Axel & Associates, Inc.

MANAGEMENT CONSULTANTS

by FedEX

December 20, 2017

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

Dear Ms. Avery:

Enclosed please find Certificate of Exemption ("COE") applications addressing the change of ownership/control of the following IDPH-licensed health care facilities:

- Presence Saint Joseph Hospital (Chicago) E-058-17
- Presence Resurrection Medical Center (Chicago) E-063-17
- Presence Saint Mary of Nazareth Hospital (Chicago) E-061-17
- Presence Saint Elizabeth Hospital (Chicago) E-060-17
- Presence Saint Joseph Medical Center (Joliet) E-054-17
- Presence St. Mary's Hospital (Kankakee) E-062-17
- Presence Mercy Medical Center (Aurora) E-064-17
- Presence Saint Joseph Hospital (Elgin) E-059-17
- Presence Saint Francis Hospital (Evanston) E-057-17
- Presence Holy Family Medical Center (Des Plaines) E-056-17
- Presence Lakeshore Gastroenterology (Des Plaines) E-055-17
- Belmont/Harlem Surgery Center, LLC (Chicago). E-053-17

In addition, enclosed please find originally-signed "Certification" pages for the following entities, each of which is an applicant on multiple applications:

- Ascension Health
- Alexian Brothers-AHS Midwest Region Health Co. (d/b/a AMITA Health)
- Presence Health Network
- Presence Chicago Hospitals Network
- Presence Central and Suburban Hospitals Network

675 North Court, Suite 210
Palatine, Illinois 60067

Phone (847) 776-7101
Fax (847) 776-7004

Last, enclosed please find a check in the amount of $30,000.00, provided as the required filing and review fees for the twelve COE applications identified above.

Should any additional information be required, please do not hesitate to call me.

Sincerely,

Jacob M. Axel
President

enclosures

cc P. Wendell (w/o enclosures)
A. Sherline (w/o enclosures)

CERTIFICATION

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

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

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

SIGNATURE

Mark A. Frey

PRINTED NAME

President/CEO

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 7th day of November 2017

Signature of Notary

Seal

MARGARET J WENDELL
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
September 05, 2018

SIGNATURE

PAUL E BELTER

PRINTED NAME

SVP/CFO

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 7th day of November 2017

Signature of Notary

Seal

MARGARET J W... L
OFFICIAL S...
Notary Public, St... inois
My Commiss... ires
Septembe... 8

*Insert the EXACT legal name of the applicant

CERTIFICATION

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

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

SIGNATURE

Christine McCoy
PRINTED NAME

Assistant Secretary
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 10th day of November, 2017

Signature of Notary

Seal

ELFRIEDE M. ROHE
Notary Public - Notary Seal
STATE OF MISSOURI
Comm. Number 01505902
St. Louis County
My Commission Expires: July 13, 2020

SIGNATURE

Rhonda Anderson
PRINTED NAME

Assistant Treasurer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 10TH day of NOVEMBER, 2017

Signature of Notary

Seal

PATRICIA D. CHITWOOD
Notary Public - Notary Seal
State of Missouri, St Louis County
Commission Number 12383265
My Commission Expires Aug 15, 2020

*Insert the EXACT legal name of the applicant

CERTIFICATION

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

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

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

M. Englehart
SIGNATURE

Michael Englehart
PRINTED NAME

President and Chief Executive Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 14th day of November

Kimberly A. Rellinger
Signature of Notary

Seal

OFFICIAL SEAL
KIMBERLY A. RELLINGER
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 2/8/18

Jeannie C Frey
SIGNATURE

Jeannie C. Frey
PRINTED NAME

Chief Legal Officer and Secretary
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 14th day of November

Lori B. Brinker
Signature of Notary

Seal

OFFICIAL SEAL
LORI B BRINKER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:04/05/18

*Insert the EXACT legal name of the applicant

CERTIFICATION

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

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

SIGNATURE

James Kelley
PRINTED NAME

Treasurer
PRINTED TITLE

Notarization:
Subscribed and swom to before me
this 14th day of November

Signature of Notary

Seal

OFFICIAL SEAL
LORI B BRINKER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:04/05/18

SIGNATURE

Jeannie C. Frey
PRINTED NAME

Secretary
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 14th day of November

Signature of Notary

Seal

OFFICIAL SEAL
LORI B BRINKER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:04/05/18

*Insert the EXACT legal name of the applicant

CERTIFICATION

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

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

SIGNATURE

James Kelley
PRINTED NAME

Treasurer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 14th day of November

Signature of Notary

Seal

OFFICIAL SEAL
LORI B BRINKER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:04/05/18

SIGNATURE

Jeannie C. Frey
PRINTED NAME

Secretary
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 14th day of November

Signature of Notary

Seal

OFFICIAL SEAL
LORI B BRINKER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:04/05/18

*Insert the EXACT legal name of the applicant

E-054-17

ORIGINAL

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION PERMIT

RECEIVED
DEC 22 2017
HEALTH FACILITIES & SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Belmont/Harlem Surgery Center, LLC—Change of Ownership			
Street Address:	3101 North Harlem Avenue			
City and Zip Code:	Chicago, IL 60634			
County:	Cook	Health Service Area	VI	Health Planning Area: A-03

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

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

Exact Legal Name:	Ascension Health
Street Address:	4600 Edmunson Road
City and Zip Code:	St. Louis, MO 63134
Name of Registered Agent:	Illinois Corporation Service C
Registered Agent Street Address:	801 Adlai Stevenson Drive
Registered Agent City and Zip Code:	Springfield, IL 62703
Name of Chief Executive Officer:	Patricia Maryland
CEO Street Address:	4600 Edmunson Road
CEO City and Zip Code:	St. Louis, MO 63134
CEO Telephone Number:	314/733-8000

Type of Ownership of Applicants

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

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

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

Primary Contact [Person to receive ALL correspondence or inquiries]

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

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

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

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

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

Exact Legal Name:	Presence Health Network
Street Address:	200 S. Wacker Drive, 11th Floor
City and Zip Code:	Chicago, Illinois 60606
Name of Registered Agent:	Kathleen Cronin
Registered Agent Street Address:	18927 Hickory Creek Drive
Registered Agent City and Zip Code:	Mokena, IL 60448
Name of Chief Executive Officer:	Michael Engelhart
CEO Street Address:	200 S. Wacker Drive, 11th Floor
CEO City and Zip Code:	Chicago, Illinois 60606
CEO Telephone Number:	312/308-3291

