

ORIGINAL

13-014

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

MAR 25 2013

This Section must be completed for all projects.

HEALTH FACILITIES &
SERVICES REVIEW BOARD

Facility/Project Identification

Facility Name:	Northwestern Lake Forest Hospital		
Street Address:	660 North Westmoreland Road		
City and Zip Code:	Lake Forest, Illinois 60045		
County:	Lake	Health Service Area	8 Health Planning Area: A-09

Applicant /Co-Applicant Identification

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

Exact Legal Name:	Northwestern Lake Forest Hospital
Address:	660 North Westmoreland Road, Lake Forest, Illinois 60045
Name of Registered Agent:	Carol M. Lind
Name of Chief Executive Officer:	Dean Harrison
CEO Address:	251 East Huron Street, Chicago, Illinois 60611
Telephone Number:	312-926-3007

Type of Ownership of Applicant/Co-Applicant

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

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

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

Primary Contact

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

Name:	Bridget Orth
Title:	Manager, Regulatory Facility Planning
Company Name:	Northwestern Memorial HealthCare
Address:	211 East Ontario Street Room 11-1103, Chicago, Illinois 60611
Telephone Number:	312-926-8650
E-mail Address:	borth@nmh.org
Fax Number:	312-926-4545

Additional Contact

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

Name:	Robin Zacher
Title:	Manager, Business Planning and Development
Company Name:	Northwestern Lake Forest Hospital
Address:	660 North Westmoreland Road, Lake Forest, Illinois 60045
Telephone Number:	847-535-7989
E-mail Address:	rzacher@ifh.org
Fax Number:	847-535-7845

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

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

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		Health Planning Area:	A-09

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E-mail Address:	rzacher@ifh.org
Fax Number:	847-535-7845

Post Permit Contact

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

Name:	Bridget Orth
Title:	Manager, Regulatory Facility Planning
Company Name:	Northwestern Memorial HealthCare
Address:	211 East Ontario Street Room 11-1103
Telephone Number:	312-926-8650
E-mail Address:	borth@nmh.org
Fax Number:	312-926-4545

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Northwestern Lake Forest Hospital
Address of Site Owner:	660 North Westmoreland Road, Lake Forest, IL 60045
Street Address or Legal Description of Site:	
Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.	
APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

Operating Identity/Licensee

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

Exact Legal Name:	Northwestern Lake Forest Hospital		
Address:	660 North Westmoreland Road, Lake Forest, IL 60045		
<input checked="" type="checkbox"/>	Non-profit Corporation	<input type="checkbox"/>	Partnership
<input type="checkbox"/>	For-profit Corporation	<input type="checkbox"/>	Governmental
<input type="checkbox"/>	Limited Liability Company	<input type="checkbox"/>	Sole Proprietorship
		<input type="checkbox"/>	Other
<ul style="list-style-type: none"> ○ Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. ○ Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. ○ Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership. 			
APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Organizational Relationships

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

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

Flood Plain Requirements

[Refer to application instructions.]

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

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

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

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

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

DESCRIPTION OF PROJECT**1. Project Classification**

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

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

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

Northwestern Lake Forest Hospital (NLFH) proposes to "discontinue" its 10-bed pediatrics category of service. Upon approval of this discontinuation, NLFH would add 10 beds to its medical/surgical category of service under Illinois Health Facilities Planning Act (20 ILCS 3960/5) (from Ch. 111 1/2, par. 1155) Sec. 5 c ("20-bed/10% rule"). NLFH will continue to treat and admit pediatrics cases. Patients aged 0-14 years will be admitted to a medical/surgical bed upon approval of this project.

NLFH is located at 660 North Westmoreland Road in Lake Forest, Illinois.

The project is classified as substantive because it proposes the discontinuation of an IDPH-designated category of service.

There is no project cost.

Project Costs and Sources of Funds

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

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	\$0	\$0	\$0
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	\$0	\$0	\$0
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Related Project Costs

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

Land acquisition is related to project	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Purchase Price: \$	_____	
Fair Market Value: \$	_____	
The project involves the establishment of a new facility or a new category of service		
	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
If yes, provide the dollar amount of all 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 \$ _____ N/A _____.		

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:	
<input checked="" type="checkbox"/> None or not applicable	<input type="checkbox"/> Preliminary
<input type="checkbox"/> Schematics	<input type="checkbox"/> Final Working
Anticipated project completion date (refer to Part 1130.140): <u>June 25, 2013</u>	
Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):	
<input type="checkbox"/> Purchase orders, leases or contracts pertaining to the project have been executed.	
<input type="checkbox"/> Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies	
<input type="checkbox"/> Project obligation will occur after permit issuance.	
APPEND DOCUMENTATION AS ATTACHMENT-8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

State Agency Submittals

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

Cost Space Requirements

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

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

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

Facility Bed Capacity and Utilization

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

FACILITY NAME: Northwestern Lake Forest Hospital		CITY: Lake Forest			
REPORTING PERIOD DATES: CY12 From: 1/1/12 to: 12/31/12					
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	74	5,655	18,893*	0	74
Obstetrics	23	1,581	4,102*	0	23
Pediatrics	10	424	770*	-10	0
Intensive Care	10	796	2,215	0	10
Comprehensive Physical Rehabilitation	0	0	0	0	0
Acute/Chronic Mental Illness	0	0	0	0	0
Neonatal Intensive Care	0	0	0	0	0
General Long Term Care	84	684	18,949	0	84
Specialized Long Term Care	0	0	0	0	0
Long Term Acute Care	0	0	0	0	0
Other ((identify))	0	0	0	0	0
TOTALS:	201	9,140	44,929	-10	191

*Inpatient days only. The above tables does not include observation days.

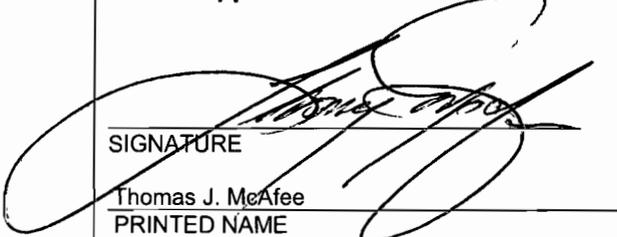
Note: Upon approval of this discontinuation, NLFH plans to add 10 beds to its medical/surgical category of service using the Illinois Health Planning Act's "20-bed/10% bed" rule.

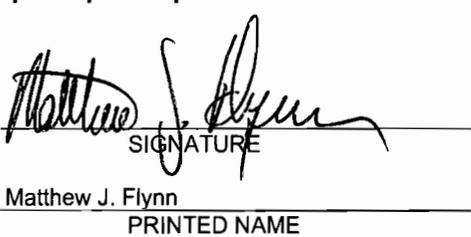
CERTIFICATION

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

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

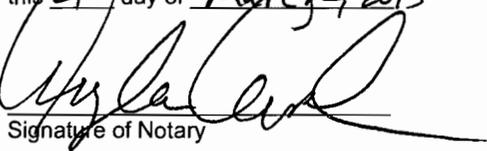
This Application for Permit is filed on the behalf of Northwestern Lake Forest Hospital *
 in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf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

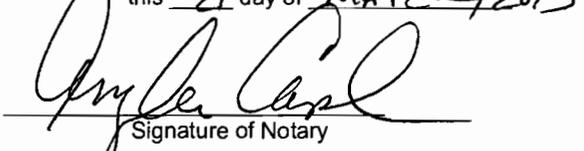

 SIGNATURE
 Thomas J. McAfee
 PRINTED NAME


 SIGNATURE
 Matthew J. Flynn
 PRINTED NAME

President, NLFH
 PRINTED TITLE

Sr. Vice President and Chief Financial Officer, NLFH
 PRINTED TITLE

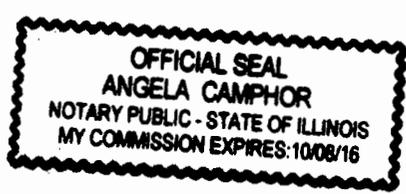
Notarization:
 Subscribed and sworn to before me
 this 21 day of March, 2013

 Signature of Notary

Notarization:
 Subscribed and sworn to before me
 this 21 day of March, 2013

 Signature of Notary

Seal

Seal

*Insert EXACT legal name of the applicant



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

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

Peter J. McCanna
SIGNATURE

Dennis M. Murphy
SIGNATURE

Peter J. McCanna
PRINTED NAME

Dennis M. Murphy
PRINTED NAME

Exec. VP & Chief Financial Officer, NMHC
PRINTED TITLE

Exec. Vice President, NMHC
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 21 day of March, 2013

