam Fluss
~~(and (2)~~ _____),
Name(s) of Signer(s)

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

KIMBERLY A. DRURY
Commission # 2105325
Notary Public - California
San Francisco County
My Comm. Expires Mar 30, 2019

Signature Kimberly A. Drury
Signature of Notary Public

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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.

Background

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 that the information was 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.

Criterion 1110.230 – Purpose of the Project, and Alternatives (Not applicable to Change of Ownership)

PURPOSE OF PROJECT

Not Applicable

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 relevant area, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.
4. Cite the sources of the 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 the age and condition of the project site, as well as 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

Not Applicable

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 V. CHANGE OF OWNERSHIP (CHOW)

1130.520 Requirements for Exemptions Involving the Change of Ownership of a Health Care Facility

1. Prior to acquiring or entering into a contract to acquire an existing health care facility, a person shall submit an application for exemption to HFSRB, submit the required application-processing fee (see Section 1130.230) and receive approval from HFSRB.

2. If the transaction is not completed according to the key terms submitted in the exemption application, a new application is required.

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

APPLICABLE REVIEW CRITERIA	CHOW
1130.520(b)(1)(A) - Names of the parties	X
1130.520(b)(1)(B) - Background of the parties, which shall include proof that the applicant is fit, willing, able, and has the qualifications, background and character to adequately provide a proper standard of health service for the community by certifying that no adverse action has been taken against the applicant by the federal government, licensing or certifying bodies, or any other agency of the State of Illinois against any health care facility owned or operated by the applicant, directly or indirectly, within three years preceding the filing of the application.	X
1130.520(b)(1)(C) - Structure of the transaction	X
1130.520(b)(1)(D) - Name of the person who will be licensed or certified entity after the transaction	
1130.520(b)(1)(E) - List of the ownership or membership interests in such licensed or certified entity both prior to and after the transaction, including a description of the applicant's organizational structure with a listing of controlling or subsidiary persons.	X
1130.520(b)(1)(F) - Fair market value of assets to be transferred.	X
1130.520(b)(1)(G) - The purchase price or other forms of consideration to be provided for those assets. [20 ILCS 3960/8.5(a)]	X
1130.520(b)(2) - Affirmation that any projects for which permits have been issued have been completed or will be completed or altered in accordance with the provisions of this Section	X
1130.520(b)(2) - If the ownership change is for a hospital, affirmation that the facility will not adopt a more restrictive charity care policy than the policy that was in effect one year prior to the transaction. The hospital must provide affirmation that the compliant charity care policy will remain in effect for a two-year period following the change of ownership transaction	X
1130.520(b)(2) - A statement as to the anticipated benefits of the proposed changes in ownership to the community	X
1130.520(b)(2) - The anticipated or potential cost savings, if any, that will result for the community and the facility because of	X

the change in ownership;	
1130.520(b)(2) - A description of the facility's quality improvement program mechanism that will be utilized to assure quality control;	X
1130.520(b)(2) - A description of the selection process that the acquiring entity will use to select the facility's governing body;	X
1130.520(b)(2) - A statement that the applicant has prepared a written response addressing the review criteria contained in 77 Ill. Adm. Code 1110.240 and that the response is available for public review on the premises of the health care facility	X
1130.520(b)(2)- A description or summary of any proposed changes to the scope of services or levels of care currently provided at the facility that are anticipated to occur within 24 months after acquisition.	X

Application for Change of Ownership Among Related Persons

When a *change of ownership is among related persons, and there are no other changes being proposed at the health care facility that would otherwise require a permit or exemption under the Act, the applicant shall submit an application consisting of a standard notice in a form set forth by the Board briefly explaining the reasons for the proposed change of ownership.* [20 ILCS 3960/8.5(a)]

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

SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

Charity Care information MUST be furnished for ALL projects [1120.20(c)].

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 41.

Kindred Hospital - Chicago

CHARITY CARE			
	2014	2015	2016
Net Patient Revenue	**$58,343,810**	**$58,345,178**	**$54,223,608**
Amount of Charity Care (charges)	$1,240,227	$228,345	$513,921
Cost of Charity Care	$498,198	$83,989	$195,429

APPEND DOCUMENTATION AS ATTACHMENT 21, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

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A table in the following format must be provided for all facilities as part of Attachment 41.

Kindred Chicago Central Hospital

CHARITY CARE			
	2014	2015	2016
Net Patient Revenue	**$26,014,177**	**$25,368,418**	**$23,101,166**
Amount of Charity Care (charges)	$0	$0	$0
Cost of Charity Care	$0	$0	$0

APPEND DOCUMENTATION AS ATTACHMENT-21, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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Charity Care information MUST be furnished for ALL projects [1120.20(c)].

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A table in the following format must be provided for all facilities as part of Attachment 41.

Kindred Hospital Peoria

CHARITY CARE			
	2014	2015	2016
Net Patient Revenue	**$14,472,682**	**$14,638,367**	**$14,876,427**
Amount of Charity Care (charges)	$0	$0	$0
Cost of Charity Care	$0	$0	$0

APPEND DOCUMENTATION AS ATTACHMENT-21, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

Charity Care information MUST be furnished for ALL projects [1120.20(c)].

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A table in the following format must be provided for all facilities as part of Attachment 41.

Kindred Hospital - Sycamore

CHARITY CARE			
	2014	2015	2016
Net Patient Revenue	**$25,424,419**	**$24,982,983**	**$26,617,555**
Amount of Charity Care (charges)	$0	$0	$0
Cost of Charity Care	$0	$0	$0

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SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

Charity Care information MUST be furnished for ALL projects [1120.20(c)].

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A table in the following format must be provided for all facilities as part of Attachment 41.

Kindred Hospital - Northlake

CHARITY CARE			
	2014	2015	2016
Net Patient Revenue	**$32,507,060**	**$32,752,443**	**$34,264,041**
Amount of Charity Care (charges)	$0	$168,313	$0
Cost of Charity Care	$0	$56,430	$0

APPEND DOCUMENTATION AS ATTACHMENT 21, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

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A table in the following format must be provided for all facilities as part of Attachment 41.

Kindred Chicago- Lakeshore

CHARITY CARE			
	2014	2015	2016
Net Patient Revenue	**$24,716,018**	**$26,179,941**	**$25,345,108**
Amount of Charity Care (charges)	$0	$0	$0
Cost of Charity Care	$0	$0	$0

APPEND DOCUMENTATION AS ATTACHMENT-21, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VII. 1120.130 - FINANCIAL VIABILITY

NOT APPLICABLE

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

Financial Viability Waiver

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

1. "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 17, 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.

	Historical 3 Years			**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 18, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VIII. 1120.140 - ECONOMIC FEASIBILITY

NOT APPLICABLE

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

A. Reasonableness of Financing Arrangements

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

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

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

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

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

B. Conditions of Debt Financing

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

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

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

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

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

NOT APPLICABLE

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

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

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

SECTION IX. SAFETY NET IMPACT STATEMENT (DISCONTINUATION ONLY)

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE STATE-OWNED HEALTH CARE FACILITIES [20 ILCS 3960/5.4]:

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 40.

NOT APPLICABLE

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

Commonwealth of Kentucky
Alison Lundergan Grimes, Secretary of State

Alison Lundergan Grimes
Secretary of State
P. O. Box 718
Frankfort, KY 40602-0718
(502) 564-3490
http://www.sos.ky.gov

Certificate of Authorization

Authentication number: 197796
Visit https://app.sos.ky.gov/ftshow/certvalidate.aspx to authenticate this certificate.

I, Alison Lundergan Grimes, Secretary of State of the Commonwealth of Kentucky, do hereby certify that according to the records in the Office of the Secretary of State,

KINDRED HEALTHCARE, INC.

, a corporation organized under the laws of the state of Delaware, is authorized to transact business in the Commonwealth of Kentucky, and received the authority to transact business in Kentucky on September 28, 1998.

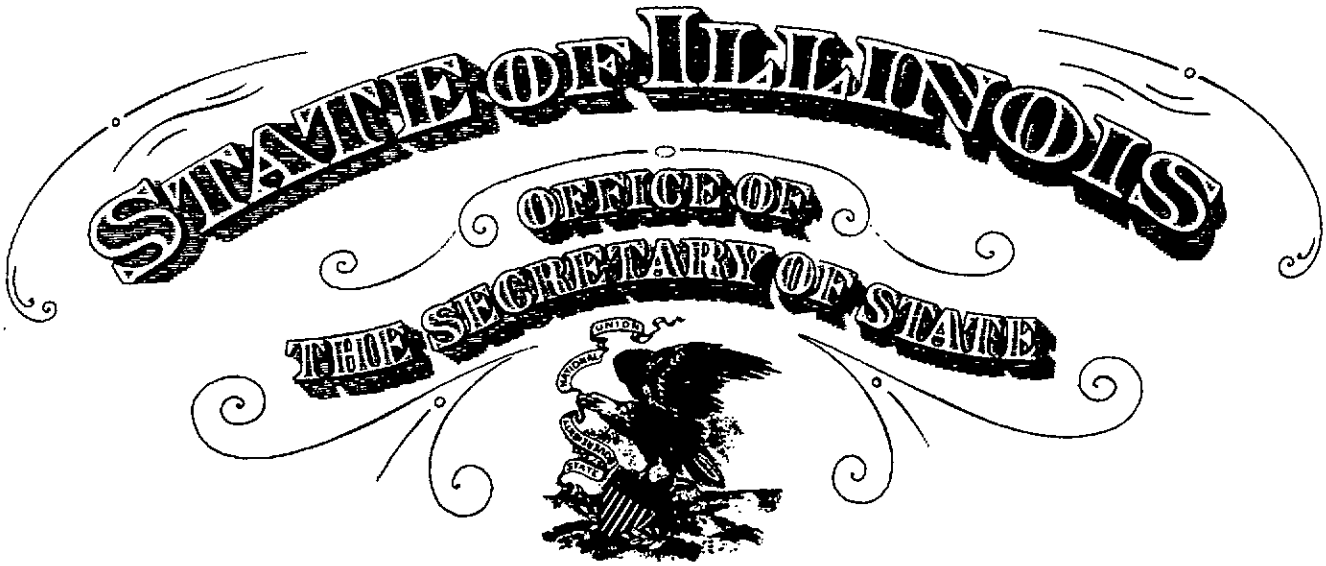
I further certify that all fees and penalties owed to the Secretary of State have been paid; that an application for certificate of withdrawal has not been filed; and that the most recent annual report required by KRS 14A.6-010 has been delivered to the Secretary of State.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my Official Seal at Frankfort, Kentucky, this 5th day of January, 2018, in the 226th year of the Commonwealth.

Alison Lundergan Grimes
Secretary of State
Commonwealth of Kentucky
197796/0462709

ATTACHMENT 1

File Number 0174560-3



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

GREATER PEORIA SPECIALTY HOSPITAL, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON JANUARY 26, 2006, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 5TH *day of* JANUARY *A.D.* 2018 .

Authentication #: 1800501248 verifiable until 01/05/2019
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

ATTACHMENT 1

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "KENTUCKY HOSPITAL HOLDINGS JV, L.P." IS DULY FORMED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE TWENTY-SIXTH DAY OF JANUARY, A.D. 2018.

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "KENTUCKY HOSPITAL HOLDINGS JV, L.P." WAS FORMED ON THE EIGHTH DAY OF JANUARY, A.D. 2018.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL TAXES HAVE BEEN ASSESSED TO DATE.

Jeffrey W. Bullock, Secretary of State

6699537 8300

SR# 20180509673

You may verify this certificate online at corp.delaware.gov/authver.shtml

Authentication: 202039567

Date: 01-26-18

ATTACHMENT I

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "KENTUCKY HOSPITAL GP, INC." IS DULY INCORPORATED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL CORPORATE EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE NINTH DAY OF JANUARY, A.D. 2018.

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "KENTUCKY HOSPITAL GP, INC." WAS INCORPORATED ON THE EIGHTH DAY OF JANUARY, A.D. 2018.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL FRANCHISE TAXES HAVE BEEN ASSESSED TO DATE.

Jeffrey W. Bullock, Secretary of State

6699528 8300

SR# 20180141049

You may verify this certificate online at corp.delaware.gov/authver.shtml

Authentication: 201940522

Date: 01-09-18

ATTACHMENT 1

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "TPG VII KENTUCKY HOLDINGS I, L.P." IS DULY FORMED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE NINTH DAY OF JANUARY, A.D. 2018.

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "TPG VII KENTUCKY HOLDINGS I, L.P." WAS FORMED ON THE FIFTEENTH DAY OF DECEMBER, A.D. 2017.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL TAXES HAVE BEEN ASSESSED TO DATE.

Jeffrey W. Bullock, Secretary of State

6664456 8300

SR# 20180140916

You may verify this certificate online at corp.delaware.gov/authver.shtml

Authentication: 201940505

Date: 01-09-18

ATTACHMENT 1

Kindred Healthcare

January 9, 2018

Illinois Health Facilities and
Services Review Board
Springfield, Illinois

RE: SITE OWNERSHIP

Please be advised of the following:

1. Ventas Realty, Limited Partnership is the site owner of the following facilities, and there will be no change of the direct owner of the sites as a result of the proposed transaction:
   - Kindred Hospital – Sycamore
   - Kindred Hospital- Chicago
   - Kindred Hospital – Northlake
   - Kindred Chicago-Lakeshore

2. Universal Health Realty Income Trust is the site owner of Kindred Chicago Central Hospital, and there will be no change of the direct owner of the site as a result of the proposed transaction

3. RI Wasco, LLL is the site owner of Kindred Hospital Peoria, and there will be no change of the direct owner of the site as a result of the proposed transaction.

Sincerely,

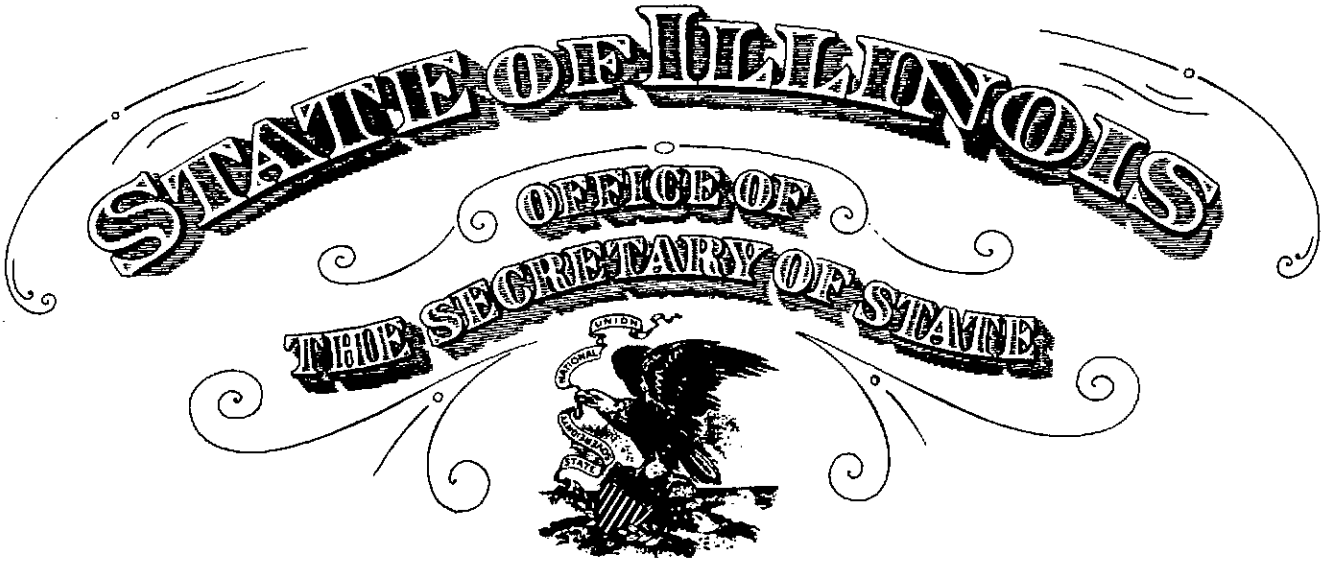
Douglas L. Curnutte, CPA
Senior Vice President, Corporate Development
Kindred Healthcare, Inc.