Type of Ownership of Applicants

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

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
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Primary Contact [Person to receive ALL correspondence or inquiries]

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

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

Name:	Jeannie C. Frey
Title:	Chief Legal Officer and Secretary
Company Name:	Presence Health Network
Address:	200 S. Wacker Drive, 11th Floor Chicago, IL 60606
Telephone Number:	312/308-3291
E-mail Address:	JFrey@presencehealth.org
Fax Number:	312/308-3397

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

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

Exact Legal Name:	Belmont/Harlem Surgery Center, LLC
Street Address:	3101 N. Harlem Avenue
City and Zip Code:	Chicago, IL 60634
Name of Registered Agent:	Faith McHale
Registered Agent Street Address:	3101 N. Harlem Avenue
Registered Agent City and Zip Code:	Chicago, IL 60634
Name of Chief Executive Officer:	Christopher Mahr, MD
CEO Street Address:	3101 N. Harlem Avenue
CEO City and Zip Code: :	Chicago, IL 60634
CEO Telephone Number:	773/889-2000

Type of Ownership of Applicants

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

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

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

Primary Contact [Person to receive ALL correspondence or inquiries]

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

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

Name:	Jeannie C. Frey
Title:	Chief Legal Officer and Secretary
Company Name:	Presence Health Network
Address:	200 S. Wacker Drive, 11th Floor Chicago, IL 60606
Telephone Number:	312/308-3291
E-mail Address:	JFrey@presencehealth.org
Fax Number:	312/308-3397

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

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

Exact Legal Name:	Alexian Brothers-AHS Midwest Region Health Co. d/b/a AMITA Health
Street Address:	3040 West Salt Creek Road
City and Zip Code:	Arlington Heights, IL 60005
Name of Registered Agent:	C T Corporation System
Registered Agent Street Address:	208 S. La Salle Street, Suite 814
Registered Agent City and Zip Code:	Chicago, IL 60604
Name of Chief Executive Officer:	Mark A. Frey
CEO Street Address:	3040 West Salt Creek Road
CEO City and Zip Code:	Arlington Heights, IL 60005
CEO Telephone Number:	847/815-5100

Type of Ownership of Applicants

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

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

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Primary Contact [Person to receive ALL correspondence or inquiries]

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

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

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

Post Exemption Permit Contact

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

Name:	Ms. Peg Wendell
Title:	Sr. Vice President and General Counsel
Company Name:	AMITA Health
Address:	3040 West Salt Creek Road Arlington Heights, IL 60005
Telephone Number:	847/815-5100
E-mail Address:	peg.wendell@amitahealth.org
Fax Number:	

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Presence Health Services

Address of Site Owner: 200 S. Wacker Drive 11th Floor Chicago, IL 60606

Street Address or Legal Description of the Site: 3101 N. Harlem Avenue Chicago, IL 60634

Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.

APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

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

Exact Legal Name: Belmont/Harlem Surgery Center, LLC

Address: 3101 N. Harlem Avenue Chicago, IL 60634

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

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

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

Organizational Relationships

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

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

Flood Plain Requirements

[Refer to application instructions.] **NOT APPLICABLE**

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at **www.FEMA.gov** or **www.illinoisfloodmaps.org**. **This map must be in a readable format**. In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 **(http://** www.illinois.gov/sites/hfsrb).

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

Historic Resources Preservation Act Requirements

[Refer to application instructions.] **NOT APPLICABLE**

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

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

DESCRIPTION OF PROJECT

1. Project Classification

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

Part 1110 Classification:

- [X] Change of Ownership
- [ ] Discontinuation of an Existing Health Care Facility or of a category of service
- [ ] Establishment or expansion of a neonatal intensive care or beds

2. Narrative Description

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

Through a proposed Definitive Agreement ("the Agreement"), Ascension Health or one or more of its subsidiaries will assume ownership and control of the acute care and long term care facilities, ambulatory surgical treatment centers ("ASTC's") and other entities currently owned and controlled by Presence Health Network ("Presence"). The ten Presence hospitals and the two ASTCs that Presence controls and that are included in the Agreement will operate as components of AMITA Health ("AMITA"). The facilities' license holders/licensees will not change.

This Certificate of Exemption ("COE") application addresses the change of ownership and control of Belmont/Harlem Surgery Center, LLC, located at 3101 North Harlem Avenue in Chicago, Illinois.

Key points of the Agreement include:

1. The transaction will address the following types of facilities and services requiring a HFSRB approval through the Certificate of Exemption process: acute care hospitals and ambulatory surgery facilities; and the following types of facilities and services not requiring HFSRB approval: physician groups, home health, hospice, educational institutions and programs, and skilled nursing and senior care or residence facilities.

2. The change of control transaction will occur through a membership substitution for Presence, the current ultimate system parent of the Presence hospitals and ASTCs, through which (i) Ascension Health, or a newly formed subsidiary thereof (hereinafter, "Newco"), will become the sole corporate member of Presence and (ii) Ascension Living, a subsidiary of Ascension Health, shall become the sole corporate member of the Presence entities providing long-term care or senior-related services. Ascension Health is further exploring the possibility of merging Alexian Brothers Health System, a subsidiary of Ascension Health, into Presence and changing the name of the merged entity to Presence Alexian Brothers Health System (formerly known as "Presence Health Network"). Certain members of the current Presence Board will be asked to either remain members of the Presence Board post the transaction or become members of the Board of Newco.

3. The membership substitutions described in paragraph 2 above will be accomplished through amendments to existing governing documents.

4. Presence acute care facilities and services, ambulatory care facilities and services, and physician groups will be operated as a part of AMITA.

5. Ascension Health will assure capital investments are made for routine needs, conversion of EHR and ERP systems, and strategic initiatives.

6. The transaction will strengthen the ministry of Catholic health care in the Chicagoland region.

7. All entities will maintain their Catholic identities will operate as Catholic organizations, and abide by the *Ethical and Religious Directives for Catholic Health Care Services.*

8. The transaction will enhance and assure the ability of Presence facilities and services to continue to serve the health care and related needs of their communities through the provision of high quality, affordable, and accessible health care services.