Notarization:
Subscribed and sworn to before me
this 21 day of March, 2013

Angela Camphor
Signature of Notary

Angela Camphor
Signature of Notary

Seal

Seal

*Insert EXACT legal name of the applicant



SECTION II. DISCONTINUATION

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

Criterion 1110.130 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

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

REASONS FOR DISCONTINUATION

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

IMPACT ON ACCESS

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

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

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

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

VIII. - 1120.120 - Availability of Funds

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

_____	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: <ol style="list-style-type: none"> 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
_____	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: <ol style="list-style-type: none"> 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions.
_____	e)	Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
_____	f)	Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
_____	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
TOTAL FUNDS AVAILABLE		

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

IX. 1120.130 - Financial Viability

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

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

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

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

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

2. Variance

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

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

X. 1120.140 - Economic Feasibility

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

A. Reasonableness of Financing Arrangements

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

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

B. Conditions of Debt Financing

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

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

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

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

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

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

XI. Safety Net Impact Statement

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

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

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

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

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

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

Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

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

XII. Charity Care Information

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

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

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

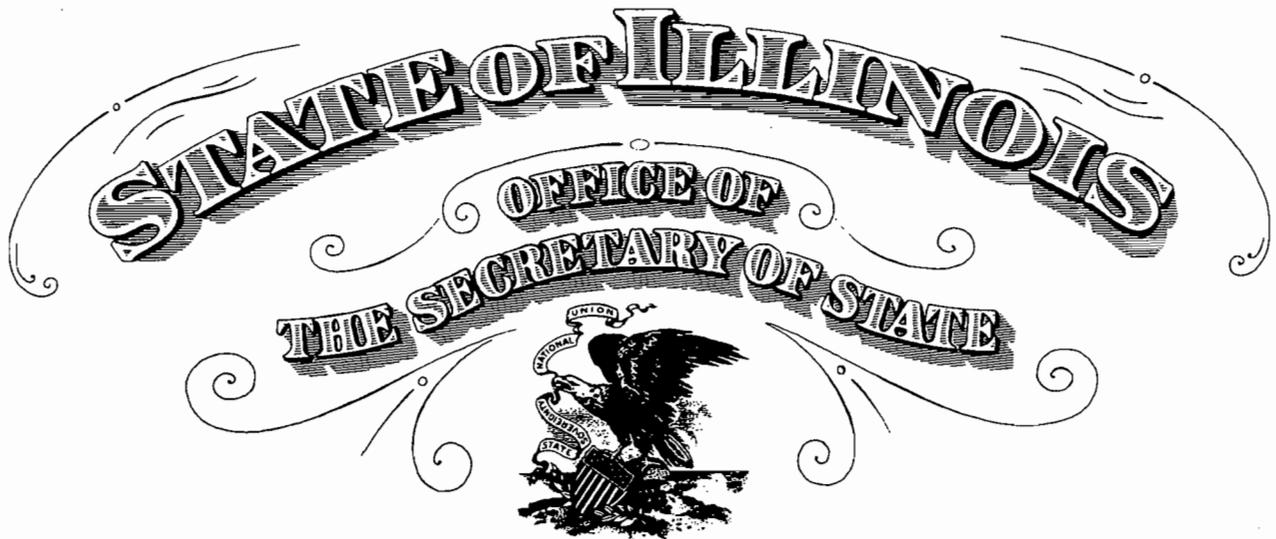
A table in the following format must be provided for all facilities as part of Attachment 44.

CHARITY CARE			
	Year	Year	Year
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

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

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

INDEX OF ATTACHMENTS		
ATTACHMENT NO.		PAGES
1	Applicant/Coapplicant Identification including Certificate of Good Standing	19-20
2	Site Ownership	21-23
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	N/A
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	24
5	Flood Plain Requirements	N/A
6	Historic Preservation Act Requirements	N/A
7	Project and Sources of Funds Itemization	N/A
8	Obligation Document if required	N/A
9	Cost Space Requirements	N/A
10	Discontinuation	25-49
11	Background of the Applicant	N/A
12	Purpose of the Project	N/A
13	Alternatives to the Project	N/A
14	Size of the Project	N/A
15	Project Service Utilization	N/A
16	Unfinished or Shell Space	N/A
17	Assurances for Unfinished/Shell Space	N/A
18	Master Design Project	N/A
19	Mergers, Consolidations and Acquisitions	N/A
	Service Specific:	
20	Medical Surgical Pediatrics, Obstetrics, ICU	N/A
21	Comprehensive Physical Rehabilitation	N/A
22	Acute Mental Illness	N/A
23	Neonatal Intensive Care	N/A
24	Open Heart Surgery	N/A
25	Cardiac Catheterization	N/A
26	In-Center Hemodialysis	N/A
27	Non-Hospital Based Ambulatory Surgery	N/A
28	General Long Term Care	N/A
29	Specialized Long Term Care	N/A
30	Selected Organ Transplantation	N/A
31	Kidney Transplantation	N/A
32	Subacute Care Hospital Model	N/A
33	Post Surgical Recovery Care Center	N/A
34	Children's Community-Based Health Care Center	N/A
35	Community-Based Residential Rehabilitation Center	N/A
36	Long Term Acute Care Hospital	N/A
37	Clinical Service Areas Other than Categories of Service	N/A
38	Freestanding Emergency Center Medical Services	N/A
	Financial and Economic Feasibility:	
39	Availability of Funds	N/A
40	Financial Waiver	N/A
41	Financial Viability	N/A
42	Economic Feasibility	N/A
43	Safety Net Impact Statement	50-53
44	Charity Care Information	54



To all to whom these Presents Shall Come, Greeting:

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

NORTHWESTERN LAKE FOREST HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON DECEMBER 10, 1918, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



Authentication #: 1230501338

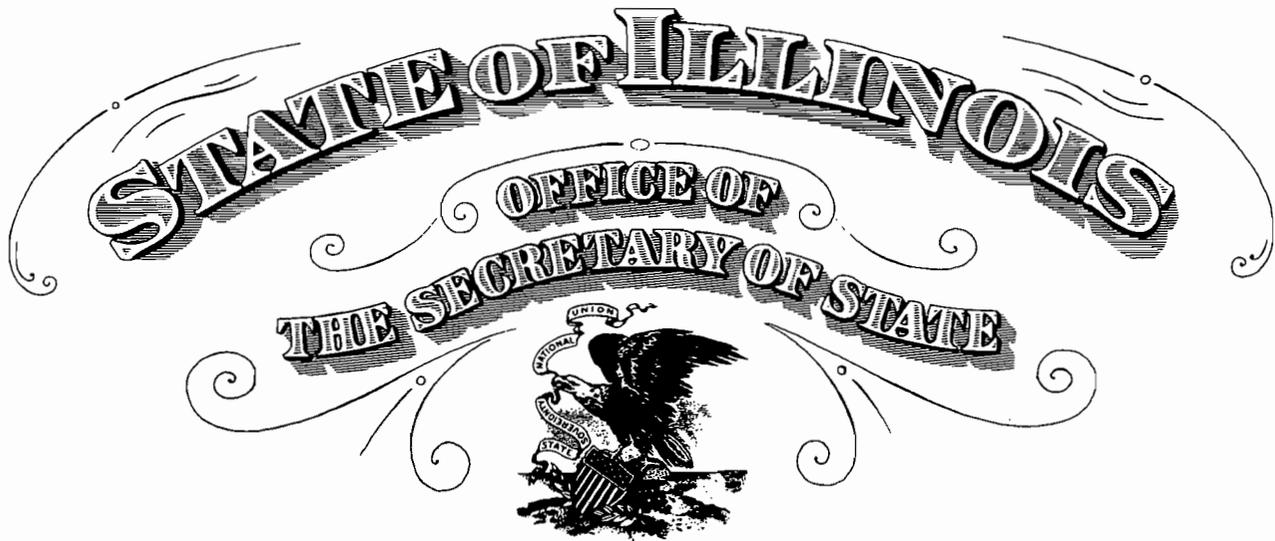
Authenticate at: <http://www.cyberdriveillinois.com>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 31ST day of OCTOBER A.D. 2012 .

Jesse White

SECRETARY OF STATE

ATTACHMENT-1



To all to whom these Presents Shall Come, Greeting:

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

NORTHWESTERN MEMORIAL HEALTHCARE, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 30, 1981, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



Authentication #: 1230501314

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

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 31ST day of OCTOBER A.D. 2012 .*

Jesse White

SECRETARY OF STATE

ATTACHMENT-1



TRUSTEE'S DEED

DOC. 1040040
FILED FOR RECORD IN RECORDERS
OFFICE LAKE COUNTY, ILLINOIS

DEC 20 73-11 09 AM

362980

The above space for recorder's use only. *Frank J. Mustra*

THIS INDENTURE, made this 18th day of December, 1973, between the **First National Bank of Lake Forest**, a banking corporation of the United States of America, being qualified to accept and execute Trusts under the laws of the State of Illinois, as Trustee under the provisions of a Deed or Deeds in Trust, duly recorded and delivered to said Corporation, in pursuance of a Trust Agreement, dated the 1st day of October, 1954, and known as Trust Number 1154, Party of the First-Part, and

THE LAKE FOREST HOSPITAL, a not-for-profit Illinois Corporation

of Lake County, Illinois, Party of the Second-Part.