ELIZABETH D NEARY
Official Seal
Notary Public - State of Illinois
My Commission Expires Jun 10, 2020

Elizabeth D Neary

ATTACHMENT 2

File Number 0174560-3



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

GREATER PEORIA SPECIALTY HOSPITAL, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON JANUARY 26, 2006, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 5TH *day of* JANUARY *A.D.* 2018 .

Authentication #: 1800501248 verifiable until 01/05/2019
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

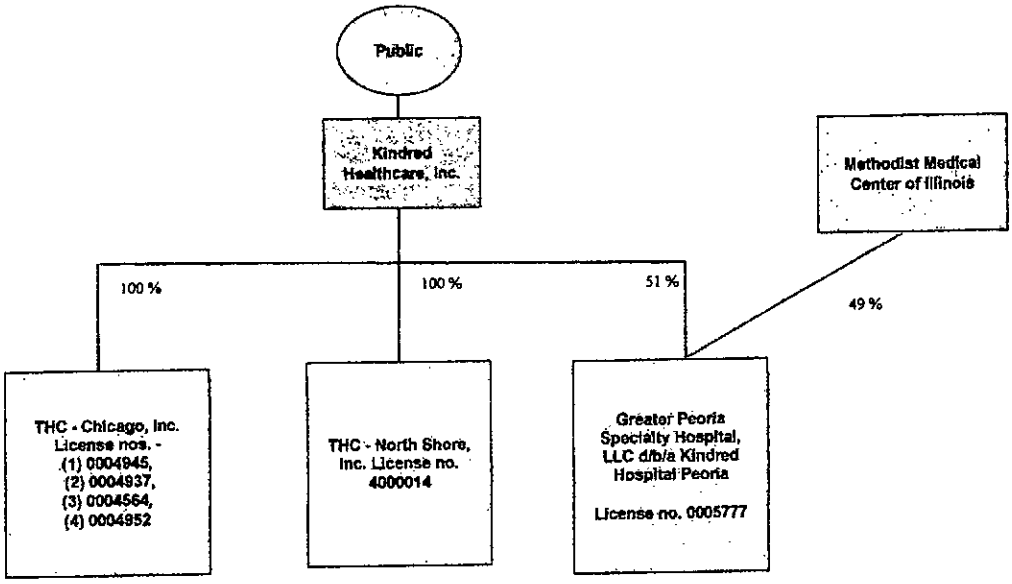
ATTACHMENT 3

OPERATING IDENTITY/LICENSEE

50.93%	TPG VII Kentucky Holdings I, L.P.
25.52%	Welsh, Carson, Anderson & Stowe XII, L.P. (and affiliates)
15.7%	Port-Aux-Choix Private Investments, Inc.
7.85%	Teachers Retirement System of Texas

ATTACHMENT 3

ILLINOIS - HOSPITALS
(STRUCTURE PRIOR TO THE TRANSACTION)

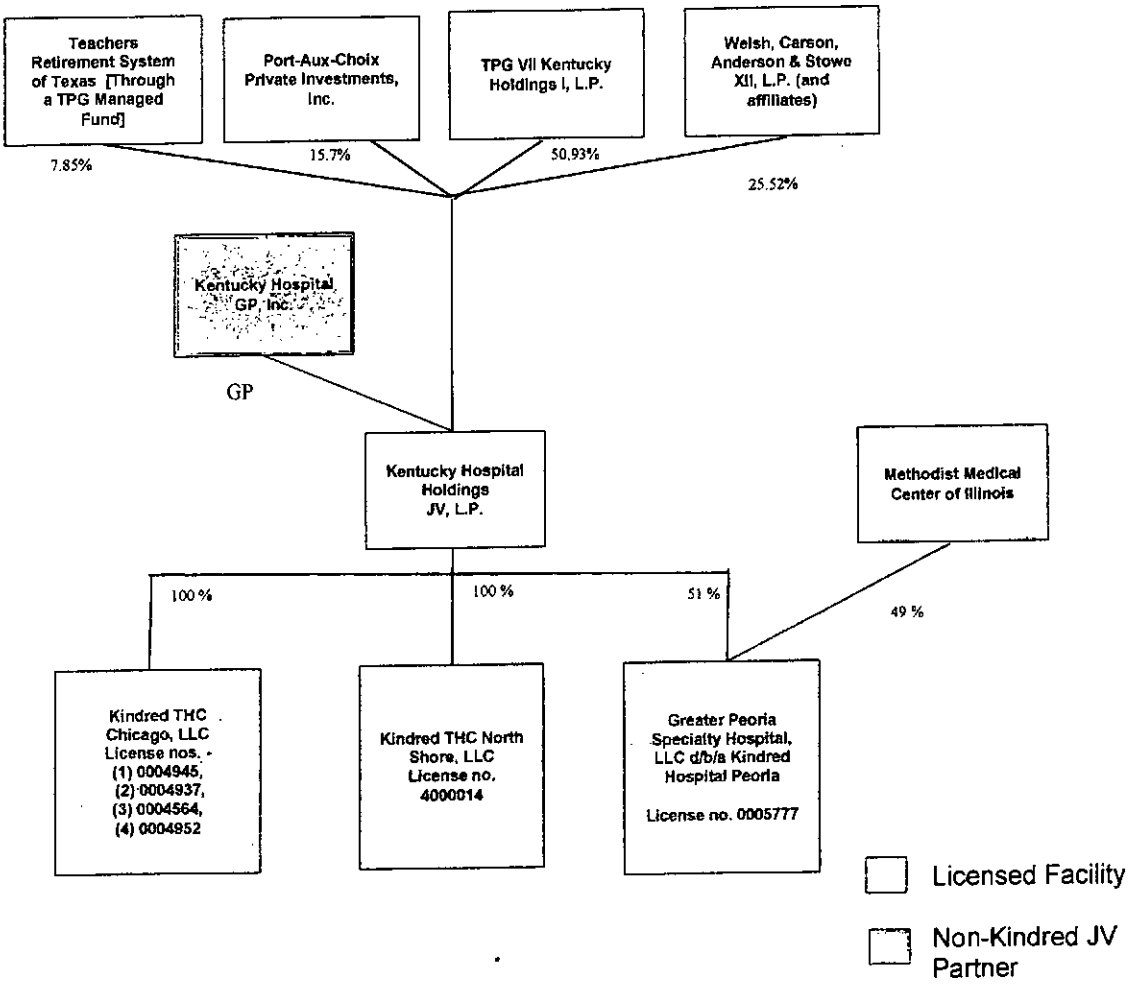


Licensed Facility

Non-Kindred JV Partner

ATTACHMENT 4

ILLINOIS – KINDRED HOSPITALS
(STRUCTURE FOLLOWING THE TRANSACTION)



ATTACHMENT 4

BACKGROUND OF APPLICANT

Applicant Kindred Healthcare, Inc. owns and/or operates the following licensed health care facilities in Illinois:

1. Kindred Hospital- Sycamore, a Long-Term Acute Care Hospital
   Sycamore, Illinois
   IDPH License # 0004945

2. Kindred Hospital – Chicago, a Long-Term Acute Care Hospital
   Chicago, Illinois
   IDPH License #0004937

3. Kindred Chicago Central Hospital, a Long-Term Acute Care Hospital
   Chicago, Illinois
   IDPH License #0004564

4. Kindred Hospital – Northlake, a Long-Term Acute Care Hospital
   Northlake, Illinois
   IDPH License #0004952

5. Kindred Hospital – Peoria, a Long-Term Acute Care Hospital*
   Peoria, Illinois
   IDPH License #0005777

6. Kindred Chicago- Lakeshore, a Subacute Care Hospital Demonstration Program
   Chicago, Illinois
   IDPH License #4000014

*Kindred Healthcare, Inc., through a subsidiary entity, owns 51%

Kindred Healthcare
Hospitals and Nursing Canters
As of: 12/31/2017

Type	Name	Street Address	City	State
IRF	Dignity Health East Valley Rehabilitation Hospital	1515 West Chandler Boulavard	Chandler	AZ
SNF	Kindred Transitional Care and Rehabilitation-Foothill	401 West Ada Avanue	Glendora	CA
SAU	Kindred Hospital - Brea	875 North Brea Boulevard	Brea	CA
LTACH	Kindred Hospital Baldwin Park	14148 E. Francisquito Avenue	Baldwin Park	CA
LTACH	Kindred Hospital Riverside	2224 Medical Center Drive	Perris	CA
LTACH	Kindred Hospital South Bay	1246 W. 155th Street	Gardena	CA
LTACH	Kindred Hospital Rancho	10841 White Oak Avenue	Rancho Cucamonga	CA
LTACH	Kindred Hospital - Brea	875 North Brea Boulevard	Brea	CA
LTACH	Kindred Hospital - Dntario	550 North Monterey Avenue	Ontario	CA
LTACH	Kindred Hospital - San Francisco Bay Area	2800 Benedict Drive	San Leandro	CA
LTACH	Kindred Hospital - La Mirada	14900 E. Imperial Highway	La Mirada	CA
LTACH	Kindred Hospital - San Gabriel Valley	845 North Lark Ellen	West Covina	CA
LTACH	Kindred Hospital - Santa Ana	1901 N. College Avenua	Santa Ana	CA
LTACH	Kindred Hospital - Westminster	200 Hospital Circle	Westminster	CA
LTACH	Kindred Hospital - San Diego	1940 El Cajon Boulevard	San Diego	CA
LTACH	Kindred Hospital - Los Angeles	5525 Wast Slauson Avanue	Los Angeles	CA
LTACH	Kindred Hospital - Denver South	2525 South Downing St., 3rd Floor	Denver	CO
LTACH	Kindred Hospital - Denver	1920 High Streat	Danver	CO
LTACH	Kindrad Hospital Aurora	700 Potomac St., 2nd Floor	Aurora	CD
SAU	Kindred Hospital - South Florida - Hollywood	1859 Van Buren Street	Hollywood	FL
LTACH	Kindred Hospital Ocala	1500 SW 1st Avenua, 5th Floor	Ocala	FL
LTACH	Kindred Hospital The Palm Beaches	5555 W. Blua Heron Boulevard	Riviera Beach	FL
LTACH	Kindred Hospital - South Florida - Coral Gables	5190 Southwest 8th Street	Coral Gables	FL
LTACH	Kindred Hospital - Bay Area St. Petersburg	3030 6th Street South	SL Petersburg	FL
LTACH	Kindred Hospital - Bay Area - Tampa	4555 South Manhattan Avenue	Tampa	FL
LTACH	Kindred Hospital - South Florida Ft. Lauderdale	1516 East Las Olas Boulevard	Ft. Lauderdale	FL
LTACH	Kindred Hospital - North Florida	801 Oak Streat	Green Cove Springs	FL
LTACH	Kindred Hospital - Central Tampa	4801 North Howard Avenue	Tampa	FL
LTACH	Kindred Hospital Melbourne	765 West Nasa Boulevard	Melbourne	FL
LTACH	Kindred Hospital - South Florida - Hollywood	1859 Van Buren Street	Hollywood	FL
LTACH	Kindred Hospital Rome	320 Tumer McCall Blvd.	Rome	GA
LTACH	Kindred Hospital - Sycamore	225 Edward Street	Sycamore	IL
LTACH	Kindred Hospital - Chicago (North Campus)	2544 West Montrosa Avenue	Chicago	IL
LTACH	Kindred - Chicago - Central Hospital	4058 Wast Melrose Street	Chicago	IL
LTACH	Kindred Hospital - Chicago (Northlake Campus)	365 East North Avenue	Northlake	IL
LTACH	Kindred Hospital Peoria	500 West Romeo B. Garrett Avenua	Peoria	IL
LTACH	Kindred - Chicago - Lakeshore	6130 North Sheridan Road	Chicago	IL
SNF	Kindred Transitional Care and Rehabilitation-Columbus	2100 Midway	Columbus	IN
IRF	Community Health Network Rehabilitation Hospital	7343 Clearvista Drive	Indianapolis	IN
LTACH	Kindred Hospital Indianapolis North	8060 Knue Road	Indianapolis	IN
LTACH	Kindred Hospital - Indianapolis	1700 Wast 10th Streat	Indianapolis	IN
LTACH	Kindred Hospital Northwest Indiana	5454 Hohman Avanue, 5th Fl.	Hammond	IN
LTACH	Kindred Hospital Northern Indiana	215 W 4th SL Ste 200	Mishawaka	IN
SAU	Kindred Hospital - Louisville	1313 St. Anthony Place	Louisville	KY
LTACH	Kindred Hospital - Louisville at Jewish Hospital	200 Abraham Flexner Way, 2nd Fl Frazier Inst.	Louisville	KY
LTACH	Kindred Hospital - Louisville	1313 St. Anthony Place	Louisville	KY
SNF	Kindred Transitional Care and Rehabilitation-Highgate	10 CareMatrix Drive	Dedham	MA
SNF	Kindred Transitional Care and Rehabilitation-Avery	100 West Street	Needham	MA
SNF	Kindred Nursing and Rahabilitation-Tower Hill	One Meadowbrook Way	Canton	MA
SNF	Kindred Nursing and Rehabilitation-Harborlights	804 East 7th Street	South Boston	MA
SNF	Clerk House Nursing Center at Fox Hill Village	30 Longwood Driva	Westwood	MA
IRF	Marcy Rehabilitation Hospital Springfield	5904 S. Southwood Road	Springfield	MO
IRF	Mercy Rehabilitation Hospital St. Louis	14561 North Outer Forty Road	Chesterfield	MO
LTACH	Kindred Hospital - St. Louis - St. Anthony's	10018 Kennerly Road, 3rd Floor, Hyland Bldg. B	St. Louis	MO
LTACH	Kindred Hospital - St. Louis	4930 Lindell Boulevard	St. Louis	MD
LTACH	Kindred Hospital Northland	500 NW 68th Street	Kansas City	MD
IRF	St. Luka's Rehabilitation Hospital	14709 Olive Blvd.	Chesterfield	MO
SAU	Kindred Hospital - Greensboro	2401 Southsida Boulevard	Greensboro	NC
LTACH	Kindred Hospital - Greensboro	2401 Southside Boulevard	Greensboro	NC
LTACH	Kindred Hospital New Jersey - Morris County	400 W. Bleckwell Street	Dover	NJ
LTACH	Kindred Hospital New Jersey - Rahway	865 Stone Street, 4th Floor	Rahway	NJ
LTACH	Kindred Hospital New Jersey - Wayne	224 Hamburg Tumpike, 6th Floor	Wayne	NJ
LTACH	Kindred Hospital - Albuquerque	700 High Street, N.E.	Albuquerque	NM
SNF	Kindred Transitional Care and Rehabilitation-Spring Valley	5650 S. Rainbow Boulevard	Las Vegas	NV
SAU No Ct.	Kindred Hospital Las Vegas - Flamingo Campus	2250 East Flamingo Road	Las Vagas	NV