9. The transaction will act to further the respective charitable and educational purposes of the parties.

10. A plan relating to employees' credit for prior service to Presence entities will be implemented.

The transaction addressed in this application is limited to the change of ownership and control of an IDPH-licensed health care facility, and as such, qualifies for review as a Certificate of Exemption.

Related Project Costs

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

Land acquisition is related to project ☐ Yes ☐ No **NOT APPLICABLE**

Purchase Price: $_____

Fair Market Value: $_____

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

☐ Yes X No

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

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

Project Status and Completion Schedules

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

Indicate the stage of the project's architectural drawings:

X None or not applicable ☐ Preliminary

☐ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): ___April 31, 2018_____

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

NOT APPLICABLE

☐ Purchase orders, leases or contracts pertaining to the project have been executed.

☐ Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies

☐ Financial Commitment will occur after permit issuance.

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

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable:

X Cancer Registry

X APORS

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

X All reports regarding outstanding permits

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

CERTIFICATION

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

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

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

SIGNATURE

Christine McCoy
PRINTED NAME

Assistant Secretary
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 10th day of November, 2017

Signature of Notary

Seal

ELFRIEDE M. ROHE
Notary Public - Notary Seal
STATE OF MISSOURI
Comm. Number 01505902
St. Louis County
My Commission Expires July 13, 2020

SIGNATURE

Rhonda Anderson
PRINTED NAME

Assistant Treasurer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 10TH day of NOVEMBER, 2017

Signature of Notary

Seal

PATRICIA D. CHITWOOD
Notary Public - Notary Seal
State of Missouri, St Louis County
Commission Number 12383265
My Commission Expires Aug 15, 2020

*Insert the EXACT legal name of the applicant

CERTIFICATION

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

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

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

Michael Englehart
SIGNATURE

Michael Englehart
PRINTED NAME

President and Chief Executive Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 14th day of November

Kimberly A. Rellinger
Signature of Notary

Seal

OFFICIAL SEAL
KIMBERLY A. RELLINGER
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 2/8/18

Jeannie C. Frey
SIGNATURE

Jeannie C. Frey
PRINTED NAME

Chief Legal Officer and Secretary
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 14th day of November

Lori B. Brinker
Signature of Notary

Seal

OFFICIAL SEAL
LORI B BRINKER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:04/05/18

*Insert the EXACT legal name of the applicant

CERTIFICATION

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

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

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

SIGNATURE

Dana Gilbert
PRINTED NAME

Manager
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 20th day of November

Lori B. Brinker
Signature of Notary

Seal

OFFICIAL SEAL
LORI B BRINKER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:04/05/18

SIGNATURE

Robert Dahl
PRINTED NAME

Manager
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 14 day of November, 2017

L Krawczyk
Signature of Notary

Seal

OFFICIAL SEAL
L KRAWCZYK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:11/14/19

*Insert the EXACT legal name of the applicant

CERTIFICATION

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

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

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

SIGNATURE

Mark A. Frey

PRINTED NAME

President/CEO

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 7th day of November 2017

Signature of Notary

Seal

MARGARET J WENDELL
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
September 05, 2018

SIGNATURE

PAUL E BEZEK

PRINTED NAME

SVP/CFO

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 7th day of November 2017

Signature of Notary

Seal

MARGARET J W... L
OFFICIAL S...
Notary Public, Sta... inois
My Commiss... ires
Septembe... 8

*Insert the EXACT legal name of the applicant

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

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

Background

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

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

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

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

NOT APPLICABLE

PURPOSE OF PROJECT

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

achieving the stated goals **as appropriate**.

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

NOTE: Information regarding the "Purpose of the Project" will be included in the State Board Report.
APPEND DOCUMENTATION AS ATTACHMENT 12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

NOT APPLICABLE

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

Alternative options **must** include:

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

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

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

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

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

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

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

SECTION V. CHANGE OF OWNERSHIP (CHOW)

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

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

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

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

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

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

Application for Change of Ownership Among Related Persons

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

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

SECTION VII. 1120.130 - FINANCIAL VIABILITY

NOT APPLICABLE

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

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

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

	Historical 3 Years			Projected
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

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

2. Variance

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

obligations should the applicant default.

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

SECTION VIII. 1120.140 - ECONOMIC FEASIBILITY

NOT APPLICABLE

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

A. Reasonableness of Financing Arrangements

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

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

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

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

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

B. Conditions of Debt Financing

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

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

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

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

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

NOT APPLICABLE

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

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

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

SECTION IX. SAFETY NET IMPACT STATEMENT (DISCONTINUATION ONLY)

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

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

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

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

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

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

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

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

A table in the following format must be provided as part of Attachment 40.

NOT APPLICABLE

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

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

SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

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

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

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

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

Belmont/Harlem Surgery Center, LLC

CHARITY CARE			
	2014	**2015**	**2016**
Net Patient Revenue	**$3,188,815**	**$3,942,160**	**$3,732,266**
Amount of Charity Care (charges)			
Cost of Charity Care	$0	$0	$0

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

SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

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

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.

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3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

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

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

Presence Holy Family Hospital

CHARITY CARE			
	2014	**2015**	**2016**
Net Patient Revenue	**$76,433,375**	**$69,586,245**	**$66,443,333**
Amount of Charity Care (charges)	$3,943,801	$222,461	$2,255,848
Cost of Charity Care	$771,013	$460,355	$441,092

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

SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

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

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3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

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

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

Presence Mercy Medical Center

CHARITY CARE			
	2014	**2015**	**2016**
Net Patient Revenue	**$184,786,001**	**$173,471,950**	**$185,662,250**
Amount of Charity Care (charges)	$34,260,134	$29,885,457	$36,903,020
Cost of Charity Care	$5,622,088	$5,421,983	$6,050,491

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

SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

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

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

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

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

Presence Resurrection Medical Center

CHARITY CARE			
	2014	**2015**	**2016**
Net Patient Revenue	**$237,542,999**	**$257,729,252**	**$264,576,914**
Amount of Charity Care (charges)	$27,761,453	$22,922,240	$18,571,646
Cost of Charity Care	$4,949,867	$4,492,981	$3,321,912

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

SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

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

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.