Witnesseth, The said Party of the First-Part, in consideration of the sum of Ten and No/100ths ----- Dollars (\$ 10.00),

and other good and valuable considerations in hand paid, does hereby grant, sell and convey unto said Party of the Second-Part, the following described Real Estate, situated in Lake County, Illinois, to-wit:

Lots 2 and 3 in Westmoreland Resubdivision, being a Subdivision of part of Lot 14 and Lot "A", all in Westmoreland Acres, in Sections 31 and 32, Township 44 North, Range 12, East of the 3rd P.M., according to the plat of Westmoreland Resubdivision, recorded August 2, 1968, as Document 1387934, in Book 44 of Plats, page 76, in Lake County, Illinois.



together with the tenements and appurtenances thereunto belonging. TO HAVE AND TO HOLD the same unto said party of the second part, and to the proper use, benefit and behoof forever of said party of the second part. SUBJECT TO:

Building lines, utility easements of record, rights, if any, of City of Lake Forest in and to water mains running through premises in question, and general taxes for 1973 and subsequent years.

This deed is executed pursuant to and in the exercise of the power and authority granted to and vested in said trustee by the terms of said deed or deeds in trust delivered to said trustee in pursuance of the trust agreement above mentioned. This deed is made subject to the lien of every trust deed or mortgage (if any there be) of record in said county given to secure the payment of money, and remaining unreleased at the date of the delivery hereof.

IN WITNESS WHEREOF, said party of the first part has caused its corporate seal to be hereto affixed, and has caused its name to be signed to these presents by its Vice-President and attested by its Secretary.



First National Bank of Lake Forest,
as Trustee as aforesaid, (not personally or individually),

By *William D. Sommers*

Vice-President

Attest *Ronald E. Moss*

Secretary

State of Illinois, ss. COUNTY OF LAKE

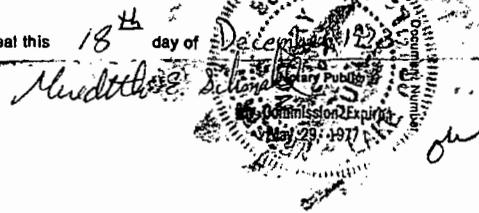
A Notary Public in and for said County and State aforesaid, Do HEREBY CERTIFY, that William D. Sommers a Vice-President of the

First National Bank of Lake Forest and Ronald E. Moss the Secretary of said Bank, personally known to me to be the same persons whose names are subscribed to the foregoing instrument as

such Vice-President and Secretary, respectively, appeared before me this day in person and acknowledged that they signed and delivered the said instrument as their own free and voluntary act, and as the free and voluntary act of said Bank, for the uses and purposes therein set forth; and the said Secretary

did also then and there acknowledge that he, as Custodian of the Corporate Seal of said Bank, did affix the said Corporate Seal of said Bank to said instrument as his own free and voluntary act, and as the free and voluntary act of said Bank, for the uses and purposes therein set forth.

Given under my hand and Notarial Seal this 18th day of December, 1973



Address of grantees *J. J.*

660 Westmoreland Road
Lake Forest, Illinois

NAME [Wilson & McIlvaine (RCF)]

STREET [135 South LaSalle Street]

CITY [Chicago, Illinois 60603]

INSTRUCTIONS

OR

RECORDER'S OFFICE BOX NUMBER

FOR INFORMATION ONLY
INSERT STREET ADDRESS OF ABOVE
DESCRIBED PROPERTY HERE

CHICAGO TITLE INSURANCE CO.

DELIVERY

ATTACHMENT-2

(7) 510484 305401
TRUST DEED

THIS INDENTURE, made as of August 29, 1968, between Lake Forest Hospital a corporation organized under the laws of Illinois, herein referred to as "Mortgagor", and CHICAGO TITLE AND TRUST COMPANY, an Illinois corporation doing business in Chicago, Illinois, herein referred to as TRUSTEE, witnesseth: THAT, WHEREAS the Mortgagor is justly indebted to the legal holder or holders of the Instalment Note hereinafter described, said legal holder or holders being herein referred to as Holders of the Note, in the principal sum of Sixty Thousand and no/100 (\$60,000.00) Dollars. evidenced by one certain Instalment Note of the Mortgagor of even date herewith, made payable TO THE ORDER OF BEARER and delivered, in and by which said Note the Mortgagor promises to pay the said principal sum in instalments as follows:

Fifteen Thousand and no/100 (\$15,000.00) Dollars on the second day of January 1969 and Fifteen Thousand and no/100 (\$15,000.00) Dollars on the second day of each January thereafter, to and including the second day of January 1971, with a final payment of the balance due on the second day of January 1972, with interest from August 29, 1968 on the principal balance from time to time unpaid at the rate of six (6) per cent per annum; each of said instalments of principal bearing interest after maturity at the rate of seven per cent per annum, and all of said principal and interest being made payable at such banking houses or trust companies in Lake Forest Illinois, as the holder or holders of the said Instalment Note may from time to time, by writing or otherwise, direct in writing at the office of The First National Bank of Lake Forest in said City, NOW, THEREFORE, the Mortgagor to secure the payment of the said principal sum of money and said interest in accordance with the terms, provisions and limitations of this trust deed, and the performance of the covenants and agreements herein contained, by the Mortgagor to be performed, and also in consideration of the sum of One Dollar in hand paid, the receipt whereof is hereby acknowledged, does by these presents CONVEY and WARRANT unto the Trustee, its successors and assigns, the following described Real Estate and all of its estate, right, title and interest therein, situate, lying and being in the City of Lake Forest, COUNTY OF LAKE AND STATE OF ILLINOIS, to wit:

Lot 1 in Westmoreland Resubdivision, being a Subdivision of Lot 14 (except that part of the East 460 feet thereof lying South of the North 547 feet of said Lot 14) and Lot "A", all in Westmoreland Acres, in Sections 31 and 32, Township 44 North, Range 12 East of the 3rd P. M., according to the plat of Westmoreland Resubdivision, recorded August 2, 1968 as Document 1387934, in Lake County, Illinois.

which, with the property hereinafter described, is referred to herein as the "premises." TOGETHER with all improvements, tenements, easements, fixtures, and appurtenances thereto belonging, and all rents, issues and profits thereof for so long and during all such times as Mortgagor may be entitled thereto (which are pledged primarily and on a parity with said real estate and not secondarily), and all apparatus, equipment or articles now or hereafter therein or thereon used to supply heat, gas, air conditioning, water, light, power, refrigeration (whether single units or centrally controlled), and ventilation, including (without restricting the foregoing), screens, window shades, storm doors and windows, floor coverings, inador beds, sawings, stoves and water heaters. All of the foregoing are declared to be a part of said real estate whether physically attached thereto or not, and it is agreed that all similar apparatus, equipment or articles hereafter placed in the premises by the mortgagor or its successors, or assigns, shall be considered as constituting part of the real estate.

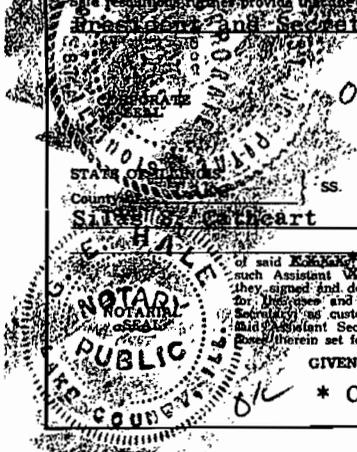
TO HAVE AND TO HOLD the premises unto the said Trustee, its successors and assigns, forever, for the purposes, and upon the uses and trusts herein set forth. This trust deed consists of two pages. The covenants, conditions and provisions appearing on page 2 (the reverse side of this trust deed) are incorporated herein by reference and are a part hereof and shall be binding on the mortgagor, its successors and assigns.

In Witness Whereof this Mortgagor has caused its corporate seal to be hereunto affixed and these presents to be signed by its President and attested by its Secretary on the day and year first above written, pursuant to authority given by resolutions duly passed by the Board of Directors of said corporation.

Said premises and the provisions hereinafter described may be executed on behalf of said corporation by its President/Vice President and Secretary or Assistant Secretary LAKE FOREST HOSPITAL BY: [Signature] PRESIDENT ATTEST: [Signature] SECRETARY

I, G. E. HALE, Notary Public in and for (and residing in) said County in the State aforesaid, DO HEREBY CERTIFY THAT I am a Notary Public in and for the County of Lake, State of Illinois, and that I am the President of the Lake Forest Hospital and Kent Chandler, Jr. Secretary of said Hospital.