ATTACHMENT 11

Type	Name	Street Address	City	State
LTACH	Kindred Hospital – Las Vegas at St. Rose Dominican Hospital – Rose de Lima	102 E. Lake Mead Parkway, Third Floor	Henderson	NV
LTACH	Kindred Hospital - Las Vegas (Sahara Campus)	5110 West Sahara Avenue	Las Vegas	NV
LTACH	Kindred Hospital Las Vegas - Flamingo Campus	2250 East Flamingo Road	Las Vegas	NV
IRF	University Hospitals Rehabilitation Hospital	23333 Harvard Road	Beachwood	OH
IRF	University Hospitals Avon Rehabilitation Hospital	37900 Chester Road	Avon	OH
LTACH	Kindred Hospital - Dayton	707 S. Edwin C. Moses Boulevard	Dayton	OH
LTACH	Kindred Hospital Lima	730 West Market Street	Lima	OH
IRF	Mercy Rehabilitation Hospital Oklahoma City	5401 W. Memorial Road	Oklahoma City	OK
IRF	Lancaster Rehabilitation Hospital	675 Good Drive	Lancaster	PA
IRF	St. Mary Rehabilitation Hospital	1208 Langhorne Newtown Road	Langhorne	PA
LTACH	Kindred Hospital Philadelphia - Havertown	2000 Old West Chester Pike	Havertown	PA
LTACH	Kindred Hospital - Philadelphia	6129 Palmetto Street	Philadelphia	PA
LTACH	Kindred Hospital South Philadelphia	1930 South Broad Street, Unit #12	Philadelphia	PA
IRF	Baptist Memorial Rehabilitation Hospital	1240 South Germantown Road	Germantown	TN
LTACH	Kindred Hospital - Chattanooga	709 Walnut Street	Chattanooga	TN
IRF	Methodist Rehabilitation Hospital	3020 W. Wheatland Road	Dallas	TX
IRF	Texas Rehabilitation Hospital of Arlington	900 West Arbrook Blvd.	Arlington	TX
IRF	Texas Rehabilitation Hospital of Fort Worth	425 Alabama Avenue	Fort Worth	TX
LTACH	Kindred Hospital - San Antonio Central	111 Dallas Street, 4th Floor	San Antonio	TX
LTACH	Kindred Hospital - Dallas	9525 Greenville Avenue	Dallas	TX
LTACH	Kindred Hospital - San Antonio	3636 Medical Drive	San Antonio	TX
LTACH	Kindred Hospital - Tarrant County (Arlington Campus)	1000 North Cooper Street	Arlington	TX
LTACH	Kindred Hospital - Tarrant County (Fort Worth Southwest Campus)	7800 Oakmont Boulevard	Fort Worth	TX
LTACH	Kindred Hospital Houston NW	11297 Fallbrook Drive	Houston	TX
LTACH	Kindred Hospital (Bay Area)	4801 East Sam Houston Parkway South	Pasadena	TX
LTACH	Kindred Hospital - Mansfield	1802 Highway 157 North	Mansfield	TX
LTACH	Kindred Hospital - Fort Worth	815 Eighth Avenue	Fort Worth	TX
LTACH	Kindred Hospital Houston Medical Center	6441 Main Street	Houston	TX
IRF	Kindred Rehabilitation Hospital Northeast Houston	18839 McKay Boulevard	Humble	TX
LTACH	Kindred Hospital Sugar Land	1550 First Colony Blvd.	Sugar Land	TX
IRF	Kindred Rehabilitation Hospital Clear Lake	655 E. Medical Center Blvd.	Webster	TX
LTACH	Kindred Hospital Dallas Central	8050 Meadow Road	Dallas	TX
IRF	Central Texas Rehabilitation Hospital	700 West 45th Street	Austin	TX
LTACH	Kindred Hospital El Paso	1740 Curie Drive	El Paso	TX
LTACH	Kindred Hospital Spring	205 Hollow Tree Lane	Houston	TX
LTACH	Kindred Hospital Tomball	505 Graham Drive	Tomball	TX
LTACH	Kindred Hospital The Heights	1800 West 28th Street	Houston	TX
LTACH	Kindred Hospital Clear Lake	350 Blossom Street	Webster	TX
SNF	Kindred Transitional Care and Rehabilitation-Birchwood Terrace	43 Starr Farm Road	Burlington	VT
SNF	Starr Farm Nursing Center	98 Starr Farm Road	Burlington	VT
LTACH	Kindred Hospital Seattle - First Hill	1334 Terry Avenue	Seattle	WA
LTACH	Kindred Hospital Seattle - Northgate	10631 8th Avenue NE	Seattle	WA
IRF	UW Health Rehabilitation Hospital	5115 N. Biltmore Lane	Madison	WI
IRF	Rehabilitation Hospital of Wisconsin	1625 Coldwater Creek Drive	Waukesha	WI

ATTACHMENT 11

Illinois Department of PUBLIC HEALTH

HF113309

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	I.D. NUMBER
05/31/2018		0005777

Long Term Acute Care Hospital

Effective: 06/01/2017

Greater Peoria Specialty Hospital LLC
dba Kindred Hospital Peoria
500 West Romeo B Garrett Avenue

Peoria, IL 61605

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #48240 5M 5/16

ATTACHMENT 11

Greater Peoria Specialty Hospital, LLC

Peoria, 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

October 9, 2015

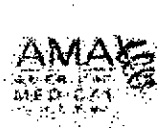
Accreditation is customarily valid for up to 36 months.

Rebecca J. Patchin, MD
Chair, Board of Commissioners

ID #484161
Print/Reprint Date: 12/15/2015

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.



ATTACHMENT 11

Kindred Healthcare

January 29, 2018

Ms. Courtney Avery
Illinois Health Facilities
And Services review Board
525 West Jefferson
Springfield, IL 62761

RE: Certificate of Exemption Applications

Dear Ms. Avery:

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

1. Neither Kindred Healthcare, Inc., THC – Chicago, Inc., THC – North Shore, Inc., Kindred THC Chicago, LLC, Kindred THC North Shore, LLC, or Greater Peoria Specialty Hospital, LLC ("the Kindred applicants") have had any adverse actions against any facility owned, operated, and/or controlled by the Kindred applicants during the three (3) year period prior to the filing of this application, and
2. The Kindred applicants authorize the State Board and Agency access to information to verify documentation or information submitted in response to the requirements of Review Criterion 1110.230.b or to obtain any documentation or information which the State Board or Agency finds pertinent to this application.

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

Sincerely,

Joseph L. Landenwich
General Counsel and Corporate Secretary
Kindred Healthcare, Inc.

STATE OF KENTUCKY

COUNTY OF JEFFERSON

The foregoing instrument was acknowledged and sworn to before me this 29th day of January, 2018 by Joseph L. Landenwich, General Counsel and Corporate Secretary of KINDRED HEALTHCARE, INC., on behalf of the company.

SEAL

Notary Public

Commission Expiration Date: 3-28-18

ATTACHMENT 11

680 South Fourth Street Louisville, Kentucky 40202
502.596.7300 KY TDD/TTY# 800.648.6057

Ms. Courtney Avery
Illinois Health Facilities
And Services review Board
525 West Jefferson
Springfield, IL 62761

RE: Certificate of Exemption Applications

Dear Ms. Avery:

This letter is being provided on behalf of Kentucky Hospital GP, Inc., TPG VII Kentucky Holdings I, L.P. and Kentucky Hospital Holdings JV, L.P. ("the TPG applicants"). The TPG applicants operate licensed health care facilities in Illinois.

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

1. The TPG applicants have not had any adverse actions against any facility owned, operated, and/or controlled by the applicants during the three (3) year period prior to the filing of this application, and
2. The TPG applicants authorize the access to information to verify documentation or information submitted in response to the requirements of Review Criterion 1110.230.b or to obtain any documentation or information which the State Board or Agency finds pertinent to this application.

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

Sincerely,

Adam Fliss
Secretary of Kentucky Hospital GP, Inc.,
General Partner of Kentucky Hospital Holdings JV, L.P.
Vice President and Secretary of TPG VII Kentucky GP, Inc.,
General Partner of TPG VII Kentucky Holdings I, L.P.

Date: 1/23, 2018

Notarized See attached

ATTACHMENT 11

CALIFORNIA ALL-PURPOSE ACKNOWLEDGMENT **CIVIL CODE § 1189**

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)
County of San Francisco)

On Jan 23, 2018 before me, Kimberly Drury, Notary Public
Date Here Insert Name and Title of the Officer

personally appeared Adam Flisa
Name(s) of Signer(s)

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/~~are~~ subscribed to the within instrument and acknowledged to me that he/~~she/they~~ executed the same in his/~~her/their~~ authorized capacity~~(ies)~~, and that by his/~~her/their~~ signature~~(s)~~ on the instrument the person~~(s)~~, or the entity upon behalf of which the person~~(s)~~ acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

KIMBERLY A. DRURY
Commission # 2105325
Notary Public - California
San Francisco County
My Comm. Expires Mar 30, 2019

Signature Kimberly A. Drury
Signature of Notary Public

Place Notary Seal Above

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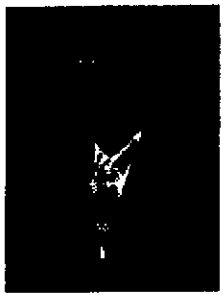
Accreditation Quality Report

The Joint Commission

Attachment 11

Version: 3
Date: 8/29/2016



Welcome to the Joint Commission's Quality Report. We know how important reliable information is to you and your family when making health care decisions. This Quality Report will help you make the right decisions to meet your needs. Since 1951, the Joint Commission has been the national leader in setting standards for health care organizations. When a health care organization seeks accreditation, it demonstrates commitment to giving safe, high quality health care and to continually working to improve that care.

The Quality Report is only one way to determine whether a health care organization can meet your needs. Discuss this report with your doctor or with other professional acquaintances before making a care decision. In addition to the accreditation status of the organization, the Quality Report uses checks, pluses, and minuses in each of the following key areas to help you compare a health care organization with similar accredited organizations.

- National Patient Safety Goals - safety guidelines that target the prevention of medical errors such as surgery on the wrong side of the body and safe medication use.
- National Quality Improvement Goals - measures the care of patients with specific conditions such as heart failure or pregnancy.

Not all measures are relevant to or available for all types of health care organizations. The Joint Commission will add relevant measures of health care quality as more measures become available. Your comments are just as important to us. The content and format of the Quality Report will be updated from time to time based on changes in the health care industry and your suggestions. Please call Customer Service at 630-792-5800 or e-mail the Joint Commission at qualityreport@jointcommission.org with your comments and suggestions.

Mark R. Chassin, MD, MPP, MPH
President of the Joint Commission

Summary of Quality Information

Symbol Key

- The organization has met the National Patient Safety Goal.
- The organization has not met the National Patient Safety Goal.
- The Goal is not applicable for this organization.

For further information and explanation of the Quality Report contents, refer to the "Quality Report User Guide."

Accreditation Programs	Accreditation Decision	Effective Date	Last Full Survey Date	Last On-Site Survey Date
Hospital	Accredited	10/9/2015	10/8/2015	10/8/2015
Laboratory Accreditation Program	Accredited	2/24/2016	2/23/2016	2/23/2016

Accreditation programs recognized by the Centers for Medicare and Medicaid Services (CMS)

Pathology and Clinical Laboratory

Hospital

		Compared to other Joint Commission Accredited Organizations	
		Nationwide	Statewide
Hospital	2015National Patient Safety Goals	✓	✓*
Laboratory Accreditation Program	2016National Patient Safety Goals	✓	✓*

Attachment 11

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Locations of Care

* Primary Location

Locations of Care	Available Services
Greater Peoria Specialty Hospital, LLC * DBA: Kindred Hospital Peoria 500 W. Romeo B Garret Avenue Peoria, IL 61605	**Services:** • Blood Donor Center • CT Scanner (Imaging/Diagnostic Services) • General Laboratory Tests • Inpatient Unit (Inpatient) • Medical /Surgical Unit (Inpatient) • Medical ICU (Intensive Care Unit)

Attachment 11

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2015 National Patient Safety Goals

Symbol Key

The organization has met the National Patient Safety Goal.

The organization has not met the National Patient Safety Goal.

The Goal is not applicable for this organization.

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fer to the "Quality
eport User Guide."

Hospital

Safety Goals	Organizations Should	Implemented
Improve the accuracy of patient identification.	Use of Two Patient Identifiers	✓
	Eliminating Transfusion Errors	✓
Improve the effectiveness of communication among caregivers.	Timely Reporting of Critical Tests and Critical Results	✓
Improve the safety of using medications.	Labeling Medications	✓
	Reducing Harm from Anticoagulation Therapy	✓
	Reconciling Medication Information	✓
Use Alarms Safely	Use Alarms Safely on Medical Equipment	✓
Reduce the risk of health care-associated infections.	Meeting Hand Hygiene Guidelines	✓
	Preventing Multi-Drug Resistant Organism Infections	✓
	Preventing Central-Line Associated Blood Stream Infections	✓
	Preventing Surgical Site Infections	✓
	Preventing Catheter-Associated Urinary Tract Infection	✓
The organization identifies safety risks inherent in its patient population.	Identifying Individuals at Risk for Suicide	✓
Universal Protocol	Conducting a Pre-Procedure Verification Process	✓
	Marking the Procedure Site	✓
	Performing a Time-Out	✓

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2016 National Patient Safety Goals

Symbol Key

The organization has met the National Patient Safety Goal.

The organization has not met the National Patient Safety Goal.

The Goal is not applicable for this organization.

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uality Report contents,
fer to the "Quality
eport User Guide."

Laboratory Accreditation Program

Safety Goals	Organizations Should	Implemented
Improve the accuracy of patient identification.	Use of Two Patient Identifiers	✓
Improve the effectiveness of communication among caregivers.	Timely Reporting of Critical Tests and Critical Results	✓
Reduce the risk of health care-associated infections	Meeting Hand Hygiene Guidelines	✓

Attachment 11

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SECTION V
CHANGE OF OWNERSHIP (CHOW)
Kindred Hospital Peoria

Applicable Review Criteria

Criterion 1130.520(b)(1)(A) Names of the parties
The parties named as an applicant are:

1. Greater Peoria Specialty Hospital, LLC, the entity that is the hospital's License Holder
2. Kindred Healthcare, Inc., the entity currently having "final control" over the License Holder
3. Kentucky Hospital Holdings JV, L.P., the entity that will have "final control" over the License Holder through its General Partner Kentucky Hospital GP, Inc.
4. Kentucky Hospital GP, Inc., the general partner of Kentucky Hospital Holdings JV, L.P.
5. TPG VII Kentucky Holdings I, L.P., which will hold a 50.93% interest in Kentucky Hospital Holdings JV, L.P.

Note: The hospital is a joint venture, with Kindred Healthcare, Inc. holding a 51% interest

Criterion 1130.520(b)(1)(B) Background of the parties
Provided in ATTACHMENT I are Certificates of Good Standing for each applicant identified above. Provided in ATTACHMENT 11 are:

1. Listings of Illinois Health Care Facilities owned by the applicants
2. A certification from each applicant that no adverse actions have been taken again any facility owned and/or operated in Illinois by the applicant during the past three years
3. Each applicants' authorization permitting HFSRB and IDPH access to documents necessary to verify the information submitted
4. A photocopy of the facility's IDPH license
5. Confirmation of accreditation.
6. A photocopy of The Joint Commission *Accreditation Quality Report*

Criterion 1130.520(b)(1)(C) Structure of transaction
The change of ownership will be the result of a stock acquisition.