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3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

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

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

Presence Saint Joseph Hospital
Elgin

CHARITY CARE			
	2014	**2015**	**2016**
Net Patient Revenue	**$134,898,999**	**$132,597,966**	**$148,323,932**
Amount of Charity Care (charges)	$22,234,047	$21,617,399	$20,728,074
Cost of Charity Care	$3,839,820	$4,181,813	$3,402,216

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

SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

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

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

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

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

Presence Saint Joseph Hospital-Chicago

CHARITY CARE			
	2014	**2015**	**2016**
Net Patient Revenue	**$194,424,001**	**$203,357,193**	**$203,939,322**
Amount of Charity Care (charges)	$13,524,341	$10,750,603	$9,569,562
Cost of Charity Care	$2,679,172	$3,128,453	$2,145,618

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

SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

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

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.

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

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

Presence Saint Francis Hospital

CHARITY CARE			
	2014	**2015**	**2016**
Net Patient Revenue	**$145,949,009**	**$164,750,923**	**$173,355,470**
Amount of Charity Care (charges)	$41,695,821	$21,880,375	$22,691,367
Cost of Charity Care	$6,904,828	$4,631,770	$4,000,556

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

SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

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

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

Presence Saint Joseph Medical Center

CHARITY CARE			
	2014	**2015**	**2016**
Net Patient Revenue	**$375,960,998**	**$349,215,843**	**$378,696,949**
Amount of Charity Care (charges)	$52,088,514	$41,754,548	$42,334,283
Cost of Charity Care	$9,391,559	$7,849,352	$7,428,236

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

SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

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

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

Presence Saints Mary and Elizabeth Medical Center

CHARITY CARE			
	2014	**2015**	**2016**
Net Patient Revenue	**$270,532,798**	**$272,669,684**	**$304,874,152**
Amount of Charity Care (charges)	$51,412,650	$39,232,810	$36,373,058
Cost of Charity Care	$10,010,043	7,961,698	$6,916,782

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

SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

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

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.

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3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

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

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

Presence St. Mary's Hospital

CHARITY CARE			
	2014	**2015**	**2016**
Net Patient Revenue	**$110,166,000**	**$109,622,889**	**$118,438,780**
Amount of Charity Care (charges)	$16,601,153	$17,119,961	$13,900,377
Cost of Charity Care	$2,936,744	$3,237,561	$2,224,727

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

SECTION X. CHARITY CARE INFORMATION (CHOW ONLY)

NOT APPLICABLE, FACILITY WAS NOT OPERATIONAL

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

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

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

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

Presence Lakeshore Gastroenterology, LLC

CHARITY CARE			
	2014	2015	2016
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

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

File Number 6783-860-2

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

ASCENSION HEALTH, INCORPORATED IN MISSOURI AND LICENSED TO CONDUCT AFFAIRS IN THIS STATE ON JUNE 27, 2011, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO CONDUCT AFFAIRS IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 31ST *day of* MARCH *A.D.* 2017 .

Authentication #: 1709001850 verifiable until 03/31/2018
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

ATTACHMENT 1

File Number 2595-936-1

To all to whom these Presents Shall Come, Greeting:

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

PRESENCE HEALTH NETWORK, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JANUARY 05, 1939, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 23RD *day of* JUNE *A.D.* 2017 .

Authentication #: 1717402660 verifiable until 06/23/2018
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

ATTACHMENT 1

File Number 0195292-7

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

BELMONT/HARLEM SURGERY CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON AUGUST 25, 2006, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 21ST *day of* SEPTEMBER *A.D.* 2017 .

Jesse White

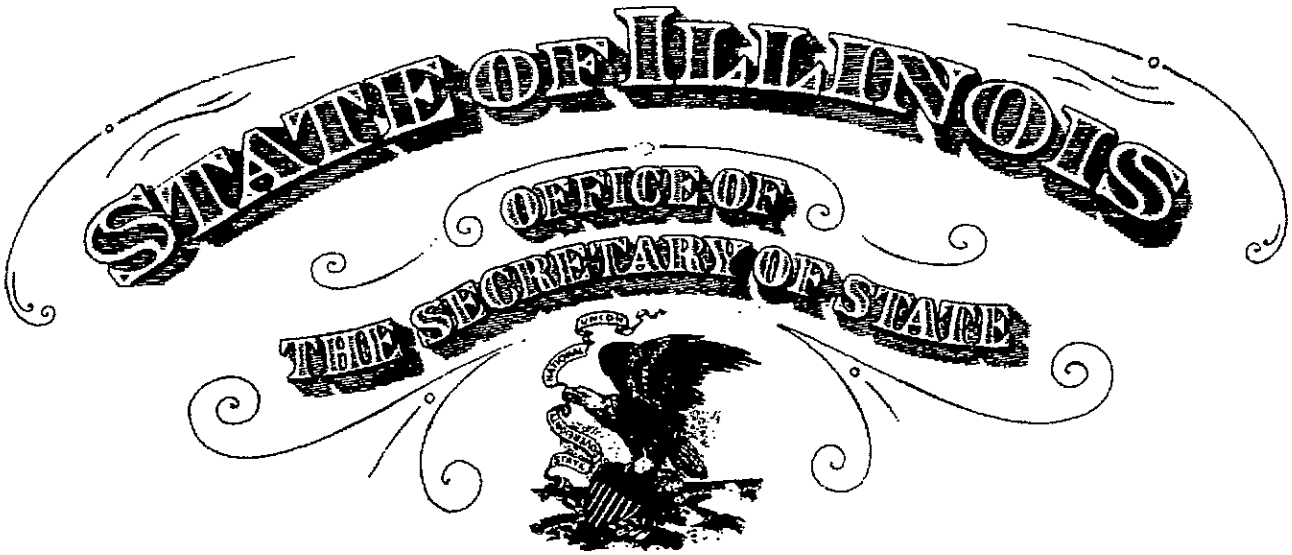
SECRETARY OF STATE

Authentication #: 1726401912 verifiable until 09/21/2018

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

ATTACHMENT 1

File Number 6964-462-7



To all to whom these Presents Shall Come, Greeting:

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

ALEXIAN BROTHERS-AHS MIDWEST REGION HEALTH CO., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON SEPTEMBER 26, 2014, ADOPTED THE ASSUMED NAME AMITA HEALTH ON APRIL 14, 2015, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 31ST *day of* MARCH *A.D.* 2017 .

Jesse White

SECRETARY OF STATE

Authentication #: 1709001842 verifiable until 03/31/2018

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

ATTACHMENT 1

SITE OWNERSHIP

Belmont/Harlem Surgery Center's site is owned by Presence Healthcare Services. There will be no change of the direct owner of the site as a result of the proposed transaction.