GIVEN under my hand and Notarial Seal this 27th day of August A. D. 1968. * Corporation [Signature] NOTARY PUBLIC



THE COVENANTS, CONDITIONS AND PROVISIONS REFERRED TO ON PAGE 1 (THE REVERSE SIDE OF THIS TRUST DEED):

1. Mortgagor shall (1) promptly repair, restore or rebuild any buildings or improvements now or hereafter on the premises which may become damaged or be destroyed; (2) keep said premises in good condition and repair, without waste, and free from mechanics' or other liens or claims for lien not expressly subordinated to the lien hereof; (3) pay when due any indebtedness which may be secured by a lien or charge on the premises superior to the lien hereof, and upon request exhibit satisfactory evidence of the discharge of such prior lien to Trustee or to holders of the note; (4) complete within a reasonable time any building or buildings now or at any time in process of erection upon said premises; (5) comply with all requirements of law or municipal ordinances with respect to the premises and the use thereof; (6) make no material alterations in said premises except as required by law or municipal ordinance.
2. Mortgagor shall pay before any penalty attaches all general taxes, and shall pay special taxes, special assessments, water charges, sewer service charges, and other charges against the premises when due, and shall, upon written request, furnish to Trustee or to holders of the note duplicate receipts therefor. To prevent default hereunder Mortgagor shall pay in full under protest, in the manner provided by statute, any tax or assessment which Mortgagor may desire to contest.
3. Mortgagor shall keep all buildings and improvements now or hereafter situated on said premises insured against loss or damage by fire, lightning or windstorm under policies providing for payment by the insurance company sufficient either to pay the cost of replacing or repairing, the same or to pay in full the indebtedness secured hereby, all in companies satisfactory to the holders of the note, under insurance policies payable, in case of loss or damage, to Trustee for the benefit of the holders of the note; such policies to be evidenced by the standard mortgage clause to be attached to each policy, and shall deliver all policies, including additional and renewal policies, to holders of the note, and in case of insurance about to expire, shall deliver renewal policies not less than ten days prior to the respective date of expiration.
4. In case of default therein, Trustee or the holders of the note may, but need not, make any payment or perform any act heretofore required of Mortgagor in any form and manner deemed expedient, and may, but need not, make full or partial payments of principal or interest on prior encumbrances, if any, and purchase, discharge, compromise or settle any tax lien or other prior lien or title or claim thereof, or redeem from any tax sale or forfeiture affecting said premises or contest any tax or assessment. All moneys paid for any of the purposes herein authorized and all expenses paid or incurred in connection therewith, including attorneys' fees, and any other moneys advanced by Trustee or the holders of the note to protect the mortgaged premises and the lien hereof, plus reasonable compensation to Trustee for each matter concerning which action herein authorized may be taken, shall be so much additional indebtedness secured hereby and shall become immediately due and payable without notice and with interest thereon at the rate of seven per cent per annum. Inaction of Trustee or holders of the note shall never be considered as a waiver of any right accruing to them on account of any default hereunder on the part of Mortgagor.
5. The Trustee or the holders of the note hereby secured making any payment hereby authorized relating to taxes or assessments, may do so according to any bill, statement or estimate procured from the appropriate public office without inquiry into the accuracy of such bill, statement or estimate or into the validity of any tax, assessment, sale, forfeiture, tax lien or title or claim thereof.
6. Mortgagor shall pay each item of indebtedness herein mentioned, both principal and interest, when due according to the terms hereof. At the option of the holders of the note, and without notice to Mortgagor, all unpaid indebtedness secured by this Trust Deed shall, notwithstanding anything in the note or in this Trust Deed to the contrary, become due and payable (a) immediately in the case of default in making payment of any installment of principal or interest on the note, or (b) when default shall occur and continue for ~~thirty~~ ^{thirty} days in the performance of any other agreement of the Mortgagor herein contained.
7. When the indebtedness hereby secured shall become due whether by acceleration or otherwise, holders of the note or Trustee shall have the right to foreclose the lien hereof, in any suit to foreclose the lien hereof, shall be allowed and included as additional indebtedness in the decree for sale all expenditures and expenses which may be paid or incurred by or on behalf of Trustee or holders of the note for attorneys' fees, Trustee's fees, appraiser's fees, outlays for documentary and expert evidence, stenographers' charges, publication costs and costs (which may be estimated as to items to be expended after entry of the decree) of procuring all such abstracts of title, title searches and examinations, guarantee policies, Torrens certificates, and similar data and assurances with respect to title as Trustee or holders of the note may deem to be reasonably necessary either to prosecute such suit or to evidence to bidders at any sale which may be had pursuant to such decree the true condition of the title to or the value of the premises. All expenditures and expenses of the nature in this paragraph mentioned shall become so much additional indebtedness secured hereby and immediately due and payable, with interest thereon at the rate of seven per cent per annum, when paid or incurred by Trustee or holders of the note in connection with (a) any proceeding, including probate and bankruptcy proceedings, to which either of them shall be a party, either as plaintiff, claimant or defendant, by reason of this trust deed or any indebtedness hereby secured; or (b) preparations for the commencement of any suit for the foreclosure hereof after accrual of such right to foreclose whether or not actually commenced; or (c) preparations for the defense of any threatened suit or proceeding which might affect the premises or the security hereof, whether or not actually commenced.
8. The proceeds of any foreclosure sale of the premises shall be distributed and applied in the following order of priority: First, on account of all costs and expenses incident to the foreclosure proceedings, including all such items as are mentioned in the preceding paragraph hereof; second, all other items which under the terms hereof, constitute secured indebtedness additional to that evidenced by the note, with interest thereon as herein provided; third, all principal and interest, remaining unpaid on the note; fourth, any overplus to Mortgagor, its successors or assigns, as their rights may appear.
9. Upon, or at any time after the filing of a bill to foreclose this trust deed, the court in which such bill is filed may appoint a receiver of said premises. Such appointment may be made either before or after sale, without notice, without regard to the solvency or insolvency of Mortgagor at the time of application for such receiver and without regard to the then value of the premises or whether the same shall be then occupied as a homestead or not and the Trustee hereunder may be appointed as such receiver. Such receiver shall have power to collect the rents, issues and profits of said premises during the pendency of such foreclosure suit and, in case of a sale and a deficiency, during the full statutory period of redemption, whether there be redemption or not, as well as during any further times when Mortgagor, except for the intervention of such receiver, would be entitled to collect such rents, issues and profits, and all other powers which may be necessary or are usual in such cases for the protection, possession, control, management and operation of the premises during the whole of said period. The Court from time to time may authorize the receiver to apply the net income in his hands in payment in whole or in part of (1) the indebtedness secured hereby, or by any instrument secured by this trust deed, of any tax, special assessment or other lien which may be or become superior to the lien hereof or of such decree, provided such application is made prior to foreclosure sale; (2) the deficiency in case of a sale and deficiency.
10. No action for the enforcement of the lien or of any provision hereof shall be subject to any defense which would not be good and available to the party interposing same in an action at law upon the note hereby secured.
11. Trustee or the holders of the note shall have the right to inspect the premises at all reasonable times and access thereto shall be permitted for that purpose.
12. Trustee has no duty to examine the title, location, existence, or condition of the premises, nor shall Trustee be obligated to record this trust deed or to exercise any power herein given unless expressly obligated by the terms hereof, nor be liable for any acts or omissions hereunder, except in case of its own gross negligence or misconduct or that of the agents or employees of Trustee, and it may require indemnities satisfactory to it before exercising any power herein given.
13. Trustee shall release this trust deed and the lien thereof by proper instrument upon presentation of satisfactory evidence that all indebtedness secured by this trust deed has been fully paid; and Trustee may execute and deliver a release hereof to and at the request of any person who shall, either before or after maturity thereof, produce and exhibit to Trustee the note representing that all indebtedness hereby secured has been paid, which representation Trustee may accept as true without inquiry. Where a release is requested of a successor trustee, such successor trustee may accept as the genuine note herein described any note which bears a certificate of identification purporting to be executed by a prior trustee hereunder or which conforms in substance with the description herein contained of the note and which purports to be executed on behalf of the corporation herein designated as the maker thereof; and where the release is requested of the original trustee and it has never executed a certificate on any instrument identifying same as the note described here, it may accept as the genuine note herein described any note which may be presented and which conforms in substance with the description herein contained of the note and which purports to be executed on behalf of the corporation herein designated as maker thereof.
14. Trustee may resign by instrument in writing filed in the office of the Recorder or Registrar of Titles in which this instrument shall have been recorded or filed. In case of the resignation, inability or refusal to act of Trustee, the then Recorder of Deeds of the county in which the premises are situated shall be Successor in Trust. Any Successor in Trust hereunder shall have the identical title, powers and authority as are herein given Trustee, and any Trustee or successor shall be entitled to reasonable compensation for all acts performed hereunder.
15. This Trust Deed and all provisions hereof, shall extend to and be binding upon Mortgagor and all persons claiming under or through Mortgagor, and the word "Mortgagor" when used herein shall include all such persons and all persons liable for the payment of the indebtedness or any part thereof, whether or not such persons shall have executed the note or this Trust Deed.
16. The mortgagor hereby waives any and all rights of redemption from sale under any order or decree of foreclosure of this trust deed, on its own behalf and on behalf of each and every person, except decree or judgment creditors of the mortgagor, acquiring any interest in or title to the premises subsequent to the date of this trust deed.