Criterion 1130.520(b)(1)(D) Name of the person who will be licensed or certified entity after the transaction
Please see Criterion 1130.520(b)(1)(A), above.

Criterion 1130.520(b)(1)(E) List of the ownership or membership interests in such licensed or certified entity both prior to and after the transaction, including a description of the applicant's organization structure with a listing of controlling or subsidiary persons.
Current and post-closing organizational charts are provided in ATTACHMENT 4, identifying all applicable Illinois facilities. The facility is currently 51% owned by Kindred Healthcare, Inc. as the ultimate parent entity, and upon the finalizing of the transaction will be 51% owned by Kentucky Hospital Holdings JV, L.P. as the ultimate parent entity.

Criterion 1130.520(b)(1)(F) Fair market value of assets to be transferred
The health care facility's value, per its November 30, 2017 balance sheet is $8,572,878. This amount is identified as the facility's fair market value for purposes of this Certificate of Exemption application, exclusively.

Criterion 1130.520(b)(1)(G) The purchase price or other forms of consideration to be provided for those assets
Kindred Healthcare, Inc., including entities not addressed through Illinois' Certificate of Exemption process will be acquired for $9.00 per share, with the entire transaction being valued at approximately $4.1 Billion, including incurred debt.

Criterion 1130.520(b)(2) Affirmation that any projects for which Permits have been issued have been completed or will be completed or altered in accordance with the provisions of this Section.
By its respective signatures on the Certification Pages of this Certificate of Exemption application, the applicants affirm that none of the applicants hold COEs or Certificate of Need ("CON") Permits that have not been completed.

Criterion 1130.520(b)(2) If the ownership change is for a hospital, affirmation that the facility will not adopt a more restrictive charity care policy than the charity care policy that was in effect one year prior to the transaction. The hospital must provide affirmation that the compliant charity care policy will remain in effect for a two-year period following the change of ownership transaction.
Kindred hospitals located in Illinois are committed to providing high quality, comprehensive health care services to patients regardless of their ability to pay. Eligibility for charity care may be considered for those individuals who provide documentation of ineligibility and/or denial of coverage, including government sponsored programs.

The facility addressed through this COE application does not have formal charity care policies. Following the completion of the proposed acquisition, the potential of developing formal charity care policies will be evaluated.

Criterion 1130.520(b)(2) A statement as to the anticipated benefits of the proposed changes in ownership to the community
Kindred Healthcare, Inc. will retain responsibility for the day-to-day operation of the facility. As a result, no appreciable benefits or detriments to the community are anticipated.

Criterion 1130.520(b)(2) The anticipated or potential cost savings, if any, that will result for the community and facility because of the change in ownership.
To date, no anticipated savings have been quantified by the applicants.

Criterion 1130.520(b)(2) A description of the facility's quality improvement mechanism that will be utilized to ensure quality control
Kindred Healthcare, Inc. operates its facilities consistent with a detailed *Strategic Quality Operational Plan*, addressing a variety of quality assurance initiatives. Following the proposed transaction, Kindred Healthcare, Inc. will maintain responsibility for the day-to-day operation of the facility addressed in this COE application, and will continue to operate the facility under the *Plan*. A copy of the *Plan* is attached.

ATTACHMENT 15

Criterion 1130.520(b)(2) A description of the selection process that the acquiring entity will use to select the facility's governing body
Membership in the governing Board will be named by the acquiring entity as the acquisition process progresses, but prior to the transaction's closing.

Criterion 1130.520(b)(2) A statement that the applicant has prepared a written response addressing the review criteria contained in 77 Ill. Adm Code. 1110.240 and the response is available for public review on the premises of the facility
The applicants have prepared a written response, which is available for public view at the facility.

Criterion 1130.520(b)(2) A description or summary of any proposed changes to the scope of services or levels of care currently provided at the facility that are anticipated to occur within 24 months after acquisition.
None are currently anticipated.

Strategic Quality Operational Plan

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SECTION I

Commitment to Quality

Kindred's commitment to key quality indicators are aligned with and driven by our Mission, Vision, Values, Critical Success Factors, and our Management Philosophy. The Strategic Quality plan incorporates research and evidence from a variety of sources including the Institute for Healthcare Improvement (IHI), the Agency for Healthcare Research and Quality, the National Quality Forum and others.

Our Mission

Kindred Healthcare's mission is to promote healing, provide hope, preserve dignity and produce value for each patient, resident, family member, customer, employee and shareholder we serve.

Our Vision

Kindred Hospital Division's Vision is to be the hospital company of choice in the past-acute hospital setting and to provide a level of service and quality that is unequaled in the field.

Our Values

- Give your best
- Respect individuality to create team
- Be kinder than expected
- Do the right thing
- Treat others the way they want to be treated
- Create fun in all that you do
- Stay focused on the patient
- Take responsibility for every action you make

Critical Success Factors

- Manage Capital Wisely
- Be Efficient
- Grow
- Take Care of our People
- Organizational excellence through performance improvement
- Take care of our patients and customers

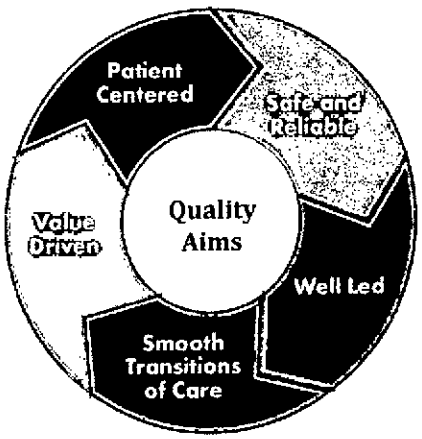
Kindred Management Philosophy

Focus on our people, on quality and customer service, and our business results will follow

Quality Aims

Our Strategic Quality Plan is the roadmap to excellence. The foundational underpinnings to Quality at Kindred are based on 5 Quality AIMS, adapted from the Institute of Medicine's (IOM) landmark report *Crossing the Quality Chasm*, the Institute for Healthcare Improvement's (IHI) Triple Aims, and Agency for Healthcare Research and Quality's (AHRQ) National Quality Strategy:

I. Patient Centered
II. Well Led
III. Safe and Reliable
IV. Smooth Transitions of care
V. Value Driven



Implementation of the Strategic Quality Plan is a strategy to mold the culture into one that values the Quality AIMS. Clinical programs, patient care processes and practices are evidence-based and focus on reducing variation and improving outcomes.

AIM I - Patient Centered Care

AIM One is an unwavering focus on patient's needs and expectations

- Care that is coordinated, informed and grounded in respectful interactions with care providers that are consistent with the patient's values, expectations and care decisions
- Care is efficient through appropriate use of resources at the least expense to the patient, provider and care setting
- Care is timely and provided without delay to mitigate any harm to a patient

Patient-centered care requires regular re-examination of the "Voice of the Customer" to gain ongoing feedback and insight about the effectiveness of processes critical to the patient.

AIM II - Safe, Reliable, Predictable and Regulatory Compliant

AIM Two is to provide care, which is safe, reliable and meets regulatory standards

- Delivery of care in a manner that minimizes the risk of harm to a patient
- Effective and reliable through use of evidence-based practices
- Ongoing compliance with regulatory and accreditation standards'
- Monitoring and Self-Assessment to ensure a continued state of survey readiness
- Compliance with mandatory reporting requirements

It is a core operational responsibility for every executive and every person providing and supporting care in our hospitals to ensure an environment where care is safe, effective and centered on patients' needs.

AIM III - Well-Led

AIM Three is to be well led with a bias towards action by clinical and operational leaders to achieve quality and safety objectives.

- Leaders set direction by aligning and coordinating strategic priorities and key initiatives
- Leaders build the foundation for execution by hiring, mentoring and retaining competent, quality-driven key leaders.
- Leaders who are quality driven effectively identifying issues, allocating resources, ensuring accountability and leading the execution of operational processes to maintain quality
- Leaders are visible conducting leadership rounding that ensures an understanding of needs, barriers and expectations of patients, families, and staff.

Leaders set expectations for continuous improvement by never being satisfied with anything less than the best.

AIM IV - Smooth Transitions of Care

AIM Four is to ensure smooth transitions of care during the hospital stay and to the next site of care. A standardized approach to key meetings ensures a safe, smooth and effective patient-centric approach during all transition of care **(Appendix D: Data Reporting Procedures)**

- Interdisciplinary Team (IDT) meetings ensure care planning begins upon admission and includes the development of discharge plans for each patient.
- IDT meetings are focused on "completing the care" to assure patients receive the right care at the right time and in the right place. The team utilizes a quality crosswalk **(see APPENDIX C for location of IDT Quality Crosswalk)** to ensure outcomes are viewed and discussed in "real time."
- Daily Transitions meetings track progress in order to maintain continuity of care and services needed to achieve treatment goals, eliminate barriers and facilitate the transition to the next level of care.

Identifying preventable delays that may prolong the hospital stay enhances patient satisfaction and continually creates patient value.

AIM V - Value-Driven

AIM Five is to provide care that is patient centered while adding patient value, conserving resources and avoiding waste.

- Resource utilization decisions, particularly in terms of additional new resources, should be evaluated as to the value added to the patient.
- Process improvement efforts work to eliminate non-value added steps hence improving performance and reducing cost.

- Hospital performance is compared to other hospitals within Kindred and external organizations or benchmarks, to achieve a best in class standard of excellence.

The leadership team must align all improvement activities with the strategic AIMS for the organization and identify gaps in activities and infrastructure that would be barriers to reaching goals.

- Clarify accountability for processes and outcomes throughout the organization
- Build the infrastructure for regular review and alignment of new and on-going initiatives, through data collection, analysis and reporting structures
- Create and publish a hospital-wide view of how key improvement activities and strategies throughout the organization align with strategic goals and aims. Make the Balanced Scorecard visible!
- Create reward and recognition systems for attainment of goals aligned with the strategic aims, assuring that the systems contribute to gain for the whole organization

SECTION II

Scope, Authority and Responsibilities

The Strategic Quality Plan provides the structure and processes for identifying, responding to, and implementing opportunities to fulfill our commitment to organizational excellence and the achievement of our Quality Aims. This quality plan is the central performance improvement plan in the organization and encompasses the inter-related functions and processes of clinical care, governance, operational and support services. Leaders foster performance improvement through planning, educating, setting priorities, providing appropriate time and resources and by constantly focusing on the primary tenets of the Strategic Quality Plans Quality Aims.

The Committee Structure is standardized to ensure consistent, transparent and effective implementation and oversight. The structured process:

- Facilitates a consistent unified structure to meet Strategic Quality Plan goals and objectives.
- Ensures an effective process for implementing the Hospital's QAPI program.
- Promotes transparent communication to the Quality Council, Medical Executive Committee and Governing Board.

The standardized Committee Structure, which includes standardized committee dashboards, provides a transparent method for data collection, aggregation, analysis and review of quality of care and safety concerns at the primary committee level. Utilization of the committee standardization process facilitates integration of quality and patient safety throughout the hospital through self-identification of issues, development of interdisciplinary action plans, to include physicians, and monitoring for rapid cycle improvement. The leadership of the facility, Quality Council, Medical Executive Committee, and Governing Board has the ultimate responsibility for monitoring and oversight of the effectiveness of the QAPI process. (See Section VI)

Governing Body

The ultimate responsibility for performance improvement rests with the Hospital Governing Board. The authority and responsibility for the day-to-day operations and performance improvement activity is delegated to the Hospital Quality Council and hospital leadership, including the leadership of the Medical Executive Committee.

Quality Council

The Hospital Quality Council is the central coordinating body for all performance improvement and patient safety activities within the hospital. The Quality Council meets regularly to ensure oversight of quality activities within the hospital. The President of the Medical Staff (or designee) shall serve as Chairperson and the Chief Executive Officer shall serve as Vice-Chairperson. Membership includes representation from both Medical Staff and various leadership positions; Medical Staff Members must be present (telephonically, if necessary).

The Quality Council coordinates the performance improvement process by:

- Establishing a planned, systematic, organization-wide approach to performance measurement, analysis and improvement.
- Utilizing Quality Council (QC) Committee structure that supports the implementation of the hospital-wide improvement process to include the following:
  - Planning the process of improvement activity to meet quality patient safety goals
  - Determining the scope and focus of measurement
  - Setting priories for improvement
  - Systematically measuring, analyzing and directing performance improvement
  - Implementing improvement activities based on assessment conclusions
  - Maintaining achieved improvements
- Standardized dashboards are utilized to ensure all performance improvement activities are reviewed in the appropriate QC Committee prior to review at Quality Council meetings. Committee configurations may vary according to size of facility, but standard dashboards covering established functions will be followed.
- Setting expectations for leadership and staff participation in interdisciplinary and interdepartmental performance improvement and patient safety activities.
- Allocating resources for the hospital's performance improvement and safety activities. Commissions/convenes performance improvement teams and approval of project selection for specific improvement efforts and monitors its progress.
- Ensuring that processes for identifying and managing serious and sentinel patient safety events are defined and implemented.
- Implementing and monitoring compliance with the National Patient Safety Goals (NPSG).
- Evaluating the effectiveness of the Strategic Quality Operational Plan and the effectiveness of leadership's contributions to performance improvement and patient safety at least annually. (See Appendix C for location of Quality Council Evaluation)

First Level Working Committees (also see Section VI)

First level working committees report to the Quality Council using specified dashboards with established meeting frequencies (minimum meeting frequency is quarterly). The first level working committees ensure substantive analysis of data and action planning occurs prior to review at Quality Council. These committees work to conduct data review and analysis as well as action planning and tracking and trending of action plans effectiveness on results.

This continuous flow of information and feedback ensures that quality of care and safety concerns are brought forth and addressed by the appropriate individuals and committees responsible for quality assurance and improvement activities.

The Medical Staff

The medical staff has a leadership role in organizational performance improvement and patient safety activities, particularly when a process is dependent primarily on the activities of individuals with clinical privileges. The Medical Staff Bylaws describe the expectations of members of the Medical Staff and allied health practitioners (AHPs) and their roles in quality improvement. The Medical Staff Rules and Regulations are expected to conform to the Medical Staff Bylaws.

The medical staff provides leadership in the areas of performance improvement and patient safety including though not limited to:

- Medical assessment and treatment of patients.
- Use of medications including safe ordering, transcription, dispensing and administration of medications.
- Outcomes related to resuscitative services
- Utilization of services and clinical products (i.e. operative and other procedure(s), blood products)
- Appropriateness and significant departures from established patterns of clinical practice
- Accurate, timely, and legible completion of patients' medical records
- Other activities as specified in the Medical Staff By-Laws

SECTION III

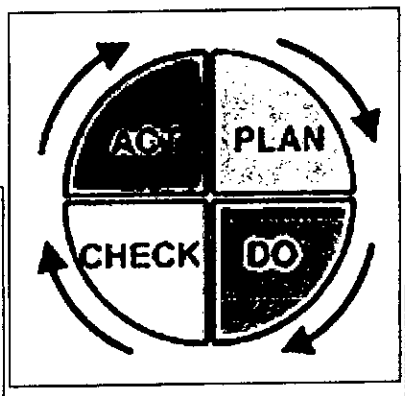
Quality Framework

Integrating Performance Improvement methodologies and tools is essential to a systematic approach to continuous process improvement. Continuous improvement is an ongoing effort to improve products, services or processes. These efforts can seek "incremental" improvement over time or "breakthrough" improvement all at once. PDCA is used to coordinate improvement efforts through emphasis on planning. The PDCA cycle goes from problem identification to implementation of the solution.