Jeannie C. Frey
Chief Legal Officer and Secretary
Presence Health Network

Subscribed and sworn to me
This 15th day of November, 2017

Lori B. Brinker
Notary Public

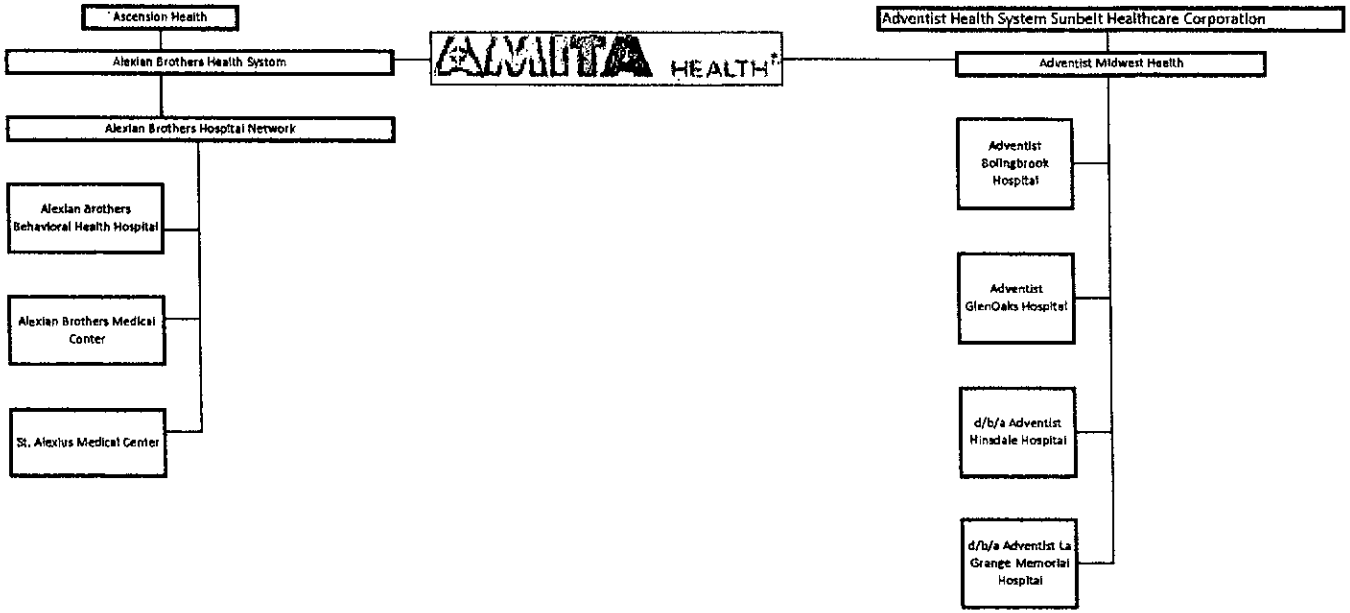
OFFICIAL SEAL
LORI B BRINKER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:04/05/18

OPERATING IDENTITY/LICENSEE

The following individuals each own a 5.0% ownership interest in the Licensee:

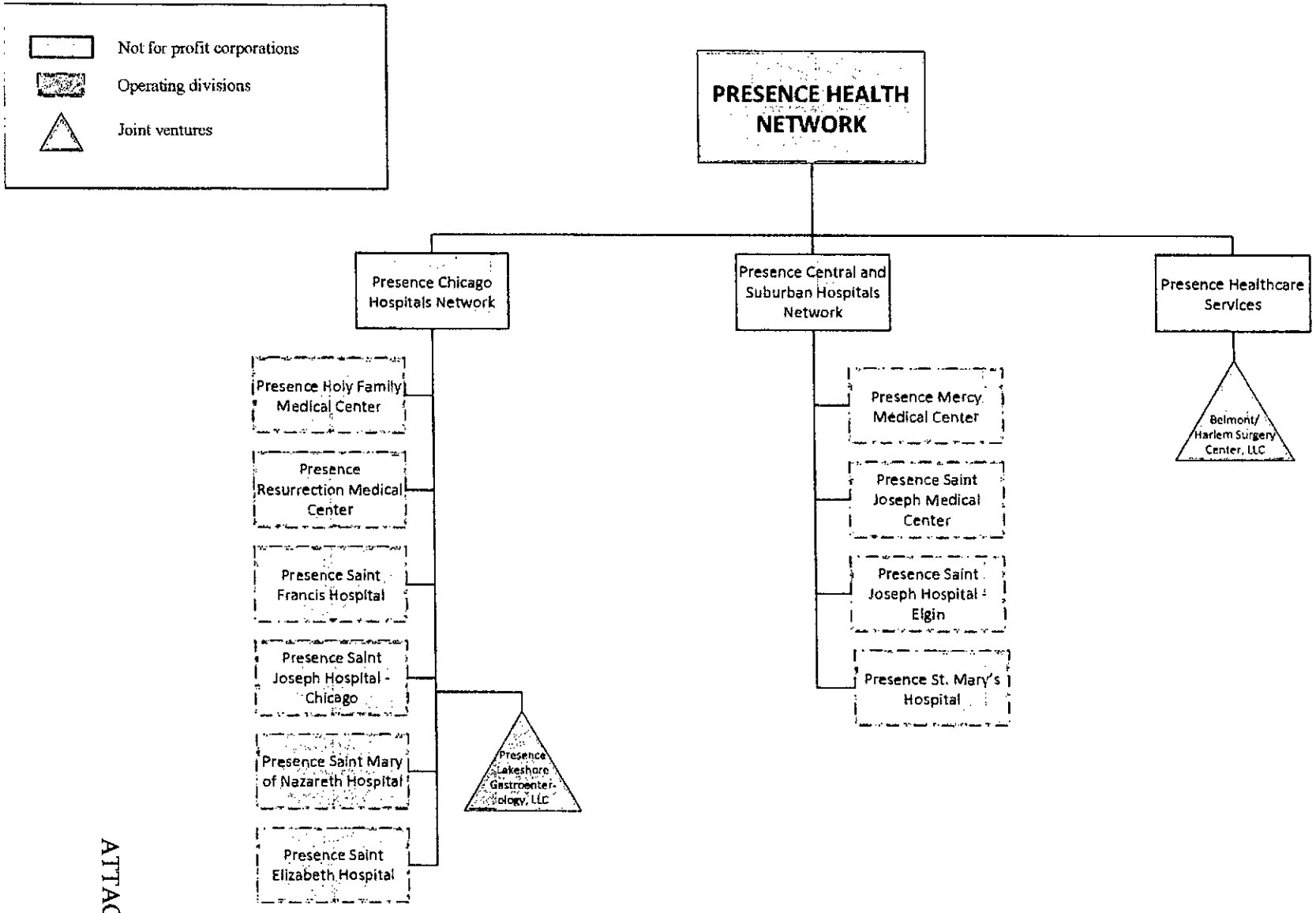
• Jasmeet Dhaliwal, MD	7435 Talcott Avenue Chicago, IL
• Todd Rimmington, MD	7435 Talcott Avenue Chicago, IL
• Mark Sokolowski, MD	1 Erie Court Oak Park, IL
• Brian McCall, MD	7447 Talcott Avenue Chicago, IL
• Christopher Mahr, MD	7447 Talcott Avenue Chicago, IL
• Gregory Fahrenbach, MD	1220 Lawrence Avenue Chicago, IL