FEB 1972

LED X Same

1391906
 FILED FOR RECORD IN THE
 OFFICE CLERK COUNTY, ILLINOIS
 SEP 4 - '68 - 11 12 AM
Edward J. [Signature]

IMPORTANT

FOR THE PROTECTION OF BOTH THE BORROWER AND LENDER, THE NOTE SECURED BY THIS TRUST DEED SHOULD BE IDENTIFIED BY THE TRUSTEE NAMED HEREIN BEFORE THE TRUST DEED IS FILED FOR RECORD.

The Installment Note mentioned in the within Trust Deed has been identified herewith under Identification No. 510484

CHICAGO TITLE AND TRUST COMPANY, as Trustee.

by *Edward J. [Signature]*
 Assistant Vice President
 Trust Officer

D E L I V E R Y INSTRUCTIONS

NAME George L. Reilly

STREET 262 E. Deerpath

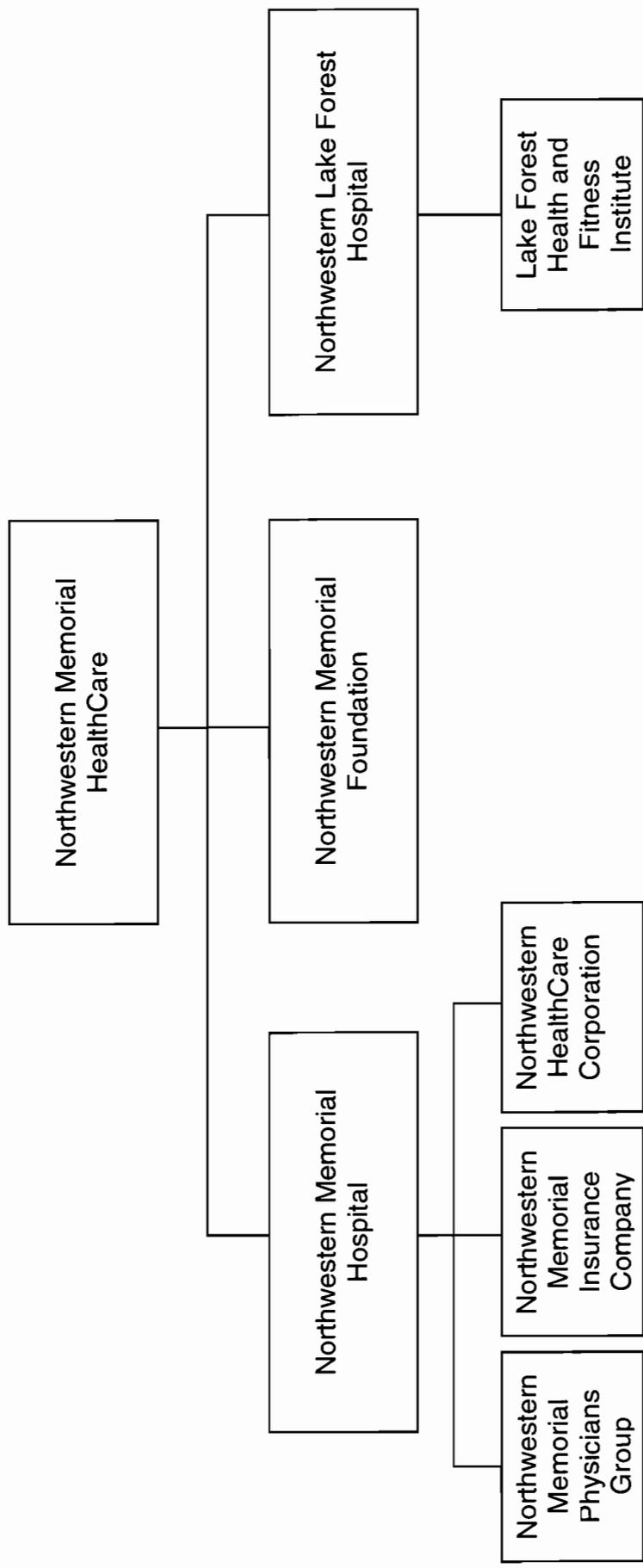
CITY Lake Forest, Illinois

OR

RECORDER'S OFFICE BOX NUMBER _____

FOR RECORDERS INDEX PURPOSES
 INSERT STREET ADDRESS OF ABOVE
 DESCRIBED PROPERTY HERE

NMHC Organizational Chart



SECTION II. DISCONTINUATION

Criterion 1110.130 – Discontinuation

GENERAL INFORMATION REQUIREMENTS

NLFH proposes to discontinue its 10-bed pediatrics category of service. No other clinical services will be discontinued in conjunction with this project. Conversely, NLFH plans to continue treating and admitting patients aged 0 – 14 years, but under the medical/surgical category of service.

Upon HFSRB approval of this project, NLFH plans to convert the pediatrics unit to a medical/surgical unit, adding the 10 beds to NLFH's medical/surgical inventory through the Illinois Health Facilities Planning Act (20 ILCS 3960/5) (from Ch. 111 1/2, par. 1155) Sec. 5 c ("20-bed/10% rule"). Because NLFH plans to continue to treat pediatrics patients, this discontinuation will not be noticeable to staff and/or patients.

Medical records will be retained in accordance with the NMHC Records Retention policy. According to that policy, Patient Medical Documents are kept permanently at NLFH.

REASONS FOR DISCONTINUATION

Over the past decade, pediatrics volume at NLFH has been low with an average daily census ranging from 2.06 to 3.37 patients/day. This has resulted in average annual occupancies of 20.6 – 33.7%, far below the State's occupancy standard.

NLFH Pediatrics

	CY02	CY03	CY04	CY05	CY06	CY07	CY08	CY09	CY10	CY11	CY12
Cases	187	261	279	392	412	558	566	546	471	545	424
Patient Days	950	1163	751	936	924	1231	1200	1110	909	1136	770
ADC	2.60	3.19	2.06	2.56	2.53	3.37	3.29	3.04	2.49	3.11	2.11
Beds	10	10	10	10	10	10	10	10	10	10	10
Occupancy	26.0%	31.9%	20.6%	25.6%	25.3%	33.7%	32.9%	30.4%	24.9%	31.1%	21.1%

Pediatrics volume is low for all four pediatrics providers in Planning Area A-09. The average daily census for the four other providers ranges from 0 – 4.8 patients/day with the highest occupancy of only 34.3%. The focus on pediatric preventative services as well as the presence of Lurie Children's Hospital, a specialty pediatrics facility within 30 miles of the area, are key factors for the low pediatrics volumes at the community hospitals in the area.

Hospital Name	ADC	Beds	Occupancy
Advocate Condell Medical Center	3.3	16	20.9%
Advocate Good Shepherd Hospital	4.8	14	34.3%
NorthShore University HealthSystem-Highland Park Hospital	1.9	6	31.2%
Vista Medical Center East	0	35	0.0%

In order to have more flexibility and to better utilize the beds at NLFH, as mentioned above, patients aged 0 – 14 years will be admitted under the medical/surgical category of service.

NLFH does not anticipate any change in the management of pediatric volumes with this discontinuation. Because of this, NLFH does not anticipate any impact to other providers.

IMPACT ON ACCESS

As stated above, NLFH does not anticipate any change in the management of its current pediatrics volume with this discontinuation and therefore do not anticipate any impact to area hospitals.

On February 19, 2013, certified letters, consistent with the requirements in Section 1110.130, were sent to all hospitals with approved pediatrics beds within 45 minutes of NLFH. Letters were sent to the following hospitals:

- Advocate Condell Medical Center
- Advocate Good Shepherd Hospital
- Advocate Illinois Masonic Medical Center
- Advocate Lutheran General Hospital
- Alexian Brothers Medical Center
- Lurie Children's Hospital
- Elmhurst Memorial Hospital
- Gottlieb Memorial Hospital
- John H. Stroger Hospital of Cook County
- NorthShore University HealthSystem – Evanston Hospital
- NorthShore University HealthSystem – Highland Park Hospital
- NorthShore University HealthSystem – Skokie Hospital
- Northwest Community Hospital
- Norwegian American Hospital
- Resurrection Medical Center
- Rush University Medical Center
- Saint Francis Hospital
- Saint Joseph Hospital
- Saints Mary & Elizabeth Medical Center, Division Street
- Shriners Hospitals for Children-Chicago
- St. Alexius Medical Center
- Swedish Covenant Hospital
- University of Illinois Medical Center at Chicago
- Vista Medical Center East

A copy of the letter is attached, as are the return receipts received, confirming delivery of the letters.