P: Plan, determine what the improvement will be and the method for data collection.
D: Do, implement the plan.
C: Check, review, and analyze the results.
A: Act, hold the gain and continue with the improvement

Act:
Keep the change or go back to planning.

Check the results of the change:
- Find out from people involved what happened.
- Identify positives and negatives.
- Measure and compare before and after results.
- Is the result/outcome better?
- Was the defined goal met?



PLAN the test of change via activities, actions, process steps (examples):
- Flowchart current processes.
- Determine the cause and effect of why you do what you do (to identify barriers).
- Flowchart a streamlined process removing waste or steps.

Do implement the change:
- Make sure all staff involved are aware of the plan.
- Make sure the Administrative team is on board and supportive of plan.

PDCA should be repeated for continuous improvement. If the solution does not improve the process, it is removed and the cycle is repeated with a different plan. If the solution does improve the process, it is standardized and the new process system knowledge is used to implement new improvements, beginning the cycle again.

Performance Improvement Teams (PIT) are convened when specific hospital-wide or interdepartmental issues are identified. The purpose of the PIT is to perform intensive analysis using a planned, systematic, organization-wide approach that facilitates designing, measuring, assessing and improving performance, using the PDCA methodology. Dependent upon the complexity of the process for improvement or design, other models may be selected such as process re-engineering, Rapid Cycle Improvement methods, etc.

Telling Your Quality Story through Data Visualization

Aggregation and analyses transform data into information that can be used to plan, change or monitor care. Performance is compared against industry standards, internal benchmarks, comparable external organizations and best practices in order to determine patterns and trends. Information from data analyses, process review and performance improvement efforts are used to make changes that improve performance, increase safety and reduce risk of a sentinel event occurring.

The utilization of statistical tools and methods in the analysis process is an expectation. Their use allows us to display data in different ways to uncover specific kinds of information, such as performance over time and performance depending on certain variables. When data is organized in a chart format, trends, patterns and relationships emerge. Charts give us a way to summarize large amounts of data at a quick glance. Different tools are designed for different purposes but all are generally designed to help us better understand our processes and the variation inherent in them. By understanding the type and cause of variation through the use of statistical tools and methods, the organization can focus its attention and resources on making improvements to the processes that will result in better outcomes.

The main goal of data visualization is to clearly and effectively communicate the information and performance through graphical means. When telling the story, the focus should be on providing visual analysis of data sets and communicating key aspects in an intuitive way. Example tools used to tell the story include:

Flow Charts: Flow charts show all steps in a process and give people a visual of the "big picture" so they see how each step is related to the next. Flow charts also help identify the most efficient way to complete a task or process:

Pareto Charts: Pareto charts are bar graphs that show in descending order how often a situation occurs. They identify consistent or frequent problems, and they help the team decide where to begin the improvement process.

Scatter Diagrams: Scatter diagrams show relationships between occurrences, situations, or actions. They allow the team to identify variables and the ways these variables affect the outcome.

Fishbone Diagrams: Fishbone diagrams are visuals used to show cause and effect. They help people explore what, when, and why therapy went wrong (or right).

Control Charts: Control charts, also known as Shewhart charts, are tools used to determine if a process is in a state of statistical control. Data are plotted in time order. It always has a central line for the average, an upper line for the upper control limit and a lower line for the lower control limit. These lines are determined from historical data.

Trend lines: A trend line visually identifies both trends and random variations in data. The more points used to draw the trend line, the more validity attached to the direction represented by the trend line.

SECTION IV

Using Outcomes to Drive Performance

Quality Assurance and Performance Improvement (QAPI) is a philosophy that encourages all members of a facility to identify new and better ways to do their job. The single best indicator of the effectiveness of the QAPI is the ability of a hospital to self-identify quality issues. Integrating self-assessment methodologies into everyday work processes makes for an efficient way to collect data and identify where systems are falling short, to make corrective adjustments, and to track outcomes.

The following Kindred processes are examples of concurrent *self-assessment* activities performed to evaluate compliance to regulatory and accreditation standards as well as key internal policies and procedures.

Examples of Self-Assessment Activities:

Tracers: Tracers are designed to "trace" the care experiences that a patient had while at Kindred or "trace" one specific process within the organization (i.e., complaint/grievance process). It is a way to analyze the system or process using actual patients as the framework for assessing compliance. While individual tracers follow a patient through his or her course of care, the system tracer evaluates the system or process, including the integration of related processes, and the coordination and communication among disciplines and departments in those processes. The results of tracers are used to formulate an action plan to address any identified deficiencies or issues.

Leadership Rounding: Rounding for outcomes is one of the skills used to better serve our patients, physicians and staff. Leaders round to build relationships, assess employee morale, harvest wins and identify and remove barriers that prevent staff from doing their jobs. Leadership rounding brings a different set of eyes and ears to the patient's bedside on a regular basis. As a result it presents an opportunity for service recovery, allows for gathering of information for staff reward and recognition, and helps connect leaders to our mission of serving patients.

Complaint and Grievance Process: A process to timely review, investigate, and resolve a patient's dissatisfaction. In addition to meeting regulatory requirements, a complaint and grievance process is an essential part of the quality program through identification of trends and patterns within the clinical and customer service program.

Quality Assurance (QA)/Quality Control (QC) Audits: QA audits may be a systematic review of care against explicit criteria (prevention of "defects"). QC audits are used to identify "defects" (temperatures, lab QCs, etc.). Departments use audits specific to their own PI goals. Regulatory audits may be specific to State and Federal expectations. The results of QA audits are often used to calculate rates for benchmark and other key performance indicators.

Quality and Regulatory Review (QRR) and Survey Readiness Visits (SRVs): The Division (through regional clinical operations and plant operations contract partners conducts formal onsite and offsite reviews to determine survey readiness in meeting The Joint Commission (TJC) accreditation

standards and Centers for Medicare/Medicaid Services' (CMS) Hospital Conditions of Participation. QRRs rely heavily on patient and system tracers to evaluate the organization's potential performance during a survey.

Interdisciplinary Team (SQP/IDT crosswalk): The interdisciplinary team oversight and discussion of quality of care services, risk reduction and prevention opportunities, resource appropriateness and efficiency, and patient & family education allows for rapid cycle improvement opportunities. It also facilitates a concurrent review for accurate clinical documentation as a way to provide a clear story of each patient's care.

Flash/Daily Transitions/Care Plan Management Meetings: Daily Flash meeting is a CEO led interdisciplinary forum for daily evaluation of operations (e.g., staffing, patient change of conditions, equipment needs, plant issues, etc.). Daily Transitions meetings is a CCO led interdisciplinary forum for daily evaluation of 1) details related to timely follow up of patient care plan needs and 2) safe, organized transitions to next levels of care. These meetings allow for a concurrent evaluation of multiple performance indicators.

Failure Modes and Effects Analysis (FMEA): A proactive step-by-step approach for identifying all possible failures in a design, process, or a product or service. "Failure modes" means the ways, or modes, in which something might fail. Failures are any errors or defects, especially ones that affect the customer, and can be potential or actual.

Hazard Vulnerability Analysis (HVA): Provides a systematic approach to documenting potential threats that may affect demand for the hospitals services or its ability to provide those services. It is an essential component to a risk assessment, particularly related to emergency operations in a disaster.

Satisfaction Surveys: Patient, Employee and Physician feedback allow for identification of what your customers think is important, what they want, and where you need to improve. Patient safety culture surveys evaluate whether quality and safety are core values in the organization.

Annual Plans: This scheduled activity provides a consistent evaluation that highlights the achievements and continued challenges facing specific clinical programs such as Infection Prevention and Control, Risk Management, Environment of Care and Education.

Event/Error and Near Misses Analysis: Reporting of errors in a just culture environment allows individuals to report errors or near misses without fear of reprimand or punishment. This allows for identifying and addressing systems issues that lead individuals to engage in unsafe behaviors, while maintaining individual accountability by establishing zero tolerance for reckless behavior. Analysis with or without event calls can lead to identification of process change needs.

Clinical and Service Indices: A composite of several indicators into a single measure. Provides a quick self-assessment of several key division indicators.

Mortality Review: Review of patient deaths to evaluate clinical practice patterns and identify significant departure from established patterns of clinical practice.

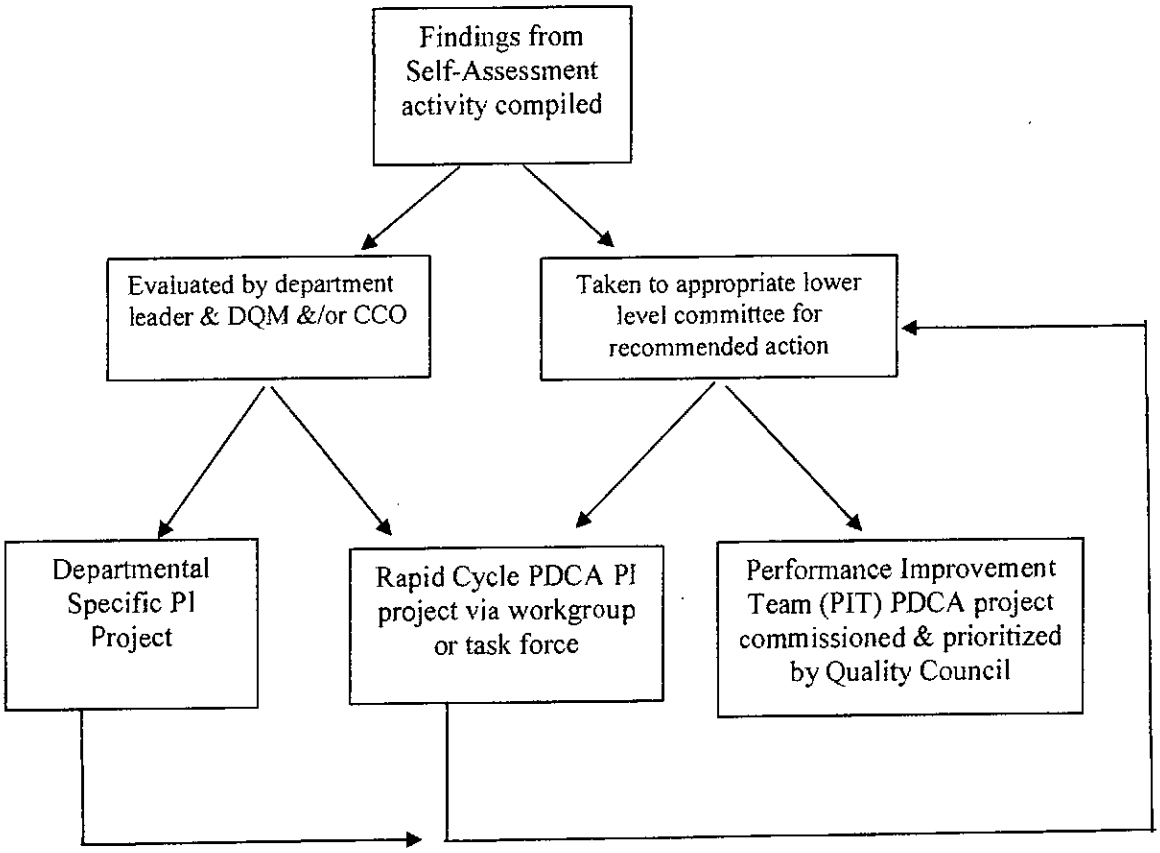
Findings from the above (and other) self-assessment strategies trigger the performance improvement methodology used to drive change. The flow diagram depicted in Figure 1 is the typical process used. In summary, the process is such that self-assessment results are either evaluated by a department leader or DQM, and in collaboration with the CCO, who determine an appropriate PI project plan. If the results involve clinicians from more than a single department a decision is made to commission a PDCA project, either via a rapid cycle process or a more traditional Quality Council sanctioned Performance Improvement Team (PIT) project.

Rapid cycle is applying the recurring sequence of PDCA in a brief period of time to solve a problem or issue facing the team that will achieve breakthrough or continuous improvement results quickly.

If the results are to be reviewed and analyzed for committee recommended actions, Quality Council would commission and prioritize a formal PIT PDCA project. These QC sanctioned PIT projects typically include those improvements that are more organization-wide oriented (involves multiple departments), may require input from outside subject matter experts, and just generally command more time and human resources making the process slower and more methodical. Additionally, the Quality Council determines the prioritization of the performance improvement teams needed based on specific criteria. Performance Improvement Teams report progress and/or results through the Quality Council committee structure.

A PI project may begin as rapid cycle but evolve to a formal QC sanctioned PIT because of additional information obtained and a necessity to have more organizational level oversight.

Figure 1: PI Process



This same process is used when improvement opportunities are identified from external agencies (e.g., complaint survey, triennial accreditation survey, health department inspection). The goal, however, is to integrate an ample number of the right kind of self-assessments that provide a satisfactory sampling of current processes that are considered to be high risk, problem prone, low volume, etc.

See Appendix C for Location of Example PI Tools:

SECTION V

Quality Indicators

Quality indicators (or measures) are important as a way to document the outcomes of care, treatment and services provided and to identify opportunities for improvement. Kindred Hospitals annually determine the indicators it will use to measure performance as well as set corresponding goals. This process is done via one of two mechanisms:

a) Key Quality Indicators are those measures hard-wired on the agendas/dashboards of the first level working quality committees. These indicators are not optional and must be measured and reported on a frequency established by the quality committee (generally tracked monthly, reported quarterly). These indicators are often a condition of a regulatory or accreditation requirement but can also include items that are important to the patient population served.
   - A subsection of the key quality indicators are those core measures which all Kindred hospitals track with the expectation that the results will be compared to other Kindred Hospitals as well as national comparative benchmarks or databases. These key indicators are chosen as a result of an evidence-based look at the patient population served and are determined to have the greatest influence on outcomes of care.

   - Key quality indicators also include those areas that assess compliance with federally-mandated measures such as CMS' Quality Reporting Program (QRP) reporting requirements or IMPACT Act Requirements for 2018 (new/worsened PW).

   Key quality indicators are expected to be measured and reported despite level of compliance. Goals are set by the hospital unless the dashboard includes a goal or threshold that is expected to be used (Appendix B identifies the goals/thresholds set by the hospital and which are set as a common goal to be used by all hospitals).

b) Hospital-Specific Quality Indicators are chosen by the facility due to the significance related to one of its own key success factors, results of self-assessment activities, quality control processes, other high-risk high/low volume, problem-prone, or patient safety issues.

   - Department-specific performance indicators are chosen based on a process or system that department(s) want to improve.
   - Self-assessment activity findings may trigger a need to add an indicator to one of the first level working quality committee agendas in order to draw attention to an improvement needed. A rapid cycle PDCA or QC commissioned PIT PDCA project may be warranted.
   - Critical check list findings (CEO and CCO checklists) and quality control results may trigger a need to add an indicator to one of the first level working quality committee agendas in order to draw attention to an improvement needed. A rapid cycle PDCA or QC commissioned PIT PDCA project may be warranted.