ATTACHMENT 3



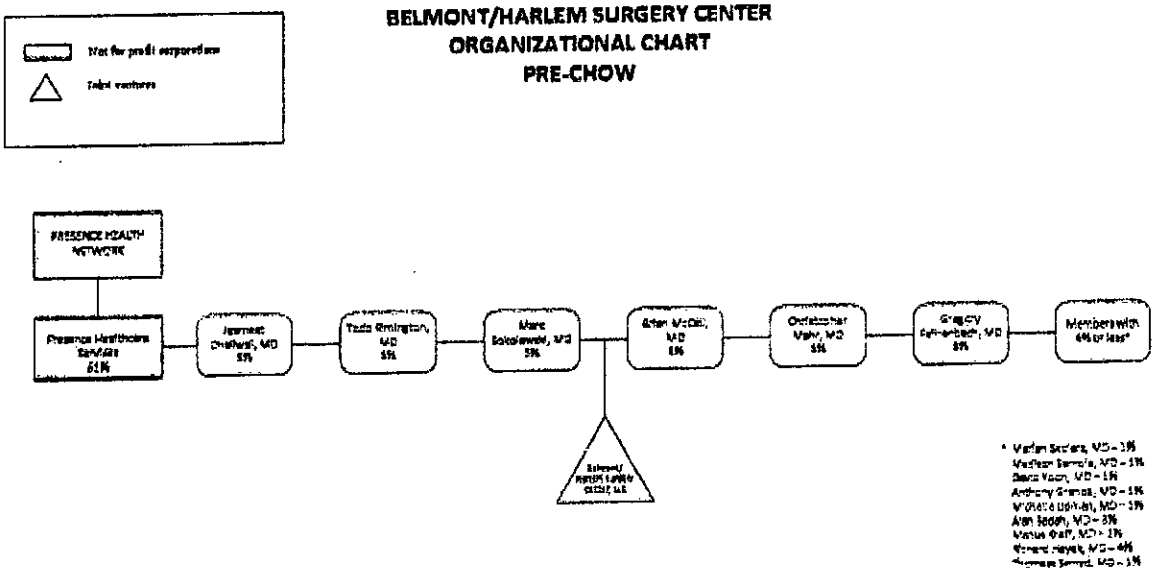
ATTACHMENT 4

PRESENCE HEALTH ORGANIZATIONAL CHART
PRE-CHOW

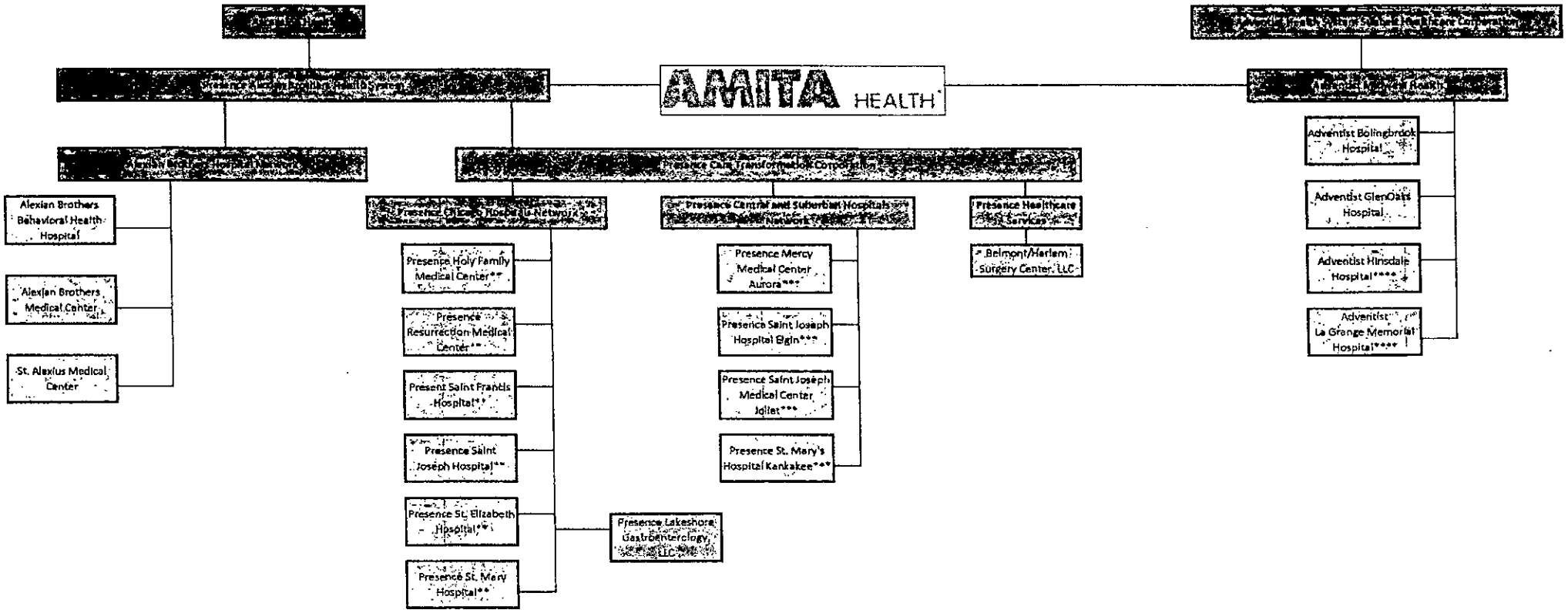


ATTACHMENT 4

BELMONT/HARLEM SURGERY CENTER
ORGANIZATIONAL CHART
PRE-CHOW



Proposed Organization



d/b/a AMITA Health Medical Group
d/b/a Presence Chicago Hospitals Network
* d/b/a Presence Central and Suburban Hospitals Network
** d/b/a Adventist Midwest Health