As of the filing of this application, no responses have been received by NLFH. The lack of responses indicates that the proposed discontinuation will have no impact on the facilities.

by Certified Mail

February 19, 2013

Name
Facility Name
Street Address
City, State, Zip

**RE: Request for Impact Determination
Discontinuation of Pediatrics Category of Service
Northwestern Lake Forest Hospital**

Dear :

Northwestern Lake Forest Hospital is preparing a Certificate of Need application addressing the discontinuation of its 10-bed pediatrics category of service. The hospital is located at 660 North Westmoreland Road in Lake Forest. The discontinuation is scheduled to occur following Illinois Health Facilities and Services Review Board approval in June, 2013.

Over the past two years, NLFH averaged approximately 485 pediatric admissions per year (545 CY11 and 426 in CY12). Admissions to the pediatrics unit have been relatively flat over the last decade with an average daily census ranging from 2.1 to 3.4 patients/day. This has resulted in annual occupancies of 20 - 33%, far below the State's occupancy standard. In order to have more flexibility and to better utilize existing beds at NLFH, we plan to continue to admit patients aged 0 – 14 years under the medical/surgical category of service. Because of this, we do not anticipate any impact to your facility or other providers in our planning area.

As part of the discontinuation process, and consistent with the requirements of Section 1110.130, you are hereby asked to, within 15 days, identify any impact the proposed discontinuation of the pediatrics category of service will have on your operations. Again, we do not anticipate any change in our management of our pediatric volumes with this discontinuation, so we do not anticipate any impact to your facility.

Thank you for your prompt attention to this request.

Sincerely,

Bridget S. Orth
Regulatory Facility Planning

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Ms. Dominica Tallarico
Advocate Condell Medical Center
801 South Milwaukee Avenue
Libertyville, IL 60048

PS Form 3800, August 2006

See Reverse for Instructions

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Ms. Dominica Tallarico
Advocate Condell Medical Center
801 South Milwaukee Avenue
Libertyville, IL 60048

COMPLETE THIS SECTION ON DELIVERY

A. Signature *[Signature]* Agent Addressee

B. Received by (Printed Name) *Steve Nery* C. Date of Delivery *0-2-02*

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

3. Service Type

Certified Mail Express Mail

Registered Return Receipt for Merchandise

Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee) Yes

2. Article Number (Transfer from service label) 7011 2000 0002 0214 5102

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Total Postage & Fees	\$	

Sent To
 Ms. Karen Lambert
 Street Advocate Good Shepherd Hospital
 or PO 450 West Highway 22
 City, St Barrington, IL 60010

PS Form 3800, August 2006 See Reverse for Instructions

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY
<ul style="list-style-type: none"> ■ Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. ■ Print your name and address on the reverse so that we can return the card to you. ■ Attach this card to the back of the mailpiece, or on the front if space permits. <p>1. Article Addressed to:</p> <p style="margin-left: 40px;">Ms. Karen Lambert Advocate Good Shepherd Hospital 450 West Highway 22 Barrington, IL 60010</p>	<p>A. Signature <input checked="" type="checkbox"/> <i>R. Kedra</i> <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) <i>ROBERT KEDRA</i></p> <p>C. Date of Delivery <i>02-22-13</i></p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p>
<p>2. Article Number <i>1111</i> (Transfer from service label)</p>	<p>3. Service Type <input checked="" type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input checked="" type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>
<p>7011 2000 0002 0214 5119</p>	
<p>PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540</p>	

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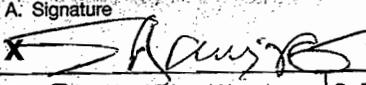
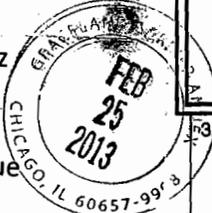
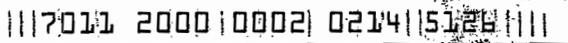
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Return Receipt Fee (Endorsement Required)		
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Total Postage & Fees	\$	

Se
 Ms. Susan Nordstrom Lopez
 St Advocate Illinois Masonic Medical Center
 or
 836 West Wellington Avenue
 Ch Chicago, IL 60657

PS Form 3800, August 2006 See Reverse for Instructions

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. 	A. Signature <input type="checkbox"/> Agent <input checked="" type="checkbox"/> Addressee  B. Received by (Printed Name) <input type="checkbox"/> Agent <input checked="" type="checkbox"/> Addressee C. Date of Delivery D. Is delivery address different from item 1? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If YES, enter delivery address below:
1. Article Addressed to: Ms. Susan Nordstrom Lopez Advocate Illinois Masonic Medical Center 836 West Wellington Avenue Chicago, IL 60657 	3. Service Type <input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.
2. Article Number (Transfer from service label) 	4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes

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Mr. Anthony Armada
Advocate Lutheran General Hospital
1775 Dempster Street
Park Ridge, IL 60068

See Reverse for Instructions

PS Form 3800, August 2006

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- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Anthony Armada
Advocate Lutheran General Hospital
1775 Dempster Street
Park Ridge, IL 60068

2. Article Number
(Transfer from service label)

7011 2000 0002 0214 5133

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

[Handwritten Signature]

Agent

Addressee

B. Received by (Printed Name) Date of Delivery

GLEN M. PETERSEN

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

3. Service Type

Certified Mail

Express Mail

Registered

Return Receipt for Merchandise

Insured Mail

C.O.D.

4. Restricted Delivery? (Extra Fee)

Yes

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Return Receipt Fee (Endorsement Required)		
Restricted Delivery Fee (Endorsement Required)		
Total Postage & Fees	\$	

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

PS Form 3800, August 2006 See Reverse for Instructions

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- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

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

2. Article Number
 (Transfer from service label) 7011 2000 0002 0214 5140

COMPLETE THIS SECTION ON DELIVERY

A. Signature Agent
 Addressee

B. Received by (Printed Name) *JS* C. Date of Delivery *2-22-13*

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

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

4. Restricted Delivery? (Extra Fee) Yes

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Total Postage & Fees	\$

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Mr. W. Peter Daniels
 Elmhurst Memorial Hospital
 155 East Brushhill Road
 Elmhurst, IL 60126

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- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. W. Peter Daniels
 Elmhurst Memorial Hospital
 155 East Brushhill Road
 Elmhurst, IL 60126

2. Article Number

(Transfer from service label)

7011 2000 0002 0214 5164

PS Form 3811, February 2004

Domestic Return Receipt

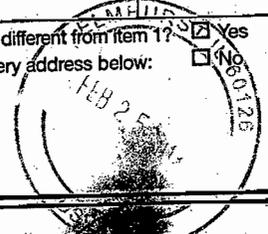
102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature  Agent
 Addressee

B. Received by (Printed Name) C. Date of Delivery

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



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

4. Restricted Delivery? (Extra Fee) Yes

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Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	\$

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Mr. Kenneth Fishbain
 Gottlieb Memorial Hospital
 701 West North Avenue
 Melrose Park, IL 60160

PS Form 3800, August 2006

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<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. 	<p>A. Signature <i>[Signature]</i> <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) <i>[Signature]</i> C. Date of Delivery</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p>
<p>1. Article Addressed to:</p> <p>Mr. Kenneth Fishbain Gottlieb Memorial Hospital 701 West North Avenue Melrose Park, IL 60160</p>	<p>3. Service Type <input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p>
<p>2. Article Number (Transfer from service label)</p> <p>7011 2000 0002 0214 5171</p>	<p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>
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Total Postage & Fees	\$	

Mr. Patrick M. Magoon
 Lurie Children's Hospital
 2300 Children's Plaza
 Chicago, IL 60614

PS Form 3800, August 2006 See Reverse for Instructions

SENDER: COMPLETE THIS SECTION

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

1. Article Addressed to:

Mr. Patrick M. Magoon
 Lurie Children's Hospital
 2300 Children's Plaza
 Chicago, IL 60614

COMPLETE THIS SECTION ON DELIVERY

A. Signature
 X: *[Signature]* Agent Addressee

B. Received by (Printed Name) *J Flores* C. Date of Delivery *2/22/13*

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

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

4. Restricted Delivery? (Extra Fee) Yes

2. Article Number (Transfer from service label) 7011 2000 0002 0214 5157

7011 2000 0002 0214 5195

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Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	\$

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Mr. J.P. Gallagher
 NorthShore University HealthSystem-
 Evanston Hospital
 1301 Central Street
 Evanston, IL 60201