Once sustained compliance is achieved data collection and reporting on that indicator may conclude. Goals or thresholds are set by the hospital.

- In the case of department-specific indicators, the indicator that has achieved sustained compliance should be replaced with another improvement indicator.
- Self-assessment findings (including CEO & CCO checklists) or external agency deficiency findings that have been corrected with sustained compliance do not need to be replaced with another quality indicator.

Refer to the **Appendix B** for a complete library of Key Quality Indicators. Hospital-specific quality indicators can be added to the list locally or kept separately.

There are no specific requirements for a total number of indicators. A single indicator may fulfill the obligation for several categories (CLABSI is a key indicator on the Balanced Score Card, a CMS-QRP metric and meets the TJC requirement for monitoring infection control practices). Hospitals achieving desired performance targets, specifications or thresholds on hospital-specific measures may choose to change measures at any time, once performance levels are achieved and sustained.

Compliance to quality indicators is documented and presented to committee one of three ways:

1. Numeric Goal: A numeric goal includes a numerator and denominator. The numerator and denominator need to be explicit with regard to what is included or excluded in the measurement. For example, the numerator of mortality rate is total number of deaths for a month. The denominator is total number of discharges for that month. That definition must be followed exactly as written to ensure data validity. For example, changing the denominator to include only all non-hospice discharges would significantly change the result.

2. Summary Report: Those goals that are not numeric in nature are best evaluated through a summary report that demonstrates trends and patterns in outcomes achieved. For example, a Code Blue summary report allows for presentation of multiple elements included in that quality indicator. Some of the elements might be numeric, others might be non-numeric targets. The summary format allows for inclusion of key anecdotal notes, qualitative characteristics, and general observations, etc.

3. Existing Report: The Balanced Score Card and Benchmark Report are examples of static reports or queries available from the Business Warehouse (BW) that can be presented to a committee meeting as is. Analysis and action plans are added to these reports to demonstrate appropriate oversight and management of the data.

SECTION VI

Committee Structure

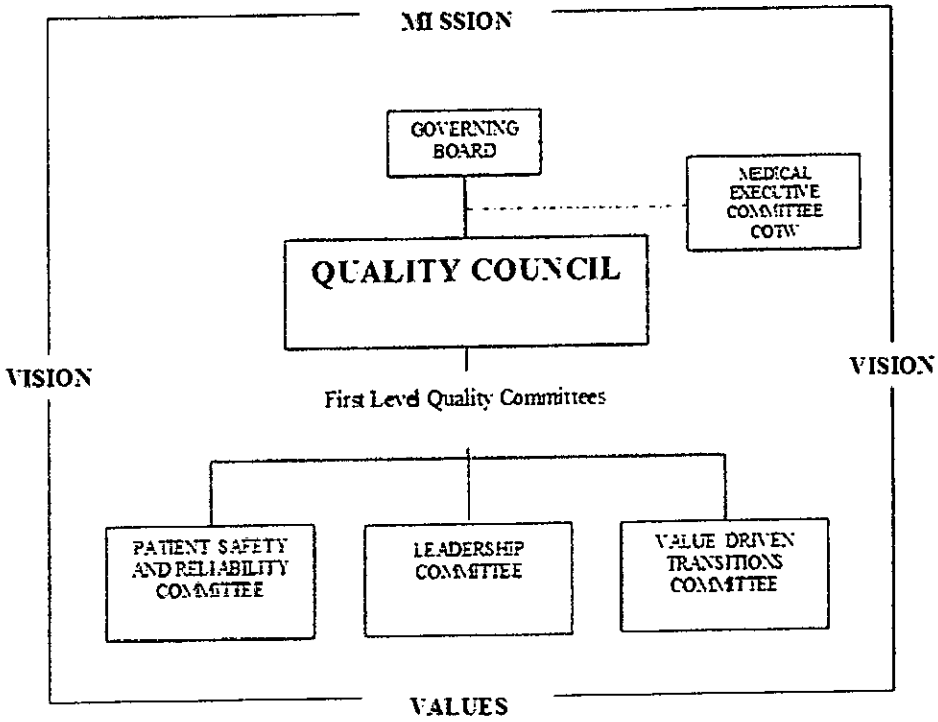
The Quality Council is the coordinating body for all hospital-wide quality assurance and performance improvement activities and processes. The Quality Council's Committee Structure supports implementation of the Quality Plan utilizing first level working quality committees with specified agendas, standardized dashboards and minimum meeting frequencies to ensure substantive analysis occurs prior to review at Quality Council. First level working committees report findings, analyses, recommendations, actions and follow up specific to the individual committee's functions.

Three first level working quality committees support the work of the Quality Council and cover all or parts of the following functions:

- Patient Safety and Reliability Committee
  - Pharmacy Nutrition and Therapeutics (PNT)
    - Antibiotic Stewardship
  - Infection Prevention and Control (IP&C)
  - Patient Care & Safety (including Critical Care, Operative & Invasive Procedures)
  - Laboratory / Radiology
- Leadership Committee
  - Leadership
  - Environment of Care (EOC)
  - Ethics
- Value Driven Transitions Committee
  - Utilization Management (UM)
  - Health Information Management (HIM)

Standardized Dashboards are utilized to help organize, track and trend key and hospital-specific quality indicators, monitoring activities and improvement efforts. Data are collected and reported on a frequency established by the first level committee (generally reviewed monthly and reported quarterly) to the designated first level committee. Subcommittees (often functional subcommittees such as PNT or HIM) may be designated to support the collection, aggregation, analyses and monitoring activities of a first level committee. Subcommittee summary forms are included in the Dashboard workbooks for documentation of subcommittee work that occurs between the quarterly first level committees. Hospital-specific quality indicators or performance improvement activities can be added to a specific dashboard at any time at the discretion of the hospital.

Credentialing activities may warrant more frequent meetings than quarterly to expedite applications and reapplications. The subcommittee summary form should be used to document discussions and recommendations between quarterly MEC meetings as well as for ad hoc (tele board) Governing Board approval activities.



When committee or monitoring findings fall outside of the parameters of expected or desired performance, an action plan is developed at the committee level. The PDCA process is utilized and clear responsibilities assigned. Proven strategies for prevention such as the Institute for Healthcare Improvement (IHI) Ventilator-Associated Pneumonia, Blood-Stream Infection and Catheter-Associated Urinary Tract Infection Bundles serve as the foundation for relevant improvement plans.

The Quality Council may determine additional actions or requirements are needed and redirect such actions to the working committees. Performance Improvement Teams may be convened by the Quality Council for significant and/or hospital-wide performance issues. Performance Improvement Teams will report progress and results to the Quality Council. The Quality Council will monitor compliance of the action plans and timelines as necessary.

This continuous flow of information and feedback encourages involvement from the individuals who are closest to the work and the committees they represent while having appropriate oversight by the leaders who are ultimately accountable for the quality assurance and improvement activities and program.

SECTION VII
Appendices

Appendix A: Terms / Definitions

Aggregate
A process for displaying data in a spreadsheet to provide results over time. Patterns and trends related to performance and/or compliance are identified and can then be analyzed.

Analysis
A process of interpretation and summarization of the data for a specific time period. The time frame may be determined based on the indicator or previous findings.

Clinical Quality Index
A composite of two or more indicators into a single metric used to measure performance in clinical care and outcomes.

Control Chart
A graphic display of data in the order they occur with statistically determined upper and lower control limits of expected common-cause variation.

Balanced Scorecard
Kindred Healthcare's key success factors scorecard. The indicators are reviewed with targets set on an annual basis.

Benchmark
A standard or point of reference against which things may be compared or assessed. Benchmarking is the process of comparing processes and performance metrics to best practices from other companies.

Benchmark Report
The title of one set of quality indicator data that is housed in Business Warehouse (such as Vent Admits, Vent Days, Restraint Days, CVL Days etc.).

Business Warehouse (BW)
Kindred Healthcare's Data Repository. Software that integrates, manages and stores data within the company from various data sources. Allows for business planning and analysis through data mining and visualization. Data entry is performed monthly for those elements that are not able to be compiled automatically.

CARE Data Set (Continuity Assessment Record and Evaluation)

A standardized patient assessment tool developed for use at acute hospital discharge and at post-acute care admission and discharge. The CARE Data Set is designed to standardize assessment of patients' medical, functional, cognitive, and social support status across acute and post-acute settings, including long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), and home health agencies (HHAs).

Daily Flash Meeting

A CEO led interdisciplinary forum for daily evaluation of operations (e.g., staffing, patient change of conditions, equipment needs, plant issues, etc.).

Daily Transitions Meeting

A CCO led interdisciplinary forum for daily evaluation of 1) details related to timely follow up of patient care plan needs and 2) safe, organized transitions to next levels of care.

Dashboard

Standardized tools utilized throughout the quality council reporting structure to help organize, track and trend key and hospital-specific quality indicators, monitoring activities and improvement efforts.

Data

Un-interpreted material, facts, or clinical observations.

Failure Mode, Effects, and Analysis (FMEA)

A systematic approach for identifying the ways that a process can fail, the potential effects of such a failure and the seriousness of that effect, resulting in a process or system redesign to minimize the risk of failure.

GAP analysis

Comparison of actual performance with potential or desired performance.

IMPACT Act

On September 18, 2014, Congress passed the *Improving Medicare Post-Acute Care Transformation Act of 2014* (the IMPACT Act). The Act requires the submission of standardized patient assessment data related to quality measures, resource use, and other measures. The data elements are standardized across post-acute settings to facilitate coordinated care and improve Medicare beneficiary outcomes.

Indicator

A measure used to determine, over time, an organization's performance of functions, processes, and outcomes. Therapists rate patients' abilities to complete specific functional tasks as part of assessments in both LTAC and Nursing Centers.

Performance Improvement (PI)

The continuous study and adaptation of a health care organization's functions and processes to increase the probability of achieving desired outcomes and to better meet the needs of individuals and other users of services.

Performance Measure

A quantitative tool generally defined as regular measurement of outcome results which generates reliable data on effectiveness and efficiency of a specified process.

Patient Safety Index

A composite of two or more indicators into a single metric used to measure performance in areas important to Patient Safety.

Patient Satisfaction Index

A composite of two or more indicators into a single metric used to measure performance in customer service or satisfaction.

Plan of Correction (POC)

Specific, clearly defined steps or plans developed to eliminate identified root causes or implement new processes.

Quality Control (QC)

Quality control (QC) is a procedure or set of procedures intended to ensure that a product or performed service adheres to a defined set of quality criteria or meets the requirements of the customer. QC is similar, but not identical to, quality assurance (QA).

Quality Regulatory Review (QRR)

A hospital division program designed to determine survey readiness in meeting The Joint Commission (TJC) accreditation standards and Centers for Medicare/Medicaid Services' (CMS) conditions of Participation.

Quality Reporting Program (QRP)

The IMPACT Act of 2014 requires the specification of quality measures for the LTCH QRP, including such areas as skin integrity, functional status, such as mobility and self-care, as well as incidence of major falls. Beginning in FY 2014, the applicable annual update for any LTCH that did not submit the required data to CMS was reduced by two percentage points.

Root Cause Analysis

A process for identifying the basic or causal factor(s) that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event.

Sentinel Event

An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance

of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response.

Tracer Methodology

A method used to "trace" a patient's care experience or a process using actual patients as the framework for assessing compliance. Individual Patient Tracers follow a patient through his or her course of care. System Tracers evaluate the systems or processes, including the integration of related processes, and the coordination and communication among disciplines and departments in those processes.

Appendix B: Key Quality Indicators Definitions, Formulas and Targets

(Target = Expected Goal, Threshold = Minimum Expectation, Comparative Reference = A reference to use for goal setting)

KEY QUALITY INDICATOR	FORMULA / DEFINITION	Target / Threshold / Comp Ref
1. Mortality Rate	Number of deaths / Total number of discharges for month X 100	Comparative Reference: Kindred HD 2016 = 14.51%
2. Wean Rate	Number of discharges for the month who were admitted* on a vent and were weaned for > 72 hours during the admission** / Total number of patients discharged who were admitted on the ventilator*** X 100 * Admitted on a vent = All patients admitted on a ventilator or placed on a ventilator within 7 days of admission. ** Only the 1st successful wean episode counts. *** As determined by daily vent charges that are dropped (use of drilldown on Benchmark report will indicate a 'N' for each patient that is excluded from the denominator (no vent charge) and a 'Y' for each patient that is included in the denominator (vent charge). For example, *BiPAP vio vent* is not expected to count in the denominator yet since a vent is in use a charge may drop inadvertently adding this patient to the denominator count. In this case, incorrect charges must be corrected by the facility prior to the 8th of the month in order for Calculated Wean Rates to be correct Patients who are transferred out of our hospital for < 72 hours for a procedure/treatment at another hospital is not considered a discharge for the purposes of this indicator. Please Note: Although the successful wean is "counted" at the time of discharge, it makes no difference if the patient is on or off the ventilator at the time of discharge. If the patient was successfully weaned (off the ventilator for > 72 hours) once during the admission, it counts as a wean. If a patient is subsequently placed back on the ventilator at any time during the admission, it will not be counted, in the numerator or the denominator, again. Inclusions Numerator: Patients off vent >72 hours and placed on Trach collar or T-piece is a wean. Exclusions Numerator: Nocturnal vent is not a wean. Denominator: NIPPV is not a vent episode. Excludes all patients going on the vent > 7 days of admission. Weans that later die are successful weans. Ignore repeated episodes of ventilation. ***NO exclusions for chronic vent admissions.*** NOTE: Risk-adjusted outcome algorithms may vary slightly from above.	Comparative Reference: Kindred HD 2016 = 49.78%