ATTACHMENT 4

BACKGROUND

Ascension Health owns, operates and/or controls* the following Illinois licensed health care facilities:

AMITA Health Adventist Medical Center Bolingbrook
Bolingbrook, IL IDPH #5496

AMITA Health Adventist Medical Center GlenOaks
Glendale Heights, IL IDPH #3814

AMITA Health Adventist Medical Center Hinsdale
Hinsdale, IL IDPH #0976

AMITA Health Adventist Medical Center La Grange
La Grange, IL IDPH #5967

AMITA Health Alexian Brothers Medical Center Elk Grove Village
Elk Grove Village, IL IDPH #2238

AMITA Health St. Alexius Medical Center Hoffman Estates
Hoffman Estates, IL IDPH #5009

AMITA Health Alexian Brothers Behavioral Health Hospital
Hoffman Estates, IL

Presence Health Network owns, operates, and/or controls* the following Illinois licensed health care facilities:

Presence Holy Family Medical Center
Des Plaines, IL

Presence Resurrection Medical Center
Chicago, IL IDPH #6031

Presence Saint Francis Hospital
Evanston, IL IDPH #5991

Presence Covenant Medical Center
Urbana, IL IDPH #4861

Presence United Samaritans Medical Center
Danville, IL IDPH #4853

Presence Saint Joseph Hospital-Chicago
Chicago, IL IDPH #5983

Presence Mercy Medical Center
Aurora, IL IDPH #4903

Presence Saint Joseph Hospital-Elgin
Elgin, IL IDPH #4887

Presence Saint Joseph Medical Center
Joliet, IL IDPH #4838

Presence St. Mary's Hospital
Kankakee, IL IDPH #4879

Presence Saint Mary of Nazareth Hospital
Chicago, IL IDPH #6007

Presence Saint Elizabeth Hospital
Chicago, IL IDPH #6007

Presence Lakeshore Gastroenterology
Des Plaines, IL

Belmont/Harlem Surgery Center
Chicago, IL IDPH #7003131

Presence Arthur Merkel and Clara Knipprath Nursing Home
Clifton, IL IDPH #21832

Presence Villa Scalabrini Nursing and Rehabilitation Center
Northlake, IL IDPH #44792

Presence Villa Franciscan
Joliet, IL IDPH# 42861

Presence Saint Joseph Center
Freeport, IL IDPH # 41871

Presence Saint Benedict Nursing and Rehabilitation Center
Niles, IL IDPH #44784

Presence Saint Anne Center
Rockford, IL IDPH #41731

Presence Resurrection Nursing and Rehabilitation Center
Park Ridge, IL IDPH #44362

Presence Resurrection Life Center
Chicago, IL IDPH #44354

Presence Pine View Care Center
St. Charles, IL IDPH #43430

Presence Our Lady of Victory Nursing Home
Bourbonnais, IL IDPH # 41723

Presence Nazarethville
Des Plaines, IL IDPH #54072

Presence McCauley Manor
Aurora, IL IDPH #42879

Presence Maryhaven Nursing Home and Rehabilitation Center
Glenview, IL IDPH #44768

Presence Heritage Village
Kankakee, IL IDPH #42457

Presence Cor Mariae Center
Rockford, IL IDPH #41046

*per HFSRB definition

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

Dear Ms. Avery:

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

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

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

Sincerely,

Mark A. Frey
President and
Chief Executive Officer

Date: April 11, 2017

Notarized:

DONNA GAUTHIER
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
June 17, 2018

ATTACHMENT 11

BACKGROUND OF THE APPLICANT

Belmont/Harlem Surgery Center does hereby attest no adverse action, as that term is defined in the rules of the Illinois Health Facilities and Services Review Board, has been taken against it in the three (3) years preceding this application.

In addition, it authorizes the HFSRB and IDPH to access information necessary to verify information submitted in this application.

Jeannie C. Frey
Chief Legal Officer and Secretary
Presence Health Network

Subscribed and sworn to before me
This 15th day of November, 2017

Notary Public

<Seal>
OFFICIAL SEAL
LORI B BRINKER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:04/06/18

HF112977

Illinois Department of PUBLIC HEALTH

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

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

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
4/30/2018		7003131

Ambulatory Surgery Treatment Center

Effective: 05/01/2017

Belmont/Harlem Surgery Center, LLC
3101 North Harlem Avenue
Chicago, IL 60634

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

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 4/30/2018

Lic Number 7003131

Date Printed 3/21/2017

Belmont/Harlem Surgery Center, LLC

3101 North Harlem Avenue
Chicago, IL 60634

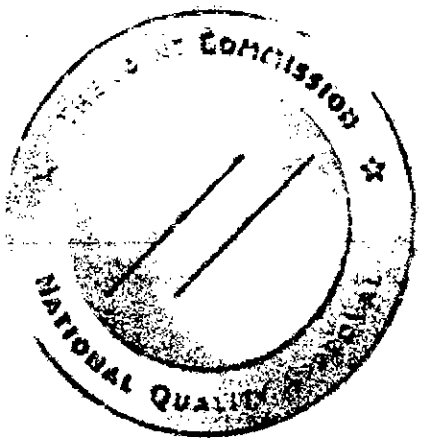
FEE RECEIPT NO.

ATTACHMENT 11

Belmont/Harlem Surgical Center, LLC

Chicago, IL

has been Accredited by



The Joint Commission

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

Ambulatory Health Care Accreditation Program

February 25, 2016

Accreditation is customarily valid for up to 36 months.