PS Form 3800, August 2000

See Reverse for Instructions

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY
<ul style="list-style-type: none"> ■ Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. ■ Print your name and address on the reverse so that we can return the card to you. ■ Attach this card to the back of the mailpiece, or on the front if space permits. <p>1. Article Addressed to:</p> <p>Mr. J.P. Gallagher NorthShore University HealthSystem Evanston Hospital 1301 Central Street Evanston, IL 60201</p>	<p>A. Signature X <i>[Signature]</i> <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) Brandon Nyanya</p> <p>C. Date of Delivery 2-22-13</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p> <p>3. Service Type <input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>
<p>2. Article Number (Transfer from service label)</p>	<p>7011 2000 0002 0214 5195</p>

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Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	\$

Postmark
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Sent To **Mr. Jesse Peterson Hall**
NorthShore University HealthSystem-
 Street, Apt. **Highland Park Hospital**
 or PO Box
 City, State, **777 Park Avenue West**
Highland Park, IL 60035

PS Form 3811, AUGUST 2004 See Reverse for Instructions

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. 	<p>A. Signature <input checked="" type="checkbox"/> <i>Joe Parkin</i> <input checked="" type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) JOE PARKIN C. Date of Delivery 1/25/12</p>
<p>1. Article Addressed to:</p> <p>Mr. Jesse Peterson Hall NorthShore University HealthSystem Highland Park Hospital 777 Park Avenue West Highland Park, IL 60035</p>	<p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p> <p>3. Service Type <input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>
<p>2. Article Number (Transfer from service label) 7011 2000 0002 0214 5201</p>	
<p>PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540</p>	

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Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	\$

Postmark
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Ms. Kristen Murtos
 NorthShore University HealthSystem-Skokie
 Hospital
 9600 Gross Point Road
 Skokie, IL 60076

See Reverse for Instructions

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. 	<p>A. Signature <input checked="" type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) <i>Joby Gonzales</i></p> <p>C. Date of Delivery</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, enter delivery address below:</p>
<p>1. Article Addressed to:</p> <p>Ms. Kristen Murtos NorthShore University HealthSystem Skokie Hospital 9600 Gross Point Road Skokie, IL 60076</p>	<p>3. Service type <input checked="" type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>
<p>2. Article Number (Transfer from service label)</p>	<p>7011 2000 0002 0214 5218</p>



7011 2000 0002 0214 5225

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Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	\$

Postmark
Here

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

PS Form 3800, August 2006 See Reverse for Instructions

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. 	<p>A. Signature <input checked="" type="checkbox"/> Agent <input checked="" type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) <i>M. P. ...</i></p> <p>C. Date of Delivery <i>2/25/13</i></p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, enter delivery address below:</p>
<p>1. Article Addressed to:</p> <p>Mr. Bruce Crowther Northwest Community Hospital 800 West Central Road Arlington Heights, IL 60005</p>	<p>3. Service Type</p> <p><input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail</p> <p><input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise</p> <p><input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p>
<p>2. Article Number (Transfer from service label)</p> <p>7011 2000 0002 0214 5225</p>	<p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>

PS Form 3811, February 2004

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Return Receipt Fee (Endorsement Required)		
Restricted Delivery Fee (Endorsement Required)		
Total Postage & Fees	\$	

7011 2000 0002 0214 5249

Mr. John Baird
 Resurrection Medical Center
 7435 West Talcott Avenue
 Chicago, IL 60631

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<ul style="list-style-type: none"> ■ Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. ■ Print your name and address on the reverse so that we can return the card to you. ■ Attach this card to the back of the mailpiece, or on the front if space permits. <p>1. Article Addressed to:</p> <p>Mr. John Baird Resurrection Medical Center 7435 West Talcott Avenue Chicago, IL 60631</p> <p style="text-align: right; font-size: small;">FEB 22 2013 1309 ST 100 PARK ST</p>	<p>A. Signature <input checked="" type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p><i>[Signature]</i></p> <p>B. Received by (Printed Name) C. Date of Delivery</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p> <p>3. Service Type</p> <p><input type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>
<p>2. Article Number (Transfer from service label) 7011 2000 0002 0214 5249 </p>	
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Dr. Larry J. Goodman, M.D.
 Rush University Medical Center
 1653 West Congress Parkway
 Chicago, IL 60612

PS Form 3800, August 2006

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1. Article Addressed to:

Dr. Larry J. Goodman, M.D.
 Rush University Medical Center
 1653 West Congress Parkway
 Chicago, IL 60612

2. Article Number
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A. Signature

x *C. Irwin*

- Agent
 Addressee

B. Received by *(Printed Name)*

C. Irwin

C. Date of Delivery

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Mr. Jeff Murphy
 Saint Francis Hospital
 355 Ridge Avenue
 Evanston, IL 60202

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1. Article Addressed to:

Mr. Jeff Murphy
 Saint Francis Hospital
 355 Ridge Avenue
 Evanston, IL 60202

2. Article Number

(Transfer from service label)

7011 2000 0002 0214 5263

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X *D. Varallo*

- Agent
 Addressee

B. Received by (Printed Name)

D. VARALLO

C. Date of Delivery

2-25-17

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ATTACHMENT-10

Page 18

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Restricted Delivery Fee (Endorsement Required)	
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Ms. Margaret McDermontt
 Saints Mary & Elizabeth Medical Center,
 Division Street
 2233 West Division Street
 Chicago, IL 60622

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1. Article Addressed to:

Ms. Margaret McDermontt
 Saints Mary & Elizabeth Medical
 Center, Division Street
 2233 West Division Street
 Chicago, IL 60622

2. Article Number
 (Transfer from service label)

7011 2000 0002 0214 5287

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 Addressee

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4. Restricted Delivery? (Extra Fee) Yes

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Total Postage & Fees	\$	

Mr. Mark Niederpruem
 Shriners Hospitals for Children-Chicago
 2211 North Oak Park Avenue
 Chicago, IL 60707

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- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

 Mr. Mark Niederpruem
 Shriners Hospitals for Children-Chicago
 2211 North Oak Park Avenue
 Chicago, IL 60707

COMPLETE THIS SECTION ON DELIVERY

A. Signature
 X *J. Terteltch* Agent Addressee

B. Received by (Printed Name) C. Date of Delivery

D. Is delivery address different from item 1? Yes
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3. Service Type
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4. Restricted Delivery? (Extra Fee) Yes

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Mr. Edward M. Goldberg
 St. Alexius Medical Center
 1555 North Barrington Road
 Hoffman Estates, IL 60169

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1. Article Addressed to:

Mr. Edward M. Goldberg
 St. Alexius Medical Center
 1555 North Barrington Road
 Hoffman Estates, IL 60169

2. Article Number
 (Transfer from service label)

7011 2000 0002 0214 5300

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A. Signature
 X *[Signature]* Agent
 Addressee

B. Received by (Printed Name)
Chris Ellis

C. Date of Delivery
2-25-17

D. Is delivery address different from item 1? Yes
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3. Service Type
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4. Restricted Delivery? (Extra Fee) Yes

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Restricted Delivery Fee (Endorsement Required)		
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Mr. Mark Newton
 Swedish Covenant Hospital
 5145 North California Avenue
 Chicago, IL 60625

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1. Article Addressed to:

Mr. Mark Newton
 Swedish Covenant Hospital
 5145 North California Avenue
 Chicago, IL 60625

2. Article Number.
 (Transfer from service label)

COMPLETE THIS SECTION ON DELIVERY

A. Signature
 Thomas J. ... Agent
 Addressee

B. Received by (Printed Name)
Tom Farr

C. Date of Delivery
2/22

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

3. Service Type

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4. Restricted Delivery? (Extra Fee) Yes

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Total Postage & Fees	\$

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Mr. John DeNardo
 University of Illinois Medical Center at
 Chicago
 1740 West Taylor Street
 Chicago, IL 60612

For Instructions

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1. Article Addressed to:

Mr. John DeNardo
 University of Illinois
 Medical Center at Chicago
 1740 West Taylor Street
 Chicago, IL 60612

2. Article Number
(Transfer from service label)

7011 2000 0002 0214 5324

COMPLETE THIS SECTION ON DELIVERY

A. Signature Agent
 Maribel Vellon Addressee

B. Received by (Printed Name) C. Date of Delivery

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3. Service Type
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 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee) Yes

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Return Receipt Fee (Endorsement Required)		
Restricted Delivery Fee (Endorsement Required)		
Total Postage & Fees	\$	

Ms. Carol Schneider
 John H. Stroger Jr. Hospital of Cook County
 1901 West Harrison Street
 Chicago, IL 60612

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Certified Fee		
Return Receipt Fee (Endorsement Required)		
Restricted Delivery Fee (Endorsement Required)		
Total Postage & Fees	\$	

Ms. Roberta Luskin-Hawk
 Saint Joseph Hospital
 2900 North Lake Shore Drive
 Chicago, IL 60657

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Return Receipt Fee (Endorsement Required)		
Restricted Delivery Fee (Endorsement Required)		
Total Postage & Fees	\$	

Mr. Jose Sanchez
 Norwegian American Hospital
 1044 North Francisco Avenue
 Chicago, IL 60622

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ATTACHMENT-10
 Page 25

XI. Safety Net Impact Statement

Northwestern Lake Forest Hospital provides access to specialty medical care, clinical trials and a host of other healthcare services for patients in Lake County and surrounding regions. From its founding 114 years ago as Alice Home on the campus of Lake Forest College, NLFH has upheld its promise to provide Lake County residents convenient access to the highest quality, most advanced healthcare services available.