KEY QUALITY INDICATOR	FORMULA / DEFINITION	Target / Threshold / Comp Ref
3. Infection-Related Ventilator-Associated Event (VAE)	NHSN Definition-01/2016 (http://www.cdc.gov/nhsn/pdfs/pscmanual/10-vae_final.pdf) # Episodes of IVAC in ventilated patient X 1000 Total number Ventilator days Ventilator-Associated Condition (VAC) Patient has a baseline period of stability or improvement on the ventilator, defined by ≥ 2 calendar days of stable or decreasing daily minimum* FiO2 or PEEP values. The baseline period is defined as the 2 calendar days immediately Preceding the first day of increased daily minimum PEEP or FiO2. *Daily minimum defined by lowest value of FiO2 or PEEP during a calendar day that is maintained for at least 1 hour. After a period of stability or improvement on the ventilator, the patient has at least one of the following indicators of worsening oxygenation: 1) Minimum daily FiO2 values increase ≥ 0.20 (20 points) over baseline & remain at or above that increased level for ≥2 calendar days. 2) Minimum daily PEEP values increase ≥ 3 cmH2O over baseline and remain at or above that increased level for ≥2 calendar days. NOTE: It is important to use the date the patient was placed on the ventilator when entering in NHSN. DO NOT use the date of admission unless that is the day the patient was intubated. If the patient comes to Kindred and you cannot get the date of first ventilation you can estimate the date. Infection-related Ventilator-Associated Complication (IVAC) On or after calendar day 3 of mechanical ventilation and within 2 calendar days before or after the onset of worsening oxygenation, the patient meets both of the following criteria: 1) Temperature > 38 °C (100.4F) or < 36°C (96.8F), OR white blood cell (WBC) count ≥12,000 or ≤4,000 cells/mm3. AND 2) A new antimicrobial agent(s) is started, and is continued for ≥ 4 calendar days. Possible Ventilator- Associated Pneumonia (PVAP) (Possible and Probable VAP combined) On or after calendar day 3 of mechanical ventilation and within 2 calendar days before or after the onset of worsening oxygenation, ONE of the following criteria is met (taking into account organism exclusions specified in the protocol): □ Criterion 1: Positive culture of one of the following specimens, meeting quantitative or semi- quantitative thresholds as outlined in protocol, without requirement for purulent respiratory secretions: • Endotracheal aspirate, ≥ 10^5 CFU/ml or corresponding semi-quantitative result • Bronchoalveolar lavage, ≥ 10^4 CFU/ml or corresponding semi-	Comparative Reference: Kindred HD 2016 VAC = 0.55 per 1000 ventilator days Comparative Reference: NHSN = As of 12/2016 NHSN has not published VAE data

	quantitative result • Lung tissue, ≥ 10^4 CFU/g or corresponding semi-quantitative result • Protected specimen brush, ≥ 10^3 CFU/ml or corresponding semi-quantitative result □ Criterion 2: Purulent respiratory secretions (defined as secretions from the lungs, bronchi, or trachea that contain >25 neutrophils and <10 squamous epithelial cells per low power field [lpf, x100])† plus a positive culture of one of the following specimens (qualitative culture, or quantitative/semi-quantitative culture without sufficient growth to meet criterion #1): • Sputum • Endotracheal aspirate • Bronchoalveolar lavage • Lung tissue • Protected specimen brush † If the laboratory reports semi-quantitative results, those results must correspond to the above quantitative thresholds. See additional instructions for using the purulent respiratory secretions criterion in the VAE Protocol. □ Criterion 3: One of the following positive tests: • Pleural fluid culture (where specimen was obtained during thoracentesis or initial placement of chest tube and NOT from an indwelling chest tube) • Lung histopathology, defined as: 1) abscess formation or foci of consolidation with intense Neutrophil accumulation in bronchioles and alveoli; 2) evidence of lung parenchyma invasion by fungi (hyphae, pseudo hyphae or yeast forms); 3) evidence of infection with the viral pathogens listed below based on results of immunohistochemical assays, cytology, or microscopy performed on lung tissue • Diagnostic test for Legionella species • Diagnostic test on respiratory secretions for influenza virus, respiratory syncytial virus, adenovirus, parainfluenza virus, rhinovirus, human metapneumovirus, coronavirus Inclusions: Patients on BiPAP via Tracheostomy Exclusions: Skilled Nursing Units (SNU) and Subacute Units (SAU) PLEASE REFER TO THE CENTRAL LINE ASSOCIATED BLOOD STREAM INFECTION DECISION TREE LOCATED IN THE CLNICAL RESOURCE LIBRARY or the **NHSN DEFINITIONS at:** **http://www.cdc.gov/nhsn/PDFs/pscManual/pcsManual_current.pdf**	
4. New or worsening Pressure Ulcers	Patients with Pressure Ulcers That Are New or Worsened on Discharge CARE Assessments X 100 Number of Discharge CARE Assessments	Comparative Reference: **Kindred HD 2016 = 2.29** **LTRAX Nation 2016 = 1.67**

	Measures "Percent of Patients with Pressure Ulcers that are New or Worsened" following CMS QRP reporting rules. Excludes expired patient discharge CARE Assessments.	
KEY QUALITY INDICATOR	FORMULA / DEFINITION	Target / Threshold / Comp Ref
5. Central Line Associated Blood Stream Infection (CLABSI) Rate	NHSN Definition-1/2016 (http://www.cdc.gov/nhsn/pdfs/pscmanual/4psc_clabscurrent.pdf) Episodes of CLABSI in CVL X 1000 Total number of central line days Blood Stream infection must meet one of the following criteria: 1. Patient has a pathogen (not a common commensal) cultured from one or more blood cultures and organism cultured is not related to infection at another site. 2. Patient has a common commensal cultured from the blood culture (See note below) a. Patient has at least one of the following signs and symptoms: fever (>38C or > 100.4F), chills, or hypotension. AND b. Positive laboratory results and signs and symptoms are not related to an infection at another site. AND c. Common skin contaminant is cultured from two or more blood cultures drawn on separate occasions. NOTE: * Cultures positive with "common commensals" must be identified in at least one bottle of each set to be worked up as a CLABSI * Catheter tip cultures are not used to determine whether a patient has a primary BSI. * Lines can be removed without blood culture based on site inflammation. Line days: *Day of admission or insertion is Day 1 *Patients with 1 or more central lines will be counted as 1 line-day per hospital day. Line days should be counted at the same time of the day, 7 days per week. **Risk factor is line-days, not days of a given line.* Inclusion Numerator: Episodes of bacteremia as described above, in presence of a Central Line (An Intravascular catheter that terminates at or close to the heart or in one of the great vessels which is used for infusion, withdrawal of blood or hemodynamic monitoring.) Denominator: All non-midline catheters including non-tunneled (non-cuffed/temporary) or surgically-placed (cuffed/permanent catheters.	Comparative Reference: Kindred HD • 2016 = 1.61/1000 line days • 2017 Target: = TBD National SIR Apr 2015 – Mar 2016 = • CMS .905 • Kindred 1.235 (National benchmark =1.0)

ATTACHMENT 15

	Exclusion Numerator: Automatic exclusion if occurs within 3 calendar days before admission, date of admission and 3 calendar days after admission. Blood cultures drawn after the date of the catheter removal are excluded. Denominator: Catheters that do not terminate at or above the superior vena cava (i.e. Midline Catheters) and Hemodialysis reliable outflow dialysis catheters (HeRO). Present on Admission (POA): 2 calendar days prior to the date of admission, Hospital day 1 and Hospital day 2. Hospital day 3= HAI Infection Window Period (first positive diagnostic test, 3 days before and 3 days after). Repeat Infection Timeframe (RIT) - (14 day timeframe where date of event = day 1) If a RIT you must go back to the 1st event in NHSN and enter the new organism if the organism changed. PLEASE REFER TO THE CENTRAL LINE ASSOCIATED BLOOD STREAM INFECTION (CLABSI) DECISION TREE LOCATED IN THE CLNICAL RESOURCE LIBRARY	
KEY QUALITY INDICATOR	FORMULA / DEFINITION	Target / Threshold / Comp Ref
6. Central Line Utilization Ratio	Central Line Days / Patient Days The Central Line Utilization Ratio is calculated by dividing the number of central line days by the number of patient days. Exclusion: Implanted ports are not counted as a central line day until it is accessed. Once accessed (even if flushed or used for blood draw) it is counted as a line day until discharged or the port is removed.	2017 Target: HD = TBD Comparative Reference: •
7. Patient Satisfaction	Patient Satisfaction HCAHPS Discharge Survey questions: • #4 During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it? • #14 During this hospital stay, how often did the hospital staff do everything they could to help you with your pain? • #22 Would you recommend this hospital to your family and friends? Percent "Top Box" Scores: Total Top Responses / Total Responses X 100 *#4 Call Button "Top Box" response = "Always* *#14 Help With Poin "Top Box" response = "Always"* *#22 Would you Recommend "Top Box" response = "Definitely Yes"*	2017 Targets: #4: HD = TBD #14: HD = TBD #22: HD = TBD

ATTACHMENT 15

KEY QUALITY INDICATOR	FORMULA / DEFINITION	Target / Threshold / Comp Ref
8. Employee Turnover Rate	Total number of resignations/terminations X 100 Total number of monthly filled positions Numerator is a rolling 12 month # of terminations for full-time AND part-time employees Denominator - Average number of beginning active FT and PT employees for the last 12 months	2017 Target: HD = TBD
9. Patient Falls with Injury	Total number of falls with injury X 1000 Total number of patient days Fall with injury: Any fall resulting in injury and requiring more than first aid and an alteration in treatment. Includes falls with fractures, lacerations, changes in level of consciousness due to the fall. *Example* – Fall requiring an X-ray (positive for fracture) and surgical intervention. Note: *Does not include falls requiring first oid only or minor treotment* CMS (QRP) Definition: (Reporting begins April 1, 2016) CMS def. = bone fracture, joint dislodgement, closed head injury with altered consciousness, subdural hematoma.	Comparative Reference: Kindred HD 2016 = 0.27 per 1000 pt. days
10. Patient Falls without Injury	Total number of falls without injury X 1000 Total number of patent days Fall without injury: A fall where no change in treatment is required. *Example* – A patient has a fall with no lacerations, minor pain and negative x-ray. *Note:* A fall requiring basic first aid treatment (i.e., Band-Aid or ice pack) is considered a Level 2 fall without injury. *A potient ossisted to the floor is considered o foll.* CMS (QRP) Definition: (Reporting begins April 1, 2016) CMS def. = superficial bruising, hematomas, sprains or any fall related injury that causes the patient to complain of pain.	Comparative Reference: Kindred HD 2016 = 3.91 per 1000 pt. days
11. Restraint Rate	Number of patients each day in restraints, during the month X 1000 Total number of patient days • Restraint days are determined by the number of patients reported in restraints for any part of the prior 24 hours. • Four side rails, Freedom Splints and mitts (tied or untied), Fingerless positioning devices/mitts are counted as a restraint • Patients in restraints will be identified through direct observation rather than chart review.	2017 Target: HD = TBD

12. Catheter – Associated Urinary Tract Infection (CAUTI) Rate	NHSN Definition 1/2016 (http://www.cdc.gov/nhsn/pdfs/pscmanual/7psccauticurrent.pdf) Number of patient episodes during the month which develop newly diagnosed urinary catheter associated UTI X 1000 Total number of indwelling catheter days for the month. Symptomatic UTI (SUTI) 1A Patient must meet 1, 2, and 3 below: 1. Patient has an indwelling urinary catheter in place for the entire day on the date of event and such catheter had been in place for >2 calendar days, on that date (day of device placement = Day 1) 2. Patient has at least one of the following signs or symptoms: • fever (>38.0°C or 100.4°F) • suprapubic tenderness* • costovertebral angle pain or tenderness* • urinary urgency ^ • urinary frequency ^ • dysuria ^ 3. Patient has a urine culture with no more than two species of organisms, at least one of which is a bacteria of $\geq 10^5$ CFU/ml. All elements of the UTI criterion must occur during the Infection Window Period (See Definition Chapter 2 Identifying HAIs in NHSN) NOTE: ^ These symptoms cannot be used when a catheter is in place. * With no other recognized cause Asymptomatic Bacteremic UTI (ABUTI) Patient must meet 1, 2, and 3 below: 1. Patient with* or without an indwelling urinary catheter has no signs or symptoms of SUT1 according to age (NOTE: Patients > 65 years of age with a non-catheter associated ABUTI may have a fever and still meet the ABUTI Criterion) 2. Patient has a urine culture with no more than two species of organisms identified, at least one of which is a bacterium of $\geq 10^5$CFU/ml 3. Patient has organism identified** from blood specimen with at least one matching bacterium identified in the urine specimen. NOTE: * Patient had an indwelling urinary catheter in place for > 2 calendar days, with day of device placement being Day 1, and catheter was in place on the date of the event or the day before. ** Organisms identified by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment. Asymptomatic Bacteremic Urinary Tract Infection is not considered a CAUTI in patients *without* a urinary catheter.	Comparative Reference: Kindred HD Dec. YTD • 2016 = 1.73/1000 catheter days • 2017 Target: = TBD National SIR Apr 2015 – Mar 2016 = • CMS .887 • Kindred .929 (National benchmark = 1.0)

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	Inclusion Numerator: Episodes of UTI as described above, in presence of indwelling catheter (*see below) Denominator: Indwelling urinary catheter days Exclusion Numerator: Positive Urine cultures that are positive only for yeast, mold, dimorphic fungi, or parasites are excluded. If urine culture is positive for those exclusions and there is positive blood culture then the CLABSI definition should be followed. Patients who meet the Infection Window Period of first diagnostic test, 3 calendar days before, and 3 calendar days after. More than two microorganisms indicate a dirty" / contaminated specimen and not an infection. Denominator: Suprapubic catheters and nephrostomy tubes are not included in this definition, only catheters that enter through the urethra. *NOTE: **Present on Admission (POA)**: 2 calendar days prior to the date of admission, Hospital day 1 and Hospital day 2. Hospital day 3=HAI **Infection Window Period** (first positive diagnostic test, 3 days before and 3 days after) **Repeat Infection Timeframe (RIT)** - (14 day timeframe where date of event = day 1) If a RIT you must go back to the 1st event in NHSN and enter the new organism if the organism changed. ***PLEASE REFER TO THE CATHETER-ASSOCIATED URINARY TRACT INFECTION DECISION TREE LOCATED IN THE CLNICAL RESOURCE LIBRARY***	
KEY QUALITY INDICATOR	FORMULA / DEFINITION	Target / Threshold / Comp Ref
13. Urinary Catheter Utilization Ratio	Urinary Catheter Days / Patient Days The Urinary Catheter Utilization Ratio is calculated by dividing the number of urinary catheter days by the number of patient days.	2017 Target: HD = TBD Comparative Reference: NHSN 2013 = • ICU: 0-51 • Adult Ward: 0.43
14. Return to Acute Care within 30 Days of Admission (RTA-30 days)	Number of discharges in the month with Discharge disposition equals "Return to STAC" within 30 days of admission / Total number of discharges for the month X 100	2017 Target: HD = TBD
15. Finger Stick (FS) Blood Glucose	Total number of finger sticks resulting in Glucose measure between 80 and 180 mg/dl / Total number of finger sticks X 100 Percent of glucose measures between 80 and 180 mg/dl. This does not constitute "tight control" or even "normal", but rather physiologic for a sick patient where low glucose is higher risk than high glucose.	2017 Target: HD = TBD

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	Method: Finger sticks collected electronically now. No exceptions. We accept that for a given patient, when glucoses are out of range, more repeat testing is ordered, at a frequency proportional to the number out of range, i.e., "keep checking until it is back in range."	
KEY QUALITY INDICATOR	FORMULA / DEFINITION	Target / Threshold / Comp Ref
16. Successful Intubations	Number of "Successful" Intubations / Total number of patients with intubation episodes X 100 "Successful" is defined as within 3 attempts	2017 Target: HD = TBD
17. Multi-Drug Resistant Organisms (MDRO) LabID Reporting	Report the NHSN components MDRO and CDI Module for facility wide inpatient (FacWidIN) MDRO Laboratory Identification Events that are reported as Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C-Diff). MRSA: All blood cultures positive for MRSA will be entered in the NHSN system regardless of when it was identified during the inpatient stay. Numerator: Patient Events reported in the NHSN Denominator: Patient Days Total Facility Wide and Total Number of Admissions C-Diff: All stool cultures positive for C-Diff will be entered in the NHSN system regardless of when it was identified during the inpatient stay. Numerator: Patient Events reported in the NHSN Denominator: Patient Days Total Facility Wide and Total Number of Admissions NOTE: Do Not enter more than one event in NHSN within a 14-day period.	New for 2015. As of 12/2016 NHSN has not published data.
KEY QUALITY INDICATOR	FORMULA / DEFINITION	Target / Threshold / Comp Ref
20. Healthcare Personnel Influenza	NHSN Definition 08/2014 (http://www.cdc.gov/nhsn/pdfs/hps-manual/vaccination/hps-flu-vaccine-protocol.pdf) Influenza season is defined by NHSN as October 1st through March 31st or sooner if the vaccinations become available. Each hospital is required to enter a reporting for at least one month during the reporting period. Summary data required is total number of employees on payroll (full time, part-time and PRN employees are included) that worked at least one day during the defined influenza period. Inclusions: Also included are all physicians, licensed independent practitioners, advanced practice nurses, physician assistants, adult students/trainees	Incremental increase in compliance according to the Joint Commission and Healthy People 2020.