Rebecca J. Patchin, MD
Chair, Board of Commissioners

ID #452703
Print/Reprint Date: 04/12/2016

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

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

ATTACHMENT 11

SECTION V
CHANGE OF OWNERSHIP (CHOW)
Belmont/Harlem Surgery Center

Applicable Review Criteria

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

1. Presence Chicago Hospitals Network, the entity that is and will remain the ambulatory surgery treatment center's ("ASTC's) License Holder
2. Alexian Brothers-AHS Midwest Region Health Co. (d/b/a AMITA Health) which will meet the IDPH definition of control found in Section 1130.140, through its power to approve the use of the ASTC's funds, among other qualifications of having "control"
3. Presence Health Network, the entity currently having "final control" of the ASTC
4. Ascension Health, the entity that will have "final control" over the ASTC following the change of ownership.

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

1. Listings of Illinois Health Care Facilities owned by the applicants
2. A certification from each applicant that no adverse actions have been taken again any facility owned and/or operated in Illinois by the applicant during the past three years.
3. Each applicants' authorization permitting HFSRB and IDPH access to documents necessary to verify the information submitted.

Criterion 1130.520(b)(1)(C) Structure of transaction
The transaction is structured as a series of membership substitutions.

Criterion 1130.520(b)(1)(D) Name of the person who will be licensed or certified entity after the transaction
The license holder, as identified in Section I of this Certificate of Exemption Permit application will not change following the transaction.

Criterion 1130.520(h)(1)(E) List of the ownership or membership interests in such licensed or certified entity both prior to and after the transaction, including a description of the applicant's organization structure with a listing of controlling or subsidiary persons.
Current and post-closing organizational charts are provided in ATACHMENT 4, identifying all applicable Illinois facilities. Presence Health Network currently holds a 70% ownership interest in the ASTC, and upon the finalizing of the transaction, 70% of the ASTC will be owned by Ascension Health.

Criterion 1130.520(b)(1)(F) Fair market value of assets to be transferred
The health care facility's value, per its August 31, 2017 balance sheet is $1,312,084.51. This amount is identified as the ASTC's fair market value for purposes of this Certificate of Exemption application, exclusively.

Criterion 1130.520(b)(1)(G) The purchase price or other forms of consideration to be provided for those assets
Money will not change hands as a result of the proposed change of ownership and control. However, Ascension Health will assure capital investments are made for routine needs, conversion of EHR and ERP systems, and strategic initiatives.

Criterion 1130.520(b)(2) Affirmation that any projects for which Permits have been issued have been completed or will be completed or altered in accordance with the provisions of this Section.
As of the time of this Certificate of Exemption application filing, the applicants have four active Certificate of Need Permits, with Ascension Health named as a Permit holder:

- CON Permit 17-020, AMITA Health Bartlett Medical Clinics Building (Bartlett), establishment of a medical clinics building, scheduled for completion January 31, 2019
- CON Permit 17-021, AMITA Health Woodridge Medical Clinics Building (Woodridge), establishment of a medical clinics building, scheduled for completion January 31, 2019
- CON Application 17-028, AMITA Health Adventist Medical Center La Grange, modernization program, scheduled for IHFSRB consideration on November 14, 2017
- CON Application 17-046, AMITA Health St. Alexius Medical Center (Hoffman Estates), modernization program, scheduled for IHFSRB consideration on November 14, 2017

As of the time of the filing of this Certificate of Exemption application, two Certificate of Exemption applications have been approved by the IHFSRB, but the associated transaction has yet to be completed, and a notification has yet to be filed:

- COE Application E-044-17, Presence Covenant Medical Center (Urbana), change of ownership, anticipated completion date of "on or around" February 1, 2018.
- COE Application E-045-17, Presence United Samaritans Medical Center (Danville), change of ownership, anticipated completion date of "on or around" February 1, 2018.

As of the time of this Certificate of Exemption application filing, the applicants have two active Certificate of Need Permits, with Presence Health Network named as a Permit holder:

- CON Permit 13-011, Presence Saint Joseph Hospital Chicago, construction and renovation project, final report due January 18, 2018
- CON Permit 15-005, Presence Lakeshore Gastroenterology Des Plaines, establishment of a limited specialty ambulatory surgery treatment center, scheduled for completion December 31, 2017

By its respective signatures on the Certification Page of this Certificate of Exemption application, Ascension Health and Presence Health Network affirm that each Certificate of Need Permit or project and each Certificate of Exemption identified above will be completed consistent with rules of the Illinois Health Facilities and Services Review Board.

Criterion 1130.520(b)(2) If the ownership change is for a hospital, affirmation that the facility will not adopt a more restrictive charity care policy than the charity care policy that was in effect one year prior to the transaction. The hospital must provide affirmation that the compliant charity care policy will remain in effect for a two-year period following the change of ownership transaction.

Not Applicable

Criterion 1130.520(b)(2) A statement as to the anticipated benefits of the proposed changes in ownership to the community

The communities of northeastern Illinois, and particularly persons living in poverty within the service area, will benefit from the efficiencies to be realized through the consolidation of two like-minded partners with similar values and a common desire to increase access to quality health care while reducing the cost of that care. In addition to the facilities addressed in the Certificate of Exemption applications filed with the HFSRB, the proposed transaction would integrate networks of outpatient facilities and programs, well-established and extensive physician networks, and highly-successful Accountable Care Organizations, while facilitating the sharing best practices; all targeting better outcomes and better value.

Criterion 1130.520(b)(2) The anticipated or potential cost savings, if any, that will result for the community and facility because of the change in ownership.

Savings are anticipated for both the ASTC and the community, however, neither amount has been quantified to date.

Criterion 1130.520(b)(2) A description of the facility's quality improvement mechanism that will be utilized to ensure quality control

Both Ascension Health and Presence Health Network place great importance in quality control, with each system implementing best practices models through the individual systems' facilities and programs. Quality improvement mechanisms will not initially change, but will be evaluated against parallel programs in use at Ascension Health facilities, with adjustments being made as appropriate. That process will evolve into a single ongoing process for all of the facilities operated by AMITA, and will address clinical as well as non-clinical opportunities for improvement.

Criterion 1130.520(b)(2) A description of the selection process that the acquiring entity will use to select the facility's governing body

Not Applicable

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

The applicants have prepared a written response, which is available for public view at the facility.

Criterion 1130.520(b)(2) A description or summary of any proposed changes to the scope of services or levels of care currently provided at the facility that are anticipated to occur within 24 months after acquisition.

None are currently anticipated.