NLFH has continually expanded its healthcare services to respond to the growing needs of its community. NLFH shares Northwestern Memorial's commitment to provide care for those unable to pay, consistently providing the highest percentage of charity care as a percent of patient revenue among Lake County hospitals. Additionally, in 2011, NLFH provided 28% of the total charity care in Lake County, the highest percentage in the county.

Additionally, NLFH's board-certified emergency physicians and trauma-trained nurses serve and support the Region 10 Emergency Medical System, providing trauma and emergency care to patients at its Level II Trauma Center at NLFH and emergency services at the Northwestern Grayslake Emergency Center. In 2011, NLFH's Emergency Department was among 20 national recipients to receive the Emergency Nurses Association's 1st annual Lantern Award. The award recognizes emergency departments that exemplify exceptional and innovative performance in leadership, practice education, advocacy and research, and a commitment to excellence.

NLFH continues to earn recognition for quality care. NLFH earned an "A" rating in hospital safety by the Leapfrog Group, an organization that provides the only national, public comparison of hospitals across safety, quality and efficiency of care dimensions. NLFH was among only 92 hospitals selected out of nearly 1,200 surveyed to achieve this rating.

NLFH received the Consumer Choice Award for Lake and Kenosha counties in 2012 for the 8th consecutive year. NLFH achieved the prestigious Magnet designation from the American Nurses Credentialing Center, the gold standard for nursing excellence and an organizational commitment to quality care. NLFH is among an elite group of the nation's healthcare organizations to do so.

Providing Access to Care for Medically Underserved Lake County Residents

NLFH works with community-based organizations to support efforts to reach the most medically underserved residents in Lake County.

For more than seven years, NLFH has provided vital patient care services to medically underserved residents of Lake County in partnership with the Lake County Health Department and Community Health Center. Through this relationship, NLFH provided needed colonoscopy, radiology, imaging services and neurologic consultations.

NLFH supports health care for the medically underserved in Lake County through its partnership with HealthReach, an independent not-for-profit organization that partners with public and private organizations to provide access to free primary and specialty medical care, dental, vision and pharmaceutical services for uninsured Lake County residents. In FY12, NLFH provided grant funding to HealthReach, helping the organization to provide more than 20,000 patient visits and pay for more than 28,000 prescriptions for those who could not afford their medications.

Also in FY12, NLFH provided more than \$97,000 in laboratory support, diagnostic imaging and testing and hospitalization for HealthReach patients. Surgeons and physicians on the medical staff of NLFH also provided pro bono services for patients in need of care for life-threatening diseases and illnesses.

NLFH Free and Discounted Care Policy

Free and Discounted Care is available to those seeking care at NLFH based upon the following program criteria:

- The Free and Discounted Care Policy measures patient income against the U.S. Health and Human Services Federal Poverty Guideline, known as the federal poverty level (FPL) to determine eligibility. One hundred percent free care is provided to patients with incomes less than or equal to 250% of the FPL. Additionally, patient care services are provided at approximate cost for those qualifying patients with family income between 251% and 600% of the FPL.
- The Free and Discounted Care Policy includes a Catastrophic Program for qualifying patients with household income above 250% of the FPL (patients at or below this level are eligible for free care). Under this program, the patient's total responsibility to either NLFH or to NMH and affiliates will not exceed 21% of annual household income over a three year period (7% of annual household income per year for three years) for patients with annual household income between 251% and 600% of the FPL. This is less burdensome for patients than the amount defined by the Illinois Hospital Uninsured Patient Discount Act enacted April 1, 2009, which allows healthcare organizations to hold patients in this category responsible for up to 25% of annual household income. For uninsured and underinsured patients with annual household income over 600% of the FPL, the patient's maximum responsibility is limited to 35% of household income. The Illinois Hospital Uninsured Patient Discount Act does not limit an uninsured or underinsured patient's responsibility when household income is over 600% of FPL.
- The Free and Discounted Care Policy includes a discount program for patients who do not have third-party insurance (uninsured) with incomes above the threshold to qualify for free care. This program is also available to patients with third-party insurance that does not cover services deemed to be medically necessary. The discount program provides patients a 30% discount off billed charges, which represents the median managed care discount rate based on NMH managed care contracts with non-governmental payors during the prior fiscal year.

Other NLFH Community Benefit Activities

NLFH provides health education lectures and awareness programs at schools, nursing homes and other locations throughout Lake County, as well as support groups and services for patients and their families including:

- Presentations to area school staff and parents regarding care of the child with type 1 diabetes in school.
- An annual children's safety fair.
- Health education to members of the Down Syndrome Development Council regarding childhood obesity in children with special needs.
- Programs for cancer patients and survivors offered free of charge, including:
 - Support for newly diagnosed patients
 - "I Can Cope" for patients in treatment for cancer

- “Look Good, Feel Better” for patients suffering from cosmetic challenges relating to treatment
- Nutrition consultations for diagnosed patients
- Wig boutique
- Cancer survivors networking group
- Survivors health and nutrition programs
- Meditation class
- Yoga class
- NLFH staff provide medical career advisory training at Lake County High Schools Technical Campus for students pursuing careers in healthcare directly following high school or seeking professional healthcare careers.
- NLFH provides on-site training for physically, mentally and emotionally challenged students learning to perform housekeeping duties in partnership with the Special Education District of Lake County, a cooperative educational organization working among 35 school districts in Lake County, Illinois.
- More than 160 NLFH employees and their families participated in a day of service at Lambs Farm, a not-for-profit organization that provides residence, vocational services, employment and support to adults with developmental disabilities in Lake County, Illinois. The families helped with painting and landscaping services.

Impact of the Project on Safety Net Services at Other Hospitals

The proposed project will not have a negative impact on essential safety net services in the community. Nor will this project impact the ability of other providers to cross-subsidize safety net services. Because NLFH does not plan to change the management of its pediatric cases, there is no anticipated impact on area providers at all.

NLFH Community Benefit

To help meet the needs of the community during FY12, NLFH contributed \$50.2 million in community benefits, which represents 22.3% of its patient service revenues. Included in the \$50.2 million is \$10.0 million in charity care alone. Other elements of our community benefit contribution are:

- \$37.2 million Government sponsored care (unreimbursed cost of Medicaid and Medicare).
- \$0.7 million other community benefits: NLFH provides community benefit through subsidized health services including education and information to improve the health of the community; donations to charitable and community organizations; volunteer efforts; language assistance and translation services for patients and their families; and more.
- \$2.3 million Bad Debt (based on cost): An important part of NLFH's commitment to providing quality and accessible healthcare includes covering the expense of payments that were expected but not received.

Charity Care and Medicaid

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	FY10	FY11	FY12
Inpatient	366	284	353
Outpatient	3,267	2,596	4,884
Total	3,633	2,880	5,237
Charity (cost in dollars)			
Inpatient	\$ 1,451,301	\$ 3,347,000	\$ 3,548,681
Outpatient	\$ 4,373,232	\$ 6,874,000	\$ 6,663,782
Total	\$ 5,824,533	\$ 10,221,000	\$ 10,212,163
MEDICAID			
Medicaid (# of patients)	FY10	FY11	FY12
Inpatient	537	527	450
Outpatient	18,012	18,557	23,211
Total	18,549	19,084	23,661
Medicaid (revenue)			
Inpatient	\$ 1,059,683	\$ 2,085,210	\$ 1,754,716
Outpatient	\$ 2,095,646	\$ 4,297,078	\$ 3,854,036
Total	\$ 3,155,329	\$ 6,382,288	\$ 5,608,752

Source: IDPH Annual Hospital Questionnaires

XII. Charity Care Information

Charity Care

NLFH is committed to providing care for those who are unable to pay, consistently providing the highest percentage of charity care as a percent of patient revenue among Lake County hospitals. Additionally, in 2011, NLFH provided 28% of the total charity care provided in Lake County, the highest percentage in the county.

NLFH CHARITY CARE			
	FY10	FY11	FY12
Net Patient Revenue	\$ 121,181,582	\$ 222,102,446	\$ 217,261,274
Amount of Charity Care (charges)	\$ 19,546,464	\$ 31,708,397	\$ 32,560,946
Cost of Charity Care	\$ 5,824,533	\$ 10,221,000	\$ 10,212,163
Charity Care as % of Net Revenue	4.8%	4.6%	4.7%