	and volunteers. Exclusions: All contract workers are excluded (JLL, Pharmerica, Rehab Care, etc). When answering the six (6) questions in the summary, questions 2-6 must equal question one (1). The formatted questions can be found in the link listed in this document. Annual Vaccination Survey is not required but highly recommended it be completed prior to entering you summary data.	
21. Clinical Index	Comprised of the 3 clinical measures: CLABSI, CAUTI and Restraint Rate. The individual rates are divided by their individual *base* rates to get the individual index. The individual indexes are <u>summed</u> to calculate the overall Clinical Index: Example: CLABSI = 1.64 divided by base rate of 2.33 = 0.70 Restraint = 65.00 divided by base rate of 70.00 = 0.93 CAUTI = 1.B9 divided by base rate of 3.06 = <u>0.62</u> 2.25 (sum) Overall Clinical Index = 2.25 *NOTE: The base rates are standard across all facilities and da nat change from year to year. Base rates were established in year 2010.*	2017 Target: HD =TBD

22. Service Index	Comprised of 3 Patient Satisfaction HCAHPS discharge survey questions: #4 During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it? #14 During this hospital stay, how often did the hospital staff do everything they could to help you with your pain? #22 Would you recommend this hospital to your family and friends? The percentage of "top box" responses are <u>averaged</u> to calculate the overall Service Index: Example: Question #4 % Always = 85% Question #14 % Always = 90% Question #22 % Definitely Yes = <u>90%</u> 88.33% (average) Overall Service Index = 88.33%	2017 Target: HD = Index Measure on Hold due to change to vendor change in 2016 (Press Ganey) 2017 Target: Call Light Response only- HD = TBD
23. Patient Safety Index	Comprised of the 4 clinical measures: % Reposition Orders Executed, % Wound Dressing Completed, % Consistent Braden Scores and % Wound Education Completed The percentage scores are <u>averaged</u> to calculate the overall Patient Safety Index. Example: % Reposition Drders Executed = 82% % Wound Dressing Completed = 75% % Consistent Braden Scores = 93% % Wound Education Completed = <u>95%</u> 86.25% (average) Overall Patient Safety Index = 86.25%	2017 Target: HD = TBD
24. Reputation.com	Composite Score based on six components: Star Average, Volume, Recentness, Length, Spread, and Visibility. Reputation BSC Indicator Information.	2017 Target: HD = TBD

ATTACHMENT 15

Leadership Committee Indicators (not already listed in 1-24 above)		
KEY QUALITY INDICATOR	DESCRIPTION OF INFORMATION TO BE REVIEWED/ANALYZED	ADDITIONAL INFO
Regulatory / Survey Activity	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Regulatory Plan of Correction Update	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Patient Satisfaction Survey Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Complaints / Grievances Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Contract Services Oversight	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Competency Evaluations	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Licensure Verifications	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Employee Satisfaction	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
KHAT Utilization	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Ethics Case Review Summary	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Termination of Life Support	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Organ/Tissue Donation	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Occupational Incidents Analysis (Loss Prevention) & RCA trends	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Patient / Visitor Event Summary (related to EOC)	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Safety Management	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Security Incidents Summary	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Hazardous Materials/Waste Summary	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Fire-Safety Summary	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Medical Equipment Management Summary	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Utility Systems Management Summary	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
CEO Physical Environment Compliance Oversight Checklist Review	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples

Environmental Tour Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples

Patient Safety and Reliability Committee Indicators (not already listed in 1-24 above)		
KEY QUALITY INDICATDR	DESCRIPTION OF INFORMATION TO BE REVIEWED/ANALYZED	ADDITIONAL INFO
Code Blue Reviews / Outcomes	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Rapid Response Events / Outcomes	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Decannulation Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Consent to Treat Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Change of Condition Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Mortality Reviews	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Hospital Acquired Pressure Wound RCA Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Fall RCA Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Surgical Program / Invasive Procedures	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Critical Results-Read Back (General Tests & ABG Tests)	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Critical Results-Timeliness of Reporting (General Lab and ABG)	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Cross-Match / Transfusion Ratio	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Transfusion Appropriateness	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Infusion Timeliness	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Blood Bank Testing Log	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Blood Product Transfusion Paperwork	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
RCA completed on all suspected blood transfusion reactions	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Radiology Dashboard	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Event Reporting System Trends Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples

Restraint Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Sentinel Event/Near Misses/Sentinel Event Alerts Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
FMEA Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples

Value Driven Transitions Committee Indicators		
KEY QUALITY INDICATOR	DESCRIPTION OF INFORMATION TO BE REVIEWED/ANALYZED	ADDITIONAL INFO
Hospital Performance Opportunity Trend Report. 3 Indicators: a) ALOS; b) Stay type percentages; c) CMI	1) All Payer types to be reviewed; 2) HD Common Goal for Combined Medicare & Medicare Mgd ALOS of >=25 but may be additional specificity based on patient historical data of population types (ex: high volume complex, vent patients may result in anticipated avg LOS well over 25) 3) Hospital-Specific Goals and/or analysis of trends for all other indicators.	See Dashboard HELP document for examples
Care Management Barriers/Avoidable Delay Occurrences: 4 categories of "avoidable delay occurrences" collected and trended: a) physician-related; b) external causes; c) internal causes; d) patient/family-related. Also discuss trends with "barriers" identified through preadmission (barrier to admission) and/or daily flash meetings	1) All Payer types to be reviewed; 2) No HD or hospital-specific goals - but universal goal is to decrease trends/causes in all categories. 3) CMs to adhere to H-ML 09-020 policy when collecting, reporting and analyzing the data.	See Dashboard HELP document for examples
Clinical Coordination and Documentation Improvement: 6 categories: a) Top 10 DRGs b) Focus DRG Analysis c) Tier Rates; d) IDT Assessment Results (two metrics: "Role-Specific" and "IDT Overall Functioning" scores; e) Physician Snap Shot	1) All Payer types to be reviewed with additional report for Medicare Top DRGs and Tier Rates; 2) Common hospital goals: a. Reduce/eliminate presence of filter DRG in top 10; percent tier rate of ALL DRGs is hospital-specific with goal of continued increased trend; b. Top 10 DRGs at highest tier; c. IDT	See Dashboard HELP document for examples

Report; f) Documentation Opportunity Trends		
KEY QUALITY INDICATOR	DESCRIPTION OF INFORMATION TO BE REVIEWED/ANALYZED	ADDITIONAL INFO
Transition Disposition Rates and Analysis 8 categories: a) expiration; b) STAC (RTA); c) Acute Rehab; d) SNF/NH; e) Hospice; f) Home w/HH; g) Home w/o HH; h) Other	1) All payers; 2) Individual hospital goals for RTA rate	See Dashboard HELP document for examples
Denial Management Tracking: 2 categories: a) Reasons for denials; b) Trends in reviewer/payer types	Indicator Parameters: Informational only. Calculate denials by total denials received during the month in Payer category. Report PI plans on any medical necessity/auth/LOC denials and reasons.	See Dashboard HELP document for examples
Medical Necessity Reviews: 2 categories: a) Physician Advisor Referral Review; b) High Cost Outlier Oversight	1) All payers for PA referrals; 2) Medicare & Medicare Mgd patients for HCO review	See Dashboard HELP document for examples
Case Management Quality Monitoring: 3 categories: a) Case Management Documentation Audit (Admission, Continued Stay, Discharge); b) Resource Utilization Trends/ Opportunities; c) Departmental PI Activities	Case Mgmt Proficiency parameters: Ensure "proficiency" rates (90% or higher), "acceptable" rates (80%-89%) and "unacceptable rates" (<80%) are discussed and action plans proposed as per policy; 2)Resource Utilization Trends/Opportunities - parameters to be hospital-specific; 3)Departmental PI Activities - focuses on process improvement initiatives specific to CM and/or CCDI functions within a hospital based on trends.	See Dashboard HELP document for examples
TJC/CMS/State Regulatory updates/changes related to Utilization Management	Indicator Parameters: Awareness for updates that require compliance/monitoring	See Dashboard HELP document for examples

KEY QUALITY INDICATOR	DESCRIPTION OF INFORMATION TO BE REVIEWED/ANALYZED	ADDITIONAL INFO
Consultation Summary Report • Timeliness of Consultations • Timeliness of Consultation Reports	Summary Report of Consultation Reviews.	See Dashboard HELP document for examples
Medical Record Delinquencies Report Summary (Overall Delinquent Numbers / Percentage and Late H&Ps)	Summary Report. HIM Rep provides the data in an aggregated format with analysis of trends. Data reported from monthly HIM statistics worksheet. H-IM 04-010A	See Dashboard HELP document for examples
Operative / Invasive Reports	Summary Report. HIM Rep provides the data in an aggregated format with analysis of trends. H-SIP 02-011 and H-SIP 02-011 PRO	See Dashboard HELP document for examples
Order Entry and Usage - Verbal & Telephone Orders	Summary Report. HIM Rep provides the data in an aggregated format with analysis of trends. See policies H-IM 02-020 (Concurrent Analysis of Orders) & H-IM 02-021 (Differentiation between Verbal and Written Orders). H-IM 02-021 PRO	See Dashboard HELP document for examples
Order Entry and Usage - Verbal & Telephone Orders	Summary Report. HIM Rep provides the data in an aggregated format with analysis of trends. See policies H-IM 02-020 (Concurrent Analysis of Orders) & H-IM 02-021 (Differentiation between Verbal and Written Orders). H-IM 02-021 PRO	See Dashboard HELP document for examples

Appendix C: Performance Improvement Tools

Item		Location
Annual Plans	CRL Path	Knect\Hospital Division\ClinicalResourceLibrary\Quality Management\ Annual Plan and Review ToolBox
Audit Tools	CRL Path	Knect\Hospital Division\ClinicalResourceLibrary\Quality Management\Audit Tools
CCO Checklist	CRL Path	Knect\Hospital Division\ClinicalResourceLibrary\Quality Management\CEO-CCO Checklists\CCO Checklist
CEO Checklist	CRL Path	Knect\Hospital Division\ClinicalResourceLibrary\ Quality Management\ CEO-CCD Checklists\CEO Checklist
Dashboard training webinars	CRL Path	Knect\Hospital Division\ClinicalResourceLibrary\Quality Management\Committee Standardization\2016 Dashboard Training Sessions
HVA Form	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\Physical Environment\Emergency Management\Standardized Emergency Management Tools
ISMP Newsletters	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\Pharmacy – Medication Mgmt\Medication Safety
PIT Documentation Template	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\QualityManagement\Strategic Quality Plan\PIT Documentation
PIT Commission / Charter Template	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\QualityManagement\Strategic Quality Plan\PIT Documentation
PIT Prioritization Grid	CRL Path	Knect\Hospital Division\ClinicalResourceLibrary\Quality Management\Quality Council\PIT Documentation
PIT Progress Report Template	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\QualityManagement\Strategic Quality Plan\PIT Documentation
QC Evaluation Form	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\QualityManagement\AnnualPlanandReviewToolBox\Strategic Quality Plan
RCA Form	Policy	Policy H-PC 05-002C
IDT Evaluation Form	CRL Path	Knect\Hospital Division\ClinicalResourceLibrary\Quality Management\IDT\Master IDT Assessment Tool
IDT Follow-Up Form	CRL	Knect\Hospital Division\ClinicalResourceLibrary\Quality Management\IDT Follow Up Form
IDT Quality Crosswalk	CRL	Knect\Hospital Division\ClinicalResourceLibrary\Quality Management\IDT Crosswalk
Tracers	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\Tracers
Trend line chart template	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\QualityManagement\Committee Standardization \Departmental PI Forms

APPENDIX D: Data Reporting Procedures

Data Reporting Procedures	Procedures
Reporting for Benchmark Report (BW) • Submission:	Benchmark data must be entered into the Data Entry Application in the Business Warehouse by the 8th of the month. After the 8th you will no longer have access to key your data. Contact Roxann Walker or Chastity Dailey at the Support Center if you are unable to key your data in order to receive further instructions. **TIPS WHEN SUBMITTING YOUR BENCHMARK DATA** 1. Once you have keyed your data, ALWAYS double check your numbers. 2. If you are a NON-ProTouch facility entering Wound Initial/Difference scores, make sure your numbers match your Wound Care Initiative Sheet.
• Corrections/Revisions	Requests to correct previously reported data must be submitted via e-mail addressed to either Chastity Dailey or Roxann Walker.
Patient Satisfaction Surveys	All surveys results will be aggregated in the month in which they are received by our 3rd party vendor, Press Ganey. For example: Jan surveys must be received at Press Ganey processing center by Jan 31st to be credited to January. If the last day of the month falls on a weekend or holiday, surveys must be received at Press Ganey on the last open business day prior. It is strongly recommended that you send completed surveys to Press Ganey on a weekly basis. If you send your surveys once monthly and miss the deadline, you will have 0 surveys posted for that month. Reports are available via the Press Ganey Portal.
NHSN Reporting	Events are entered monthly. NHSN submits quarterly (120 days after the end of the quarter) to CMS. Each hospital is required to enter their monthly reporting plans, summary data related to CLABSI, CAUTI, VAE, MRSA Blood Lab ID and Clostridium difficile (C-Diff) LabID data and patient specific events in the NHSN website by the 8th of the following month. Following the submission of data the hospital should run the CMS reports in the NHSN website to validate that data has been reported. Healthcare Personnel (HCP) Influenza data is also entered each year by the May 15th reporting deadline in NHSN. HCP includes all staff including students, volunteers, physicians and allied

	health professionals that were employed or credentialed in the facility for 1 day during the October 1st to March 31st influenza reporting period. *This requirement does not include contract workers at this time.* Influenza reporting also requires that a survey be completed by each hospital annually when the annual summary is completed. Each year the facility is to complete the NHSN Annual Survey with hospital specific information in the NHSN website by the end of February the following year.
CMS CARE Data Submissions (Quality Reporting Program)	Admissions Assessments: CMS requires an admission CARE Data Set record to be submitted no later than the 15th calendar day of the patient's admission for all patients admitted to a Long Term Care Hospital (LTCH) regardless of payer type. Discharge Assessments: CMS requires a discharge CARE Data Set record to be submitted for all patients discharged from the LTCH no later than 13 days (discharge date counts as day 1) post discharge regardless of payer type. This includes discharge assessments for all discharge types: Planned, Unplanned and Expired. Interrupted Stays: For purposes of the QRP, an Interrupted Stay is when a patient is transferred to a short-term acute hospital and returns to the LTCH within 3 calendar days (discharge day is day 1). Patients that return after Day 4 must have a Discharge Assessment completed for the discharge to STAC and a new Admission CARE Assessment completed for the "new admission." Following submission of Admission and Discharge CARE Data Set Records, a CASPER Validation report must be retrieved from the CMS site and reviewed to ensure all records were Accepted. Accepted records are documented as such in the LTRAX database. Records not accepted must be corrected and resubmitted to CMS. The CASPER Validation report must be stored in the secure CMS CARE Data Set Documents folder located on the Kindred Network. Information on mapping to the secure CMS Care Data Set Documents folder can be found in the Clinical Resource Library (CRL/CMS/CMS Mandatory Quality Reporting/CARE Assessment Process).